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.

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

Larry Meredith, Ph.D.
DIRECTOR

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APPROVED
JUL 8 2014
MARIN COUNTY
BOARD OF SUPERVISORS

July 8, 2014

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

SUBJECT: Department of Health and Human Services, Division of Mental Health and Substance Use Services: Approve the Mental Health Services Act (MHSA) FY 2014-15 Annual Update

Dear Supervisors:

RECOMMENDATION: Authorize the President to approve the Mental Health Services Act (MHSA) FY 2014-15 Annual Update.

SUMMARY: In FY 2014-15, approximately $11,253,843 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 and substance use issues in primary care settings, and youth activities ($1,900,500);
- Community Services and Supports (CSS) programs such as case management for older adults, homeless individuals and the Support and Treatment After Release (STAR) program focusing on alternatives to incarceration ($7,035,675);
- Innovation Programs for culturally appropriate innovative programs that can further work to reduce stigma and discrimination ($621,055);
- Capital Facilities and Technological Needs (CFTN) programs such as an electronic health record, scanning capability and other practice management programs ($1,264,058);
- Workforce, Education and Training programs such as our American Psychological Association (APA) accredited intern program and culturally appropriate trainings for consumers, family members and providers of service ($432,555).

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 process be approved, after a public comment period by the Mental Health Board and then by the County Board of Supervisors. Outcomes for FY 2012-13 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 FY 2014-15 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 Act webpage for public comment and feedback beginning on Friday, April 11, 2014 and ending on Saturday, May 10, 2014. On Tuesday, May 13, 2014, the Mental Health and Alcohol and Other Drug Joint Board provided their recommendations and a legal notice ran in the Marin Independent Journal (IJ) seeking public comment and feedback as well. All input has been considered with adjustments made, as appropriate and incorporated into the FY 2014-15 MHSA Annual Update.

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 for on-going costs in the Annual Update are included in the existing community mental health budget in the Mental Health Prop 63 Funds Center 1000047000. There is no additional net county cost associated with this request.

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

Complete documentation is available at the Clerk's Office, Room 329

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Marin County

☐ Three-Year Program and Expenditure Plan

X Annual Update

☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Suzanne Tavano	Name: Roy Given
Telephone Number: 415.473.7595	Telephone Number: 415.473.3736
E-mail: STavano@MarinCounty.org	E-mail: RGiven@MarinCounty.org
Local Mental Health Mailing Address: County of Marin Department of Health and Human Services Mental Health and Substance Use Services Division 3240 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, 5847, 5891 and 5892; and Title 9 of the California Code of Regulations section 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 counties in future years.

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

Suzanne Tavano — Local Mental Health Director (PRINT)

Suzanne Tavano — Signature — 7/21/14 — Date

I hereby certify that for the fiscal year ended June 30, 2014, 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 1/31/14 for the fiscal year ended June 30, 2013. I further certify that for the fiscal year ended June 30, 2014, 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 if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

County Auditor Controller — County Auditor Controller / City Financial Officer (PRINT)

Roy Given — Signature — 7/25/2014 — Date

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Marin County

Local Mental Health Director	Program Lead
Name: Suzanne Tavano	Name: Kasey Clarke
Telephone Number: 415.473.7595	Telephone Number: 415.473.7465
E-mail: STavano@MarinCounty.org	E-mail: KClarke@MarinCounty.org
County Mental Health Mailing Address: County of Marin Department of Health and Human Services Mental Health and Substance Use Services Division 3240 Kerner Boulevard San Rafael, CA 94901	

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

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on July 8, 2014.

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

All documents in the attached annual update are true and correct.

Suzanne Tavano — Local Mental Health Director/Designee (PRINT)

Suzanne Tavano 7/21/14 — Signature — Date

County: Marin County

Date: 7/21/14

COUNTY OF MARIN

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MENTAL HEALTH SERVICES ACT

WELLNESS • RECOVERY • RESILIENCE

FY2014-2015
ANNUAL UPDATE

Reporting MHSA FY2012-2013
Programs and Outcomes

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

Mental Health Services Act (MHSA) brings resources and guiding principles to assist in the transformation of the mental health system here in Marin County. An incredible amount of work has gone into developing and implementing the MHSA programs discussed in this report. This report covers the period of July 1, 2012 through June 30, 2013 and includes the program overviews, accomplishments and challenges.

Marin County Health and Human Services, Mental Health and Substance Use 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. As detailed in the MHSA Three Year Plan for FY2014-15 through FY2016-17, Marin recently did an extensive community input process to hear feedback on current services and support as well as recommendations for new services beginning in FY2014-15.

Mental Health Services Act (MHSA)

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:

https://www.marinhhs.org/mhsa

or by calling 415-473-7465 to request a paper copy by mail.

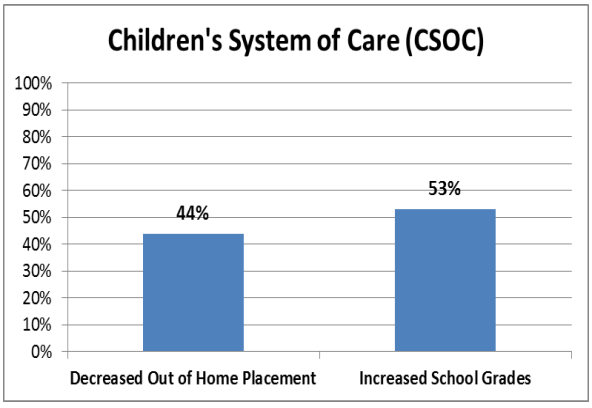
Fiscal Year 2014-2015 Annual Update Overview

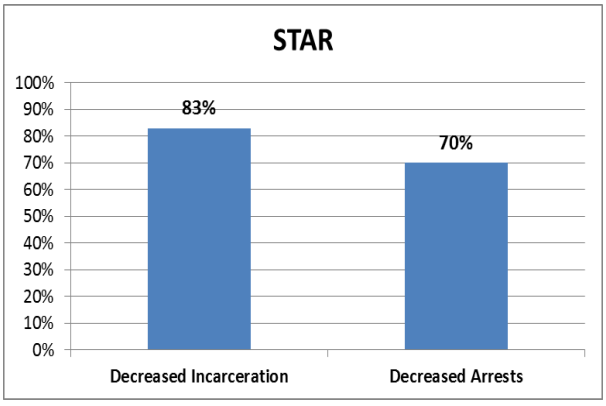
MHSA provides an opportunity to transform the mental health system in alignment with the MHSA principles. MHSA has facilitated an increase in community collaboration, as evidenced by the strong involvement in the planning processes and implementation committees. Consumers and families have been especially 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 have further increased access to culturally competent services.

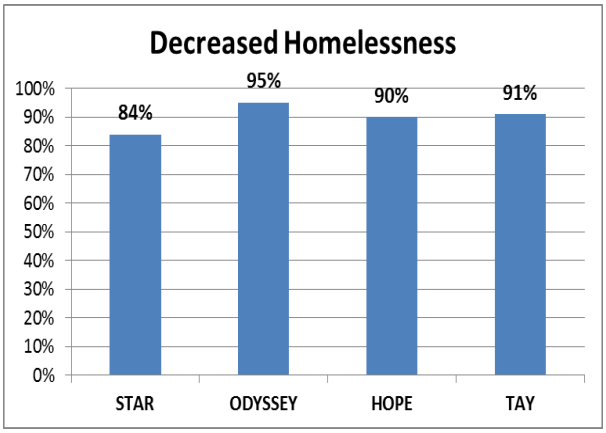
Community Services and Supports (CSS)

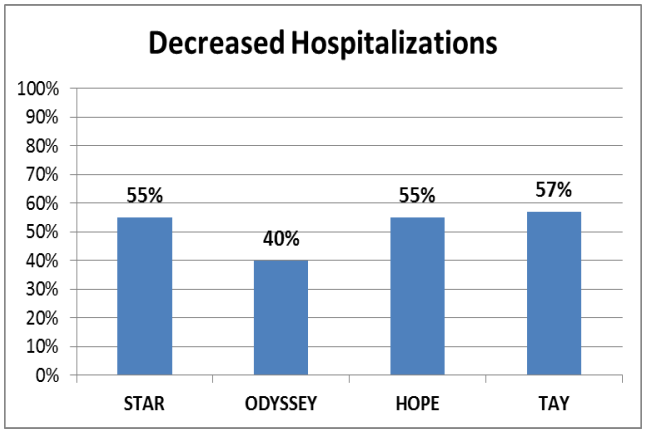
CSS programs have led to a variety of outcomes for participants. These charts below show some highlights from the Marin CSS Full Service Partnerships (FSPs).

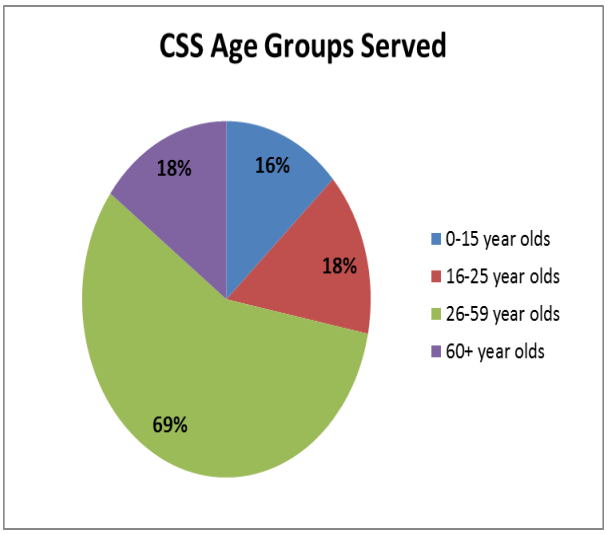
These charts report cumulative outcomes since the beginning of the CSS program. Percentages are calculated based on the number of clients within each program for whom the measure is appropriate, i.e., only those for whom there was data reported for each measure during the 12 months prior to enrollment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

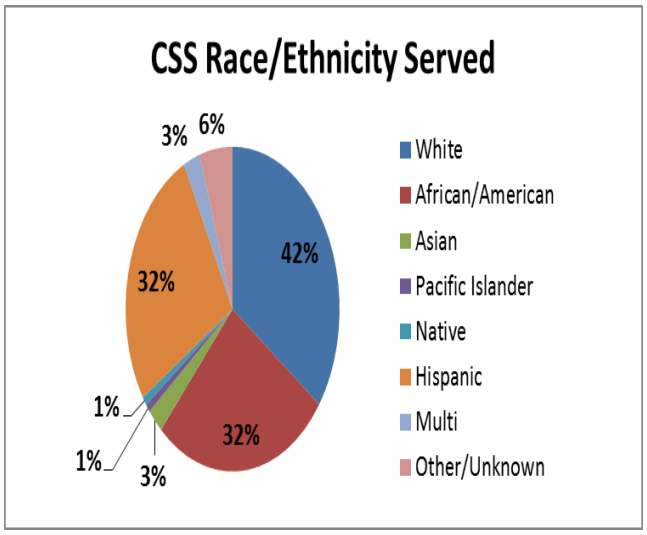


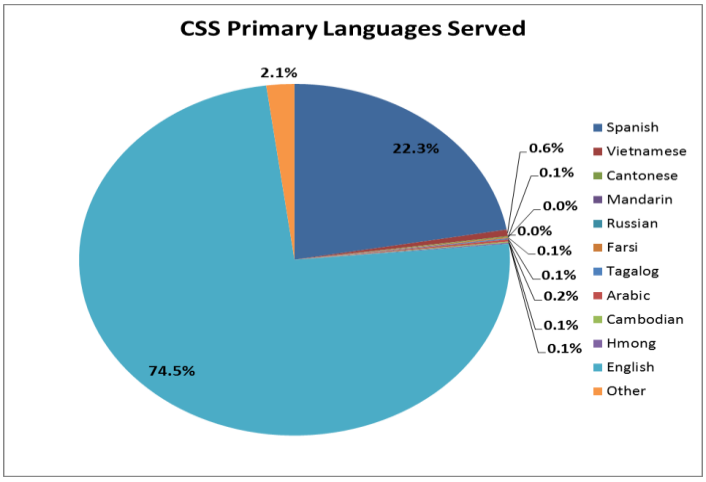










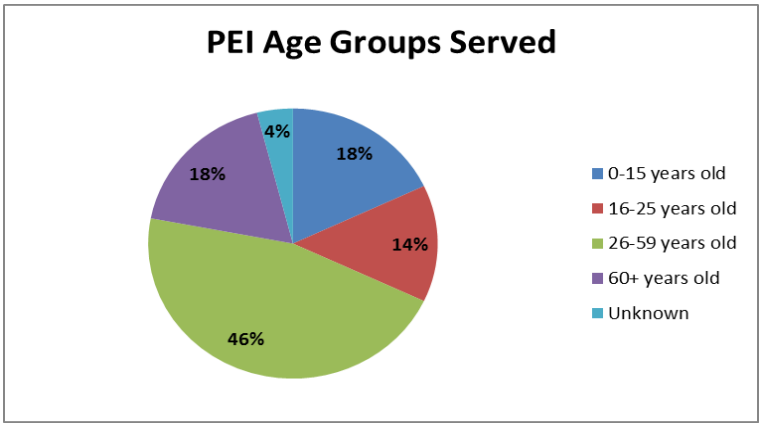


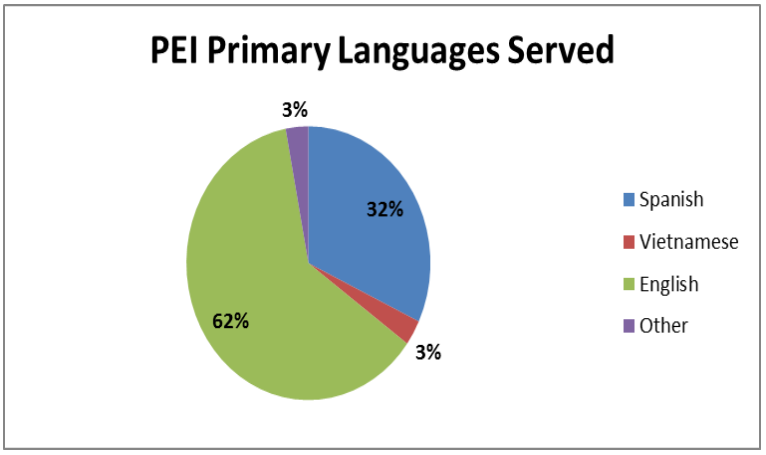
Further details on CSS programs are provided in this report.

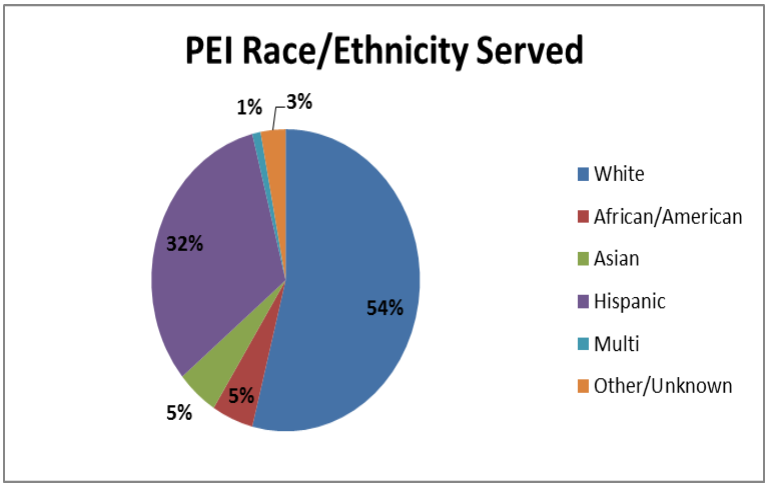
Prevention and Early Intervention (PEI)

PEI Programs have successfully reached un/underserved populations.

Total Individuals Served: 9979







Further details on PEI programs are provided in this report.

Innovation

Currently, Marin's Innovation Program funds are being 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 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.

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 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.

Capital Facilities and Technological Needs

In Marin County, our goal focused on technological improvements that supported the development of an Electronic Health Record (EHR) which enabled the advancement towards a paperless record. The existing system was a hybrid of electronic and paper documentation and provided many elements of an EHR. Prescribers were hand writing prescriptions, and the legacy billing system (INSYST) needed upgrading and modernization.

Fiscal Year 2014-15 Annual Update

For a copy of the MHSA FY2014-15 Annual Update please call: 415.473.7465 or you can find it on our website at: https://www.marinhhs.org/mhsa3year.

Please review the MHSA FY2014-15 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 FY2014-15 Annual Update begins on **Friday, April 11, 2014** and ends on **Saturday, May 10, 2014.**

A Public Hearing for the MHSA FY2014-15 Annual Update will take place at the Mental Health Board Meeting on Tuesday, May 13, 2014 at 6:00 pm at the Marin County Office of Education, located at 1111 Las Gallinas Avenue, San Rafael, CA 94903 in the Foundation Conference Room. The public is welcome.

MHSA Moving Forward

Marin's MHSA Three-Year Program and Expenditure Plan as required by the State for the period of FY2014-15 through FY2016-17 has also been posted for the required thirty (30) day public comment period which begins on **Friday, April 11, 2014** and ends on **Saturday, May 10, 2014.**

A Public Hearing for both the MHSA Annual Update for FY2014-15 and the MHSA Three-Year Program and Expenditure Plan for the period of FY2014-15 through FY2016-17 will take place at the Mental Health Board Meeting on Tuesday, May 13, 2014 at 6:00 pm at the Marin County Office of Education, located at 1111 Las Gallinas Avenue, San Rafael, CA 94903 in the Foundation Conference Room. The public is welcome.

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

Dr. Suzanne Tavano, Director
County of Marin
Department of Health and Human Services
Mental Health and Substance Use Services Division
3230 Kerner Boulevard
San Rafael, CA 94901

MENTAL HEALTH SERVICES ACT

STAKEHOLDER PROCESS

Ongoing Stakeholder Input

Marin County's annual 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 in other forums. Input received in these settings is brought to MHSUS Senior Management, the MHSA Coordinator and Component coordinators and other settings as appropriate 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 providers, community advocates, consumers, Marin Health and Human Services representatives, Mental Health Board members, school representatives, and other community organizations.
- 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 twice a year to oversee the implementation of, and discuss lessons learned, regarding the Client Choice and Hospital Prevention program.
- A panel including county staff, 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 in this report lists the members and affiliations for the Implementation Committee in place during the reporting period, FY2012-13.

FY2014-15 Annual Update Process

This year counties were required to develop a MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 (Plan). Marin took this opportunity to conduct and extensive community planning process. That is described in full in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. The Annual Update was informed by that process. The Annual Update was developed by MHSUS staff and agencies contracted to provide MHSA services. The Annual Update and the Plan will both follow the same approval process:

The MHSA Annual Update for FY2014-15 will posted for 30-day public comment from Friday, April 11, 2014 through Saturday, May 10, 2014. It will be widely distributed:

- The MHSA Annual Update was posted for 30-day public comment on Marin County's website, including instructions on how to receive a copy of the report, 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 MHSA Annual Update for FY2014-15 are 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) staff, contractors, community based organizations, Marin Mental Health Board, Alcohol and Other Drug Board, MHSUS staff, MHSA Implementation Committee, and other MHSA related distribution lists and committees.

On Tuesday, May 13, 2014, a public hearing will be held at the Mental Health Board meeting at 6pm at the Marin County Office of Education, 1111 Las Gallinas Avenue, San Rafael, CA 94903 in the Foundation Conference Room. All input will be considered and substantive comments will be summarized and analyzed (see below). The final MHSA Annual Update for FY2014-15 will go before the Board of Supervisors after the public hearing.

Prior annual updates are available at: https://www.marinhhs.org/mhsa

Substantive Comments and Responses:

No comments received during the thirty (30) comment period or during the MHSA Public Hearing at the Mental Health Board meeting on May 13, 2014.

MARIN COUNTY CHARACTERISTICS

Marin County is a mid-sized county with a population of 258,365 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 continues to rank 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. African Americans are over-represented among County clients, possibly due to lack of appropriate services that might reduce the need for this level of service. Other identified underserved populations included older adults, transition aged youth (16-25 years old) and persons living in West Marin. Designation of un/underserved populations is based on those Marin residents who are eligible for County mental health services, best represented by the "Medi-Cal Beneficiaries'" column on the following table, compared to those receiving county mental health services.

Overall, since the implementation of MHSA programs, the rate of mental health services provided by the County has increased substantially for the Latino population and older adults. In addition, there has been some reduction in rate of intensive mental health services for African Americans. Given that there has been an increase in outreach and prevention services for African Americans, we are hopeful that the decrease in intensive service rates reflects that African American's are being more appropriately served, reducing the need for such services. Comparison of make-up of county mental health services clients to total population, Medi-Cal beneficiary population and homeless populate is on Table 1 and Table 2 is the comparison of make-up of county mental health services clients before MHSA was implemented to now. Even though MHSA funding has allowed Marin to develop new programs 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
Comparison of make-up of County Mental Health clients to total population, Medi-Cal beneficiary population and homeless population.

Ethnicity	Total Population 2012	Medi-Cal Beneficiaries CY2011	Homeless 2013 Count	County MH Clients FY12-13
Total	**258,365**	**24,147**	**933**	**3,716**
White	86.3%	32.3%	43.4%	57.9%
African American	2.9%	7.1%	12.8%	7.7%
Native Am/ Alaska Native	1.1%	0.2%	1.4%	0.4%
Asian	5.9%	5.4%	3.2%	3.2%
Native Hawaiian/ Other Pacific Islander	0.2%	0.0%	0.3%	0.4%
Some Other Race	0.0%	4.3%	4.0%	24.5%
Two or More Races	3.6%	0.0%	0.0%	0.0%
Unknown	0.0%	0.0%	14.6%	5.9%
Hispanic or Latino (of any race)	15.7%	50.6%	20.4%	23.8%

Table 2
Comparison of make-up of County Mental Health clients before MHSA was implemented to now.

Race/Ethnicity	Total Pop 2000	FY06-07 County MH Clients (N=3,818)	Total Pop 2012	FY12-13 County MH Clients (N=3,716)
White	83.8%	69.5%	86.3%	57.9%
African American	2.9%	9.9%	2.9%	7.7%
Native	0.4%	0.5%	1.1%	0.4%
Asian	4.5%	3.4%	5.9%	3.2%
Pacific Islander	0.4%	0.4%	0.2%	0.4%
Multi	3.5%	0.0%	3.6%	0.0%
Other/Unknown	4.5%	16.3%	0.0%	30.4%
Hispanic	11.1%	15.7%	15.7%	23.8%
Age	**2000 Census**	**FY06-07 County MH Clients**	**2010 Census**	**FY12-13 County MH Clients**
0-17	20.3%	27.4%	20.7%	26.8%
18-25	5.5%	9.9%	5.8%	9.0%
26-59	56.1%	54.1%	49.2%	50.1%
60+	18.1%	8.4%	24.3%	14.1%

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 FY2005-06 Latinos comprised 12.8% of County mental health clients, in FY2010-11 it was 20.4% and in FY2012-13 it is 23.8%. There was not a significant change in rates for other ethnic populations. MHSA has allowed for an increase in bilingual staff across CSS and PEI programs.

The County recognizes the need to better engage and serve diverse populations, especially those identified as un/underserved. For instance, in FY2012-13 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 FY2012-13.

Total Individuals Served: 1991

Age Group	# served	% of Served
0-15 years old	266	13%
16-25 years old	290	15%
26-59 years old	1142	57%
60+ years old	293	15%
Race/Ethnicity		
White	703	35.3%
African American	528	26.5%
Asian	45	2.3%
Pacific Islander	23	1.2%
Native	19	1%
Hispanic	525	26.4%
Multi	57	2.9%
Other/Unknown	91	4.6%

Primary Language	# served	% of served
English	1486	75%
Spanish	441	22%
Vietnamese	12	1%
Cantonese	1	0.1%
Mandarin	1	0.1%
Tagalog	2	0.1%
Cambodian	1	0.1%
Hmong	2	0.1%
Russian		
Farsi	1	0.1%
Arabic	3	0.2%
Other	41	2.1%

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, 84% of 87 STAR clients have experienced a reduction in homelessness while 55% of 62 have experienced a reduction in psychiatric hospitalization. This outcome data is discussed further within the respective program narratives.

FSP Program Name	STAR		Odyssey		HOPE		TAY		CSOC	
Age Group Served	**Adult**		**Adult**		**Older Adult**		**TAY**		**Youth**	
Total Clients Served since 2007	**189**		**223**		**145**		**64**		**218**	
	%	**(n)**	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**
Decreased Homelessness	84%	(87)	95%	(78)	90%	(21)	91%	(11)	100%	(2)
Decreased Psych Hospitalization	55%	(62)	40%	(42)	55%	(47)	57%	(14)	50%	(2)
Decreased Incarceration	83%	(148)	76%	(17)			60%	(10)	53%	(152)
Decreased Arrests	70%	(33)	50%	(6)			100%	(1)	48%	(52)
Decreased School Suspensions									93%	(139)
Increased School Attendance									42%	(166)
Decreased Out-of-Home Placement									44%	(27)
Increased School Grades									53%	(72)

CHILDREN'S SYSTEM OF CARE (CSOC)

PROGRAM DESCRIPTION
July 2012 – June 2013

Marin County's Children's System of Care (CSOC) Program is a Full Service Partnership program serving 40+ seriously high risk youth who are on formal 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 continue to represent the largest group in terms of referrals from both juvenile justice and at County Community School. The CSOC program is equipped to serve these youth with three (3) bilingual Spanish speaking 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 (i.e., uninsured.) and are not typically motivated to seek services at outpatient mental health clinics. The CSOC model is a supportive, strengths based model with the goal of meeting youth and families at school, in their homes and in the community. CSOC clinicians strive to help families identify their needs and implement ways to address them successfully. An important component of this program is the support from the CSOC team Family Partner, who provides support and guidance to parents in navigating the various systems and with parenting youth engaged in high risk behaviors.

Several CSOC staff also partnered with Juvenile Probation, Marin County Office of Education and the Canal Welcome Center to pilot a youth leadership internship over the summer. This collaboration identified about 15 young men in the community who were interested in participating, and provided them with group based exercises and community outings to develop leadership, explore being part of a group, and develop new skills. This collaboration is currently expanding into a year-long leadership program with some of these same youth to continue addressing leadership and skill building as one means of decreasing problematic behaviors.

OUTCOMES
July 2012 – June 2013

The CSOC Program served 91 youth over the course of FY 2012-13. Of these, 57 participated in the FSP. For those 57, their mean age was 16.9 years, 22 clients or 39% were female and 35 clients or 61% were male. During the FY2012-13, CSOC clients were from the following race/ethnic groups: Other (46%, likely Latino), African American (14%), Caucasian (14%), Multiple (19%) and unknown (7%).

CSOC program objectives include decreasing time spent in juvenile hall, decreasing arrests, decreasing school suspensions and increasing school attendance and performance. Too little data has been collected to draw meaningful conclusions regarding homelessness and hospitalizations. Overall, CSOC continues to demonstrate signs of success in meeting its objectives to serve these youth who are often underserved and remain at high risk.

From beginning of the CSOC Full Service Partnership (FSP) program, notable outcomes include:

- Of youth with poor grades in the 12 months prior to enrollment or since enrollment in the FSP, 53% (n=72) demonstrated improvement in grades, with a 2.79 pre-enrollment average to 3.09 post-enrollment average.
- Of those with school attendance difficulties in the 12 months prior to enrollment or since enrollment in the FSP, 42% (n=166) achieved better attendance in the post FSP enrollment period.
- Of youth having been arrested in the 12 months prior to enrollment or since enrollment in the FSP, arrests following FSP enrollment decreased by 48% (n=52).
- For youth with school suspensions (n=139), rates since enrollment decreased by 93%.

Age Group	# served	% of served
0-15 years old	25	27%
16-25 years old	66	73%
26-59 years old		
60+ years old		
Total	**91**	**100%**
Race/Ethnicity		
White	7	7.7%
African/American	17	18.7%
Asian		
Pacific Islander		
Native		
Hispanic	60	65.9%
Multi	4	4.4%
Other	1	1.1%
Unknown	2	2.2%

Primary Language	# served	% of served
English	61	67%
Spanish	30	33%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		

CHALLENGES AND UPCOMING CHANGES

The CSOC program faces several challenges. The program continues to serve youth with significant substance abuse issues. CSOC staff was trained in Motivational Interviewing techniques (a method that focuses on the client values and concerns to strengthen their motivation for change) and general harm reduction approaches. Staff will continue to receive training in substance abuse interventions to support real integration of mental health and substance use services. The CSOC team also released an Request for Proposal (RFP) this past year to hire a substance use counselor. After reviewing the single proposal, we decided to reevaluate the program's needs in conjunction with juvenile probation's efforts to address substance use issues.

Another challenge for the CSOC program is the declining probation population this past year. With fewer referrals overall, CSOC clinicians are challenged to consider new and innovative ways to reach high risk youth. CSOC staff continue to outreach to high risk youth and identify where needs are not being met. Some youth, for example, turn 18 and transition to adulthood but are not able to access similar supports in the County's Adult System of Care. Juvenile Probation has requested assistance from the CSOC program to look at ways to address these unmet needs. One consideration is to expand the age limit for CSOC clients to serve the TAY probation population.

CSOC clients typically 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, including Seneca Sustaining Families, Juvenile Probation, etc., to leverage existing supports and resources. However, chronic stressors and difficulty in accessing services continue to present external challenges to CSOC clients and their families.

The CSOC program is recommending in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 to recruit for a full time bilingual substance use counselor to address substance abuse issues that are not being adequately addressed for youth involved in the juvenile justice system. This decision will be made in collaboration with Juvenile Probation after identifying existing needs and community resources.

CHILDREN'S SYSTEM OF CARE (CSOC)

CLIENT STORIES

A few specific examples highlight the work the CSOC team has accomplished. In one case, a CSOC client became homeless, stopped attending school regularly and was placed in foster care due to parenting difficulties. This client received services for over a year to learn communication skills, to decrease anger and to address symptoms of anxiety and depression. The CSOC team held ongoing meetings with probation and the foster family to ensure communication and to develop an effective treatment plan. This client began to attend a community based running group for teens and became a leader with peers. The client subsequently graduated high school with honors, received several scholarships, enrolled in college and got a job on campus.

Another client was referred by a juvenile probation officer to the CSOC program to receive court ordered counseling. This client and legal guardian were struggling with social isolation, inadequate support systems and limited financial resources. The client was abusing marijuana and other drugs, getting involved in criminal activities and increasing a pattern of truancy and running away. The CSOC program provided the client and guardian with individual counseling, parenting support and extensive case management services, including outpatient drug/alcohol counseling for the client and legal guardian, wraparound services through Seneca Center, a Family Partner and an afterschool and summer job internship for the client. Due to these efforts, the client and legal guardian were able to improve their overall life situation and the client will soon graduate from Juvenile Probation's Drug Court program.

TRANSITION AGE YOUTH (TAY) PROGRAM

PROGRAM DESCRIPTION
July 2012 – June 2013

Marin County's Transition Age Youth (TAY) Partnership, provided by Buckelew Programs, is a Full Service Partnership (FSP) providing up to 20 young people (16-25 year olds) 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 as well as, 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 clients 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 a Men's Group, Building Relationships Group, Foreign Cinema Day, Driver's Ed Training, Expressive Arts, Chop & Chat, Job Support, Poetry Slam, 5Rhythms Dancing, and the Garden Project. These activities provide a forum for healthy self-expression, an opportunity for participants to expand their cultural horizons, and a place to for them to practice their social skills. The iRest group continues to be well attended. It is an integrated, evidence supported practice that teaches emotional regulation and helps heal unresolved issues. The monthly TAY calendar of activities is available in English and Spanish. A bimonthly Family Support Group for families of TAY with mental health illness, whether or not they are enrolled in the TAY programs is provided by a TAY staff member.

In FY2012-13 increased funding allowed for the addition of a substance use specialist and an on-site psychiatrist. The substance use specialist, a licensed clinician, provides individual therapy for the youth, as well as family therapy. She coordinates closely with TAY staff and therapists. She meets with all new FSP participants upon enrollment to discuss their needs and preferences for psychotherapy, substance use services and family support. This facilitates her visibility among all participants and reduces potential stigma. She provided a multi-family psycho-educational group based on the McFarlane model. She will change to a similar model that only includes parents, as the parents expressed a need to talk without the presence of the youth. She also offered a men's discussion group that includes substance use issues and topics. The second expansion has been on-site availability of the TAY psychiatrist at the TAY office 3 weeks per month. He consults with the TAY staff about medication issues in general as well as specific clients who are taking medication and he holds some medication appointments on site at the TAY office. These expanded hours have enabled him to follow some TAY participants more closely when they are in crisis, adapting to a new medication or needing more frequent contact to stabilize symptoms.

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 2012 – June 2013

In FY12/13, the TAY Program met most of its goals (see table below) and going forward will be drilling down to report more specific outcomes such as number of days a client engages in school, work or vocational training, so a better analysis can inform what is working for individual participants and where there may be room for improvement. One time Mental Health Services Act (MHSA) funds were used to integrate physical exercise into the program which research has shown is beneficial for mental health as well as physical health. A part time personal trainer was hired and 66% of FSP clients worked with this trainer, which included hiking, biking, or one-on-one fitness training with 31% participating 8-20 times, and 21% participating more than 20 times. Although the funding for the personal trainer ended, gym equipment was purchased for ongoing use. Other MHSA one-time funds supported the creation of a vegetable and flower garden at the TAY House. Residents of the TAY House assist with the daily watering in the summer and the vegetables are being used in meals cooked by the participants.

At the end of FY12/13, a bilingual/bicultural Spanish speaking TAY Team Leader who has clinical experience working with this age group was hired. It is expected Latino youth with mental health needs will be more successfully engaged with more culturally appropriate services.

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=11), 91% experienced a decrease in homelessness.
- Among those who were hospitalized (N=14), 57% experienced a decrease in hospitalization.

Outcome	Goal	Actual FY12-13
Number of Full Service Partnership (FSP) clients served	20	29
Number of Partial Service Partnership clients served	100	84
FSP clients engaged in work, vocational training or school	70%	86% *N=29*
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	75%	86% *N=24*
Time that the TAY House is fully occupied.	75%	79%

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	29	100%
26-59 years old		
60+ years old		
Total	**29**	
Race/Ethnicity		
White	21	72%
African/American	1	3%
Asian	2	7%
Pacific Islander		
Native		
Hispanic	2	7%
Multi	1	3%
Other/Unknown	2	7%

Primary Language	# served	% of served
English	28	97%
Spanish	1	3%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		

Latino youth, 18 years of age and over continue to be underrepresented in the TAY Program as they are in other programs in the county. In FY2010-11, 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, and with the hiring of a bicultural Spanish speaking TAY team leader, the program is positioned to be able to outreach more successfully to Latino transitional age youth.

CHALLENGES AND UPCOMING CHANGES

There has been a great deal of feedback from the community, family members and youth themselves about how to address the needs of transitional age youth that are coping with symptoms of mental illness in addition to the normal challenge of transitioning to adulthood.

There are several challenges specific to Marin County: Latino youth are underrepresented in programs that serve those 18 years and older in Marin County; the well-documented high use of alcohol and drugs which negatively impacts mental health; the importance of engaging the family, who remain a support long after the youth leaves a TAY Program; finally, the need for stable housing which requires a creative, flexible approach to maximize the limited TAY housing available. All of these factors impact the long term well-being of a transition aged youth.

Given these issues, planning for a new Request For Proposal (RFP) for the TAY Program is underway to include specific approaches to address these concerns in a focused way and to include long term outcomes for the TAY Program, such as six months follow up after discharge, so as to guide program development in the future.

All of these factors, including input from the community process, will be part of the strategic thinking going in to the TAY FSP RFP process in the MHSA Three Year Plan beginning FY2014-15 through FY2016-17.

SUPPORT AND TREATMENT AFTER RELEASE (STAR) PROGRAM

PROGRAM DESCRIPTION
July 2012 – June 2013

Marin's Support and Treatment After Release (STAR) Program is a Full Service Partnership (FSP) 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 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; 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 Community Services and Supports (CSS) FY2011-12 one-time expansion funds and continued through FY2013-14, 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 one-time expansion funds through FY2013-14, 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.

CSS FY2012-13 one-time expansion funds were approved through FY2013-14 to provide Independent Living Skills (ILS) training for targeted STAR clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget.

OUTCOMES
July 2012 – June 2013

The STAR Program was fully operational during FY2012-13, serving 58 individuals who had serious mental illness and significant criminal justice involvement, and exceeding the program's target enrollment of 40. Twenty-seven of the program enrollees participated in STAR Mental Health Court with 6 successfully graduating. Of the 22 program participants referred by the team for employment services, 7 (32%) were successfully engaged in job development activities, 5 (23%) of whom were successfully placed in jobs, and 11 (50%) engaged in volunteer work. An additional 5 (23%) participants received education planning services, focused on academic or training goals for expanding employability. ILS services were provided during the last 6 months of the fiscal year to 6 program participants, exceeding the projected goal of 4-5 individuals, with 67% remaining engaged in ILS services at the end of this reporting period.

Since the beginning of the program, the STAR Program has achieved the following outcomes, meeting the goals of the program:

- Among those program participants with incarcerations in the 12 months prior to enrollment or since enrollment in the FSP (N=148), 83% have shown a decrease on this measure. Among those served during FY2012-13 (N=50), 84% have experienced a decrease.
- Similarly, 70% of participants with arrests (N=33) experienced a reduction in arrests and 84% a reduction in homelessness (N=87), while those with acute psychiatric inpatient hospitalizations (N=31) decreased by 55%. Among those served during FY2012-13, reductions were 71% for arrests (N=14), 73% for homelessness (N=26), and 35% for hospitalizations (N=20).

During this reporting period, services funded by one-time CSS expansion funds met or exceeded the projected goals. The STAR clinician co-located with the Jail Mental Health Team served a total of

134 inmates. Eighty-three inmates received comprehensive in-custody assessments, well in excess of the program annual target of 75, with 51 of these individuals receiving post-release support and linkages to services, also exceeding the goal of 20. Seven of these inmates were admitted to the STAR Program intensive community treatment component. Twenty STAR Program participants received substance abuse services provided by the program's substance use specialist, meeting the program annual target of 15-20. This represents a 33% increase over the previous year.

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. 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 one-time expansion funds were approved beginning in FY2011-12 through FY2013-14 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). Thirty sworn officers and dispatch staff attended the CIT Training offered during this reporting period. To date, 305 sworn officers have received CIT training with at least one CIT trained officer in every law enforcement jurisdiction in Marin.

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 this high-risk group with 86% (50) of participants served during FY2012-13 being incarcerated for an average of 82 days during the 12 months prior to enrollment. On average, 71% 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. During this reporting period, 17% percent of program participants were female, an increase of 30% over the previous year and considerably higher than the 10-11% that has constituted the Marin County Jail population.

Since program referrals require that individuals must be justice-involved 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 (72%), with Hispanics/Latinos being slightly higher at 17% than the 14% found in the County adult population of 14% (18 years of age and older), but underrepresented when compared to the County Hispanic/Latino jail population of 26%. Black/African Americans at 3% were consistent with the County adult population but were also lower compared to the County jail population, while Asians at 3% were underrepresented when compared to 6% in the adult population. The MHSA-funded STAR Program mental health clinician co-located at the County Jail served a more diverse population, with Black/African-Americans comprising 27% (36 inmates), Hispanics/Latinos 25% (34 inmates) and Caucasians 37% (49 inmates).

Note: County adult population data from 2010 census
County data from JFA 2010 report on Marin County jail population projections

Age Group	# served	% of served
0-15 years old		
16-25 years old	7	12.1%
26-59 years old	45	77.6%
60+ years old	6	10.3%
TOTAL	**58**	**100%**
Race/Ethnicity		
White	42	72.4%
African American	2	3.4%
Asian	2	3.4%
Pacific Islander		
Native		
Hispanic	10	17.2%
Multi		
Other/Unknown	2	3.4%

Primary Language		
English	53	91.4%
Spanish	4	6.9%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic	1	1.7%
Other		

CHALLENGES AND UPCOMING CHANGES FOR FY13/14

The STAR Program continues to explore better ways of engaging program participants in working on their recovery and to increasingly add wellness and recovery strategies to the program. During FY2013-14, the STAR Program team will be offering 2 new services to participants: a psycho-educational group and a vocation and values group, aimed at assisting STAR clients in managing their illness and planning their lives and careers.

As noted above, the STAR Program has had limited success with outreach to and engagement with minority populations, especially Hispanic/Latino. The program will continue to explore additional methods for improvement in this area, including a proposal in Marin's upcoming MHSA Three Year Plan to expand the core assertive community treatment team by one mental health clinician in order 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/Latino access to the STAR Program. Additionally, it is anticipated that partnering with two new Prevention and Early Intervention (PEI) projects just implemented in FY2012-13 – Community Health Advocates (CHAs) and Vietnamese Community Connection – has the potential for increasing the program's opportunities for outreach and engagement to both populations. The Adult System of Care (ASOC) CHA Liaison, also newly implemented in FY2012-13, will be instrumental in linking these new PEI projects with STAR and other system of care programs.

Additionally, the MHSA CSS one-time expansion funding for 3 STAR Program services – the clinician sited with the Jail Mental Health Team, the substance use specialist, and the ILS training –

ends in FY2013-14. Proposals are included in the MHSA Three Year Plan for FY2014-15 through FY2016-17 to continue those expansions that provide services that are essential to serving the program's target population and have already demonstrated success.

HELPING OLDER PEOPLE EXCEL (HOPE) PROGRAM

PROGRAM DESCRIPTION
July 2012– June 2013

The HOPE (Helping Older People Excel) Program is a Full Service Partnership (FSP) 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 (MHSUS), 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 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 Spanish-speaking social services worker, volunteer senior peer counselors and some in-kind deputy public guardian time. 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 Community Services and Supports (CSS) FY2011-12 one-time expansion funds and continued through FY2012-13, 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.

CSS FY2012-13 one-time expansion funds were approved through FY2013-14 to provide Independent Living Skills (ILS) training for targeted HOPE clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. One-time funds were also approved to expand the HOPE assertive community treatment component by adding a part-time substance use specialist to provide assessments and consultation to the team, as well as assist in outreaching to and engaging target population older adults to identify substance use problems and participate in appropriate treatment.

In addition, Prevention and Early Intervention (PEI) FY2011-12 one-time expansion funds were continued through FY2013-14 to increase the outreach to at-risk Hispanic/Latino older adults by increasing the hours of the Spanish-speaking mental health clinician supporting and supervising the Amigos Consejeros a su Alcance (ACASA) component of the Senior Peer Counseling Program. These additional hours are used to outreach into the community to increase awareness of the mental health needs of Hispanic/Latino older adults and their families, and the services that ACASA and the HOPE Program offer.

OUTCOMES
July 2012 – June 2013

During FY2012-13, the HOPE Program and Senior Peer Counseling provided information, referral, outreach and engagement, assessment and professional consultation to over 350 individuals, families and other treating professionals. The HOPE Program was fully operational during this reporting period, serving 59 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, 15% of participants in the Hope Program have presented with a co-occurring substance use disorder, putting them at even greater risk. An additional 61 older adults were served by the Senior Peer Counseling Program, the outreach and engagement component of the HOPE Program. ILS services were provided during the last 6 months of the fiscal year to 2 program participants, markedly less than the projected goals of 4-5 individuals, with both participants remaining engaged in ILS services at the end of this reporting period.

Since the beginning of the program, the clients of the Full Service Partnership (FSP) 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=21), 90% have shown a decrease on this measure. Among those served during FY2012-13 (N=12), 83% have experienced a decrease.
- Similarly, 55% of participants with acute inpatient hospitalizations (N=47) experienced a decrease in hospitalizations. Among those served during FY2012-13 (N=25), 56% have experienced a decrease.

During FY2012-13, the Senior Peer Counseling Program supported a total of 34 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 1,366 visits during the year, a 24% decrease compared to the prior year. Fifteen (25%) of the individuals served by the senior peer counselors were Hispanic/Latino and received 16% of the total FY2012/13 visits (215)).

Marin's older adult population, age 60 and older, is largely Caucasian (92%), with 4% Asian, 4% Hispanic/Latino, and 1% Black/African-American. Eighty-eight percent of the older adults served by the HOPE Program's intensive community treatment component were Caucasian, slightly lower than the County older adult proportion, while Black/African-Americans were overrepresented at 7% served. Hispanics/Latinos were underrepresented with the program serving 0% during FY2012-13 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	3.4%
60+ years old	57	96.6%
Total	**59**	**100%**
Race/Ethnicity		
White	52	88.1%
African/American	4	6.8%
Asian	1	1.7%
Pacific Islander		
Native		
Hispanic		
Multi	1	1.7%
Other/Unknown	1	1.7%

Primary Language	# served	% of served
English	55	93.2%
Spanish		
Vietnamese	1	1.7%
Cantonese		
Mandarin		
Tagalog	1	1.7%
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	2	3.4%

CHALLENGES AND UPCOMING CHANGES FOR FY13/14

While Marin's Hispanic/Latino 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 potentially underserved population, enrolling no Hispanic/Latino older adults in the assertive community treatment component of the program for the past four years. ACASA conducted extensive outreach to the Latino community with a goal of increasing referrals by educating over twenty community leaders about services. Despite employing this and other creative strategies, the program appears to remain unsuccessful in this area. Unknown at this point is what proportion of Marin's older adult population is suffering from serious mental illness and remains un/underserved. Feedback received suggests that families who have migrated to Marin cannot yet afford to bring their elders to the area.

Though MHSA CSS FY2010-11 one-time funds were approved to restore funding (lost due to previous County budget reductions) of the part-time Spanish-speaking social services worker to work with the HOPE Program, the County adult protective services program (formerly part of the County Division of Social Services) was unable to fill the position and a mutual decision was made to discontinue this strategy. Recognizing the need for Spanish-speaking capacity in the assertive treatment component, a proposal is included in Marin's upcoming MHSA Three Year Plan to add this capacity. It is anticipated that partnering with two new PEI projects just implemented in FY2012-13 – Community Health Advocates (CHAs) and Vietnamese Community Connection – has the potential for increasing the program's opportunities for outreach and engagement. The ASOC (Adult System of Care) CHA Liaison, also newly implemented in FY2012-13, will be instrumental in linking these new PEI projects with HOPE and other system of care programs.

Also challenging was the implementation of the MHSA CSS FY2012-13 expansion strategy to add a part-time substance use counselor to the HOPE Program. Estimates of the prevalence of co-occurring mental health and substance abuse disorders in older adults range from 7%-38%. Though this rate is lower than that of the adult population, the impact and negative effects of substance use and abuse increases with age, as does the effect of its interaction with serious mental illness. However, it proved difficult to find a substance use counselor with sufficient expertise/experience/interest in working with the substance use issues presented by older adults being served by the public mental health system who have serious mental illness and co-occurring substance use disorders. Eventually, it was decided to discontinue this strategy and focus instead on providing additional training, support and supervision to the existing HOPE Program staff on assessing and treating co-occurring substance use disorders.

The MHSA PEI and CSS one-time expansion funds for two (2) HOPE Program services – the ACASA clinician and ILS training – will end in FY2013-14. Despite some challenges in fully implementing the ILS training, these expansions provide services that are considered to be essential for success in serving the program's target population. Proposals are included in Marin's upcoming MHSA Three Year Plan to continue both expansions.

ODYSSEY PROGRAM (HOMELESS)

PROGRAM DESCRIPTION
July 2012 – June 2013

The Odyssey Program is a Full Service Partnership (FSP) 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 Mental Health and Substance Use Services (MHSUS) traditional adult system of care. Program participants and their families are provided education regarding the management of health and mental health issues, with a focus on reducing stigma, restoring hope and promoting recovery of health and functioning. Recognizing the critical role that families and other natural support systems play in their family member's recovery, family members have access to an array of family support services to assist them to develop alternative strategies and skills for coping with and addressing the effects of serious mental illness on themselves and their family member.

The team consists of 3 mental health clinicians, one of whom is bilingual/bicultural (Spanish-speaking); a part-time nurse practitioner; a part-time psychiatrist; 4 peer specialists, a part-time employment specialist, and a part-time substance use specialist. Outreach and engagement services are provided by a team of 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.

Funded by Community Services and Supports (CSS) FY2011-12 one-time expansion funds and continued through FY2013-14, 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.

CSS FY2012-13 one-time expansion funds were approved through FY2013-14 to provide Independent Living Skills (ILS) training for targeted Odyssey clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget.

OUTCOMES
July 2012 – June 2013

The Odyssey Program was fully operational during FY2012-13, 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 17 program participants referred by the team for employment services, 10 (59%) were successfully engaged in job development activities, a considerable increase over the 33% who engaged in job development activities the previous year. Three participants (18%) were successfully placed in jobs, 3 (18%) engaged in volunteer work, and 1 received education planning services focused on academic/training goals for expanding employability. ILS services were provided during the last 6 months of the fiscal year to 6 program participants, exceeding the projected goal of 4-5 individuals, with 50% remaining engaged in ILS services at the end of this reporting period.

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=78), 95% have shown a decrease on this measure. Among those served during FY2012-13 (N=53), 92% have experienced a decrease.
- Similarly, 50% of participants with arrests (N=6) experienced a reduction in arrests and 76% a reduction in incarcerations (N=17), while those with acute inpatient hospitalizations decreased by 40% (N=42). Among those served during FY2012-13, reductions were 60% for arrests (N=5), 82% for incarcerations (N=11), and 35% for hospitalizations (N=31).

Outreach and engagement services for the homeless are provided by the Enterprise Resource Center (ERC), 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 FY2012-13, 130 individuals received homeless outreach services from the CARE team. The majority of these individuals were Caucasian (83%), with African-Americans comprising 7%, Hispanics 5%, and Asians <1%.

During this reporting period, the services funded by the one-time CSS FY2012-13 expansion funds had mixed results. Seven 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. It is notable; however, that participant retention in substance use services once begun has been significant with the only losses being due to incapacitating medical conditions or relocation. Five program participants participated in the transitional supportive housing component and 3 (60%) 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 this high-risk group with 72% (53) of participants served during FY2012-13 being homeless for an average of 232 days during the 12 months prior to enrollment: On average, 58% 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 13% reported in Marin's homeless population. Hispanics were underrepresented at 8% compared to 14% in the adult population and 20% in the homeless population. Also underrepresented were Asians at 1% 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 2013

Age Group	# served	% of served
0-15 years old		
16-25 years old	1	1.4%
26-59 years old	57	77.0%
60+ years old	16	21.6%
Total	**74**	100%
Race/Ethnicity		
White	51	68.9%
African/American	10	13.5%
Asian	1	1.4%
Pacific Islander		
Native	2	2.7%
Hispanic	6	8.1%
Multi	2	2.7%
Other/Unknown	2	2.7%

Primary Language	# served	% of served
English	68	91.9%
Spanish	4	5.4%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi	1	1.4%
Arabic		
Other	1	1.4%

CHALLENGES AND UPCOMING CHANGES FOR FY13/14

Marin's Hispanic/Latino 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/Latino adults. It is anticipated that partnering with two new Prevention and Early Intervention (PEI) projects just implemented in FY2012-13 – Community Health Advocates (CHAs) and Vietnamese Community Connection – has the potential for increasing the program's opportunities for outreach and engagement. The ASOC (Adult System of Care) CHA Liaison, also newly implemented in FY2012-13, will be instrumental in linking these new PEI projects with Odyssey and other system of care programs.

During FY2012-13, 68% of the Odyssey Program participants were female, while males comprised only 32%. Most studies of the homeless population show that single homeless adults are more likely to be male than female, with 68% being male. This over-representation of females is relatively new for the Odyssey Program, with males predominating up until FY2011-12. Program staff have begun exploring reasons for this shift, as well as strategies for engaging and enrolling more males in the 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. Implementation of the integrated substance use services expansion has been challenging. Given the high retention rate once participants actually do access this essential service, the Odyssey Program team is exploring

methods for increasing and supporting the engagement and participation of Odyssey Program clients in the program's integrated substance abuse services.

The MHSA CSS one-time expansion funds for 3 Odyssey Program services – the substance use specialist, transitional housing and ILS training – ends in FY2013-14. All 3 expansions provide services that are considered to be essential for success in serving the program's target population. Proposals are included in Marin's upcoming MHSA Three Year Plan to continue all 3 expansions.

ENTERPRISE RESOURCE CENTER EXPANSION

PROGRAM DESCRIPTION
July 2012 – June 2013

During the Mental Health Services Act (MHSA) planning process, one priority identified was to expand Marin's consumer-operated Enterprise Resource Center (ERC). This program work plan included adding two (2) 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 and 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 7 days a week. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, increase social supports and reduce isolation.

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

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

ERC offers a full schedule of activities, classes and groups 7 days per week, as well as serving as host to such meetings as Dual Recovery Anonymous, Smokebusters, and NAMI Family Support Groups. ERC programs and services designed to provide personal support and foster growth and recovery include the Warm Line, available 7 days/week; 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 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.

FY2012-13 CSS one-time expansion funds were used for the purchase of replacement computers and vehicles that support the work of the CARE Team and Peer Specialists.

OUTCOMES
July 2012– June 2013

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 FY2012-13, the Enterprise Resource Center Expansion project served 196 at-risk individuals with serious mental illness. Attendance at the ERC increased by 10% to 1,554 monthly visits with an average of 57 visits per day, well in excess of its goal of 35. Homeless individuals comprised 11% of the average monthly attendance and first time visitors comprised 2%. Warm Line contacts for the year were 9,398, a decrease of 20% and lower than the program's annual target of 9,000.

CSS FY2011-12 one-time CSS expansion funds were approved through FY2013-14 to add a full-time peer specialist to work on the CARE team and help stabilize staffing, plus a small flexible fund to support outreach and engagement efforts. With these increases, the CARE Team was projected to serve an additional 80 individuals annually. During this reporting period, the CARE Team served 130 homeless individuals with serious mental illness; successfully linking 40 individuals to public mental health services; and assisting 17 to obtain housing, 2 to obtain competitive employment, 7 to obtain benefits, 8 to obtain medical insurance, and 38 to receive primary medical care. While the CARE Team served 13% fewer than the previous year and did not meet their target of 180, the team averaged 199 monthly outreach contacts, well in excess of the expected 100 contacts/month, suggesting that though the team is serving fewer individuals, it is providing them with more intensive outreach and support services.

The Enterprise Resource Center served a predominantly Caucasian population, with African-Americans being overrepresented at 8% in comparison to the County adult population of 3% (18 years of age and older) and American Indians/Alaskan Natives overrepresented at 6% in comparison to less than 1%. Hispanics were underrepresented at 5% compared to 14% in the adult population, while Asians at 6% were comparable to 6% found in the adult population. The number of older adults served continued to increase markedly from last year, from 71 to 96 individuals.
Note: County adult population data from 2010 census

Age Group	# served	% of served
0-15 years old		
16-25 years old	13	6.6%
26-59 years old	87	44.4%
60+ years old	96	49.0%
Total	**196**	**100%**
Race/Ethnicity		
White	117	59.7%
African/American	15	7.7%
Asian	12	6.1%
Pacific Islander	4	2.0%
Native	12	6.1%
Hispanic	9	4.6%
Multi	13	6.6%
Other/Unknown	14	7.1%

Primary Language	# served	% of served
English	141	71.9%
Spanish	39	19.9%
Vietnamese	2	1.0%
Cantonese		
Mandarin	1	<1%
Tagalog		
Cambodian	1	<1%
Hmong	2	1.0%
Russian		
Farsi		
Arabic	2	1.0%
Other	8	4.6%

CHALLENGES AND UPCOMING CHANGES FOR FY13/14

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 partnering with two new Prevention and Early Intervention (PEI) projects just implemented in FY2012-13 – Community Health Advocates (CHAs) and Vietnamese Community Connection – has the potential for increasing the program's opportunities for outreach and engagement. The ASOC (Adult System of Care) CHA Liaison, also newly implemented in FY2012-13, will be instrumental in linking these new PEI projects with ERC and other system of care programs.

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. A proposal is included in Marin's upcoming MHSA Three Year Plan to further expand ERC by developing a second site with additional focused services that will enable the ERC to effectively serve both populations and functions.

The MHSA CSS one-time expansion funding for the CARE Team component of ERC – additional peer specialist staffing and a client support fund – ends in FY2013-14. This expansion provides services that are considered to be essential for success in serving the program's target population. A proposal is included in Marin's MHSA Three Year Plan to continue this expansion.

SOUTHERN MARIN SERVICES SITE (SMSS)

PROGRAM DESCRIPTION
July 2012 – June 2013

In the Mental Health Services Act (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 at the Phoenix Project, which focuses on young men in Marin City. The provide psycho-education, clinical counseling and case management services, parenting support, assistance with re-entry, and goal setting.

OUTCOMES
July 2012 – June 2013

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 diverse staff, which includes two African American clinicians, an Asian clinician, a Mexican American clinician, several culturally competent Caucasian clinicians, and an African American family advocate. Family Service Agency has continuously looked for effective ways to partner with the community and be responsive to client needs.

All program goals have been met (see table). SMSS has partnered with other providers in the community to increase the accessibility of the services, including providing home-visits and services within other programs and local schools. In addition, the increased Administrative Assistant time has led to easier access for clients as well as an improved billing process.

Outcome	Goal	Actual FY12-13
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%	75% *N=37*
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%	71% *N=85*
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%	100% *N=18*
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%	99% *N=41*
Families participating in PCIT that show improvement in at least 3 areas as evidenced by pre/post Outcome Surveys.	NA	100% *N=6*

Outreach and Engagement Activities

Age Group	# served	% of served
0-15 years old	200	27%
16-25 years old	150	20%
26-59 years old	350	46%
60+ years old	50	7%
TOTAL	**750**	**100%**
Race/Ethnicity		
White	125	16.6%
African/American	450	60%
Asian	5	0.6%
Pacific Islander	15	2%
Native	5	0.6%
Hispanic	60	9%
Multi	30	4%
Other/Unknown	60	8%

Primary Language	# served	% of served
English	715	95.4%
Spanish	10	1.3%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	25	3.3%
Other Cultural Groups		
LGBTQ	85	11.3%

Clinical Services

Age Group	# served	% of served
0-15 years old	14	13%
16-25 years old	13	12%
26-59 years old	68	62%
60+ years old	14	13%
TOTAL	**109**	**100%**
Race/Ethnicity		
White	60	55%
African/American	21	19%
Asian	5	4%
Pacific Islander	2	2%
Native		
Hispanic	12	11%
Multi	4	4%
Other/Unknown	5	5%

Primary Language	# served	% of served
English	104	95.4%
Spanish	1	0.9%
Vietnamese	1	0.9%
Cantonese	1	0.9%
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	2	1.8%

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

One challenge in providing services is the stigma associated with mental health services. SMSS continues to find ways to increase referrals from and provide services in community base settings. For example, providing interns in the school, conducting home visits, and collaborating with trusted community agencies are expected to have a positive impact on referrals.

This program has been recommended to be continued in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

ADULT SYSTEM OF CARE DEVELOPMENT (ASOC)

PROGRAM DESCRIPTION
July 2012 – June 2013

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 Adult System of Care (ASOC) at large, and 5) providing short-term housing assistance. 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 who have 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. This program component promotes the concepts of wellness, recovery and self-help within the county-operated core non-FSP (Full Service Partnerships) 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. Mental Health Services Act (MHSA) funding was used to add a part-time bilingual (Spanish-speaking) psychiatrist to provide medication support services. MHSA funding was also used to fund a part-time bilingual (Spanish-speaking) mental health clinician to assist primary care physicians at the County Health Clinic in the care of depressed patients. The project's outreach and engagement to Hispanics/Latinos was impacted by closure of the County Health Clinic and subsequent unsuccessful efforts to site this staff position within a community-based health clinic in order to continue the original outreach and engagement strategy. Prevention and Early Intervention (PEI) one-time funds were approved in FY2011-12 and continued through FY2013-14 to increase the capacity of Community Health Advocates/Promotores (CHAs) to address mental health and substance abuse concerns in their

communities. In FY2012-13, the ASOC Spanish-speaking staff position was restructured to function as CHA Liaison to this evidence-based PEI project and provide training, supervision and support to the Spanish-speaking CHAs, as well as assistance in linking community members to public mental health services.

- **Increased Outreach and Engagement to Vietnamese-Speaking Individuals**
  The Vietnamese population in Marin County has 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.

  Additionally, PEI FY2012-13 one-time funds were approved through FY2013-14 to support the development of a Community Health Advocate (CHA) model for the Vietnamese community. The MHSA-funded Vietnamese-speaking clinician and MHSA-funded Spanish-speaking CHA Liaison will partner with this CHA project to provide support and assistance, as well as promote opportunities for the two CHA projects to collaborate.

- **Family Outreach, Engagement and Support Services**
  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. This program component expanded the operations of the Family Partnership Program into the ASOC through the addition of a part-time Family Partner with 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 NAMI-Marin and other local community resources, 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, Community Services and Supports (CSS) FY2011-12 one-time expansion funds were approved through FY2013-14 to add an additional part-time Spanish-speaking Family Partner position. In partnership with the Children's System of Care, the ASOC jointly added one full-time Spanish-speaking Family Partner position using FY2012-13 one time expansion funds approved through FY2013-14 to complement the work of the Psychiatric Emergency Services (PES) staff, so that discharge plans and follow-up can be developed with the family as a full partner. The PES Family Partner provides community/home-based follow-up with family members to provide support during the post-crisis transition and assistance in developing family safety plans.

- **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 through FY2013-14 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 2012 – June 2013

During FY2012-13, the ASOC Development project served a total of 609 at-risk individuals who had serious mental illness and their families, well in excess of the project's goal of 275.

- Increased peer specialist services on the Adult Intensive Case Management team were provided to 11 individuals.
- The Spanish-speaking psychiatrist sited at the Health and Wellness Campus provided services to 82 individuals, 19 of whom were Hispanic.
- The Community Health Advocate (CHA) Liaison provided outreach and engagement services to 361 individuals and families, 324 of whom were Hispanic/Latino. This part-time clinician partnered with the CHAs and other key partners, utilizing a variety of strategies intended to improve community awareness of mental health issues and resources, improve access and increase mental health related services to Hispanic/Latino and Vietnamese community members, including:
  - Training/support of the Spanish-speaking CHAs through participation in 6 structured trainings, including Mental Health First Aid and the Visión Compromiso 2-day conference.
  - Training/supervision of Latino Family Health and Vietnamese Family Health bilingual interns (APA-accredited pre-doctoral internships) providing culturally appropriate therapy services, a DBT group in Spanish, and a Vietnamese stress management and relaxation class.
  - Provision of information, referral, brief intervention, and linkage to services to 26 Latino adults.
  - Provision of no-cost trainings and workshops in Spanish, including 70 sessions of parenting classes, 3 stress management workshops in different locations in the County, 2 Weekly Walking Groups and a Weekly Dance Therapy Group.
  - Presentations on mental health issues in the community at 8 different locations.
  - Participation in 7 community events.
  - Provision of educational presentations in Spanish using county-wide public media, including 11 radio broadcasts, 3 television interviews and 9 newspaper columns.
- The third component of the program – increased outreach and engagement to Vietnamese-speaking individuals – served a total of 9 Asian individuals, 7 of whom used Vietnamese as their primary language.

- The family outreach, engagement and support services component served 147 individuals who were family members of adults, age 18 and older, who have serious mental illness. The PES Family Partner was hired in April 2013. Because of this late start, data collection and reporting for this expansion did not occur during this reporting period and will begin in FY2013-14.
- The ASOC Housing Assistance Fund was used to provide much needed short-term housing assistance to 48 clients of the Adult Intensive Case Management team whose community tenure was at-risk.

Across the entire ASOC Development project, the proportion of Hispanics served was 60% and the proportion of Spanish-speaking individuals served was 58%, significantly exceeding the program's goals of 15% and 10%, respectively. The proportion of Asians served was 3%, below the program's goal of 5% and considerably lower than the County adult population of 6%. The proportion of Vietnamese-speaking individuals served was 1.3%, slightly lower than the goal of 2% and comparable to the 1.2% served by the County public mental health system in FY2012-13, and indicative of the need to continue developing strategies to expand outreach efforts to this population. The actual number of Asians served through this project increased by 31% from 13 in FY2010-11 to 17 in FY2012-13, while the number of Vietnamese-speaking individuals served increased by 1.

Note: County adult population data from 2010 census

Age Group	# served	% of served
0-15 years old	26	4.3%
16-25 years old	10	1.6%
26-59 years old	522	85.7%
60+ years old	51	8.4%
Total	**609**	**100%**
Race/Ethnicity		
White	215	35.3%
African/American	7	1.1%
Asian	17	2.8%
Pacific Islander	2	<1%
Native		
Hispanic	364	59.8%
Multi	2	<1%
Other/Unknown	2	<1%

Primary Language	# served	% of served
English	245	40.2%
Spanish	352	57.8%
Vietnamese	8	1.3%
Cantonese		
Mandarin		
Tagalog	1	<1%
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	3	<1%

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

As discussed previously, the program's outreach to and engagement with Hispanics/Latinos increased significantly with the implementation of the newly restructured CHA Liaison position in FY2012-13. Asians, especially Vietnamese, continue to be underserved by the ASOC. As the MHSA-funded PEI Vietnamese CHA project continues development and implementation in FY2013-14, there will be increased opportunities for partnership in outreach and engagement with this population. Partnership and support strategies involving the ASOC CHA Liaison and the ASOC Vietnamese-speaking clinician are part of the Vietnamese CHA implementation plan.

The MHSA CSS one-time expansion funding for 2 ASOC Program services – the part-time Spanish-speaking family partner and the Housing Assistance Fund – ends in FY2013-14. Both expansions provide services and supports that are considered to be essential for success in serving the program's target population. Proposals are included in Marin's upcoming MHSA Three Year Plan to continue these expansions with a modification of the Housing Assistance Fund, based on experience with the utilization of this fund in FY2012-13, to broaden its use to address other, equally critical client needs such as emergency and short-term transitional housing, medications, medical/dental care, and transportation.

A proposal in Marin's Three Year Plan includes the development of a new CSS component addressing Marin's continuum of crisis response. The expanded Family Partner service for PES is included as part of the proposed new CSS program, rather than the ASOC Expansion Program.

FAMILY PARTNER at PSYCHIATRIC EMERGENCY SERVICES

FAMILY PARTNER CLIENT STORY

A client was brought to Psychiatric Emergency Services (PES) by his family as they had just moved back to Marin County. The client and their family members were in crisis and homeless. The client has developmental disabilities as well as psychiatric challenges which were both exacerbated by this situational challenge. Once PES staff was able to help the client stabilize psychiatrically, it was realized that his family was also in crisis.

Prior to adding the Family Partner position to PES staffing, we would have just compassionately listened and provide referrals for the family. Having a Family Partner on the PES team allowed time to go into the community, meet with the family, and assist the mother in obtaining housing for her and her son. Not only was housing obtained, but it allowed the client to come home and live with her again. Furthermore, the Family Partner continued to work with them to assist the mother in enrolling the young man in a local school. The Family Partner was also able to assist the mother in advocating with another community provider to arrange for more appropriate assistance to the family going forward.

CO-OCCURRING CAPACITY

PROGRAM DESCRIPTION
July 2012 – June 2013

In the original community planning process for Mental Health Services Act (MHSA), addressing co-occurring disorders for clients in the mental health system of care was identified as a priority. While some of the Community Services and Supports (CSS) programs incorporate co-occurring capacity to differing degrees, the 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 (MHSUS) provided an opportunity to begin building capacity across the system. While enhancing co-occurring capacity is a long-term and ongoing effort, in FY2012-13, there were a number of small-scale projects that were implemented to begin assessing and identifying needs and resources for clients — and staff working with clients — who have co-occurring mental health and alcohol, tobacco and/or drug issues. In addition to those described here, program specific efforts are described within the appropriate program narrative.

Co-Location

Beginning in January 2014, a Licensed Consulting Addiction Specialist (0.60 FTE), from Bay Area Community Resources' Recovery Connections Center, began offering staff consultation, screening, assessment, linkage, collaborative treatment planning and care management services for seriously mentally ill clients with substance use issues. Services were offered and provided at mental health service sites located throughout the County, including Psychiatric Emergency Services and other programs at the Bon Air and Health and Human Services' Campus locations. This initiative provides direct services to clients, as well as increases the capacity of mental health staff to provide integrated services.

Improve Policies and Procedures

Marin County Health and Human Services has been working with internally and with consultants with expertise in systems integration to increase the co-occurring capacity of the County and contracted provider system of care. 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. Beginning in January 2014, 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

In response to local survey data (n=47) that showed a disproportionately higher rate of smoking (72%) among Marin County mental health consumer respondents compared to the overall Marin smoking rate (7.4%) — coupled with study data showing that, with the right support, 30.5% of smokers with recent mental illness were able to remain abstinent from tobacco for one year — Bay Area Community resources engaged peers to conducted a needs assessment to gather information

on what supports or inhibits tobacco cessation for mental health consumers in Marin. Through this project, peers were trained and conducted interviews with 125 tobacco using consumers from across the continuum of services. The results provide data and actionable recommendations that have been shared with various stakeholders and are being used to provide a basis for future cessation efforts.

OUTCOMES
July 2012 – June 2013

Co-Location

The new initiative to co-locate substance use staff consultation and direct client care at mental health sites and programs throughout the County met key program objectives during its six-month project period (January – June 2013).

- There were 15 informational presentations, meetings and case consultation sessions with mental health staff from across the system of care, including Psychiatric Emergency Services, Odyssey Program, STAR program, HOPE Program, Adult Case Management, Youth and Family Services, and other Providers.
- In March 2013, the Licensed Consulting Addiction Specialist provided began providing direct client care, including providing assessments, case management and other support services, to 16 unduplicated clients over 39 sessions.

Clinical Services (March - June 2013) – Co-Location

Age Group	# served	% of served
0-15 years old	1	6%
16-25 years old	1	6%
26-59 years old	11	69%
60+ years old	3	19%
TOTAL	**16**	**100%**
Race/Ethnicity		
White	13	81%
African/American	1	6%
Asian		
Pacific Islander		
Native		
Hispanic	2	13%
Multi		
Other/Unknown		

Primary Language	# served	% of served
English	16	100%
Spanish		
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		

Improve Policies and Procedures

- To expedite the admission process in order to be more welcoming and to help remove the stigma from enrolling in services, Marin Treatment Center reviewed, analyzed and redesigned their admission process, resulting in a 30% reduction in time for a client to complete an admission.
- Redesigned and adopted a continuous quality improvement framework and process to ensure ongoing assessment and improvement in serving clients with co-occurring mental health and substance use disorders.
- Provided training and consultation to 15 treatment, nursing and administrative staff on topics including effectively addressing PTSD, trauma and other co-occurring disorders.

Tobacco Cessation Capacity

- Seven peer mental health consumers were trained in interview techniques and successfully interviewed 125 consumers as part of the needs assessment process.
- Data generated during the interview process was used to develop a comprehensive assessment report — which was disseminated to stakeholders — identifying needs, service gaps and recommendations for enhancing system capacity to implement tobacco policies and provide cessation services that can effectively assist mental health consumers to quit smoking.

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

While co-location of a consulting addiction specialist has been invaluable in terms of staff consultation services and direct client care, the staff time needed to successfully address the complex needs of the client population does not afford the additional time necessary of many mental health staff and programs to also take on the capacity building aspect of the project as anticipated. In the absence of additional staffing or reduced caseloads, it is expected this initiative will continue to largely focus on ancillary consultation services to mental health staff and clients, rather than on building internal staff capacity to provide comprehensive services to clients with complex co-occurring mental health and substance use disorders.

The training and policy development initiatives implemented during FY 2012-13 were of a one-time nature and were intended to establish practices that institutionalized a welcoming and continuous quality improvement framework. As such, funding is not being allocated in FY 2013-14 to continue this particular effort.

Although the tobacco cessation needs assessment was a one-time project that ended in FY 2012-13, in FY 2013-14, Bay Area Community Resources will be implementing a series of strategies and cessation services for mental health consumers recommended in the needs assessment report. Strategies include stipend peer cessation support class facilitation, and policy development and on-site cessation services at agencies that work with mental health consumers.

HOUSING

In August 2007, the State Department of Mental Health released the guidelines for the Mental Health Services Act (MHSA) Housing Program (MHSAHP), a collaborative program administered by the California Housing Finance Agency and the State Department of Mental Health. MHSAHP funds can be used to build or renovate rental housing or shared housing. Rental housing developments are 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 2012 – June 2013

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 2012 – June 2013

During this reporting period, 3 of the 5 Fireside Senior Apartment MHSAHP-funded units continued to be occupied by the original tenants, with 2 of the units being vacated in late FY2012-13, continuing to indicate that this supportive housing project has been successful in reducing homelessness and enabling older adults with serious mental illness to maintain housing in the community and live independently. Both vacant apartments were scheduled to be occupied in early FY2013-14.

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

Marin has additional MHSAHP funds reserved for leveraging the development of permanent supportive housing for transition age youth (ages 16-25) and adults. 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, visits to potential housing sites, and the assistance of Craig S. Meltzner & Associates, a professional housing and community development consulting firm with experience in developing MHSAHP housing in other counties.

PREVENTION AND EARLY INTERVENTION (PEI) OVERVIEW

Marin County began the community planning process for development of the Prevention and Early Intervention (PEI) Plan, one of the components of the Mental Health Services Act (MHSA), 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 help prevent mental illnesses from becoming severe and disabling. This includes intervening early in the onset of symptoms; reducing risks related to mental illness; increasing recognition of signs of mental illness; reducing stigma and discrimination related to mental illness; preventing suicide; and connecting individuals to appropriate services. A minimum of 51% of PEI funds are required to be dedicated to youth and transition age youth (0-25 years old).

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, PEI Technical Assistance funds were available through FY2013-14. 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 by themselves 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. A continuing challenge is assessing the impact of PEI as a whole. Marin has continued to work with RAND Corporation in FY2013-14 to further develop its capacity to assess and report on both the program specific outcomes and the overarching impact of PEI.

Marin, along with a large majority of California counties, assigned a portion of MHSA PEI funds to a **Statewide PEI** effort. Those funds, managed by California Mental Health Services Authority (CalMHSA), have supported:

Suicide Prevention: Family Service Agency of Marin – a division of Buckelew Programs leads the North Bay Suicide Prevention Project, which is expanding suicide prevention services throughout 5 North Bay Counties, including a 24/7 suicide hotline and suicide prevention training for community members and providers.

Stigma and Discrimination Reduction: SDR uses a full range of Prevention and Early Intervention Strategies across the lifespan and across diverse backgrounds to confront the fundamental causes of stigmatizing attitudes and discriminatory and prejudicial actions. Campaigns include Each Mind Matters and Reach Out.

Student Mental Health Initiative: SMHI promotes and applies strategies to strengthen student mental health statewide across K-12 educational systems and through institutions of higher education. Marin is part of a regional effort focusing on anti-bulling strategies in K-8.

For more details about these programs and how they have impacted Marin, see Appendix B.

POPULATIONS SERVED BY PEI PROGRAMS

This table summarizes the individuals served by all PEI programs in FY2012-13.

Total Individuals Served: 9669

** Data is not collected on most Prevention (i.e., education and screening services.)*

Age Group	# served	% served
0-15 years old	1777	18%
16-25 years old	1343	14%
26-59 years old	4434	46%
60+ years old	1793	19%
Unknown	322	3%
Race/Ethnicity	**# served**	**% served**
White	5264	54.4%
African/American	434	4.5%
Asian	445	4.6%
Pacific Islander	19	0.2%
Native	24	0.2%
Hispanic	3051	31.6%
Multi	115	1.2%
Other/Unknown	317	3.3%

Primary Language	# served	% served
English	6110	63.2%
Spanish	3061	31.7%
Vietnamese	239	2.5%
Cantonese	8	0.1%
Mandarin	6	0.1%
Tagalog		
Cambodian		
Hmong		
Russian	11	0.1%
Farsi	4	0.04%
Arabic		
Other	230	2.4%
Other*	**# served**	**% served**
LGBTQ	81	16.1%
Homeless	371	73.9%
Veterans	50	10%

Of those receiving PEI services, 3837 received Early Intervention services. The initiations of the Vietnamese Community Connection and Southern Marin Community Connection programs have increase PEI services to Vietnamese and African American residents. 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 and has funded services in Central Marin, West Marin, Novato and South Marin.

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	2013
Participation on the PEI Committee helps my organization to develop expertise in MH prevention and programs	2.85	3.04
The PEI Com fosters a "culture of prevention" for mental health	3.00	3.17
The PEI Com works collaboratively with other efforts in the community to address issues	3.00	3.27
Participation on the PEI Com helps my organization to collaborate effectively with other organizations	2.89	3.32
The PEI Com contributes to the development of a mental health system of care	3.12	3.33

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.

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

PROGRAM DESCRIPTION
July 2012 – June 2013

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, Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funds expanded the mental health consultation services previously provided by Jewish Family and Children's Services in subsidized pre-schools and other early childhood education sites. All consultation services have the goal of increasing the capacity of the childcare providers and families in addressing the needs of children and families.

Prevention: 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 conducted as indicated. In FY2012-13 an Occupational Therapist was added to the consultation team, providing training and consultation regarding children with behavioral issues impacted by developmental delays.

Early Intervention: When children or families are identified as needing intervention, consultants assist with developing and facilitating the implementation of an intervention plan.

OUTCOMES
July 2012 – June 2013

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

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, including increasing their access to services due to early identification and effective linkages. 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 FY12-13
Prevention		
Children that received prevention services.	820	830
Percent of these children that come from un/underserved populations (Latino, Asian, African American, West Marin).	70%	85% *N=830*
Children in childcare setting served by ECMH consultants that were retained in their current program, or transitioned to a more appropriate preschool setting.	100%	100% *retained N=830*
Parents/primary caregivers participating in parent education programs that report increased understanding of their child's development and improved parenting strategies. *123 attended, 50 returned survey*	85%	100% *N=50*
Childcare staff that received additional consultation and/or training	165	160
Teachers 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 • increased ability to recognize and intervene with children's sensory needs	85%	94% 92% 90% 86% 93% *N=70*
Early Intervention		
Children/families identified for enhanced intervention and provided services through ECMH Consultation (intervention plan, warm hand-off, case consultation, etc).	75	90
Parents/primary caregivers receiving case consultation that report increased understanding of their child's development and improved parenting strategies. *27 received services, 12 returned survey*	85%	100% *N=12*
Satisfaction		
Families receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent).	85%	100%
Teachers receiving ECMH Consultation services that report: • they would recommend the services to other teachers • satisfaction with the services (rated services as Good or Excellent)	85%	100% 98% N=70
Director's receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent)	85%	100% N=15

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	830	100%
16-25 years old		
26-59 years old		
60+ years old		
Total	**830**	**100%**
Race/Ethnicity		
White	199	24%
African/American	25	3%
Asian	41	5%
Pacific Islander	5	1%
Native		
Hispanic	485	58%
Multi	64	8%
Other/Unknown	11	1%

Primary Language	# served	% of served
English	341	41.1%
Spanish	485	58.4%
Vietnamese		
Cantonese		
Mandarin	4	0.5%
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		

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. Many of these families do not have other opportunities to obtain identification and intervention services for their children's behavioral issues.

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

Due to a lack of access to adjunct services for many children in these settings, PEI provided additional funds in FY2012-13 and FY2013-14 for a part-time Occupational Therapy Consultant (OTC) to provide training, consultation, observation, and, as appropriate, treatment planning. The OTC has been instrumental in increasing the capacity of the ECMH consultants, childcare providers, and families to recognize and address sensory processing problems.

The ECMH program works closely with the Marin County Office of Education (MCOE) to further efforts to have children ready to learn when they enter kindergarten by increasing the quality of care provided in early childcare settings. MCOE provides ongoing training to childcare providers, and the ECMH consultants help to integrate this training through coaching childcare staff at the childcare sites during their weekly visits.

EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

CLIENT STORY

Joseph was one of 13 children in an infant-toddler classroom and had been at the center since he was 4 months old. Although beginning to wonder about his speech, the staff had no serious concerns until he was 19 months old and experienced the trauma of being taken from his father's arms at the county fair by a plainclothes police officer. Joseph's dad, an undocumented immigrant with a criminal history, was immediately transferred to detention and eventually deported. Joseph began biting and hitting other children, moving constantly, and was unable to focus or sleep well. The childcare staff and administration was at the point of expelling Joseph because of his injurious behavior toward the other children. The consultant began working with the staff to help them understand the impact of Joseph's trauma and shift their frustration and despair into empathy. She began meeting with Joseph's mother, who had been hesitant to share much and engage with the teachers. Knowing that Mom's well-being was dependent on the staff's ability to help her child, our consultant worked to gain her trust and to help Mom and childcare staff forge a trusting partnership.

With the consultant's support, Mom followed through on her referrals for Infant-Parent Psychotherapy (IPP) and speech therapy at Golden Gate Regional Center. The consultant collaborated with the IPP and speech therapists to coordinate care and interventions in the classroom and at home. She facilitated Joseph's transfer to the preschool classroom at the same site, meeting with Mom and the teachers, together and separately, to bridge the trust that had developed in the infant room. They developed a treatment plan based on the results of the DECA-C assessment tool.

Shortly after the transition to the Preschool classroom, Joseph's mom was confronted with two new overwhelming stressors: the family became homeless and Mom was diagnosed with thyroid cancer. The consultant sprang into action, helping center staff and administration advocate for Mom with several community agencies to guarantee appropriate and timely medical treatment as well as an extension to her homeless shelter stay. Additional stress was the result of Mom's awareness of Dad's continued attempts to cross the border until his most recent arrest and sentence that included a 20-year ban on entry to the United States under any circumstances.

Throughout the most recent changes to the now 3-year-old Joseph, the staff reported very little regression, no biting, hitting, or unfocused hyperactivity, and a significant decrease in previously expressed fears. Current work with the staff involves helping Joseph to gain the play skills that were deferred as he was helped to cope with the trauma in his life, and helping

teachers sustain their empathy for Joseph and Mom and increase their awareness of his need for reassurance and security.

Thanks to the supportive relationships our ECMH consultant nurtured among Mom and staff, and the concrete supportive services she helped put in place, Mom has continued to function very effectively, staying fully engaged with Joseph and his older sister, following through on all of the referrals, continuing in therapy, and getting Joseph to speech therapy. Our consultant has also helped her begin conversations with the staff of the site's afterschool program regarding the needs of Joseph's older sister. ECMH consultation has created the community to support and provide continuity to this mom who has faced daunting challenges, and to rescue her child.

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

PROGRAM DESCRIPTION
July 2012 – June 2013

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.

Prevention: The Mental Health Services Act (MHSA) Triple P Program provides training in Triple P levels 2-5. Levels 2 and 3 are primarily prevention, "light touch" oriented. In addition, in FY2012-13 the following were provided:

- Workshops for school staff to increase their skills in working with students and parents, as well as knowledge of available parenting resources;
- Stipends for participating agencies to conduct Level 2 seminars;
- Outreach to gatekeepers about Triple P services available to parents.

Early Intervention: The MHSA Triple P Program provides training in Triple P levels 2-5. Levels 4 and 5 are primarily early intervention.

Triple P Levels

1	Media/Information Campaign to normalize need for parenting help and inform families and providers about services
2	Group presentations about general child development and parenting issues.
3	Individual or group, brief parent "coaching" about a specific concern the parent(s) has. Provided by a wide range of providers who work with families.
4	Individual or group parenting "coaching" over approximately 10 sessions. Usually provided by licensed mental health workers.
5	3-10 individual sessions with parents with complex issues affecting their parenting. Usually provided by licensed mental health workers.

OUTCOMES
July 2012 – June 2013

MCOE has successfully trained a broad array of family providers in multiple levels of Triple P, as well as piloted a school staff training effort. These agencies serve a very diverse client base. In FY2012-13, 164 families received Level 3 or 4 services (demographics below).

Outcome	Goal	Actual FY12-13
Prevention		
Number of parents that participated in Level 2 seminars. *55% in Spanish.*		566
Number of families that received Level 3 services.		155
Providers certified in Level 3		29
Providers certified in Level 2		17
Early Intervention		
Number of families that received Level 4 services.		9

Age Group	# served	% of served
0-15 years old	164	100%
16-25 years old		
26-59 years old		
60+ years old		
Total	**164**	**100%**
Race/Ethnicity		
White	53	32%
African/American	10	6%
Asian	3	2%
Pacific Islander		
Native		
Hispanic	91	56%
Multi	3	2%
Other/Unknown	4	2%

Primary Language	# served	% of served
English	76	46.3%
Spanish	80	48.8%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi	3	1.9%
Arabic		
Other	5	3.0%

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

Providing training and technical assistance for providers, but almost no support for direct services, has made it difficult to ensure fidelity to the model and the collection of outcome data. MCOE has enhanced the technical assistance provided to increase providers readiness to implement Triple P with fidelity and has worked with providers to increase data reporting.

One of the barriers to implementing Triple P that providers have expressed is that parents are not aware of it and therefore not always receptive to it. MCOE and the Mental Health and Substance Use Services Division have research on the feasibility of implementing Level 1, the social media campaign, to reduce stigma associated with accessing parenting services and to increase awareness of Triple P as an effective program. While there would be benefits to such a campaign, research showed that there are likely more cost-effective methods for increasing access to and utilization of parenting services.

ACROSS AGES MENTORING

PROGRAM DESCRIPTION
July 2012 – June 2013

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 components: (1) adults mentoring youth, (2) youth performing community service, (3) youth participating in a life skills/problem-solving curriculum, and (4) regular 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.

Prevention:

- MCN provides life skills workshops and community service opportunities for more students than are matched with mentors.

Early Intervention:

- Students receiving mentoring services are referred by school counselors and teachers based on being identified as most at-risk. While the mentors may not be professional mental health workers, the extent of the relationship should provide early intervention benefits.

OUTCOMES
July 2012 – June 2013

In FY2012-13, the goal of matching mentors and mentees was not met, therefore there is not outcome data for the core aspect of the program. During the year, the infrastructure was developed to implement Across Ages as a school-community program, rather than a community-based program, which is considered more effective. Seven mentors were screened and trained, ready to be matched with a mentee for the 2013/14 school year. Mentors and referred students attended a barbeque to begin the matching process. Community service and life skills components of the program were implemented for 11 girls (outcomes below). Of these 11 girls, seven also received services that included their families. In addition, MCN collaborates with 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 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 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 FY12-13
Prevention		
Number of female students that received group services.	12	11
Percent of these students that come from un/underserved populations.	90%	100% *N=11*
Number of life skills lessons conducted.	15	18
Percent of students receiving group services that participated in community service.	60%	82% *N=11*
Outcomes for mentor activities not available because goal of matching mentors and mentees was not met.		

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	11	100%
16-25 years old		
26-59 years old		
60+ years old		
Total	**11**	**100%**
Race/Ethnicity		
White		
African/American	9	82%
Asian		
Pacific Islander		
Native		
Hispanic	1	9%
Multi	1	9%
Other/Unknown		

Primary Language	# served	% of served
English	10	90.9%
Spanish	1	9.1%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

During the MHSA Three Year Plan community planning process, school age youth in Southern Marin continued to emerge as a priority population. At the same time, there is a significant increase in the level of school-community partnership underway in Southern Marin. MHSA PEI will increase the funding available for serving school age youth in Southern Marin and conduct a Request for Proposal (RFP) process under the MHSA PEI "School Age Program" described in the MHSA Three Year Plan for FY2014-15 through FY2016-17 in order to determine the most effective services given the infrastructure changes.

ACROSS AGES MENTORING

CLIENT STORY

In an effort to become better acquainted with the students in the fifth grade class at MLK Academy, understand some of the issues and behaviors, and build a relationship with the teacher, Sharon Turner of Marin City Network's (MCN) spends one morning each week in the classroom.

The teacher would often have to send some of the students out of the classroom to help limit some of the distraction and interruptions to teaching. She began to have Sharon sit with the students in the hall. On one occasion, she had the opportunity to talk at length with one of the male students. He admitted that a lot his behavior was to fit in with a couple of his so-called 'friends'. They talked a little about what friendship meant. She described the mentoring program MCN was developing. Before she saw it coming, tears welled up in his eyes and he softly said, "I want one". He asked her to please talk to his mom about it. She did. Mom's first response was, "When?" This is was one of the first school referrals and was one of the participants in our first mentoring activity.

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2012 – June 2013

The Transitional Aged Youth (TAY) PEI program aims to increase wellness by increasing access for transition age youth (16-25 year olds) to behavioral health support. Huckleberry Youth Program (HYP) and Novato Youth Center (NYC) have implemented screening and brief intervention in their teen health clinics since July 2009, as well as psycho-education workshops for TAY and their parents in a variety of settings. In FY2012-13, skill-building workshops for high-risk teens and their caregivers were provided by LIFT-Levántate and the Center for Restorative Practice.

Prevention:

- Screening: Clients complete a validated screening for an array of mental health and substance use issues when accessing teen heath clinic services.
- Psycho-education: Single session workshops for TAY focusing 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.

Early Intervention:

- Skill Building Groups: Multiple session groups are held at high schools and in the community to promote coping and problem-solving skills. Services are for at risk teens, such as students who have been in the US less than 6 months, teens who are at-risk of school failure, those who have contact with the law, are in foster care or who struggle with depression, anxiety or suicidal ideation.

- Brief Intervention: Youth screening positive for risk factors in the teen health clinics 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.

OUTCOMES
July 2012 – June 2013

The TAY PEI Program continues to provide effective services (see Outcome Table). All services have a focus on un/underserved populations. Outreach was conducted with agencies such as Canal Alliance, Marin City Health and Wellness Center, Marin City, Southern Marin Multi-Disciplinary Team, and Marin Asian Advocacy Project. As can be seen below, the services are successfully reaching underserved populations. Many of the staff hired with MHSA funds are bilingual and bicultural.

Outcome	Goal	Actual FY12-13
Prevention		
Number of TAY that received Prevention services.	600	453
Percent of clients from un/underserved cultural populations. *Includes those receiving prevention and/or early intervention*	65%	67% *N=576*
Percent of TAY participating in psycho-education activities that report an increase in knowledge regarding resources and coping skills.	80%	100% *N=67*
Percent of providers completing training sessions that show an increase in knowledge about screening and referring TAY for mental health concerns.	90%	100% *N=28*
Early Intervention		
Number of TAY that received Early Intervention services at teen clinics.	80	198
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%	90% *N=92*
Number of TAY that participated in skills building workshops.	70	60
Satisfaction		
Clients completing brief intervention (3 sessions or more) reporting satisfaction with the services. *93 received 3 or more sessions, 80 completed survey*	75%	98% *N=80*

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	39	6%
16-25 years old	593	93%
26-59 years old	4	1%
60+ years old		
Total	**636**	**100%**
Race/Ethnicity		
White	191	30%
African/American	33	5.2%
Asian	20	3.1%
Pacific Islander	4	.6%
Native	5	.8%
Hispanic	324	50.9%
Multi	26	4.1%
Other/Unknown	33	5.2%

Primary Language	# served	% of served
English	398	62.6%
Spanish	173	27.2%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi	1	0.2%
Arabic		
Other	64	10.1%
Others	**# served**	**% served**
LGBTQ	56	8.8%
Homeless		
Veterans		

636 clients received services.
96 parents/caregivers participated in workshops or brief intervention services.

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

In FY2012-13 and FY2013-14 NYC and HYP received increased funding to implement additional evidence-based programs. Clinical staff received 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.

In FY2012-13 and FY2013-14 funds were provided to LIFT/Levántate and The Center for Restorative Practice to offer skill-building workshops to at-risk teens (13-18 year olds) and their parents. While the services were well received, higher priority strategies for reaching this age group were identified during the community planning process, such as focusing on services in schools. The skills-building workshops were not recommended to be continued in the MHSA Three Year Plan for FY2014-15 through FY2016-17.

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

CLIENT STORY

"Marcos" is a 17 year old Latino male referred for feeling overwhelmed with stress, feelings of doubt, lack of confidence, low self-esteem and anxiety. Marcos experienced loss of his grandfather who was killed in a tragic accident 3 months prior to beginning counseling. He also experienced a loss in 2011 when his brother was convicted of a gang-related crime and was deported. Marcos reports that he had close relationships with both his brother and his grandfather, and has had difficulty coping with the loss. He also experienced a loss of many of his close friendships after changing schools and making lifestyle changes to avoid gang involvement himself. He describes feeling stress and insecurity around these issues and has developed some health issues (ulcers) during this time of stress.

In addition, Marcos has been under pressure from family to succeed and not follow in the footsteps of his older brother. Marcos attends individual therapy weekly and family therapy occasionally. In individual counseling Marcos discusses the feelings of stress he has over being the last remaining son living at home and the pressure he feels to succeed. He has been able to express feelings of sadness and loss, as well as not take responsibility for all of his family's problems on himself. When his mother came for the first family therapy meeting she presented as frustrated and almost hostile with Marcos. Marcos appeared anxious, hurt and at times and frustrated, trying to communicate concerns to his mother about worries over school, stress, and low self-esteem. During the meeting the therapist used positive reframes (Behavioral Family Systems Therapy) to provide affirmation to his mother and reduce defensiveness and negativity.

She acknowledged the amount of stress the family has experienced and the resulting worries she has for her son, at which point she became tearful and expressed her concerns for Marcos and fears about his upcoming departure to college in one year. The therapist normalized Marcos's developmental stage, and while his mother wants to protect him, he is also working on the task of creating his own identity and finding his career path, ultimately to leave home for college. Through family and individual work the client has reported much higher scores on the Outcome Rating Scale which measures client's wellbeing (from 18.5/40 at first session to 39/40 at the 8th session).

CANAL COMMUNITY-BASED PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2012 – June 2013

Canal Community-Based Prevention and Early Intervention (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.

Prevention:

- Training CA front line workers to identify and refer clients in need of behavioral health support, as well as to increase their skills in supporting clients with such concerns.
- Assessment sessions to identify issues and resources for individuals and families.

Early Intervention:

- Groups for anxious, depressed and/or traumatized individuals for mutual support, training in individual and group tools to reduce symptoms and increase and maintain mental wellbeing.
- Individual/family problem-solving sessions.

Canal Alliance (CA) 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 2012 – June 2013

The Canal Community-Based PEI Program exceeded its goals (see Outcome Table below). CA effectively adjusts its program to respond to client need, while maintaining focus on the desired mental health outcomes. The Wellness Groups have been expanded to include: stress management for men and women, survivors of domestic violence, mothers with trauma, parenting groups for young mothers and their children, and families reunifying after separation. 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 and programs addressing domestic violence.

Outcome	Goal	Actual FY11-12
Prevention		
Number of clients receiving Prevention services.	300	386
Percent of clients from un- or underserved cultural populations.	75%	91% + *N=386*
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*
Early Intervention		
Number of clients receiving Early Intervention services.	80	126
Percent of CAPEI clients who complete the brief intervention program that report improved mental health status.	75%	83% + *N=36*
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		 94% 94% 83%
Percent of CAPEI clients who complete the brief intervention program that report a decreased sense of isolation and increased sense of social support.	85%	94% + *N=36*
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		 100% 94%
Percent of CAPEI clients who complete the brief intervention program that increase their knowledge and demonstrate their use of wellness strategies.	80%	73%+ *N=36*
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%
Satisfaction		
Percent of PEI clients completing the brief intervention program that report satisfaction with the services.	85%	100% *N=36*
Specific responses: • I am satisfied with the services I received in this agency • I would recommend this agency to a friend or family member • The staff believes I can grow, change and recover		100% responded "strongly agree"

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	45	12%
26-59 years old	315	82%
60+ years old	26	7%
Total	**386**	**100%**
Race/Ethnicity		
White	10	2.6%
African/American		
Asian		
Pacific Islander		
Native		
Hispanic	345	89.4%
Multi		
Other/Unknown	31	8%

Primary Language	# served	% of served
English	22	5.7%
Spanish	321	83.2%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	43	11.1%
Others	**# served**	**% served**
LGBTQ		
Homeless		
Veterans		
Indigenous	17	4.4%

CHALLENGES AND UPCOMING CHANGES FORY FY13-14

The Separation/Reunification Pilot Project has been funded in FY2012-13 and FY2013-14. In FY2012-13 13 families participated in the program, but none completed the entire format as designed. In FY2013-14, a variety of changes have been made to the program to increase participation. Currently 12 youth are participating and the parents report significant improvement in their behavior. Canal Alliance will continue these services in the future.

In the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, the Canal Community Based PEI program will be merged with the Community Health Advocates (CHA) program.

INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

PROGRAM DESCRIPTION
July 2012 – June 2013

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 Mental Health Services Act (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. In FY2012-13, Marin City Health and Wellness Center and Ritter Center received MHSA funds to expand their IBH programs. In addition, Sutter Health Access to Care funds were provided through Marin Community Foundation to expand IBH services.

In FY2012-13, MCC, CHA, and Ritter center provided the following services:

Prevention:

- routine screening for depression and other behavioral health concerns
- warm hand-off to behavioral health staff if indicated

Early Intervention:

- 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
- consultation for behavioral health staff and primary care providers with a psychiatrist to inform client care.

OUTCOMES
July 2012 – June 2013

Outcome	MCC		CHA	
	Goal	Actual FY12-13	Goal	Actual FY12-13
Prevention				
Number of clients screened for behavioral health concerns. *(PHQ2 at a minimum)*		1,028		3,445
Early Intervention				
Number of clients that received brief intervention services.	300	712	180	150
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 (below 10 on PHQ9).	50%	44% *N=438*	50%	33% *N=103*
Percent of those screening positive for depression that enrolled in brief intervention services.	40%	47% *N=123*	40%	55% *N=264*

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

In FY2012-13, Marin City Health and Wellness Center and Ritter Center were provided 7 months of funding to develop/expand their IBH programs. During that time outcomes measures were not required.

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. Most staff 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. Marin City Health and Wellness Center is well integrated into the diverse area it serves. Ritter Center serves very low-income, precariously house, and homeless Marin residents. Ritter provides a range of free services, including case management, primary health care, food and clothing, emergency financial assistance, and substance use services.

In addition, Center Point, a substance use services agency, provided mental health services for 40 of their clients with substance use disorders and mental health diagnosis, but who were not eligible for county mental health services.

Marin Community Clinics (MCC)

Age Group	# served	% of served
0-15 years old	197	12%
16-25 years old	216	13%
26-59 years old	1083	63%
60+ years old	211	12%
Total	**1707**	**100%**
Race/Ethnicity		
White	1301	76.2%
African/American	79	20.5%
Asian	42	10.9%
Pacific Islander	4	1%
Native	13	3.4%
Hispanic	190	49.2%
Multi	6	1.6%
Other/Unknown	72	18.7%

Primary Language	# served	% of served
English	1090	63.9%
Spanish	561	32.9%
Vietnamese	5	0.3%
Cantonese		
Mandarin	2	0.1%
Tagalog		
Cambodian		
Hmong		
Russian	8	0.5%
Farsi		
Arabic		
Other	41	2.4%

1,028 clients were screened for behavioral health concerns.
712 received brief intervention (some were referred by brief intervention without screening).

Coastal Health Alliance (CHA)

Age Group	# served	% of served
0-15 years old	39	1%
16-25 years old	318	9%
26-59 years old	2168	63%
60+ years old	920	27%
Total	**3445**	**100%**
Race/Ethnicity		
White	2358	68.4%
African/American		
Asian		
Pacific Islander		
Native		
Hispanic	1037	30.1%
Multi		
Other/Unknown	50	1.5%

Primary Language	# served	% of served
English	2446	71.0%
Spanish	963	28.0%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian	3	0.1%
Farsi		
Arabic		
Other	33	1.0%
Others	**# served**	**% served**
LGBTQ		
Homeless		
Veterans	13	0.4%

3,445 clients were screened for behavioral health concerns.
150 received brief intervention.

Marin City Health and Wellness Center (MCHWC)

Age Group	# served	% of served
0-15 years old	4	9%
16-25 years old	4	9%
26-59 years old	30	67%
60+ years old	7	16%
Total	**45**	**100%**
Race/Ethnicity		
White	23	51%
African/American	15	33%
Asian	2	4%
Pacific Islander	0	0%
Native	1	2%
Hispanic	1	2%
Multi	2	4%
Other/Unknown	1	2%

Primary Language	# served	% of served
English	44	97.8%
Spanish	1	2.2%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Others	**# served**	**% served**
LGBTQ		
Homeless		
Veterans		

45 clients received brief intervention.

Ritter Center

Age Group	# served	% of served
0-15 years old		
16-25 years old	54	8%
26-59 years old	525	80%
60+ years old	76	12%
Total	**655**	**100%**
Race/Ethnicity		
White	393	60%
African/American	97	14.8%
Asian	10	1.5%
Pacific Islander	3	.5%
Native	5	.8%
Hispanic	54	8.2%
Multi		
Other/Unknown	93	14.2%

Primary Language	# served	% of served
English	625	95.4%
Spanish	30	4.6%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Others	**# served**	**% served**
LGBTQ		
Homeless	20	3.1%
Veterans	319	48.7%

655 clients received brief intervention

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

In FY2014-15, Prevention and Early Intervention (PEI) will significantly change this program in part due to the Affordable Care Act (ACA). The ACA provides for increased mental health and substance services for insured clients, as well as increasing the number of individuals with insurance. PEI will focus on providing similar behavioral health services for the uninsured in primary care settings. The revised program is further described in Marin's MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 under Integrated Behavioral Health in Primary Care.

INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

CLIENT STORY

"Ken" is a 64 year-old patient referred by his primary care provider for problem solving therapy (PST). Ken had an initial PHQ-9 score of 12 points. When he returned for his behavioral health appointment three days later and was re-screened, his PHQ-9 was at 22 points, indicating severe depression. He had lost his job.

During his behavioral health intake, Ken stated that he worked as a bartender for 33 years. One day, while on the job, he took a sip of alcohol and was caught on camera and fired on the spot. While he denied alcohol abuse, he admitted to having a drink occasionally to help decrease stress on the job. During the intake visit he was tearful, fearful about his future, and worried about finances. He said he had no support system and had never married or had children. He was not only depressed but was also experiencing severe grief regarding loss of his work identity.

During the second session, Ken created a list of his immediate problems: need for affordable housing; need for financial planning; decision-making regarding employment vs. retirement; health insurance benefits; medication support; and self-care. He used the intervention sessions to focus and find direction. Two months later, he found affordable housing through the Housing Authority. With lower rent, he was able to accomplish his goal of managing his finances. Regarding employment, he decided that the job market was tough and chose retirement. He applied for health and retirement benefits. He also decided that the primary care setting at Marin Community Clinics was a good place to get his health needs met.

Ken met with a psychiatrist twice for medication support. Throughout the process he exercised good judgment in self-care, nutrition and exercise. At the mid-point in his counseling he realized that he had some good friends and went out to lunch with them. He also visited his co-worker and previous employer (who fired him) and felt welcomed. Ken was happy to reconcile his emotions and put closure to this episode of his life.

After nine visits including intake, Ken had a PHQ-9 score of 0 – a remarkable improvement. He has continued in the behavioral health program, coming once a month for support in reviewing his life goals as a retired man and his ever-changing identity. PST has had a grounding effect for him and provided the support he needed to address changes in his life.

OLDER ADULT PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2012 – June 2013

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 Prevention and Early Intervention (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.

Prevention:

- Outreach and education 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.

Early Intervention:

- Brief intervention for depression, including developing care management plans, behavioral activation (Healthy IDEAS), and short-term problem-focused treatment.
- Linkages to other services as needed.

OUTCOMES
July 2012 – June 2013

The Older Adult PEI program exceeded its goals (Outcome Table below). Workshops have been provided in a variety of locations, especially targeting African-American, Asian and Latino communities. More in-depth trainings were provided for 105 Marin Villages leaders, volunteers and members. The Spanish-speaking peer provider program, Amigos Consejeros a su Alcance (ACASA), developed relationships with 14 leaders in the Latino and mental health community to increase access to services and continuity of care for Spanish speaking older adults. Jewish Family and Children's Services expanded their existing older adult intervention services to address depression, substance use and other behavioral health concerns, including an evidence-based approach to depression, Healthy IDEAS. In addition, the Novato Fire Department completed a study about falls among older adults, including the link between falls and depression. They expect to use the results to inform first responder practices, such as potentially screening older adults for depression and providing referrals for mental health services.

Outcome	Goal	Actual FY12-13
Prevention		
Number of clients, community members or providers receiving outreach and education presentations.	400	411
Percent of those receiving educational presentations from un/underserved populations (Latino, African-American, Asian, LGBTQ, ESL).	20%	56% *N=411*
Number of Seniors At Home clients screened for depression and substance use.	150	157
Early Intervention		
Number of low-income clients receiving early intervention services, including care management, depression care, and linkages to services.	30	32
Percent of older adults completing the Healthy IDEAS intervention experiencing a reduction in symptoms of depression. *(PHQ9)*	75%	87% *N=15*
Percent of older adults receiving brief intervention reporting that the program "helped me to feel more connected to others." *(61% strongly agreed, 29% somewhat agreed)*	75%	90% *N=28*
Percent of older adults receiving brief intervention that will successfully address one or more client goals in the client's care plan.	75%	82% *N=22*

Age Group	# served	% of served
0-15 years old		6%
16-25 years old		93%
26-59 years old	114	1%
60+ years old	434	0%
Total	**548**	**100%**
Race/Ethnicity		
White	288	52.6%
African/American	127	23.2%
Asian	103	18.8%
Pacific Islander		
Native		
Hispanic	30	5.5%
Multi		
Other/Unknown		

Primary Language	# served	% of served
English	468	71.5%
Spanish	2	.3%
Vietnamese	55	8.4%
Cantonese	8	1.2%
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	15	2.3%
Others	**# served**	**% served**
LGBTQ	56	8.8%
Homeless		
Veterans		

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

In FY2012-13, Mental Health Services Act (MHSA) PEI provided funds for the "Preventing Depression Associated with Falls" research project. 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: analyzed NFD data to determine trends related to falls in elderly patients; piloted the use of a depression screening tool (PHQ2) by paramedics and EMTs; are developing fall prevention strategies based on the research. This was a one-time project in FY2012-13 to inform practices and policies in the future.

OLDER ADULT PREVENTION AND EARLY INTERVENTION

CLIENT STORY

"Sarah", a 78-year-old client, was responding well to cancer treatment, but was very depressed about recent events and her current frail health. She did not want to get up most days and gave up many of her previous interests, such as reading and knitting. Her initial screening scores on the PHQ-9 and GAD-7 indicated moderate, clinically significant depression and anxiety. Her companion of many years, also in frail health, was her primary caretaker. She was estranged from her children and did not want them to see her in her present state.

The client was encouraged to come to our office for a brief therapy protocol of eight sessions so that she would have a reason to get dressed and leave her apartment. Her treatment focus included cognitive restructuring, guided imagery, and Healthy IDEAS behavioral activation. She learned how her anxiety was exacerbated by helplessness she felt in the past, and mastered tools to help her manage this anxiety. The client was connected to Jewish Family and Children's Services Rides for transportation and to our Home Care program for respite care to help preserve her relationship with her companion.

At treatment's end, the client's depression and anxiety were considerably improved as documented on PHQ-9 and GAD-7. She is now going to the library and enjoys eating out weekly with her companion. She is paying more attention to her attire and recently had a haircut. Sarah reported, "Six months ago, I would say I would not be around in a couple of years. Now I have hope, and maybe I could even be ready to see some of my grandchildren that I never met."

CLIENT CHOICE AND HOSPITAL PREVENTION CRISIS PLANNING

PROGRAM DESCRIPTION
July 2012 – June 2013

Prevention and Early Intervention (PEI) and Innovation (INN) 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 facility 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 Crisis 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 (PES) 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.

Prevention:

- Development of crisis plans with those at risk of a psychiatric crisis.

OUTCOMES
July 2012 – June 2013

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 its second year, it focused on reaching clients who have accessed PES multiple times in the past, as well as following up with clients who developed their plans last year.

Due to this program's importance within the larger Client Choice and Hospital Prevention (CCHP) program, an evaluation consultant has been engaged to establish the evaluation process for CCHP. The Crisis Planning evaluation has only needed to adjust slightly to be a useful part of that.

Crisis Planning services and written materials are available in English and Spanish. This year Crisis Planning personnel worked with TAY programs, the Prisoner Services Program, and other programs to reach a wider range of clients.

Outcome	Goal	Actual FY12-13
Prevention		
Number of clients and/or families that will receive Crisis Planning services.	100	Outreach Svcs 150 Planning Svcs 60
Percent of clients receiving planning services that file a completed Crisis Plan in their medical records.	50%	55% *N=60*
Percent of clients receiving Crisis Planning Services that have accessed PES multiple times in the past.	30%	*48%* *N=33*
Percent of clients and/or families completing a Crisis Plan that report increased understanding of the community resources available to them.	60%	63% *N=33*
Percent of clients completing a Crisis Plan that report increased awareness of their individual symptoms and supports.	60%	54% *N=33*
Percent of clients reporting that Crisis Planning decreased their need to psychiatric emergency services 3-6 months after completing the plan.	50%	59% *N=37*
Percent of clients reporting that having a Crisis Plan improved their experience at PES.	50%	44% *N=9*

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	7	12%
26-59 years old	48	80%
60+ years old	5	8%
Total	**60**	**100%**
Race/Ethnicity		
White	47	78.3%
African/American	1	1.7%
Asian	3	5%
Pacific Islander	2	3.3%
Native		
Hispanic	7	11.7%
Multi		
Other/Unknown		

Primary Language	# served	% of served
English	59	98.3%
Spanish	1	1.7%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		

In addition to the 60 clients reflected here, 2 families were served.

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

It has been recommended in the MHSA Three Year Plan for FY2014-15 through FY2016-17 to continue the Crisis Planning program through Community Services and Supports (CSS) component to increase its integration with the continuum of crisis services.

CLIENT CHOICE AND HOSPITAL PREVENTION CRISIS PLANNING

CLIENT STORY

"Aaron" is a 43 year-old male who started working on his Crisis Plan shortly after a lengthy inpatient stay in a hospital out of county. The client reported that the hospitalization was a traumatic event that left him feeling misunderstood and abandoned by clinical staff at Community Mental Health.

During the process of creating a plan, Aaron embraced the client choice model, relating that he felt misdiagnosed with Schizophrenia and that clinicians should take greater account of Post Traumatic Stress in their treatment planning. Aaron was also hopeful that more emphasis could be placed on homeopathic remedies to address the stress, anxiety and physical pain that he experienced from medication side effects.

Finally, Aaron had a safe space to convey that medication monitoring (a compulsory component of his supported housing) was an intervention that left him feeling powerless and closer to crisis rather than farther from it. After meeting with the Crisis Planning program Aaron was able to have more productive conversations with clinical and community providers. This resulted in a treatment conference where the clinical team agreed to enlist the services of a homeopathic provider and reduce the level of antipsychotic medication that Aaron was prescribed. The conference also fostered discussion around how Aaron could best be intervened with and supported if there were concerns about his behaviors so that a crisis or hospitalization could be averted.

Ultimately there was a shift in Aaron's attitude and a stronger belief that he could partner with his mental health providers. More importantly, he had concrete results that indicated his choices as a client were being taken seriously and had a positive impact on management of his mental illness.

VIETNAMESE COMMUNITY CONNECTION

PROGRAM DESCRIPTION
July 2012 – June 2013

Members of the Vietnamese community are at risk for mental health issues due to isolation, racism, poverty and exposure to trauma. Due to the lack of cultural competency and linguistic barriers in the current mental health system, individuals and families often seek assistance from only the most trusted and familiar sources. Yet, these sources are often not trained to identify and respond to mental health and emotional disturbances. It is important to provide a trusted and trained resource for the community.

The goal of the Vietnamese Community Connection program is to increase access for the Vietnamese population to supports and services at the earliest possible signs of mental health problems so that there will be an increase in wellness and a reduction in stigma. Most of the Prevention and Early Intervention (PEI) programs do not have the capacity to serve the monolingual Vietnamese community or to do effective outreach into the Vietnamese community.

This program provides:

Prevention:

- Provide outreach and behavioral health education for the Vietnamese community.
- Assist Vietnamese residents in accessing mental health services by providing referrals, warm hand-offs, translation and accompaniment to appointments.
- Provide information to increase the behavioral health system's understanding of the needs of the Vietnamese community.

Early Intervention:

- Individual and family sessions, including assessments and brief interventions.
- Group sessions for those experiencing stress, depression, and other mental health concerns.

OUTCOMES
July 2012 – June 2013

The Vietnamese Community Connection program has been provided by Community Action Marin's Marin Asian Advocacy Program since July 2012. It has already made significant strides in connecting the Vietnamese community to mental health services. Five community health advocates (CHAs) have provided outreach at community events, including hosting "field trips" to get isolated older adults together. A bilingual, bicultural mental health worker has assessed and provided individual and group support for clients referred from the CHA's, as well as other sources. During community

meetings regarding the MHSA Three Year Plan community input process, Vietnamese participants expressed great appreciation for the program.

Outcome	Goal	Actual FY12-13
Prevention		
Individuals receiving prevention services.	200	170
Individuals receiving assistance in accessing services (translation, etc.).	30	36
Percent of those receiving behavioral health education that show an increase in knowledge.	50%	80% *N=65*
Early Intervention		
Individuals receiving early intervention services.	30	44
Percent of those receiving brief intervention that show an improvement in mental health status.	50%	80% *N=44*

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	35	21%
16-25 years old	45	26%
26-59 years old	0	0%
60+ years old	90	53%
Total	**170**	**100%**
Race/Ethnicity		
White		
African/American		
Asian	170	100%
Pacific Islander		
Native		
Hispanic		
Multi		
Other/Unknown		

Primary Language	# served	% of served
English		
Spanish		
Vietnamese	170	100.0%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

There is a lack of mental health providers in Marin who are fluent in English and Vietnamese, resulting in barriers to services. Vietnamese Community Connection is increasing mental health knowledge and skills among the Vietnamese community, while also collaborating with Vietnamese speaking providers throughout Health and Human Services, to increase the capacity for responding to Vietnamese speaking individuals efficiently and effectively. In addition, Mental Health and Substance Use Services Division (MHSUS) prioritizes recruiting Vietnamese speaking interns.

VIETNAMESE COMMUNITY CONNECTION

CLIENT STORY

During the first session of the Vietnamese Stress Management group, the facilitators asked the group, "What do you hope to get out of this group?" There was a male participant who answered, "I'm looking for support because I'm crazy. I'm crazy so I need mental health counseling." The facilitators took the opportunity to discuss the term "crazy."

What the male client was describing sounded very much like PTSD symptoms from his hardships related to the Vietnam War and immigration, so they provided some psycho-education about trauma. The client appeared receptive. Three weeks later, during group introductions, a brand new female participant introduced herself and said, "I'm here because I'm crazy." Before the facilitators had a chance to say anything, the male client said "Excuse me, we don't use that term here. Nobody is 'crazy.' We're here to help and support each other because we've all had a lot of hardships in our lives and we have some symptoms. Nobody is 'crazy.'"

This was an especially powerful moment because other members of the group nodded in agreement and offered supportive statements to the new participant. The facilitators could see that, not only was the male participant receptive to the information, but he was able to use it to shift his perceptions of himself, and he was able to communicate this to others. The entire interaction illustrated very positive movement towards de-stigmatizing mental health services in the Vietnamese community.

MENTAL HEALTH COMMUNITY TRAINING

PROGRAM DESCRIPTION
July 2012 – June 2013

To provide mental health community training, Marin chose Mental Health First Aid, an evidence-based training about mental illnesses and substance use disorders. It is for community members and providers to identify, support and refer people in need of behavioral health services, such as primary care professionals, school personnel, law enforcement, nursing home staff, mental health board members, librarians, volunteers, and others. It is shown to increase understanding of mental health/substance abuse, increase likelihood of helping others, and decrease stigma.

Prevention and Stigma Reduction:

- Train community members and providers to identify, support and refer people in need of behavioral health services.
- Provide a training that increases understanding and reduces stigma.

OUTCOMES
July 2012 – June 2013

California Institute for Mental Health began provided trainings in July 2012. Five trainings were held, including one in Spanish for Community Health Advocates. All trainings were no-cost to the participants and efforts were made to ensure a broad array of participants enrolled.

Outcome	Goal	Actual FY12-13
Prevention		
Individuals participating in the training.	100	107
Percent of participants reporting an increase in level of knowledge about behavioral health disorders.	80%	99% *N=107*
Percent of participants reporting an increase in skills in responding to individuals with behavioral health disorders.	80%	98% *N=107*
Percent of participants reporting an increase in ability to connect a person that may be dealing with a behavioral health problem to community, peer or personal supports.	80%	98% *N=107*
Percent of participants reporting satisfaction with the workshop.	70%	97% *N=107*

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	0	0%
16-25 years old	38	36%
26-59 years old	47	44%
60+ years old	22	21%
Total	**107**	**100%**
Race/Ethnicity		
White	45	42.1%
African/American	8	7.5%
Asian	14	13.1%
Pacific Islander	1	.9%
Native		
Hispanic	26	24.3%
Multi	2	1.9%
Other/Unknown	11	10.3%

Primary Language	# served	% of served
English	71	66.4%
Spanish	20	18.7%
Vietnamese	9	8.4%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	7	6.5%
Others	**# served**	**% served**
LGBTQ	10	9.3%
Homeless		
Veterans		

Participant representation:

- CBOs (adult focus) 48
- CBOs (youth/family focus) 14
- Health Care 4
- Law Enforcement 6
- County Social Services 26
- Community Member 9

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

Mental Health First Aid has been very well received. In FY2013-14, some PEI Technical Assistance funds have been used to respond to the high demand for this training, including a request from the public libraries to train 60 of their staff.

MENTAL HEALTH COMMUNITY TRAINING

CLIENT STORY

Just a note to let you know the Mental Health First Aid (MHFA) really works.

I had the opportunity, for lack of a better word, to apply it to a suicidal woman on the College of Marin campus on a recent Saturday where I was participating in a photography class. Her place of choice was the Golden Gate Bridge. Using the MHFA principles, I calmed her down and talked her into letting me take her to San Rafael for help instead of calling the cops.

Gary G Scheppke
Marin County Mental Health Board and Alcohol and Other Drugs Advisory Board

TEEN SCREEN

PROGRAM DESCRIPTION
July 2012 – June 2013

The goal of this program is to increase the identification of and early intervention services for teens at the earliest possible signs of mental health and substance use problems so that there will be an increase in wellness and a reduction in stigma. Teen Screen is an evidence-based program that provides voluntary screening for middle and high school students on eight issues (depression, anxiety, substance use, eating disorders, etc.), followed by an interview with a clinician. Students that are doing well are provided additional protective strategies. 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.

Prevention:

- Screen teens for behavioral health risks and link them to appropriate services.

OUTCOMES
July 2012 – June 2013

Beginning July 2012, Prevention and Early Intervention (PEI) funds were provided to Family Service Agency (FSA) to increase participation in the existing Teen Screen program, especially among un/underserved youth, as well as expand follow-up services. 32% percent fewer students participated in FY2012-13, due to less schools participating. The PEI funds were used in part to increase FSA's ability to provide the services in a wider variety of venues using laptops.

Outcome	Goal	Actual FY12-13
Prevention		
Percent of youth participating in Teen Screen that report an increase in knowledge of mental health resources.	50%	97% *N=298*
Percent of youth participating in Teen Screen that report an increase in knowledge of resilience/protective factors.	50%	94% *N=298*
Percent of youth participating in Teen Screen that are from un/underserved populations.	30%	21%
Increase in number of students participating in Teen Screen. Baseline: 532	15%	-32%

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	357	99%
16-25 years old	3	1%
26-59 years old	0	0%
60+ years old	0	0%
Total	**360**	**100%**
Race/Ethnicity		
White	285	79.2%
African/American	13	3.6%
Asian	16	4.4%
Pacific Islander		
Native		
Hispanic	39	10.8%
Multi	6	1.7%
Other/Unknown	1	.3%

Primary Language	# served	% of served
English	352	97.8%
Spanish	8	2.2%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Others	**# served**	**% served**
LGBTQ		
Homeless		
Veterans		

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

PEI funds were provided for Teen Screen in FY2012-13 and FY2013-14 to increase the capacity of the program by assisting schools to implement Teen Screen for the first time, as well as increasing FSA's capacity to provide screening and follow-up services. While funding is one barrier to schools implementing Teen Screen, it is not the main barrier, as evidenced by fewer schools implementing Teen Screen even with PEI funds available. During the community planning process for the MHSA Three Year Plan higher priority strategies for reaching the target population were identified, therefore Teen Screen is not recommended for funding in FY2014-15.

TEEN SCREEN

CLIENT STORY

The program screened a 14 year-old female who presented with a very high score. Her results were 22 out of 28 on the Diagnostic Predictive Scale for symptoms and 14 out of 14 on the Diagnostic Predictive Scale for impairments. She was experiencing suicidal ideation, and she had attempted suicide four times. She had engaged in cutting and had also used and abused alcohol and other substances. She was experiencing depression and anxiety. She was not engaged at school, and she was receiving below average grades. She was not receiving any mental health services.

Her parents were divorced, and her mother was homeless and abusing substances. Her other parent was living out of the state, and he maintained infrequent contact with her. She was living with her grandparents.

The program's clinician contacted her grandparents to advise them of her suicidal ideation, and she recommended both school based counseling and psychotherapy at an agency. Her grandparents were not aware of her suicidal ideation or how much pain she was in. They were very receptive to the recommendation. One of the agencies the clinician referred the grandparents to was Family Service Agency (FSA) and the grandparents decided to have her begin treatment at FSA.

She began psychotherapy at FSA promptly, and she was also supported by a school-based counselor. She was able to form a strong bond with her therapist. The therapist reported that her suicidal ideation, depression and anxiety reduced dramatically within weeks of beginning treatment. She continued with treatment to the end of the school year. Upon termination of treatment she was receiving a B average, able to identify and utilize healthy coping strategies, able to identify her strengths, and able to ask for help when she was in need. She also requested that her therapist contact her in the fall to resume treatment.

MENTAL HEALTH COMMUNITY COALITIONS

PROGRAM DESCRIPTION
July 2012 – June 2013

Community coalitions bring together local stakeholders to assess community needs and develop effective policy and community level solutions. The use of coalitions is an evidence-based strategy for substance use issues that promotes coordination and collaboration and makes efficient use of limited community resources. Marin County has been funding three community coalitions, Twin Cities, Novato and San Rafael, to address substance use issues. Prevention and Early Intervention (PEI) funds were made available to expand existing coalitions, or develop new coalitions, to address mental health concerns.

Prevention:

- Identify community mental health needs and develop policy and community level solutions that increase collaboration and effective use of limited resources.

OUTCOMES
July 2012 – June 2013

In FY2012-13 PEI funds supported PEI providers to participate in existing community coalitions, as well as staff time for the Novato coalition to expand their work into mental health.

- The Novato Blue Ribbon Coalition expanded their work into mental health, including looking at factors leading to depression and anxiety among youth. These efforts help to frame PEI strategies and priorities.
- Four PEI providers participated in the Community Coalitions, leading to increased collaboration and understanding of prevention approaches.

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

Support for Community Coalition's continues in FY2013-14, including funding for the Novato Coalition to expand their mental health efforts. The collaborations and skills developed in these two years will continue to support PEI planning and implementation efforts, as well as increase the existing coalition's ability to address mental health issues related to substance use issues. In the MHSA Three Year Plan for FY2014-15 through FY2016-17, the program funding is not recommended to continue.

MENTAL HEALTH
COMMUNITY HEALTH ADVOCATES

PROGRAM DESCRIPTION
July 2012 – June 2013

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) in mental health and substance use. 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.

Prevention:

- Trained Community Health Advocates to provide outreach, education and links to services.

OUTCOMES
July 2012 – June 2013

In July 2012, Canal Alliance began this program, focusing on Spanish-speaking CHAs in the Canal and Novato communities. This program is coordinated with Prevention and Early Intervention (PEI) and other programs that provide early intervention for mental health and substance use issues for the Latino community.

Outcome	Goal	Actual FY12-13
Prevention		
Number of underserved community members receiving behavioral health information and education from CHAs.	250	418
Number of underserved community members receiving behavioral health interventions from CHAs.	50	62
Number of CHA's trained in behavioral health skills.	8	7
Number of CHA's showing an increase in knowledge and skills regarding behavioral health issues. • Ability to recognize signs/symptoms of mental health and substance use issues • Knowledge of services to refer clients to • Confidence to help people facing mental health issues	8	7

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	96	20%
16-25 years old	9	2%
26-59 years old	59	12%
60+ years old	1	0%
Unknown	322	66%
Total	**487**	**100%**
Race/Ethnicity		
White	61	12.5%
African/American	3	.6%
Asian	18	3.7%
Pacific Islander		
Native		
Hispanic	402	82.5%
Multi	0	0%
Other/Unknown	3	.6%

Primary Language	# served	% of served
English	64	13.1%
Spanish	402	82.5%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown	21	4.3%
Others	**# served**	**% served**
LGBTQ		
Homeless		
Veterans		

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

In the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, is being recommended that the Community Health Advocates (CHA) program will be merged with the Canal Community Based PEI program and efforts will be made to expand the number of Promotores and regions served by merged program. For a detailed description, see the Latino Community Connection program in the MHSA Three-Year Program and Expenditure Plan.

LEGAL ASSISTANCE

PROGRAM DESCRIPTION
July 2012 – June 2013

In the original Prevention and Early Intervention (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. An example is 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.

Prevention and Early Intervention:

- Provide legal services for existing PEI and Mental Health System of Care clients whose mental health is affected by legal issues.

OUTCOMES
July 2012 – June 2013

In December 2012, Legal Aid of Marin (LAM) began providing legal services for clients referred from Mental Health System of Care and PEI programs. In the initial months LAM developed procedures and protocols for referring and serving clients, as well as conducting outreach to PEI and System of Care programs. During FY2012-13, 22 referrals were received, with 5 resulting in legal assistance through this program. Others either did not follow-through on the referral or were referred to other agencies. Methods for evaluating the impact of the services on mental status were developed and will be implemented in FY2013-14.

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old	5	100%
60+ years old		
Total	**5**	**100%**
Race/Ethnicity		
White	3	60%
African/American		
Asian		
Pacific Islander		
Native		
Hispanic	2	40%
Multi		
Other/Unknown		

Primary Language	# served	% of served
English	3	60.0%
Spanish	2	40.0%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Others	**# served**	**% served**
LGBTQ		
Homeless		
Veterans		

4 PEI clients served.
1 Mental Health System of Care client served.

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

While there are likely a significant number of people experiencing negative mental health impacts due to legal stressors, MHSA funds are only available for those who are PEI or System of Care clients. This has greatly limited the number of referrals being received. Funds will continue in FY2013-14. This program is not recommended to continue in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

LEGAL ASSISTANCE

CLIENT STORY

"Jason," a client referred to us by Marin Mental Health and Substance Use Services Division (MHSUS), sought help with the voucher issued to him by the Marin Housing Authority (MHA). He is 50 years old and has mental health issues including schizophrenia and depression. He also cares part-time for his 3 young daughters, ages 4, 7, and 9 years old, one of whom is autistic, on his limited fixed SSI income. His landlord decided to sell the condo he has lived in for 7 years and gave him notice to move out. Because he had been in the same place so long, his rent was very low.

MHA determined the client could not receive more than his old rent amount, due to federal cut backs. Jason was not able to find any new housing within this price range despite concerted efforts. He came to Legal Aid of Marin (LAM) very stressed. He did not want to be evicted or become homeless but he had no place to go. He was very worried about losing his daughters or damaging his relationship with them. LAM was able to secure an extension and asserted that it was extremely important that our client maintain stable housing because of his and his daughter's disabilities. After considerable negotiation, HUD finally agreed to increase the rent voucher so that he could find a new apartment for himself and his family. Jason was elated. He is currently looking for new housing.

** Funding for this program is provided by both MHSA Prevention and Early Intervention (PEI) and Community Services and Supports (CSS).*

SOUTHERN MARIN COMMUNITY CONNECTION

PROGRAM DESCRIPTION
July 2012 – June 2013

In original Mental Health Services Act (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. Prevention and Early Intervention (PEI) has successfully reached many of the underserved populations identified, but has further work to do regarding the African American community. The goal of this program is to reach high-risk residents of Marin City, including those living in subsidized housing or with no permanent residence, providing assessment and services to promote protective factors and reduce the need for more intensive services.

Prevention:

- Brief intervention and case management services. Services are provided in the home or in the community, including street-based outreach.

OUTCOMES
July 2012 – June 2013

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 and Latino, living in subsidized housing or with no permanent residence. Sixty-percent are women, most are single with children. Assistance is provided regarding mental health, parenting, housing, economics, medical services and education. In FY2012-13 the MDT worked with the California Reducing Disparities Project (CRPD) to develop data collection and analysis methods. Behavioral health outcomes, measured by the *Family Functioning Scale*, will be available for FY2013-14.

Outcome	Goal	Actual FY12-13
Individuals receiving early intervention services.	50	53

Age Group	# served	% of served
0-15 years old	5	9%
16-25 years old	11	21%
26-59 years old	36	68%
60+ years old	1	2%
Total	**53**	**100%**
Race/Ethnicity		
White	7	13.2%
African/American	14	26.4%
Asian	3	5.7%
Pacific Islander		
Native		
Hispanic	17	32.1%
Multi	5	9.4%
Other/Unknown	7	13.2%

Primary Language	# served	% of served
English	41	77.4%
Spanish	11	20.8%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown	1	1.9%
Others	**# served**	**% served**
LGBTQ	3	5.7%
Homeless		
Veterans		

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

This program was one of a number funded in FY2012-13 and FY2013-14 from one-time funds. During the MHSA Three Year Plan community planning process, support for the growing community and school collaboration was identified as a high priority. In the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, it is being recommended that we increase the funding available for serving school age youth in Southern Marin through a Request for Proposal (RFP) process. More details can be found in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 under School Age Programs.

For FY2013-14 the Southern Marin Community Connection (SMCC) and the Marin Multidisciplinary Team have instituted monthly case conferences and trainings that target high-risk families with significant mental health problems. SMCC also conducts monthly conferences with the schools in Southern Marin, will co-lead groups for middle school girls and boys, and consult with the Manzanita Preschool therapeutic classroom.

CLIENT CHOICE AND HOSPITAL PREVENTION PROGRAM

PROGRAM DESCRIPTION
July 2012 – June 2013

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

Marin's proposed 3- to 4-year Client Choice and Hospital Prevention (also referred to as "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 2012 – June 2013

Fiscal year 2012-2013 has been a year of learning how to "increase the quality of services, including better outcomes" for those who experience a psychiatric crisis. As specified in the previous annual update, the Client Choice & Hospital Prevention Program Advisory Committee began to learn that if there was going to be a significant systems change in how an individual psychiatric crisis is managed, those involved in the crisis continuum of care need to partner well. To this end the Advisory Committee defined a working hypothesis to test. The working hypothesis states:

"When we partner well, the quality of our work and the outcomes for all will improve."

We believe we can 1) work towards a system that prevents a situation from turning into a mental health crisis and that 2) we can move away from the most restrictive approach to managing a crisis (i.e. involuntary hospitalization) to a more client-centered and voluntary approach. We will do this by not only weaving evidence-based practices together but by highlighting and examining the *need for partnerships* between: peers and professionals; between providers and clients; and between all those who provide support to an individual who is at risk of experiencing a psychiatric crisis.

In FY2012-13 one focus was developing a Logic Model for the Client Choice & Hospital Prevention Program (see Appendix C). This Logic Model was tucked into the larger MHSA Theory of Change that was also developed. From this CCHP Logic Model, and from the working hypothesis, evaluation tools began to be developed to measure "partnership". Evaluation tools will completed in FY2013-14 and data will begin to be collected, analyzed and reported back to all parties involved beginning in early 2014. This data will be used to assess what we are learning and if, or where, we need to make adjustments.
Marin's CCHP plan is a complicated plan. Due to the complexity of the plan and due to the complexity of a logic model, the Advisory Committee determined that a one-page narrative needed to be developed so that all parties involved could speak from the same, common and clear message (see Appendix D). What we learned was that in order to partner well, communication needs to be clear and consistent. The Advisory Committee wanted to ensure that they were giving the same clear message about the nature of this complex project, hence the need for a clear narrative.

The use of peer-driven crisis planning (MHSA PEI funded) has continued to move forward on helping clients create individualized psychiatric advance directives. Participating clients have avoided hospitalization and increased their sense of participation in their care. The larger system has embraced the use of crisis planning and feels the peer-providers who offer this service are very effective in engaging clients in this important wellness tool. Additionally, there is discussion regarding the need to increase capacity for this service and it is hoped that more peer-providers will be trained to provide this service.

A key element of this project is allowing clients who do experience a psychiatric crisis to do so in a home-like environment in their community. To achieve this goal a crisis-residential unit was built in a centrally located area of Marin County. The facility opened on February 2, 2014.

FY2013-14 looks to be the most exciting year for the Client Choice & Hospital Prevention Program project as this is the year that all the pieces will finally come together. The INN evaluation tool will be completed, administered and analyzed. The crisis continuum of care will continue to take shape. More partners will be folded into the ultimate goal of this plan, which is to increase client choice, wellness and recovery for those who may experience a psychiatric crisis.

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

Over the last FY the crisis continuum of care in Marin has not only expanded, but has actually been shaped into a continuum of care, not just a Psychiatric Crisis Unit. Management and staff will continue to participate in the evaluation of partnership and will use the data collected to inform systems change. To this end, applications were submitted for the "Investment in Wellness Grants". Marin has been awarded funds to place three (3) crisis triage workers in the community. Triage workers will be located at:

1) Marin Public Housing Authority,
2) Marin Shelters, and
3) Marin youth provider location.

On April 4, 2014, Marin County was notified that we were also awarded a grant to support Mobile Crisis Teams.

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 FY2012-13 the WET program in Marin has focused on moving our staff and provider agencies towards service delivery using evidence based practices.

Stakeholder Process:

In FY2012-13 we engaged stakeholders in two specific committees. The consumer subcommittee met monthly at the Enterprise Resource Center. The Family Subcommittee also met on a monthly basis, comprised of family members, family partners and the WET consultant. The WET advisory committee began meeting bi-monthly.

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

WET PLAN ACTION
June 2012 – July 2013

1. Training Coordinator

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. The training coordinator assisted in the selection of trainers for the initiatives listed below as well as being a leader in the planning of the Trauma Informed Care conference.

2. 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.

We have developed a cohort of 20 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 to provide trainings to our internal and CBO staff. Two of these champions have gone on to obtain advanced training in MI and are bringing that knowledge back to the group as well as providing trainings the MHSUS system.

3. 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:

- **Trauma Informed Care Conference:** In April 2013 we hosted a 2 day conference on trauma informed care. This included the culturally relevant breakout sessions on the impact of trauma on Latino and LGBTQ, populations. The conference also provided sessions on evidence based practices with different populations spanning children through adults. There were at total of 100 attendees at this ranging from county staff, CBO's and peer providers.

The WET program continued the 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.

4. 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 FY2012-13 to identify specific training needs of consumers and to review and agree upon training initiatives.

Dual Diagnosis:

A Dual Diagnosis and Harm Reduction training was held on 7/26/2012 and 8/2/2012 with 46 people in attendance. This was targeted specifically for peer providers in our system to assist them in working with individuals who present with co-occurring disorders.

Group Leadership:

A monthly peer group leader facilitation group was held this year at the Enterprise Resource Center, led by a peer expert, again continuing to move in the direction of having consumers leading groups relevant for them.

One of the peer group leaders attended a 2 day WRAP conference in September and has brought back this knowledge to facilitate groups at the peer run wellness center. Another peer provider attended a one day WRAP conference and they have brought back these tools to the intensive case management team.

5. 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 has been meeting on a monthly basis to bring ideas and determine the trainings relevant for them.

Family Communication Trainings: In October of this year, we completed a four-week training that served 30 family members. The focus of this training is to teach skills that family members can use to facilitate working as partners to help mentally ill loved ones accept mental health treatment.

From this initial group, we hosted training series utilizing the Train the Trainer model for 19 family members. They began meeting in February 2013 on a monthly basis and these families will serve as consultants to other families in the community.

Nonviolent Communication: In October 2012 we hosted a 7 week course facilitated by Bay Area Nonviolent Communication to 20 family members. Of these 20, 13 members have continued in a monthly consultation group starting in February 2013. These individuals have agreed to serve as consultants to other families in the community.

6. Systems Wide Integrated Dual Disorders Training

Our entire Mental Health and Substance Use Services system underwent an integration process to bring together our two previously separate divisions of Mental Health and Alcohol and Other Drugs. Our stakeholder group for this training fund has held bi- monthly meetings to discuss the most effective strategies for rolling out this training program. We have been gathering suggestions on best practices and promising practices so that we can facilitate a system wide approach that addresses co-occurring challenges including trauma informed care.

7. Clinical Practice Forums

This action item is to institute ongoing learning groups to support and expand the learning provided by WET trainings. In FY2012-13:

- **Harm Reduction in Case Management** consultation group meets on a monthly basis and includes CBO's, county staff and peer providers. This group has been co-facilitated by our WET consultant and has begun to self -govern with the expertise and confidence of the members growing throughout the year. The number of attendees averages about 15 each month.
- The **Group Therapy** supervision series was offered monthly throughout the year to support the integration of knowledge learned in the previous immersion trainings. This group was co-facilitated by two experienced group therapists.

8. 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 FY2012-13 two staff was sent to the Leadership training, one from mental health and one from substance abuse services.

9. Intern Stipend System

This action item is to provide stipends for mental health interns 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	**$8,000**	**6 MFT interns Spanish- Speaking/ African American**
Huckleberry Youth Programs	**$5,400**	**2 interns Spanish-speaking and Lived experience**
Catholic Charities CYO	**$9,000**	**3 interns Spanish-speaking**
Community Institute for Psychotherapy	**$5,000**	**1 full time intern working at Homeless Resource Center- Ritter**

10. 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.

11. 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.

This was the first year of our scholarship process. The recommendations from the consumer and family subcommittees were to offer $ 2,000 per individual to support their education towards working in the public mental health system. This year we were able to offer scholarships to 4 separate individuals in both the fall and spring semesters. These individuals attended College of Marin, Dominican University and San Francisco State. Two of the stipends went to peer providers who currently work in the public mental health system and want to further their ability to advance. One stipend went to a family member pursuing MFT degree and one to a consumer wanting to gain the education needed to work in the public mental health system. The stipends were utilized to offset commuting costs, the purchase of books and technology needed to participate in courses.

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 (CFTN). CFTN goals and projects are essential in supporting the development of an integrated infrastructure to modernize clinical and administrative systems. This goal not only improves quality and coordination of care for our clients in Marin County, but also increases operational efficiency, and cost effectiveness that contributes to the transformation of the mental health system. 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

In Marin County, our goal focused on technological improvements that supported the development of an Electronic Health Record (EHR) which enabled the advancement towards a paperless record. The existing system was a hybrid of electronic and paper documentation and provided many elements of an EHR. Prescribers were hand writing prescriptions, and the legacy billing system (INSYST) needed upgrading and modernization.

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 2012 – July 2013

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 2011/12, the upgrade to replace the INSYST system included existing billing and reporting functionality, including managed care, as well as being able to interface with our hybrid EHR, Clinicians Gateway.

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

Consumer Empowerment

This component proposed to dedicate funding for the purchase of desk top computers and internet access for the use of consumers living in county-contracted residences with six or more people. Additionally, 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. In addition to the laptop supplied to a consumer member of the Marin Mental Health Board, a project goal is to supply more tablet/laptop support to an additional 6 consumers who are participating on boards or committees.

Marin County continues to host Network of Care which is a resource for individuals, families and agencies that provides information about behavioral health services, laws, and related news, as well as communication tools and other features. Client computer kiosks are set up in waiting rooms throughout the MHSUS service sites so that clients can sign into Network of Care as they desire.

E-Prescribing

This component involved implementation of electronic prescribing by County psychiatrists and Mental Health Nurse Practitioners using RxNT a secure web-based electronic prescribing and medication management system. Benefits of e-Prescribing include enhanced patient safety, increased medical provider productivity, reduction in pharmacy call backs and adherence to security and confidentiality standards. RxNT also improves the agility of care and reduces medication errors. The electronic creation and transmission of medication orders from the medical provider's computer to the pharmacy reduces the possibility of a misread prescription by a pharmacist. This component is fully integrated with our existing EHR, Clinicians Gateway, and was implemented in FY 2010-11.

As more pharmacies in Marin County are able to receive controlled substance (scheduled) prescriptions electronically, it is the objective of this component to provide our medical staff with access tokens to enable them to securely and easily prescribe for controlled medications. Until full implementation of this particular functionality occurs, there will continue to be a limited number of hand-written prescriptions in the medical record.

Electronic Health Record and Emergency Backup

A fully functioning EHR allows for greater integration as well as smoother secure access to health information. Marin's mental health staff and select contract providers have used Clinicians Gateway since 2006 to write electronic progress notes.

This component proposed to move the medical record further towards a more complete EHR by adding 10-15 key forms to Clinicians Gateway. In addition, numerous upgrades to existing electronic forms were made.

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. This portion of the project was

delayed due to other priorities in FY2012-13. A contract with our EHR vendor was approved on January 29, 2013 to develop, implement and upgrade Clinicians Gateway to meet Meaningful Use Requirements. The vendor began the process of upgrading the system to meet the Meaningful Use (MU) objectives and measures first year of participation where providers can attest that they have adopted implemented and upgraded certified EHR technology. As a result, Marin was able to register all medical providers as eligible providers under Meaningful Use guidelines with both the Federal and State governments. The component goal continues to support system enhancements and upgrades for further modernization and information sharing.

Practice Management Upgrade

The Practice Management project constituted the most complicated component of Marin's TN plan. After extensive review of existing systems in California, 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 was approved in late January 2011 with a target implementation go-live date of July 1, 2011. Project implementation focused on the completion of intensive tasks essential for a successful system conversion, including purchase of hardware, data clean up, crosswalk set-up, ShareCare system set up and preparation for integration with our EHR, Clinicians Gateway. In June of 2011, in preparation for the July go-live, Echo provided System Administrator core training, Train-the-Trainer training, and Managed Care training for key staff. Continued enhancements to the system allow for analytics, which extend the functionality of the system to meet federal and state reporting requirements. Implementation of ShareCare occurred on August 1, 2011, only one month after the projected go-live date. During FY2011-12, continued implementation of ShareCare remained the primary focus of the TN project, and by April 2012, Marin was able to successfully bill all major third party payers. In FY2012-13 client invoices began being generated from our ShareCare system.

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 FY2010-11, the software and hardware necessary for implementation was purchased. This is an on-going project and Krasson, Inc, has installed the program in a QA environment for testing and to develop training materials for staff to be developed.

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.

Outcomes
June 2012 – July 2013

Consumer Empowerment

Since FY2011-12 Marin has provided client computer kiosks in their main Medication Sites for clients to access Network of Care. Marin continues to provide a laptop and related connectivity for one consumer on the Marin Mental Health Board.

E-Prescribing

The component goal continues to support system enhancements and upgrades. 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 2012 Marin's EHR vendor began the process of upgrading the system to meet the Meaningful Use (MU) objectives and measures first year of participation where providers can attest that they have adopted implemented and upgraded certified EHR technology. As a result, Marin was able to register all medical providers as eligible providers under Meaningful Use guidelines with both the Federal and State governments.

Practice Management Upgrade

Transfer to ShareCare occurred on August 1, 2011, only one (1) month behind the projected go-live date. During FY2011-12, continued implementation of ShareCare remained the primary focus of the TN project. By late FY2012-13 Marin was completely current on Medicare, Medi-Cal, insurance billing and client invoicing.

Scanning Project

In FY2011-12, initial software setup on the project was begun. Other CFTN priorities delayed the completion of this project in FY2012-13.

CHALLENGES AND UPCOMING CHANGES FOR FY13-14

ICD-10 Implementation - ICD- 10, International Classification of Diseases – Tenth Edition is a set of diagnosis and inpatient procedure codes used in the health care system. In FY2013-14 the major system upgrade will be completed to implement and transition to ICD-10 codes, as required by Health Insurance Portability and Accountability Act of 1996 (HIPAA) by October 1, 2014. The project will provide Mental Health and Substance Use services with coding analysis and crosswalk, impact analysis, implementation and training. The implementation will include both county and contract operated services.

Rapid Insight Analytics – Echo, Inc. also supports the addition of Rapid Insight; a unique software tool for performing data analyses, ad hoc reporting, and managing analytic data sets, and developing predictive models. Veera is a companion system attached to Rapid Insight that provides

a user-friendly interface to produce easily read and presentation quality reports from data extrapolated from Rapid Insight. In 2013 testing of the Rapid Insight analytics was completed and the system will roll out to 7 additional staff in FY2013-14.

IT Security Risk Assessment – An IT security risk assessment will be conducted in FY2013-14 as a result of the standards of the HIPAA Security Rule which is a function of the Meaningful Use requirements of the Medicare and Medicaid EHR Incentive Programs. This assessment is done to ensure the privacy and security of clients protected health information. This assessment must be completed for both Stage 1 and Stage 2 of meaningful use and must be completed by October 1, 2014.

Reportal - It is a goal of the Practice Management component to purchase and implement the ShaRP (Reportal) System, also supported by Echo's ShareCare. Reportal maintains a data warehouse of claim and service related data extracted periodically from 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 to develop tools for identifying challenges and changes needed to system of care. Implementation of these systems is planned for FY2013-14.

Behavioral Health Information Crosswalk – This project is currently on hold pending the outcome of a review of Electronic Health Records (EHR) systems currently under consideration by a team of MHSUS staff members. Once the review is completed, MHSUS will determine appropriate next steps as it relates to this project.

MARIN COUNTY MHSA PROGRAM FUNDING FY2014-2015

All Program information for FY2014-2015 can be found in the MHSA Three Year Program and Expenditure Plan for FY2014-2015 through FY2016-2017 at https://www.marinhhs.org/mhsa.

The FY2011-2012 MHSA Revenue and Expenditure Report has been submitted to the State Department of Health Care Services.

At this time, the MHSA Revenue and Expenditure Report template for FY2012-2013 has not been released from the State yet.

Numbers Served

Program			FY12-13 Actual
FSP-01	Children's System of Care (CSOC)	FSP	91
FSP-02	Transition Age Youth (TAY)	FSP	29
		Partial	84
FSP-03	Support and Treatment After Release (STAR)	FSP	58
FSP-04	Helping Older People Excel (HOPE)	FSP	59
FSP-05	Odyssey (Homeless)	FSP	74
SDOE-01	Enterprise Resource Center (ERC)	SDOE	196
SDOE-04	Southern Marin Services Site (SMSS)	SDOE	750
SDOE-07	Adult System of Care (ASOC)	SDOE	609
SDOE-08	Co-Occurring Capacity	SDOE	16
	Housing		5
PEI-1	Early Childhood Mental Health Consultation (ECMH)	P	830
		EI	90
PEI-2	Triple P	*	*
PEI-3	Across Ages Mentoring	P	11
		EI	18
PEI-4	Transition Age Youth (TAY) PEI	P	453
		EI	198
PEI-5	Canal Community-Based PEI	P	386
		EI	126
PEI-6	Integrated Behavioral Health in Primary Care (IBH)	P	4473
		EI	862
PEI-7	Older Adult PEI	P	411
		EI	32
PEI-10	Crisis Planning	PEI	60
PEI-11	Vietnamese Community Connection	P	170
		EI	44
PEI-12	Mental Health Community Training	P	107
PEI-13	Teen Screen	P	360
PEI-14	Community Coalitions	*	*
PEI-15	Mental Health Community Advocates	P	487
PEI-16	Legal Assistance	P	4
PEI-17	Southern Marin Community Connection	P	53

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

Appendix B
CalMHSA Statewide Prevention and Early Intervention Programs

STATEWIDE PREVENTION AND EARLY INTERVENTION PROGRAMS

transforming mental health care in Marin County

CalMHSA's statewide Prevention and Early Intervention (PEI) initiatives enhance the ability of counties to meet the mental health needs of their communities through effective and cost-efficient suicide prevention and student mental health programs. Marin County's partnership in California's nationally-recognized Stigma and Discrimination Reduction campaign is critical to achieving the transformation of mental health services by communicating to all Californians that help is available and recovery is achievable, thereby removing barriers to seeking help.

In a dynamic policy environment and with the implementation of the Affordable Care Act, the cost-effective delivery of statewide PEI initiatives frees up county resources for community-responsive and innovative local efforts. With participation in this statewide partnership, Marin County has invested in California's mental health transformation and in development of breakthrough and culturally relevant best practices that serve the needs of California's diverse communities.

Benefitting all California Counties

- Invest now, save later. Research suggests that for each dollar invested in prevention today, dollars are saved by avoiding suffering, loss of income and lives.
- Achieve economies of scale by purchasing services across counties. Bulk media purchases stretch dollars 35-50% further. Regional county partnerships deliver value in crisis hotline services.
- Prepare counties for Affordable Care Act implementation through Integrated Behavioral Health Care training and technical assistance.
- Create lasting systems change. K-12 educator credential standards now include training to improve early identification of at-risk students.
- Associated Press standards now support accurate reporting on mental health, supporting help-seeking behavior.
- Reduce each county's cost for critical investments, such as culturally adapted training, social marketing, and Stigma and Discrimination Reduction best practices.
- Promote mental health awareness, inclusion and equity for individuals with mental health challenges through a coordinated campaign, Each Mind Matters.

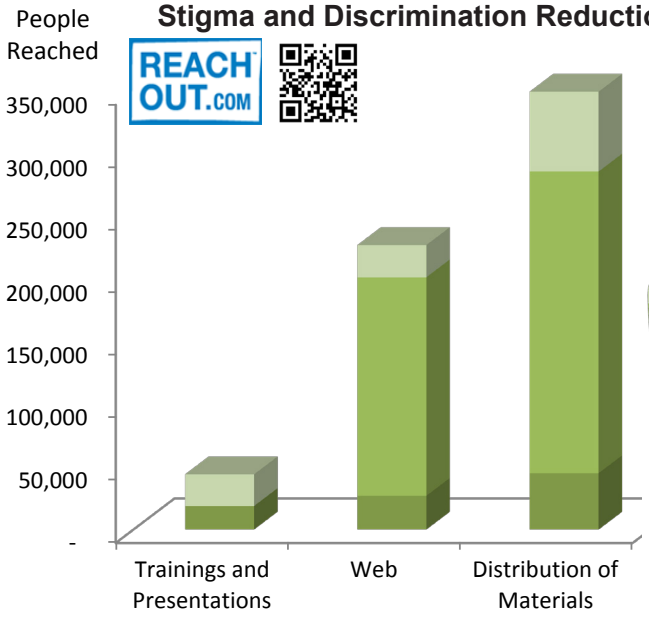
Marin County's initial investment in statewide Prevention and Early Intervention programs is $211,280 per year over a four year period. This initial investment built and strengthened California's crisis delivery, student mental health, and stigma reduction infrastructure. These capacities can now be sustained at much lower funding levels.

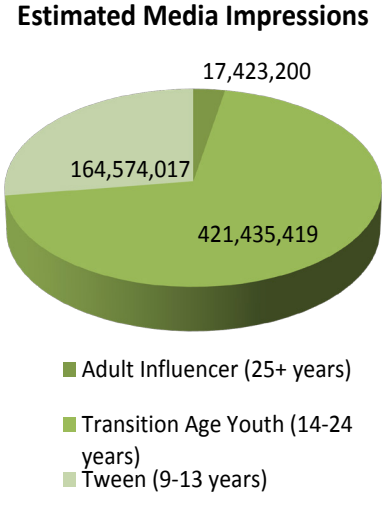
Statewide Impact: January- December 2013

Approximate reach across all CalMHSA programs:

Individuals	Program/Activity
124,774	Trained and/or educated on prevention strategies
819,881	Reached through crisis and early intervention services, etc.
1,475,713	Reached through informational resources
265,764,543	Views of social marketing campaign materials

Stigma and Discrimination Reduction (SDR) Social Marketing Campaign: Statewide Reach





This campaign includes: Each Mind Matters: California's Mental Health Movement; lifespan-specific campaigns including Walk In Our Shoes (9-13 year olds), ReachOutHere (14-24 year olds), "A New State of Mind" documentary and Community Dialogues (adults 25+); and targeted campaigns for Latino, African American, Native American, Asian Pacific Islander and LGBTQ communities.

Key Examples of Local Reach in Marin County

Prevention and Early Intervention (PEI) Statewide Projects are designed to complement local efforts while building statewide capacity to improve mental health.

Enhanced Local Crisis Response

Suicide Prevention Crisis Centers respond 24/7 to individuals in a mental health crisis. The local crisis center is the Marin Suicide Prevention & Crisis Hotline **(415-499-1100)**. CalMHSA partners with the hotline to enhance local crisis response with: training, outreach and marketing, support to the local suicide prevention committee and Native American community, which held a *Gathering of Native Americans* training focused on youth suicide prevention.

Calls to the hotline from Marin County residents are provided below:

YEAR	2012	2013
CALL VOLUME	10,275	8,902

Identify Warning Signs and Access Help before a Crisis

The Know the Signs Suicide Prevention campaign informs Californians of warning signs, how to talk to someone they are worried about and identify helpful resources.

Pain Isn't Always Obvious
KNOW THE SIGNS
Suicide Is Preventable

Marin County residents received this information through: TV (e.g. cable, Univision; **255,600 views**), online (e.g. Hulu, Facebook; nearly **2.4 million views**), magazines (nearly **149,000 views**), resulting in nearly **2.8 million total views** of the campaign materials. During the first 4 months, **over 2,700** Marin County residents visited the campaign websites to seek information.

Marin County and the Family Service Agency of Marin customized the campaign materials in English and Spanish and distributed them to community-based organizations and middle and high schools.

Why Statewide? In 2008, state strategic plans were developed for suicide prevention, stigma and discrimination reduction and student mental health. CalMHSA, a Joint Powers Authority, was created by counties in 2009 to implement the PEI Statewide projects efficiently and effectively. These are just a few program highlights; for more information please visit: www.calmhsa.org

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA
WELLNESS · RECOVERY · RESILIENCE

CalMHSA
California Mental Health Services Authority
Compassion. Action. Change.

EACH MIND MATTERS
California's Mental Health Movement

Training and Education Investments to Improve Local Response

Student Mental Health Partners offered local training in the following areas:

- Pre-K-12 (January-December 2013): The Marin County Office of Education partners with local law enforcement and district attorneys to host educational opportunities on bullying prevention, and related policies and legislation; as well as providing suicide prevention awareness training to community providers serving residents across the lifespan.
- During 2013, trained 2,391 faculty, community members, school mental health staff and administrators on topics such as teen dating violence, depression, suicide, and anti-bullying workshops.

Prevention and early intervention save lives and dollars by delivering help before a crisis when it's most effective and less costly.

Stigma and Discrimination Reduction Partners offered local training in the following areas:

- Help seeking through online forums: 427 local youth sought information and support at ReachOutHere.com, and 240 in Spanish at BuscaApoyo.com ReachOutHere materials providing support and education were sent to four local clinics, to encourage local youth to engage in online support at ReachOutHere.com, or in Spanish at BuscaApoyo.com (RSE)
- Reached 85 elementary and junior high school students through school-based performances, which educate youth about mental illness, the importance of seeking help, and supporting others who experience mental health challenges. (RSE)
- Provided technical assistance on integrated behavioral health implementation to the Partnership Health Plan. More information can be found at www.ibhp.com

Draft Document Updated: 4/4/14

Appendix C
Client Choice and Hospital Prevention (CCHPP) Logic Model

FINAL 02/24/14

CCHPP: Crisis Residential Logic Model

Resources

Partners

- Advisory Committee
- Clients
- CBO Mental Health Staff (Buckelew)
- Crisis Planning Staff (CAM)
- Peer Providers
- Family Partners
- County Mental Health and Substance Use Services staff

Referral System

House for Program

Activities

Partners design, implement and operate crisis services in a home-like environment

Program implements and operates integrated peer-professional staffing, including crisis planning staff

Program staff is trained to understand and use the SBIRT model.

Outputs

Number of partners who attend meetings, representation at meetings, frequency of meetings and meeting topics

Number of peer and professional providers working in facility, including crisis planning staff (FTEs)

Number of program staff trained to use SBIRT model

Number of substance use screenings completed by program residents

Number of individuals served at facility, number of days served and types of services received

Outcomes: Short Term *(knowledge/attitudes)*

Partners are knowledgeable about how to work together, understand their role, and report improved attitudes about collaboration, integrated peer professional staffing and serving individuals with co-occurring disorders

Partners report changes in knowledge and attitudes about how to best respond to and help prevent psychiatric crisis

Partners report knowledge of quality crisis services and willingness to make changes to improve quality

Outcomes: Intermediate /Long Term *(behavior)*

Program design, implementation and operation decisions are reviewed and influenced by ***partners.***

Peer and professional program staff report working as equal partners

Changes are made in mental health system and substance use system, to prevent and treat psychiatric crisis.

Changes are made to improve quality of crisis system

Partners report that the quality of crisis services is improved.

The number and percentage of involuntary and voluntary hospitalizations is reduced

Individuals with co-occurring disorders have improved outcomes

Individuals who are served at the house for the program demonstrate better illness self-management (MH and SU) and report improved sense of wellness and recovery

Impact

System transformation in response to mental health crisis

TRANSFORM MENTAL HEALTH SYSTEM

State-of-the-art mental health system that promotes:

- **Continuum of care** from prevention through recovery services
- **Partnerships** with consumers, community members, mental health providers and community providers
- **Reducing stigma**
- **Reducing disparities** in access and outcomes for different populations
- **Mental health services that address the whole person** including physical health and substance use

Appendix D
Client Choice and Hospital Prevention (CCHPP) Narrative

The Client Choice & Hospital Prevention Program (CCHPP)

Changing the way Marin County provides mental health crisis services

With the help of MHSA Innovation funding, Marin County Mental Health and Substance Use Services (MHSUS) is working to become a system that (1) prevents a situation from turning into a mental health crisis and (2) moves away from the most restrictive approach to managing a crisis (i.e. involuntary hospitalization) to a more client-centered and voluntary approach. By weaving evidence-based practices together, this program highlights and examines the need for partnerships between peers and professionals, partnerships between providers and clients, and partnerships between different providers to improve crisis mental health services.

There are three approaches to this program:

Peer and Professional Staffing (partnerships between peers and professionals)**:** We believe that combining the use of peers and professionals will result in a more effective recovery for clients. Peers work as equal treatment partners, side-by-side with professionals to aid in an individual's recovery.

Crisis Planning (partnerships between providers and clients): Offered by Community Action Marin (CAM), peer staff helps individuals articulate and document their support options to prevent a crisis as well as their support preferences during a time of crisis. A person can name the individuals he or she can rely on and describe specific concerns if they are in crisis (i.e. rent, pets). With the permission of the client, Psychiatric Emergency Services (PES) will have a copy of the crisis plan in the client's chart and will review the plan as they care for the client.

Crisis Residential Home (partnerships between providers): Run by Buckelew Programs, this voluntary program will offer a homelike setting where individuals can stay in their own community and stabilize during a time of crisis. The Crisis Residential Home staff will work with each individual's circle of support: family, friends, psychiatric treatment professionals, substance abuse professionals, health care providers, naturally occurring resources (such as 12-step programs), faith-based organizations and any other entity that is important to the individual's recovery. Individuals will also be offered individual, group and family therapy.

Using both peers and professionals, the Crisis Residential Home will be staffed 24 hours a day. Crisis Planning staff will be present at the home to work with individuals to review and/or create crisis plans as requested. To enhance the mental health services, each client will also be screened for substance use and provided with brief intervention services and additional resources as indicated.