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.

July 8, 2014

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

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

Larry Meredith, Ph.D.
DIRECTOR

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SUBJECT: Department of Health and Human Services, Division of Mental Health and Substance Use Services: Approve the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for FY 2014-15 through FY 2016-17.

Dear Supervisors:

RECOMMENDATIONS:

1. Authorize the President to approve the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for FY 2014-15 through FY 2016-17.
2. Authorize the President to approve the personnel adjustments detailed in Attachment A.
3. Authorize the President to approve the budget adjustments detailed in Attachment B.

SUMMARY: For FY 2014-15 through FY 2016-17, $32,669,758 in Mental Health Services Act (MHSA) funds are proposed for a broad range of community-based and County operated 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 ($5,701,500);
- 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 ($22,487,025);
- Innovation services including crisis planning and Casa Rene, a crisis residential home-like facility ($1,863,165);
- Capital Facilities and Technological Needs (CFTN) programs such as an electronic health record, scanning capability and other practice management programs ($1,617,513);
- Workforce, Education and Training (WET) programs such as our American Psychological Association (APA) accredited intern program and culturally appropriate trainings for consumers, family members and providers of service ($1,000,555).

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. Please note that the community planning process for innovation funding is pending, and is expected to start by September 2014.

This MHSA Three-Year Program and Expenditure Plan 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 MHSA Three-Year Program and Expenditure Plan for FY 2014-15 through FY 2016-17 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 IJ seeking public comment and feedback as well. All input has been considered with adjustments made, as appropriate and incorporated into the MHSA Three-Year Program and Expenditure Plan for FY 2014-15 through FY 2016-17.

CSS Housing Funds

Approximately $1.4 million of CSS Housing Funds are still available for future planning. This funding is administered separately by the California Housing Finance Agency (CALHFA), and is not part of the $22.487m CSS funds referenced above.

Local Prudent Reserve

The local MHSA Prudent Reserve available balance is $2,175,490, which is separate from the $32.6 million in the Three-Year Program and Expenditure Plan. Welfare and Institutions Code 5847 (b)(7) requires Counties to establish and maintain a Prudent Reserve to ensure the County programs will continue to be able to serve those currently being served should MHSA revenues decline.

Personnel Adjustments:

The MHSA plan includes adding the following positions:

1.0 FTE Mental Health Practitioner STAR Program

The position will help increase capacity to enable the program to serve an additional 15 clients without the requirement of participation in STAR Mental Health Court.

0.10 FTE Mental Health Practitioner Bilingual - HOPE Program

The position will provide continued support for the Amigos Consejeros A Su Alcance (ACASA) (Senior Peer Counseling) Program which is the HOPE Program's component for outreach and engagement of Hispanic/Latino older adults. Formerly funded by one-time PEI funds, this part-time bilingual (Spanish-speaking) mental health practitioner provides training, support and supervision to the ACASA bi-lingual senior peer counselors.

1.0 FTE Mental Health Practitioner - Alliance in Recovery (AIR)

The position will provide intensive outreach and engagement services to adults whose co-occurring mental health and substance use disorders have resulted in treatment failure in one or both treatment systems.

1.0 FTE Mental Health Practitioner – Adult System of Care (ASOC) Program

The position will provide assertive outreach and engagement services targeting adults with untreated or inappropriately treated serious mental illness who are at imminent risk because of their inability and/or unwillingness to engage in services.

1.0 FTE Mental Health Program Manager I - Ethnic Services Manager

The position will chair the MHSUS cultural competence advisory board, gathering input from the community for policy consideration; develop and coordinate cultural

competence trainings; identify the service needs of underserved communities for consideration for program planning.

1.0 FTE Support Service Worker II – Odyssey (Homeless Program)
The position will help implement a program component targeting individuals already enrolled in the Odyssey Program who no longer need intensive case management services and supports, but continue to require more support and service than can be provided by the Enterprise Resource Center program and other community supports and resources. Individuals with lived experience as a mental health consumer and experience working as a peer specialist will be encouraged to apply for this position.

1.0 FTE Mental Health Practitioner - HOPE (Older Adult Program)
The position will help expand the program's intensive community treatment service capacity by serving an additional 10 underserved older adult clients.

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: The total 3-year MHSA funding of $32,669,758 is allocated as follows: FY 2014-15 $11,253,843; FY 2015-16 $10,765,457; FY 2016-17 $10,650,458 (see Attachment B). These amounts include existing previously approved funds, and expansion/growth funds. Through the proposed budget adjustments, a total of $4,072,028 for FY 2014-15, and $4,242,489 for FY 2015-16 of growth funds will be approved in the MHSA Prop 63 Funds Center 1000047000 resulting in a $91,452 reduction in net County cost in each year. The Department will work with the CAO to make the FY 2015-16 and 2016-17 adjustments.

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

Sincerely,

Larry Meredith, Ph.D.
Director

SAP FMBB Document Number: Pending

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

ATTACHMENT A

Action	Cost Center	Description	FTE	Job Title	Step	Class	Position #
Add	1000047100	MH Prop 63	1.00	Mental Health Practitioner/Licensed Mental Health Practitioner	4	1089	1089TBD
Add	1000042100	Adult Mental Health	0.10	Mental Health Practitioner Bilingual/Licensed Mental Health Practitioner Bilingual	4	1091	10910002
Add	1000047100	MH Prop 63	1.00	Mental Health Practitioner/Licensed Mental Health Practitioner	4	1089	1089TBD
Add	1000047100	MH Prop 63	1.00	Mental Health Practitioner/Licensed Mental Health Practitioner	4	1089	1089TBD
Add	1000047100	MH Prop 63	1.00	Mental Health Program Manager 1	4	0271	0271TBD
Add	1000047100	MH Prop 63	1.00	Support Service Worker II	4	1161	1161TBD
Add	1000047100	MH Prop 63	1.00	Mental Health Practitioner /Licensed Mental Health Practitioner	4	1089	1091TBD

ATTACHMENT B
FUND 10000
Community Services and Supports (CSS)

Action	Fund Center	Description	Commitment Item	CI Description	Budget Adjustment FY 2014-15	Budget Adjustment FY 2015-16
Increase	1000047000	MH - Prop 63	5110110	Salaries and Benefits	$789,296	$789,296
Increase	1000047000	MH - Prop 63	5210400	CBO Contracts	$1,436,050	$2,536,050
Increase	1000047000	MH - Prop 63	5210100	Professional Services	$29,384	$29,384
Increase	1000047000	MH - Prop 63	5211300	Professional Development - Training	$20,000	$20,000
Increase	1000047000	MH - Prop 63	5211400	Travel	$43,737	$43,737
Increase	1000047000	MH - Prop 63	5211500	Misc Services	$24,550	$24,550
Increase	1000047000	MH - Prop 63	5220100	Office Supplies	$43,735	$43,735
Total Expenses					**$2,386,752**	**$3,486,752**
Increase	1000047000	MH - Prop 63	4550760	Medi-Cal Federal	$203,384	$478,384
Increase	1000047000	MH - Prop 63	4810166	Transfers In - Prop 63		$225,000
Increase	1000047000	MH - Prop 63	4810166	Transfers In - Prop 63	$2,274,820	$2,874,820
Total Revenues					**$2,478,204**	**$3,578,204**
Net County Cost Adjustment					**($91,452)**	**($91,452)**

Prevention and Early Intervention (PEI)

Action	Fund Center	Description	Commitment Item	CI Description	Budget Adjustment FY 2014-15	Budget Adjustment FY 2015-16
Increase	1000047000	MH - Prop 63	5210100	Professional Services	$30,525	$30,525
Increase	1000047000	MH - Prop 63	5210400	CBO Contracts	$521,536	$521,536
Total Expenses					**$552,061**	**$552,061**
Increase	1000047000	MH - Prop 63	4810166	Transfers In - Prop 63	$552,061	$552,061
Total Revenues					**$552,061**	**$552,061**

Workforce Education and Training (WET)

Action	Fund Center	Description	Commitment Item	CI Description	Budget Adjustment FY 2014-15	Budget Adjustment FY 2015-16
Increase	1000047000	MH - Prop 63	5410100	Support of Clients	$34,034	$0
Total Expenses					**$34,034**	**$0**
Increase	1000047000	MH - Prop 63	4810166	Transfers In - Prop 63	$34,034	$0
Total Revenues					**$34,034**	**$0**

Capital Facilities and Technological Needs (CFTN)

Action	Fund Center	Description	Commitment Item	CI Description	Budget Adjustment FY 2014-15	Budget Adjustment FY 2015-16
Increase	1000047000	MH - Prop 63	5110200	Extra Hire	$539,529	$7,976
Increase	1000047000	MH - Prop 63	5210100	Prof Services	$369,000	$134,000
Increase	1000047000	MH - Prop 63	5210400	CBO Contracts	$44,352	$0
Increase	1000047000	MH - Prop 63	5211500	Misc Services	$20,000	
Increase	1000047000	MH - Prop 63	5220100	Office Supplies	$67,100	$6,820
Increase	1000047000	MH - Prop 63	5220200	Maintenance - Equipment	$59,200	$54,880
Total Expenses					**$1,099,181**	**$203,676**
Increase	1000047000	MH - Prop 63	4810166	Transfers In - Prop 63	$1,099,181	$203,676
Total Revenues					**$1,099,181**	**$203,676**

SUMMARY

Total Expenses					**$4,072,028**	**$4,242,489**
Total Revenues					**$4,163,480**	**$4,333,941**
Net County Cost					**($91,452)**	**($91,452)**

Special Revenue Fund: 25049 MHSA Prop 63

Action	Fund Center	Description	Commitment Item	CI Description	Budget Adjustment FY 2014-15	Budget Adjustment FY 2015-16
Increase	1000047000	MH - Prop 63	5490120	Operating Transfers Out	$2,274,820	$2,874,820
Increase	1000047000	MH - Prop 63	5490120	Operating Transfers Out	$0	$225,000
Increase	1000047000	MH - Prop 63	5490120	Operating Transfers Out	$552,061	$552,061
Increase	1000047000	MH - Prop 63	5490120	Operating Transfers Out	$34,034	$0
Increase	1000047000	MH - Prop 63	5490120	Operating Transfers Out	$1,099,181	$203,676
Total Expenses					**$3,960,096**	**$3,855,557**
Increase	1000047000	MH - Prop 63	4520110	Transfers In - Prop 63	$2,274,820	$2,874,820
Increase	1000047000	MH - Prop 63	4520110	Transfers In - Prop 63	$0	$225,000
Increase	1000047000	MH - Prop 63	4520110	Transfers In - Prop 63	$552,061	$552,061
Increase	1000047000	MH - Prop 63	4520110	Transfers In - Prop 63	$34,034	$0
Increase	1000047000	MH - Prop 63	4520110	Transfers In - Prop 63	$1,099,181	$203,676
Total Revenues					**$3,960,096**	**$3,855,557**

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Marin County

X Three-Year Program and Expenditure Plan

☐ 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: 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)

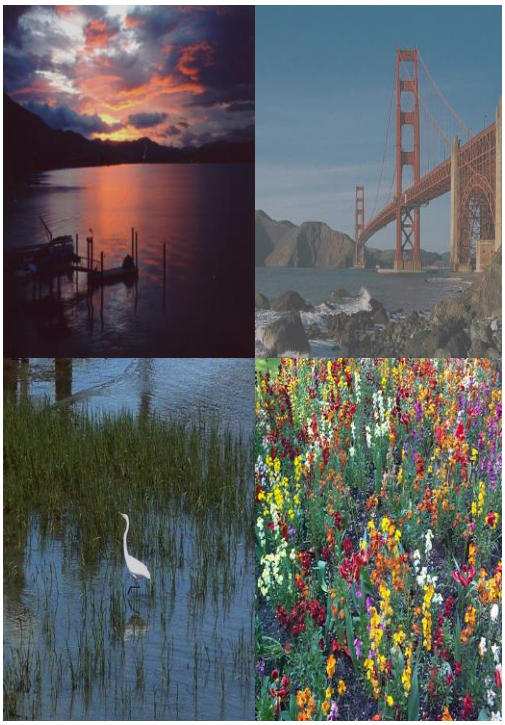
Suzanne Tavano 7/21/14
Signature Date

County: Marin County

Date: 7/21/14

MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH AND SUBSTANCE USE SERVICES DIVISION

MENTAL HEALTH SERVICES ACT
THREE-YEAR PROGRAM AND EXPENDITURE PLAN



FY2014-15 THROUGH FY2016-17

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

3240 KERNER BOULEVARD • SAN RAFAEL • CA • 94901

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

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INTRODUCTION

Dear Community Members,

Please allow me to begin by thanking you for your interest in Marin County's Mental Health Services Act planning process and proposed plan for services over the next three years.

This year marks the 10th Anniversary of the passage of Proposition 63, the Mental Health Services Act. This hallmark legislation was the result of dedicated advocacy by mental health clients, family members, service providers and many interested community members who for months canvassed at train and bus stations, went door to door to talk with neighbors, and stood outside grocery stores and many other public gathering spaces to talk with fellow residents about the importance of supporting the public mental health system through passage of this legislation. It is important to commemorate Proposition 63 not only for its support of essential mental health services and system infrastructure, but also for its inclusion of funding to support housing, provide population based prevention and early intervention efforts and to launch organized efforts to decrease stigma and discrimination of those experiencing mental health issues. The Mental Health Services Act provided the basis to modernize and transform community mental health. It is with pride in this community that I mention the residents of Marin County overwhelmingly supported passage of the Act in 2004.

In preparing the Three-Year Program and Expenditure Plan for fiscal years 2014 through 2017, Marin undertook a robust community planning process that commenced in July, 2013 and extended through January, 2014. Community forums were widely advertised and well attended by interested community members, with town hall meetings held at multiple sites throughout the county reaching from Marin City to San Rafael to Novato and west to Point Reyes. Some of these forums focused specifically on identifying the mental health needs of the Older Adult, African American, Latino, and Vietnamese communities.

As we enter our 10th year of the Mental Health Services Act, it is a time of reflection on all that has been accomplished and an opportunity, in the spirit of continuous quality improvement, to identify new or different types of services we might implement to help us better achieve our ultimate goal: improvement in the quality of life of the diverse population we serve. Hearing directly from clients and family members about what is essential to foster resilience in youth and recovery for adults has been essential in identification of appropriate, culturally sensitive and effective services. We are deeply appreciative of this important information.

Again, we would like to thank the Marin community for its initial and ongoing support of the Mental Health Services Act.

My best regards,

Suzanne Tavano, Ph.D.
Director, Mental Health and Substance Use Services

Mental Health Services Act Principles

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

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

Mental Health Services Act Components

The MHSA has five (5) components:

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.

Mental Health Services Act (MHSA) Background

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, now known as the Department of Health Care Services. WIC § 5891 states that MHSA funds may only be used to pay for MHSA programs.

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

Three-Year Program and Expenditure Plan

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates for Mental Health Services Act programs and expenditures.

WIC § 5847 and CCR § 3310 state that a Three-Year Program and Expenditure Plan shall address each MHSA component: Community Services and Supports (CSS) for children, youth, transition age youth, adults, older adults (WIC § 5800 and § 5850); Capital Facilities and Technology Needs (CFTN) (WIC § 5847); Workforce, Education and Training (WET) (WIC § 5820); Prevention and Early Intervention (PEI) (WIC § 5840); and Innovative Programs (INN) (WIC § 5830). All component are required to be in one Plan, incorporating these elements and making expenditure projections for each component per year.

Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within thirty (30) days after Board of Supervisor adoption. WIC § 5484 states the Mental Health Board shall conduct a public hearing on the draft Three-Year Plan at the close of the thirty (30) comment period.

The MHSA Three-Year Plan is different than an Annual Update. CCR § 3310 states that a county shall update the MHSA Three-Year Plan annually. An MHSA Annual Update includes an update to the MHSA Three-Year Plan addressing the elements that have changed, the service outcomes for the reporting year and that year's expenditure plan.

For a copy of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, please call: 415.473.7465 or you can find it on our website at: https://www.marinhhs.org/mhsa3year.

Please review the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 and post your comments on the website or you can mail comments or questions to:

Kasey Clarke
MHSA Coordinator
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 Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 begins on Friday, April 11, 2014 and ends on Saturday, May 10, 2014.

A Public Hearing for the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 and the MHSA Annual Update for FY2014-15 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, 1111 Las Gallinas Avenue, San Rafael, CA 94903 in the Foundation Conference Room. The public is welcome.

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

STAKEHOLDER PROCESS IN MARIN COUNTY

Background

In 2004, before the first Mental Health Services Act (MHSA) funds were provided to counties, Marin conducted an extensive community stakeholder process to identify unmet needs and strategies for addressing those needs. Over 1,000 people participated in that planning process, including clients, their families, diverse community members, providers, and other sectors of the community. (For a copy of the original Community Services and Support Plan, visit the following web-link: https://www.marinhhs.org/mhsa). The results of this process developed the underlying framework for ensuing MHSA component plans.

The funding for the five (5) components of the Mental Health Services Act was released at different times after the Act was approved by voters. For each MHSA component, additional community stakeholder processes were conducted to develop the specific component plans. These are posted on the MHSA website at: https://www.marinhhs.org/mhsa. Every year, Marin County develops an MHSA Annual Update that reports the program descriptions and outcomes for the reporting period, and identifies challenges and changes to programs as needed.

This year the State required that counties develop a MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 that includes all five (5) MHSA components. Marin County took this opportunity to conduct another in-depth community planning process, including review of the existing programs, updating the needs assessment, and gathering extensive input about what changes and additions should be made to existing MHSA component programs.

The Plan was developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, community-based providers of mental health and alcohol and other drug services, law enforcement agencies, education, social services, veterans, health care organizations, representatives and families of unserved and/or underserved and other important interests. Also included were stakeholders that reflect the diversity of the demographics of Marin, including, but not limited to, geographic location, age, gender and race/ethnicity.

Ongoing Stakeholder Input

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

Mental Health and Substance Use Services Division (MHSUS) representatives regularly discuss MHSA services and supports with individuals, the Mental Health Board, Alcohol and Other Drug Advisory Board, the Quality Improvement Committee, Probation and other forums. Input received

in these settings is brought to MHSUS Senior Management and the MHSA component coordinators for consideration.

MHSA Component Meetings

- The Prevention and Early Intervention (PEI) Committee meets quarterly to discuss PEI Program implementation, including reviewing annual program evaluation reports. It is comprised of PEI providers of service, community advocates, consumers, Marin Health and Human Services representatives, Mental Health Board members, school representatives, and other community-based organizations.
- The WET Consumer Subcommittee meets on a monthly basis. Its 6-8 members meet at the consumer run drop in center. In addition, family members, family partners and the WET consultant meet monthly as the Family Subcommittee.
- The Innovation Advisory Committee meets twice a year to oversee the implementation of the Client Choice and Hospital Prevention program to discuss and document the lessons learned during the implementation and startup of this innovative program.

MHSA Implementation Committee

The MHSA Implementation Committee has been an ongoing body of MHSA stakeholders established to review outcomes of MHSA programs and make recommendations regarding all significant changes/additions to MHSA programs. Appendix E – MHSA Implementation Committee, lists the members and affiliations for the current Implementation Committee.

In February 2012, the Mental Health Director for Marin County retired after decades of service. The Deputy Director for Health and Human Services became the Interim Mental Health Director while recruitment for a new Mental Health Director could be implemented. During this transition, additional members were asked to join the MHSA Implementation Committee to ensure Marin had the appropriate stakeholders involved. Pending the placement of a new Mental Health Director, the membership met only as needed and we saw a drop off in attendance at those meetings.

With the arrival of Marin's new Mental Health and Substance Use Services Director, in the Spring/Summer of 2014, Marin will be reformulating the MHSA committee membership through an application process to ensure compliance with WIC § 5848 and CCR § 3320. Current members will be invited to re-apply, and the county will do extensive outreach to the residents of Marin in order add new membership representing all communities.

Three-Year Planning Process

MHSA Planning Committee

In late 2012, MHSUS created an internal committee to oversee the planning process. This was made up of internal Mental Health and Substance Use Services Division staff, the MHSA Component Coordinators for Prevention and Early Intervention (PEI), Community Services and Supports (CSS), Workforce, Education and Training (WET), Capital Facilities and Technological Needs (CFTN) and Innovation (INN), the Ethnic Services Coordinator, fiscal representatives, and other

MHSUS Senior Management. It met monthly throughout the process. Kasey Clarke, the MHSA Coordinator, coordinated the overall MHSA planning process.

Program Evaluations

All MHSA programs submit outcome data and narratives annually in the MHSA Annual Updates. Generally this data is used to make adjustments to the existing programs each year. In preparation for the MHSA Three-Year Program and Expenditure Plan, this data was used to assist in determining if there were more significant changes needed, such as changing program capacity or significantly altering the program.

In addition, Marin engaged Allen, Shea and Associates (ASA) in late 2012 to assist with developing an MHSA logic model as well as component logic models (See Appendix F – MHSA Logic Models). These were used to take a broader look at each program's role in achieving the overall goals of MHSA. These will be updated in early FY2014-15 to be consistent with the MHSA Three-Year Program and Expenditure Plan.

Planning Steps

Allen, Shea and Associates (ASA) also assisted with the community input meeting planning process and facilitation at the community meetings. Because Marin had their HHS Deputy Director acting as the Interim Mental Health Director, it was determined that we would contract with the recently retired Assistant Director of the Napa Health and Human Services Department, James Featherstone, to assist with the facilitation of the MHSA Community Planning Process.

The MHSA Planning Committee, described earlier in this section, was established to oversee the process for developing the Three-Year Program and Expenditure Plan.

MHSUS compiled original needs and priorities; evaluations of existing programs; feedback received to date from a wide variety of sources; and initial expected funding levels to develop early thoughts on which MHSA programs should be continued, which should be adjusted, which may not be funded in the future, and potential new programs.

The proposed community process and early thoughts on MHSA programs were presented to a number of committees with broad representation, such as the Mental Health Board, MHSA Implementation Committee, Policy Committee, Provider Meeting, and others. The feedback received informed the final shape of the community input process.

Initial County Proposals

Given that Marin conducts annual MHSA planning processes and gathers input on an ongoing basis, as well as gathers outcome data on all MHSA programs annually, there was already a lot of information gathered about possible changes to be made in FY2014-15. In addition, sometimes the community perception of planning processes such as these is that the County has already decided what the outcome will be, and then conducts the planning process without being transparent.

Marin chose to draft up proposed changes, including which programs to continue, which to terminate, and proposed new programs, to share openly and receive feedback about during each of

the community input meetings. These proposals were discussed with the Mental Health Board, the MHSA Implementation Committee, and MHSUS providers before being shared at the community input meetings (See Appendix G – County Proposal for Three-Year Plan and Appendix H – MHSA New Program Descriptions).

Community Input Process

There were multiple factors that provided the context for the process:

- While the initial MHSA planning processes were focused on how to apply a new funding source, during this planning process we had to balance the needs and priorities identified in the original planning process, the experience of the existing MHSA programs, and current feedback about services and gaps.
- In 2012, Marin County began integrating two divisions, Mental Health and Alcohol and Other Drugs, into one: Mental Health and Substance Use Services (MHSUS). This supported the focus and need to provide co-occurring competent services.
- MHSA funding interacts with a variety of other funding and policy factors, including the Affordable Care Act, Medi-cal, Grants, and substance abuse treatment funding.
- Clients and families experience services throughout the continuum of care, usually without knowledge of the funding source and related regulations.

Due to these factors, Marin determined that it was essential to get community input on the full spectrum of mental health and substance use services, without requiring them to target their feedback by funding source. MHSUS could then use this input to determine what funding sources could be use to meet the community needs expressed. Information specific to MHSA funding and programs was provided to ensure participants were able to comment more specifically, but feedback was solicited in a broader context in order to not create a barrier to participation.

In all meetings addressing the development of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, an overview of the planning process was provided, as well as an overview of MHSA including the core purposes:

- Community collaboration
- Cultural Competence
- Client Driven
- Wellness, recovery, and resilience focused
- Integrated service experiences for clients and their families

Documents provided to those attending any of the MHSA Community Input Meetings can be found in Appendix I – Community Meeting Documents. All documents provided at the meetings were available in English, Spanish and Vietnamese. Translators were available on site for Spanish and Vietnamese participants if needed.

Community Conversations

Between July 23, 2013 and September 20, 2013, Marin County hosted six (6) community meetings which were held throughout Marin to gather input from all sectors of the community (see Appendix J – Community Meeting Flyers). Context for the meetings was presented with most of the time spent on getting input from participants in small groups. The meetings were conducted throughout the County and included translation in Spanish and Vietnamese, transportation, refreshments, and child supervision. Invitations were distributed to MHSUS staff, MHSUS contractors, all MHSA related committees, Mental Health Board, Alcohol and Other Drug Advisory Board, MHSA contact list, NAMI, Board of Supervisors. Flyers were displayed at MHSUS services, community services, libraries, stores and other locations throughout the community. Community-based organizations and providers were asked to personally invite clients and other providers. Announcements were included on the county website and in the local Marin Independent Journal newspaper.

In addition, Marin hosted an All Staff MHSUS meeting to provide the same Community Input presentation and gather feedback from them on existing programs and recommendations for new programs. Two (2) ad hoc meetings in response to specific requests by stakeholders that attended a community meeting were also provided out in the community to gather their feedback and input on new programs. Marin also gathered feedback and recommendations at the September PEI Committee and the MLK Coalition meetings.

An online survey was also available from July 23, 2013 through September 20, 2013. The survey gave individuals who could not or did not want to attend a community meeting in person, or had other recommendations after attending a meeting, to provide their input and recommendations for the MHSA Three-Year Plan.

ASA summarized all the input and MHSUS and the MHSA Implementation Committee analyzed it to inform what changes should be made to existing MHSA programs, what additional MHSA programs are needed, and what needs should be addressed through other programmatic and funding resources. For the complete report on the community input, please see Appendix K – Community Conversation Summary.

Three-Year Plan Stakeholder Participation

Overall, 196 community members, consumers, families, and providers attended the community meetings and 76 individuals completed the online survey. A review of this demographic data shows that men, youth (age 0-25), LGBTQ and Veteran individuals did not participate in the community process at the same rate as other groups. In addition to the participants in the six Community Meetings and Online Survey, over 100 people participated in Board and Committee meetings (see Community and Provider Meeting table below). Demographics were not collected for all of the Board and Committee meetings.

A summary of the representation and demographic information from the 196 participants at the community meetings is below.

Age Group	# participants	% of participants
0-15 years old	1	1%
16-25 years old	5	3%
26-59 years old	104	53%
60+ years old	85	43%
No Reply	1	1%

Primary Language	# participants	% of participants
English	150	76.5%
Spanish	24	12.2%
Vietnamese	20	10.2%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown	1	0.5%
No Reply	1	0.5%

Gender	# participants	% of participants
Male	51	26%
Female	144	73%
No Reply	1	1%

Race/Ethnicity	# participants	% of participants
White	101	51.5%
African American	21	10.7%
Asian	10	5.1%
Pacific Islander	5	2.6%
Native	1	0.5%
Hispanic	28	14.3%
Multi	14	7.1%
Other/Unknown	9	4.6%
No Reply	7	3.6%

Representation	# participants	% of participants
Provider of MHSUS	52	27%
Someone who uses/has used MHSUS	38	19%
Family Member of someone who uses/used MHSUS	21	11%
Homeless	18	9%
LGBTQ	5	3%
Law Enforcement	6	3%
Veterans	5	3%
Volunteer/Advocate	0	0%
Other	39	20%
No Reply	12	6%

Geography	# participants	% of participants
Central Marin	72	37%
Northern Marin	25	13%
Southern Marin	32	16%
West Marin	28	14%
Other	19	10%
No Reply	20	10%

A summary of the representation and demographic information from the 76 online survey respondents is below.

Age Group	# participants	% of participants
0-15 years old	0	0%
16-25 years old	2	3%
26-59 years old	36	47%
60+ years old	25	33%
No Reply	13	17%

Primary Language	# participants	% of participants
English	63	82.9%
Spanish	2	2.6%
Vietnamese		
Cantonese	1	1.3%
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown		
No Reply	10	13.2%

Gender	# participants	% of participants
Male	18	24%
Female	39	51%
No Reply	19	25%

Race/Ethnicity	# participants	% of participants
White	54	71.1%
African American	1	1.3%
Asian	1	1.3%
Pacific Islander		
Native		
Hispanic	1	1.3%
Multi	3	3.9%
Other/Unknown		
No Reply	16	21.1%

Representation	# participants	% of participants
Provider of MHSUS	12	16%
Someone who uses/has used MHSUS	7	9%
Family Member of someone who uses/used MHSUS	25	33%
Homeless	5	7%
LGBTQ	5	7%
Law Enforcement	2	3%
Veterans	3	4%
Volunteer/Advocate	9	12%
Other	0	0%
No Reply	8	11%

Geography	# participants	% of participants
Central Marin	22	29%
Northern Marin	10	13%
Southern Marin	16	21%
West Marin	6	8%
Other	7	9%
No Reply	15	20%

On January 22, 2014, the MHSA Implementation Committee met to review program and budget recommendations created by the MHSA component coordinators based on the feedback received through the Community Planning Process. Each component coordinator provided an overview of the programs and services proposed for the MHSA Three-Year Plan, as well as budget recommendations based on projected MHSA funding for the Plan period. The Implementation Committee members provided their feedback both verbally and in writing. Members were asked to fill out a form for each Component to rank their recommendations by "Support", "Do Not Support" and "No Opinion". This important feedback was gathered and used as MHSA component coordinators, the MHSA Planning Committee and the MHSUS Director finalized their draft recommendations to include in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

MHSA Three-Year Planning Meeting Overview

Date	Meeting Description
July 9, 2013	MHSA Implementation Committee Meeting - Review Community Planning Process
July 9, 2013	Mental Health Board - Review Community Planning Process
July 17, 2013	MHSUS Provider Meeting - Review Community Planning Process
July 19, 2013	Community Planning Process Facilitator Training
July 23, 2013	Community Conversation - Novato Youth Center, Novato
July 23, 2013	Community Conversation Online Survey Opened
July 25, 2013	MHSA Planning Committee Meeting
August 5, 2013	Alcohol and Other Drug Advisory Board - Review Community Planning Process
August 12, 2013	MHSUS Policy Group - Review Community Planning Process
August 13, 2013	Community Conversation - All MHSUS Staff, San Rafael
August 13, 2013	Community Conversation - Dance Palace, Pt. Reyes
August 15, 2013	Community Conversation - Margarita C. Johnson Senior Center, Marin City
August 21, 2013	Community Conversation - Albert J. Boro Community Center, San Rafael
August 22, 2013	MHSA Planning Committee Meeting
August 27, 2013	Community Conversation - West Marin Collaborative, Pt. Reyes
September 9, 2013	MHSUS Policy Group - Update Community Planning Process
September 11, 2013	Community Conversation - Marin Advocates for Mental Health, San Rafael
September 13, 2013	Community Conversation - HHS Connection Center, San Rafael
September 13, 2013	Community Conversation - PEI Committee, San Rafael
September 18, 2013	Community Conversation - San Rafael Recreation Center, San Rafael
September 19, 2013	Community Conversation - MLK Coalition, Marin City
September 20, 2013	Community Conversation Online Survey Closed
September 26, 2013	MHSA Planning Committee Meeting
October 14, 2013	MHSUS Policy Group - Update Community Planning Process
October 21, 2013	MHSA Implementation Committee Meeting - Review Report from the Community Conversations
November 4, 2013	Alcohol and Other Drug Advisory Board - Review Report from the Community Conversations
November 7, 2013	MHSA Planning Committee Meeting

Date	Meeting Description
November 11, 2013	Mental Health Board - Review Report from the Community Conversations
December 9, 2013	MHSUS Policy Group - Update on MHSA Three-Year Planning Process
December 17, 2013	MHSA Planning Committee Meeting
January 22, 2014	MHSA Implementation Committee Meeting - Draft Component Recommendations for Three Year Plan
April 11, 2014	MHSA Three-Year Plan for FY14-15 through FY16-17 Public Comment Period Opened
May 10, 2014	MHSA Three-Year Plan for FY14-15 through FY16-17 Public Comment Period Closed
May 13, 2014	MHSA Three-Year Plan for FY14-15 through FY16-17 Public Hearing

Community Boards, Commissions and Committees Sector Representation

Sector	Representation
County Mental Health and Substance Use Services (MHSUS)	❖ Senior Management ❖ Supervisors ❖ All-Staff meeting ❖ Mental Health Board ❖ Alcohol and Other Drug Advisory Board
Community-based Mental Health Providers	❖ County Contractors (20) ❖ Additional agencies
Community-based Substance Use Services Providers	❖ County Contractors (13) ❖ Additional agencies
Health Care Services	❖ Community Clinics (5 clinics) ❖ Teen Clinics (2 clinics)
Social Services	❖ Children & Family Services ❖ Aging and Adult Services ❖ Employment Services
Education	❖ Marin County Office of Education ❖ Early Childhood Education ❖ School Districts (4 Districts)
Law Enforcement	❖ Sheriff ❖ Police Departments
Veterans/Veterans Orgs	❖ Marin County Veterans' Services
Community-Family Resource Centers	❖ Community-based Organizations (3)

Stakeholder Involved	Policy	Program Planning and Implementation	Monitoring	Quality Improvement	Evaluation	Budget Allocations
Mental Health Board	X	X	X			
MHSA Implementation Committee	X	X	X			X
PEI Committee		X	X	X	X	
WET Committees		X	X	X	X	X
INN Advisory Committee	X	X	X	X	X	
Policy Committee	X					
Alcohol & Other Drug Advisory Board	X	X	X			
Quality Improvement Committee	X			X		
MHSUS Contractor Meetings			X	X		
Board of Supervisors	X		X			X

Additional Stakeholder Participation Efforts

Innovation Planning Process

Based on the completed community planning process, a priority theme for the next Innovation Plan will be "engaging and serving underserved and culturally diverse communities." A community planning process will be conducted in Spring/Summer of 2014 to further define the next Innovation Plan.

Engaging New Community Providers

In order to increase the capacity of community providers to engage in the Request for Proposal (RFP) process, MHSUS has conducted two trainings on topics including: how to obtain a 501(c)3 fiscal agent, understanding RFPs, developing Proposals, MHSA overview, and upcoming funding opportunities.

Request for Proposals Processes

A panel including peers/families, community members, community providers and others is convened to review proposals received in response to Requests for Proposals to implement MHSA programs.

Final MHSA Plan Approval Process

The final approval process for the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 includes:

- The MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 will posted for 30-day Public Comment beginning Friday, April 11, 2014 through Saturday, May 10, 2014 on Marin County's website at: https://www.marinhhs.org/mhsa3year.
- For a copy of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, please call: 415.473.7465
- On April 11-13, 2014 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 Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 will be 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) providers, Mental Health Board, Alcohol and Other Drug Advisory Board, MHSUS staff, MHSA Implementation Committee, other MHSA committees, and all individuals and agencies who submitted their contact information during the planning process.
- On Tuesday, May 13, 2014, a Public Hearing will be held with the Mental Health Board at 6pm at the Marin County Office of Education, 1111 Las Gallinas Avenue, San Rafael, CA 94903 in the Foundation Conference Room.
- Substantive comments from the 30-day posting and Public Hearing will be summarized, analyzed and incorporated as appropriate to the final MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.
- The MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 will go before the Marin County Board of Supervisors sometime after the public hearing.

Substantive Comments and Responses:

Include program outcomes over time

Program outcomes are included in the MHSA Annual Update in more detail than in the MHSA Three-Year Program and Expenditure Plan. We will consider expanding outcome data in future MHSA Annual Update reports and focusing on additional measures that reflect the effectiveness of the program as whole.

Tobacco Cessation Services for Mental Health consumers
Based on comments received during the MHSA thirty (30) day public comment period and at the MHSA Public Hearing held on May 13, 2014 to continue funding the peer to peer smoking cessation program for consumers in the Mental Health System of Care, the program has been added into the MHSA Three-Year Plan. The Community Services and Supports (CSS) Co-Occurring Capacity – SDOE-08 section of this Plan has been updated to include the program description, target population and intended outcomes.

Need for Assisted Outpatient Treatment (AOT) services
Within Community Services and Supports (CSS), Adult System of Care (ASOC) Program Expansion, the ASOC Outreach and Engagement Team intends to provide outreach and engagement services to those at-risk individuals in the community who are unable/unwilling to engage in mental health treatment despite the severe negative consequences they experience because of their untreated mental illness and despite the efforts of family, friends and others in the community to encourage them to seek treatment.

Culturally relevant mental health services for indigenous populations
The focus of the upcoming MHSA Innovation funding planning process will be on reaching un/underserved and culturally and ethnically diverse communities. The specific needs in the community will be assessed during the Innovation planning and funding process which will begin in Summer/Fall 2014.

Budget information at MHSA Implementation Committee lacked details
MHSA budget information provided at the MHSA Implementation Committee meeting was an allocation amount for the proposed programs by MHSA component. Specific program budget details for FY14-15 services are being created from the allocation amounts and are available by contacting Kasey Clarke, the MHSA Coordinator, at kclarke@marincounty.org.

Clarification of Administrative and Indirect budget line items
The three year MHSA budgeted administration and indirect Community Services and Supports (CSS) cost of $2,854,829 is based on approximately 15% of direct costs. 15% is the maximum administration percentage allowed for Medi-Cal reimbursement which is used as a standard for administration fees. The Marin Mental Health budget actual indirect cost rate is approximately 20% (19.66%).

Ensuring capacity of mental health providers to serve domestic violence victims
Prevention and Early Intervention (PEI) providers regularly serve domestic violence victims and their families. Trauma informed care training has been provided. The PEI Coordinator and some PEI providers are participating in the current Intimate Partner Violence (IPV) strategic planning process. The Department of Health and Human Services also partners with the Center for Domestic Peace to provide a 24 hour crisis intervention hotline, support groups, shelter and transitional housing services to victims and families. We will continue to look at opportunities to train providers and coordinate with other domestic violence efforts in our community.

Consumer Operated Services should meet SAMHSA's definition
The Enterprise Resource Center does not meet SAMHSA's definition of a Consumer-Operated service because the contracted organization does not have a Board that is at least 50% consumers with lived experience. The language in the MHSA Three-Year Plan has been changed to identify the Enterprise Resource Center as being a consumer-staffed, not consumer-operated program.

Increasing services for Marin's older adult population, especially concerning dementia/Alzheimer's Disease.
HOPE and the Older Adult PEI program specifically serve the older adult population. In addition, all programs serving adults, serve older adults. Beginning in FY2014-15, the Adult System of Care will expand services to include an Outreach and Engagement Team for at-risk individuals and the HOPE program will add a full-time Spanish speaking clinician to the assertive community treatment team which will enable the program to enroll an additional 10 individuals. While Marin's Senior Access program (www.senioraccess.org) is an adult day health center serving individuals with dementia, there is the potential for an innovative program that could serve individuals with mental health issues that are also experiencing the onset of dementia through the MHSA Innovation component. We recognize that older adults continue to be an underserved population and outreach and engagement efforts will continue.

MHSA Implementation Committee process did not have adequate time allocated for review and feedback
In FY2014-15 Marin will be reformulating the MHSA committee to ensure proper stakeholder participation through an application process for membership. The committee will begin meeting on a regular/monthly schedule to ensure communication and input on all MHSA related programs services and expenditures. This will include more in depth information on all programs and outcomes.

Community Based treatment for Non-Violent Criminal Justice involved offenders
Mental illness contributes to criminal justice involvement that could be prevented through appropriate services. Currently, AB109 and SB678 offenders referred back to Marin are assigned a Recovery Coach/Care Manager and are taken for a mental health and substance use assessment. As appropriate, they are then referred for treatment services and supports. Individuals with severe mental illness and involved in the criminal justice system are eligible to be referred into the STAR Full Service Partnership treatment program. We continue to work with the justice system to ensure all individuals in need of mental health or substance use services have access to those services.

New Innovation funding timeline
The planning process will begin Summer 2014 with the intention of funding being available during FY14-15. County Innovation plans are subject to approval by the State before funding can be distributed.

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%

CULTURAL COMPETENCE ADVISORY BOARD (CCAB)

IMPROVEMENT PLAN TO REDUCE STIGMA AND ENHANCE PENETRATION RATES AMONG HARD-TO-REACH POPULATIONS

Marin's MHSA Plan continuously strives to improve the penetration rate among the hard-to-reach populations, as evidenced by the proposed sustaining and/or increasing funding levels for programs and services that have proven to reduce barriers and improve access to services. Marin will also further examine best-practice approaches to ensure that the system is poised to meet one of its underlying goals of achieving and maintaining health equity. This will involve a multi-level approach that will work with policy makers, administrators, management, line staff, consumers, consumer advocates and contract agency providers to ensure that the process is inclusive and representative of the stakeholder community.

Beginning in FY2014-15, Marin is recommending a full-time Ethnic Service Manager (ESM) position be added, 50% funded through MHSA Community Services and Supports and 50% funded through other mental health revenue sources. The ESM will be available to consult with administrative, management and line staff throughout the division related to policy, improving culturally competent service delivery, outreach and engagement, and access in a culturally competent and strategic manner. The ESM will also serve as the communication bridge (liaison) between internal staff and the stakeholder community on emerging/current trends, issues, ideas and concerns that pertain to the cultural competence efforts being undertaken by MHSUS.

In 2013 the Mental Health and Substance Use Services Division (MHSUS) re-established a Cultural Competence Advisory Board (CCAB). Whereas the past board was comprised only of MHSUS staff, this current board is comprised of MHSUS management, line staff of MHSUS, contract agency providers, consumer advocates, consumers, community leaders from ethnic communities and an administrative aide to one of the county's Supervisors. This 21-member board is tasked to analyze data, review existing improvement plans, examine practice approaches (evidenced-based and community-defined promising practices) and make recommendations related to policy, service delivery, staffing and training needs, and system improvements. There are three (3) existing working committees within the Board: Training, Policy, and Access.

Efforts are also under way to explore the feasibility of establishing a similar board in West Marin, the outlying coastal area of Marin where there is a high concentration of under-served Latino immigrants who work on ranches and farms. Designated MHSUS staff has been attending established monthly service providers' collaborative meetings to assess the area's mental health and substance use service needs, and to develop collaborative relationships with providers, community leaders and residents. Continuing efforts will be undertaken to ensure that West Marin's under-served communities, particularly Latinos, will have an increased voice and understanding of current and future mental health and substance use services.

Lastly, MHSA will promote and foster culturally appropriate innovative and/or promising practices that can further work to reduce stigma and discrimination, and that will improve access for the hard to reach and under-served communities. This process has already begun as evidenced by two recent grant-writing workshops that were offered to, and conducted for, historically unfunded individuals and grassroots organizations (see Appendix D – Grant Writing Workshops). One workshop was conducted at a local church in the multi-cultural community of Marin City, while the other was conducted at the Health and Human Services Wellness Campus, located in the predominantly Latino neighborhood, the Canal community. A total of 87 participants throughout the county participated in the workshops. A consultant was hired to provide technical assistance to workshop participants to support them in their efforts to equitably compete for future funding opportunities through the county Request for Proposal process with well-established organizations that already have the organizational and infrastructural capacity to write and submit effective grants.

COMMUNITY SERVICES AND SUPPORTS (CSS) OVERVIEW

A primary goal of MHSA is to reduce the long-term adverse impacts of untreated mental illness and serious emotional disorders through funding and implementing community services and supports aimed at identifying, engaging and effectively serving unserved, underserved and inappropriately served at-risk populations. CSS funds are intended to expand and transform services provided for children, youth, adults, and older adults living with serious mental illness and emotional disorders towards evidence-based, recovery-oriented service models. Programs that are CSS-funded incorporate the MHSA key principles of: 1) Community collaboration, 2) Cultural competence, 3) Client and family driven, 4) Wellness, recovery and resilience focused, and 5) Integrated service experiences for clients and their families.

MHSA funding is available for three different types of system transformation strategies under the CSS component:

Full Service Partnerships (FSPs)

Designed to provide all necessary services and supports – a "whatever it takes" approach – for designated priority populations. Fifty-one percent of CSS funding continues to be required to be devoted to FSPs.

System Development (SD)

Dedicated to improving services, supports, and infrastructure for all clients and families, including the Full Service Partnership populations, to help change service delivery systems and build transformational structures and services, such as adding Spanish-speaking staff, developing peer specialist services, and implementing effective, evidence-based practices.

Outreach and Engagement (OE)

Designed for enhancing outreach and engagement of those populations that are receiving little or no services, with particular emphasis on eliminating ethnic disparities.

Marin recognizes the need to continue to expand efforts to reduce ethnic disparities and increase services for those who are un/underserved. Efforts to address disparities are described in the previous section (Improvement Plan to Reduce Stigma and Enhance Penetration Rates). CSS aims to increase the number of linguistically and culturally competent providers, provide outreach and engagement services, develop programs responsive to needs of specific target populations, and partner with Prevention and Early Intervention (PEI) programs to increase timely access to services. The CSS overview in the FY2014-15 MHSA Annual Update reports on the effect of these strategies, and program-specific strategies for reducing disparities are discussed in each program narrative.

CSS Programs for FY2014-15 through FY2016-17

In developing the CSS component of the MHSA Three-Year Program and Expenditure Plan (Plan) for FY2014-15 through FY2016-17, many factors were taken into consideration, including: input from an extensive community planning process, evaluations of existing CSS programs, and the changing environment and evolving needs of the community. Existing CSS programs have been successful in reaching and serving priority populations and achieving program-specific goals (see

detailed program reports below). These programs will be continued in FY2014-15 and will incorporate many of the program expansions funded with one-time (unexpended) MHSA funds during the prior 2-3 years. In addition, a few new program expansions and one new CSS program will be started in FY2014-15 to address identified needs. Marin will continue to make adjustments to the Plan as available funding changes, programs are implemented, and additional community needs emerge.

CSS funding is also being used in FY2014-15 to continue the one-time MHSA Administration expansion funding of a full-time MHSA Coordinator position responsible for overseeing and coordinating Marin's MHSA planning, development, implementation, and reporting. In addition, Marin is creating a new full-time Ethnic Services Manager position in FY2014-15 which will be partially funded (0.5) by CSS funding. The Ethnic Services Manager will be responsible for overseeing and coordinating cultural competence activities and strategies throughout Marin's Mental Health and Substance Use Services system, with an emphasis on promoting and supporting the reduction of ethnic and racial disparities through the implementation of MHSA-funded services and programs. Finally, all existing CSS programs with ongoing funding that is being continued in FY2014-15, with the exception of the MHSA Housing Program, will receive an allocation adjustment of 5% funded by MHSA CSS funds to address increases in the costs of operating these programs and other expenses.

Program Name	Program Overview
Youth Empowerment Services (YES) FSP-01	YES, formerly known as the Children's System of Care (CSOC), is a full service partnership program serving seriously high-risk youth through age 18 who are involved with Probation and/or attend County Community School, an alternative high school. In FY14-15 this program will incorporate the previously one-time expansion of family outreach and support. It will also add substance use specialist services.
Transition Age Youth (TAY) FSP-02	TAY is a full service partnership providing young people (16-25) with serious emotional disturbance or emerging mental illness with independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services. A Request for Proposal (RFP) process will be conducted to determine the provider in FY14-15.
Support and Treatment after Release (STAR) Program FSP-03	STAR is a full service partnership serving adults with serious mental illness who are at risk of incarceration or re-incarceration. In FY14-15 this program will incorporate previously one-time components, including substance use specialist services, independent living skills training, Crisis Intervention Team Training, and will expand capacity.
Helping Older People Excel (HOPE) Program FSP-04	HOPE is a full service partnership serving older adults with serious mental illness who are at risk of homelessness, hospitalization or institutionalization. In FY14-15 this program will incorporate previously one-time funded components, including outreach to Latino older adults and independent living skills training. It will also expand capacity.
Odyssey Program (Homeless) FSP-05	Odyssey is a full service partnership serving adults with serious mental illness who are homeless or at-risk of homelessness. In FY14-15 this program will continue previously one-time components, including substance use specialist services, transitional housing, and independent

Program Name	Program Overview
	living skills training. It will also develop a bridge into less intensive services.
Enterprise Resource Center (ERC) SDOE-01	ERC is an outreach and engagement project serving adults with serious mental illness who are reluctant to become involved in the public mental health system. In FY14-15 this program will continue one-time expansion of the CARE Team, providing outreach to homeless individuals, and open a second site to provide recovery support for individuals no longer requiring intensive case management.
Southern Marin Services Site (SMSS) Program SDOE-04	SMSS 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.
Adult System of Care (ASOC) Expansion – SDOE-07	ASOC Expansion is a system development program to increase services for adults with serious mental illness who are unserved or underserved. In FY14-15 this program will continue one-time expansion of family outreach and support, client support and housing assistance, and will add new outreach and engagement services. It will also advance pay equity for peer specialists.
Co-Occurring Capacity SDOE-08	Co-Occurring Capacity is a systems development program intended to further develop the capacity to effectively serve individuals with co-occurring disorders. Programs within this include Alliance in Recover (AIR) and co-location of mental health and substance use providers.
Crisis Continuum of Care SDOE-09 (NEW PROGRAM)	Crisis Continuum of Care is a systems development program intended to reduce acute crises and increase client choice by developing and coordinating a full continuum of crisis services. Programs within this include crisis planning, crisis residential, crisis triage staff, and a PES family partner.
MHSA Housing Program	Fireside Apartments were developed for low-income older adults with serious mental illness. There are ongoing efforts to identify further housing projects that fit within the funding guidelines.

In the event that additional CSS funds become available, such as through allocated funds being unexpended or an increase in projected MHSA revenue, the following program expansion has been identified through the planning process as a priority for use of those funds:

- ASOC Expansion - Increase Adult Case Management team capacity by adding a full time Mental Health Registered Nurse for intensive services to 75 Adult System of Care clients being served in more restrictive levels of care in order to accelerate their return to community-based lower level of care and promote more successful community tenure.

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

YOUTH EMPOWERMENT SERVICES (YES)

Program Overview

Marin County's Youth Empowerment Services (YES), formerly known as the Children's System of Care (CSOC), is a full service partnership program serving 40+ seriously high risk youth through age 18 who are involved with Probation and/or attend County Community School, an alternative high school.
This program was originally implemented as a Children's System of Care grant in the late nineties. In FY2005-06 the Mental Health Services Act began supporting a major portion of the program which enabled the program to expand and hire Family Partners with lived experience with children who had been in the mental health system and/or juvenile justice system.

The YES program, a continuing program, aims to serve youth who do not have ready access to other mental health resources and are not typically motivated to seek services at more traditional mental health clinics. The YES model is a supportive, strengths based model with the goal of meeting youth and families in their homes and in the community to provide culturally appropriate mental health services with a 'whatever it takes' model.

From beginning of the YES 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%.

Target Population

In FY2012-13 client ages ranged from 10-18 with the majority falling within the teen age years, with a mean age of 16.9 years. Latino youth and other youth of color continued to make up the majority of the YES clients: approximately 66% self-identified as Spanish being their primary language, while 18% were African American and 8% were white.

Full Service Partnership Client Demographics FY2012-13

Age Group	# served	% of served
0-15	25	27%
16-25	66	73%
26-60		
60+		
TOTAL	**91**	**100%**

PRIMARY LANGUAGE	# served	% of served
Spanish	30	33%
Vietnamese		
Cantonese		
Pacific Islander		
Mandarin		
Russian		
Farsi		
Arabic		
English	61	67%
Unknown		

RACE/ETHNCITY	# served	% served
White	7	7.7%
African American	17	18.7%
Asian		
Pacific Islander		
Native American		
Hispanic	60	65.9%
Multi	4	4.4%
Other	1	1.1%
Unknown	2	2.2%

Program Description

The YES model is a MHSA CSS supportive, strengths based model with the goal of meeting youth and families in their homes and in the community. The services incorporate a wraparound philosophy, focusing on working as a team to help families identify their needs and implement ways to address them successfully. The YES program provides culturally appropriate 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 be over-represented in the juvenile justice system and at County Community School. The YES program is appropriately serving these youth with three (3) bilingual clinicians, one of whom is a Latino male working with mostly Latino male students at County Community School and a bilingual Spanish speaking Family Partner. Family Partners are parents who have had a child in the mental health or juvenile justice system and are able to engage and support the parent because of their life experience in a unique manner that a professional cannot. These partners provide support and guidance to parents in navigating the various systems and with parenting youth engaged in high-risk behaviors.

This combination of YES staff provides both linguistic and cultural capability to address the diverse needs of the client population who face many challenges including trauma and environmental stressors.

Proposed Program Expansion

Marin MHSUS proposes to use MHSA CSS funds to continue the positions of Family Partners currently being funded with one time MHSA funds. These 2.0 FTE bilingual Family Partner positions will provide increased bilingual capacity for children's mental health services in Youth & Family Services (YFS) needed to address the increased number of referrals because of the Katie A. settlement which has resulted in increased identification of those in need of services as well as an increase in intensity of mental health services for foster children. Additionally, the Medi-Cal referrals to YFS show an increasing need for bilingual/cultural competency of Family Partners to help Spanish speaking parents navigate the system.

Marin MHSUS also will continue to recruit for a 1.0 FTE bilingual (English and Spanish speaking) substance use specialist to address substance use issues that are not being adequately addressed for youth involved in the juvenile justice

Outcomes Expected and Evaluation

YES program objectives include 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.

Because the number of youth in this program each year is small for purposes of statistical analysis outcomes have been calculated to include all participants over the course of this program, adding each year's data. However, the YES supervisor and Children's Mental Health Program Manager will be working with the staff to decide on one or two of these data points to track changes year to year so as to be able to focus on areas where there could be program improvement.

FY2014-15 Goals

Outcome	Goal
Decrease in Arrests	25%
Decrease in School Suspensions	75%
Increase School Attendance	50%

Program Continuation [X] **Program Expansion** [ ] **New Program** [ ]

Transitional Age Youth (TAY)

Program Overview

Marin County's Transition Age Youth (TAY) Program, provided by Buckelew Programs, is a full service partnership (FSP) providing young people (16-25) with serious emotional disturbance or emerging mental illness with independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services. This program was started by Buckelew in partnership with Family Service Agency (FSA) in FY2006-07. Buckelew and FSA are now one agency and continue to provide this program, utilizing their complementary resources. 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. There is also a well-attended Partial program for youth who can take advantage of the group activities and ongoing social support.

Target Population

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.

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 who publishes an activity calendar in Spanish and English and does outreach in a variety of venues in the community. At the end of FY2012-13 a bicultural Spanish speaking TAY team leader was hired, so the program is now positioned to be able to outreach more successfully to Latino transitional age youth.

Full Service Partnership Client Demographics FY2012-13

Age Group	# served	% of served
0-15 years old		
16-25 years old	29	100%
26-59 years old		
60+ years old		
TOTAL	**29**	**100%**
Race/Ethnicity		
White	21	
African American	1	
Asian	2	
Pacific Islander		
Native		
Hispanic	2	
Multi	1	
Other/Unknown	2	

Primary Language		
Spanish	1	
Vietnamese		
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic		
English	28	
Other		

Program Description

The TAY Program is a full service partnership (FSP) providing young people (16-25) with 'whatever it takes' to move them toward their potential for self sufficiency and appropriate independence with the natural supports in place from their family, friends and community. Initial outreach and engagement is essential for this age cohort who are naturally striving toward independence and face more obstacles due to their mental illness than the average youth. Independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services are available through the TAY Program which strives to be strengths based, evidence based and client centered. A multi-disciplinary team provides assessment, individualized treatment plans and linkages to needed supports and services as well as, coordinated individual and group therapy and psychiatric services for TAY participants.

A member of the team is available to TAY clients 24 hours per day, 7 days a week. This program provides 'whatever it takes' with the goal of providing treatment, skills and the level of self-sufficiency necessary to TAY to manage their illness and accomplish their goals, avoiding deep end services, incarceration and homelessness. In addition, partial services, such as drop-in hours and activities, are available to TAY who are not in the full service partnership.

Partial services are provided on a drop-in basis to full and partial clients. These services include 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 and substance use, whether or not their child is enrolled in the TAY programs is provided by a TAY staff.

One time 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 as well as funds for a vegetable and flower garden that the TAY participants enjoy.

Proposed Program Expansion

Marin MHSUS proposes to continue the one-time funds for a substance abuse counselor to provide needed services for youth with co-occurring disorders who need support in recognizing the impact of substance abuse on their mental health and comprehensive services that promote recovery and self-sufficiency. The success of an integrated approach with mental health and substance use staff working together with individuals with co-occurring psychiatric and substance abuse disorders is well documented. All TAY participants are screened by the substance abuse counselor and groups for youth and families are regularly provided.

Outcomes Expected and Evaluation

The TAY Program objectives include decreasing hospitalization and homelessness and increasing attendance at school or work. Homelessness shows a downward trend but too little data has been collected to draw meaningful conclusions regarding school and work attendance.

- The TAY program objective was 70% of FSP TAY members will have engaged in work, vocational training or school and 86% engaged in work, vocational training or school in FY2012-13.
- The TAY Program objective was the TAY house would be fully occupied 75% of the time and the TAY house was fully occupied (3 residents) 79% of the time.

Because the number of youth in this program each year is small for purposes of statistical analysis tracking year to year has proved difficult to extract meaningful data for which to shape quality improvement activities. However, in the interest of being able to observe changes month to month and year to year the TAY staff started tracking daily attendance separately for school or work with a small number of TAY participants. This is an on-going project and the Children's Mental Health supervisor who is the liaison to this program along with the Children's Mental Health Program Manager will be working with the program staff to analyze these data points so as to be able to focus on areas where there could be program improvement.

There will be a Request for Proposal for a TAY program put out in late spring/early summer of 2014 to envision a fresh perspective on meeting the needs of these youth with mental illness. Part of the new focus will be on utilizing peer mentors, family members, Family Partners and the youth themselves in shaping a new program with an emphasis on natural occurring supports and outcomes, including post discharge follow up so the program can better address areas for improvement. The new proposal will also be requiring a creative approach to maximizing the limited housing available for TAY recognizing that stable housing is important in maintaining mental health.

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

SUPPORT AND TREATMENT AFTER RELEASE (STAR) PROGRAM

Program Overview

The STAR Program has been an MHSA-funded Full Service Partnership serving adults with serious mental illness who are at risk of incarceration or re-incarceration since 2006.

The Marin County Support and Treatment After Release (STAR) Program was originally implemented in 2002 through a competitive Mentally Ill Offender Crime Reduction Grant (MIOCRG) awarded by the California Board of Corrections. A collaborative effort that included the Sheriff's Department, Probation Department, Marin County Superior Court, San Rafael Police Department, Department of Health and Human Services-Division of Community Mental Health Services (CMHS), and Community Action Marin's Peer Mental Health Program, the program implemented an improved system for providing strengths-based modified assertive community treatment and support for adult mentally ill offenders with the goal of reducing their recidivism and improving their ability to function within the community. The STAR Program's unique combination of law enforcement's community policing, problem-solving approach, the county's clinical treatment delivery methods, and multi-disciplinary outreach and collaboration clearly demonstrated that Marin was able to effectively serve individuals who have been previously thought to be beyond help.

The initial grant that supported the program ended in June 2004. In March 2004, the Marin Community Foundation approved a grant to support continuation of the STAR Program for an additional 12 months. Key stakeholders and community partners fully supported the conversion of the STAR Program into a new full service partnership to continue serving the MIOCRG target population. During FY2005-06, the County Board of Supervisors provided bridge funding to continue the STAR Program until MHSA funding became available. This plus additional funding commitments from key partners in the program made it possible to build upon the initial success of the STAR Program to further the development of a comprehensive system of care for Marin's mentally ill offenders that consists of three critical components: 1) In-custody screening and assessment, individualized treatment and comprehensive discharge planning; 2) post-release intensive community-based treatment and services to support functioning and reduce recidivism, and 3) a mental health court – the STAR Court – to maximize collaboration between the mental health and criminal justice systems and ensure continuity of care for mental health court participants.

The re-design of the program incorporated the valuable experiences and lessons learned from the MIOCRG-funded services and in 2006, the STAR Program was approved as a new full service partnership providing culturally competent intensive, integrated services to 40 mentally ill offenders. Operating in conjunction with Marin's mental health court – the STAR Court – the program was designed to provide comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports.

The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce incarceration, and reduce hospitalization.

Because of its origins in MIOCRG, the STAR Program is able to report on population, service and outcome data since 2002. Since its beginning, the program has served 189 program participants and has achieved and/or exceeded almost all program goals, as shown below:

	GOAL	ACTUAL
Decrease in homelessness	75%	84%
Decrease in arrests	75%	70%
Decrease in incarceration	80%	83%
Decrease in hospitalization	40%	55%

Target Population

The target population of the STAR Program is adults, transition-age young adults, and older adults with serious mental illness, ages 18 and older, who are currently involved with the criminal justice system and are at risk of re-offending and re-incarceration. Priority is given to individuals who are currently unserved by the mental health system or are so inappropriately served that they end up being incarcerated, often for committing "survival crimes" or other nonviolent offenses related to their mental illness. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

The STAR Program clearly has served individuals who have serious mental illness, with 45% (65) of participants presenting with Mood Disorders and 46% (66) with Psychotic Disorders. Seventy-two percent (136) of all program participants had a co-occurring substance use disorder.

As noted above, 189 individuals have been served by the STAR Program, with 22 participants being re-enrolled once and 1 re-enrolled twice. Average length of stay in the program has been 2.5 years. The average age of program participants at the time of enrollment was 37. Other characteristics of program participants are reported below:

Full Service Partnership Client Demographics FY2002-2013

AGE AT ADMISSION		
	#	%
0-15		
16-25	45	21%
26-60	160	76%
60+	7	3%
GENDER		
	#	%
Female	49	26%
Male	140	74%

RACE/ETHNICITY		
	#	%
Caucasian or White	142	75%
African American or Black	14	7%
Asian	5	3%
Pacific Islander		
Native-American		
Hispanic	21	11
Multi	1	<1%
Other	5	3%
Unknown	1	<1%

Program Description

Marin's Support and Treatment After Release (STAR) Program is a full service partnership providing culturally competent intensive, integrated services to 40 mentally ill offenders. As stated

above, 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 comprised of professional and peer specialist staff provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psychoeducation, 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. The team's mental health nurse practitioner furnishes psychiatric medication to program participants under the supervision of the team psychiatrist. The team's mental health nurse practitioner also provides participants with medical case management, health screening/promotion and disease prevention services, and coordinates linkage to community-based physical health care services. The program also has a volunteer family member who brings the voice and perspective of families to the program and is available to provide outreach to family members of STAR Program participants.

Proposed Expansion

Marin proposes to use MHSA CSS funds to continue the following successful program expansions currently being funded with one-time MHSA funds:

Substance Abuse Specialist Position

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. Studies have documented the effectiveness of an integrated approach to individuals with co-occurring psychiatric and substance use disorders, in which the mental illness and substance use disorder are treated by the same clinician or team. Funded by 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. This position is expected to provide integrated substance abuse services to 15-20 program participants annually.

Independent Living Skills Training

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. ILS training is expected to be provided to 4-5 program participants annually.

Crisis Intervention Team (CIT) Training

CSS one-time expansion funds were approved beginning in FY2011-12 through FY2013-14 to provide 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. Funds are use for stipends to local law enforcement jurisdictions to enable them to send officers to the training, support their ongoing participation in the monthly meetings of the county-wide problem-

solving Forensic Multi-Disciplinary Team (FMDT), and help pay for the cost of the training. This training is provided to 25-30 sworn officers annually.

Expand STAR Program Capacity

Currently CSS one-time expansion funds, approved in FY2011-12 and extended through FY2013-14, are used to fund a part-time mental health clinician who is co-located with the Jail Mental Health Team and conducts comprehensive in-custody assessments and provides post-release support and linkages to services. Increased staffing on the Jail Mental Health Team has reduced the need for the STAR Program to continue to provide this Jail-based service. At the same time, current demand for STAR Program services exceeds its capacity. Additionally, the current requirement that all program enrollees agree to participate in STAR Court has presented an obstacle to enrollment for some individuals who would clearly benefit from the program's services. Using MHSA funding to increase this position to full-time and reassign it to the core assertive community treatment team will enable the program to serve an additional 15 clients without the requirement of participation in STAR Court and hopefully will allow the STAR Program to engage and enroll a more diverse participant population.

Outcomes Expected and Evaluation

Listed in the table below, the expected outcomes for the STAR Program are based on the goals of the program and remain unchanged The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the STAR Program staff on a daily basis. Program staff will continue to explore methods for measuring self-sufficiency and recovery that will permit the program to evaluate its success in these key areas.

	GOAL
Decrease in homelessness	75%
Decrease in arrests	75%
Decrease in incarceration	80%
Decrease in hospitalization	40%

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

HELPING OLDER PEOPLE EXCEL (HOPE) PROGRAM

Program Overview

The HOPE Program has been an MHSA-funded Full Service Partnership serving older adults with serious mental illness who are at risk of homelessness, hospitalization or institutionalization since 2007.

Prior to implementation of MHSA, Marin County did not operate a comprehensive integrated system of care for older adults with serious mental illness. Due to limited resources and service capacity, the existing Older Adult Services County mental health program had been unable to provide much more than assessment and peer support services. Of all the age groups served by Marin's public mental health services, older adults had received the least services and had the lowest penetration rates, despite the fact that they constituted the fastest growing age cohort in Marin.

Key stakeholders and community partners had consistently agreed that Marin needed to more comprehensively address the needs of older adults who have serious mental illness, and they strongly supported the creation of a new full service partnership as a critical step toward an integrated system of care for this population. In 2006, Marin's HOPE Program was approved as a new MHSA-funded full service partnership providing culturally competent, intensive, integrated services to 40 priority population at-risk older adults. The HOPE Program was designed to provide community-based outreach, comprehensive geropsychiatric assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports by a multi-disciplinary, multi-agency team. The over-arching vision of the HOPE Program is "*Aging with dignity, self-sufficiency and in the life style of choice*".

The goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.

Since beginning operations in 2007, the program has served 145 program participants and has achieved and/or exceeded all program goals, as shown below:

	GOAL	ACTUAL
Decrease in homelessness	75%	90%
Decrease in hospitalization	50%	55%

Target Population

The target population of the HOPE Program is older adults with serious mental illness, ages 60 and older, who are currently unserved by the mental health system, who have experienced or are experiencing a reduction in their personal or community functioning and, as a result, are at risk of hospitalization, institutionalization or homelessness. These older adults may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

Transition age older adults, ages 55-59, may be included when appropriate.

The HOPE Program clearly has served individuals who have serious mental illness, with 45% (65) of participants presenting with Mood Disorders and 47% (68) with Psychotic Disorders. Fifteen percent (22) of all program participants had a co-occurring substance use disorder.

As noted above, 145 individuals have been served by the HOPE Program, with 18 participants being re-enrolled once and 4 re-enrolled twice. Average length of stay in the program has been 1.6 years. The average age of program participants at the time of enrollment was 69. Other characteristics of program participants are reported below:

Full Service Partnership Client Demographics FY2007-2013

AGE AT ADMISSION		
	#	%
0-15		
16-25		
26-60	18	11%
60+	149	89%
GENDER		
	#	%
Female	95	66%
Male	49	34%
Unknown	1	<1%

RACE/ETHNICITY		
	#	%
Caucasian or White	120	83%
African American or Black	10	7%
Asian	3	2%
Pacific Islander		
Native-American	1	<1%
Hispanic	6	4%
Multi	2	1%
Other	1	<1%
Unknown	2	1%

Program Description

The Hope Program is a full service partnership that provides culturally competent intensive, integrated services to 40 priority population at-risk older adults. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. As stated above, the goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.

The HOPE Program's multi-disciplinary assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psychoeducation, assistance with money management, and linkages to/provision of all needed services and supports. 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.

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

Because of the stigma associated with mental health issues for older adults in general, mental health issues often reach crisis 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 ready to graduate from intensive services.

Proposed Expansion

Marin proposes to use MHSA CSS funds to continue the following successful program expansions currently being funded with one-time MHSA funds:

Outreach and Engagement of Hispanic/Latino Older Adults

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. ACASA is expected to identify and engage with 5 new monolingual community liaisons annually.

Independent Living Skills Training

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. ILS training is expected to be provided to 4-5 program participants annually.

Marin also proposes to use MHSA CSS funds for the following new expansion of the HOPE Program:

Expand HOPE Program Capacity

Older adults have been identified to be Marin's fastest growing population and comprise 24% of the total population. Demand for HOPE Program services exceeds its capacity, especially within the assertive community treatment component which currently has the capacity to serve only 40 individuals. In FY2012-13 alone, the HOPE Program was contacted for assistance by over 350 individuals, families and treating professionals. Using MHSA funding to add a full-time Spanish speaking clinician to the assertive community treatment team will enable the program to enroll an additional 10 individuals. It is also anticipated that the addition of Spanish-speaking capacity to the assertive community treatment team will facilitate the identification, engagement, and enrollment of at-risk Hispanic/Latino older adults who have serious mental illness and continue to be unserved by the HOPE Program's full service partnership component.

Outcomes Expected and Evaluation

Listed in the table below, the expected outcomes for the HOPE Program are based on the goals of the program and remain unchanged. The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the HOPE Program staff on a daily basis. Program staff will continue to explore age-appropriate methods for measuring self-sufficiency and isolation that will permit the program to evaluate its success in these key areas.

	GOAL
Decrease in homelessness	75%
Decrease in hospitalization	50%

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

ODYSSEY PROGRAM (HOMELESS)

Program Overview

The Odyssey Program has been an MHSA-funded Full Service Partnership serving adults with serious mental illness who are homeless or at-risk of homelessness since 2008.

Following the loss of AB2034 funding for Marin's Homeless Assistance Program which had been in operation since 2001, key stakeholders and community partners fully supported the creation of a new full service partnership, the Odyssey Program, to continue serving the AB2034 target population. Over the course of its existence, Marin's AB2034 program demonstrated significant success in assisting adults with serious mental illness who were homeless to obtain and maintain housing, despite the County's very challenging housing environment, and to avoid incarceration and hospitalization. The design of the new program incorporated the valuable experiences and lessons learned from the AB2034-funded services and in FY2007-08, the Odyssey Program was approved as a new MSHA-funded CSS full service partnership providing culturally competent intensive, integrated services to 60 priority population adults who were homeless or at-risk of homelessness. The Odyssey Program was designed to provide comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports by a multi-disciplinary, multi-agency team.

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.

Because of its origins in AB2034, the Odyssey Program is able to report on population, service and outcome data since 2001. Since its beginning, the program has served 223 program participants and has achieved and/or exceeded all program goals, as shown below:

	GOAL	ACTUAL
Decrease in homelessness	80%	95%
Decrease in arrests	50%	50%
Decrease in incarceration	60%	76%
Decrease in hospitalization	40%	40%

Target Population

The target population of the Odyssey Program is 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 Odyssey Program clearly has served individuals who have serious mental illness, with 54% (121) of participants presenting with Mood Disorders, 38% (85) with Psychotic Disorders, and 4% (9) with Anxiety Disorders. Fifty-eight percent (130) of all program participants had a co-occurring substance use disorder.

As noted above, 223 individuals have been served by the Odyssey Program, with 8 participants being re-enrolled once and 1 re-enrolled twice. Average length of stay in the program has been 4.5 years. The average age of program participants at the time of enrollment was 44. Other characteristics of program participants are reported below:

Full Service Partnership Client Demographics FY2008-2013

AGE AT ADMISSION		
	#	%
0-15		
16-25	16	7%
26-60	205	88%
60+	12	5%
GENDER		
	#	%
Female	110	49%
Male	113	51%

RACE/ETHNICITY		
	#	%
Caucasian or White	162	73%
African American or Black	25	11%
Asian	6	3%
Pacific Islander		
Native-American	3	1%
Hispanic	19	9%
Multi	4	2%
Other	3	1%
Unknown	1	<1%

Program Description

The Odyssey Program is a full service partnership that provides culturally competent intensive, integrated services to 60 priority population at-risk adults. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. As stated above, 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 comprised of professional and peer specialist staff provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psychoeducation, 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.

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

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.

Supportive housing is provided through partnerships with the Marin Housing Authority's Shelter Plus Care Program and a community-based organization with a long history of providing supportive housing to clients of the Marin Community Mental Health Services traditional adult system of care.

Proposed Expansion

Marin proposes to use MHSA CSS funds to continue the following successful program expansions currently being funded with one-time MHSA funds:

Substance Abuse Specialist Position

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. Studies have documented the effectiveness of an integrated approach to individuals with co-occurring psychiatric and substance use disorders, in which the mental illness and substance use disorder are treated by the same clinician or team. Funded by 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. This position provides integrated substance abuse services to 15-20 program participants annually.

Transitional Housing

CSS FY2011-12 one-time expansion funds were approved through FY2013-14 to fund transitional housing in a 2-bedroom apartment for program participants who are homeless, reducing the program's reliance on hotel rooms. 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. Transitional housing serves 5-10 program participants annually.

Independent Living Skills Training

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. This training is provided to 4-5 program participants annually.

Marin also proposes to use MHSA CSS funds to develop the following new Odyssey Expansion Program component:

Odyssey Program "Step-Down" Component

The demand for Odyssey Program services continues to exceed its current capacity. As reported earlier, Odyssey Program participants have an average 4.5 years length of stay in the program,

considerably longer than that of Marin's other full service partnerships. Contributing to this extended length of stay is the fact that the program provides permanent supportive housing services. While this enables the Odyssey Program to support participants to successfully obtain housing, it also requires the provision of long-term support services in order for program participants to successfully maintain their housing. Marin's adult system of care does not currently have a less intensive community treatment component equipped to provide this service. As a result, many adults who qualify for and are in need of the Odyssey Program's assertive community treatment services must continue to wait for an opening in the program.

Marin proposes to use MHSA funding to expand the Odyssey Program to implement a program component targeting individuals already enrolled in the program who no longer need assertive community treatment services, but continue to require more support and service than can be provided by the proposed new consumer-staffed Step-Up Recovery Program. This team of a full time mental health paraprofessional and a full-time peer specialist would serve a caseload of up to 40 individuals and would enable more individuals to enroll in the assertive community treatment component of the Odyssey Program. Individuals with lived experience as a mental health consumer and experience working as a peer service provider in the public mental health system would be encouraged to apply for the mental health paraprofessional position.

Outcomes Expected and Evaluation

Listed in the table below, the expected outcomes for the Odyssey Program are based on the goals of the program and remain unchanged The data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the Odyssey Program staff on a daily basis. Program staff will continue to explore methods for measuring self-sufficiency and recovery that will permit the program to evaluate its success in these key areas.

	GOAL
Decrease in homelessness	80%
Decrease in arrests	50%
Decrease in incarceration	60%
Decrease in hospitalization	40%
# served – Step-Down component	30
# Step Down participants who do not require return to assertive community treatment services	80%

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

ENTERPRISE RESOURCE CENTER (ERC) EXPANSION

Program Overview

Since 2006, the ERC Expansion Program has been an MHSA-funded Outreach and Engagement project serving adults with serious mental illness who are reluctant to become involved in the public mental health system.

Prior to implementation of the MHSA, Marin's consumer-staffed Enterprise Resource Center averaged approximately 600 client visits per month in its small multi-purpose drop-in center and had outgrown its space and management infrastructure. In 2006, MHSA funding for the ERC Expansion Program was approved, adding new consumer management positions and establishing a Wellness/Recovery Center in central Marin through enlarging and co-locating the ERC with housing, employment and clinical services at the new Health & Human Services Health and Wellness Campus. In late FY2007-08, the Enterprise Resource Center 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 ERC to increase its hours of operation to 7 days a week.

An expanded client-operated ERC co-located with other adult system of care services optimizes outreach and engagement possibilities, promotes consumer empowerment and, most importantly, embodies the concepts of wellness and recovery. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, increase social supports and reduce isolation.

The ERC Expansion Program has been remarkably successful with the number of client visits per month increasing from 600 to over 1,500; its average daily attendance goal has been met with consistent gains each year. As shown in the table below, the program has had varied results on its other goals, likely due to the impact of staff turnover and programmatic changes that have been made to accommodate the variability in the outreach population being served by this program. In addition, collecting accurate data on an outreach population is difficult and program staff have worked on improving the accuracy of the ERC data collection. As a result, some of the variability and less positive outcomes may be an artifact of the changes in data collection, rather than in the actual data.

	Goal	FY12-13	FY11-12	FY10-11	FY09-10
# served - ERC		196	246	361	235
Avg monthly attendance		1,554	1,410	1,267	1,058
Avg daily attendance	35	57	50	42	35
# Warm Line contacts	9,000	7,549	9,398	9,997	9,544
# served - CARE	180	130	150	123	138
Avg monthly contacts - CARE	100	199	71	57	51

Target Population

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

Characteristics of the population served by the ERC Expansion Program are reported below:

	FY2012-13		FY2011-12		FY2010-11		FY2009-10	
Age Group	**# served**	**% of served**	**# served**	**% of served**	**# served**	**% of served**	**# served**	**% of served**
0-15 years old								
16-25 years old	13	7%	15	6%	48	13%	20	9%
26-59 years old	87	44%	160	65%	284	79%	191	81%
60+ years old	96	49%	71	29%	29	8%	24	10%
TOTAL	**196**	**100%**	**246**	**100%**	**361**	**100%**	**235**	**100%**

	FY2012-13		FY2011-12		FY2010-11		FY2009-10	
Race/Ethnicity	**# served**	**% served**	**# served**	**% served**	**# served**	**% served**	**# served**	**% served**
White	117	60%	164	67%	287	81%	180	77%
African American	15	8%	15	6%	26	7%	17	7%
Asian	12	6%	3	1%	12	3%	8	3%
Pacific Islander	4	2%	3	1%	5	1%		
Native	12	6%	7	3%	12	3%	11	5%
Hispanic	9	5%	9	4%	15	4%	15	6%
Multi	13	7%	8	8%				
Other/Unknown	14	7%	37	15%	4	1%	4	2%

	FY2012-13		FY2011-12		FY2010-11		FY2009-10	
Primary Language	**# served**	**% served**	**# served**	**% served**	**# served**	**% served**	**# served**	**% served**
Spanish	39	20%	14	6%	15	4%	15	6%
Vietnamese	2	1%	1	<1%	1	<1%		
Cantonese			2	1%				
Mandarin			1	<1%	1	<1%		
Tagalog								
Russian			2	1%				
Farsi					1	<1%		
Arabic	2	1%	1	<1%				
English	141	72%	220	89%	343	95%	220	94%
Other	12	6%	5	2%				

Program Description

Prior to implementation of MHSA, Marin's consumer-staffed Enterprise Resource Center averaged over 600 client visits per month in its multi-purpose drop-in center and had outgrown its space and management infrastructure. The ERC Expansion Program included adding consumer management positions, increasing hours of operation to 7 days a week and establishing a Wellness/Recovery Center in central Marin through co-locating the Enterprise Resource Center with housing, employment and clinical services at the then new Health & Human Services Health and Wellness Campus. Currently, the Enterprise Resource Center averages over 1,500 client visits per month and offers a much expanded array of services and activities. As stated above, 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, the Enterprise Resource Center plays a key role in Marin's efforts to outreach to and engage with adults with serious mental illness in the county who are disenfranchised and reluctant to seek help and services. In addition to optimizing outreach and engagement possibilities, an expanded client-operated Enterprise Resource Center co-located with other services that promote and support recovery, such as supported housing and employment services, builds trust, maximizes opportunities for collaboration and increasingly engages clients in their own recovery process. Managed and staffed entirely by mental health consumers, the center promotes a strengths-based, harm-reduction approach and offers clients a one-stop central location to access and receive services such as socialization activities, peer counseling, mentoring, psycho-educational activities, and support groups. Consumers working to assist other consumers serve as role models and a message of hope that further promotes wellness and recovery.

ERC offers a full schedule of activities, classes and groups 7 days per week, as well as serving as host to such meetings as Dual Recovery Anonymous, Smokebusters, and NAMI Family Support Groups.

ERC programs and services designed to provide personal support and foster growth and recovery include the Warm Line, available 7 days/week; the Linda Reed Activities Club; specialty groups and classes; supportive counseling with trained Peer Counselors; and a Peer Companion Program that outreaches to individuals who tend to isolate. 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 Peer Counseling and Case Management training programs and on-the-job internships for consumers seeking to work as service providers in the public mental health system.

Proposed Expansion

Marin proposes to use MHSA CSS funds to continue the following successful program expansion currently being funded with one-time MHSA funds:

CARE Team Expansion

As noted above, an essential service of the Enterprise Resource Center is its outreach to and engagement with adults who have serious mental illness, are homeless or at-risk of homelessness and are not involved with the mental health system. Operating out of the Enterprise Resource Center, the consumer-staffed CARE Team provides the "street" based component of these outreach and engagement services and is the primary source of referrals for the Odyssey Program. Over time, the demand for CARE Team services far exceeded its capacity. 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 is expected to serve an additional 80 individuals annually.

Marin also proposes to use MHSA CSS funds to develop the following new ERC Expansion Program component:

ECR Step-Up Recovery Program

Marin's Adult System of Care (ASOC) does not currently operate a program for clients who no longer need intensive services and are ready to graduate from the Adult Intensive Case Management and MHSA-funded Full Service Partnership programs, but are in need of continued support and assistance with their recovery. Consequently, many clients remain in these programs longer than necessary while others in need of the intensive services must wait for an opening.

Marin proposes to use MHSA funding for further expansion of the ERC Program through opening an ERC-2. This expansion will enable the ERC to develop, staff & operate a new Wellness and Recovery Program that will serve as the next step ("step down") for individuals who no longer require intensive case management services provided by the ASOC, which in turn will enable the ASOC to serve other individuals currently not receiving services. The ERC Wellness and Recovery Program will be consumer staffed and operated and provide an array of classes, groups, skill-building, and services focused on recovery, illness self-management, and self-sufficiency, as well as limited supportive case management for those newly transitioning from the ASOC intensive programs. Additionally, this expansion will help address the current over-crowding at the existing ERC, as those current attendees who are already working on their recovery will attend the new program, while those who are still in early stages of outreach and engagement will continue to be served at the original ERC.

The program will have access to ASOC resources and staff as needed for consultation and assistance.

Outcomes Expected and Evaluation

Listed in the table below, the expected outcomes for the ERC Expansion Program are based on the goals of the program and currently remain unchanged, with the exception of goals added for the proposed new ERC Step Up Recovery Program component. As discussed above, there may be a need to adjust some of the program goals in response to the more accurate data being collected and reported. The data for these measures are obtained from CSS logs that program staff are required to fill out and keep up-to-date.

	Goal
# served - ERC	200
Avg daily attendance	35
# Warm Line contacts	9,000
# served - CARE	180
Avg monthly contacts - CARE	100
# served – Step Up Recovery Program	50
# Step Up participants who do not require return to intensive services	80%

Program Continuation [X] **Program Expansion** [ ] **New Program** [ ]

SOUTHERN MARIN SERVICES SITE (SMSS) PROGRAM

Program Overview

In the original and recent MHSA planning processes, community members identified reaching unserved and underserved populations as a high priority, in line with the MHSA principles. In 2007, the Southern Marin Services Site Program (SMSS), was developed as 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.

Target Population

Children, adults and older adults with serious emotional disturbance or serious mental illness, with special attention paid to providing services to ethnic minorities in Southern Marin. Approximately one third of Marin's Medi-Cal beneficiaries live in Southern Marin. The program specifically outreaches to Marin City, the most diverse region in Marin City and home to a significant portion of public housing residents. Total population of Marin City is 2,666 (2010 Census). The racial makeup of Marin City in 2010 was 39% White, 38% African American, 0.5% Native American, 11% Asian, 1% Pacific Islander, 4.5% other races, and 6% two or more races. Hispanic or Latino of any race was 13.7%.

Numbers to be served in FY14-15	Total	0-15	16-25	26-59	60+
Outreach and Engagement	700	190	140	320	50
Clinical Services	90	12	12	54	12

Program Description

The Southern Marin Services Site Program (SMSS), initially implemented by Family Service Agency, which is now part of Buckelew, is a program with a strong outreach and engagement component 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). 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 Expected and Evaluation

The Southern Marin Services Site (SMSS) is expected to:

- Provide culturally competent outreach and engagement services that increase access to mental health services.

  The number of clients receiving outreach and engagement services will be tracked. In addition, an annual narrative includes a report on barriers to access and how SMSS addresses them.

- Reduce prolonged suffering by reducing symptoms of mental illness and increasing functioning.

  Clients receiving individual or family therapy, or Parent Child Interaction Therapy, will be assessed upon entry and exit using the Child Outcome Survey or Adult Outcome Survey. Students receiving group or individual services will be assessed for emotional functioning, coping skills, peer/family relationships, and high-risk behavior using pre and post evaluations completed by the counselor. Changes by individuals will be tracked and then reported in aggregate.

This data, and client/family demographics, are collected annually so as to analyze whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis as part of the quality improvement process by the program leadership.
The program achieves the intended results due to implementing program practices that have been shown to achieve positive impacts over the course of this program and the use of evidence based practices including Parent Child Interaction Therapy and Triple P. In addition, the program has built a diverse and culturally competent staff, as well as strong relationships with trusted agencies within the community.

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

ADULT SYSTEM OF CARE (ASOC) EXPANSION

Program Overview

The ASOC Expansion Program has been an MHSA-funded General System Development/Outreach and Engagement program serving adults with serious mental illness who are unserved or underserved by the adult system of care since 2008.

The overarching vision of Marin's system of care for adults who have serious mental illness is "*A Home, Family & Friends, A Job, Safe & Healthy*." Prior to MHSA, Marin's Adult System of Care (ASOC) consisted of 3 intensive community treatment teams which were responsible for providing and connecting clients to a broad continuum of services including supported housing, employment services, peer-operated services, medication support services, residential care services, integrated physical-mental health care, jail mental health services, and psychiatric emergency services, in addition to traditional outpatient mental health treatment interventions. Expansion and enhancement of Marin's existing ASOC was identified as a priority in the initial county MHSA stakeholder process, especially in terms of engaging and serving Hispanic/Latino, Vietnamese, and other adults who tended to be un/underserved within the ASOC. Unfortunately, there were not sufficient MHSA funds available at that time to permit Marin County to address all of the needs and priorities identified in the planning process. In FY2007-08, additional MHSA funds became available and the ASOC Expansion general system development project was created to make additions/enhancements to the ASOC that would further its existing efforts at system transformation.

The ASOC Expansion Program was approved as a General System Development/Outreach and Engagement project designed to expand and enhance supports and services available in Marin's system of care for priority population adults and their families through the implementation of 5 components: peer specialist services; outreach to Hispanics/Latinos; outreach and support to Vietnamese; family outreach, engagement and support services; and short-term housing assistance. 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.

Since beginning operations, the ASOC Expansion Program has been challenged by staff turnover and loss of key programs and partnerships that were especially important in terms of the Hispanic/Latino outreach and engagement efforts. With the recent implementation of the MHSA-funded PEI Community Health Advocate (CHA) Hispanic/Latino and Vietnamese projects, development of new partnerships and related strategies greatly increases the ASOC Expansion Program's ability to engage with these underserved populations. Despite the challenges of the past several years, the program has been successful in reaching and serving its target population and has met and/or exceeded almost all of its goals, as shown below.

	Goal	FY12-13	FY11-12	FY10-11	FY09-10
# Served	**275**	609	297	253	297
% Hispanic	**50%**	60%	11%	15%	30%
# Primary language-Spanish	**100**	352	26	32	81
# Asian	**15**	17	13	13	14
# Primary language-Vietnamese	**10**	8	7	10	9

Target Population

The target population of the ASOC Expansion Program is transition-age youth (18+), adults and older adults who have serious mental illness and their families, and 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 un/underserved by the mental health system, especially Latino (Spanish-speaking) and Vietnamese (Vietnamese-speaking) individuals. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

Characteristics of the population served by the ASOC Expansion Program are reported below:

	FY2012-13		FY2011-12		FY2010-11		FY2009-10	
Age Group	**# served**	**% of served**	**# served**	**% of served**	**# served**	**% of served**	**# served**	**% of served**
0-15 years old	26	4%						
16-25 years old	10	2%	12	4%	24	10%	37	12%
26-59 years old	522	86%	228	77%	193	76%	213	72%
60+ years old	51	8%	57	19%	36	14%	47	16%
TOTAL	**609**	**100%**	**297**	**100%**	**253**	**100%**	**297**	**100%**

	FY2012-13		FY2011-12		FY2010-11		FY2009-10	
Race/Ethnicity	**# served**	**% served**	**# served**	**% served**	**# served**	**% served**	**# served**	**% served**
White	215	35%	239	81%	178	70%	174	59%
African American	7	1%	6	2%	9	4%	5	2%
Asian	17	3%	13	4%	13	5%	14	5%
Pacific Islander	2	<1%	1	<1%	1	<1%	2	<1%
Native								
Hispanic	364	60%	34	11%	37	15%	89	30%
Multi	2	<1%	2	<1%	12	5%	9	3%
Other/Unknown	2	<1%	2	<1%	3	1%	4	1%

	FY2012-13		FY2011-12		FY2010-11		FY2009-10	
Primary Language	**# served**	**% served**	**# served**	**% served**	**# served**	**% served**	**# served**	**% served**
Spanish	352	58%	26	9%	32	13%	81	27%
Vietnamese	8	1%	7	2%	10	4%	9	3%
Cantonese								
Mandarin								
Tagalog	1	<1%						
Russian			1	<1%	1	<1%	1	<1%
Farsi							1	<1%
Arabic							1	<1%
English	245	40%	256	86%	204	81%	200	67%
Other	3	<1%	7	2%	6	2%	4	1%

Program Description

The ASOC Expansion Program is a general system development/outreach and engagement project designed to expand and enhance supports and services available in Marin's system of care for adults with serious mental illness and their families by 1) increasing peer specialist services on the Adult Intensive Case Management team, 2) providing outreach and engagement services to Hispanics/Latinos, 3) increasing Vietnamese outreach and engagement services, and 4) adding family outreach, engagement and support services to the ASOC at large.

Increased Peer Specialist Services

An MHSA-funded full-time peer specialist provides services and supports to clients of the Adult Intensive Case Management team 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 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 un/underserved Hispanics/Latinos. 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 provide targeted outreach and engagement to Hispanics/Latinos. In FY2012-13, the ASOC Spanish-speaking staff position was restructured to function as Community Health Advocate (CHA) Liaison to the evidence-based MHSA-funded PEI CHA project designed to increase the capacity of CHAs to address mental health and substance abuse concerns of Hispanics/Latinos in their communities. The CHA Liaison provides 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 also been un/underserved. By using MHSA-funding to increase 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, MHSA PEI funds were recently approved to support the development of a 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

This program component expanded the operations of the existing Children's System of Care 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

Proposed Expansion

Marin proposes to use MHSA CSS funds to continue the following successful program expansions currently being funded with one-time MHSA funds:

Family Outreach, Engagement and Support Services

Because the outreach/engagement needs of family members of adults with serious mental illness exceeded the capacity of the part-time Family Partner position, especially in terms of working with Spanish-speaking family members, CSS FY2011-12 one-time expansion funds were approved through FY2013-14 to add an additional part-time Spanish-speaking Family Partner position. This position is expected to serve 75 monolingual family members annually.

Short-Term Client Support and Housing Assistance

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 at-risk clients of the Adult Intensive Case Management team to successfully access and/or maintain appropriate housing in the community. Experience with this funding over the past 2-3 years has revealed the need to broaden its use to address other, equally critical client needs. The Adult Intensive Case Management team will use this funding as a pool of flexible funds to support clients and purchase needed goods and services, including emergency and short-term transitional housing, medications, and transportation, that cannot be otherwise obtained. This fund will be used to assist 40 clients annually and, where feasible, will be made available to clients as loans with the expectation of repayment.

Marin also proposes to use MHSA CSS funds to develop the following new ASOC Expansion Program components:

Equity Adjustment for Community Action Marin (CAM) ASOC Peer Specialists

Community Action Marin is the community-based organization contracted by Marin to operate services provided by para-professionals with specific lived experiences. In FY2012-13, CAM employed or paid stipends to over 60 peer specialists who provided a range of services throughout the ASOC. The pay range for many of CAM's peer specialists is considerably lower than that of the other CAM para-professionals providing similar services. Marin proposes to use MHSA funds for an equity adjustment to realign the salaries of those ASOC peer specialists to be comparable with the other para-professional positions. This adjustment will affect approximately 30 ASOC peer specialist positions and will also ensure that the peer specialist salaries continue to meet the Marin County Living Wage Ordinance minimum compensation requirements.

ASOC Outreach and Engagement Team

The consequences of untreated serious mental illness on the individual, family, and community are devastating and well-documented. Families often despair that their ill family member has to become homeless, incarcerated, or otherwise "hit bottom" before the public mental health system is able to intervene. A key component to a comprehensive system of care for adults with serious mental illness is the ability to provide outreach and engagement services to those at-risk individuals in the community who are unable/unwilling to engage in mental health treatment despite the severe negative consequences they experience because of their untreated mental illness and despite the efforts of family, friends, and other in the community to convince them to seek treatment.

Marin's ASOC does not currently operate an outreach and engagement program for the adult population, other than the MHSA-funded CARE Team which targets homeless adults with untreated serious mental illness. Experience with the CARE Team has demonstrated that targeted assertive outreach efforts can be highly successful.

Marin proposes to use MHSA funds to create a mobile outreach and engagement team consisting of a full-time mental health clinician and a full-time peer specialist. The target population for this program is adults (18+) who have a serious mental illness with symptoms that contribute to a serious functional impairment in activities of daily living, social relations, and/or ability to sustain housing but are not in crisis, are not current clients of the public mental health system; and are unwilling or unable to engage in treatment. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

The team will respond to calls for assistance and provide outreach services in-home and in the community. Calls from family members will be given priority. The team will work closely with the County mobile crisis team to ensure collaboration and avoid duplication of services. Where time permits, the team will also conduct proactive outreach to organizations, providers, and community members who may have access to and/or have knowledge about potential clients.

The Outreach and Engagement Team will serve a caseload of 10-15 individuals through assertive outreach in an attempt to engage them voluntarily in treatment. The focus of the team will be to do "whatever it takes" for as long as it takes to develop the trust necessary to enable individuals to accept referral to and engage in mental health treatment. A pool of flexible funding will be available to the team members in order to purchase services and supports needed at this community-based street-level engagement phase. An important function of the team will be the provision of support and education to family members and friends of adults referred to the team.

The team will have access to ASOC resources and staff as needed for consultation and assistance. Referrals from the team to ASOC programs will be given priority.

Outcomes Expected and Evaluation

Listed in the table below, the expected outcomes for the ASOC Expansion Program are based on the goals of the program and remain unchanged, with the exception of goals added for the proposed new ASOC Outreach and Engagement Team component. The data for these measures are obtained from CSS logs that program staff are required to fill out and keep up-to-date.

	Goal
# Served	325
% Hispanic	50%
# Primary language-Spanish	100
# Asian	15
# Primary language-Vietnamese	10
# Served – Outreach & Engagement team	20
# Successfully engaged in treatment –Outreach & Engagement Team	15

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

CO-OCCURRING CAPACITY

Program Overview

In both the original and recent MHSA Three-Year planning processes, effectively identifying, engaging and treating clients with complex co-occurring mental health and substance use disorders continues to be identified as a priority. While some of the CSS programs incorporate co-occurring capacity to differing degrees—and steps have been taken in recent years to begin increasing administrative and service coordination and integration of mental health and substance use services—the Three-Year plan presents the opportunity to expand and institutionalize efforts at increasing the capacity of the service delivery system to effectively and seamlessly serve clients with co-occurring mental health and substance use disorders, including tobacco dependence.

While the co-location of a Consulting Substance Use Specialist and implementation of Peer to Peer Smoking Cessation Services are being continued due to the ongoing need to increase co-occurring capacity at the staffing and service delivery levels and prior year positive outcomes, a new program—Alliance in Recovery—is also being included in the Three-Year plan to enhance efforts to effectively serve clients with co-occurring mental health and substance use disorders.

Due to the increasing identification of individuals with complex co-occurring disorders, coupled with information that the current service delivery models were struggling to meet the needs of some of these populations, the Co-Occurring Disorders Collaborative—which includes representation from County mental health and substance use staff, family members and contracted providers—recommended piloting an intensive outreach and engagement program composed of staff from both the mental health and substance use systems of care. Given the importance of identifying, testing and implementing strategies to more effectively meet the needs of individuals with co-occurring disorders, it was recommended to implement immediately, rather than wait until the Three-Year Planning process. As such, the Division of Mental Health and Substance Use Services allocated one-time non-MHSA funding to start-up a program—Alliance in Recovery—with the understanding that it was bridge funding until MHSA funding became available. Lessons learned during the pilot phase have informed program changes—including the addition of a Peer Specialist—as outlined in the Program Description below.

The programs included in the Three-Year plan represent multiple approaches to increasing co-occurring capacity. In addition to those described here, program specific efforts are described within the appropriate program narrative.

Target Population

Alliance in Recovery (AIR) Program

The target population of the Alliance in Recovery (AIR) Program is individuals with co-occurring substance use and mental health disorders—referred from either system of care—and who are not adequately being served through the programs currently available in the mental health and/or substance use services system of care. Participants may be currently enrolled in services—or have a recent history of repeated episodes—but for which services are not adequately addressing their needs. The program is for adults (18+ years), though other demographics may vary and are not focused on or limited to any particular population.

There is a maximum caseload of 20 at any given time, with an estimated 40 individuals served annually.

Co-Location of Substance Use Specialist – Recovery Connections Center

The target populations of the services provided by the Licensed Consulting Substance Use Specialist are both County and County-contracted mental health staff/providers, and youth, adult and older adult clients and families in the County Mental Health System of Care. The demographics may vary and are not focused on or limited to any particular population.

The expected numbers served are as follows:

- Case consultation and staff training/presentations to at least 50 mental health County and contractor staff/providers
- Assessment, care management and other support services to at least 75 clients in the mental health system of care

Peer to Peer Tobacco Cessation Services

The target populations of the Peer to Peer Tobacco Cessation Services program include mental health consumers and agency staff working with consumers with serious and persistent mental illness. The demographics may vary and are not focused on or limited to any particular population, other than being a consumer in the Mental Health System of Care.

The expected numbers served annually are as follows:

- Train and supervise 10 peers to provide peer to peer smoking cessation services
- Provide smoking cessation services to 75 mental health consumers
- Work with five County and/or contractor agencies and clinics providing services to County mental health clients to integrate comprehensive, sustainable cessation support into their programs

Program Description

Alliance in Recovery (AIR) Program

The Alliance in Recovery (AIR) Program provides intensive outreach and engagement services for adults whose co-occurring mental health and substance use disorders have resulted in treatment failure in one or both treatment systems. Staffed by a County mental health clinician, a contracted

substance abuse counselor, and a contracted peer specialist—all who are a co-located team—the goal of the program is to provide flexible outreach and support services that build trust and relationships with these difficult-to-engage individuals, increase their motivation to change, and support them to access and participate in formal treatment services. Services provided will vary on the client's needs, strengths and stage of readiness, and may include services such as outreach, individual counseling, group counseling, case management and linkage to other supportive services. The capacity of the AIR program is 20 clients at any given time.

This program—which is being expanded to include a Peer Specialist—has seen statistically significant improvements in terms of reduced psychiatric emergency service admissions (-100%), reduced homeless days (-73%) and reduced hospital days (-81%).

Co-Location of Substance Use Specialist – Recovery Connections Center

In order to increase co-occurring capacity across the Mental Health System of Care, a Licensed Substance Use Specialist (0.60 FTE), from Bay Area Community Resources' Recovery Connections Center, offers staff consultation and training, and services such as screening, assessment, linkage, collaborative treatment planning and care management for seriously mentally ill clients with substance use issues. Services are provided at various locations and across Community Services and Supports (CSS) programs in the Mental Health System of Care.

This service—which began as a pilot project with one-time MHSA funding in 2013—has provided capacity building informational presentations and case consultation to all of the Full Service Partnerships, as well as to Adult Case Management, Psychiatric Emergency Services, the Medication Clinic and County-contractors providing services through CSS. The consulting Substance Use Specialist has also had approximately 200 appointments to provide direct client care to individuals in the mental health system of care.

Peer to Peer Tobacco Cessation Services

Local Needs Assessment data—which aligns with national trends—highlights the interest and importance of integrating tobacco cessation services into behavioral health settings. Not only is there a higher prevalence of tobacco use among mental health consumers as compared to the general population, but also, the majority of Marin consumers interviewed during the needs assessment process reported wanting to quit or reduce their tobacco use. To address the disproportionate prevalence of smoking among mental health consumers—coupled with the reported lack of tailored face-to-face ongoing cessation groups—Bay Area Community Resources (BACR) launched a Peer to Peer Tobacco Cessation Program.

This program—which began as a pilot project with one-time MHSA funding in 2013—trains and supervises peer cessation specialists: initially using a *Thinking About Thinking About Quitting* curriculum developed by BACR and evaluated by an external evaluator, in order to gain community buy-in. This preliminary success will be followed by the larger-scale, evidence-based *Peer-to-Peer Tobacco Dependence Recovery Program,* designed by Chad Morris, Ph.D. In addition to the peers providing ongoing cessation support to consumers in the Marin Mental Health System of Care, project staff will work concurrently with County and contractor agencies and clinics serving mental health consumers to adopt policies and practices that integrate sustainable tobacco cessation support into their programs.

Since the program's inception in June 2013, 11 peers have been trained as tobacco cessation specialists and 60+ consumers have engaged in peer-led cessation groups and/or adjunct cessation support at sites including: Enterprise Resource Center, Voyager Carmel, Lakeside House, Draper House, Marin Alano Club, D Street, and in Marin City. Trainings and technical assistance in tobacco cessation services have been conducted at nine programs including multiple Buckelew sites, Enterprise Resource Center, Marin City Multi-Disciplinary Team, Marin City Community Development Corporation, West Marin Mental Health Services, and the Odyssey Program.

Outcomes Expected and Evaluation

Alliance in Recovery (AIR) Program

Listed in the table below, the expected outcomes for the AIR Program are based on the goals of the program. Although this is not a Full Service Partnership, the data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the AIR Program staff on a daily basis. Program staff will continue to explore methods for measuring engagement.

Expected outcomes for AIR participants include the following:

	GOAL
Reduced hospital days	30%
Reduced Psychiatric Emergency Services admissions	30%
Reduced homeless days	30%
Reduced criminal justice involvement	30%

Co-Location of Substance Use Specialist – Recovery Connections Center

As this project focuses on staff capacity building and providing an ancillary or short-term service for clients in the mental health system of care, the expected outcomes associated with this project are largely process-oriented. Data is being collected and reported through a combination of Marin WITS—the substance use electronic health record—and presentation and service logs. Expected outcomes include:

	GOAL
Consultation provided to mental health staff/providers	50
Unduplicated clients served	75
Staff receiving consultation report increase in ability to address substance use issues	80%
Clients served will take recommended action in relationship to reducing substance use and/or related problems	50%

Peer to Peer Tobacco Cessation Services

As the project focuses on both client services and capacity building, the expected outcomes listed below reflect a combination of outcome and performance measures. Supervised by an independent external evaluator, data is being collected and reported through a combination of training logs, group sign-in sheets, key informant interviews with County and contractor staff, and an analysis of intake, completion and follow-up survey data with consumers to assess their smoking status. Data will also be collected on methods used to assist in smoking cessation efforts, including, but not limited to: participation in peer-led cessation groups and/or peer-led individual motivational interventions; use of a nicotine patch, gum or nasal spray; Bupropion; and/or other supports. Beginning in Year 2, data will also be collected on how County and contractor agencies participating in these efforts have sustained peer-led tobacco cessation services.

	GOAL
Percentage of clients participating in peer-led cessation services who report reducing their tobacco use	60%
Percentage of clients participating in peer-led cessation services who report attempting to quit smoking	75%
Percentage of clients participating in peer-led cessation services who maintained their quit status at 3-month follow-up	30%
Number of County and contractor agencies that integrate tobacco cessation support into their programs	5

Program Continuation ☐ **Program Expansion** ☐ **New Program** ☒

CRISIS CONTINUUM OF CARE

Program Overview

The Crisis Continuum of Care consolidates MHSA funded crisis services into one Systems Development program to enhance and streamline the crisis continuum in Marin. The Crisis Planning program will be moved from Prevention and Early Intervention; the Psychiatric Emergency Services (PES) located Family Partner will be moved from CSS Adult System of Care and Children's System of Care (now Youth Empowerment Services); and we anticipate moving the Crisis Residential from Innovation in FY2015-16. The theory behind these changes is that having a crisis continuum more clearly outlined will enable these services and the individuals who are receiving them, to experience them as more fluid and not as barriers to access. In addition, Marin County MHSUS received a grant from Mental Health Service Oversight and Accountability Commission (MHSOAC) for Triage Personnel which will go into effect in late FY2013-14. Marin was also just notified that we were awarded a grant for Crisis Mobile services from California Health Facilities Financing Authority (CHFFA).

The overarching goal of the changes to the crisis continuum is to intervene early in a crisis, rather than waiting until an individual requires the highest level of care, where there is often less choice on the client's part about services. Our hypothesis is that if crises can be detected early on and the individual can be linked to appropriate services, such as crisis planning, crisis residential, or other support services, then higher level services such as PES or acute inpatient hospitalizations can be avoided or drastically reduced. Additionally, individuals are empowered to make choices for themselves at these levels of intervention, rather than others making the decisions for them when the crisis escalates, for example: police intervention, PES intervention, or jail.

<u>Crisis Planning</u>
Crisis Planning has been a part of the Prevention and Early Intervention component of MHSA until this year. Crisis planning is part of the Client Choice and Hospital Prevention program, under MHSA Innovation, and works closely with PES and the Crisis Residential site which opened in early 2014. Crisis Planning aims to (1) increase clients' knowledge, skills and network of support to decrease crises; (2) provide crisis plans to Psychiatric Emergency Services that increase the role of the client and their network of support in case of a crisis; and (3) to engage and support clients who are residing in the Crisis Residential in the completion of a crisis plan.

Moving this program to CSS facilitates the coordination of crisis services in Marin. Developing and using crisis plans allows for a more recovery-oriented focus, supporting individuals in choosing how they want to engage in their recovery.

Target Population

The target population focuses upon those individuals at-risk of experiencing a psychiatric crisis, including individuals with a recent visit to PES, clients in the Full Service Partnership programs, and those who are currently in the Crisis Residential Program. The planning services are available in both English and Spanish. In the coming fiscal year Marin County will be implementing a new program of triage personnel at various sites in the community. This triage team will be working closely with clients who may be experiencing crisis but not meeting 5150 criteria. There will be many opportunities for the crisis planning team to engage with clients referred by the triage team.

Program Description

The Crisis Planning program consists of peer providers assisting individuals at risk of psychiatric crises to create a crisis plan. This team reaches out to PES, Crisis Residential, Case Managers and others to engage individuals. They meet with individuals in the community, often over multiple sessions to create a solid crisis plan that the client can utilize if they find themselves experiencing signs of a crisis. The plan is placed in the client's Mental Health and Substance Use Services chart, with client permission, so that it can be used as a guide if the client presents to PES in crisis. Part of the crisis plan may be to access the Crisis Residential program, serving clients in a homelike community environment rather than a locked psychiatric hospital. The crisis planning team are integral members of the Crisis Continuum, participating in weekly Crisis Residential meetings and regular Client Choice and Hospital Prevention (CCHP) Advisory Committee meetings.

Outcomes Expected and Evaluation

Outcomes	Goal
Number of clients and/or families that will receive Crisis Planning services.	80
Percent of clients receiving planning services that file a completed Crisis Plan in their medical records.	50%
Percent of clients receiving Crisis Planning Services that have accessed PES multiple times in the past.	30%
Percent of clients and/or families completing a Crisis Plan that report increased understanding of the community resources available to them.	60%
Percent of clients completing a Crisis Plan that report increased awareness of their individual symptoms and supports.	60%
Percent of clients reporting that Crisis Planning decreased their need to psychiatric emergency services 3-6 months after completing the plan.	50%
Percent of clients reporting that having a Crisis Plan improved their experience at PES.	50%

The crisis planning team will gather these data points as they work with clients. In addition, they utilize a client satisfaction survey after the crisis plan has been completed. The crisis planning team is partnering with the Crisis Residential Unit in the Client Choice and Hospital Prevention Program and will also have some data available through the Innovation grant's evaluation process. This data will illuminate the system's change in regards to partnering well with peers, professionals, and law

enforcement. One focus of that evaluation is how well the partnership is working between peers and professionals working in the crisis continuum of care.

PES Family Partner

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

Target Population

The target population consists of families referred by or coming to Psychiatric Emergency Services or Crisis Residential.

Program Description

The family partner is an integral member of the PES team. They are on site 11am-7pm, five days a week, and take referrals from the PES staff when a family arrives with a loved one in crisis or PES receives a call from the community from a family in crisis. The family partner assists families in navigating the mental health system and advocating for families to find the appropriate resources. The family partner also co-facilitates a family support group located at Bon Air to support and guide families who may be experiencing a crisis with their loved one. This role also has the capability of meeting families in the community to create family crisis plans and help families in the post crisis phase. This role is a resource advocate and offers short-term interventions. If the family is deemed to need longer term supports, the PES family partner may refer to the family partners located in the in the adult or youth and family systems of care.

Outcomes Expected and Evaluation

The family partner will track number of contacts with family members and the language in which the service was provided. The target number for each fiscal year is 100 family contacts. The family partner is part of the crisis continuum of care and will be included in the evaluation process of the Client Choice and Hospital Prevention (CCHP).

Crisis Residential – Casa René

This program is funded under MHSA Innovation through FY2014-15. It is expected to be continued under CSS beginning in FY2015-16. The program is a 10-bed Crisis Residential facility administered by Buckelew Programs. The program aims to reduce unnecessary acute psychiatric hospitalizations by giving clients the choice to recover from a psychiatric crisis in a home-like setting rather than a locked, involuntary inpatient unit. The program consists of further integrating peer and professional staffing as well as client centered programing focused on wellness and recovery

principles. In addition the SBIRT model (Screening Brief Intervention Referral and Treatment) is used to provide screening and referral on-site for substance use issues. Currently all referrals to this program come through Marin County Psychiatric Emergency Services in collaboration with Buckelew Programs. This program is a key component of the crisis continuum of care in that it offers clients a voluntary recovery-focused residential option to recover from a crisis.

Target Population

The target population is those individuals, age 18 and above, experiencing a psychiatric crisis and who are able to voluntarily agree to go to Casa René in lieu of a hospitalization. The county will focus on the Marin residents who have Medi-cal and are experiencing psychiatric crisis.

Program Description

The program is a collaboration among many community partners, primarily Buckelew Programs, Community Action Marin and County Mental Health and Substance Use Services. Buckelew Programs provide the facility and staffing; MHSUS provides a nurse practitioner that follows the clients while at Casa René; and Community Action Marin provides the crisis planning.

Casa René offers a home-like setting where individuals can stay in their own community and stabilize for up to 30 days during a time of crisis. The crisis residential 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.

Outcomes Expected and Evaluation

In utilizing the crisis residential program we will reduce the number of inpatient bed days by 900 per year. Casa René will maintain an occupancy rate of at least 75% the first year and 90% thereafter. Seventy-five percent of clients discharged from the program will have engaged in crisis planning; 90% of the clients will be linked to outpatient services at discharge; 90% of clients will be discharged to a lower level of care; and 95% of clients will not require hospitalization within 48 hours after discharge.

The program evaluation that was developed under MHSA Innovation will continue to be used to measure the success of Casa René. The focus on partnership among the collaborative partners is a pivotal focus of this Innovation program, in addition to the outcomes stated above.

Program Continuation [X] **Program Expansion** [ ] **New Program** [ ]

HOUSING

Program Overview

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

Target Population

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.

Program Description

<u>Fireside Senior Apartments</u>
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 Expected and Evaluation

Marin's goals for the MHSA Housing Program are to 1) maintain an occupancy rate at the MHSAHP-funded Fireside Senior Apartment units of 95% or higher, with no residents of the 5 MHSAHP funded units returning to homelessness, and 2) develop an additional 5-15 MHSAHP-funded permanent supportive housing units 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. We will continue to pursue identification of an appropriate housing development project that fits within the parameters for MHSAHP funding through our existing strong partnerships with local housing developers/providers, homeless providers, and County Community Development Planning Managers.

MHSA Community Services and Support (CSS)

Three-Year Plan (FY2014-2015 through FY2016-2017)

Program	FY14-15	FY15-16	FY16-17	Total
FSP-01 Youth Empowerment Services (YES)	$639,227	$639,227	$639,227	$1,917,682
FSP-02 Transitional Age Youth (TAY) Program	$446,773	$446,773	$446,773	$1,340,318
FSP-03 Support and Treatment After Release (STAR)	$519,644	$519,645	$519,645	$1,558,933
FSP-04 Helping Older People Excel (HOPE)	$672,482	$672,482	$672,482	$2,017,446
FSP 04 -Helping Older People Excel-Intensive Community Treatment	$159,990	$159,990	$159,990	$479,970
FSP- 05 Odyssey (Homeless)	$1,138,543	$1,138,543	$1,138,543	$3,415,630
FSP 05 Odyssey (Homeless) Step Down Recovery Program	$144,492	$144,492	$144,492	$433,476
SDOE-01 Enterprise Resource Center (ERC)	$347,387	$347,387	$347,387	$1,042,161
SDOE 01-ERC -Step Up Program-New	$254,942	$254,942	$254,942	$764,826
SDOE-04 Southern Marin Services (SMSS)	$277,729	$277,729	$277,729	$833,188
SDOE-07 Adult System of Care (ASOC)	$801,460	$801,460	$801,460	$2,404,380
SDOE-08 - Co- Occurring Capacity	$342,409	$342,409	$342,409	$1,027,227
SDOE-09 - Crisis Continuum of Care	$0	$600,000	$600,000	$1,200,000
Subtotal	**$5,745,079**	**$6,345,079**	**$6,345,079**	**$18,435,237**
MHSA Coordinator	$140,986	$140,986	$140,986	$422,958
Ethnic Services Manager	$88,000	$88,000	$88,000	$264,000
Administration and Indirect	$896,110	$986,110	$986,110	$2,868,329
Operating Reserve	$165,500	$165,500	$165,500	$496,500
Total	**$7,035,675**	**$7,725,675**	**$7,725,675**	**$22,487,025**

	FY14-15	FY15-16	FY16-17	Total	%
County	$2,698,048	$2,698,049	$2,698,049	$8,094,147	36%
Contract Provider	$3,276,017	$3,876,017	$3,876,017	$11,028,050	49%
Administration	$896,110	$986,110	$986,110	$2,868,329	13%
Operating Reserve	$165,500	$165,500	$165,500	$496,500	2%
Total	**$7,035,675**	**$7,725,675**	**$7,725,676**	**$22,487,026**	**100%**

Full Service Partnership (FSP)	64.77%	58.65%	58.65%
System Development Outreach and Engagement (SDOE)	35.23%	41.35%	41.35%
Total	**100.00%**	**100.00%**	**100.00%**

PREVENTION AND EARLY INTERVENTION (PEI) OVERVIEW

In developing the PEI component of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 (Plan) many factors were taken in to consideration, including: input from the Community Planning Process; evaluations of existing PEI programs; the changing environment, including the Affordable Care Act (ACA) and the changes in funding for mental health services for K-12 students; and the current process to develop revised state PEI regulations. We will continue to make adjustments to the Plan as available funding changes, programs are implemented, and community needs develop.

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

Recognizing that increased funding and services are not in themselves sufficient to reach PEI goals, the PEI Coordinator convenes the **PEI Committee** on quarterly basis to facilitate the implementation of the PEI programs, review PEI program evaluations, and collaborate towards a stronger system of care. In addition, short-term workgroups are convened to identify and address gaps in existing systems of care. In FY2014-15 one of the focus areas will be improving access to care by increasing provider knowledge of available resources and best practices for effective referrals.

Marin will continue to support **Statewide PEI** efforts through California Mental Health Services Authority (CalMHSA) in FY2014-15. Funds will be directed towards all three focus areas: Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction. For more details about these programs and how they have impacted Marin, see Appendix A – CalMHSA Statewide PEI overview.

PEI programs are an important component for increasing services for **underserved communities**. By locating services within trusted community sites, hiring culturally and linguistically competent staff, and employing strategies such as Promotores/Community Health Advocates, PEI increases timely access for populations that have cultural and linguistic barriers to services. In addition, most PEI contracts specify a percentage of clients that must be from underserved populations. While PEI programs are reaching target populations, more needs to be done to increase the service rates. The PEI overview in the FY2014-15 Annual Update details the demographics of PEI clients.

PEI Programs for FY2014-15 through FY2016-17

Many of the original PEI programs have been successful in reaching underserved communities and achieving mental health related goals (see FY2014-15 Annual Update) and therefore will be continued in FY2014-15. A couple of the ongoing programs will be significantly changed. In FY2012-13 unexpended funds were provided on a "one-time" basis to expand existing programs or start new programs. A couple of the new programs will be continued into FY2014-15, but due to limited funding and the one-time nature of the funding, many will not continue under PEI. And finally, a few new programs will be started in FY2014-15 to respond to identified gaps.

Program Name	Program Overview
Early Childhood Mental Health Consultation (ECMH) PEI-1	*Target Population: 0-5 year olds and their families, underserved* Continue training for staff and parents at 18 subsidized childcare sites in supporting emotional well-being of children. Provide assessment and linkages to services.
Triple P (Positive Parenting Program) PEI-2	*Target Population: Providers working with underserved families with children 0-15 years old* Triple P is an evidence-based model for coaching and empowering parents to improve their parenting skills. This will provide ongoing support to providers previously trained in Triple P to implement it effectively, as well as offer seminars for parents.
Transition Age Youth (TAY) PEI PEI-4	*Target Population: 16-25 years old, underserved* Continue screening and brief intervention in Teen Clinics. Expand groups in high schools for at- risk students. Discontinue one-time projects.
Latino Community Connection PEI-5	*Target Population: Latino* Combine the Canal Community-based PEI and Community Health Advocates program. Provide linguistically and culturally competent outreach, risk reduction, linkages to services.
Behavioral Health in Primary Care PEI-6	*Target Population: uninsured, underserved* Previously this program focused on establishing behavioral health services in primary care settings. In FY14-15 PEI will focus on providing behavioral health services for uninsured patients in primary care settings. Request for Proposals will be released.
Older Adult PEI PEI-7	*Target Population: 60+ years old, underserved* Continue screening, brief intervention, and linkages within existing older adult services. Continue outreach and education for providers, gatekeepers and older adults.

Program Name	Program Overview
Vietnamese Community Connection PEI-11	*Target Population: Vietnamese* Continue providing linguistically and culturally competent outreach, risk reduction, and linkages to services.
Community and Provider PEI Training PEI-12	*Target Population: Providers, consumers, family members, community members* Provide PEI related trainings, such as Mental Health First Aid and implementing best practices.
School Age PEI PEI-18	*Target Population: K-8 students (5-15), underserved* New program to provide services for high-risk youth in San Rafael City Schools, Sausalito Marin City School District, and West Marin. Request for Proposals will be released.
Veteran's Community Connection PEI-19	*Target Population: Veterans* New program. Provide peer support for veterans on probation or parole to complete their mental health plans.
Statewide PEI PEI-20	*Target Population: Community* Provide funding to Statewide PEI efforts including: Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction.

In the case of additional funds becoming available, such as through allocated funds being unexpended or an increase in projected MHSA revenue, the following areas are priorities for use of those funds:

- Ensure adequate funding of existing PEI programs.
- Community Connection Programs, especially the use of the Community Health Advocates (Promotores) model.
- High-risk Teens/TAY, such as pro-social oriented programs for teens in high-school, especially Continuation and Alternative schools.

Program Continuation [X] **Program Expansion** [ ] **New Program** [ ]

EARLY CHILDHOOD MENTAL HEALTH (ECMH) CONSULTATION

Program Overview

In 2009, MHSA PEI funds expanded an existing "Early Childhood Mental Health Consultation" program provided by Jewish Family and Children's Services (JFCS). This has been a very successful program, reaching 18 subsidized pre-schools a year that serve over 800 children. Training, coaching and interventions are provided by a team of JFCS consultants who are licensed mental health providers. The program aims to increase the skills of teachers and parents to observe, understand and respond to children's emotional and developmental needs to:

- reduce the likelihood of behavioral problems and school failure in pre-school;
- identify students with behavioral problems that may indicate mental/emotional difficulties;
- provide services to pre-schools and families that reduce the likelihood of mental illness and school failure in the future.

Target Population

The target population is pre-school students (0-5), and their families, who attend subsidized pre-schools. These students are approximately 60% Latino and/or Spanish speaking, 5% Asian, 3% African American, and 10% multi-racial. The majority of families are low-income. The children and families face risk factors including poverty, racism, social inequality, trauma, adverse childhood experiences, substance use, and others.

Numbers to be served in FY2014-15	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Outreach to Increase Recognition						**200**	**160**
Reducing Risks	75				**75**	**100**	

Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

Program Description

- Outreach for Increasing Recognition of Early Signs of Emotional Disturbance (prevention)
- Reducing Risks Related to Emotional Disturbance (prevention)

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. Childcare providers' skills are expanded by receiving training and ongoing

coaching to integrate evidence based practices and best practices into their daily interactions with children and families. Practices include "Powerful Interactions," "Social and Emotional Foundations for Early Learning," and "Triple P." These increase the provider's ability to reduce behavioral issues in the classroom, increase the social-emotional skills of the students, and identify and respond to behaviors that may be due to mental or emotional difficulties.

If a child is identified as potentially having mental or emotional difficulties, the child and family are assessed by a consultant, including methods such as parental depression screening and/or a validated social-emotional screening for children aged 3-5 (DECA-C: Devereux Early Childhood Assessment-Clinical Form). When children or families are identified as needing intervention, consultants assist with developing and facilitating the implementation of an intervention plan. Interventions may include: meeting with the adults in the child's life (family and childcare) to identify the function of the child's behavior; identify areas of resilience in child and create support plan to build on these strengths; support staff and parents with self-initiated strategies (both child-directed and programmatic) to meet the needs of the child's identified behavior; emphasis on developing strong bond between teacher and child, and between teacher and parents; facilitate meeting(s) between parent and staff; help parents identify areas of personal/familial stress as a bridge to referrals; and linkages to additional services.

The program improves timely access to services for underserved populations by being located in pre-schools with high rates of students/families from underserved populations, and by ensuring service providers are culturally and linguistically competent. Services are free, culturally appropriate, and provided in the home and other community settings as needed. Services are non-stigmatizing by being initiated through the pre-school and identified as assisting with school success, rather than specifically mental health related.

Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by ECMH consultants, who are licensed mental health providers. They make the referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the "access line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Mental Health and Substance Use Services, clients, families, and other key agencies in order to facilitate successful collaboration.

Intended Outcomes and Evaluation

Early Childhood Mental Health Consultation is intended to:

- Educate and engage pre-school staff and families to recognize and respond to early signs of significant risk for emotional disturbance.
  The number of staff and family members trained will be tracked. In addition JFCS' "Consultation Questionnaire" is completed by pre-school staff to track changes in relevant knowledge and skills.

- Reduce Prolonged Suffering by increasing protective factors and reducing risk factors. JFCS' "Consultation Questionnaire" is completed by families at the conclusion of receiving intervention services to track changes in parenting skills and strategies. A DECA-C pre and post-test is completed by teacher to track changes in the child's behavior in the preschool setting.

This data, as well as client and family demographics, is reported annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

The program is expected to achieve the intended results due to implementing evidence-based practices and best practices that have been shown to achieve positive impacts over the course of this program.

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

TRIPLE P (POSITIVE PARENTING PROGRAM) MARIN

Program Overview

In 2009, MHSA PEI began the "Triple P: Provider Training and Support" program. Triple P is an evidence-based program for improving parenting skills and outcomes for children. Providers throughout the county - including clinical mental health providers, family partners/advocates, and school staff - have received training and support to implement Triple P in their work with families. In FY2014-15, PEI will focus on supporting these providers to implement the program with fidelity and to provide group services in underserved communities. Training of more providers will be considered in the future. The program name has been changed to Triple P Marin to include all ways PEI will support Triple P implementation.

Target Population

The target population for this program is:

- Providers working with families from underserved populations. Providers include mental health clinicians, family partners/advocates, school staff, front-line workers and others who work with families on a regular basis.
- Families from underserved populations, including Latino, Asian, African American, Spanish-speaking, and residents of West Marin, with children ages 0-15. The parents and children may be at risk for mental illness due to adverse childhood experience, severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, family conflict, domestic violence, experiences of racism and social inequality, social/economic and other factors.

Numbers to be served in FY2014-15	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Outreach to Increase Recognition						100	15

Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

Program Description

- Outreach for Increasing Recognition of Early Signs of Mental Illness (prevention)

Triple P Marin will increase the skills of potential responders by providing technical assistance for providers already trained in Triple P. Technical assistance will include ensuring that they implement the program with fidelity, collect outcome data, identify at-risk families appropriate for Triple services, and identify and effectively refer families needing services outside of their scope. Triple P trains providers to respond to families with an evidence-based coaching method to improve parenting skills, thereby reducing risk for negative outcomes.

This program will also provide outreach to at-risk families by providing Triple P Level 2 and 3 group services, including seminars and group discussions on behavioral issues, parenting skills, and information about accessing further services.

Providers trained in Triple P also offer other levels of services that are aimed at reducing risk related to mental illness, but these services are not funded by PEI. In order to better understand the impact of the training, technical assistance, and outreach services provided by PEI, those receiving technical assistance will be required to submit data on client outcomes (more below).

The program improves timely access to services for underserved populations because the trained providers are already serving the target population throughout the community and in the appropriate languages. The seminars and discussion groups are offered for free in English and Spanish, by diverse providers, and in community settings, including existing playgroups serving target populations. Services are non-stigmatizing by being offered through sites clients are already accessing and by focusing on the common challenges with parenting, rather than "mental health problems."

Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is provided through assessment and referral by licensed mental health providers trained in Triple P. They make the referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the "access line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Mental Health and Substance Use Services, clients, families, and other key agencies in order to facilitate successful collaboration.

Intended Outcomes and Evaluation

Triple P Marin is intended to:

- Assist existing providers to recognize and respond to at-risk families
  The number and type of providers participating in the technical assistance will be tracked. Every six months, this data will be analyzed to ensure that participating providers are adequate to serve the target populations based on number, settings, language and other factors.
- Outreach to at-risk families
  The number and demographics of the families participating in group services will be tracked. Every six months, this data will be analyzed to ensure the target populations are being reached..

This data is collected annually.

In addition, providers receiving technical assistance will be required to submit client data every six months to ensure that expected client outcomes are being reached. Expected outcomes include

decrease in problematic behaviors as evidenced by the Eyberg Child Behavior Inventory intensity scale, as well as the parent's level of distress as measured by the ECBI Problem Scale.

All data noted above will be analyzed annually to determine whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

The program is expected to achieve the intended results due to implementing an evidence-based practice that has been validated for the target populations.

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

TRANSITIONAL AGE YOUTH PREVENTION AND EARLY INTERVENTION

Program Overview

In 2009, MHSA PEI funds began the Transition Age Youth (TAY) Prevention and Early Intervention (PEI) program, provided by Huckleberry Youth Programs (HYP) and Novato Youth Center (NYC). TAY PEI provides brief intervention for mental health concerns in teen clinics, psycho-education for TAY, and community members, which often include parents and providers of TAY, and group services in high schools for at-risk TAY. This has been a very successful program, reaching over 500 TAY and 50 families per year. In response to needs identified during the community planning process, FY2014-15 TAY PEI will expand services provided in high schools.

Target Population

The target population is 16-25 year olds from underserved populations. TAY reached are approximately 50% Latino, 30% Spanish speaking, 4% Asian, 5% African American, and 5% multi-racial. Many of the TAY are unlikely to receive services through other routes due to lack of insurance, lack of parental connection, unfamiliarity with navigating the service systems, concern about cost of services, or lack of linguistically accessible services.

Numbers to be served in FY2014-15	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Outreach to Increase Recognition	100	450			**550**		**15**
Reducing Risks	10	40			**50**		
Early Intervention	40	140			**180**	**30**	

Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

Program Description

- Outreach for Increasing Recognition of Early Signs of Mental Illness (prevention)
- Reduce Risk Related to Mental Illness (prevention)
- Intervene Early in the Onset of Mental Illness (early intervention)

The TAY PEI program aims to reduce prolonged suffering due to unaddressed mental illness by increasing identification of at-risk TAY, increasing protective factors for those with significantly higher risk, and providing access to services for those with early onset of signs of emotional disturbance.

Outreach for Increasing Recognition:

- Provider Training: Providers within HYP and NYC are trained to recognize and respond to signs of mental health difficulties.
- Mental Health Screening: Teen health clinic clients complete a validated screening (GAIN Short Screen) for an array of mental health and substance use issues.
- TAY and Family Training: Single session workshops for TAY focusing on behavioral health, coping skills, and community resources.

Reducing Risk:

- Skill Building Groups: Multiple session groups are held at high schools to promote coping and problem-solving skills. Services are for at risk teens, such as students who have recently immigrated to the US or at risk for dropping out of traditional school settings. Skill building groups are offered at high schools and classrooms that specifically target these groups of students therefore involvement in the group is determined by participation in one of these schools and/or classrooms.

Early Intervention:

- Brief Intervention: Youth screening positive for signs of emotional disturbance in the teen health clinics, identified through the school groups, or referred from elsewhere, are linked directly to a licensed mental health provider at the clinics or school sites for further assessment. Brief intervention services are most often provided for TAY struggling with severe trauma, substance use, disordered eating, sexual identity and orientation issues, and complex family issues often experienced in immigrant families. Families of TAY are included in brief intervention services as appropriate.

The program improves timely access to services for underserved populations by being located within primary care services they already access, as well as in schools. Many TAY who experience distress are unable to identify when their distress falls outside of the norm or becomes a clinical concern. Behavioral health screening, provided along with routine health visits, enables them to recognize when the need for intervention is present, and in turn access services they might not have otherwise. Providers are culturally and linguistically competent and services are provided at low- to no-cost. Services are non-stigmatizing by being initiated through the clinic services and schools and identified as assisting with stress and school success, rather than specifically mental health related.

Individuals at risk or showing signs of developing emotional disturbance are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by licensed mental health providers at the clinic or school sites. They make the referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the "access line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Mental Health and Substance Use Services, clients, families, and other key agencies in order to facilitate successful collaboration.

Intended Outcomes and Evaluation

Transition Age Youth (TAY) PEI is intended to:

- Educate and engage providers to recognize early signs of emotional disturbance or mental illness and link TAY to appropriate services.
  The number of staff trained will be tracked. Participant surveys are conducted to show changes in knowledge and skill.
- Educate and engage TAY to recognize early signs of emotional disturbance or mental illness and link them to appropriate resources.
  The number of TAY engaged in educational workshops will be tracked. Participant surveys are conducted to show changes in knowledge.
- Screen clients for an array of mental health and substance use issues at Teen Clinics for early identification of mental health issues and linkage to appropriate services.
  Number of clients screened at Teen Clinics will be tracked.
- Reduce Prolonged Suffering for those at significantly higher risk of emotional disturbance or mental illness by increasing protective factors and reducing risk factors.
  Participants of school groups complete an evidence-based tool, the Outcome Rating Scale (ORS), at each session which asks the client to rate how they are doing individually, interpersonally, socially and their overall sense of well-being. The change in these scores will be evaluated for clients that participate in three or more sessions.
- Reduce Prolonged Suffering for those experiencing early onset of symptoms of emotional disturbance or mental illness by reducing symptoms and improving related functioning.
  Clients receiving early intervention services complete an evidence based tool, the Outcome Rating Scale (ORS), at each session which asks the client to rate how they are doing individually, interpersonally, socially and their overall sense of well-being. The change in these scores will be evaluated for clients that participate in three or more sessions.

This data, and client/family demographics, is collected annually so there can be an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

The program achieves the intended results due to implementing program practices that have been shown to achieve positive impacts over the course of this program and evidence-based intervention services, such as Brief Strategic Family Therapy, Cognitive Behavioral Therapy, Motivational Interviewing, and Seeking Safety.

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

LATINO COMMUNITY CONNECTION

Program Overview

In 2009, MHSA PEI funds began the Canal Community-Based Prevention and Early Intervention program. Canal Alliance, a trusted community agency, trained their front-line workers in identifying and responding to signs of mental health risks and symptoms, and provides skill building interventions. In 2011, PEI launched a Community Health Advocates (CHA) program with the intention of supporting CHAs in a variety of underserved communities. CHAs are trusted community members trained in identifying and responding to behavioral health concerns, including peer support and linkages to services. Canal Alliance was awarded a contract to develop and support CHAs (Promotores) in the Latino Community. In FY2014-15 these two programs will be combined as the Latino Community Connection program. The purpose is to provide mental health outreach, engagement, and prevention services for Latino communities throughout the County. In addition, PEI funds will co-sponsor a radio show in Spanish on health issues, including mental health and substance use.

Target Population

The target population is Latinos throughout the County, especially newer immigrants facing many stressors and barriers to access of services. In FY2014-15 the Promotores will be expanded to West Marin to service the geographically isolated Latino population.

Numbers to be served in FY2014-15	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Outreach to Increase Recognition		50	300	50	**400**	**100**	**12**
Reducing Risks		20	60	20	**100**	**20**	

Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

Program Description

- Outreach for Increasing Recognition of Early Signs of Mental Illness (prevention)
- Reduce Risk Related to Mental Illness (prevention)

The Latino Community Connection program aims to reduce prolonged suffering due to unaddressed mental illness by increasing identification of individuals with mental health difficulties and increasing protective factors for those with significantly higher risk for mental illness due to trauma.

Outreach for Increasing Recognition:

- Radio Show: A licensed mental health provider will host a weekly live one hour radio show in Spanish on the health of Latino individuals, families and communities, in particular mental health topics. It will be broadcast from stations in central Marin, West Marin and other regions in California. A similar program focused on parenting was well-received.
- Promotores Training and Support: For hard to reach populations, trusted community members provide an effective cultural and linguistic bridge to information and services. This project provides training, supervision and stipends for Promotores to provide mental health and substance use education, identification of risk and signs, and linkages to services. This program increases the efficacy of existing mental health programs by reducing the barriers for accessing those services. In addition it creates a culture shift in the target communities that reduces stigma and increases the natural supports available within the community. MHSUS provides staff time in-kind for training, supervision, and program development by a licensed mental health practitioner.

Reducing Risk:

- Skill Building: Individuals referred to the program are assessed for PTSD using the Posttraumatic Stress Disorder Checklist (PCL-C). Those determined eligible are referred to ongoing groups provided at Canal Alliance for increasing coping skills and functioning. The groups provided incorporate the framework developed by the Institute on Violence, Abuse and Trauma (IVAT) regarding addressing complex trauma, such as emotional regulation, stress reactions, psycho-education on trauma, dissociation, and relational aspects. In addition, clients not appropriate for the groups, but assessed as having significant risk, especially family conflict, or having signs/symptoms of mental illness, are provided one to three individual sessions including psycho-education, coping skills, communication skills, and linkages to appropriate services.

The program improves timely access to services for underserved populations by being located within a trusted multi-service agency serving primarily Latino immigrants, as well as reaching hard-to-reach communities through Promotores. Services are provided at no-cost by culturally and linguistically competent providers. Services are non-stigmatizing by being co-located with other services and addressing "stress," rather than specifying mental health issues.

Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by the program's behavioral health provider. Promotores, family advocates and others are trained to identify signs and symptoms and refer clients to the behavioral health provider as needed. The behavioral health provider makes referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the "access line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Mental Health and Substance Use Services, clients,

families, and other key agencies in order to facilitate successful collaboration.

Intended Outcomes and Evaluation

Latino Community Connection is intended to:

- Train Promotores and other front-line workers to recognize and respond to early signs of mental illness.
  The number and type of providers trained will be tracked. Participant surveys are conducted to track changes in knowledge and skill.
- Reduce Prolonged Suffering for those at significantly higher risk of mental illness by increasing protective factors and reducing risk factors.
  The Posttraumatic Stress Disorder Checklist will be completed by group participants upon entry to and exit from the program. Changes for individuals will be tracked and then reported in aggregate.

This data, and client/family demographics, are reported annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

The program achieves the intended results due to implementing program practices that have been shown to achieve positive impacts over the course of this program, the use of best practices associated with Promotores programs, and incorporating research-based frameworks.

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

Program Overview

In 2009, MHSA PEI began "Integrated Behavioral Health in Primary Care" to support the integration of mental health and substance use services into primary care clinics serving underserved populations. These programs have served thousands of clients that likely would not have otherwise accessed these services. In FY2014-15, 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.

Target Population

The target population for this program is uninsured individuals accessing primary care at community clinics. In Marin, the majority of those not eligible for coverage are Spanish-speaking immigrants.

Numbers to be served in FY2014-15	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Early Intervention	35	35	245	35	**350**	**30**	

Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

Program Description

- Intervene Early in the Onset of Mental Illness (early intervention)

The ACA provides screening and intervention services for mild to moderate mental health and substance use concerns in primary care settings, for insured clients. PEI will provide support to primary care settings to provide similar services for uninsured clients. The providing agencies and exact services will be determined through a Request for Proposal (RFP) process. Applicants will be expected to use the same processes, assessments and interventions required by the ACA, or explain how they will differ yet still meet the expectations of the program, such as identifying clients needing intervention, determining the level of intervention, successfully providing interventions for mild to moderate concerns, and successfully linking clients to further assessment and services if it is beyond the primary care clinic's scope. Services may also be provided to the caregivers of the individual facing mental illness.

The most common concerns presenting in the primary care setting include depression, anxiety, substance use, and PTSD. The primary care clinics have worked with a variety of screening tools for clients, and will now implement one that meets ACA standards. If a client screens positive, they are

further assessed during the primary care visit, or are referred to on-site behavioral health providers, depending on the clinic. Assessments may include PHQ9, GAD7, or other validated tools. Clients are offered on-site services or referred out as appropriate. On-site providers are trained in evidence-based practices, such as Problem Solving Treatment.

The program improves timely access to services for underserved populations because the target population already accesses the community clinics for primary care. The screening and interventions offered are culturally and linguistically appropriate, including Spanish speaking staff and interpretation for other languages as needed. Due to federal guidelines regarding client copays, the cost of the services can be a barrier for a portion of the target population, therefore PEI will provide some funding to reduce the costs to the client. In addition, PEI supports the Latino Community Connection program, which provides similar services for free in a community-based setting. These two programs work together to assist clients in receiving the most appropriate services available. Services are non-stigmatizing by being offered through sites clients are already accessing and by focusing on issues like stress and wellness rather than "mental health."

Individuals/families at risk or showing signs of developing mental illness or emotional disturbance are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is provided through assessment and referral by licensed mental health providers in the primary care setting. They make the referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the "access line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Mental Health and Substance Use Services, clients, families, and other key agencies in order to facilitate successful collaboration.

Intended Outcomes and Evaluation

Integrated Behavioral Health in Primary Care is intended to:

- Reduce Prolonged Suffering by reducing symptoms and improving mental, emotional and related functioning.
  Providers track the number and demographics of the clients/families served. Each client completes an assessment at the beginning of services, such as the PHQ9, and periodically throughout intervention services. Change in status is measured for each client, then reported in aggregate.

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

The program is expected to achieve the intended results due to implementing key aspects of integrated behavioral health (IBH), including evidence-base practices, such as Problem Solving Treatment, and promising practices developed for IBH.

Program Continuation [X] **Program Expansion** [ ] **New Program** [ ]

OLDER ADULT PREVENTION AND EARLY INTERVENTION

Program Overview

Older adults represent a growing percentage of the population of Marin and face many risks for mental illness. In 2009, MHSA PEI funds began a program targeting older adults receiving Meals on Wheels services. Due to feedback that these services needed to be available to additional older adults, in 2011 this program was revised into its current version now provided by Jewish Family and Children's Services (JFCS). This program provides community education about mental health concerns in older adults and early intervention services for depression and anxiety. In FY2012-13 over 400 community members received education and over 30 older adults received early intervention.

Target Population

The target population is older adults (60+ years old), including individuals from underserved populations such as Latino, Asian, African-American, LGBT, low-income, and geographically isolated. Spanish Speaking older adults are primarily served by a peer-counseling program provided by Mental Health and Substance Use Services, but not PEI.

Numbers to be served in FY2014-15	Individuals					Family Members	Community Memebers
	0-15	16-25	26-59	60+	Total		
Outreach to Increase Recognition							**200**
Early Intervention				35	**35**	**15**	

Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

Program Description

- Outreach for Increasing Recognition of Early Signs of Mental Illness (prevention)
- Intervene Early in the Onset of Mental Illness (early intervention)

Due to changes brought on by aging and health decline, older adults are at-risk for isolation, chronic health problems, substance abuse, poverty, retriggering of early trauma, and other issues. The Older Adult PEI program aims to reduce Prolonged Suffering by providing:

Outreach for Increasing Recognition:

- Training: Providers, older adults, community leaders and gatekeepers are trained to recognize signs of depression and other mental health concerns among older adults and how to get appropriate help.

Early Intervention:

- Brief Intervention: Older adults referred to JFCS services are assessed for depression (PHQ9), anxiety (GAD7) and other mental health concerns. Those identified as having depression receive brief intervention including developing care management plans, behavioral activation (Healthy IDEAS), and short-term problem-focused treatment (Cognitive Behavioral Therapy). Family members are included in brief intervention services as appropriate.

The program improves timely access to services for underserved populations by providing outreach and education to diverse providers and community members throughout the County, as well as providing services within an agency that already provides many older adult services. Services provided by PEI funds are free, culturally appropriate, and provided in the home and other community settings as needed. Services are non-stigmatizing by being co-located with other services and focusing on "successful transitions for older adults." Program success lies in its flexibility, responsiveness and ability to coordinate care with its longstanding partners in the health and social service systems that provide service to this vulnerable population.

Individuals at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness is achieved through assessment and referral by JFCS licensed mental health providers. They make the referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the "access line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Mental Health and Substance Use Services, clients, families, and other key agencies in order to facilitate successful collaboration.

Intended Outcomes and Evaluation

Older Adult PEI is intended to:

- Educate providers, older adults, and gatekeepers to recognize and respond to early signs of mental illness through providing training and written materials to organizations and networks.
  The number and types of individuals trained will be tracked. Participant surveys are conducted to show changes in knowledge and skill for those receiving training.
- Reduce Prolonged Suffering for those experiencing early onset of depression and/or anxiety by reducing symptoms and improving related functioning.
  For clients completing treatment, including CBT or the Healthy IDEAS intervention, pre- and post-PHQ9s are conducted. Reduction in isolation and success in addressing goals in the

client care plan are also measured through client report. Changes in scores are tracked by individual and reported in aggregate.

This data, and client/family demographics, are reported annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

The program achieves the intended results due to implementing a combination of clinical approaches and program practices that have been shown to achieve positive impacts over the course of this program and evidence-based services, such as Healthy IDEAS and Cognitive Behavioral Therapy.

Program Continuation [X] **Program Expansion** [ ] **New Program** [ ]

VIETNAMESE COMMUNITY CONNECTION

Program Overview

In 2011, MHSA PEI began the Vietnamese Community Connection program to implement effective ways of engaging the Vietnamese community in mental health outreach and education efforts, risk reduction, and intervention. The program consists of Community Health Advocates (CHAs) and skill building groups. CHAs are trusted community members trained in identifying and responding to behavioral health concerns, including peer support and linkages to services.

Target Population

The target population is Vietnamese residents throughout the County. Members of the Vietnamese community experience risk factors, including trauma, poverty, racism, social inequality, prolonged isolation, and others.

Numbers to be served in FY2014-15	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Outreach to Increase Recognition	20	30	30	70	**150**	**30**	**5**
Reducing Risks		10	10	20	**40**	**10**	

Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

Program Description

- Outreach for Increasing Recognition of Early Signs of Mental Illness (prevention)
- Reduce Risk Related to Mental Illness (prevention)

The Vietnamese Community Connection program aims to reduce prolonged suffering due to unaddressed mental illness by increasing identification of individuals with mental health difficulties and increasing protective factors for those with significantly higher risk for mental illness.

Outreach for Increasing Recognition:

- Community Health Advocates Training and Support: For hard to reach populations, trusted community members provide an effective cultural and linguistic bridge to information and services. This project provides training, supervision and stipends for CHAs to provide mental health and substance use education, identification of risk and signs, and linkages to services. 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. MHSUS provides staff time in-kind for training, supervision, and program development by a licensed mental health practitioner.

Reducing Risk:

- Skill Building: Mental health providers conduct groups intended to increase coping skills and functioning. Eligible clients are those with significantly higher risk of mental illness, such as prolonged isolation, trauma, or social inequality. Services include psycho-education, stress management, and techniques from Cognitive Behavioral Therapy, Dialectical Therapy, Behavioral Activation and Health Psychology. In addition, the group builds social support and decreases isolation. For those not appropriate for, or unable to attend, the groups, but identified with significant risk or signs of mental illness, a mental health provider conducts an individual community-based assessment and brief intervention, including psycho-education, problem solving, stress management, techniques from Cognitive Behavioral Therapy, Dialectical Therapy, Behavioral Activation and Health Psychology for individuals and families, and linkages to services.

The program improves timely access to services for underserved populations by being provided by a trusted multi-service agency, as well as reaching hard-to-reach communities through Community Health Advocates. Services are provided at no-cost by culturally and linguistically competent providers. Services are non-stigmatizing by being co-located with other services and addressing "stress," rather than specifying mental health issues.

Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by the program's behavioral health provider. CHAs and others front-line workers are trained to identify signs and symptoms and refer clients to the behavioral health provider as needed. The behavioral health provider makes referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the "access line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Mental Health and Substance Use Services, clients, families, and other key agencies in order to facilitate successful collaboration.

Intended Outcomes and Evaluation

Vietnamese Community Connection is intended to:

- Train Community Health Advocates (CHA) to recognize and respond to early signs of mental illness.
  The number and type of providers trained will be tracked. Participant surveys are conducted to track changes in knowledge and skill.
- Reduce prolonged suffering for those at significantly higher risk of mental illness by increasing protective factors and reducing risk factors.

A survey will be completed by participants at the beginning and end of services. This survey is based on questions in the MHSUS Consumer Survey on coping skills and isolation. Changes for individuals will be tracked and then reported in aggregate.

This data, and client/family demographics, are reported annually to assist with an analysis of whether the target population and outcomes are being achieved, and how to improve the program on an ongoing basis.

The program achieves the intended results due to implementing program practices that have been shown to achieve positive impacts over the course of this program and the use of best practices associated with Promotores programs.

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

COMMUNITY AND PROVIDER PREVENTION AND EARLY INTERVENTION TRAINING

Program Overview

In 2012 Marin County MHSA Prevention and Early Intervention (PEI) began providing Mental Health First Aid (MHFA) trainings. These trainings have been very well-received, and continuously maintain a waiting list. Under PEI Technical Assistance funds trainings have been offered to PEI providers and others on best practices. Topics have included cultural competence, trauma informed care, Problem Solving Treatment, evaluation, and others. In addition, funds have been made available to send providers, consumers, families and others to conferences related to PEI efforts, such as Community Health Advocates and Stigma and Discrimination Reduction. In FY2014-15, PEI funds will be dedicated to supporting a range of training opportunities under the Community and Provider PEI Training Program.

Target Population

The target population for this program is:

- Providers, consumers, family members and other community members who may be in a position to recognize and respond to early signs of mental illness. These include school staff, front-line workers in health and human service agencies, community health advocates/promotores, family members, probation staff, security guards, librarians, and others.
- Providers, consumers, family members and other community members who are in a position to implement stigma and discrimination reduction activities. These include community leaders, peer providers, appropriate county staff, and others.
- PEI providers.

Numbers to be served in FY2014-15	Community Member and Providers
Outreach to Increase Recognition and Stigma and Discrimination Reduction	**100**

Program Description

- Outreach for Increasing Recognition of Early Signs of Mental Illness (prevention)
- Stigma and Discrimination Reduction (prevention)

Mental Health First Aid (MHFA) is an evidenced based training that:

- increases understanding of mental health and substance use disorders
- increases knowledge about signs and symptoms of issues such as depression, anxiety, psychosis, and substance abuse
- reduces negative attitudes and beliefs about people with symptoms of mental health disorders
- increases skills for responding to people with signs of mental illness and connecting individual to services
- increases knowledge of resources available

Trainings are offered throughout the community. In the past, three to five trainings have been offered per year. Most often the standard training is offered, but the youth focused one has also been offered. The type of trainings, locations, and frequency will depend on the demand for the trainings.

Funds will continue to be available to provide trainings for PEI providers, and others, on best practices for providing PEI services. In addition, funds will support attendance at conferences on PEI issues such as stigma reduction.

The program improves timely access to services for underserved populations because a wide array of community members are trained in identifying signs/symptoms and responding, including skills on connecting individual to services. In some cases the appropriate referral will be to the MHSUS "access line," enabling the County to make appropriate assessments and referrals, and to track that process.

Intended Outcomes and Evaluation

Community and Provider Trainings are intended to:

- Train community members to recognize signs/symptoms of mental health and substance use disorders and to respond, including linking individuals to services.
  The number and type of individuals participating will be tracked. Every six months, this data will be analyzed to ensure that target numbers and representation are being reached. In addition, MHFA conducts pre and post surveys to assess change in knowledge and behavior.
- Reduce stigma and discrimination
  The number and type of individuals participating will be tracked. In addition, MHFA conducts pre and post surveys to assess change in knowledge and behavior.

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

The program is expected to achieve the intended results due to implementing MHFA, an evidence-based practice. In addition, the other conferences and trainings will address evidence based practices and promising practices.

Program Continuation ☐ **Program Expansion** ☐ **New Program** X

SCHOOL AGE PREVENTION AND EARLY INTERVENTION

Program Overview

In the community planning process for the MHSA Three-Year Plan, the need for services for school age youth was a high priority. Beginning in FY2014-15, MHSA PEI will provide funding for increased services for students in three school districts with a large proportion of low income children. The purpose of these services is to:

- Identify students who are at high risk of school failure and at significantly higher risk than average of developing symptoms of an emotional disturbance
- Provide services that increase the students' protective factors and reduce the risk of developing signs of emotional disturbance

Target Population

The target population is Kindergarten through eighth grade students (ages 5-14) in three areas of Marin County:

Target Schools	Latino	American Indian	Asian	African American	Multiple Races	English Learners
San Rafael City Schools	60%	1%	4%	1%	2%	43%
West Marin Schools	40%	1%	1%	1%	2%	35%
Sausalito/Marin City Schools	25%		10%	30%	7%	20%

** Percentages are approximate.*

Initially a higher portion of funding will target the Sausalito Marin City School District, as we believe that region receives fewer services through County-wide PEI programs than the other regions. In the future we plan to collect data to better analyze services by region. If funds become available, we will also consider adding School Age PEI funds targeting North Marin. Some school based services, primarily in Central and North Marin, are funded through the Transition Age Youth (TAY) PEI program, mostly targeting high schools, and some younger grades.

Students at high risk of school failure and at significantly higher risk of developing signs of emotional disturbance will be identified in the following ways:

- Identifying high risk students:
  Student Success/Study Teams (SST), and Student Attendance Review Teams (SART) and Boards (SARB) identify students at risk of school failure. School counselors, teachers, and

others may identify individuals to be assessed based on indicators other than attendance, such as emotional and behavioral factors evidenced in the classroom.

- Assessment:
  Referred students will be assessed for risk factors including family history (i.e. family environment, adverse childhood experiences such as trauma and domestic violence, and having a family member with a serious mental illness), behavioral/functional challenges, and substance use.

Numbers to be served in FY2014-15	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Reducing Risks	60					40	

Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

Program Description

- Reducing Risks Related to Mental Illness (prevention)

The primary objective of this program is to reduce risks related to emotional disturbance and prevent further impairment in functioning.

This program will improve timely access to services for underserved populations by being located in schools with high rates of underserved students/families, ensuring service providers are culturally and linguistically competent, and being offered at no-cost. Services will be non-stigmatizing by being initiated through the school and identified as assisting with school success, rather than specifically mental health related.

Once a student has been identified as eligible, services will be provided with the goal of increasing protective factors and reducing risk factors for developing signs of emotional disturbance. The specific services will be determined through a Request for Proposal (RFP) process seeking providers who demonstrate school-community partnership, success working with the target population, and capacity to achieve the intended outcomes. An RFP process has been chosen because each school and school district has different services, and therefore different service gaps. Potential programs may include:

- Mentoring programs that include social-emotional skill building and caregiver involvement
- Mental Health Provider to collaborate with SST, SART, and/or SARB to assist in developing and coordinating the student plan, provide brief interventions for student and/or caregivers, and link students/caregivers to further services
- Student Assistance Program (SAP) to develop the nine key components of SAPs identified by the National Student Assistance Association.

Individuals/families at risk or showing signs of developing serious emotional disturbance or mental illness will be linked to services as needed. These services may be provided by the PEI program, the school, community based organizations, or other available providers. Individuals eligible for services

through health coverage, including Medi-Cal, Early Periodic Diagnosis Screening and Treatment (EPDST), or private coverage will be referred to those resources. Individuals experiencing symptoms of serious mental illness or emotional disturbance will be referred to Marin County Mental Health and Substance Use Services (MHSUS), private health coverage or primary care. Families will be provided assistance with making an initial appointment as needed.

Referrals to County MHSUS go to the "access line," enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Mental Health and Substance Use Services, clients, families, and other key agencies in order to facilitate successful collaboration.

Intended Outcomes and Evaluation

School Age PEI is intended to:

- Reduce prolonged suffering by increasing protective factors and reducing risk factors
  Assessments using validated tools will be conducted when a student enters the program and at the end of each school term, or at the time of completing the program. Results for each student will be analyzed to measure amount of change over time. Results for all individuals will be aggregated and reported. This data, as well as student/family demographics, will be reported annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

In addition, school records on student attendance and grades will be compared for each student prior to entering the program and after completion of the program to assist with determining efficacy of the program.

The program is expected to achieve the intended results by implementing evidence-based practices or promising practices appropriate for the target population, or community-based practices that have some evidence of success in the population to be served, such as a track record of success and/or the inclusion of key elements shown to be successful. For example, parent involvement is shown to be a key element in effectively working with children in the area of mental health.

Program Continuation ☐ **Program Expansion** ☐ **New Program** ☒

VETERAN'S COMMUNITY CONNECTION

Program Overview

Veterans are recognized as being at high risk for mental illness, without adequate access to necessary care. While there are efforts on a Federal level to address this need, there is much that can be done on a local level to prevent prolonged suffering, as well as a need for more intensive services. Beginning in FY2014-15, MHSA PEI will provide funding to the Marin County Veterans' Service Office, within the Department of Health and Human Services, to provide supportive services for veterans with a mental illness being released from jail or prison on probation or parole in order to complete their treatment plan established by Veterans' Affairs.

Target Population

The target population is veterans being released from San Quentin or Marin County Jail on probation or parole who have a treatment plan for mental illness developed by Veterans' Affairs (VA). Most of the target population may be diagnosed with Post Traumatic Stress Disorder, while some may be diagnosed with depression or other concerns.

Numbers to be served in FY2014-15	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Reducing Risks		20	80	20	**120**	**20**	

Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

Program Description

- Reduce Risk Related to Mental Illness (prevention)

When an incarcerated Veteran with a mental health treatment plan is released on parole or probation, the VA covers clinical treatment costs associated with the plan, but there are many barriers to a veteran completing their treatment. When they do not complete their treatment, they are at high risk for escalating mental health needs, as well as recidivism.

The VA will contact Marin County Veterans' Services when an eligible veteran will be released to Marin. Veterans' Services will dedicate a part-time case manager to assist the veterans in completing their treatment. The case manager will have experience with outreach and engagement with adults with mental health challenges and providing family support. They will provide:

- Supervising volunteer Veterans to provide peer support
- Assistance with logistical barriers, such as transportation

- Ongoing contact to increase likelihood of engaging with the treatment plan
- Services for significant support people, such as family, to increase their capacity to assist the veteran with completing their treatment plan
- Assistance with obtaining other forms of support available to the veterans and their families, such as financial benefits or community resources

The program will improve timely access to services for underserved populations by providing the support services needed to access treatment that is available, and required. These support services will be provided at no-cost by veteran's who have had similar experiences, can meet the client where they are literally and figuratively, and can help to de-stigmatize the situation. Access and linkage to treatment will be provided by the VA, who will be providing clinical assessments and services.

Intended Outcomes and Evaluation

Veteran's Community Connection is intended to achieve the following outcomes:

- Reduce Prolonged Suffering by ensuring previously incarcerated veterans engage in mental health treatment expected to reduce their symptoms and increase their functioning.
  The Veterans' Services case manager will maintain records on contacts with participating veterans and rate of completion of VA treatment plan. This data will be analyzed to help determine what interventions are most successful in ensuring completion of treatment plan.

This data, and client/family demographics, are reported annually to assist with an analysis of whether the target population and outcomes are being reached, and how to improve the program on an ongoing basis.

The program will be expected to achieve the intended results due to:

a. Integrating peer veterans in all aspects of the program;
b. Completion of treatment plans designed by the VA to reduce symptoms and increase functioning.

Program Continuation ☐ **Program Expansion** ☐ **New Program** ☒

STATEWIDE PREVENTION AND EARLY INTERVENTION

Program Overview

In 2008 Marin County assigned a portion of MHSA PEI funds to a statewide effort for four years. Those funds, managed by California Mental Health Services Authority (CalMHSA), have supported:

- Suicide Prevention: This includes Statewide efforts, such as the Know the Signs campaign, as well as a regional effort led be Family Service Agency of Marin – a division of Buckelew Programs (FSA) to develop the North Bay Suicide Prevention (NBSP) project. This has expanded Marin's local Suicide Prevention and Crisis Hotline into a regional hotline, as well as provided community suicide prevention trainings and regional coordination.
- Student Mental Health Initiative (SMHI): This includes Statewide efforts, such as amending K-12 educator credential standards to include training to improve early identification of at-risk students, as well as a regional effort led by Marin County Office of Education to provide training for educators in bullying prevention, suicide prevention, teen dating violence, and other mental health topics.
- Stigma and Discrimination Reduction (SDR): This includes Statewide efforts such as the Reach Out Here campaign.

For more detail, see Appendix A.

The funds previously assigned will be expended in FY2013-14. Marin is recommending additional MHSA funds to continue supporting these statewide and regional efforts. In FY14-15 a portion of the funds will be allocated to CalMHSA to manage and evaluate, while some of the funds will be allocated directly. In FY2014-15 CalMHSA will conduct a planning process with the counties to determine their future funding and scope of work for all three initiatives. At that time, Marin will determine how to best continue these program areas.

Numbers to be served in FY2014-15	
Suicide Prevention Hotline	**8000**

MHSA Prevention and Early Intervention (PEI)
Three-Year Plan (FY2014-2015 through FY2016-2017)

Program	FY14-15	FY15-16	FY16-17	Total
PEI-1 Early Childhood Mental Health Consultation - ECMH	$230,000	$230,000	$230,000	$690,000
PEI-2 Triple P (Positive Parenting Program) Marin	$55,000	$55,000	$55,000	$165,000
PEI-4 Transition Age Youth (TAY)PEI	$140,000	$140,000	$140,000	$420,000
PEI-5 Latino Community Connection	$199,000	$199,000	$199,000	$597,000
PEI-6 Behavioral Health in Primary Care	$180,000	$180,000	$180,000	$540,000
PEI -7 Older Adult Prevention and Early Intervention	$100,000	$100,000	$100,000	$300,000
PEI-11 Vietnamese Community Connection	$53,000	$53,000	$53,000	$159,000
PEI-12 Community and Provider PEI Training	$65,000	$65,000	$65,000	$195,000
PEI-18 School Age Prevention and Early Intervention Programs	$310,000	$310,000	$310,000	$930,000
PEI-19 Veteran's Community Connection	$60,000	$60,000	$60,000	$180,000
PEI-20 Statewide Prevention and Early Intervention	$131,536	$131,536	$131,536	$394,608
Subtotal Direct Services	**$1,523,536**	**$1,523,536**	**$1,523,536**	**$4,570,608**
Evaluation	$40,000	$40,000	$40,000	$120,000
PEI Coordinator	$64,900	$64,900	$64,900	$194,700
Administration and Indirect	$244,265	$244,265	$244,265	$732,795
Operating Reserve	$27,799	$27,799	$27,799	$83,397
Total	**$1,900,500**	**$1,900,500**	**$1,900,500**	**$5,701,500**

	FY14-15	FY15-16	FY16-17	Total	%
County	$0	$0	$0	$0	0%
Contract Provider	$1,628,436	$1,628,436	$1,628,436	$4,885,308	86%
Administration	$244,265	$244,265	$244,265	$732,795	13%
Operating Reserve	$27,799	$27,799	$27,799	$83,397	1%
Total	**$1,900,500**	**$1,900,500**	**$1,900,500**	**$5,701,500**	**100%**

Program Continuation [X] **Program Expansion** [ ] **New Program** [ ]

CLIENT CHOICE AND HOSPITAL PREVENTION PROGRAM (CCHPP)

Program Overview

The MHSA Oversight and Accountability Commission's Innovation Committee defines Innovative Programs as novel, creative, or ingenious mental health approaches developed within communities that are inclusive and representative, especially of un-served, underserved, and inappropriately served individuals.

An Innovative Program is one that contributes to learning in one or more of the following ways:

- Introduces new, never-been-done-before, mental health practices or approaches,
- Makes a change to an existing mental health system practice or approach including adaptation for a new setting, or
- Introduces a new application to the mental health system of a promising community-driven practice or approach that has been successful in a non-mental health setting

Working within the parameters of the MHSA Oversight and Accountability Commission's definition of Innovation, the Client Choice and Hospital Prevention Program (also referred to as CCHPP) is the result of a diverse and collaborative community planning process conducted in Marin County. While the INN community planning process started in September 2009 the planning process dates back to 2005 with the launch of the first MHSA stakeholder planning process. The success of this INN project will be built on the success and ideas generated in our CSS, PEI and WET planning processes.

This program was approved by the Mental Health Services Oversight and Accountability Commission in 2011. Funding for this 4-year project will draw to a close the end of Fiscal Year 2014-2015.

Target Population

The population to be served by the Client Choice and Hospital Prevention program includes adults, age 18 and above who suffer from, or who are at risk of developing, severe mental illness. No one will be denied services due to race, ethnicity or language. The project plans to serve between 150-200 adults annually.

Client Choice and Hospital Prevention Program	FY14-15
Crisis Planning	80
Crisis Residential	120
SBIRT (Screening, Brief Intervention, Referral to Treatment)	120

Program Description

In Fiscal year 2009-2010, it was decided through a comprehensive community planning process involving diverse stakeholders to focus Marin's Innovation Program on increasing quality of services, including better outcomes, through transforming how Marin responds to psychiatric crises. Options for adults experiencing psychiatric crises that did not resolve within the first 23 hours were limited to inpatient hospitalization in a locked setting, sometimes in an out-of-county facility. Clients, families, providers and key partners had come to expect hospitalization as the most appropriate strategy for resolving psychiatric crises and became frustrated with the mental health system when this did not occur. Those individuals whose crises were not severe enough to justify hospitalization had no options available to them after the first 23 hours of crisis stabilization services other than to return to the care of outpatient/community providers, family, and friends who did not always have the skills, resources or resiliency to provide sufficient support. This often led to a repetitive series of crisis visits until either the crisis eventually resolved over time or the individual's condition deteriorated to the point of requiring hospitalization, often leaving clients, families, friends, providers and key partners feeling drained, discouraged, and disempowered.

Marin's proposed four year Client Choice and Hospital Prevention Program 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 (previously under Prevention and Early Intervention, in FY2014-15 funded with Community Services and Supports under Crisis Continuum of Care) 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. See Appendix B – CCHPP Description and Brochure and Appendix C – CCHPP Logic Model)

Outcomes Expected and Evaluation

This project expects to teach us how to "…increase the quality of services, including better outcomes…" for those experiencing a psychiatric crisis. A working hypothesis has been developed and will be tested. It is believed that if there is 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. The working hypothesis states:

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

We believe we can work towards a system that (1) 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.

The nature of an MHSA Innovative project is to try a never-been-done-before approach in order to solve a challenging problem. Customized evaluation tools have been created to help guide the learning nature of this charge. CCHPP will use the customized surveys, focus groups and hard data to determine if we are learning how to become a client choice and hospital prevention system. Evaluation cycles will take place, over the course of several months, and the data will be compiled and evaluated. This data will be brought back to the CCHPP Advisory Committee and to Marin's Mental Health and Substance Use Director for review. This review will then be used to guide the process towards our hoped for goals and objectives.

Next Innovation Project Planning and Stakeholder Process

Given that Fiscal Year 2014-2015 is the final year of the Client Choice & Hospital Prevention Program, a new community stakeholder planning process will concurrently take place to determine the next Innovative project(s). All of Marin's stakeholders, and the community at large, will be invited to continue to discuss what they see as gaps in our mental health and substance use system. One theme that consistently emerged as a priority via the 3-Year Planning process was the need to more effectively serve the underserved culturally and ethnically diverse communities. Through this community stakeholder planning process, Innovation guidelines will be explained, ideas will be generated to address this priority theme, and community stakeholders will be invited to submit solutions to this hard to solve problem that Innovation funding is designed to address. It is expected that the planning process, the refinement of the issue(s) to be addressed, and the plan(s) will be designed so Innovation funding will be available for community-based services during FY2014-2015.

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

WORKFORCE, EDUCATION AND TRAINING (WET)

Program Overview

This Workforce Education and Training component is consistent with and supportive of the vision, values, mission, goals, objectives and actions of the MHSA. All proposed education, training and workforce development programs and activities contribute to developing and maintaining a culturally competent workforce, to include individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resiliency, leading to measurable, values-driven outcomes. This Workforce Education and Training component has been developed with stakeholders and public participation.

In 2008 Marin had our Workforce, Education and Training (WET) component approved by the state and implementation began immediately. We have been utilizing this funding stream to support training our current workforce in Evidence Based practices as well as developing pipelines for the future workforce, including hard-to-fill positions, and peer providers. At this point, we have exhausted most of the funding. This proposal is to support the transfer of funds from the CSS component to the WET component to continue current initiatives as well as to adapt to the changing landscape of recovery oriented mental health services and input from stakeholders.

In continuing the WET component of MHSA, we will be able to further the integration of peer and professional staffing with a focus on mentoring programs aimed at assisting consumers to enter the public mental health workforce. This combined with the stipend program to further their education with the goal of becoming able to work in the public mental health system

In addition, we will be able to again offer stipends to interns in our local CBO's that are able to serve consumers in a culturally and linguistically relevant manner. Intern stipends will also be offered to our APA accredited internship candidates as well as social work interns from local universities. This will also allow us the opportunity to create an internship tract that focuses on the rural population in West Marin where there are significant numbers underserved youth and families.

Target Population

The target population for the WET programs span the county behavioral health workforce, community based organizations, including primary care providers, consumer providers and family members and community members. The trainings are targeted toward the current workforce in addition to reaching out to future workforce members.

Trainings are open to all county, CBO, peer provider, family members. The intent is to be inclusive and to reach beyond the traditional training of the "professional" staff in the public mental health system. The Consumer and Family Sub-committees guide and direct and create trainings for their respective populations and fully participate in the process.

Program Description

The WET program will continue to implement evidence based practices including Motivational Interviewing, Harm Reduction, and Trauma Informed Care. The funding of the stipends for interns, both in the county's APA accredited program and the local CBO counseling centers, will enhance the ability to serve individuals in culturally appropriate and linguistically appropriate manner. There is also support for programming that is not "evidence based" but "community defined best practices" and promising practices that have been found to work in our particular community. Therefore, we are setting aside some funding each year to support local organizations that have not had the opportunity to respond to count RFP's due to lack of understanding of this process. This past year we have hosted two workshops aimed at these groups who are currently providing community based services to educate them on the RFP process.

The WET trainings utilize the train the trainer model, which allows our system to have exposure and education in evidence and community based practices, but that also provides for the knowledge to remain in our system. We have developed a peer consultation network that consists of county, CBO staff and family members who are "experts" in certain areas and who can then train others in the public mental health system. This will continued to be supported in the ongoing consultation networks

Another major initiative is the system wide culturally competent co-occurring training to the Mental Health and Substance Use Services system and its contractors. This approach will provide training in evidence based practices such as Motivational Interviewing, Harm Reduction, and Trauma Informed Care. The co-occurring collaborative- a group of county staff, CBO staff, family members and consumers will oversee the rollout of this initiative.

There is also additional funding requested for coordination. There are many stakeholder committees and training functions that the coordinator oversees and supports. This includes identifying trainers for training initiatives, assisting in the implementation of the WET plan and a role in program planning for the trainings offered.

WET will continue to support sending upcoming leaders in our Mental Health and Substance Use Services system to the California Institute for Mental Health leadership trainings. These are intensive trainings aimed at supporting leadership internally as well as being an opportunity to network across the state.

Outcomes Expected and Evaluation

The outcomes of the WET program are to reach at least 300 people per year with the various training series. In all of the trainings offered through the WET program we gather data on attendees: what setting they are working in, level of experience, applicability of training to their work, evaluation of trainer and ideas for future trainings.

The intern stipends for the county internship program will fund 8 positions that will include individuals who are able to offer services in Spanish and Vietnamese. The interns in the county program provide group and individual therapy to the SMI population. In addition, we have interns collaborating with our CBO substance use providers in the Marin County Jail setting. We intend to

expand this to the special housing pod in the Marin County Jail in the coming year. In the children's system interns offer a variety of services for the underserved Latino community by working in partnership with community based organizations that serve the migrant population. In addition they work with the Promotores program, supporting and providing services to underserved communities. We are in the process of expanding the internship program to our West Marin rural clinic where children, families and older adults are underserved.

The CBO intern stipends will allow us to support up to 24 interns each year who are bi-lingual and are serving the SMI population in Marin through the local counseling centers. They offer individual therapy and evidence based group interventions such as Seeking Safety.

The consumer and peer focused aspects of the WET plan are intended to support peer providers in gaining more educational experience through the stipend programs so they can enter the public mental health workforce. In addition, the proposal for peer mentoring is one that will support peers as they work in various roles in the county and contract services.

MHSA Workforce, Education and Training (WET)
Three-Year Plan (FY2014-2015 through FY2016-2017)

Program	FY14-15	FY15-16	FY16-17	Total
1) System-wide Dual Diagnosis Training	$95,555			$95,555
2) Family Member Focus Training	$15,000			$15,000
3) Scholarships for Underserved Consumers & Family Members	$38,000			$38,000
4) Community Based Organization (CBO) Intern Stipends	$30,000	$30,000	$30,000	$90,000
5) Training Initiatives	$50,000	$50,000	$50,000	$150,000
6) Peer Mentoring	$15,000	$15,000	$15,000	$45,000
7) MHSUS Intern Stipends	$152,000	$152,000	$152,000	$456,000
8) WET Coordination	$30,000	$30,000	$30,000	$90,000
9) California Institute for Mental Health-Training	$7,000	$7,000	$7,000	$21,000
Total	**$432,555**	**$284,000**	**$284,000**	**$1,000,555**

One-Time Funding Sources:	
Prior Year Unspent WET Funds	**$148,555**
Prior Year Unspent CSS Funds	**$852,000**
TOTAL	**$1,000,555**

Program Continuation [X] **Program Expansion** [X] **New Program** [ ]

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

Program Overview

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

Marin's initial CFTN planning process did not identify any capital improvement projects, so focus was placed on identifying and addressing growing technology needs. While the existing system provided Mental Health with several elements of an Electronic Health Record (EHR), the system continued to be a hybrid of electronic and paper documentation, including hand-written prescriptions. In addition, the existing billing system was a legacy system which needed to be upgraded and modernized. In late FY2009-10, Marin County received approval of our Technological Needs (TN) Proposal to further advance mental health towards a future paperless EHR, as well as build on existing efforts to utilize technology to further consumer and family empowerment.

Replacement of Marin's legacy billing system was the project's top priority, requiring high levels of staff and IT resources for 2-3 years and necessitating delays in implementation of many of the project's other components. Since beginning implementation, Marin's TN Project has also been impacted by changes in technology requirements at the federal, state and county levels which resulted in further reallocation of limited resources, re-prioritization, and corresponding delays in implementation. Despite these challenges, Marin has made a great deal of progress in implementing many parts of our TN Project, especially those identified to be the highest priority.

Program Descriptions

Capital Facilities

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

Technological Needs

Marin's TN Project is designed to use technology resources and strategies to increase consumer and family members' access to health information and records electronically in public and private settings and modernize and transform clinical and administrative information systems through the following components: 1) consumer empowerment, 2) e-prescribing, 3) electronic health record (EHR) and emergency backup, 4) practice management upgrade, and 5) scanning project. A sixth component – behavioral health information crosswalk – was added in FY2012-13 with one-time expansion funds.

Consumer Empowerment

This component provides funding for computers and consumer IT staff time at Enterprise Resource Center, Marin's consumer-staffed drop-in center. Funding is also dedicated for the purchase of desktop computers and internet access for the use of consumers living in county-contracted residences with 6 or more people, as well as "loaner" laptops and related connectivity for consumers participating on boards and committees, such as the Mental Health Board. Additionally, TN funds are provided for the development and/or maintenance of a Network of Care or similar website as a resource for individuals, families and agencies that provide information about behavioral health services, laws, and related news, as well as communication tools and other features. Public access computers have been set up in waiting rooms at many MHSUS service sites to provide easy access to the website for consumers, family and other visitors.

E-Prescribing

This project component has been almost fully implemented since FY2010-11, with all County psychiatrists and mental health nurse practitioners using e-prescribing through RxNT, a web-based electronic prescribing program fully integrated with Clinician's Gateway, the County's existing EHR system, for all prescriptions except controlled (scheduled) substances. Expanding e-prescribing to include controlled substances has been delayed due to a lack of local pharmacies certified to accept electronic transmissions of controlled substance prescription orders.

Electronic Health Record and Emergency Backup

County mental health staff and select contract providers have used Clinician's Gateway since 2006 to write electronic progress notes. This component moved the medical record further towards a more complete EHR by funding the addition of 10-15 essential forms in Clinician's Gateway, 9 of which have been successfully implemented, while numerous upgrades have also been made to existing electronic forms. Further development of Clinician's Gateway forms and the proposed addition of digital signature pads for recording client signatures on the electronic documents have been delayed due to the need to shift vender and staff resources to meet new state and federal requirements for EHRs, including Meaningful Use and Physicians Quality Reporting System (PQRS) documentation, data collection, and reporting.

TN funding also includes the provision for an expanded hardware configuration to provide for emergency backup in case of power or system failures. This has also been delayed due to limited

County IT resources being directed toward higher priority components of this project, including the Practice Management Upgrade.

Practice Management Upgrade

This constitutes the largest and most complicated component of Marin's TN plan, as it involved replacing InSyst, the County's legacy billing system and ECura, the County's managed care software system. The upgrade was expected to include all the existing billing and reporting functionality, including managed care, as well as interface with Clinician's Gateway. After extensive review, the Echo Group was selected in January 2011 as the vendor to provide the system upgrade to ShareCare, a web-based state of the art software system. Transfer to ShareCare occurred on August 1, 2011, only 1 month behind the projected go-live date and by April 2012, Marin was able to successfully submit billing to all major third party payers. In FY2012-13, Marin began generating client invoices.

Scanning Project

This component involves 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 will 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; however, further implementation has been delayed by focus on other, higher priority components.

Program Expansion

Marin proposes to use MHSA CFTN funds to expand the following project components.

E-Prescribing

Once a sufficient number of local pharmacies obtain certification to receive controlled substance (scheduled) prescriptions electronically, Marin proposes to use MHSA funds to expand use of RxNT to include this functionality and eliminate all hand-written prescriptions.

Electronic Health Record and Emergency Backup

In order to cope with technological advances and changes in technology requirements and regulations regarding EHRs, and continue progress towards a paperless EHR system, Marin proposes to use MHSA CFTN funds to fund additional system enhancements and upgrades, both hardware and software. This includes acquiring software enhancements for recording client's electronic signatures, secure messaging, customized forms for Marin's Psychiatric Emergency Services, and an administrator alert and report system, as well as continuing to create additional electronic forms to replace current paper forms still in use and meet new or changing documentation requirements. CFTN funds will be also used to develop the capacity for a Health Information Exchange (HIE) which allows healthcare professionals and organizations to appropriately and securely share client healthcare information electronically. The goal of the HIE is to make relevant healthcare information available where and when it is needed while protecting client privacy rights.

Practice Management Upgrade

Having completed a successful transition to ShareCare, Marin proposes to use CFTN funding for continued enhancements to extend the functionality of the system to meet federal and state reporting requirements, as well as support data analysis and quality improvement efforts. This includes the purchase and implementation of 3rd party software products – Rapid Insight and Veera – which interface with ShareCare to perform data analysis, manage analytic data sets, develop predictive models and produce user-friendly presentation reports. It also includes the development or purchase and implementation of a data warehouse system which interfaces with ShareCare and generates customizable financial and clinical reports. These two system enhancements will enable Marin County to more efficiently and accurately track and monitor service delivery outcomes, financial trends, and the need for changes.

The Department of Health Care Services (DHCS) has determined that the state needs to begin a process of transition from the Short-Doyle 2 (SD2) claims system to a new platform and system. California counties need to engage in this process to ensure that the new system meets mutual needs and capacity for timely payment and encounter reporting. Marin proposes to use CFTN funds to support participation in the DHCS transition feasibility study and to address system enhancements this transition will require.

Scanning Project

As noted above, implementation of this component has continued to be delayed. It is anticipated that implementation will occur in FY2014-15 and additional CFTN funds are needed for purchase of hardware required to expand the scope of this project to all County mental health sites where medical records are currently generated and stored.

Marin also proposes to use MHSA CSS funds to develop the following new Technological Needs Project component:

Behavioral Health Information Crosswalk

As the former divisions of Marin's Community Mental Health Services and Alcohol and Other Drug Programs continue integration as the Mental Health and Substance Use Division, it is acknowledged that many clients are 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. In FY2012-13, MHSA one-time funds were approved for the development of a behavioral crosswalk between these two systems to create a secure data-sharing process to reduce duplication and improve care coordination. Unfortunately, implementation of this functionality did not occur while these one-time funds were available because other system enhancements had priority. Marin continues to consider this functionality to be vital for integration and quality of care efforts, and so we propose to use CFTN funds for the purpose of creating this interoperability between the two information systems.

Outcomes Expected and Evaluation

Marin will continue to consider potential capital facilities projects that would be appropriate for MHSA Capital Facilities funding. The expected outcomes for the CFTN Project are as follows:

1) Fully implement the Consumer Empowerment component by the end of FY2014-15 and provide loaner tablets/laptops to an additional 6 consumers who are participating on boards or committees
2) Implement e-prescribing of controlled substances by all County psychiatrists and nurse practitioners by the end of FY2014-15
3) Complete conversion to a paperless EHR by the end of FY2016-17
4) Complete implementation of emergency backup system by the end of FY2014-15
5) Complete implementation of the Behavioral Health Information Crosswalk by the end of FY2016-17
6) Fully implement the Scanner Project by the end of FY2014-15
7) Complete preparation for HIE implementation by the end of FY2016-17

MHSA Capital Facilities and Technological Needs (CFTN)
Three-Year Plan (FY2014-2015 through FY2016-2017)

Program	FY14-15	FY15-16	FY16-17	Total	Description of Project
Practice Management	$393,083	$32,775	$32,775	$458,633	Enhancements will allow for further upgrades to the Practice Management system to meet federal and state requirements and increases the systems capability for analytics, data outcome reports, and interoperability.
Scanning	$113,134	$4,600	$4,600	$122,334	This component involves the implementation of a scanning application which is fully integrated with the MHSUS electronic health record. Adding scanning capability will allow authorized staff at any work station to to have access to documentation necessary for quality care.
E-Prescribing	$46,952	$37,715	$37,715	$122,382	E-Prescription program for county psychiatrists and mental health nurse practitioners through a web-based program that interfaces with the County's electronic health record. The E-Prescription program RxNT now allows for secure prescribing of controlled Rx's.
Electronic Health Record Upgrade	$464,030	$119,347	$4,347	$587,724	System upgrade to meet Federal and State Meaningful Use guidelines. Additionally completes the remaining electronic forms/documents in CG and provides for expanded hardware to provide emergency back up in the event of a system failure
Consumer Family Empowerment	$126,110	$39,790	$39,790	$205,690	Expansion to existing resources at the Enterprise Resource Center, the county consumer drop-in center. Provides computers and connectivity in county contracted consumer residential sites and dedicated paid consumer staff time for training and IT support.
Behavioral Health Information Crosswalk	$120,750	$0	$0	$120,750	Furthers the integration efforts of MHSUS (AOD/MH) by reducing duplication and improve care coordination and interoperability between systems within our electronic health records and data sharing capabilities.
Total	**$1,264,058**	**$234,227**	**$329,250**	**$1,617,513**	

One-Time Funding Sources	
Prior Year Unspent CFTN Funds	**$709,500**
Prior Year Unspent CSS Funds	**$908,013**
Total	**$1.617,513**

NUMBERS TO BE SERVED IN FY2014-15

	Program		FY14-15 Projected	FY14-15 Cost Per Person
FSP-01	Youth Empowerment Services (YES)	**FSP**	**70**	**$9,132**
FSP-02	Transition Age Youth (TAY)	**FSP**	**30**	**$3,723**
		Partial	**90**	**$3,723**
FSP-03	Support and Treatment After Release (STAR)	**FSP**	**55**	**$9,448**
FSP-04	Helping Older People Excel (HOPE)	**FSP**	**50**	**$16,649**
FSP-05	Odyssey (Homeless)	**FSP**	**90**	**$14,256**
SDOE-01	Enterprise Resource Center (ERC)	**SDOE**	**430**	**$1,401**
SDOE-04	Southern Marin Services Site (SMSS)	**SDOE**	**700**	**$397**
SDOE-07	Adult System of Care (ASOC)	**SDOE**	**350**	**$1,890**
SDOE-08	Co-Occurring Capacity	**Assess**	**75**	**$500**
		AIR	**40**	**$6,560**
	Housing		**5**	
PEI-1	Early Childhood Mental Health Consultation (ECMH)	**P**	**275**	**$836**
PEI-2	Triple P Marin	**P**	**115**	**$478**
PEI-4	Transition Age Youth (TAY) PEI	**P**	**600**	**$179**
		EI	**180**	**$179**
PEI-5	Latino Community Connection	**P**	**500**	**$398**
PEI-6	Integrated Behavioral Health in Primary Care	**EI**	**350**	**$514**
PEI-7	Older Adult Prevention and Early Intervention	**P**	**200**	**$426**
		EI	**35**	**$426**
PEI-11	Vietnamese Community Connection	**P**	**190**	**$279**
PEI-12	Community and Provider PEI Training	**P**	**100**	**$650**
PEI-18	School Age Prevention and Early Intervention Programs	**P**	**60**	**$5,167**
PEI-19	Veteran's Community Connection	**P**	**120**	**$500**
PEI-20	Statewide Prevention and Early Intervention	**P**	**8000**	**$13**

FSP = Full Service Partnership **SDOE** = System Development Outreach and Engagement
P = Prevention Services **EI** = Early Intervention Services

Total MHSA Funds Allocation

Three-Year Plan (FY2014-2015 through FY2016-2017)

Components	FY14-15	FY15-16	FY16-17	Total	
Community Services and Support (CSS)	$7,035,675	$7,725,675	$7,725,675	$22,487,025	a)
Prevention and Early Intervention (PEI)	$1,900,500	$1,900,500	$1,900,500	$5,701,500	b)
Workforce Education and Training (WET)	$432,555	$284,000	$284,000	$1,000,555	c)
Capital Facilities and Technological Needs (CFTN)	$1,264,058	$234,227	$119,227	$1,617,513	d)
Innovation (INN)	$621,055	$621,055	$621,055	$1,863,165	e)
Total MHSA Funds Allocated	**$11,253,843**	**$10,765,457**	**$10,650,457**	**$32,669,758**	

Community Services and Supports (CSS) - Housing				**$1,400,000**	f)
Local Prudent Reserve Available Balance				**$2,175,490**	g)

a) Increase in funding for CSS is from MHSA CSS growth funds.

b) Increase in funding for PEI is from MHSA prior year unspent PEI funds.

c) Increase in funding for WET is from prior year unspent CSS funds.

d) Increase in funding for CFTN is from prior year unspent CSS funds.

e) Increase in funding for INN is from MHSA prior year unspent INN funds, and INN growth funds. INN funds have not been allocated for community planning through this plan submission. Community planning will start in the Fall 2014.

f) Approximately $1.4m of CSS Housing funds are still available. Funds are administered by the California Housing Finance Agency (CALHFA).

g) Local Prudent Reserve are funds that have been set aside for use when MHSA funds are below recent averages adjusted by changes in the State population and the California Consumer Price Index, pursuant to WIC section 5847, subdivision (b)(7). Use of the funds requires State approval.

APPENDIX A

CalMHSA Statewide PEI Overview

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.

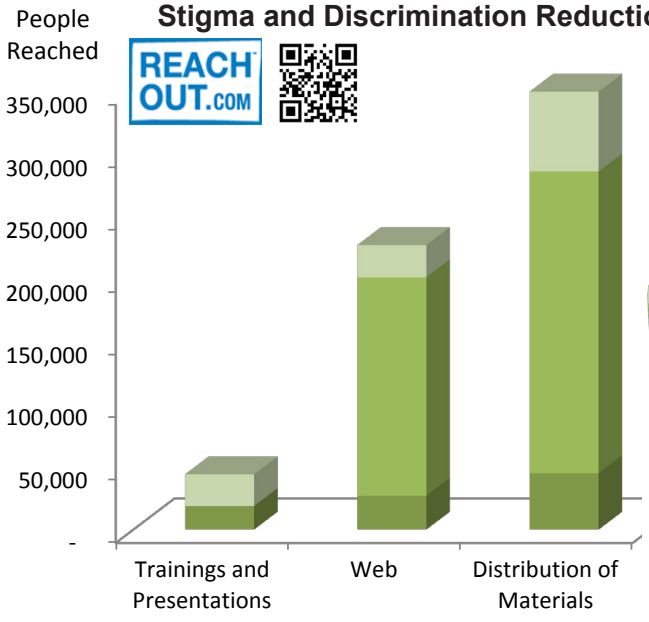
Marin County's initial investment in statewide Prevention and Early Intervention programs is $211,280 per year over a four year period. This initial investment built and strengthened California's crisis delivery, student mental health, and stigma reduction infrastructure. These capacities can now be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

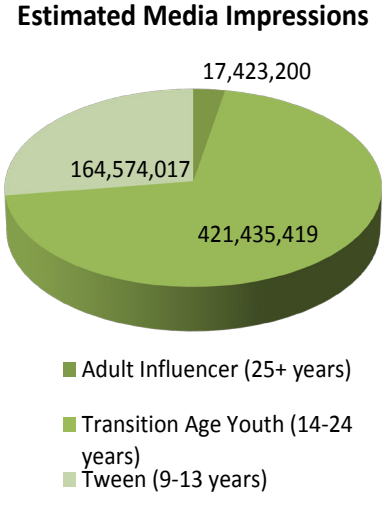
Statewide Impact: January- December 2013

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 B

Client Choice and Hospital Prevention Program Narrative

and

Casa René Brochure

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.

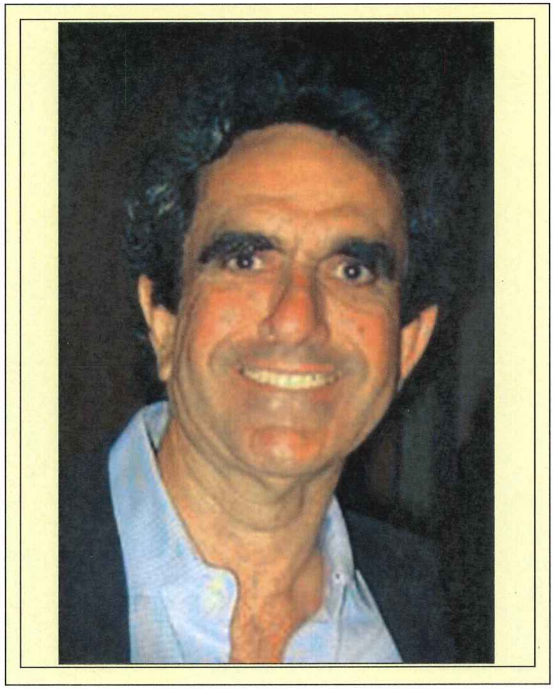
Crisis Planning (partnerships between providers and clients): Offered by Community Action Marin (CAM), peer staff helps individuals articulate and document their support options to prevent a crisis as well as their support preferences during a time of crisis. A person can name the individuals he or she 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 Services, this voluntary program will offer a home-like setting where individuals can stay in their own community and stabilize for up to 30 days 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. CAM 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.

Short Term Crisis Residential Program:

Operated by Buckelew Programs, this voluntary program offers a home-like setting where individuals can stay in their own community and stabilize during time of crisis. Casa René staff engage and collaborate with each client to create a personalized treatment plan which includes the client's care team. These teams are often comprised of family members, psychiatrists, case managers, nurse practitioners, doctors, counselors and friends.



Casa René

Kentfield, CA

Casa René is named and dedicated to René Méndez-Peñate, who was a Mental Health Social Worker and Case Management Supervisor with Marin County Mental Health and Substance Abuse Services. He was a mental health advocate for those in the community of Marin, as well as a special liaison for those who had limited access to services and who were Spanish speaking. He was a partner in the creation of this program and had a great vision and hope for clients being offered crisis support in a preventative setting, without having to undergo unnecessary hospitalization.

CASA RENÉ

CLIENT CHOICE HOSPITAL PREVENTION

Serving adults referred from Psychiatric Emergency Services (PES) of Marin County. Casa René, a 10 bed home in Kentfield, provides support and assistance to adults experiencing a mental health crisis.
Contact PES:
(415) 473-6666

Changing The Way Marin County Provides Mental Health Services

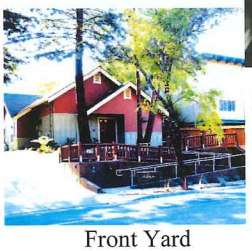
Innovative Approaches

- Attend up to four social rehabilitative groups a day focusing on symptom management and stress reduction.
- Development of a wellness action plan and identifying valuable tools.
- Learning about healthy lifestyle in conjunction with nutritional education.
- Identifying presenting issues clients may face returning to their home or place of employment.
- Identifying external stressors by supporting clients with; pets, employment, family, and school during stay at Casa René.
- Explore with client the resources in their community that they can benefit from and when appropriate, provide linkage to those resources such as housing, continued mental health services, employment counseling and detox services in addition to referral to substance abuse treatment.
- Clients and peer providers will assist staff, engage with peers, attend groups, and prepare meals using hands on skills that enhance and strengthen the client's abilities to manage their life more effectively and to reduce the need for re-occurring hospitalization.

Groups/Activities		
Nutrition and Healthy Lifestyles	Mindful Time	Relapse Prevention and Support
Seeking Safety	Expressive and Creative Arts	Crisis Planning
Deep Breathing	Karaoke, Sing it! Speak It!	Dancing Drumming
Medication support and education	Gentle Stretching	Movie Time Discussion

Buckelew Crisis Residential Program "Casa Rene" opens on February 3rd!

On October 23, 2013 a large group of NAMI/Marin members had the pleasure of touring the new Buckelew crisis residential home in Kentfield, affectionately named Casa Rene in honor of the late Rene Mendez-Penate who was the heart of the project from the very beginning. Our hosts, Katy Spence, Program Director, and Chela Fielding, Assistant Program Director, were very upbeat, enthusiastic, and proud to show us this inviting new home, funded by the Mental Health Services Act (Proposition 64).



Front Yard

Katy Spence

Chela Fielding

In planning Katy explained how they had visited similar homes and tried to incorporate all the best ideas and programs.

Everything is new and beautifully appointed, with high ceilings, and light. The rooms are painted in comforting soft hues.

All admissions to Casa Rene are made through Marin County Psychiatric Emergency Services (PES) and all 10 beds are intended for Medi-Cal clients who are residents of Marin County.

Casa Rene is a home for a person with a mental illness in crisis but who is *not* a danger to themselves or others.

Ideally the program is for short term stays but a client can stay up to 30 days depending on their need for services. Casa Rene is not a locked facility, but rather a voluntary program, where clients are actively involved in their treatment planning and goals.

Casa Rene partners with Community Action Marin's Seth Friedrich who helps clients and their families plan ahead for a crisis, see page 7.

The goal of this program is to get the client who is in crisis back to their baseline and to help them live a productive life.

livingroom & back door

There will be motivational interviewing by the staff during the intake process to find the strength base of the client using reflective listening.

A staff of trained mental health, and peer providers will provide support and assistance to clients 24/7. There will also be a meal planner who will provide cooking skills and nutrition education in addition to managing the house's menus.

Clients can view the staff at all times in rooms that are open. There is a separate medication room where staff can educate and talk to clients about their medication.

Rene Mendez-Penate, Matt Tasely, Artist

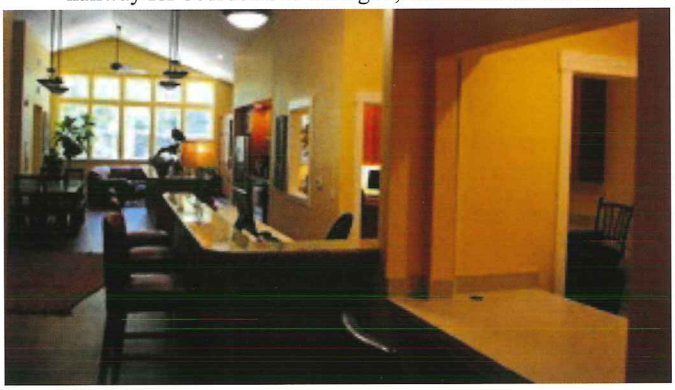
A full daily program for groups and individuals is offered for clients to participate in art therapy, including expressive art therapy (dance movement, drumming circles), yoga, meditation and many other activities.

Chela Fielding with Barbara Alexander, Judy Finn, & Carrie Morgan.

This is a place where a person living with a mental illness is treated with respect and where they can learn the tools they will need to keep them stable and hopeful for their future.

Thank you Buckelew!

Facing kitchen & work station to left, dining room to right, hallway for bedrooms to the right ,and front door center.



Showing med station to near right, work station near center, dining room far left, kitchen far right, living room far center.

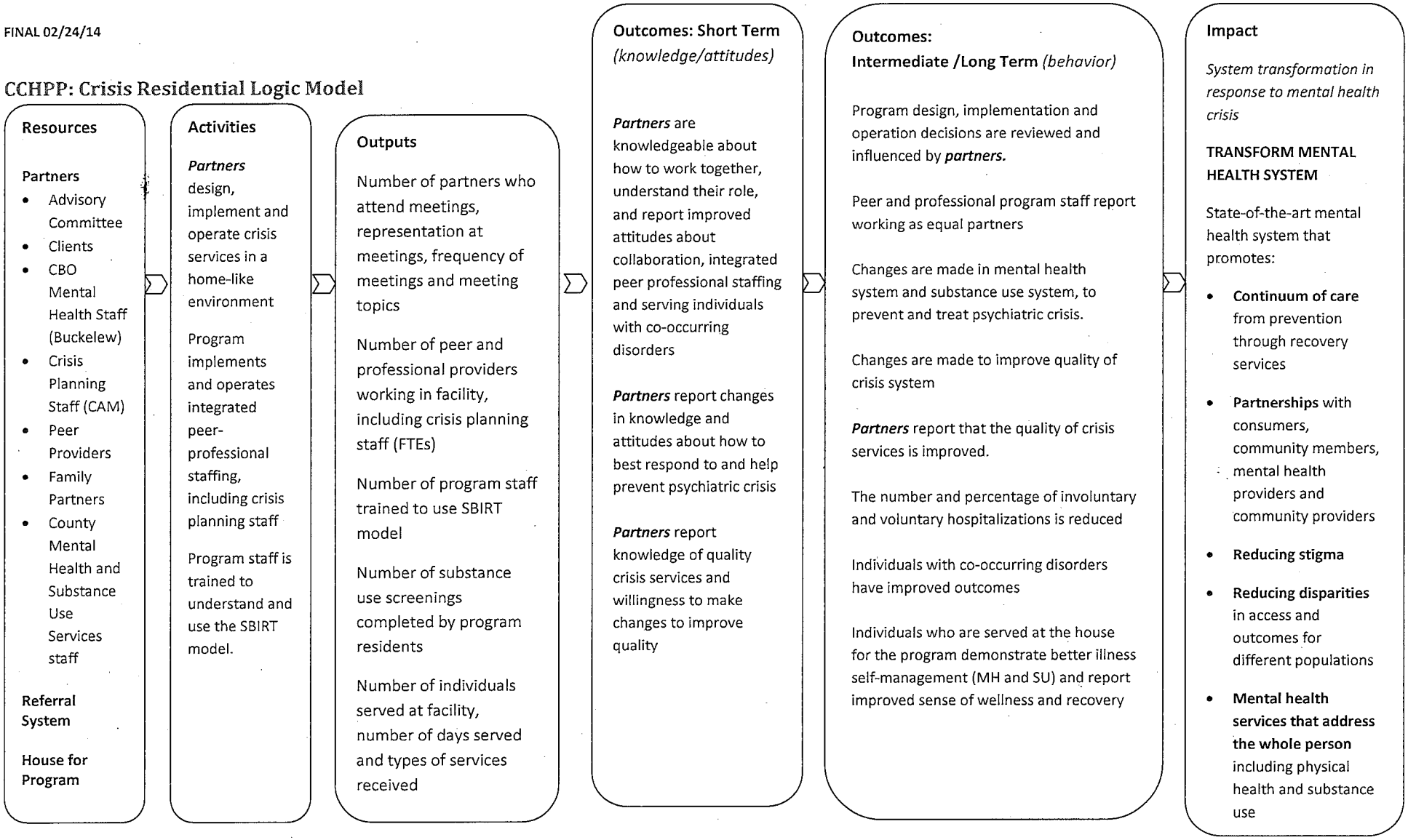
APPENDIX C

Client Choice and Hospital Prevention Program

Logic Model

FINAL 02/24/14

CCHPP: Crisis Residential Logic Model



APPENDIX D

Grant Writing Workshops

2.28.2014 and 3.14.2014

you are invited

Workshop Topics

Introduction to the Mental Health & Substance Use System of Care

Upcoming Funding Opportunities and Expectations

Tips for Developing and Submitting Proposals

Fiscal Sponsorship and Partnership Approaches

Technical Assistance Resources

Grant Writing Workshop

Tips and Tools to Prepare for Funding Opportunities in the Marin County Mental Health and Substance Use Services' System of Care

When and Where

February 28, 2014 - 1:00pm – 4:00pm

Marin County Health & Wellness Campus
3240 Kerner Blvd., Rooms 109-110, San Rafael

Who Should Attend?

While this workshop is open to everyone, this is an introductory workshop intended to provide information to individuals and organizations that have limited or no experience applying for County grants and/or providing services in the County system of care.

RSVP and Questions

For questions and/or to RSVP, please contact Cesar Lagleva: 415.473.2662 or clagleva@marincounty.org

Additional Session:
March 14, 2014 – 1:00pm – 4:00pm
First Missionary Baptist Church
501 Drake Avenue, Marin City

WELLNESS · RECOVERY · RESILIENCE

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety
www.marinhhs.org

COUNTY OF MARIN

All County public meetings are conducted in accessible locations. If you require transportation to participate at these meetings, please contact us at least 72 hours in advance by calling: (415) 473-2662 (Voice) or (415) 473-3344 (TTY) or by email at: clagleva@marincounty.org. Copies of documents used in this meeting are available in accessible formats upon written request.

you are invited

Workshop Topics

- Introduction to the Mental Health & Substance Use System of Care
- Upcoming Funding Opportunities and Expectations
- Tips for Developing and Submitting Proposals
- Fiscal Sponsorship and Partnership Approaches
- Technical Assistance Resources

Grant Writing Workshop

Tips and Tools to Prepare for Funding Opportunities in the Marin County Mental Health and Substance Use Services' System of Care

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First Missionary Baptist Church
501 Drake Avenue, Marin City

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MHSA IMPLEMENTATION COMMITTEE

Member Name	Affiliation
Suzanne Alfandari	County of Marin
Chris Asimos	Marin County Commission on Aging
Julie Baker	Ritter Center
Eileen Becker	Community Action Marin and Client Rep
Jessie Blake	Sunny Hills Services
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
Barbara Coley	Community Action Marin and Client Rep
Roberta English	NAMI of California
Elberta Eriksson	ISOJI/Multi-Disciplinary Team
Paula Glodowski Valla	County of Marin
Margaret Hallett	Buckelew Programs
Laine Vilensky Haynes	Marin General Hospital
Dawn Hensley	Community Action Marin and Family Partner
Marc Hering	Center Point, Inc.
Madeline Nieto Hope	West Marin Community Member
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
Nancy Masters	Jewish Family and Children's Services
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
Steven Siegal	Coastal Health Alliance
Diane Slager	County of Marin
Brian Slattery	Marin Treatment Center
Sean Stephens	County of Marin
Jasmine Stevenson	Huckleberry Youth Programs
Michele Stewart	Marin Mental Health Board and Client Rep
Linda Tavaszi	Marin Community Clinic
Michael Turrigiano	County of Marin

APPENDIX F

MHSA Logic Models

Marin MHSA Theory of Change Logic Model
DRAFT for review, 06/28/13

What does MHSA fund?

COMPONENTS

Community Supports and Services (CSS)

- Full Service Partnerships
- Systems Development
- Outreach & Engagement
- Housing (CSS-Housing)
- Technology Needs (TN)

Prevention & Early Intervention (PEI)

Innovation (INN)

Workforce Education & Training (WET)

What are the components doing?

STRATEGIES

Seek out and encourage input and participation from individuals who are using the public mental health system, community members, mental health providers and community providers to identify needs and trends that relate to mental health

Educate consumers, community members, mental health provider and community providers about the spectrum of mental health services and supports from prevention to recovery

Expand capacity for consumers and family members to effectively participate in the mental health system.

Train mental health and community providers to listen and respond to mental health needs

Implement activities, policies and organizational practices to **promote mental health wellness, resilience and social support.**

Provide mental health outreach and screenings to individuals at risk of mental illness

Provide integrated health services and supports to individuals at risk of or diagnosed with mental illness

Provide accessible, culturally-competent services for all individuals

Does it make a difference?

OUTCOMES

Increase in conversations between consumers, community members, mental health providers and community providers to address mental health needs and trends

Improved community understanding and response to mental health needs and trends, including **increased help-seeking and decreased stigma**

Increase in consumer and family involvement in the mental health workforce

Improved mental health and community provider understanding and response to mental health needs, including policies and organizational practices that promote wellness and increased program effectiveness due to planning, program development and evaluation

An increase in wellness and reduction in incidence of mental illness

Improved identification of individuals at risk for mental illness

Improved outcomes for those at risk of or diagnosed with mental illness, including co-occurring disorders

Increase in access to mental health services (from prevention through recovery) for unserved and underserved populations

What are the long-term changes?

IMPACT

TRANSFORMATION of the MENTAL HEALTH SYSTEM

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

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

Marin MHSA: Community Supports and Services (CSS) and Technology Needs (TN)

Strategies

Educate consumers, community members, mental health provider and community providers about the spectrum of mental health services and supports from prevention to recovery

- Outreach and engagement activities (Enterprise Resource Center and Service Site in Southern Marin)
- System Development Activities (Co-Occurring Capacity and Expansion of Adult System of Care)

Train mental health and community providers to listen and respond to mental health needs

- Co-location of substance use specialist at mental health service site for staff consultation and training

Provide mental health outreach and screenings to individuals at risk of mental illness.

- Co-location of substance use specialist at mental health service site for screening, assessment and referral.

Provide integrated health services and supports to individuals at risk of or diagnosed with mental illness

- Full Service Partnerships (FSPs) for Children, Transition Age Youth, Homeless, Older Adults and Mentally Ill Offenders (includes employment, education, physical health, substance abuse and flexible fund services)
- Implement policy and procedure changes to institutionalize co-occurring capacity.

Provide accessible, culturally-competent services for all individuals

- Regional Service Site in Southern Marin
- Mandatory cultural competency training for all FSP providers
- Bilingual and bicultural staff

Expand capacity for family and consumers to effectively participate in the mental health system.

- Enterprise Resource Center Expansion
- Family and peer involvement in FSPs and Adult System of Care
- Technology for targeted service sites (TN)
- Tobacco cessation needs assessment and training

Outcomes

Increase in conversations between consumers, community members, mental health providers and community providers to address mental health needs and trends

- Increased communication between consumers, families, ethnic communities, mental health providers, substance use providers and community providers (including law enforcement, vocational service providers and housing programs) participating in FSPs

Improved community understanding and response to mental health needs and trends

- Improved understanding and response to the MH and SU needs of older adults, mentally ill offenders, and Vietnamese and Hispanic/Latino communities.

Improved mental health and community provider understanding and response to mental health needs

- Increased participation and involvement of clients and families in all aspect of public mental health and substance use system
- Increased access to, and array of mental health services, co-occurring services, and community services for individuals with Serious Mental Illness (SMI) and youth with Severe Emotional Disturbance (SED)
- Increased access to client and family operated services
- Increased MH provider and substance use provider understanding of the Vietnamese and Spanish-speaking community norms and culture
- Increased access to mental health and substance use services for Vietnamese and Spanish-speaking individuals with SMI

Improved identification of individuals at risk for mental illness

- Improved screening of substance use clients for mental health concerns.
- Improved access for unserved clients of Vietnamese and Hispanic/Latino origin

Improved outcomes for those at risk of or diagnosed with mental illness, *including co-occurring disorders*

- Increase in independent living skills/self-sufficiency, illness, and medication management skills
- Increase in housing and decrease in homelessness for individuals with Serious Mental Illness (SMI) and youth with Severe Emotional Disturbance (SED)
- Increased opportunities for meaningful use of time (recreation and socialization, vocational training, employment) for individuals with Serious Mental Illness (SMI) and youth with Severe Emotional Disturbance (SED)
- Increase in the network of supporting relationships for individuals with Serious Mental Illness (SMI) and youth with Severe Emotional Disturbance (SED) and their families

Impact

TRANSFORM THE 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 among diverse populations
- **Mental health services that address the whole person** including physical health and substance use

What does PEI fund? ACTIVITIES	What are the programs doing? STRATEGIES	Does it make a difference? OUTCOMES	What are the long-term changes? IMPACT
Youth • Consultation and training for early childhood education sites • Training for providers in Triple P (Positive Parenting Program) • Mentoring for MLK Academy students *TAY (16-25)* • Screening and brief intervention in TAY clinics • Psycho-education workshops • Screening in school *Adult* • Support groups in Canal • Problem solving (Canal, Vietnamese) • Screening and brief intervention in primary care *Older Adult* • Community education • Screening and brief intervention • Peer counseling in Spanish *Community* • Mental Health First Aid • Community Connection/ Community Health Workers (Latino, Vietnamese, So Marin) • Community Coalitions • Legal services • Crisis Planning (see Innovation)	Seek out and encourage input and participation to identify needs/trends • PEI Committee shares information, builds a culture of prevention, and builds an integrated PEI system of care • Program advisory committees guide implementation of PEI programs • Community Coalitions identify mental health related needs and trends Educate consumers, community members, mental health providers and community providers about the spectrum of mental health services • Train community members about mental illness, identifying signs/symptoms and connecting individuals to help • Train gatekeeper to identify signs/symptoms and connect individuals to help • Educate at-risk populations on mental health issues, coping skills, and resources Train mental health and community providers to listen and respond to mental health needs • Train early childcare staff, school staff, primary care providers, front-line workers, community health advocates and others to identify signs/symptoms of mental health concerns and provide referrals for help Provide mental health outreach and screenings to individuals at-risk • Provide screening in a variety of community settings to identify individuals with behavioral health concerns Provide mental health services and supports • Provide education, support groups, problem solving and brief intervention in a variety of community settings • Provide evidence based interventions Provide accessible, culturally competent services • Provide resources for trusted agencies and individuals in un/underserved communities to address behavioral health concerns and increase access to additional services *Implement activities, policies, and organizational practices that promote mental health wellness, resilience and social support* • *Train early childhood education sites to support healthy development of students* • *Community Coalitions identify mental health related community conditions and strategies for improving them*	Increase in conversations between consumers, community members, mental health providers and community providers to address mental health needs and trends • Community participation and collaboration increase the conditions that promote wellness and access to a spectrum of mental health and other supportive services Improved community understanding and response to mental health needs and trends • Community trainings increase understanding of behavioral health, awareness of signs/symptoms and resources, and reduce stigma Improved mental health and community provider understanding and response to mental health needs • PEI Committee increases knowledge among providers of effective behavioral health services they can provide and services they can refer to • Provider trainings result in increased mental health knowledge and skills in identifying and providing intervention for behavioral health concerns Improved identification of individuals at risk for mental illness • Screening increases identification of individuals with behavioral health concerns • Trained providers and community members increases identification at-risk individuals Improved outcomes for those at risk or diagnosed with mental illness • Improved mental health status • Increased resiliency & coping skills • Increased support, reduced stressors *Increased help-seeking and decreased stigma* • *Increase in numbers of individuals and families receiving PEI services* • *Increase in numbers of un/underserved individuals and families receiving PEI services* *Increase in conditions that support wellbeing* • *Improved organizational practices* • *Increased family functioning, connection, access to basic needs* *An increase in wellness, reduction in incidence of mental illness, and reduction in negative outcomes associated with mental illness* • *Increased resilience* • *Earlier access to MH services* • *Reduced need for more intensive services* • *Decreased suicide* • *Reduced incarcerations* • *Reduced school failure or dropout* • *Reduced unemployment* • *Reduced suffering* • *Reduced homelessness* • *Reduced removal of children from the home*	Transformation of the Mental Health System State-of-the-art mental health system that promotes: • Continuum of care from Prevention through Recovery • Partnerships with consumers, community members, mental health providers and community providers • Reducing stigma • Reducing disparities in access and outcomes among diverse populations • Mental health services that address the whole person including physical health and substance use

Marin MHSA: Workforce Education and Training

Strategies

Seek out and encourage input and participation from individuals who are using the public mental health system, community members, mental health providers and community providers to identify needs and trends that relate to mental health

- Training Committee
- Consumer and Family Subcommittees

Train mental health and community providers to listen and respond to mental health needs

- Scholarships for consumers and family members
- Consumer-focused training
- Family-focused training
- Clinical Practice Forums
- Peer Consultation Network
- Targeted training in EBP
- System-wide dual diagnosis training

Provide accessible, culturally-competent services for all individuals

- Intern stipends
- Psychiatric Nurse Practitioner stipends
- Scholarships for members of under-represented populations

Previous Strategy

- *Leadership Institute*

Outcomes

Increase in conversations between consumers, community members, mental health providers and community providers to address mental health needs and trends

- Membership of Training Committee and influence on trainings
- Consumer, family member and mental health provider participation in WET programs

Improved mental health and community provider understanding and response to mental health needs

- Providers report change in understanding and changes in clinical practice as a result of participation in WET programs
- Increase in implementation and use of evidence-based practices and dual diagnosis treatment
- Improved cultural competency of MH workforce
- Improved partnerships between peers and providers
- Increase in experts in mental health system to provide training and support

Outcome about consumer and family involvement in workforce

Outcome about planning, program development and evaluation (based on trainings and staff development)

Impact

TRANSFORM THE 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 among diverse populations
- **Mental health services that address the whole person** including physical health and substance use

Marin MHSA Innovation

Strategies

Seek out and encourage input and participation from individuals who are using the public mental health system and mental health providers to identify needs and trends that relate to mental health

- Promote partnerships with Advisory Committee, crisis planning peer staff community mental health provider and county mental health services in order to design, implement and operate program.

Train mental health and community providers to listen and respond to mental health needs

- Integrated Peer Professional Staffing
- Training for staff to use client-driven crisis plans
- Training for staff to screen for co-occurring disorders

Provide integrated mental health services and supports to individuals at risk of or diagnosed with mental illness

- Client-driven crisis planning
- Least-restrictive, recovery-oriented treatment environment

Provide accessible, culturally-competent services for all individuals

- TAY, Adults, Older Adults, Transgender, etc.

Outcomes

Increase in conversations between consumers, community members, mental health providers and community providers to address mental health needs and trends

- Program design, implementation and operation are influenced by partnerships between county mental health services and Advisory Committee, crisis planning peer staff and community mental health provider.
- Improved partnerships between peers and professionals

Improved mental health and community provider understanding and response to mental health needs

- "Reorient perception of how mental health system and community can best respond to and help prevent psychiatric crisis"
- Increased quality of services
- Improved collaboration with substance use services providers

Improved mental health outcomes for those at risk of or diagnosed with mental illness

- Reduced hospitalizations
- Improved intervention for substance use
- Better illness self-management

Impact

TRANSFORM THE 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 among diverse populations
- **Mental health services that address the whole person** including physical health and substance use

APPENDIX G

County Proposals for MHSA Three-Year Community Planning Process

Preliminary Proposal for MHSA Three Year Integrated Plan

PROGRAM	*TARGET POPULATION*
EXISTING PROGRAMS PROPOSED TO CONTINUE	
(CSS) Youth empowerment services (CSOC)	Youth (0-18)
(CSS) Transition Age Youth FSP	Transition Age Youth (16-25)
(CSS) Support & Treatment After Release (STAR)	Adult (18+) in justice system
(CSS) Helping Older People Excel (HOPE)	Older Adult (60+)
(CSS) Odyssey	Adult (18+) who are homeless
(CSS) Enterprise Resource Center	Adult (18+)
(CSS) Southern Marin Services Site	So Marin
(CSS) Adult System of Care (ASOC)	Adult (18+)
(PEI) Early Childhood Mental Health	Children (0-5)
(PEI) Transition Age Youth Program (in existing TAY services)	Transition Age Youth (16-25)
(PEI) Canal Community Based (PEI) Community Health Advocates	Latino
(PEI) Integrated Behavioral Health	Adult (18+)
(PEI) Older Adult PEI / ACASA	Older Adult (60+)
(PEI) Vietnamese Community Connection	Vietnamese
(PEI) Crisis Planning	At risk of psychiatric crisis
(CSS) Co-occurring capacity	Co-occurring
(INN) Client Choice & Hospital Prevention	At risk of psychiatric crisis
(WET/CSS) Intern stipends	
(WET) Evidence based practices	Mental health providers
(WET) Consumer & Family focused trainings & stipends	Consumers/families
(Housing) Next Project to be determined	
(CFTN) Information technology upgrades	
PROPOSED NEW PROGRAMS	
(CSS) Alliance in Recovery (AIR)	Adult (18+) co-occurring clients
(CSS) Step Down Program	Adult (18+)
(CSS) Assisted Outpatient Treatment	Adult (18+)
(PEI) Southern Marin Youth Services	So Marin Youth
(PEI) School Age Programs	Youth (5-18)
(PEI) Suicide Prevention	Community
(CSS) Pay equity	Peer providers
PROGRAMS PROPOSED TO BE DISCONTINUED	
(PEI) Triple P: Positive Parenting Program	Families
(PEI) Across Ages Mentoring (see Proposed New Programs)	So Marin Youth
(PEI) Mental Health Community Training (MH First Aid)	Community
(PEI) Teen Screen	Teens (12-18)
(PEI) Community Coalitions	Community
(PEI) Legal Aid Services	Adult (18+)
(PEI) So Marin Community Connection	So Marin
(PEI) TAY Skills Workshops	Teens (12-18)

APPENDIX H

MHSA Program Descriptions – Proposed New

Mental Health Services Act
Three Year Integrated Plan
PROPOSED NEW PROGRAMS

ADULT / OLDER ADULTS SERVICES

ALLIANCE IN RECOVERY (CSS)
Intensive outreach and engagement services for adults with co-occurring mental health and substance use disorders.

STEP DOWN PROGRAM (CSS)
A wellness and recovery program for individuals who no longer need the intensive case management services provided by the formal Adult System of Care (ASOC).

ASSISTED OUTPATIENT TREATMENT (MEETS LAURA'S LAW CRITERIA) (CSS)
Assertive outreach to engage individuals with untreated or inappropriately treated serious mental illness in voluntary treatment. If not successful, Assisted Outpatient Treatment under court order would be provided.

CHILDREN / YOUTH PROGRAMS

SOUTHERN MARIN YOUTH SERVICES (PEI)
Provide prevention and early intervention services for southern Marin youth. The strategy is yet to be determined.

SCHOOL AGE PROGRAMS (PEI)
Provide prevention and early intervention services for school age youth. The strategy is yet to be determined.

OTHER PROGRAMS

SUICIDE PREVENTION (PEI)
Support the existing suicide hotline and suicide prevention services.

PAY EQUITY (CSS)
Increase pay rates for mental health peer providers.

NOTE: PROPOSED NEW PROGRAM IDEAS ARE FROM VARIOUS COUNTY STAFF AND COMMUNITY STAKEHOLDERS THAT HAVE BEEN COLLECTED BY MHSUS OVER THE LAST FEW YEARS.

APPENDIX I

MHSA Community Meeting Documents – all languages

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

WELLNESS · RECOVERY · RESILIENCE

Marin County
Mental Health and Substance Use Services Division (MHSUS)

Mental Health Services Act (MHSA)

AGENDA

"Circling Stigma"
2013 Award Winning Public Service Video
by Spencer Wilson,
Novato High School Student

I. Purpose of Community Conversation

II. Overview of Three Year Integrated Planning Process for MHSUS Services and Supports

III. Questions and Answers

IV. Small Group Discussions

V. Summary

Mental Health Services Act (MHSA)
Public Meeting at LOCATION/CITY
DATE

Marin County is committed to talking to people throughout the county. Your answers to these questions help us understand who we have heard from and who we still need to reach out to.

Your Gender:

☐ Male ☐ Female

Your Age:

☐ 0 – 15 years old ☐ 16 – 25 years old

☐ 26 – 59 years old ☐ 60+ years old

Your Primary Language:

☐ Arabic ☐ Cambodian ☐ Cantonese ☐ English

☐ Farsi ☐ Hmong ☐ Mandarin ☐ Russian

☐ Spanish ☐ Tagalog ☐ Vietnamese

☐ Other (please specify)_____

Your Race / Ethnicity:

☐ African/American ☐ Asian ☐ Hispanic ☐ Native

☐ Pacific Islander ☐ White ☐ More than one race/ethnicity

☐ Other (please specify)_____

Where do you live in Marin County?

☐ Central Marin ☐ Northern Marin ☐ Southern Marin

☐ West Marin ☐ Other (please specify)_____

Do you represent any of the following groups in our community? (check all that apply)

☐ Homeless ☐ Law Enforcement ☐ LGBTQ ☐ Veterans

☐ Someone who uses/has used Mental Health and/or Substance Use Services

☐ Family Member of someone who uses/has used Mental Health and/or Substance Use Services

☐ Provider of Mental Health and/or Substance Use Services

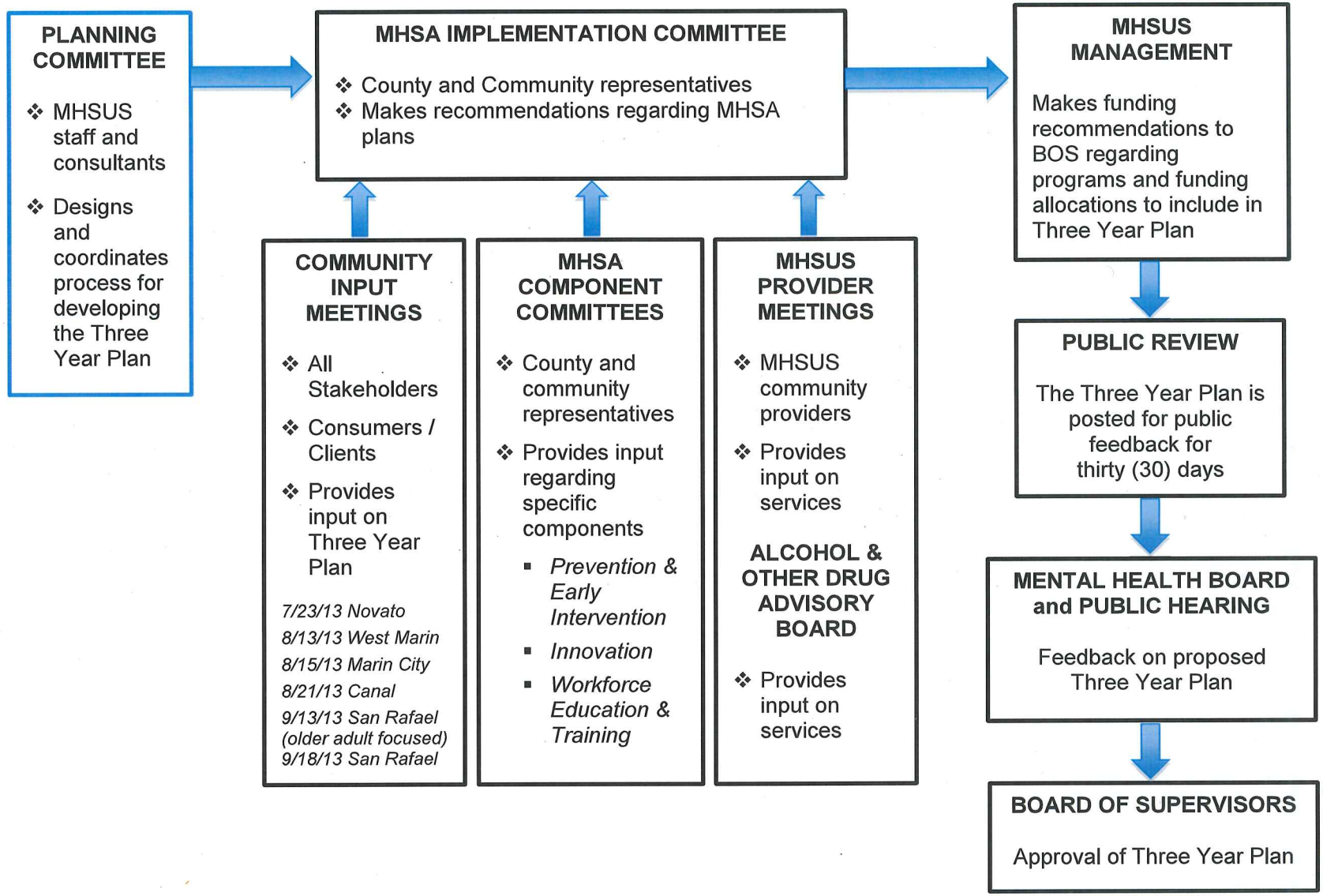
☐ Other (please specify)_____

Marin County Mental Health and Substance Use Services
Vision for Mental Health Services Act Three Year Integrated Plan

MHSUS aims to apply MHSA principles and resources towards a System of Care that:

VISION	Practice
➢ Is guided by community participation	*We will make every effort to capture the voice of our community, through outreach, surveys and forums.*
➢ Is culturally competent and effectively serves underserved communities	*Programs will reflect the culture of the individuals we serve and we will continue to improve service access for the underserved.*
➢ Empowers participants in their recovery, integrating client and family-driven services	*All services are led by the person being served with guidance from the family that supports them as defined by the client.*
➢ Develops an intervention model that is "help first" rather than "fail first"	*We embrace innovation, outreach, engagement, prevention, and interventions that start early and do not give up on people.*
➢ Integrates mental health and substance use care with other essential services	*Wellness includes an integration of all the resources needed, health care, social services, substance abuse and mental health.*
➢ Effectively responds to mental health and substance use concerns in collaboration with primary care	*The consumer guides us with the problems they need to address; our services are organized to meet the needs as presented.*
➢ Demonstrates the effectiveness of services via outcomes	*We begin where possible with evidence based services, then evaluate and adapt to create the most beneficial outcome.*

MHSA Three-Year Plan
Community Input Process



Marin County
Mental Health and Substance Use Services Division
Mental Health Services Act (MHSA)
Continuum of Services

	Prevention:	**Early Intervention:**	**Treatment:**	**Recovery:**
	Increase well-being and reduce risks for Mental Health and Substance Use issues	*Identifying Mental Health and Substance Use issues early and providing help*	*Services and supports for people with Mental Illness or co-occurring disorder**	*Maintaining Well-being when living with a Mental Illness or co-occurring disorder**
Children **Youth** **Adults** **Older Adults**	Examples: • Improve family relationships • Increase coping skills • Increase social support	Examples: • Screening for symptoms • Brief services • Linkages to needed services	Examples: • Wrap-around and Full Service Partnerships • Therapy • Medications • Independent living skills	Examples: • Peer support • Using naturally occurring supports • Employment and education support

* Co-occurring disorder is when a mental health and a substance use disorder occur simultaneously in the same person.

MENTAL HEALTH SERVICES ACT (MHSA)

Community Conversation

Three Year Integrated Plan

Fiscal Years

2014-15, 2015-16, 2016-17

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

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

Today's Purpose

Gather input on the direction of Marin County's mental health and substance use services for the Mental Health Services Act (MHSA) Three Year Integrated Plan for July 2014 through June 2017.

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

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

Marin's Vision

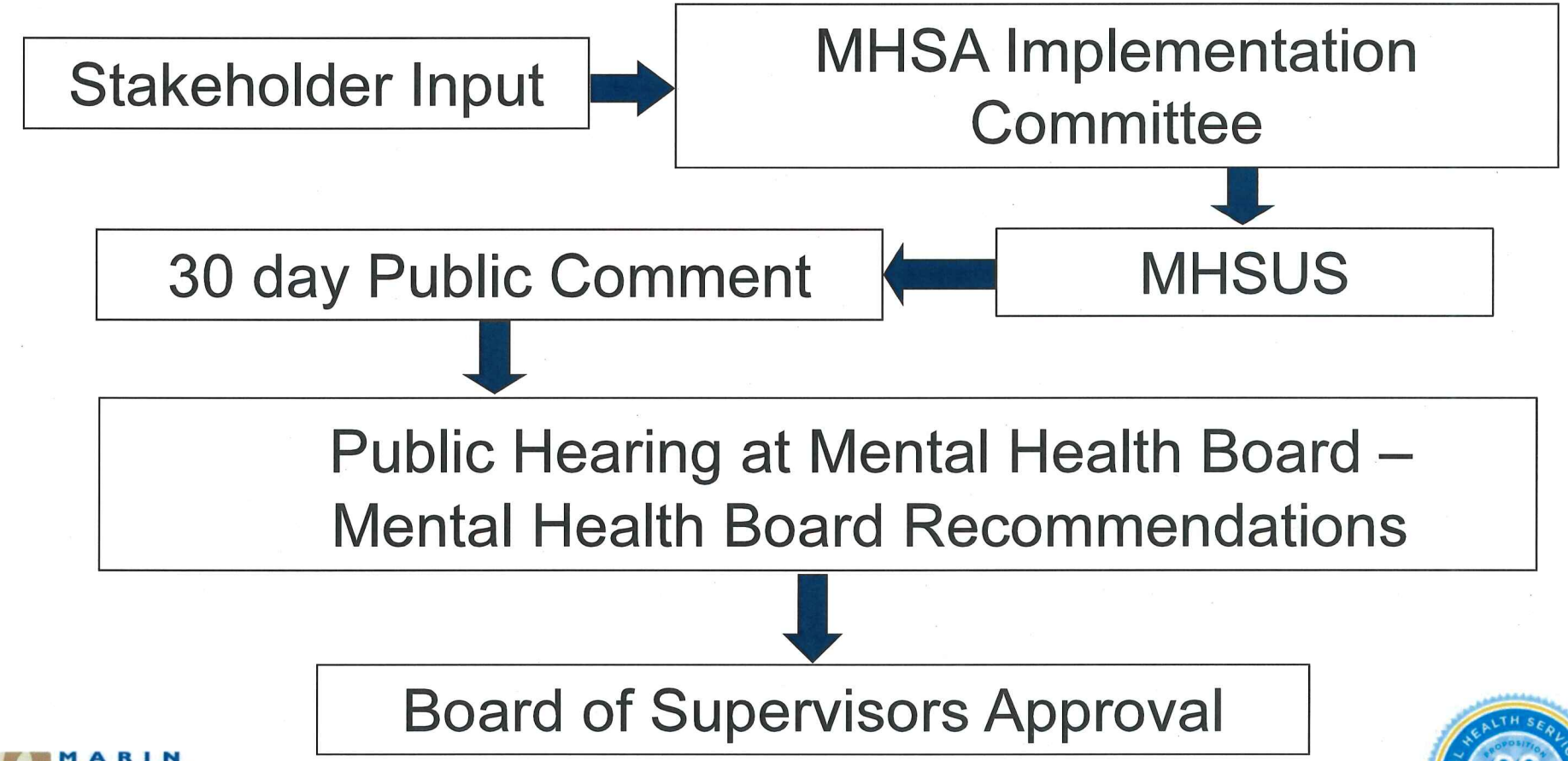
- Is guided by community participation
- Is culturally competent and effectively serves underserved communities
- Empowers participants in their recovery, integrating client and family-driven services
- Develops an intervention model that is "help first" rather than "fail first"
- Integrates mental health and substance use care with other essential services
- Effectively responds to mental health and substance use concerns in collaboration with primary care
- Demonstrates the effectiveness of services via outcomes

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

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

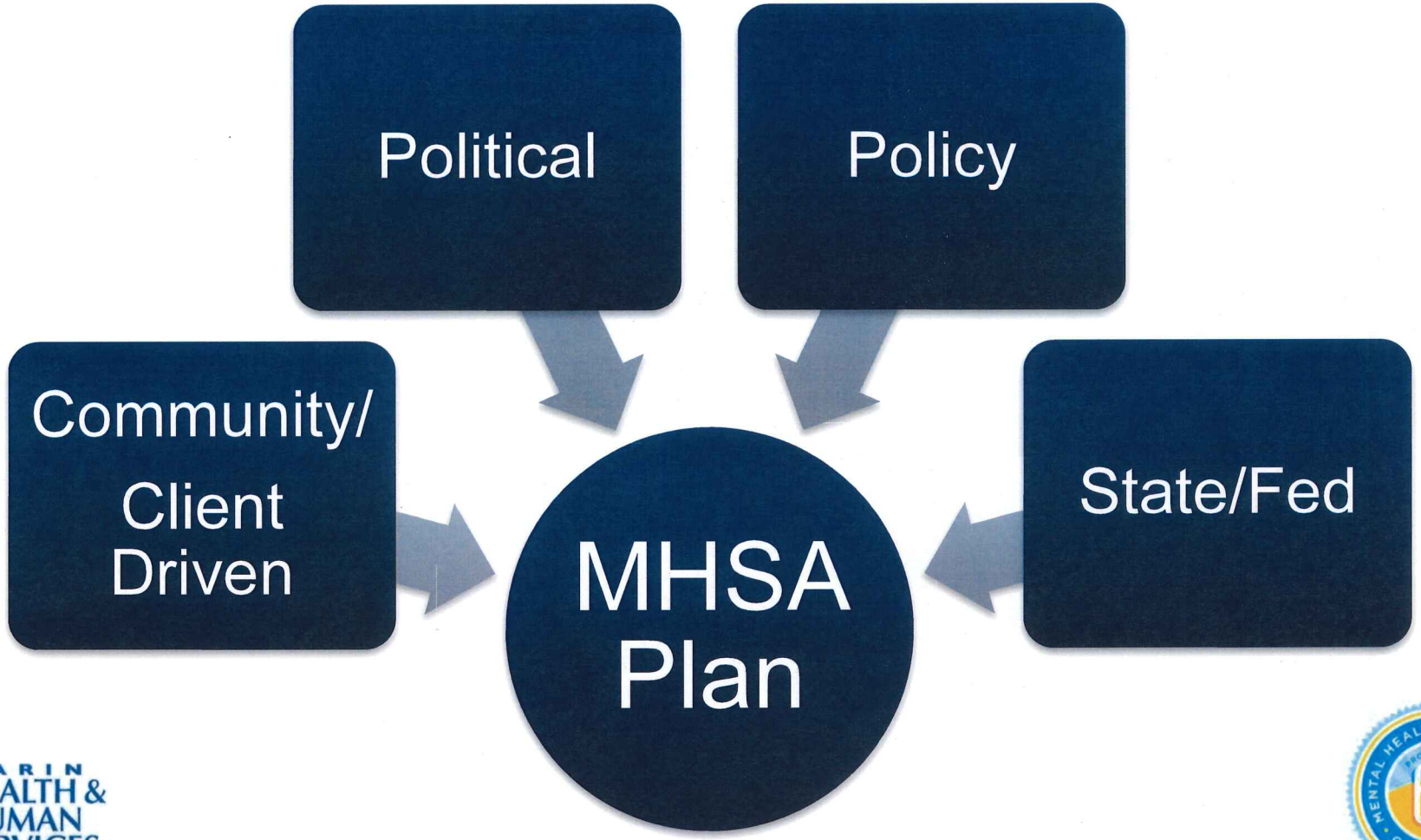
Marin Three Year Plan Process



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

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

Planning Environment



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

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

Story of MHSA

- Community Services & Supports (CSS)
- Housing (CSS)
- Prevention & Early Intervention (PEI)
- Workforce Education & Training (WET)
- Innovation (INN)
- Capital Facilities & Technology Needs (CF/TN)

Strategies

Outcomes

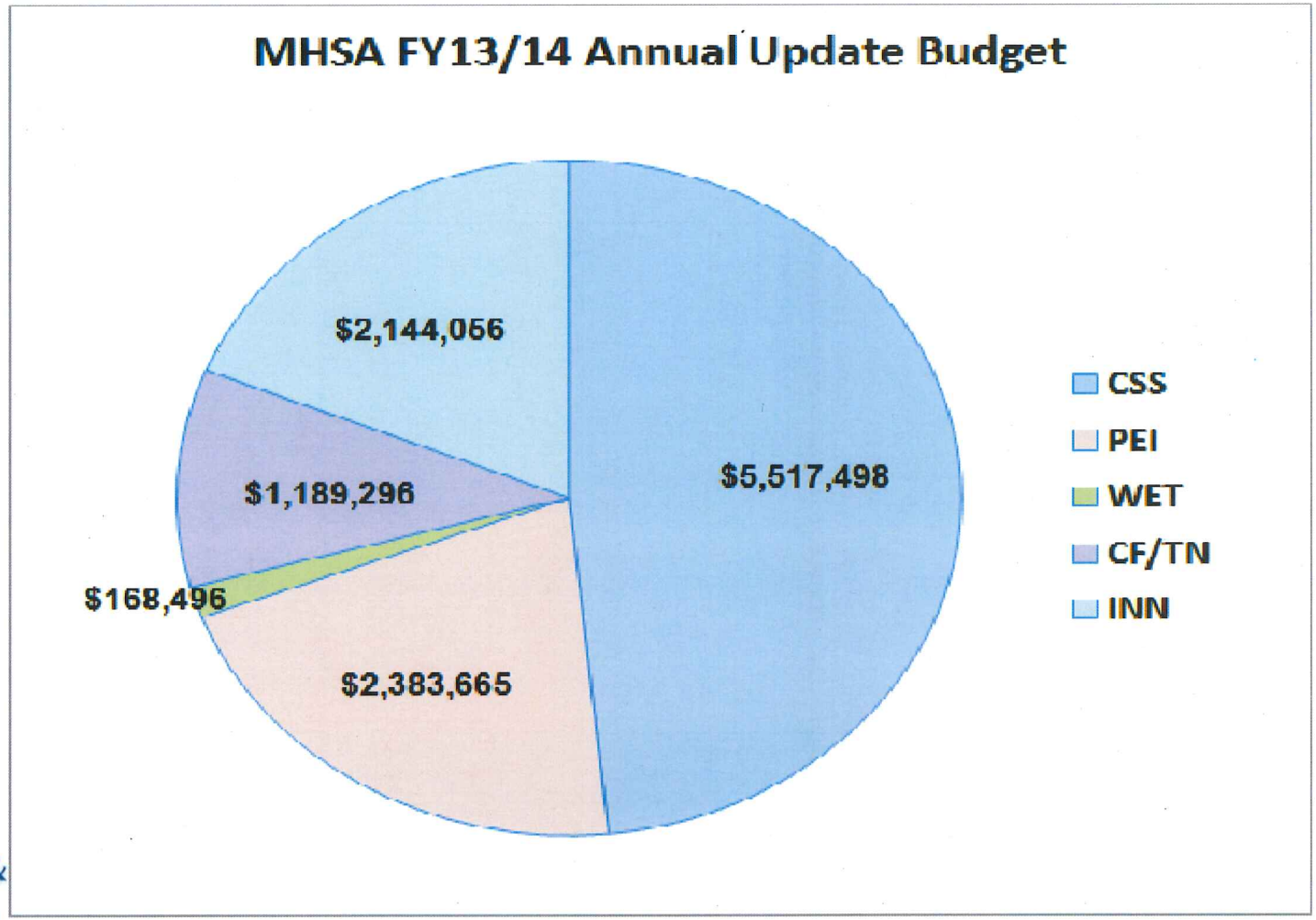
Vision / Impact

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

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

MHSA Current Funding by Component



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

WELLNESS • RECOVERY • RESILIENCE

MHSA Annual Funding

- Approximate program funds for Three Year Plan:
  - CSS $4,219,180 / year
  - PEI $1,447,500 / year
- Program funds based on State projected MHSA revenues and "troweled" across to provide consistent funding for programs throughout the Three Year planning period.
- Adjust existing programs to better address needs.
- As always, some programs will be adjusted or even end as of June 30, 2014.

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

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA
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MHSA Planning Going Forward

Community Meeting Schedule:

- 7/23 Novato Youth Center in Novato - 6:30pm
- 8/13 Dance Palace in Pt. Reyes – 6:30pm
- 8/15 Margarita C. Johnson Senior Center in Marin City – 6:30pm
- 8/21 Albert J. Boro Community Center in San Rafael – 6:30pm
- 9/13 Marin HHS Connection Center in San Rafael 10am
- 9/18 San Rafael Community Center in San Rafael 6:30pm

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

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

MHSA Survey and Online Access

To stay up-to-date with the latest information regarding Marin County's Mental Health Services Act (MHSA) Three Year Integrated Planning efforts, please check the MHSA website at:

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

If you have further input after this meeting, fill out the MHSA Survey on this website to add your feedback.

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

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

Mental Health and Substance Use Services and Supports in Marin County

Where Are We Now in Marin County Mental Health and Substance Use Services and Supports?

- We are asking the community to help us figure out what kinds of mental health and substance use services and supports are most needed.
- We are telling the community about the kinds of services and supports available.
- We are figuring out ways for consumers and their families to help provide services and supports.
- We are training people how to listen and provide person-centered services and supports.
- We are using the values of good health and community support in everything we do.
- We are working on ways to reach people before they have serious mental health or substance use challenges.
- We are working on ways to help people within all parts of their lives.
- We are doing whatever we can do to make sure that everyone who wants or needs services and supports has access to them.

What kinds of Mental Health and Substance Use Services and Supports Do We Want in Marin County?

- We want mental health and substance use services and supports for everyone.
- We want services and supports for all types of life's challenges.
- We want services and supports that look at all parts of a person's life.
- We want to make sure that people have no barriers to use services and supports when needed.
- We want to work with our community partners to provide services and supports.

How Will We Make Those Changes?

- We will talk with individuals, families, service providers and community members about changes needed in mental health and substance use services and supports.
- We will help the community understand the importance of using services when they are needed.
- We will develop service and support jobs for individuals with mental health and substance use needs and their families.
- We will support changes in services and supports that lead to better life quality for individuals.
- We will support changes in services and supports that lead to less need for services.
- We will make sure that individuals, who don't use services and need them, know about and use the services they need.

Mental Health Services Act - Overview

In November 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), intended to expand and transform community mental health services throughout California. While the proposition passed with 54% of the vote statewide, Marin County voted 63% in favor. The MHSA raises additional taxes for the State, which are then allocated to respective county mental health programs under extensive regulations developed by the State Department of Mental Health.

Mental Health Services Act 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

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; increase 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 to mental health clients and their families or for administrative offices. TN funds are to develop or improve technological systems, such as electronic health records.

Marin Un- and Underserved Populations

Mental Health Services Act is intended to address the needs of communities that are currently un- or underserved. During Marin's MHSA planning process in 2004 the following populations were identified as un/underserved by existing County mental health services:

- Latino adults were identified as the most un/underserved
- Asian Pacific Islanders
- African Americans are over-represented among County clients, possibly due to lack of services that might reduce the need for intensive service
- Older adults
- Transition age youth (16-25 years old)
- West Marin residents

Other State Identified Un- and Underserved Populations

- Veterans
- LGBTQ

Demographics of those served from July 1, 2011-June 30, 2012

Community Supports and Services (total served: 1637)

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

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

Prevention & Early Intervention (total served: 9440)

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

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

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

WELLNESS • RECOVERY • RESILIENCE

Condado de Marin
División de Servicios de Salud Mental y
Contra el Abuso de Sustancias (MHSUS)

Ley de Servicios de Salud Mental (MHSA)

ORDEN DEL DÍA

"Circling Stigma"
Video de servicios públicos premiado en el 2013
por Spencer Wilson,
Estudiante de Novato High School

I. **Propósito de la conversación con la comunidad**

II. **Panorama del proceso de planeación integral a tres años para servicios y apoyos MHSUS**

III. **Preguntas y respuestas**

IV. **Discusiones en grupos pequeños**

V. **Resumen**

Ley de Servicios de Salud Mental (MHSA)
Reunión pública en Albert J. Boro Community Center, San Rafael, CA
21 de agosto de 2013

El Condado de Marin está comprometido a hablar con la gente en todo el condado. Sus respuestas a estas preguntas nos ayudarán a entender quién nos ha contestado y a quién aún nos falta acercarnos.

Su sexo:

☐ **Masculino** ☐ **Femenino**

Su edad:

☐ **0 – 15 años de edad** ☐ **16 – 25 años de edad**

☐ **26 – 59 años de edad** ☐ **60 años de edad o mayor**

Su idioma principal:

☐ **Árabe** ☐ **Camboyano** ☐ **Cantonés** ☐ **Inglés**

☐ **Farsi** ☐ **Hmong** ☐ **Mandarín** ☐ **Ruso**

☐ **Español** ☐ **Tagalog** ☐ **Vietnamita**

☐ **Otro (por favor especifique)**_____

Su raza / origen étnico:

☐ **Afroamericano** ☐ **Asiáatico** ☐ **Hispano** ☐ **Nativo**

☐ **Isleño del Pacífico** ☐ **Blanco** ☐ **Más de una raza/etnia**

☐ **Otra (por favor especifique)**_____

¿Dónde vive usted en el Condado de Marin?

☐ **Centro de Marin** ☐ **Norte de Marin** ☐ **Sur de Marin**

☐ **Oeste de Marin** ☐ **Otro (por favor especifique)**_____

¿Representa usted a alguno de los siguientes grupos de nuestra comunidad? (marque todos los que apliquen)?

☐ **Sin hogar** ☐ **Cuerpos policiales** ☐ **LGBTQ** ☐ **Veteranos**

☐ **Alguien que usa/ha usado servicios de salud mental y/o contra abuso de sustancias**

☐ **Familiar de alguien que usa/ha usado servicios de salud mental y/o contra abuso de sustancias**

☐ **Proveedor de servicios de salud mental y/o contra abuso de sustancias**

☐ **Otro (por favor especifique)**_____

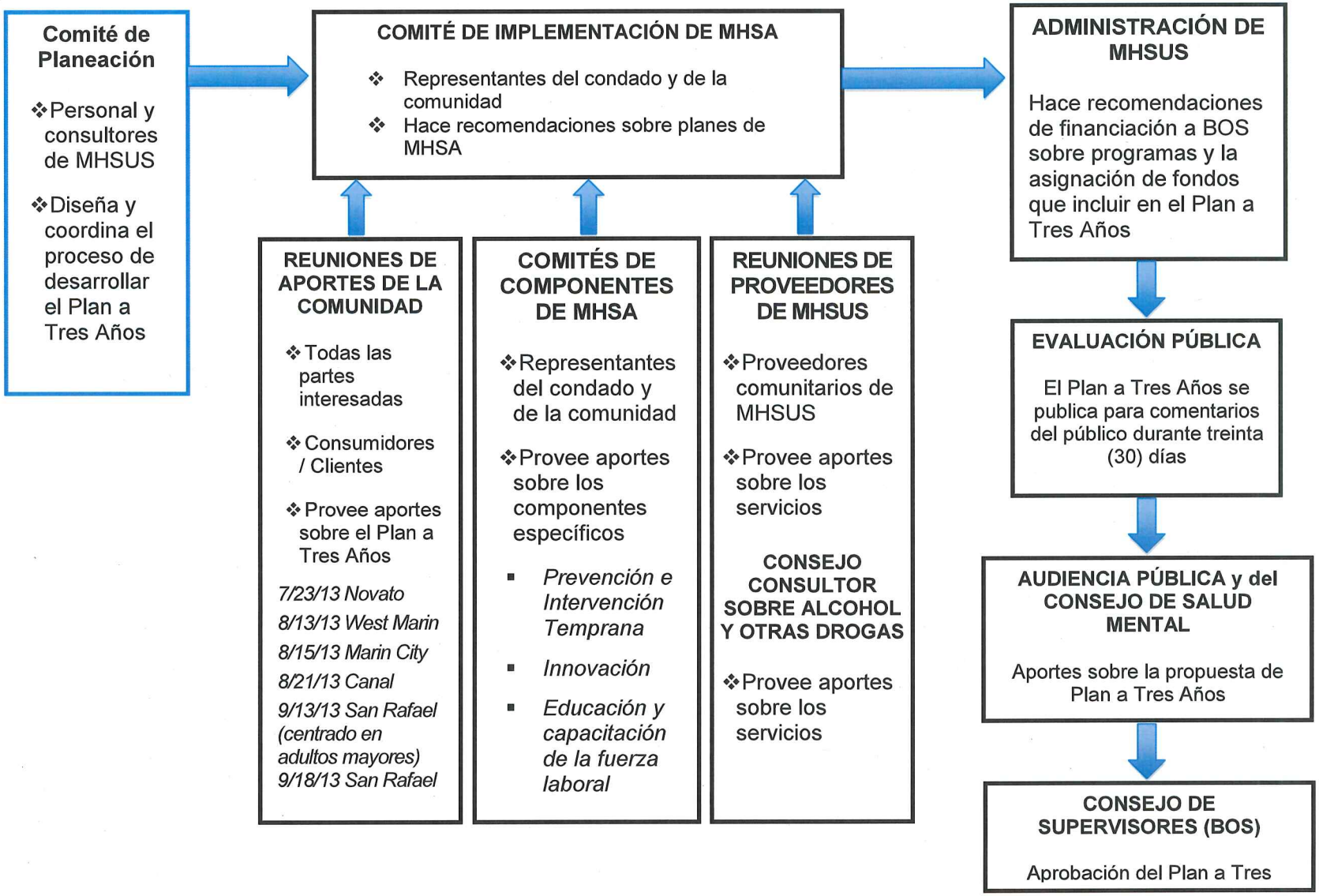
Servicios de Salud Mental y Contra el Abuso de Sustancias del Condado de Marin

Visión para el Plan Integral a Tres Años de la Ley de Servicios de Salud Mental

MHSUS busca aplicar los recursos y principios de la MHSA para un Sistema de Cuidado que:

VISIÓN	*Práctica*
➢ ***Se guía mediante la participación comunitaria***	*Haremos todos los esfuerzos para captar la voz de nuestra comunidad, mediante el acercamiento, las encuestas y los foros.*
➢ ***Es culturalmente competente y atiende eficazmente a las comunidades desatendidas***	*Los programas reflejarán la cultura de las personas a las que atendemos y seguiremos mejorando el acceso al servicio para las personas subatendidas.*
➢ ***Hace responsables a los participantes dentro de su propia recuperación, integrando servicios impulsados por la familia y por el cliente***	*Todos los servicios son dirigidos por la persona que está siendo atendida con la guía de la familia que los apoyo en la medida que lo permite el cliente.*
➢ ***Desarrolla un modelo de intervención que sea "ayuda primero" en lugar de "primero la falla"***	*Acogemos la innovación, el alcance, la participación, la prevención y las intervenciones que inician temprano y no nos rendimos con las personas.*
➢ ***Integra el cuidado de la salud mental y del abuso de sustancias con otros servicios esenciales***	*El bienestar incluye una integración de todos los recursos necesarios, el cuidado de la salud, los servicios sociales, el abuso de sustancias y la salud mental.*
➢ ***Responde de forma eficaz a las preocupaciones de salud mental y de abuso de sustancias en colaboración con la atención primaria***	*El consumidor nos guía con los problemas que necesita abordar; nuestros servicios se organizan para cumplir con las necesidades tal y como fueron presentadas.*
➢ ***Demuestra la eficacia de los servicios mediante los resultados***	*Cuando es posible comenzamos con servicios basados en evidencias, luego evaluamos y adaptamos para crear el resultado más benéfico.*

Plan a tres años de MHSA
Proceso de aportes de la comunidad



Condado de Marin
División de Servicios de Salud Mental y Contra el Abuso de Sustancias
Ley de Servicios de Salud Mental (MHSA)
Servicios Permanentes

	Prevención:	**Intervención temprana:**	**Tratamiento:**	**Recuperación:**
	Aumentar el bienestar y reducir los riesgos de problemas de salud mental y abuso de sustancias	*Identificar problemas de salud mental y abuso de sustancias en la fase temprana y proveer ayuda*	*Servicios y apoyos para personas con enfermedad mental o un trastorno concurrente**	*Mantener el bienestar cuando se vive con enfermedad mental o un trastorno concurrente**
Niños **Adolescentes** **Adultos** **Adultos mayores**	Ejemplos: • Mejorar las relaciones familiares • Aumentar las habilidades de lidiar con dificultades • Aumentar el apoyo social	Ejemplos: • Detección de síntomas • Servicios breves • Vínculos a servicios necesitados	Ejemplos: • Servicios personalizados y de servicio completo • Terapia • Medicamentos • Habilidades para una la independiente	Ejemplos: • Apoyo de compañeros • Uso de apoyos naturales • Apoyos para empleo y educación

* Un trastorno concurrente se da cuando trastornos de salud mental y abuso de sustancias ocurren simultáneamente en la misma persona.

LEY DE SERVICIOS DE SALUD MENTAL (MHSA)

Conversación Comunitaria

Plan Integral a Tres Años

Años Fiscales

2014-15, 2015-16, 2016-17

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

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

El Propósito de Hoy

Reunir las opiniones sobre la dirección de los servicios de salud mental y contra el uso de sustancias del Condado de Marin para el Plan Integral a Tres Años sobre la Ley de Servicios de Salud Mental (MHSA) para julio de 2014 hasta junio de 2017.

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La Visión de Marin

- Se guía mediante la participación comunitaria
- Es culturalmente competente y atiende eficazmente a las comunidades subatendidas
- Hace responsables a los participantes dentro de su propia recuperación, integrando servicios impulsados por la familia y por el cliente
- Desarrolla un modelo de intervención que sea "ayuda primero" en lugar de "primero la falla"
- Integra la salud mental y el control del uso de sustancias con otros servicios esenciales
- Responde de forma eficaz a las preocupaciones de salud mental y de uso de sustancias en colaboración con la atención primaria
- Demuestra la eficacia de los servicios mediante los resultados

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Proceso del Plan a Tres Años de Marin

Opiniones de las partes interesadas

Comité de implementación de MHSA

MHSUS

30 días de comentarios del público

Audiencia Pública en el Consejo de Salud Mental
Recomendaciones del Consejo de Salud Mental

Aprobación de parte del Consejo de Supervisores

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Ambiente de Planeación

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Historia de MHSA

- Servicios y Apoyos Comunitarios (CSS)
- Vivienda (CSS)
- Prevención e Intervención Temprana (PEI)
- Educación y capacitación de la fuerza laboral (WET)
- Innovación (INN)
- Edificios y Necesidades Tecnológicas (CF/TN)

Estrategias

Resultados

Visión / Impacto

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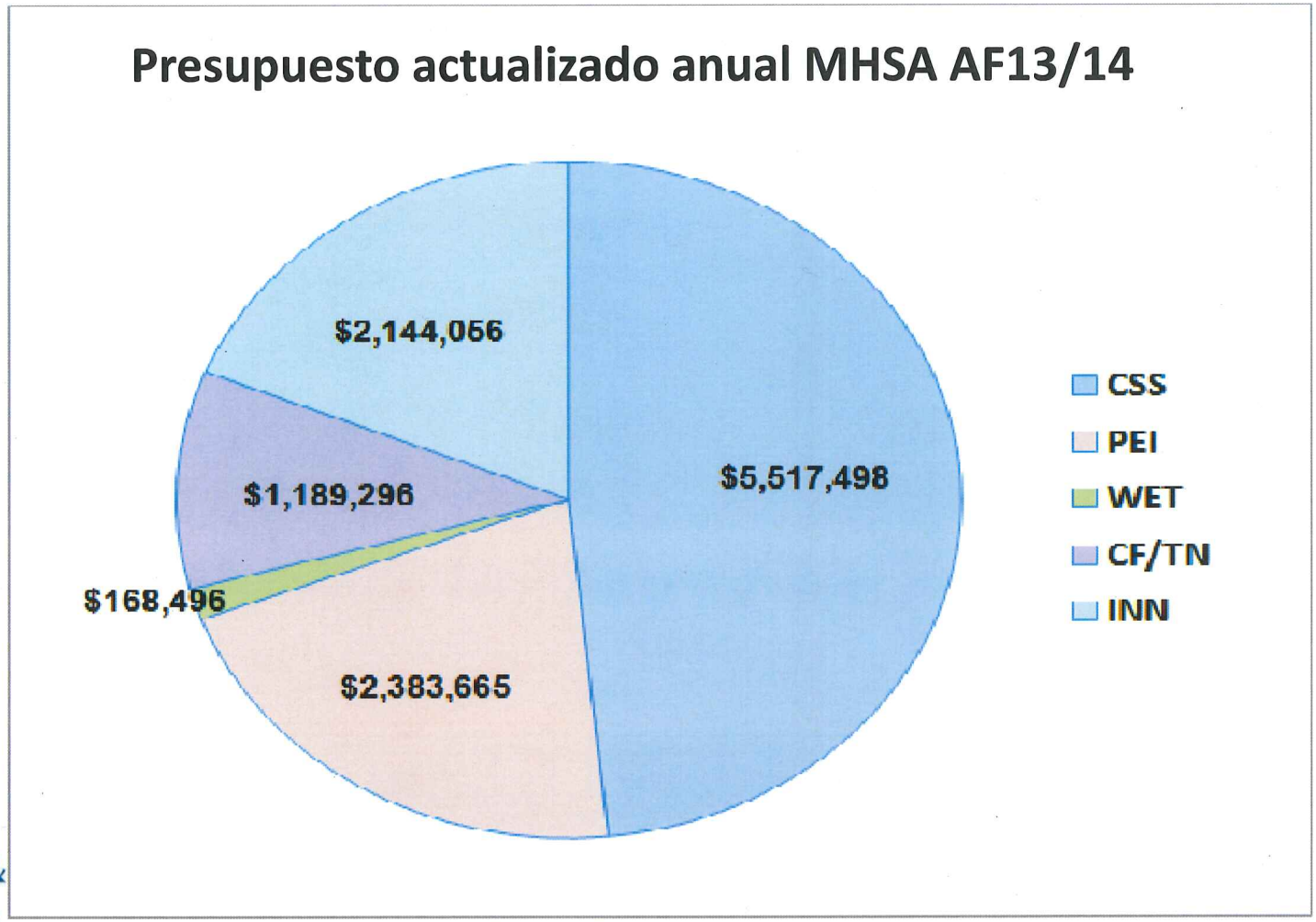
Fondos actuales de MHSA por Componente



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Fondos Anuales de MHSA

- Fondos aproximados del programa para el Plan a Tres Años:
  - CSS $4,219,180 / año
  - PEI $1,447,500 / año
- Los fondos del programa se basan en los ingresos estatales proyectados de MHSA y distribuidos para proporcionar fondos consistentes para los programas durante el periodo de planeación de tres años.
- Ajustar los programas existentes para abordar mejor las necesidades.
- Como siempre, algunos programas serán ajustados o incluso finalizarán el 30 de junio de 2014.

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Información de Programas

Propuestos y Existentes

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Preguntas y Respuestas

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Opiniones Comunitarias

en Grupos Pequeños

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Planeación de MHSA en adelante

Reuniones comunitarias aún por realizarse:

- 8/13 Dance Palace en Pt. Reyes Station 6:30pm
- 8/15 Margarita C. Johnson Community Center en Marin City 6:30pm
- 8/21 Albert J. Boro Community Center en San Rafael 6:30pm
- 9/13 Marin Health & Wellness Center en San Rafael 10am
- 9/18 San Rafael Community Center en San Rafael 6:30pm

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Encuesta de MHSA y Acceso en Línea

Para mantenerse al día con la última información referente a los esfuerzos de Planeación Integral a Tres Años sobre la Ley de Servicios de Salud Mental del Condado de Marin (MHSA), por favor consulte el sitio web de MHSA en:

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

Si tiene más opiniones después de esta junta, llene la Encuesta de MHSA en este sitio web para agregar su aportación.

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¡Gracias!

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Ley de Servicios de Salud Mental - Panorama General

En noviembre de 2004, los votantes de California aprobaron la Propuesta de Ley 63, la Ley de Servicios de Salud Mental (MHSA), que tenía la intención de expandir y transformar los servicios de salud mental comunitarios en toda California. Aunque la propuesta de ley pasó con un 54% de los votos en todo el estado, en el Condado de Marín se votó con un 63% a favor. La MHSA causa impuestos adicionales para el Estado, los cuales luego se asignan a los respectivos programas de salud mental de los condados bajo regulaciones extensivas desarrolladas por el Departamento de Salud Mental del Estado.

Principios de la Ley de Servicios de Salud Mental

- Colaboración comunitaria para desarrollar una visión compartida para los servicios
- Competencia cultural para atender de forma eficaz a las comunidades subsatendidas
- Programas Impulsados por Familias/Individuos que dan poder a los participantes dentro de su recuperación
- Enfoque en el Bienestar que incluye conceptos de resistencia y recuperación
- Experiencia en Servicios Integrales que coloca a los servicios de salud mental en las ubicaciones en las que los participantes obtienen otros servicios cruciales
- Diseño basado en resultados que demuestra la eficacia de los servicios

Componentes de la Ley de Servicios de Salud Mental

A. Apoyos y Servicios Comunitarios (CSS)
Los fondos de CSS son para expandir y transformar los servicios proporcionados a los menores, jóvenes, adultos y adultos mayores que viven con enfermedades mentales graves para que haya servicios orientados a la recuperación. Los Programas incluyen Asociaciones de Servicios Completos (FSP), Sistemas de Desarrollo y Alcance y Participación (SD/OE), y Vivienda.

B. Prevención e Intervención Temprana (PEI)
Los fondos de PEI tienen la intención de reducir los factores de riesgo y promover las habilidades positivas para aumentar el bienestar de las personas antes de los trastornos conductuales o emocionales graves. Los programas principalmente se proporcionan en la comunidad, en las poblaciones objetivo que tienen factores de riesgo u otras preocupaciones ligeras de salud mental.

C. Innovación (INN)
Las innovaciones se definen como enfoques/prácticas de salud mental ingeniosas, creativas o nuevas que se espera que contribuyan al aprendizaje de cómo aumentar el acceso para los grupos subatendidos; aumentar la calidad de los servicios, incluyendo mejores resultados; promover la colaboración entre las agencias; y aumentar el acceso a los servicios.

D. Capacitación y Educación de la Fuerza Laboral (WET)
Los fondos de WET tienen la intención de solucionar la escasez de personas calificadas para proporcionar servicios que aborden las enfermedades mentales graves. Esto incluye capacitar a los proveedores existentes, aumentar la diversidad de las personas que ingresan al campo y promover el empleo de consumidores y familias.

E. Instalaciones Capitales y Necesidades Tecnológicas (CF/TN)
Los fondos de CF son para desarrollar o mejorar los edificios utilizados para el ofrecimiento de servicios de MHSA a los clientes de salud mental y sus familias o para oficinas administrativas. Los fondos de TN son para desarrollar o mejorar sistemas tecnológicos, como los registros electrónicos de salud.

Poblaciones desatendidas y subatendidas de Marin

La Ley de Servicios de Salud mental tiene la intención de abordar las necesidades de las comunidades que actualmente están desatendidas o subatendidas. Durante el proceso de planificación de MHSA de Marin en 2004, se identificaron a las siguientes poblaciones como desatendidas o subatendidas por parte de los servicios existentes de salud mental del condado:

- Los latinos adultos se identificaron como los más desatendidos / subatendidos
- Originarios de una isla del Pacífico
- Los afroamericanos reciben más atención entre los clientes del Condado, posiblemente debido a la falta de servicios que pudiera reducir la necesidad de un servicio intensivo
- Adultos mayores
- Jóvenes en edad de transición (16-25 años)
- Residentes de West Marin

Otras poblaciones desatendidas/subatendidas identificadas en el estado

- Veteranos
- LGBTQ

Demografía de personas atendidas del 1 de julio de 2011 al 30 de junio de 2012

Servicios y Apoyos Comunitarios (total atendidos: 1637)

Grupos de edad	# de atendidos	% de atendidos
0-15 años	298	18%
16-25 años	241	15%
26-59 años	852	52%
60+ años	246	15%
Raza/Etnia		
Blanca	667	41%
Afroamericana	453	28%
Asiática	31	2%
Isleño del Pacífico	25	2%
Nativa	15	1%
Hispánica	199	12%
Varias	77	5%
Otra/desconocida	160	10%

Idioma principal	% de atendidos
Español	7%
Vietnamita	.5%
Cantonés	.2%
Mandarín	.1%
Ruso	.2%
Farsi	.1%
Árabe	.1%
Inglés	90.8%
Otro	.9%

Prevención e Intervención Temprana (total de atendidos: 9440)

Grupos de edad	% de atendidos	% de la Población de Marin
0-15 años	15%	20%
16-25 años	14%	10%
26-59 años	38%	50%
60+ años	14%	20%
Desconocido	18%	
Raza/Etnia		
Blanca	49%	75%
Afroamericana	2%	3%
Asiática	2%	5.5%
Isleño del Pacífico	0%	0.2%
Nativa	<1%	0.3%
Hispánica	43%	14%
Varias	1%	2%
Otra/desconocida	3%	0%

Idioma principal	% de atendidos
Español	38%
Vietnamita	<1%
Cantonés	0%
Mandarín	<1%
Tagalo	0%
Camboyano	0%
Ruso	<1%
Árabe	0%
Inglés	59%
Otro	3%

Servicios y Apoyos de Salud Mental y Contra el Abuso de Sustancias en el Condado de Marin

¿En dónde estamos en los Servicios y Apoyos Salud Mental y Contra el Abuso de Sustancias del Condado de Marin?

- ☐ Estamos pidiendo a la comunidad que nos ayude a descubrir qué tipo de apoyos y servicios de salud mental y contra el abuso de sustancias son los más necesarios.
- ☐ Estamos informando a la comunidad sobre los tipos de servicios y apoyos disponibles.
- ☐ Estamos descubriendo formas de que los consumidores y sus familias ayuden a proporcionar servicios y apoyos.
- ☐ Entrenamos a las personas sobre cómo escuchar y proporcionar apoyos y servicios centrados en las personas.
- ☐ Estamos utilizando los valores de buena salud y de apoyo comunitario en todo lo que hacemos.
- ☐ Estamos trabajando en formas de llegar a la gente antes de que tengan problemas de salud mental graves o desafíos de abuso de sustancias.
- ☐ Estamos trabajando en formas de ayudar a las personas en todos los aspectos de sus vidas.
- ☐ Estamos haciendo lo que podemos para asegurarnos de que quien desee o necesite servicios y apoyos tenga acceso a ellos.

¿Qué tipos de Servicios y Apoyos de Salud Mental y Contra el Abuso de Sustancias deseamos en el Condado de Marin?

- ☐ Deseamos que los servicios y apoyos de salud mental y contra el abuso de sustancias sean para todos.
- ☐ Deseamos servicios y apoyos para todo tipo de desafíos en la vida.
- ☐ Deseamos servicios y apoyos que vean todos los aspectos de la vida de una persona.
- ☐ Queremos asegurarnos de que las personas no tengan barreras para usar los servicios y los apoyos cuando sea necesario.
- ☐ Deseamos trabajar con nuestros socios comunitarios para proporcionar servicios y apoyos.

¿Cómo haremos esos cambios?

- ☐ Hablaremos con las personas, las familias y los proveedores de servicio y los miembros de la comunidad sobre los cambios necesarios en los servicios y apoyos de salud mental y contra el abuso de sustancias.
- ☐ Ayudaremos a la comunidad a comprender la importancia de utilizar los servicios cuando son necesarios.
- ☐ Desarrollaremos empleos de servicio y apoyo para las personas con necesidades de salud mental y contra el abuso de sustancias y para sus familias.
- ☐ Apoyaremos los cambios en los servicios y apoyos que provoquen una mejor calidad de vida para las personas.
- ☐ Apoyaremos los cambios en los servicios y apoyos que provoquen una menor necesidad de servicios.
- ☐ Nos aseguraremos de que las personas que no utilizan los servicios y que los necesitan, sepan sobre y utilicen los servicios que necesitan.

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Quận Marin
Ban Dịch vụ Y tế Tâm thần và Cai nghiện (Mental Health and Substance Use Services Division (MHSUS))

Đạo luật về Dịch vụ Y tế Tâm thần (Mental Health Services Act (MHSA))

NGHỊ TRÌNH

"Circling Stigma (Vết nhơ Luẩn quẩn)"
Cuốn Viđêô được Giải thưởng về Dịch vụ Công cộng năm 2013, thực hiện bởi Spencer Wilson, học sinh trung học của trường Novato High

I. Mục đích của cuộc Nói chuyện Cộng đồng

II. Tổng quan về Quy trình Hoạch định Hợp nhất cho Ba Năm về những Dịch vụ và Hỗ trợ của MHSUS

III. Câu hỏi và Trả lời

IV. Thảo luận Nhóm

V. Tổng kết

Đạo luật về Dịch vụ Y tế Tâm thần (Mental Health Services Act (MHSA))
Buổi họp Công cộng tại Trung tâm Dance Palace, Pt. Reyes Station, CA
13 tháng 8, 2013

Quận Marin cam kết sẽ nói chuyện với tất cả những người dân trong khắp quận hạt. Những câu trả lời của các bạn sẽ giúp chúng tôi biết là đã được nghe từ những ai và cần phải tiếp cận đến những ai.

Giới phái của bạn:

☐ **Nam** ☐ **Nữ**

Tuổi của bạn:

☐ **0 – 15 tuổi** ☐ **16 – 25 tuổi**

☐ **26 – 59 tuổi** ☐ **60 tuổi hoặc hơn**

Ngôn ngữ chính của bạn:

☐ **Ả rập** ☐ **Căm bốt** ☐ **Quảng đông** ☐ **Anh ngữ**

☐ **Farsi** ☐ **H' Mông** ☐ **Quan thoại** ☐ **Nga ngữ**

☐ **Tây ban nha** ☐ **Phi luật tân** ☐ **Việt nam**

☐ **Ngôn ngữ khác (xin nói rõ)**_____

Chủng tộc của bạn:

☐ **Mỹ gốc Châu Phi** ☐ **Á đông** ☐ **Tây ban nha** ☐ **Thổ dân**

☐ **Thái bình dương** ☐ **Da trắng** ☐ **Lai**

☐ **Chủng tộc khác (xin nói rõ)**_____

Bạn sống ở vùng nào trong Quận Marin?

☐ **Trung Marin** ☐ **Bắc Marin** ☐ **Nam Marin**

☐ **Tây Marin** ☐ **Vùng khác (xin nói rõ)**_____

Bạn thuộc bất cứ nhóm nào sau đây trong cộng đồng của chúng ta? (đánh dấu tất cả những gì áp dụng)

☐ **Vô gia cư** ☐ **Thi hành Luật Pháp** ☐ **Đồng giới, Chuyển giới** ☐ **Cựu chiến binh**

☐ **Một người đang/đã sử dụng Dịch vụ Y tế Tâm thần và/hoặc Dịch vụ Cai nghiện**

☐ **Thành viên gia đình của một người đang/đã sử dụng Dịch vụ Y tế Tâm thần và/hoặc Dịch vụ Cai nghiện**

☐ **Nhà Cung cấp Dịch vụ Y tế Tâm thần và/hoặc Dịch vụ Cai nghiện**

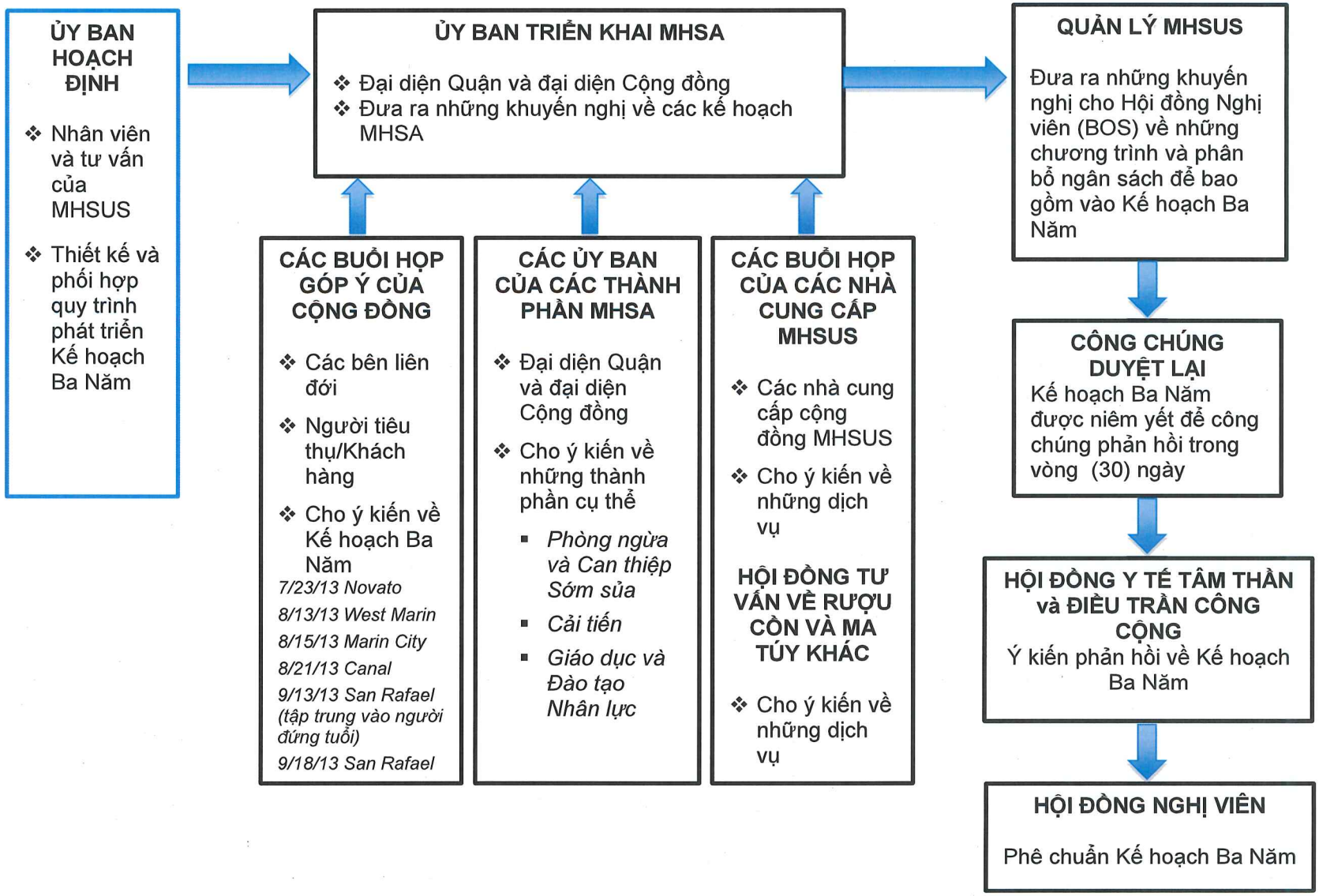
☐ **Khác (xin nói rõ)**___

Dịch vụ Y tế Tâm thần và Cai nghiện của Quận Marin
Tầm nhìn của Kế hoạch Ba Năm Hợp nhất về Dịch vụ Y tế Tâm thần

MHSUS nhắm vào việc áp dụng những nguyên tắc và tài nguyên của MHSA vào một Hệ thống Chăm sóc có những đặc điểm như sau:

TẦM NHÌN	Thực hành
➢ Được hướng dẫn bởi sự tham gia của cộng đồng	*Chúng tôi sẽ làm mọi cố gắng để nắm bắt được tiếng nói của cộng đồng qua những cuộc tiếp xúc, thăm dò ý kiến và diễn đàn.*
➢ Thông thạo về văn hóa và phục vụ hiệu quả những cộng đồng đã không được phục vụ đúng mức	*Các chương trình sẽ phản ánh nền văn hóa của các cá nhân mà chúng tôi phục vụ, và chúng tôi sẽ tiếp tục cải thiện sự tiếp cận đến dịch vụ cho những người đã không được phục vụ đúng mức.*
➢ Trao quyền cho người tham gia trong việc phục hồi của họ, hợp nhất những dịch vụ tùy biến vào khách hàng và gia đình	*Tất cả các dịch vụ đều theo sự chỉ đạo của người được phục vụ, với sự hướng dẫn từ gia đình đang hỗ trợ họ, như được định nghĩa bởi khách hàng.*
➢ Phát triển một mô hình can thiệp chú trọng trước tiên đến việc "cứu chữa" thay vì sự "thất bại"	*Chúng tôi chủ trương phải cải tiến, vươn ra, thu hút, phòng ngừa, và can thiệp sớm sủa cũng như không đầu hàng trước những khó khăn.*
➢ Hợp nhất sự chăm sóc y tế tâm thần và cai nghiện với những dịch vụ thiết yếu khác	*Sự khỏe mạnh bao gồm việc hợp nhất tất cả các tài nguyên cần thiết, chăm sóc y tế, dịch vụ xã hội, dịch vụ cai nghiện và y tế tâm thần.*
➢ Đáp ứng hiệu quả những quan ngại về y tế tâm thần và về việc sử dụng chất gây nghiện, kết hợp với y tế gia đình	*Người tiêu thụ hướng dẫn chúng tôi bằng những vấn đề họ cần giải quyết; những dịch vụ của chúng tôi được tổ chức để đáp ứng những nhu cầu khi chúng hiện ra.*
➢ Chứng minh hiệu quả của dịch vụ thông qua những kết quả	*Chúng tôi bắt đầu, ở những nơi có thể, bằng những dịch vụ dựa vào chứng cứ, sau đó sẽ thẩm định lại và thích nghi để đem lại kết quả tốt nhất.*

Kế hoạch Ba Năm của MHSA
Quy trình Góp ý của Cộng đồng



Quận Marin
Ban Dịch vụ Y tế Tâm thần và Cai nghiện
Đạo luật về Dịch vụ Y tế Tâm thần (MHSA)
Sự Liên tục của những Dịch vụ

	Phòng ngừa:	**Can thiệp Sớm:**	**Chữa trị:**	**Phục hồi:**
	Tăng thêm hạnh phúc và giảm bớt rủi ro về những vấn đề y tế tâm thần và sử dụng chất gây nghiện	*Nhận dạng sớm sửa những vấn đề y tế tâm thần và sử dụng chất gây nghiện và cung cấp sự trợ giúp*	*Dịch vụ và hỗ trợ cho người bị bệnh tâm thần hoặc người vừa bị tâm thần vừa bị nghiện ngập**	*Duy trì hạnh phúc khi sống chung với người bị bệnh tâm thần hoặc người vừa bị tâm thần vừa bị nghiện ngập**
Trẻ em **Thiếu niên** **Người lớn** **Cao niên**	Các thí dụ: • Cải thiện các quan hệ gia đình • Tăng thêm kỹ năng đối phó • Tăng thêm hỗ trợ xã hội	Các thí dụ: • Khám sàng lọc các triệu chứng • Dịch vụ ngắn hạn • Kết nối với các dịch vụ cần thiết	Các thí dụ: • Cộng tác Dịch vụ Toàn bộ và Trọn gói • Trị liệu • Thuốc men • Kỹ năng sống độc lập	Các thí dụ: • Hỗ trợ của đồng lứa • Sử dụng hỗ trợ tự nhiên xảy ra • Hỗ trợ Tìm việc và Giáo dục

* Rối loạn xảy ra cùng lúc là khi một người vừa bị bệnh tâm thần vừa bị nghiện ngập.

ĐẠO LUẬT VỀ DỊCH VỤ Y TẾ TÂM THẦN (MHSA)

Cuộc Nói chuyện với Cộng đồng

Kế hoạch Ba Năm Hợp nhất

Tài khóa

2014-15, 2015-16, 2016-17

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Health, Safety & Well-being

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Mục đích của Ngày hôm nay

Thu thập ý kiến về hướng đi của những dịch vụ y tế tâm thần và cai nghiện của Quận Marin trong Kế hoạch Ba Năm Hợp nhất của MHSA từ tháng 7, 2014 đến tháng 6, 2017.

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Tầm nhìn của Marin

- Được hướng dẫn bởi sự tham gia của cộng đồng
- Thông thạo về văn hóa và phục vụ hiệu quả những cộng đồng đã không được phục vụ đúng mức
- Trao quyền cho người tham gia trong việc phục hồi của họ, hợp nhất những dịch vụ tùy biến vào khách hàng và gia đình
- Phát triển một mô hình can thiệp, chú trọng trước tiên đến việc "cứu chữa" thay vì sự "thất bại"
- Hợp nhất sự chăm sóc về y tế tâm thần và cai nghiện với những dịch vụ thiết yếu khác
- Đáp ứng hiệu quả những quan ngại về y tế tâm thần và về việc sử dụng chất gây nghiện, kết hợp với y tế gia đình
- Chứng minh hiệu quả của dịch vụ thông qua những kết quả

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Quy trình Kế hoạch Ba Năm của Marin

Ý kiến của các bên liên đới → Ủy ban Triển khai MHSA

Ủy ban Triển khai MHSA → MHSUS

MHSUS → 30 ngày Góp ý của Công chúng

30 ngày Góp ý của Công chúng → Điều trần Công cộng tại Hội đồng Y tế Tâm thần
Khuyến nghị của Hội đồng Y tế Tâm thần

Điều trần Công cộng tại Hội đồng Y tế Tâm thần
Khuyến nghị của Hội đồng Y tế Tâm thần → Phê chuẩn của Hội đồng Nghị viên

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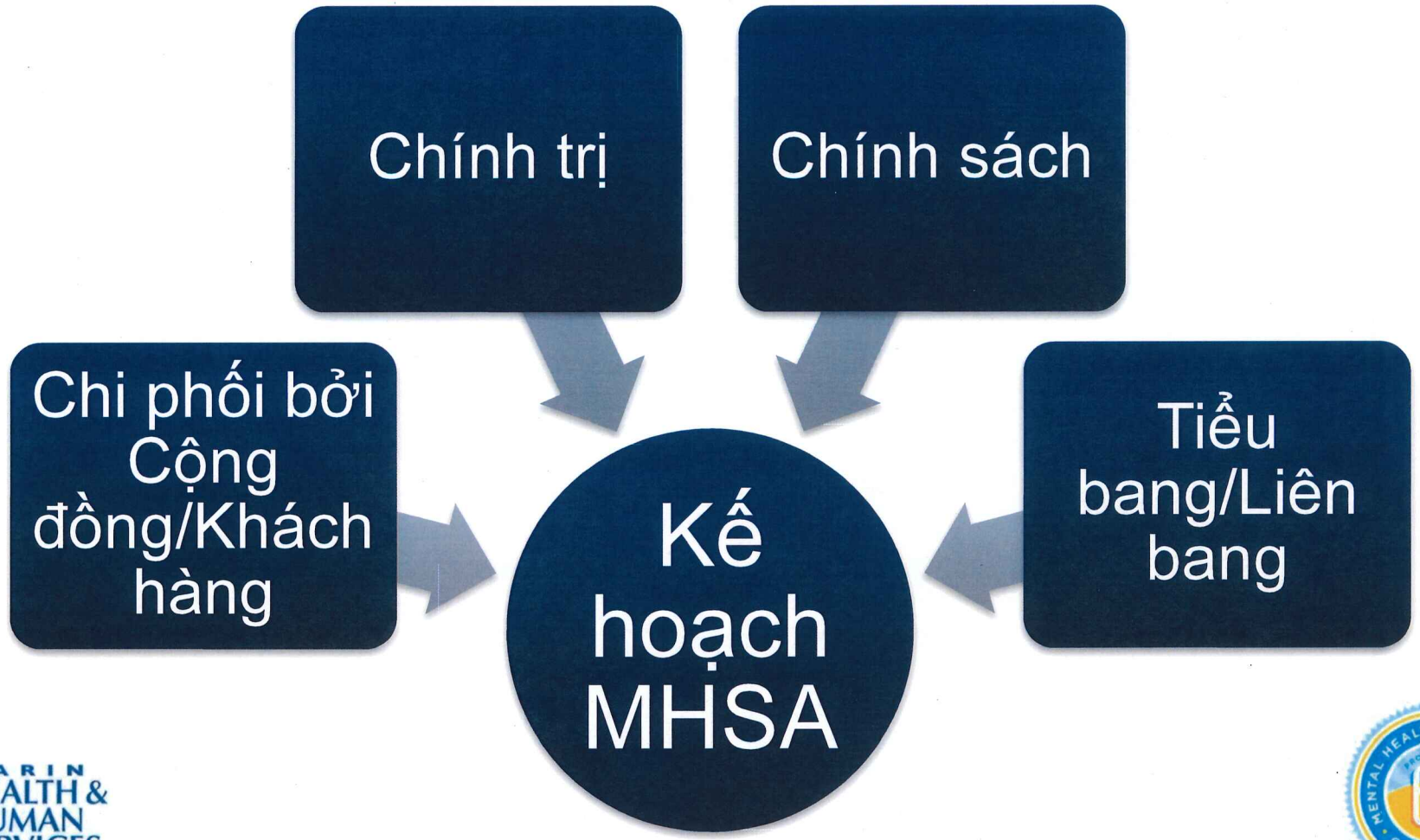
Môi trường Hoạch định



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Câu truyện của MHSA

- Dịch vụ và Hỗ trợ của Cộng đồng (CSS)
- Nhà ở (CSS)
- Phòng ngừa và Can thiệp Sớm sủa (PEI)
- Giáo dục và Đào tạo Nhân lực (WET)
- Cải tiến (INN)
- Cơ sở Chủ yếu và Nhu cầu Kỹ thuật (CF/TN)

Chiến lược

Kết quả

Tầm nhìn/ Tác động

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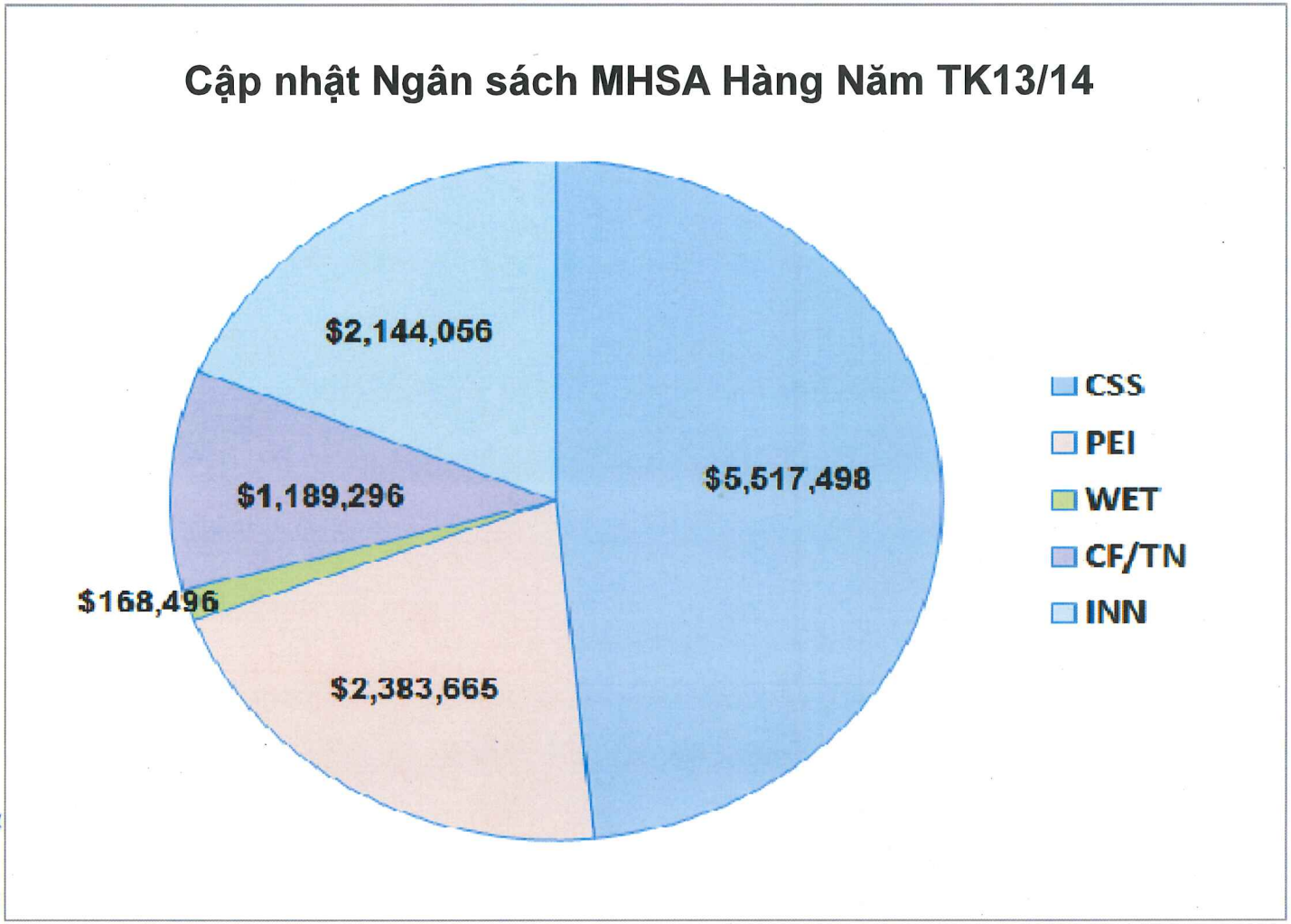
Ngân sách hiện tại của từng Thành phần trong MHSA



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Ngân sách Hàng năm của MHSA

- Dự toán ngân sách của các chương trình trong Kế hoạch Ba Năm:
  - CSS $4,219,180 / năm
  - PEI $1,447,500 / năm
- Ngân sách của chương trình được căn cứ vào lợi tức dự kiến của MHSA của Tiểu bang, và được "trải đều" để tài trợ đều đặn cho các chương trình trong suốt thời gian Ba Năm của kế hoạch.
- Điều chỉnh các chương trình hiện có để đáp ứng nhu cầu tốt hơn.
- Như luôn luôn, một vài chương trình sẽ được điều chỉnh hoặc ngay cả có thể sẽ chấm dứt vào ngày 30 tháng 6, 2014.

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Tờ rơi về những Chương trình Hiện có và những Chương trình được Đề nghị

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Phần Câu hỏi và Trả lời

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Góp Ý của các Nhóm Cộng đồng

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Hoạch định MHSA Tiến tới

Những Buổi họp Cộng đồng sắp đến:

- 15/8 Trung tâm Cộng đồng Margarita C. Johnson tại Marin City 6:30 giờ chiều
- 21/8 Trung tâm Cộng đồng Albert J. Boro tại San Rafael 6:30 giờ chiều
- 13/9 Trung tâm Marin Health & Wellness tại San Rafael 10 giờ sáng
- 18/9 Trung tâm Cộng đồng San Rafael tại San Rafael 6:30 giờ chiều

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Thăm dò Ý kiến MHSA và Tiếp cận Trực tuyến

Để theo dõi tin tức mới nhất liên quan đến những nỗ lực của Kế hoạch Ba Năm Hợp nhất về Dịch vụ Y tế Tâm thần của Quận Marin, xin hãy vào địa điểm mạng của MHSA tại:

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

Nếu bạn có thêm ý kiến sau buổi họp này, xin vui lòng điền vào bản Thăm dò MHSA trong địa điểm mạng để bổ sung ý kiến phản hồi của bạn.

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Chân thành Cám ơn Bạn!

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Những Dịch vụ và Hỗ trợ về Y tế Tâm thần và Cai nghiện tại Quận Marin

Hiện trạng về Dịch vụ và Hỗ trợ cho Y tế Tâm thần và Cai nghiện tại Quận Marin?

- ☐ Chúng tôi đang yêu cầu cộng đồng giúp chúng tôi tìm hiểu những loại dịch vụ cần thiết nhất về y tế tâm thần và cai nghiện.
- ☐ Chúng tôi đang nói lên cho cộng đồng biết về những loại dịch vụ và hỗ trợ đã có sẵn.
- ☐ Chúng tôi đang tìm hiểu những cách để người tiêu thụ và gia đình của họ có thể giúp cung cấp những dịch vụ và hỗ trợ.
- ☐ Chúng tôi đang huấn luyện nhân sự về cách lắng nghe và cách cung cấp những dịch vụ và hỗ trợ tập trung vào con người.
- ☐ Chúng tôi đặt nặng giá trị về sức khỏe và về sự hỗ trợ của cộng đồng vào tất cả những gì chúng tôi làm.
- ☐ Chúng tôi đang tìm cách tiếp cận người dân trước khi họ gặp phải những thử thách nghiêm trọng về y tế tâm thần hoặc về sự nghiện ngập.
- ☐ Chúng tôi đang tìm cách giúp người dân trong mọi khía cạnh đời sống của họ.
- ☐ Chúng tôi đang làm những gì trong khả năng để đảm bảo mọi người có thể tiếp cận được những dịch vụ và hỗ trợ khi họ muốn hoặc khi cần đến.

Chúng ta Muốn có những loại Dịch vụ và Hỗ trợ gì cho Y tế Tâm thần và Cai nghiện tại Quận Marin?

- ☐ Chúng tôi muốn có những dịch vụ và hỗ trợ y tế tâm thần và cai nghiện cho tất cả mọi người.
- ☐ Chúng tôi muốn có những dịch vụ và hỗ trợ cho tất cả những loại thử thách trong cuộc sống.
- ☐ Chúng tôi muốn có những dịch vụ và hỗ trợ trong mọi khía cạnh đời sống của một người.
- ☐ Chúng tôi muốn đảm bảo người dân không bị trở ngại trong việc sử dụng những dịch vụ và hỗ trợ khi cần đến.
- ☐ Chúng tôi muốn làm việc với những đối tác trong cộng đồng để cung cấp những dịch vụ và hỗ trợ .

Chúng ta Sẽ Thực hiện những Thay đổi đó ra sao?

- ☐ Chúng tôi sẽ nói chuyện với những cá nhân, gia đình, nhà cung cấp dịch vụ và thành viên cộng đồng về những thay đổi cần thiết trong những dịch vụ và hỗ trợ về y tế tâm thần và cai nghiện.
- ☐ Chúng tôi sẽ giúp cộng đồng hiểu được sự quan trọng của việc sử dụng dịch vụ khi cần đến.
- ☐ Chúng tôi sẽ tạo ra những việc làm về dịch vụ và hỗ trợ cho những cá nhân bị tâm thần và nghiện ngập và cho gia đình của họ nếu họ cần.
- ☐ Chúng tôi sẽ ủng hộ những thay đổi về dịch vụ và hỗ trợ nào có thể đem đến một cuộc sống có chất lượng hơn cho những cá nhân.
- ☐ Chúng tôi sẽ ủng hộ cho những thay đổi về dịch vụ và hỗ trợ nào có thể đem đến việc giảm bớt những dịch vụ.
- ☐ Chúng tôi sẽ đảm bảo là những cá nhân nào cần nhưng không dùng đến những dịch vụ sẽ biết về chúng, và sẽ dùng những dịch vụ mà họ cần đến.

Đạo luật Về Dịch vụ Y tế Tâm thần – Tổng quan

Vào tháng 11 năm 2004, cử tri California đã chấp thuận Dự luật 62, một Đạo luật về Dịch vụ Y tế Tâm thần (Mental Health Services Act (MHSA)), nhằm mở rộng và thay đổi những dịch vụ y tế tâm thần trong khắp California. Mặc dù đạo luật chỉ được thông qua với 54% phiếu thuận của toàn tiểu bang, nó đã được 63% phiếu thuận của cử tri Quận Marin. MHSA đã thu thêm thuế vào cho Tiểu bang và tiền thuế này đã được phân bổ cho các chương trình y tế tâm thần của quận, chịu dưới sự chi phối của những quy định bao quát đã được thiết lập bởi Sở Y tế Tâm thần của Tiểu bang.

Những Nguyên tắc của Đạo luật Về Dịch vụ Y tế Tâm thần

- Sự Cộng tác của Cộng động để phát triển một tầm nhìn chung về những dịch vụ
- Năng lực về Văn hóa để phục vụ hiệu quả các cộng đồng đã không được phục vụ đúng mức
- Những Chương trình chú trọng vào Cá nhân/Gia đình và trao quyền cho người tham gia trong tiến trình phục hồi của họ
- Chú trọng vào sự Khỏe mạnh bao gồm những khái niệm về tính kiên cường và sự phục hồi
- Kinh nghiệm Hợp nhất các Dịch vụ để đặt những dịch vụ y tế tâm thần tại những địa điểm mà người tham gia có thể nhận được những dịch vụ quan trọng khác
- Thiết kế dựa vào kết quả để chứng minh sự hiệu quả của những dịch vụ

Những Thành phần trong Đạo luật về Dịch vụ Y tế Tâm thần

A. Dịch vụ và Hỗ trợ của Cộng đồng (Community Services and Supports (CSS))
Ngân sách của CSS nhằm vào việc mở rộng và thay đổi những dịch vụ cung cấp cho trẻ em, thiếu niên, người lớn và cao niên bị bệnh tâm thần nặng thành những dịch vụ có tính chất phục hồi. Những chương trình này gồm có Cộng tác Dịch vụ Toàn diện (Full Services Partnerships (FSP)), Phát triển Hệ thống, Tiếp xúc và Thu hút (Systems Development and Outreach and Engagement (SD/OE)), và Nhà ở (Housing).

B. Phòng ngừa và Can thiệp Sớm sủa (Prevention & Early Intervention (PEI))
Ngân sách của PEI nhằm vào việc làm giảm bớt những yếu tố rủi ro và khuyến khích những kỹ năng tích cực để tăng thêm sự hạnh phúc cho các cá nhân, trước khi họ bị những rối loạn về cảm xúc hoặc về tập tính. Các chương trình được cung cấp chủ yếu trong cộng đồng, nhắm vào dân số có rủi ro bị bệnh tâm thần nhẹ.

C. Cải tiến (Innovation (INN))
Cải tiến được định nghĩa như là những thực hành/cách tiếp cận mới lạ, tính sáng tạo và/hoặc sự khéo léo để có thể mở rộng phạm vi hoạt động đến những nhóm không được phục vụ đúng mức; gia tăng chất lượng dịch vụ, bao gồm việc đạt được kết quả tốt hơn; khuyến khích sự cộng tác giữa các cơ quan; và gia tăng sự tiếp cận đến các dịch vụ.

D. Giáo dục và Đào tạo Nhân lực (Workforce Education & Training (WET))
Ngân sách của WET nhằm vào việc cứu chữa tình trạng thiếu hụt nhân sự có đủ khả năng để cung cấp dịch vụ, hầu có thể giải quyết những trường hợp tâm thần nghiêm trọng. Điều này bao gồm việc huấn luyện những nhà cung cấp hiện có, tăng thêm tính đa dạng của những cá nhân gia nhập vào ngành, và khuyến khích việc tuyển dụng trong số những người tiêu thụ và gia đình của họ.

E. Các Cơ sở Chủ yếu và Nhu cầu Kỹ thuật (Capital Facilities & Technology Needs (CF/TN))
Ngân sách về Cơ sở Chủ yếu (CF) được dùng để phát triển hoặc cải thiện các cơ sở dùng để cung cấp dịch vụ MHSA cho bệnh nhân tâm thần và gia đình của họ, hoặc để dùng làm văn phòng hành chánh. Ngân sách về Nhu cầu Kỹ thuật (TN) được dùng để phát triển hoặc cải thiện những hệ thống kỹ thuật như hồ sơ y tế điện tử.

Dân số Marin đã Không được Phục vụ hoặc Được Phục vụ Không Đúng Mức

Đạo luật về Dịch vụ Y tế Tâm thần nhằm giải quyết nhu cầu của những cộng đồng đã không được phục vụ hoặc được phục vụ không đúng mức. Trong tiến trình hoạch định MHSA của Quận Marin vào năm 2004, những dân số sau đây được nhận dạng là đã không được phục vụ hoặc được phục vụ không đúng mức bởi những dịch vụ y tế tâm thần của Quận:

- Người lớn gốc La tinh đã được nhận dạng là những người đông nhất đã không được phục vụ hoặc được phục vụ không đúng mức
- Thổ dân các đảo Châu Á Thái bình dương
- Người Mỹ gốc Phi châu được đại diện quá mức trong số những khách hàng của Quận, có thể là vì thiếu dịch vụ nên đã tạo ra nhiều hơn nhu cầu chăm sóc cao độ
- Cao niên
- Thiếu niên trong độ tuổi chuyển tiếp (16-25 tuổi)
- Cư dân vùng Tây Quận Marin

Những Dân số đã Không được Phục vụ hoặc được Phục vụ Không Đúng Mức khác của Tiểu bang

- Cựu Chiến binh
- Đồng giới hoặc Chuyển giới (LGBTQ)

Nhân khẩu của những người được phục vụ từ ngày 1 tháng 7, 2011 đến ngày 30 tháng 6, 2012

Hỗ trợ và Dịch vụ Cộng đồng (tổng số được phục vụ: 1637)

Nhóm tuổi	Con số được phục vụ	% được phục vụ
0-15 tuổi	298	18%
16-25 tuổi	241	15%
26-59 tuổi	852	52%
60+ tuổi	246	15%
Giống/Chủng tộc		
Da Trắng	667	41%
Mỹ gốc Phi châu	453	28%
Á đông	31	2%
Châu Á Thái bình dương	25	2%
Thổ dân	15	1%
Tây ban nha	199	12%
Lai	77	5%
Giống khác/Không rõ	160	10%

Ngôn ngữ chính	% được phục vụ
Tây ban nha	7%
Tiếng Việt	.5%
Quảng đông	.2%
Quan thoại	.1%
Tiếng Nga	.2%
Tiếng Farsi	.1%
Tiếng Ả rập	.1%
Tiếng Anh	90.8%
Tiếng khác	.9%

Phòng ngừa và Can thiệp Sớm sủa (tổng số được phục vụ: 9440)

Nhóm tuổi	% được phục vụ	% của dân số Marin
0-15 tuổi	15%	20%
16-25 tuổi	14%	10%
26-59 tuổi	38%	50%
60+ tuổi	14%	20%
Không rõ	18%	
Giống/Chủng tộc		
Da Trắng	49%	75%
Mỹ gốc Phi châu	2%	3%
Á đông	2%	5.5%
Châu Á Thái bình dương	0%	0.2%
Thổ dân	<1%	0.3%
Tây ban nha	43%	14%
Lai	1%	2%
Giống khác/Không rõ	3%	0%

Ngôn ngữ chính	% được phục vụ
Tây ban nha	38%
Tiếng Việt	<1%
Quảng đông	0%
Quan thoại	<1%
Tiếng Nga	0%
Tiếng Farsi	0%
Tiếng Ả rập	<1%
Tiếng Anh	59%
Tiếng khác	3%

APPENDIX J

MHSA Community Meeting Flyers – all languages

Presented by the County of Marin, HHS, Mental Health and Substance Use Services Division

COUNTY OF MARIN

Mental Health Services Act (Prop 63)
Three Year Program and Expenditure Plan
(FY2014-15 through FY2016-17)

Marin County residents, you are invited to provide your input and recommendations for mental health and substance use services in our community.

Tuesday July 23, 2013	***Novato Youth Center 680 Wilson Avenue, Novato***	***6:30-8:30 pm***
Tuesday August 13, 2013	***Dance Palace Community and Cultural Center 503 B Street, Pt. Reyes***	***6:30-8:30 pm***
Thursday August 15, 2013	***Margarita C. Johnson Senior Center 640 Drake Avenue, Marin City***	***6:30-8:30 pm***
Wednesday August 21, 2013	***Albert J. Boro Community Center 50 Canal Street, San Rafael***	***6:30-8:30 pm***
Friday September 13, 2013 (Older Adult Focused)	***Marin Health & Wellness Campus Connection Center Rooms 109/110 3240 Kerner Blvd., San Rafael***	***10:00 am – 12:00 pm***
Wednesday September 18, 2013	***San Rafael Community Center Auditorium 618 B Street, San Rafael***	***6:30-8:30 pm***

If you cannot attend any of these meetings, please provide your input via our online survey at:
http://www.co.marin.ca.us/depts/HH/main/mh/mhsa_faq.cfm

Refreshments and Child Supervision will be provided.

Meetings to be presented in English with Spanish and Vietnamese translation, except the August 21st meeting which will be presented in Spanish with English and Vietnamese translation. If you have any questions, please contact Kasey Clarke at: kclarke@marincounty.org or 415.473.7465.

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

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

All County public meetings are conducted in accessible locations.
If you require transportation to participate at these meetings, please contact us at least 72 hours in advance by calling: (415) 473-7465 (Voice) or (415) 473-3344 (TTY) or by email at: kclarke@marincounty.org.
Copies of documents used in this meeting are available in accessible formats upon written request.

COUNTY OF MARIN

Ley de Servicios de Salud Mental (Iniciativa 63)
Programa y Plan de Gastos a Tres Años
(Del AF 2014-15 al AF 2016-17)

Residentes del Condado de Marin, están invitados a presentar sus comentarios y recomendaciones para los servicios de salud mental y contra el abuso de sustancias en nuestra comunidad

Martes 23 de julio de 2013	***Novato Youth Center 680 Wilson Avenue, Novato***	***6:30-8:30 pm***
Martes 13 de agosto de 2013	***Dance Palace Community and Cultural Center 503 B Street, Pt. Reyes***	***6:30-8:30 pm***
Jueves 15 de agosto de 2013	***Margarita C. Johnson Senior Center 640 Drake Avenue, Marin City***	***6:30-8:30 pm***
Miércoles 21 de agosto de 2013	***Albert J. Boro Community Center 50 Canal Street, San Rafael***	***6:30-8:30 pm***
Viernes 13 de septiembre de 2013 (Orientado a adultos mayores)	***Marin Health & Wellness Campus Connection Center Salas 109/110 3240 Kerner Blvd., San Rafael***	***10:00 am – 12:00 pm***
Miércoles 18 de septiembre de 2013	***San Rafael Community Center Auditorium 618 B Street, San Rafael***	***6:30-8:30 pm***

Si no puede asistir a alguna de estas reuniones, presente sus comentarios mediante nuestra encuesta en línea en:
http://www.co.marin.ca.us/depts/HH/main/mh/mhsa_faq.cfm

Habrá refrigerios y servicio de supervisión de niños

Las reuniones se presentarán en inglés con traducción al español y vietnamita, con excepción de la reunión del 21 de agosto, que se presentará en español con traducción al inglés y vietnamita. Si usted tiene alguna pregunta, por favor comuníquese con Kasey Clarke en: kclarke@marincounty.org o al 415.473.7465.

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

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

Todas las reuniones públicas del Condado se llevan a cabo en lugares accesibles.
Si usted requiere transporte para participar en estas reuniones, por favor póngase en contacto con nosotros con por lo menos 72 horas de anticipación llamando al: (415) 473-7465 (Voz) o (415) 473-3344 (TTY) o por correo electrónico a:
kclarke@marincounty.org.
Hay disponibilidad de copias en formatos accesibles de los documentos utilizados en esta reunión, bajo solicitud escrita.

Được Trình bầy bởi Ban Dịch vụ Y tế Tâm thần và Lạm dụng Chất nghiện, HHS, Quận Marin

COUNTY OF MARIN

Đạo luật về Dịch vụ Y tế Tâm thần (Prop 63)
Kế hoạch Ba năm của Chương trình và Chi phí (TK2014-15 đến TK2016-17)

Cư dân Quận Marin được mời đến để góp ý kiến và cung cấp những đề nghị về dịch vụ y tế tâm thần và lạm dụng chất nghiện trong cộng đồng của chúng ta.

Thứ Ba ***23 tháng 7, 2013***	***Novato Youth Center*** ***680 Wilson Avenue, Novato***	***6:30-8:30 tối***
Thứ Ba ***13 tháng 8, 2013***	***Dance Palace*** ***Community and Cultural Center*** ***503 B Street, Pt. Reyes***	***6:30-8:30 tối***
Thứ Năm ***15 tháng 8, 2013***	***Margarita C. Johnson*** ***Senior Center*** ***640 Drake Avenue, Marin City***	***6:30-8:30 tối***
Thứ Tư ***21 tháng 8, 2013***	***Albert J. Boro*** ***Community Center*** ***50 Canal Street, San Rafael***	***6:30-8:30 tối***
Thứ Sáu ***13 tháng 9, 2013*** ***(Chú trọng cho Cao niên)***	***Marin Health & Wellness*** ***Campus Connection Center*** ***Rooms 109/110*** ***3240 Kerner Blvd., San Rafael***	***10:00 sáng – 12:00 trưa***
Thứ Tư ***18 tháng 9, 2013***	***San Rafael Community*** ***Center Auditorium*** ***618 B Street, San Rafael***	***6:30-8:30 tối***

Nếu quý vị không thể tham dự bất cứ những buổi họp này, xin vui lòng cung cấp ý kiến qua thăm dò trực tuyến tại:
http://www.co.marin.ca.us/depts/HH/main/mh/mhsa_faq.cfm

Chúng tôi sẽ cung cấp Giải khát và Dịch vụ Giữ trẻ.

Các buổi họp sẽ được trình bầy bằng tiếng Anh với sự thông dịch sang tiếng Tây ban nha và Việt nam, ngoại trừ buổi họp ngày 21 tháng 8 sẽ được trình bầy bằng tiếng Tây ban nha với sự thông dịch sang tiếng Anh và Việt nam. Nếu quý vị có thắc mắc, xin liên lạc với Kasey Clarke tại: kclarke@marincounty.org hoặc 415.473.7465.

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

Tất cả các cuộc họp công cộng của Quận đều được tổ chức ở những nơi có thể tiếp cận được.
Nếu quý vị cần chuyên chở để tham gia các buổi họp, xin liên lạc với chúng tôi ít nhất 72 tiếng trước bằng cách gọi (415) 473-7465 (Giọng nói) hoặc (415) 473-3344 (TTY) hoặc điện thư về: kclarke@marincounty.org.
Bản sao các tài liệu dùng trong buổi họp có sẵn dưới nhiều dạng thức nếu có đơn yêu cầu.

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

APPENDIX K

MHSA Community Conversation Summary

Executive Summary

The feedback from the community, providers and staff revealed common themes about existing services and new program ideas for mental health and substance use services. The difference in many instances was priority.

For example, all participants contributed comments that addressed the issue of access to service. For the community and provider participants, this was the most frequent theme. For staff, coordination within the mental health system and diversity (ethnic and language capacity) were more frequently noted themes, with access coming in third.

As Marin County Mental Health and Substance Use Services (MHSUS) continues the conversation with the community and continues to plan for Mental Health Services Act (MHSA) services over the next three years, this summary can serve as a touchstone about all that the stakeholders have in common and a reminder to find both the areas of mutual understanding and the areas where further discussion may be needed.

Key Themes

Three areas were frequently noted and prioritized the participants. The most common themes are inter-related to each other and many comments included more than one theme.

- **Access** was the most common theme in the community and provider input about existing services and about new ideas. It also was a top priority for community and providers who participated in the meetings and completed the online survey. Comments that were coded to this theme, included concerns about enough mental health services, limited locations, lack of services for identified needs, high-cost or no insurance coverage and the difficulty of navigating complex systems.
- **Coordination with Other Systems** was a frequently noted theme in the comments from community members, providers and staff. (Staff comments about existing services focused on Coordination within the Mental Health System.) Ideas that addressed this issue were prioritized by participants in the community meetings. Comments in this theme area related to the need to coordinate services with service systems outside of the mental health system. Frequently noted systems included housing, physical health, the justice system, and substance use treatment programs.
- **Substance Use Services** was the focus of comments about existing services and new ideas from the community and providers. It was emphasized by staff in the discussion of new ideas. Ideas that addressed this theme were prioritized by the community and provider participants. Comments that were included in this theme included increasing access to substance use services, decreasing the use of the justice system for substance use treatment, bringing treatment services into local communities, doing more to prevent teen addiction and addressing fetal alcohol syndrome in young children.

Table 1: Rank of Themes in Comments and Prioritized Ideas: Community, Provider and Staff Input

	Themes in Comments		Themes in Prioritized Ideas	
	Community and Provider Input	Staff Input	Community Ideas (Ranking of Dots)	Online Survey (Ranking of Votes)
Existing Services				
Access	1	3		
Coordination with Other Systems	2			
Coordination within Mental Health System		1		
Substance Use Services	3			
Diversity (Ethnicity/language)		2		
New Program Ideas				
Access	1		2	1
Substance Use Services	2	1		3
Coordination with other Systems	3	2 (tie)	1	
Housing		2 (tie)	3	
Schools				2

Overview of Process

Community Conversation Locations

Six community meetings were held in locations throughout Marin County during July, August and September 2013. To encourage further input, staff brought key questions to existing coalition meetings to introduce the planning process and collect ideas. MHSUS staff also participated in an all staff meeting in August 2013 to contribute their comments.

Outreach and Representation Efforts

MHSUS staff performed the outreach for all community meetings. Staff announced the availability of the online survey at community meetings and through the MHSUS/MHSA website. After the July and August meetings, staff reviewed the representation of the participants to date and did additional outreach to encourage participation from Youth, LGBTQ, and Veterans in Marin County.

Overview of Protocols

The protocols for the community meetings were developed to (1) give an overview of the planning process, (2) ask for input about the current mental health and substance use services in Marin County and (3) provide a forum for the community to share their ideas for future mental health and substance use services. As part of the introduction, participants were encouraged to look beyond the current services and constraints inherent in a single funding source to describe the types of mental health and substance use system they would like to have in Marin County.

Community, Provider and Staff Participation

Overall, 196 community members and providers attended the community meetings and 76 individuals completed the online survey. In addition, MHSUS staff participated in an all staff meeting to discuss the existing services and new ideas for the MHSA Three Year Plan. Community members, providers and staff also discussed their ideas and contributed their views through discussion at ongoing coalition, collaborative and management meetings.

Demographic information was collected from community and provider participants (at the community meetings and as part of the survey) to track the gender, age, language, race/ethnicity, geographic affiliation and representation of those who contributed ideas. A review of the demographic data shows that men, youth (age 0-25), LGBTQ and Veteran individuals did not participate in the community process at the same rate as other groups.

Further information

- Appendix B, Table B1, B2, B3 (Community and Provider Representation)
- Appendix C, Table C1, C2 (Staff Representation)

Report Organization

This report is divided into two sections and five appendices. The first two sections are summaries of the findings to provide Marin County Mental Health and Substance Use Services (MHSUS) staff an overview of the key themes that emerged during the discussions about existing services, new program ideas and priorities. The appendices are provided for reference when further detail is needed.

- The first section describes the overall themes that emerged from the community, provider and staff input and details the types of themes that were common by MHSA Component, Age Group, Geography and Special Populations.
- The second section discusses the themes of the ideas that were prioritized by the community.
- The appendices provide a more detailed summary of the findings for reference. Appendices B and C are divided into three parts. The sections begin with a demographic summary, and then provide the themes in the feedback for EXISTING services followed by the themes that emerged from the NEW program ideas.
    - Appendix A: Overall Themes
    - Appendix B: Community and Provider Input
    - Appendix C: Staff Input
    - Appendix D: Priorities
    - Appendix E: Glossary of Themes and Staff Ideas

Section One: Summary of Themes

Overall Themes

The community, provider and staff participants noted similar needs and prioritized similar ideas. The input from both groups are presented side-by-side in this report to facilitate an understanding of where the stakeholders agree and where there is room for further discussion.

Findings

- Comments from the discussion of existing services at the community meetings and the online survey focused on Access, Coordination with Other Systems, and Substance Use Services. These themes were also found in the staff discussions, but with different frequency. The staff comments emphasized Coordination within the Mental Health System, Diversity (ethnic and language capacity), and then Access to existing services.

- A similar pattern is seen when the themes for new ideas are reviewed. Access, Substance Use Services and Coordination with Other Systems were the most frequent topics in the community and provider conversation, and the percentages were slightly shifted during the staff discussion. Staff input showed Substance Use Services, Coordination with Other Systems and Housing as the top three most common themes.

Table 2: Overall Themes, Community Provider and Staff Input

	Percentage of Comments	
	Community and Provider Input	**Staff Input**
Existing Services (n)	442	95
Access	22%	15%
Coordination with Other Systems	15%	11%
Substance Use Services	13%	9%
Coordination within Mental Health System	12%	23%
Outreach/Information about Mental Health Services	10%	4%
Diversity (Ethnicity/Language)	9%	16%
Training	5%	14%
New Program Ideas (n)	730	141
Access	14%	6%
Substance Use Services	13%	15%
Coordination with Other Systems	11%	13%
Housing	6%	13%
Physical Health	5%	11%

Key
Most Common Theme
Second Most Common Theme
Third Most Common Theme

Further information

- Appendix A: Table A1
- Appendix E: Table E1 (Glossary of Themes)

MHSA Components

Findings

To better understand how the comments related to the components of MHSA, the comments were coded by each of the components: CSS, PEI, INN, WET and CFTN. Only CSS and PEI received enough comments for meaningful discussion (n>11).

- The community and provider input for CSS and PEI emphasized the need for more Access to existing services, more Coordination with Other Systems and more Outreach and Information about Mental Health Services.
- When commenting on new ideas, the community and provider input focused on Access, Substance Use Services, Coordination with Other Systems and More Beds for CSS and shifted to include Training, Nutrition/Fitness/Wellness, and Education about Mental Health/Stigma/Symptoms, as well as Coordination with Other Systems for PEI.
- Staff comments also noted the need for more Access to existing services for CSS, but were more heavily representative of the need for Diversity and Language Capacity in both components, particularly a need for Vietnamese and Latino staff and Vietnamese and Spanish language resources.
- The staff comments about new ideas showed a preference for Housing in CSS programs and continued the theme of increased Diversity for PEI programs.

Table 3: Themes in Community, Provider and Staff Input, by MHSA Component

	Percentage of Comments			
	Community and Provider Input		Staff Input	
	CSS	PEI	CSS	PEI
Existing Services (n)	57	53	28	15
Access	26%	25%	18%	7%
Coordination with Other Systems	25%	15%	11%	7%
Outreach/Information about Mental Health Services	19%	17%	4%	7%
Substance Use Services	18%	8%	11%	0%
Diversity (Ethnicity/language)	11%	11%	21%	47%
Coordination within Mental Health system	9%	2%	11%	7%
Housing	9%	0%	11%	0%
New Program Ideas (n)	93	71	42	13
Access	23%	9%	2%	8%
Substance Use Services	10%	8%	10%	0%
Coordination with Other Systems	9%	11%	14%	8%
More Beds	9%	0%	2%	0%
Housing	8%	0%	21%	0%
Physical Health	3%	7%	7%	15%
Training	2%	11%	0%	0%
Nutrition/Fitness/Wellness	2%	11%	0%	15%
Education about Mental Health/Stigma/Symptoms	1%	11%	0%	15%
Education/Employment Services	8%	0%	10%	0%
Diversity (Ethnicity/Language)	1%	4%	7%	31%
Schools	0%	9%	2%	15%

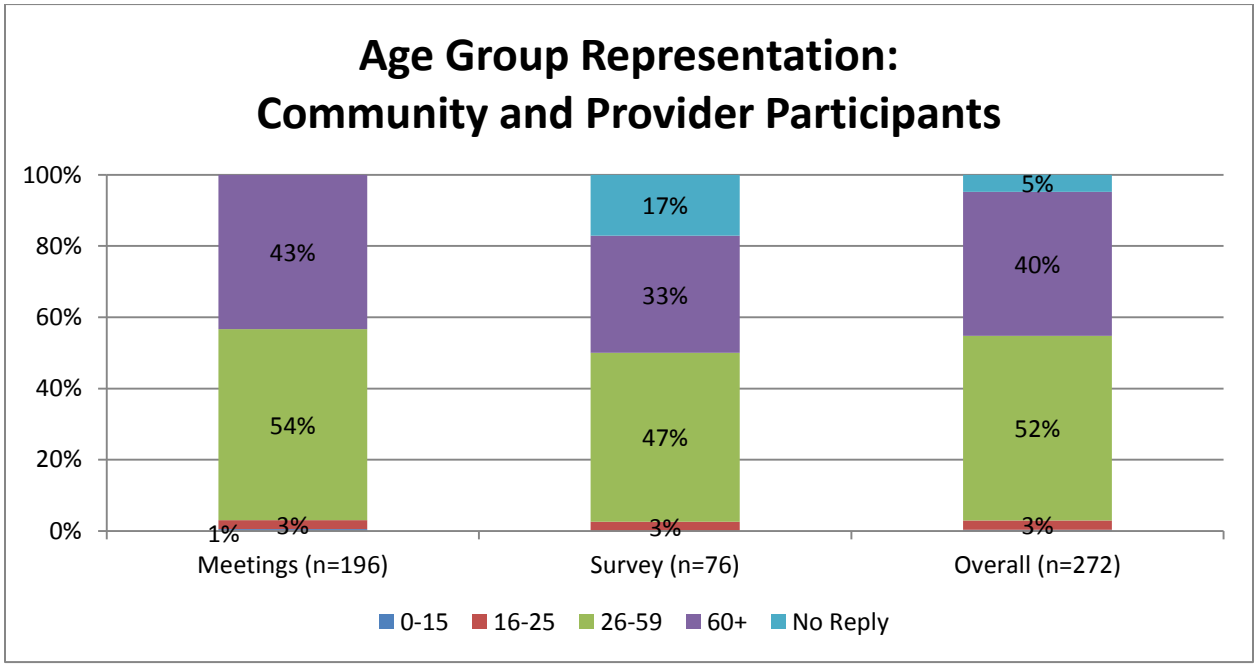
Further information

- Appendix B: Table B4, Table B9 (Community and Provider Input)
- Appendix C: Table C3, Table C6 (Staff Input)
- Appendix E: Table E1 (Glossary of Themes)

Age Groups

Representation

Outreach was done to encourage a variety of age groups to participate in the planning process. The figure below shows how the community participated in the meetings and in the survey. Overall, adults and older adults were well-represented. There was much less participation from youth age 0-25.



Findings

The data was reviewed by age group to better understand the themes.

- Community and provider input focused on Access, Schools and Substance Use Services when asked about existing programs for children and youth. When asked about new ideas, their ideas also included Caregivers and Families for young children.
- Comments from the community about existing services for adults prioritized Access and Coordination within the Mental Health System, as well as Housing and Coordination with Other Systems. Comments about new services addressed Access and Coordination with Other Systems as well as the need to include Caregivers and Families.
- Community and provider participants were most likely to comment on Access, Outreach/Information about Mental Health Services and Coordination with Other Systems for older adults when asked about existing services. Themes in new program ideas were similar to adults, emphasizing Access, Coordination with Other Systems, and Substance Use Services.
- There was not enough staff input specific to young children, adults or older adults to be meaningful for discussion (n≤10). There were enough comments to review existing services for TAY and existing and new ideas for School Age Youth.

- Staff comments emphasized Substance Use Services and the need for Diversity in existing services for TAY. For new services, the focus was on Substance Use Services (School Age and TAY), Coordination with Other Systems (School Age and TAY) and Housing (TAY).

Table 4: Themes in Community, Provider and Staff Input, by Age Group

	Percentage of Comments						
	Community and Provider					Staff	
	Young Children 0 to 5)	School age (6-18)	TAY (16-25)	Adult (26-59)	Older Adult (60+)	School Age (6-18)	TAY (16-25)
Existing Services (n)	55	63	75	50	60	n/a	15
Access	16%	13%	13%	18%	17%	n/a	7%
Schools	22%	25%	9%	4%	2%	n/a	0%
Substance Use Services	13%	13%	12%	10%	3%	n/a	20%
Coordination with Other Systems	4%	8%	8%	16%	8%	n/a	0%
Outreach/Information about Mental Health Services	9%	6%	4%	6%	10%	n/a	0%
Diversity (Ethnicity/language)	5%	5%	3%	12%	5%	n/a	20%
Housing	0%	0%	5%	16%	7%	n/a	13%
Coordination within Mental Health System	4%	3%	1%	18%	2%	n/a	0%
New Program Ideas (n)	114	177	173	85	120	23	21
Access	15%	12%	11%	28%	21%	4%	0
Schools	24%	31%	15%	2%	0%	0%	0%
Substance Use Services	9%	14%	14%	12%	12%	35%	33%
Caregivers/Families	12%	9%	7%	13%	11%	9%	5%
Coordination with Other Systems	4%	5%	6%	21%	14%	22%	19%
Education about Mental Health/Stigma/Symptoms	11%	11%	7%	7%	3%	9%	0%
Housing	3%	2%	8%	7%	8%	13%	19%
Outreach/Information about Mental Health Services	4%	5%	4%	7%	7%	13%	5%
Training	4%	4%	3%	2%	4%	13%	14%

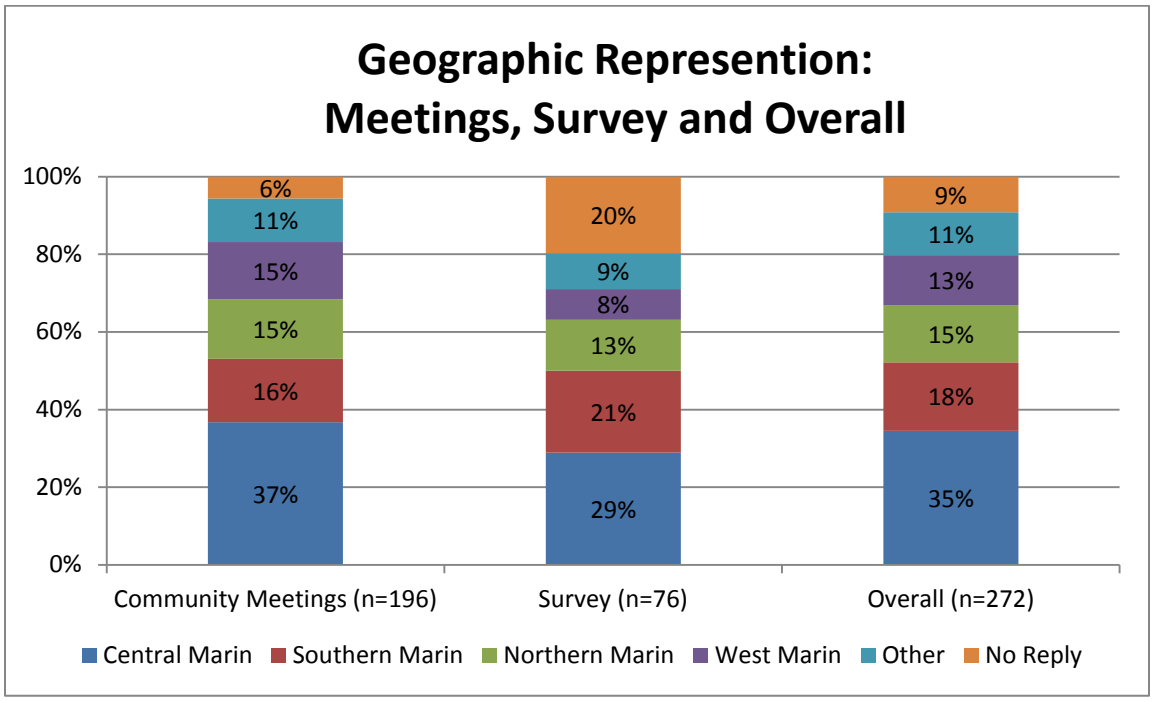
Further Information

- Appendix B:Table B1 (Demographics of Community and Provider Participants)
- Appendix B: Table B5, Table B10 (Community and Provider Input)
- Appendix C: Table C4, Table C7 (Staff Input)
- Appendix E: Table E1 (Glossary of Themes)

Geography

Representation

Geographically, Marin County is roughly divided into four regions: Central, Northern, Southern and West. Community and provider participants were most likely to report living or working in Central Marin (35% overall). The other areas of the county were represented by 13-18% of the participants.



Findings, by Comment

Community and provider input included enough specific comments about West and Southern Marin (n>11) to review existing services, and enough data about West Marin to summarize new ideas. There was not sufficient staff input that was specific to the four regions (n≤10).

- Comments specific to West Marin were most likely to note Access as a theme. Participants also noted Transportation, Substance Use Services and Outreach/Information about Mental Health Services when asked about existing services. New Ideas focused on Substance Use Services and Coordination with Other Systems in addition to Access.
- Comments about Southern Marin also noted a need for Access, and Outreach/Information about Mental Health Services. Participants also emphasized Coordination with Other Systems and Substance Use Services.

Table 5: Themes in Community and Provider Input, by Geography (Comments)

	Percentage of Comments	
	West	**South**
Existing Services (n)	18	14
Access	44%	43%
Coordination with Other Systems	6%	14%
Substance Use Services	11%	14%
Outreach/Information about Mental Health Services	11%	29%
Transportation	17%	0%
New Program Ideas (n)	36	10
Access	17%	n/a
Substance Use Services	17%	n/a
Coordination with Other Systems	14%	n/a
Physical Health	11%	n/a

Further Information

- Appendix B:Table B1 (Demographics of Community and Provider Participants)
- Appendix B: Table B6, Table B11 (Community and Provider Input)
- Appendix C: Comment on Page 41 (Staff Input)
- Appendix E: Table E1 (Glossary of Themes)

Findings, by Meeting Location

More comments were available for analysis when the data was examined by meeting location. There were sufficient comments to include all four regions.

- In West Marin, participants were most likely to comment about Access, Coordination with Other Systems and Outreach/Information about Mental Health Services when asked about existing services. For new ideas, the responses included themes from Coordination with Other Systems, Domestic Violence/Dating Violence/Sexual Assault, Substance Use Services, Access, and Caregivers/Families.
- In Southern Marin, the discussion about existing services focused on Coordination with Other Systems, Outreach and Information about Mental Health Services and Substance Use Services. New ideas showed an emphasis on Coordination within the Mental Health System and with Other Systems.
- In Northern Marin, participants commented most frequently about Outreach/Information about Mental Health Services and Access to existing services. For new program ideas, the comments continued to center around Outreach/Information about Mental Health Services, and also included Substance Use Services and Diversity.
- The three meetings that took place in Central Marin resulted in a range of themes that varied by meeting.

Table 6: Themes in Community and Provider Input, by Geography (Meeting Location)

	Percentage of Comments					
	West	South	North	Central		
	8/13/13 West Marin	8/15/13 Marin City	7/23/13 Novato	8/21/13 Canal	9/13/13 HHS Campus (San Rafael)	9/18/13 San Rafael
Existing Ideas (n)	49	26	16	20	40	40
Access	37%	12%	19%	5%	28%	18%
Coordination with Other Systems	18%	42%	6%	20%	10%	13%
Outreach/Information about Mental Health Services	14%	23%	31%	15%	13%	0%
Substance Use Services	12%	15%	6%	10%	5%	10%
Education about Mental Health/Stigma/Symptoms	4%	4%	13%	15%	8%	3%
Physical Health	4%	4%	0%	20%	3%	8%
Diversity (Ethnicity/language)	4%	4%	6%	10%	3%	3%
Schools	0%	0%	13%	5%	0%	10%
Housing	4%	0%	0%	0%	15%	0%
Dementia	0%	0%	0%	0%	13%	0%
New Program Ideas (n)	40	32	26	67	101	96
Substance Use Services	15%	13%	15%	3%	11%	14%
Coordination with Other Systems	18%	16%	4%	1%	10%	7%
Domestic Violence/Dating Violence/Sexual Assault	18%	0%	0%	1%	0%	0%
Outreach/Information about Mental Health Services	8%	9%	23%	4%	5%	3%
Access	13%	6%	0%	7%	17%	8%
Physical Health	10%	3%	0%	10%	7%	1%
Training	8%	0%	0%	4%	7%	5%
Coordination within Mental Health System	10%	22%	0%	3%	3%	3%
Caregivers/Families	13%	13%	0%	1%	5%	6%
Diversity (Ethnicity/Language)	0%	3%	15%	3%	3%	4%
Education/Employment Services	3%	13%	0%	3%	2%	5%
Housing	8%	9%	4%	6%	8%	7%
Law Enforcement/Jails/Justice System	8%	0%	0%	9%	3%	7%

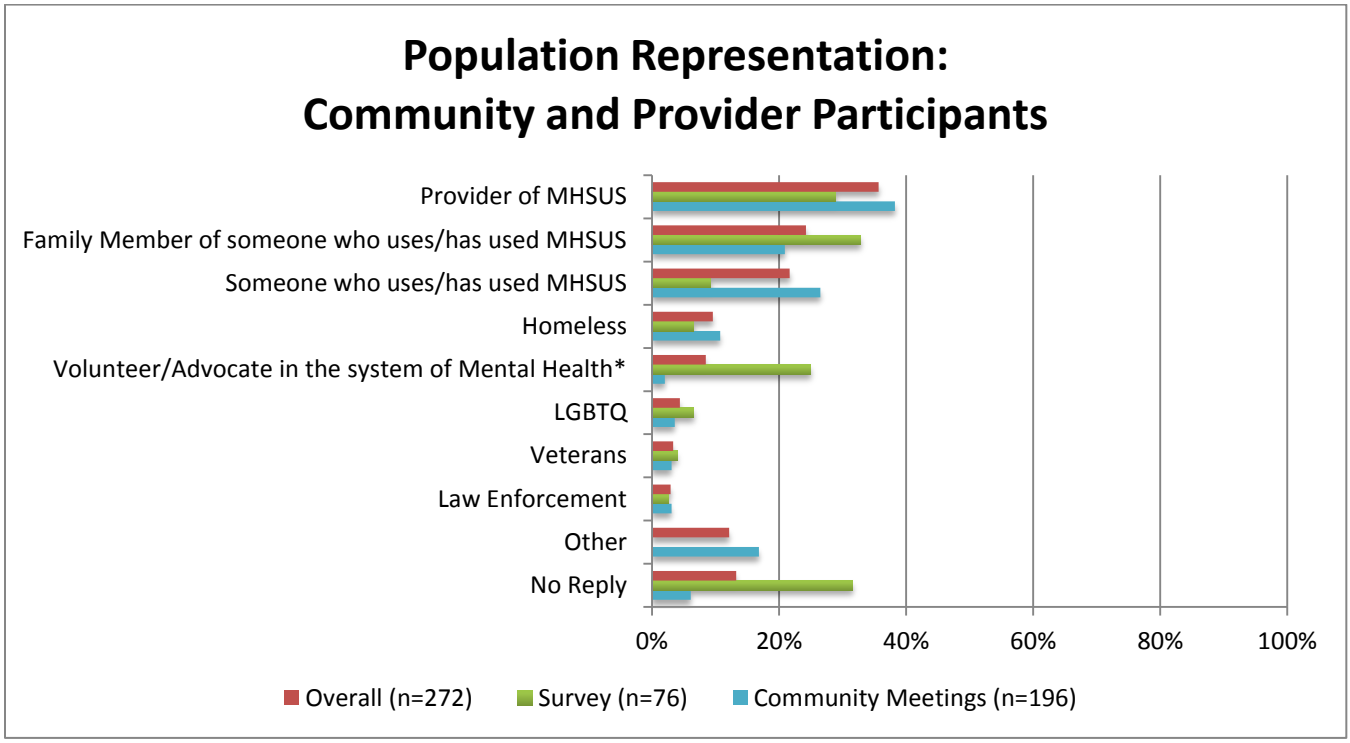
Further Information

- Appendix B: Table B7, Table B12 (Community and Provider Input)
- Appendix E: Table E1 (Glossary of Themes)

Special Populations

All community and provider participants were asked to report demographic information in an effort to understand who was attending the community meetings and who may require additional outreach. The preliminary findings were summarized in September 2013 and additional efforts were made by MHSUS staff to recruit individuals from the populations who were not represented.

Individuals representing Consumers of MHSUS comprised 22% of the participants in the community input process and 10% of the participants indicated they represented the Homeless. Individuals who identified with the LGBTQ and Veterans communities did not participate at the same rate, 4% and 3%, respectively.



**The category "Volunteer/Advocate in the system of Mental Health" was included on the survey, but not in the demographic form distributed at the community meetings. It was coded from comments on the meeting forms, but likely underrepresents the number of volunteers/advocates who participated.*

Findings

The data was reviewed to see how many comments applied to one of the four special populations: Consumers, Homeless, LGBTQ and Veterans. The staff comments for each of the populations were not sufficient to include for a meaningful comparison (n≤10). The community and provider input had enough comments to highlight the consumer and homeless populations.

- Comments related to consumers for existing services focused on the themes of Diversity and Access. For new ideas, the comments were very specific about Consumer Operated Services

(primarily the SAMSHA model) and Pay Equity for Peers. Mentors/Role Models and Caregivers/Families were tied for the third most frequent theme in new ideas.

- When asked about existing services, participants' comments that related to the Homeless highlighted the themes of Substance Use Services, Coordination with Other Systems, Housing and Law Enforcement/Jails/Justice System. New ideas related to Homeless focused on Law Enforcement/Jail/Justice System, Access and Outreach/Information about Mental Health Services.

Table 7: Themes in Community and Provider Input, by Special Population

	Percentage of Comments	
	Consumers	**Homeless**
Existing Services (n)	14	31
Coordination with Other Systems	14%	26%
Substance Use Services	7%	32%
Housing	14%	19%
Diversity (Ethnicity/language)	29%	3%
Access	21%	10%
Law Enforcement/Jails/Justice System	7%	19%
Coordination within the Mental Health System	14%	6%
Outreach/Information about Mental Health Services	14%	6%
New Program Ideas (n)	41	32
Consumer Operated Services	32%	0%
Law Enforcement/Jails/Justice System	2%	28%
Mentors/Role Models	12%	9%
Substance Use Services	7%	13%
Pay Equity for Peers	20%	0%
Caregivers/Families	12%	6%
Access	2%	16%
Outreach/Information about Mental Health Services	2%	16%
Coordination with Other Systems	5%	13%
Housing	2%	13%

Further Information

- Appendix B:Table B1 (Demographics of Community and Provider Participants)
- Appendix B: Table B8, Table B13 (Community and Provider Input)
- Appendix C: Table C5, Table C9 (Staff Input)
- Appendix E: Table E1 (Glossary of Themes)

Section Two: Priorities

Process

As staff prepared for the community conversations, they met to discuss their own priorities for the MHSA Three-Year Integrated Plan. Each component coordinator was asked to share their program ideas and the group chose seven program areas as recommendations.

These seven staff ideas were presented at the community meetings as part of the new ideas discussion. Care was taken not to promote the ideas, simply to include them and gauge community interest. At the community meetings, after all of the new ideas were generated and posted on the wall, participants were asked to use three voting stickers and choose three priorities. The specific ideas that were chosen varied from meeting to meeting depending on the participants and the content of the discussion.

The ideas were also included as part of the online survey. Survey respondents were first asked for their own ideas, then presented with a one sentence description of the staff ideas and asked to indicate their preferences. The online survey invited respondents to choose three priorities in three different sections, so each respondent prioritized nine ideas. Survey respondents were given opportunities to present their own ideas and review staff ideas, but they did not see other community ideas as the community meetings were taking place at the same time the survey was available.

Findings, Community and Provider Ideas

After all the community and provider ideas were coded into themes, the number of dots (community meetings) and votes (online survey) in each theme were calculated.

- Across both the community meetings and the surveys, ideas that addressed Access to services and Substance Use Services were frequently prioritized.
- The community meeting participants were more likely than the online survey respondents to prioritize ideas that addressed Coordination with other Systems, Housing and Outreach/Information about Mental Health Services.
- The survey respondents were more likely to choose ideas that addressed services in Schools.
- Ideas that were prioritized in each meeting varied depending on the participants and the areas of discussion. For more information about the specific ideas that were prioritized at each of the six community meetings, see Appendix D, Table D3.

Table 8: Themes in Prioritized Ideas, Community and Provider Input

	Community Meetings		Online Survey	
	Number of Dots (3 per participant)	Percent	Number of Votes (9 per respondent)	Percent
Coordination with Other Systems	39	8%	17	4%
Access	37	7%	39	8%
Housing	34	7%	15	3%
Substance Use Services	31	6%	23	5%
Outreach/Information about Mental Health Services	29	6%	9	2%
Dementia	23	4%	0	0%
Consumer Operated Services	22	4%	1	0%
Physical Health	21	4%	4	1%
Coordination within Mental Health System	21	4%	13	3%
Diversity (Ethnicity/Language)	19	4%	4	1%
More beds	16	3%	9	2%
Law Enforcement/Jails/Justice System	15	3%	10	2%
Training	13	3%	10	2%
Nutrition/Fitness/Wellness	13	3%	2	0%
Mobile Clinic/Services	13	3%	2	0%
Transportation	11	2%	1	0%
Isolation	11	2%	1	0%
Schools	8	2%	34	7%
Anger Management/Domestic Violence/Dating Violence/Sexual Assault	6	1%	10	2%
Caregivers/Families	6	1%	21	4%
Education about Mental Health/Stigma/Symptoms	5	1%	19	4%
Total Dots/Votes for Community and Provider Ideas	476	92%	305	64%
Total Dots/Votes for all Ideas	520		474	

Further Information

- Appendix D: Table D1
- Appendix E: Table E1 (Glossary of Themes)

Findings, Staff Ideas

- Many of the themes that were prioritized by the community meeting and survey participants are addressed in the staff ideas. For example, the survey respondents prioritized Alliance in Recovery (Table 9) in addition to ideas that related to Substance Use Services (Table 8).

Table 9: Staff Ideas, Community and Provider Input

	Community Meetings		Online Survey	
	Number of Dots (3 per participant)	**Percent**	**Number of Votes (9 per respondent)**	**Percent**
Pay Equity for Peer Providers	16	3%	26	5%
Assisted Outpatient Treatment	12	2%	26	5%
School Age Programs	12	2%	26	5%
Step Down Program	2	0%	18	4%
Alliance in Recovery	1	0%	31	7%
Southern Marin Youth Services	1	0%	18	4%
Suicide Prevention	0	0%	24	5%
Total Dots/Votes for Staff Ideas	44	8%	169	36%
Total Dots/Votes for all Ideas	520		474	

Further Information

- Appendix D: Table D2
- Appendix E: Table E2 (Description of Staff Ideas)

Next Steps

This summary report is one part of the planning process to develop the Marin County MHSA Three-Year Integrated Plan. The feedback, ideas and priorities that have been shared by the community, providers and staff will be shared internally with the MHSUS staff and management as well as with the MHSA Implementation Committee and the Mental Health Board.

Reaching out to the community invites conversation. The results of this planning process will be shared with the community to continue the discussion and to continue to work together to improve the mental health system in Marin County.

Appendix A: Overall Themes

This appendix includes the overall themes for existing services and new program ideas from the community, provider and staff input.

Table A1: Overall Themes, Community, Provider and Staff Input

	Percentage of Comments	
Themes	**Community and Provider Input**	**Staff Input**
Existing Services (n)	**442**	**95**
Access	22%	15%
Coordination with Other Systems	15%	11%
Substance Use Services	13%	9%
Coordination within the Mental Health System	12%	23%
Outreach/Information about Mental Health Services	10%	4%
Diversity (Ethnicity/Language)	9%	16%
Housing	7%	7%
Schools	7%	0%
Training	5%	14%
Education about Mental Health/Stigma/Symptoms	5%	5%
Physical Health	5%	3%
Transportation	3%	2%
Law Enforcement/Jails/Justice System	2%	0%
Domestic Violence/Dating Violence/Sexual Assault	2%	0%
Dementia	1%	0%
Pay Equity for Peers	1%	1%
Trauma	1%	0%
Other	10%	0%
New Program Ideas (n)	730	141
Access	14%	6%
Substance Use Services	13%	15%
Coordination with Other Systems	11%	13%
Schools	8%	2%
Caregivers/Families	8%	4%
Outreach/Information about Mental Health Services	6%	6%
Housing	6%	13%
Training	6%	8%
Coordination within the Mental Health System	6%	4%
Education about Mental Health/Stigma/Symptoms	6%	2%

	Percentage of Comments	
Themes	**Community and Provider Input**	**Staff Input**
Diversity (Ethnicity/Language)	5%	9%
Physical Health	5%	11%
Law Enforcement/Jails/Justice System	5%	1%
Domestic Violence/Dating Violence/Sexual Assault	3%	1%
More beds	3%	1%
Depression/Anxiety/Stress	3%	0%
Nutrition/Fitness/Wellness	3%	4%
Transportation	3%	1%
Education/Employment Services	2%	4%
Support Groups	2%	1%
Consumer Operated Services	2%	1%
Bullying	2%	0%
Isolation	2%	0%
Mentors/Role Models	2%	0%
Mobile Clinic/Services	2%	1%
Assisted Outpatient Treatment	2%	0%
Quality	2%	0%
Pay Equity for Peers	1%	2%
Dementia	1%	2%
Trauma	1%	4%
Other	12%	11%

Appendix B: Community and Provider Input

This appendix includes the (1) demographic summary of the community and provider participants and their comments, (2) the themes in the community and provider comments about existing mental health services and (3) the themes in the community and provider comments about new program ideas.

Demographic Summary

Table B1: Demographics of Community and Provider Participants

	Meetings		Survey		Overall	
	Frequency	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Gender						
Male	50	26%	18	24%	68	25%
Female	146	74%	39	51%	185	68%
No Reply	0	0%	19	25%	19	7%
Age						
0-15	1	1%	0	0%	1	0%
16-25	5	3%	2	3%	7	3%
26-59	105	54%	36	47%	141	52%
60+	85	43%	25	33%	110	40%
No Reply	0	0%	13	17%	13	5%
Language						
English	151	77%	63	83%	214	79%
Spanish	24	12%	2	3%	26	10%
Vietnamese	20	10%	0	0%	20	7%
Cantonese	0	0%	1	1%	1	0%
Other	1	1%	0	0%	1	0%
No Reply	0	0%	13	17%	13	5%
Race/Ethnicity						
White	101	52%	54	71%	155	57%
Hispanic	28	14%	1	1%	29	11%
African/American	21	11%	1	1%	22	8%
More than one race/ethnicity	14	7%	3	4%	17	6%
Asian	10	5%	1	1%	11	4%
Pacific Islander	5	3%	0	0%	5	2%

	Meetings		Survey		Overall	
	Frequency	**Percent**	**Frequency**	**Percent**	**Frequency**	**Percent**
Native	1	1%	0	0%	1	0%
Other	8	4%	0	0%	8	3%
No Reply	8	4%	16	21%	24	9%
Geography						
Central Marin	72	37%	22	29%	94	35%
Northern Marin	30	15%	10	13%	40	15%
Southern Marin	32	16%	16	21%	48	18%
West Marin	29	15%	6	8%	35	13%
Other	23	11%	7	9%	30	11%
No Reply	10	6%	15	20%	25	9%
Representation						
Provider of MHSUS	75	38%	22	29%	97	36%
Someone who uses/has used MHSUS	52	27%	7	9%	59	22%
Family Member of someone who uses/ has used MHSUS	41	21%	25	33%	66	24%
Homeless	21	11%	5	7%	26	10%
LGBTQ	7	4%	5	7%	12	4%
Law Enforcement	6	3%	2	3%	8	3%
Veterans	6	3%	3	4%	9	3%
Volunteer/Advocate in the system of Mental Health	4	2%	19	25%	23	8%
Other	33	17%	0	0%	33	12%
No Reply	12	6%	24	32%	36	13%
Total Participants	196		76		272	

Table B2: Language of Comments

	Existing Services		New Program Ideas	
	Number of Comments	**Percentage**	**Number of Comments**	**Percentage**
English	418	95%	680	93%
Spanish	20	4%	42	6%
Vietnamese	4	1%	8	1%
Total Comments	**442**		**730**	

Table B3: Number of Comments by Meetings

	Existing Services		New Program Ideas	
Community Meetings	**Number of Comments**	**Percentage**	**Number of Comments**	**Percentage**
9.13.13 HHS Campus	41	9%	101	14%
9.18.13 San Rafael	40	9%	96	13%
8.21.13 Canal	20	5%	67	9%
9.13.13 PEI Committee Meeting	18	4%	48	7%
8.13.13 West Marin	49	11%	40	5%
8.15.13 Marin City	26	6%	32	4%
7.23.12 Novato	16	4%	26	4%
8.27.13 West Marin Teen Collaborative	0	0%	16	2%
9.19.13 MLK Coalition Meeting	13	3%	9	1%
8.05.13 AOD Board Meeting	0	0%	1	0%
Letter, Email and Survey Responses				
Survey	218	49%	284	39%
Email	1	0%	9	1%
Letter	1	0%	1	0%
Total Comments	**442**		**730**	

Themes

Existing Services

Table B4: Themes in Community and Provider Input: Existing Services, by MHSA Component

	Percentage of Comments					
	CSS	PEI	*INN**	*WET**	*CFTN**	All Comments
Existing Services (n)	57	53	1	9	0	442
More Services/More Funding	49%	36%	*100%*	*22%*	*0%*	63%
Like Services	7%	36%	*0%*	*56%*	*0%*	19%
Themes						
Access	26%	25%	*0%*	*11%*	*0%*	22%
Coordination with Other Systems	25%	15%	*0%*	*0%*	*0%*	15%
Substance Use Services	18%	8%	*0%*	*11%*	*0%*	13%
Coordination within Mental Health System	9%	2%	*0%*	*0%*	*0%*	12%
Outreach/Information about Mental Health Services	19%	17%	*0%*	*0%*	*0%*	10%
Other	5%	8%	*0%*	*0%*	*0%*	10%
Diversity (Ethnicity/Language)	11%	11%	*0%*	*11%*	*0%*	9%
Housing	9%	0%	*0%*	*0%*	*0%*	7%
Schools	0%	4%	*0%*	*0%*	*0%*	7%
Training	2%	9%	*0%*	*22%*	*0%*	5%
Education about Mental Health/Stigma/Symptoms	2%	6%	*0%*	*0%*	*0%*	5%
Physical Health	5%	8%	*0%*	*0%*	*0%*	5%
Transportation	5%	4%	*0%*	*0%*	*0%*	3%
Law Enforcement/Jails/Justice System	5%	0%	*0%*	*0%*	*0%*	2%
Domestic Violence/Dating Violence/Sexual Assault	2%	2%	*0%*	*11%*	*0%*	2%
Dementia	2%	2%	*0%*	*0%*	*0%*	1%
Pay Equity for Peers	4%	0%	*0%*	*0%*	*0%*	1%
Trauma	0%	0%	*0%*	*0%*	*0%*	1%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Table B5: Themes in Community and Provider Input: Existing Services, by Age Group

	Percentage of Comments					
	0 to 5	School age (6-18)	TAY (16-25)	Adult	Older Adult	All Comments
Existing Services (n)	55	63	75	50	60	442
More Services/More Funding	62%	63%	49%	40%	47%	63%
Like Services	18%	17%	12%	8%	17%	19%
Themes						
Access	16%	13%	13%	18%	17%	22%
Coordination with Other Systems	4%	8%	8%	16%	8%	15%
Substance Use Services	13%	13%	12%	10%	3%	13%
Coordination within Mental Health System	4%	3%	1%	18%	2%	12%
Outreach/Information about Mental Health Services	9%	6%	4%	6%	10%	10%
Diversity (Ethnicity/Language)	5%	5%	3%	12%	5%	9%
Housing	0%	0%	5%	16%	7%	7%
Schools	22%	25%	9%	4%	2%	7%
Training	2%	2%	1%	0%	2%	5%
Education about Mental Health/Stigma/Symptoms	2%	2%	4%	0%	3%	5%
Physical Health	4%	3%	0%	6%	5%	5%
Transportation	0%	0%	3%	0%	7%	3%
Law Enforcement/Jails/Justice System	2%	2%	1%	6%	0%	2%
Domestic Violence/Dating Violence/Sexual Assault	5%	5%	3%	4%	0%	2%
Dementia	0%	0%	0%	0%	8%	1%
Pay Equity for Peers	0%	0%	0%	0%	0%	1%
Trauma	4%	2%	0%	0%	0%	1%
Other	15%	10%	15%	14%	8%	10%

Table B6: Themes in Community and Provider Input: Existing Services, by Geography (Comment)

	Percentage of Comments				
	*Central**	West	*North**	South	All Comments
Existing Services (n)	*3*	18	*0*	14	442
More Services/More Funding	*67%*	61%	*0%*	50%	63%
Like Services	*0%*	6%	*0%*	0%	19%
Themes					
Access	*33%*	44%	*0%*	43%	22%
Coordination with Other Systems	*0%*	6%	*0%*	14%	15%
Substance Use Services	*0%*	11%	*0%*	14%	13%
Coordination within the Mental Health System	*0%*	6%	*0%*	0%	12%
Outreach/Information about Mental Health Services	*0%*	11%	*0%*	29%	10%
Diversity (Ethnicity/Language)	*33%*	0%	*0%*	7%	9%
Housing	*0%*	0%	*0%*	0%	7%
Schools	*0%*	6%	*0%*	0%	7%
Trauma	*0%*	0%	*0%*	0%	5%
Education about Mental Health/Stigma/Symptoms	*0%*	0%	*0%*	0%	5%
Physical Health	*33%*	0%	*0%*	7%	5%
Transportation	*0%*	17%	*0%*	0%	3%
Law Enforcement/Jails/Justice System	*0%*	0%	*0%*	0%	2%
Domestic Violence/Dating Violence/Sexual Assault	*0%*	0%	*0%*	0%	2%
Dementia	*0%*	0%	*0%*	0%	1%
Pay Equity for Peers	*0%*	0%	*0%*	0%	1%
Training	*0%*	0%	*0%*	0%	1%
Other	*0%*	0%	*0%*	0%	10%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Table B7: Themes in Community and Provider Input: Existing Services, by Geography (Meeting Location)

	Percentage of Comments						
	West	South	North	Central			
	8/13/13 West Marin	8/15/13 Marin City	7/23/2013, Novato	8/21/13 Canal	9/13/2013, HHS Campus (San Rafael)	9/18/13, San Rafael	**All Comments**
Existing Services (n)	49	26	16	20	40	40	442
More Services/More Funding	31%	38%	19%	20%	50%	50%	63%
Like Services	6%	8%	25%	55%	13%	13%	19%
Themes							
Access	37%	12%	19%	5%	18%	28%	22%
Coordination with Other Systems	18%	42%	6%	20%	13%	10%	15%
Substance Use Services	12%	15%	6%	10%	10%	5%	13%
Coordination within the Mental Health System	6%	0%	0%	5%	8%	3%	12%
Outreach/Information about Mental Health Services	14%	23%	31%	15%	0%	13%	10%
Diversity (Ethnicity/Language)	4%	4%	6%	10%	3%	3%	9%
Housing	4%	0%	0%	0%	0%	15%	7%
Schools	0%	0%	13%	5%	10%	0%	7%
Trauma	2%	0%	0%	0%	0%	0%	5%
Education about Mental Health/Stigma/Symptoms	4%	4%	13%	15%	3%	8%	5%
Physical Health	4%	4%	0%	20%	8%	3%	5%
Transportation	6%	8%	0%	0%	5%	3%	3%
Law Enforcement/Jails/Justice System	0%	0%	0%	0%	3%	0%	2%
Domestic Violence/Dating Violence/Sexual Assault	4%	0%	0%	0%	0%	0%	2%
Dementia	0%	0%	0%	0%	0%	13%	1%
Pay Equity for Peers	0%	0%	0%	0%	5%	0%	1%
Training	4%	0%	0%	0%	5%	0%	1%
Other	2%	4%	0%	0%	3%	0%	10%

Table B8: Themes in Community and Provider Input, by Special Populations (Consumers, LGBTQ, Homeless, Veterans)

	Percentage of Comments				
	Consumer	***LGBTQ****	**Homeless**	***Veterans****	**All Comments**
Existing Services (n)	14	*0*	31	*2*	442
More Services/More Funding	36%	*0%*	39%	*50%*	63%
Like Services	14%	*0%*	6%	*0%*	19%
Themes					
Access	21%	*0%*	10%	*0%*	22%
Coordination with Other Systems	14%	*0%*	26%	*50%*	15%
Substance Use Services	7%	*0%*	32%	*0%*	13%
Coordination within Mental Health System	14%	*0%*	6%	*0%*	12%
Outreach/Information about Mental Health Services	14%	*0%*	6%	*0%*	10%
Diversity (Ethnicity/Language)	29%	*0%*	3%	*0%*	9%
Housing	14%	*0%*	19%	*0%*	7%
Schools	0%	*0%*	0%	*0%*	7%
Training	0%	*0%*	6%	*0%*	5%
Education about Mental Health/Stigma/Symptoms	0%	*0%*	3%	*0%*	5%
Physical Health	0%	*0%*	6%	*50%*	5%
Transportation	7%	*0%*	0%	*0%*	3%
Law Enforcement/Jails/Justice System	7%	*0%*	19%	*0%*	2%
Domestic Violence/Dating Violence/Sexual Assault	0%	*0%*	0%	*0%*	2%
Dementia	0%	*0%*	0%	*0%*	1%
Pay Equity for Peers	7%	*0%*	0%	*0%*	1%
Trauma	0%	*0%*	0%	*0%*	1%
Other	14%	*0%*	10%	*0%*	10%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

New Program Ideas

Table B9: Themes in Community and Provider Input: New Program Ideas, by Component

	Percentage of Comments					
	CSS	**PEI**	***INN****	**WET**	***CFTN****	**All Comments**
New Program Ideas (n)	93	74	6	33	2	730
Access	23%	9%	*17%*	0%	*0%*	14%
Substance Use Services	10%	8%	*33%*	9%	*50%*	13%
Coordination with Other Systems	9%	11%	*17%*	0%	*50%*	11%
Schools	0%	9%	*0%*	0%	*0%*	8%
Caregivers/Families	5%	7%	*17%*	6%	*0%*	8%
Outreach about Mental Health Services	4%	7%	*17%*	0%	*0%*	6%
Housing	8%	0%	*17%*	0%	*0%*	6%
Training	2%	11%	*0%*	52%	*0%*	6%
Coordination within Mental Health System	6%	3%	*17%*	12%	*50%*	6%
Education about Mental Health /Stigma/Symptoms	1%	11%	*0%*	0%	*0%*	6%
Diversity (Ethnicity/Language)	1%	4%	*0%*	27%	*0%*	5%
Physical Health	3%	7%	*17%*	3%	*50%*	5%
Law Enforcement/Jails/Justice System	8%	8%	*0%*	3%	*0%*	5%
Domestic Violence/Dating Violence/Sexual Assault	0%	3%	*0%*	0%	*0%*	3%
More Beds	9%	0%	*0%*	0%	*0%*	3%
Transportation	2%	4%	*0%*	0%	*0%*	3%
Education/Employment Services	2%	11%	*17%*	6%	*0%*	3%
Support Groups	3%	0%	*0%*	0%	*0%*	3%
Consumer Operated Services	8%	0%	*0%*	6%	*0%*	2%
Depression/Anxiety/Stress	0%	4%	*0%*	0%	*0%*	2%
Bullying	8%	0%	*0%*	0%	*0%*	2%
Isolation	0%	3%	*0%*	0%	*0%*	2%
Mentors/Role Models	0%	4%	*17%*	0%	*0%*	2%
Nutrition/Fitness/Wellness	4%	1%	*0%*	3%	*0%*	2%
Mobile Clinic/Services	5%	5%	*0%*	0%	*0%*	2%
Assisted Outpatient Treatment	2%	0%	*0%*	3%	*0%*	2%
Quality	1%	3%	*0%*	0%	*0%*	2%
Pay Equity for Peers	5%	0%	*0%*	0%	*0%*	1%
Dementia	2%	0%	*0%*	0%	*0%*	1%
Trauma	1%	1%	*0%*	9%	*0%*	1%
Other	4%	16%	*17%*	6%	*0%*	12%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Table B10: Themes in Community and Provider Input: New Program Ideas, by Age Group

	Percentage of Comments					
	0 to 5	School-Age	TAY	Adult	Older Adult	All Comments
New Program Ideas (n)	114	177	173	85	120	730
Access	15%	12%	11%	28%	21%	14%
Substance Use Services	9%	14%	14%	12%	12%	13%
Coordination with Other Systems	4%	5%	6%	21%	14%	11%
Schools	24%	31%	15%	2%	0%	8%
Caregivers/Families	12%	9%	7%	13%	11%	8%
Outreach about Mental Health Services	4%	5%	4%	7%	7%	6%
Housing	3%	2%	8%	7%	8%	6%
Training	4%	4%	3%	2%	4%	6%
Coordination within Mental Health System	6%	3%	4%	8%	4%	6%
Education about Mental Health /Stigma/Symptoms	11%	11%	7%	7%	3%	6%
Diversity (Ethnicity/Language)	4%	3%	3%	4%	5%	5%
Physical Health	1%	3%	3%	4%	6%	5%
Law Enforcement/Jails/Justice System	4%	3%	8%	2%	2%	5%
Domestic Violence/Dating Violence/Sexual Assault	5%	7%	2%	5%	2%	3%
More Beds	4%	3%	2%	8%	6%	3%
Transportation	1%	2%	5%	2%	6%	3%
Education/Employment Services	0%	1%	5%	0%	0%	2%
Support Groups	2%	3%	1%	5%	3%	2%
Consumer Operated Services	0%	0%	1%	1%	1%	2%
Depression/Anxiety/Stress	5%	5%	3%	4%	3%	2%
Bullying	6%	6%	3%	1%	0%	2%
Isolation	1%	1%	0%	2%	6%	2%
Mentors/Role Models	0%	1%	2%	0%	0%	2%
Nutrition/Fitness/Wellness	1%	1%	1%	0%	2%	2%
Mobile Clinic/Services	2%	1%	1%	0%	0%	2%
Assisted Outpatient Treatment	0%	0%	0%	5%	3%	2%
Quality	0%	1%	0%	1%	1%	2%
Pay Equity for Peers	0%	0%	0%	0%	0%	1%
Dementia	0%	0%	0%	0%	6%	1%
Trauma	1%	1%	0%	2%	0%	1%
Other	12%	7%	8%	7%	11%	7%

Table B11: Themes in Community and Provider Input: New Program Ideas, Geography (Comments)

	Percentage of Comments				
	*Central**	West	*North**	*Southern**	All Comments
New Program Ideas (n)	5	36	0	10	730
Access	*20%*	17%	*0%*	*10%*	14%
Substance Use Services	*20%*	17%	*0%*	*40%*	13%
Coordination with Other Systems	*0%*	14%	*0%*	*10%*	11%
Schools	*0%*	6%	*0%*	*0%*	8%
Caregivers/Families	*0%*	6%	*0%*	*10%*	8%
Outreach about Mental Health Services	*40%*	6%	*0%*	*10%*	6%
Housing	*0%*	8%	*0%*	*0%*	6%
Training	*0%*	6%	*0%*	*0%*	6%
Coordination within Mental Health System	*0%*	6%	*0%*	*10%*	6%
Education about Mental Health /Stigma/Symptoms	*20%*	3%	*0%*	*10%*	6%
Diversity (Ethnicity/Language)	*0%*	0%	*0%*	*10%*	5%
Physical Health	*0%*	11%	*0%*	*0%*	5%
Law Enforcement/Jails/Justice System	*0%*	0%	*0%*	*0%*	5%
Domestic Violence/Dating Violence/Sexual Assault	*0%*	8%	*0%*	*0%*	3%
More Beds	*20%*	0%	*0%*	*0%*	3%
Transportation	*0%*	0%	*0%*	*0%*	3%
Education/Employment Services	*0%*	0%	*0%*	*0%*	3%
Support Groups	*0%*	3%	*0%*	*0%*	3%
Consumer Operated Services	*0%*	0%	*0%*	*0%*	2%
Depression/Anxiety/Stress	*0%*	3%	*0%*	*0%*	2%
Bullying	*0%*	0%	*0%*	*0%*	2%
Isolation	*0%*	0%	*0%*	*0%*	2%
Mentors/Role Models	*0%*	0%	*0%*	*0%*	2%
Nutrition/Fitness/Wellness	*0%*	0%	*0%*	*0%*	2%
Mobile Clinic/Services	*0%*	3%	*0%*	*0%*	2%
Assisted Outpatient Treatment	*0%*	0%	*0%*	*0%*	2%
Quality	*0%*	0%	*0%*	*0%*	2%
Pay Equity for Peers	*0%*	0%	*0%*	*0%*	1%
Dementia	*0%*	3%	*0%*	*0%*	1%
Trauma	*0%*	0%	*0%*	*0%*	1%
Other	*0%*	0%	*0%*	*20%*	12%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Table B12: Themes in Community and Provider Input: New Program Ideas, Geography (Meeting Location)

	Percentage of Comments						
	West	South	North	Central			
	8/13/13 West Marin	8/15/13 Marin City	7/23/2013, Novato	8/21/13 Canal	9/13/2013, HHS Campus (San Rafael)	9/18/13, San Rafael	All Comments
New Program Ideas (n)	40	32	26	67	101	96	730
Access	13%	6%	0%	7%	17%	8%	14%
Substance Use Services	15%	13%	15%	3%	11%	14%	13%
Coordination with Other Systems	18%	16%	4%	1%	10%	7%	11%
Schools	5%	0%	12%	0%	0%	5%	8%
Caregivers/Families	13%	13%	0%	1%	5%	6%	8%
Outreach about Mental Health Services	8%	9%	23%	4%	5%	3%	6%
Housing	8%	9%	4%	6%	8%	7%	6%
Training	8%	0%	0%	4%	7%	5%	6%
Coordination within Mental Health System	10%	22%	0%	3%	3%	3%	6%
Education about Mental Health /Stigma/Symptoms	5%	3%	12%	0%	0%	5%	6%
Diversity (Ethnicity/Language)	0%	3%	15%	3%	3%	4%	5%
Physical Health	10%	3%	0%	10%	7%	1%	5%
Law Enforcement/Jails/Justice System	8%	0%	0%	9%	3%	7%	5%
Domestic Violence/Dating Violence/Sexual Assault	18%	0%	0%	1%	0%	0%	3%
More Beds	3%	3%	0%	1%	4%	4%	3%
Transportation	0%	3%	0%	4%	4%	1%	3%
Education/Employment Services	0%	6%	4%	9%	4%	4%	3%
Support Groups	3%	3%	0%	7%	4%	4%	3%
Consumer Operated Services	3%	13%	0%	3%	2%	5%	2%
Depression/Anxiety/Stress	8%	3%	0%	4%	0%	2%	2%
Bullying	0%	3%	4%	4%	3%	6%	2%
Isolation	0%	0%	4%	0%	0%	1%	2%
Mentors/Role Models	0%	3%	4%	0%	6%	2%	2%
Nutrition/Fitness/Wellness	0%	0%	0%	4%	1%	5%	2%
Mobile Clinic/Services	8%	0%	0%	0%	1%	3%	2%
Assisted Outpatient Treatment	0%	0%	0%	1%	0%	1%	2%
Quality	0%	0%	0%	1%	2%	2%	2%
Pay Equity for Peers	0%	0%	4%	3%	0%	3%	1%
Dementia	3%	0%	0%	0%	8%	0%	1%
Trauma	0%	0%	0%	0%	0%	1%	1%
Other	3%	25%	8%	13%	10%	10%	12%

Table B13: Themes in Community and Provider Input: New Program Ideas, Special Populations (Consumers, LGBTQ, Homeless, Veterans)

	Percentage of Comments				
	Consumer	*LGBTQ**	Homeless	*Veterans**	All Comments
New Program Ideas (n)	41	3	32	4	730
Access	2%	*0%*	16%	*0%*	14%
Substance Use Services	7%	*33%*	13%	*25%*	13%
Coordination with Other Systems	5%	*0%*	13%	*25%*	11%
Schools	0%	*0%*	0%	*25%*	8%
Caregivers/Families	12%	*0%*	6%	*0%*	8%
Outreach about Mental Health Services	2%	*0%*	16%	*0%*	6%
Housing	2%	*33%*	13%	*0%*	6%
Training	10%	*0%*	0%	*0%*	6%
Coordination within Mental Health System	0%	*0%*	9%	*0%*	6%
Education about Mental Health /Stigma/Symptoms	7%	*0%*	3%	*0%*	6%
Diversity (Ethnicity/Language)	2%	*0%*	3%	*0%*	5%
Physical Health	2%	*0%*	6%	*25%*	5%
Law Enforcement/Jails/Justice System	2%	*0%*	28%	*25%*	5%
Domestic Violence/Dating Violence/Sexual Assault	0%	*0%*	0%	*0%*	3%
More Beds	0%	*0%*	0%	*0%*	3%
Transportation	2%	*0%*	6%	*0%*	3%
Education/Employment Services	7%	*0%*	6%	*0%*	2%
Support Groups	7%	*0%*	0%	*0%*	2%
Consumer Operated Services	32%	*0%*	0%	*0%*	2%
Depression/Anxiety/Stress	0%	*0%*	0%	*0%*	2%
Bullying	0%	*0%*	0%	*0%*	2%
Isolation	2%	*0%*	0%	*0%*	2%
Mentors/Role Models	12%	*0%*	9%	*0%*	2%
Nutrition/Fitness/Wellness	7%	*0%*	0%	*0%*	2%
Mobile Clinic/Services	0%	*0%*	3%	*0%*	2%
Assisted Outpatient Treatment	0%	*0%*	3%	*0%*	2%
Quality	0%	*0%*	3%	*0%*	2%
Pay Equity for Peers	20%	*0%*	0%	*0%*	1%
Dementia	0%	*0%*	0%	*0%*	1%
Trauma	0%	*0%*	0%	*0%*	1%
Other	7%	*0%*	13%	*0%*	7%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Appendix C: Staff Input

This appendix includes the (1) demographic summary of the staff participants and their comments, (2) the themes in the staff comments about existing mental health services and (3) the themes in the staff comments about new ideas.

Demographics

Demographics were collected at one of the three staff meetings. Only 11 of the participants completed a demographic form.

Table C1: Demographics of Staff Participants

Demographic	Frequency	Percent
Gender		
Male	3	27%
Female	8	73%
Age		
0-15	0	0%
16-25	0	0%
26-59	6	55%
60+	5	45%
Language		
English	11	100%
Spanish	0	0%
Race/Ethnicity		
White	7	64%
Hispanic	1	9%
African/American	0	0%
More than one race/ethnicity	1	9%
Asian	2	18%
Geography		
Central Marin	4	36%
Northern Marin	2	18%
Southern Marin	0	0%
West Marin	1	9%
Other	4	36%
Representation		
Provider of MHSUS	8	73%
Someone who uses/has used MHSUS	2	18%
Family Member of someone who uses/has used MHSUS	1	9%
Homeless	0	0%
LGBTQ	0	0%
Law Enforcement	0	0%

Demographic	Frequency	Percent
Veterans	0	0%
Volunteer/Advocate in the system of Mental Health	0	0%
Other	0	0%
Total Staff Participants	11	

Language of Comments

For the staff input, all comments were submitted in English.

Table C2: Number of Comments by Meeting, Staff

	Existing Services		New Program Ideas	
Meeting	**Frequency**	**Percent**	**Frequency**	**Percent**
8.13.13 All Staff	85	89%	127	90%
9.19.13 Adult Mental Health Supervisors Meeting	8	8%	7	5%
9.19.13 Children's Mental Health Supervisors Meeting	2	2%	6	4%
Email	0	0%	1	1%
Total Staff Comments	95		141	

Themes

Existing Programs

Table C3: Themes in Staff Input: Existing Services, by MHSA Component

	Percentage of Comments					
	CSS	**PEI**	***INN****	***WET****	***CFTN****	**All Comments**
Existing Programs (n)	28	15	*6*	*10*	*2*	95
More Services	61%	47%	*50%*	*10%*	*0%*	37%
Like Services	29%	53%	*67%*	*40%*	*0%*	20%
Themes						
Coordination within Mental Health System	11%	7%	*17%*	*20%*	*0%*	23%
Diversity (Ethnicity/language)	21%	47%	*17%*	*10%*	*0%*	16%
Access	18%	7%	*0%*	*10%*	*0%*	15%
Training	0%	0%	*0%*	*70%*	*0%*	14%
Coordination with Other Systems	7%	0%	*0%*	*0%*	*100%*	11%
Substance Use Services	11%	0%	*0%*	*0%*	*50%*	9%
Housing	11%	0%	*0%*	*0%*	*0%*	7%
Education about Mental Health/Stigma/Symptoms	4%	20%	*0%*	*0%*	*0%*	5%
Outreach/Information about Mental Health Services	4%	7%	*0%*	*0%*	*0%*	4%
Physical Health	4%	0%	*0%*	*0%*	*50%*	3%
Transportation	4%	0%	*0%*	*0%*	*0%*	2%
Pay Equity for Peers	4%	0%	*0%*	*0%*	*0%*	1%
Trauma	0%	0%	*0%*	*0%*	*0%*	0%
Dementia	0%	0%	*0%*	*0%*	*0%*	0%
Domestic Violence/Dating Violence/Sexual Assault	0%	0%	*0%*	*0%*	*0%*	0%
Schools	0%	0%	*0%*	*0%*	*0%*	0%
Law Enforcement/Jails/Justice System	0%	0%	*0%*	*0%*	*0%*	0%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Table C4: Themes in Staff Input: Existing Services, by Age Group

	Percentage of Comments					
	*0 to 5**	*School Age (6-18)**	TAY (16-25)	*Adult**	*Older Adult**	All Comments
Existing Services (n)	*3*	*7*	15	*10*	*3*	95
More Services	*67%*	*57%*	60%	*80%*	*33%*	37%
Like Services	*33%*	*29%*	27%	*10%*	*33%*	20%
Themes						
Coordination within Mental Health System	*0%*	*0%*	0%	*20%*	*0%*	23%
Diversity (Ethnicity/Language)	*0%*	*14%*	20%	*10%*	*0%*	16%
Access	*33%*	*14%*	7%	*30%*	*0%*	15%
Training	*0%*	*0%*	0%	*0%*	*33%*	14%
Coordination with Other Systems	*0%*	*0%*	0%	*0%*	*33%*	11%
Substance Use Services	*0%*	*29%*	20%	*10%*	*0%*	9%
Housing	*0%*	*14%*	13%	*10%*	*33%*	7%
Education about Mental Health/Stigma/Symptoms	*0%*	*0%*	0%	*10%*	*0%*	5%
Outreach/Information about Mental Health Services	*0%*	*0%*	0%	*0%*	*0%*	4%
Physical Health	*0%*	*0%*	0%	*0%*	*33%*	3%
Transportation	*0%*	*0%*	7%	*10%*	*0%*	2%
Pay Equity for Peers	*0%*	*0%*	0%	*0%*	*0%*	1%
Trauma	*0%*	*0%*	0%	*0%*	*0%*	0%
Dementia	*0%*	*0%*	0%	*0%*	*0%*	0%
Domestic Violence/Dating Violence/Sexual Assault	*0%*	*0%*	0%	*0%*	*0%*	0%
Schools	*0%*	*0%*	0%	*0%*	*0%*	0%
Law Enforcement/Jails/Justice System	*0%*	*0%*	0%	*0%*	*0%*	0%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Themes in Staff Input: Existing Services, by Geography

Only two staff comments were related to a specific region of Marin County, they were coded into the following themes:

- More Services/More Funding (West Marin)
- Coordination within Mental Health System (Southern Marin)

Table C5: Themes in Staff Input: Existing Services, by Special Population (Consumers, LGBTQ, Homeless, Veterans)

	Percentage of Comments				
	Consumers*	LGBTQ*	Homeless*	Veterans*	All Comments
Existing Services (n)	10	0	3	0	95
More Services	*70%*	*0%*	*67%*	*0%*	37%
Like Services	*10%*	*0%*	*0%*	*0%*	20%
Themes					
Coordination within Mental Health System	*10%*	*0%*	*0%*	*0%*	23%
Diversity (Ethnicity/Language)	*20%*	*0%*	*0%*	*0%*	16%
Access	*30%*	*0%*	*0%*	*0%*	15%
Training	*20%*	*0%*	*0%*	*0%*	14%
Coordination with Other Systems	*0%*	*0%*	*33%*	*0%*	11%
Substance Use Services	*0%*	*0%*	*0%*	*0%*	9%
Housing	*0%*	*0%*	*33%*	*0%*	7%
Education about Mental Health/Stigma/Symptoms	*0%*	*0%*	*0%*	*0%*	5%
Outreach/Information about Mental Health Services	*0%*	*0%*	*0%*	*0%*	4%
Physical Health	*0%*	*0%*	*33%*	*0%*	3%
Transportation	*20%*	*0%*	*0%*	*0%*	2%
Pay Equity for Peers	*10%*	*0%*	*0%*	*0%*	1%
Trauma	*0%*	*0%*	*0%*	*0%*	0%
Dementia	*0%*	*0%*	*0%*	*0%*	0%
Domestic Violence/Dating Violence/Sexual Assault	*0%*	*0%*	*0%*	*0%*	0%
Schools	*0%*	*0%*	*0%*	*0%*	0%
Law Enforcement/Jails/Justice System	*0%*	*0%*	*0%*	*0%*	0%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

New Program Ideas

Table C6: Themes in Staff Input: New Program Ideas, by MHSA Component

	Percentage of Comments					
	CSS	PEI	*INN**	WET	*CFTN**	All Staff Comments
New Program Ideas (n)	42	13	*2*	17	*5*	141
Substance Use Services	10%	0%	0%	12%	20%	15%
Coordination with Other Systems	14%	8%	0%	6%	20%	13%
Housing	21%	0%	0%	0%	20%	13%
Physical Health	7%	15%	0%	0%	20%	11%
Diversity (Ethnicity/Language)	7%	31%	0%	12%	0%	9%
Training	0%	0%	0%	41%	20%	8%
Outreach about Mental Health Services	0%	8%	0%	6%	0%	6%
Access	2%	8%	0%	0%	0%	6%
Caregivers/Families	0%	0%	0%	6%	0%	4%
Trauma	2%	0%	0%	24%	0%	4%
Coordination within Mental Health System	2%	0%	0%	6%	0%	4%
Education/Employment Services	10%	0%	0%	6%	0%	4%
Nutrition/Fitness/Wellness	0%	15%	0%	0%	0%	4%
Pay Equity for Peers	7%	0%	0%	0%	0%	2%
Dementia	5%	0%	0%	0%	0%	2%
Education about Mental Health/Stigma/Symptoms	0%	15%	0%	0%	0%	2%
Schools	2%	15%	0%	0%	0%	2%
Transportation	2%	0%	0%	0%	0%	1%
Domestic Violence/Dating Violence/Sexual Assault	0%	0%	0%	0%	0%	1%
Law Enforcement/Jails/Justice System	0%	0%	0%	0%	20%	1%
More Beds	2%	0%	0%	0%	0%	1%
Support Groups	2%	0%	0%	6%	0%	1%
Consumer Operated Services	2%	0%	0%	0%	0%	1%
Mobile Clinic/Services	0%	0%	0%	0%	0%	1%
Mentors/Role Models	0%	0%	0%	0%	0%	0%
Assisted Outpatient Treatment	0%	0%	0%	0%	0%	0%
Depression/Anxiety/Stress	0%	0%	0%	0%	0%	0%
Isolation	0%	0%	0%	0%	0%	0%
Bullying	0%	0%	0%	0%	0%	0%
Quality	0%	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	0%	11%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Table C7: Themes in Staff Input: New Program Ideas by Age Group

	Percentage of Comments					
	0 to 5*	School Age (6-18)	TAY (16-25)	Adult*	Older Adult*	All Staff Comments
New Program Ideas (n)	10	23	21	5	10	141
Substance Use Services	*0%*	35%	33%	*20%*	*0%*	15%
Coordination with Other Systems	*30%*	22%	19%	*40%*	*10%*	13%
Housing	*0%*	13%	19%	*40%*	*50%*	13%
Physical Health	*10%*	4%	0%	*0%*	*20%*	11%
Diversity (Ethnicity/Language)	*10%*	9%	10%	*0%*	*0%*	9%
Training	*10%*	13%	14%	*20%*	*0%*	8%
Outreach about Mental Health Services	*0%*	13%	5%	*0%*	*0%*	6%
Access	*0%*	4%	0%	*0%*	*0%*	6%
Caregivers/Families	*20%*	9%	5%	*20%*	*0%*	4%
Trauma	*10%*	9%	10%	*20%*	*10%*	4%
Coordination within Mental Health System	*0%*	0%	5%	*0%*	*0%*	4%
Education/Employment Services	*0%*	9%	10%	*0%*	*10%*	4%
Nutrition/Fitness/Wellness	*0%*	0%	0%	*0%*	*0%*	2%
Pay Equity for Peers	*0%*	0%	0%	*0%*	*30%*	2%
Dementia	*10%*	9%	0%	*0%*	*0%*	2%
Education about Mental Health/Stigma/Symptoms	*0%*	0%	0%	*0%*	*0%*	2%
Schools	*0%*	0%	0%	*0%*	*0%*	1%
Transportation	*0%*	0%	0%	*0%*	*0%*	1%
Domestic Violence/Dating Violence/Sexual Assault	*10%*	4%	0%	*0%*	*0%*	1%
Law Enforcement/Jails/Justice System	*10%*	4%	0%	*0%*	*0%*	1%
More Beds	*10%*	4%	5%	*0%*	*0%*	1%
Support Groups	*0%*	4%	5%	*0%*	*10%*	1%
Consumer Operated Services	*0%*	0%	0%	*0%*	*0%*	1%
Mobile Clinic/Services	*0%*	0%	0%	*0%*	*0%*	1%
Mentors/Role Models	*0%*	0%	0%	*0%*	*0%*	0%
Assisted Outpatient Treatment	*0%*	0%	0%	*0%*	*0%*	0%
Depression/Anxiety/Stress	*0%*	0%	0%	*0%*	*0%*	0%
Isolation	*0%*	0%	0%	*0%*	*0%*	0%
Bullying	*0%*	0%	0%	*0%*	*0%*	0%
Quality	*0%*	0%	0%	*0%*	*0%*	0%
Other	*0%*	9%	10%	*0%*	*0%*	4%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Table C8: Themes in Staff Input: Geography (Comments)

	Percentage of Comments				
	West*	South*	North*	Central*	All Staff Comments
New Program Ideas (n)	4	6	0	1	141
Substance Use Services	*0%*	*0%*	*0%*	*0%*	15%
Coordination with Other Systems	*0%*	*17%*	*0%*	*0%*	13%
Housing	*0%*	*0%*	*0%*	*0%*	13%
Physical Health	*25%*	*0%*	*0%*	*0%*	11%
Diversity (Ethnicity/Language)	*25%*	*0%*	*0%*	*0%*	9%
Training	*0%*	*0%*	*0%*	*0%*	8%
Outreach about Mental Health Services	*50%*	*50%*	*0%*	*0%*	6%
Access	*0%*	*17%*	*0%*	*0%*	6%
Caregivers/Families	*0%*	*0%*	*0%*	*0%*	4%
Trauma	*0%*	*0%*	*0%*	*0%*	4%
Coordination within Mental Health System	*0%*	*0%*	*0%*	*0%*	4%
Education/Employment Services	*0%*	*0%*	*0%*	*0%*	4%
Nutrition/Fitness/Wellness	*0%*	*0%*	*0%*	*0%*	2%
Pay Equity for Peers	*0%*	*0%*	*0%*	*0%*	2%
Dementia	*0%*	*0%*	*0%*	*0%*	2%
Education about Mental Health/Stigma/Symptoms	*0%*	*0%*	*0%*	*0%*	2%
Schools	*0%*	*0%*	*0%*	*0%*	1%
Transportation	*0%*	*0%*	*0%*	*0%*	1%
Domestic Violence/Dating Violence/Sexual Assault	*0%*	*0%*	*0%*	*0%*	1%
Law Enforcement/Jails/Justice System	*0%*	*0%*	*0%*	*0%*	1%
More Beds	*0%*	*0%*	*0%*	*0%*	1%
Support Groups	*0%*	*0%*	*0%*	*0%*	1%
Consumer Operated Services	*0%*	*0%*	*0%*	*0%*	1%
Mobile Clinic/Services	*0%*	*0%*	*0%*	*0%*	1%
Mentors/Role Models	*0%*	*0%*	*0%*	*0%*	0%
Assisted Outpatient Treatment	*0%*	*0%*	*0%*	*0%*	0%
Depression/Anxiety/Stress	*0%*	*0%*	*0%*	*0%*	0%
Isolation	*0%*	*0%*	*0%*	*0%*	0%
Bullying	*0%*	*0%*	*0%*	*0%*	0%
Quality	*0%*	*0%*	*0%*	*0%*	0%
Other	*0%*	*33%*	*0%*	*100%*	4%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Table C9: Themes in Staff Input: New Program Ideas, by Special Population (Consumers, LGBTQ, Homeless, Veterans)

	Percentage of Comments				
	Consumers*	LGBTQ*	Homeless*	Veterans*	All Staff Comments
New Program Ideas (n)	5	0	3	1	141
Substance Use Services	0%	0%	33%	0%	15%
Coordination with Other Systems	0%	0%	33%	100%	13%
Housing	0%	0%	33%	100%	13%
Physical Health	0%	0%	0%	0%	11%
Diversity (Ethnicity/Language)	0%	0%	0%	0%	9%
Training	0%	0%	0%	0%	8%
Outreach about Mental Health Services	0%	0%	0%	0%	6%
Access	0%	0%	0%	0%	6%
Caregivers/Families	0%	0%	33%	0%	4%
Trauma	0%	0%	0%	0%	4%
Coordination within Mental Health System	0%	0%	33%	100%	4%
Education/Employment Services	0%	0%	0%	0%	4%
Nutrition/Fitness/Wellness	60%	0%	0%	0%	2%
Pay Equity for Peers	0%	0%	0%	0%	2%
Dementia	20%	0%	0%	0%	2%
Education about Mental Health/Stigma/Symptoms	0%	0%	0%	0%	2%
Schools	0%	0%	0%	0%	1%
Transportation	0%	0%	0%	0%	1%
Domestic Violence/Dating Violence/Sexual Assault	0%	0%	0%	0%	1%
Law Enforcement/Jails/Justice System	0%	0%	0%	0%	1%
More Beds	0%	0%	0%	0%	1%
Support Groups	0%	0%	0%	0%	1%
Consumer Operated Services	20%	0%	33%	0%	1%
Mobile Clinic/Services	0%	0%	0%	0%	1%
Mentors/Role Models	0%	0%	0%	0%	0%
Assisted Outpatient Treatment	0%	0%	0%	0%	0%
Depression/Anxiety/Stress	0%	0%	0%	0%	0%
Isolation	0%	0%	0%	0%	0%
Bullying	0%	0%	0%	0%	0%
Quality	0%	0%	0%	0%	0%
Other	0%	0%	0%	0%	4%

**The italicized percentages are based on very small sample sizes. Use caution when interpreting.*

Appendix D: Priorities

This appendix provides the detail of (1) the common themes in the ideas that were prioritized by the community and provider participants, and (2) how the staff ideas were prioritized by the community.

Table D1: Themes in the Prioritized Ideas, Community and Provider Input

	Community Meetings		Online Survey	
	Number of Dots (3 per participant)	Percent	Number of Votes (9 per respondent)	Percent
Coordination with Other Systems	39	8%	17	4%
Access	37	7%	39	8%
Housing	34	7%	15	3%
Substance Use Services	31	6%	23	5%
Outreach about Mental Health Services	29	6%	9	2%
Dementia	23	4%	0	0%
Consumer Operated Services	22	4%	1	0%
Physical Health	21	4%	4	1%
Coordination within Mental Health System	21	4%	13	3%
Diversity (Ethnicity/Language)	19	4%	4	1%
More beds	16	3%	9	2%
Law Enforcement/Jails/Justice System	15	3%	10	2%
Training	13	3%	10	2%
Nutrition/Fitness/Wellness	13	3%	2	0%
Mobile Clinic/Services	13	3%	2	0%
Transportation	11	2%	1	0%
Isolation	11	2%	1	0%
Education/Employment Services	8	2%	1	0%
Schools	8	2%	34	7%
Depression/Anxiety/Stress	8	2%	8	2%
Domestic Violence/Dating Violence/Sexual Assault	6	1%	10	2%
Caregivers/Families	6	1%	21	4%
Quality	6	1%	3	1%
Pay Equity for Peers	5	1%	2	0%
Education about Mental Health/Stigma/Symptoms	5	1%	19	4%
Mentors/Role Models	5	1%	1	0%
Assisted Outpatient Treatment	5	1%	3	1%
Support Groups	3	1%	4	1%
Bullying	1	0%	7	1%
Trauma	0	0%	1	0%
Other	43	8%	29	6%

	Community Meetings		Online Survey	
	Number of Dots (3 per participant)	Percent	Number of Votes (9 per respondent)	Percent
Total Dots/Votes for Community and Provider Ideas	476	92%	305	64%
Total Dots/Votes for all Ideas	520		474	

Table D2: Staff Ideas, Community and Provider Input

	Meetings		Survey	
	Number of Dots	Percent	Number of Votes	Percent
Pay Equity for Peer Providers	16	3%	26	5%
Assisted Outpatient Treatment	12	2%	26	5%
School Age Programs	12	2%	26	5%
Step Down Program	2	0%	18	4%
Alliance in Recovery	1	0%	31	7%
Southern Marin Youth Services	1	0%	18	4%
Suicide Prevention	0	0%	24	5%
Total Dots/Votes Staff Ideas	44	8%	169	36%
Total Dots/Votes for all Ideas	520		474	

The conversations and discussions at each of the community meetings varied depending on the participants and the ideas. To demonstrate the variety of suggestions that the community meeting participants favored, the top three priorities for each of the six community meetings are presented below.

Table D3: Top Three Prioritized Ideas by Meeting

Community and Provider Idea	Number of Dots
Novato (7/23/13)	
LGBT programs support	3
At the County level we need a group that works strategically to develop a workforce pipeline of bilingual, masters level, mental health clinicians	3
Implement SAMHSA's plan for consumer operated services	2
West Marin (8/13/13)	
Case worker to help find services available	6
Mobile psychiatric crisis services - mental health support to Sheriff/Fire	6
Housing in communities - temporary and permanent.	6
Marin City (8/15/13)	
Collective impact southern Marin youth services program (model program serving 0-18 year olds). Program model OGHD, model includes across age mentoring southern Marin community connects community schools.	6
More integration/collaboration with existing organizations/non-profits ex: Ambassadors of Hope and Opportunity (AHO) for TAY.	5
Youth outreach program to help homeless youth between ages 16-25 to consult and increase access to services in order for less future intervention.	4
Canal-San Rafael (8/21/13)	
Implement SAMHSA's plan for consumer-operated services	9
We need Vietnamese mental health therapist	6
Homeless young adults and teens need hope and opportunity with programs that are providing peer mentors that have succeeded so they have role models of hope that life can be different.	5
Health and Human Services Campus—San Rafael (9/13/13)	
Expand PEI for older adults (possibly utilizing the JFCS model)	9
Include dementia-related issues in any older adult program	8
Services for people dually diagnosed with dementia and mental illness	6
Housing	6
San Rafael (9/18/13)	
More beds in Marin Kaiser	7
Implement SAMHSA consumer operated services	6
Support for Veterans suffering from PTSD and MST	5

Appendix E: Glossary of Themes and Staff Ideas

The comments from community, providers and staff were coded into themes for discussion. Many comments spanned several themes.

Table E1: Glossary of Themes, Community, Provider and Staff Input

Theme	Description
Access	Difficulties finding/using existing services, cost and insurance concerns, lack of programs for specific concerns/populations, location of services, availability of services, qualifying for services, need to expand services
Assisted Outpatient Treatment	Outreach for and/or implementation of AOT, Laura's Law
Bullying	Prevention programs to address bullying, services to reduce bullying, working with schools around bullying
Caregivers/Families	Supporting caregivers and families of young children to promote mental health, outreach to caregivers to identify mental health needs, respite care
Consumer Operated Services	Implementation of the SAMHSA plan for consumer operated services, more services at the ERC, more availability of peer operated programs, more services directed by consumers
Coordination with Other Systems	Coordination of mental health services with other systems of care: Substance Use, Housing, Wellness/Nutrition/Exercise, Physical Health Care, Education, Employment, Social Services, Youth Programs, Financial Planning, Justice System/Probation
Coordination within Mental Health System	Integration of mental health services, improve intake systems, coordinate treatment services, provide range of mental health services from prevention to recovery in communities, teams of professionals to provide mental health support, early intervention to prevent crisis, coordinate mental health record systems
Dementia	Services and supports for individuals with dementia (including awareness, evaluation and treatment), programs for individuals with mental illness and dementia diagnoses
Depression/ Anxiety/ Stress	Services to address issues of depression, anxiety and stress, recreation programs to prevent stress/anxiety, education to learn how to manage depression/anxiety/stress
Diversity (Ethnicity/ Language)	Outreach to Latino and Vietnamese communities, Latino and Vietnamese staff trained to provide outreach, screenings and treatment, individuals fluent in Spanish and Vietnamese to provide information and services, culturally and linguistically relevant services
Domestic Violence/ Dating Violence/ Sexual Assault	Prevention of violence, anger management classes/support, services that address mental health and domestic/sexual violence together, screenings for domestic/sexual violence in mental health services

Theme	Description
Education about Mental Health/ Stigma/ Symptoms	Education for community members about mental health prevention, symptoms and treatment, stigma prevention campaigns, information for community/parents/providers about Fetal Alcohol Spectrum Disorders, Consumer and family member-led education campaigns, outreach to business owners about homelessness and mental health, advocacy groups
Education/ Employment Services	Vocational and/or college services for individuals with a mental health diagnosis, support to promote employment or college attendance, career ladder for peer providers, college credit for peer counseling courses
Housing	Residential treatment facilities for mental health clients, housing for those with long-term serious mental health concerns, transitional housing , housing for dual diagnosis clients (Substance Use/Mental Health, Dementia/Mental Health), home ownership, short-term residential treatment, shelter for mentally ill, temporary and permanent housing, housing with sensitivity to personality quirks and preferences
Isolation	Outreach to isolated families, addressing isolation of homebound older adults, mobile services for isolated adults, isolation of monolingual mental health clients, recreation services to prevent/reduce isolation
Law Enforcement/ Jails/ Justice System	Coordination of services for individuals with mental health concerns who are also involved in justice system, reducing use of jail as mental health treatment, veterans court, mental health services in the jail, improve point of contact with law enforcement, more mental health resources for police to utilize, more mental health outreach through law enforcement, better relationships with law enforcement, train first responders about mental health
Mentors/ Role Models	Role models and mentors for consumers, peer companions, mentors for homeless youth, mentors for individuals coming out of jail or off probation, mentors to support mental health clients in the workforce
Mobile Clinic/ Services	Mobile mental health services to reach isolated clients, provide home-based interventions, provide mobile medications to increase compliance, go to schools to provide youth with services, provide services in communities, provide education about mental health issues
More beds	More beds in Marin County to treat children, youth, adults and seniors. More beds added to PES for children, more psych beds for acute and sub-acute care, access to more beds in Marin County so consumers can have family members nearby during treatment.
Nutrition/ Fitness/Wellness	Nutrition education, exercise programs and opportunities, promote good nutrition for consumers, educate community about the role of nutrition/fitness/wellness in mental health, promote wellness for individuals and families
Other	Themes that had ten or less comments are included in this category: Suicide, Alternative Treatments, Gangs, Leadership Opportunities, Art, Step Down Program, Southern Marin Youth Services, Poverty, Alliance in Recovery, Community Center, and Learning Disabilities. Examples of additional comments include: self-esteem programs, legal aid services, video story-telling, nature deficit disorder, Head Start, auction to raise funds for county services

Theme	Description
Outreach/ Information about Mental Health Services	Outreach and education to introduce mental health services to all members of the community, information on websites, more information about services for Hispanic population, more publicity for programs, a weekly newspaper listing of services and programs, information about services available in communities, more awareness about existing services
Pay Equity for Peers	Pay raise/pay equity for peer providers
Physical Health	Programs that address primary care/physical health into mental health treatment, information on health for mental health clients, information on birth control/abstinence for teens, preventative health information, fall prevention, dental coordinator, counselors available in hospitals, treating the whole person, illness prevention, mental health services for those living with HIV/AIDS
Quality	Improve quality of mental health services, improve mental health services in schools, improve mental health services in jails, improve processes that address mental illness
Schools	Mental health prevention, screening and services in the schools, train teachers to identify mental health concerns, outreach about available services through the schools, mental health services for families at school sites, counseling in the schools, improve school culture, support for students dealing with divorce, eating disorders, etc.
Substance Use Services	Services that address substance use, prevention of substance use, coordinating mental health services with substance use services, providing mental health treatment for people even when they are not sober/clean, talking to youth about substance use, a map of how the mental health and substance use services connect, more residential treatment facilities , integrating services
Support Groups	Support groups to address mental health, substance use, nutrition, isolation, dementia and caregiver concerns. Teen groups, peer support groups.
Training	Training for parents, community members, providers (teachers, law enforcement, youth center staff, peers, first responders) and mental health professionals to prevent, identify and treat mental health concerns
Transportation	Access to transportation to address isolation, obtain services, maintain employment/education, get to activities. Advocates to drive clients to services
Trauma	Trauma informed care, trauma training for providers, addressing trauma for emotionally troubled children, trauma informed family wellness programs, parent groups to address trauma.

Table E2: Description of Staff Ideas

Proposed Program	Component	Description
Alliance in Recovery (AIR)	CSS	Intensive outreach and engagement services for adults with co-occurring mental health and substance use disorders
Step Down Program	CSS	A wellness and recovery program for individuals who no longer need the intensive case management services provided by the formal Adult System of Care (ASOC)
Assisted Outpatient Treatment (meets Laura's Law criteria)	CSS	Assertive outreach to engage individuals with untreated or inappropriately treated serious mental illness in voluntary treatment. If not successful, Assisted Outpatient Treatment under court order would be provided.
Southern Marin Youth Services	PEI	Provide prevention and early intervention services for southern Marin youth. The strategy is yet to be determined.
School Age Programs	PEI	Provide prevention and early intervention services for school age youth. The strategy is yet to be determined.
Suicide Prevention	PEI	Support the existing suicide hotline and suicide prevention services.
Pay Equity	CSS	Increase pay rates for mental health peer providers.