COUNTY OF MARIN

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

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

Grant Nash Colfax, MD
DIRECTOR

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APPROVED
AUG 25 2015
MARIN COUNTY
BOARD OF SUPERVISORS

August 25, 2015

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

SUBJECT: Department of Health and Human Services, Division of Mental Health and Substance Use Services: Approve the Mental Health Services Act (MHSA) FY 2015-16 Annual Update.

Dear Supervisors:

RECOMMENDATION: Authorize the President to approve the Mental Health Services Act (MHSA) FY 2015-16 Annual Update.

SUMMARY: In FY 2015-16, approximately $11,253,905 in Mental Health Services Act (MHSA) funds are proposed for a broad range of community-based and County run programs to provide a variety of mental health and substance use services, including:

- Prevention and Early Intervention (PEI) activities such as parenting programs, screening for mental health and substance use issues in primary care settings and youth activities ($2,005,964);
- Community Services and Supports (CSS) programs such as case management for older adults, homeless individuals and the Support and Treatment After Release (STAR) program focusing on alternatives to incarceration ($7,725,675);
- Innovation Programs for culturally appropriate innovative programs that can further work to reduce stigma and discrimination ($621,055);
- Capital Facilities and Technological Needs (CFTN) programs such as an electronic health record, scanning capability and other practice management programs ($437,711); and
- 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 ($463,500).

All of these efforts were developed through a comprehensive planning process that included the communities and stakeholders most interested in mental health and substance use issues. The State requires that the Plan developed as a result of this process be approved, after a public comment period by the Mental Health Board and then by the County Board of Supervisors. Outcomes for FY 2014-15 are included in the MHSA FY 2015-16 Annual Update.

CA-5d

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 330, Community Planning Process. The draft MHSA FY 2015-16 Annual Update was circulated to representatives of stakeholder interest and a legal notice ran in the Marin Independent Journal (IJ) seeking public comments from any interested party for thirty (30) days on the Marin County Mental Health Services Act (MHSA) webpage beginning on Friday, May 8, 2015 and ending on Sunday, June 7, 2015. On Tuesday, June 9, 2015, the Mental Health Board provided their recommendations and feedback as well. All input has been considered with adjustments made, as appropriate, and incorporated into the MHSA FY 2015-16 Annual Update.

COMMUNITY BENEFIT: 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 have brought measurable improvements to the lives of many Marin County residents.

RECOMMENDATIONS: Funds for on-going costs in the MHSA FY 2015-16 Annual Update are included in the existing community mental health budget in the Mental Health Prop 63 Funds Center 1000047000. There is no additional net county cost associated with this request.

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

Sincerely,

Grant Nash Colfax, MD
Director

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Marin County

☐ Three-Year Program and Expenditure Plan

X Annual Update

☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Suzanne Tavano	Name: Roy Given
Telephone Number: 415.473.7595	Telephone Number: 415.473.3736
E-mail: STavano@MarinCounty.org	E-mail: RGiven@MarinCounty.org

Local Mental Health Mailing Address:

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

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891 and 5892; and Title 9 of the California Code of Regulations 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 — Suzanne Tavano — 9/23/15

Local Mental Health Director (PRINT) — Signature — Date

I hereby certify that for the fiscal year ended June 30, _____, 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 _____ for the fiscal year ended June 30, _____. I further certify that for the fiscal year ended June 30, _____, 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 / City Financial Officer (PRINT) — Signature — Date

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: MARIN

☐ Three-Year Program and Expenditure Plan
☒ Annual Update

Local Mental Health Director	Program Lead
Name: Suzanne Tavano, Ph.D.	Name: Kasey Clarke
Telephone Number: 415-473-7595	Telephone Number: 415-473-7465
E-mail: stavano@marincounty.org	E-mail: kclarke@marincounty.org
Local Mental Health Mailing Address: Department of Health and Human Services Mental Health and Substance Use Services 20 N. San Pedro Rd., Suite 2021 San Rafael, CA 94903	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or 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 Three-Year Program and Expenditure Plan or 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 August 25, 2015.

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, Ph.D.
Local Mental Health Director (PRINT)

Suzanne Tavano 9/8/15
Signature Date

COUNTY OF MARIN

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MENTAL HEALTH SERVICES ACT

WELLNESS • RECOVERY • RESILIENCE

FY2015-2016
ANNUAL UPDATE

Reporting FY2013-2014 Programs and Outcomes
and includes FY2015-16 MHSA Budget

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

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

Table of Contents

INTRODUCTION

Hello All,

First, a word of acknowledgement to the many community stakeholders who contributed to the development of Marin's Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 and those who have made an ongoing commitment to serve on the MHSA Advisory Committee. Your time and effort greatly are appreciated.

I would like to make a clarifying comment about this document. The MHSA Fiscal Year 2015-16 Annual Update serves two purposes. It provides an outcome report for the MHSA services provided in Fiscal Year 2013-14 and includes the budgets for services to be provided in Fiscal Year 2015-16. Since we currently are in Fiscal Year 2014-15, it is not possible to report on this year's outcomes. These will appear in the Annual Update for Fiscal Year 2016-17.

We apologize for any confusion and again would like to thank you for your interest and participation.

Mental Health Services Act (MHSA)

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

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

Mental Health Services Act Principles

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

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

Mental Health Services Act Components

The MHSA currently has five (5) components:

A. Community Services and Supports (CSS)

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

B. Prevention & Early Intervention (PEI)

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

C. Innovation (INN)

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

D. Workforce Education & Training (WET)

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

E. Capital Facilities and Technology Needs (CFTN)

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

Marin County's MHSA Component Plans

When Proposition 63 was approved by voters in 2004, Marin County conducted community-planning process to develop plans for each MHSA component. In 2013 Marin County conducted another extensive community-planning process to develop the MHSA Three Year Program and Expenditure Plan for FY2014-15 through FY2016-17. All MHSA documentation can be viewed on the County website at:

https://www.marinhhs.org/mhsa
or by calling 415-473-7465 to request a paper copy by mail.

Fiscal Year 2015-2016 Annual Update Overview

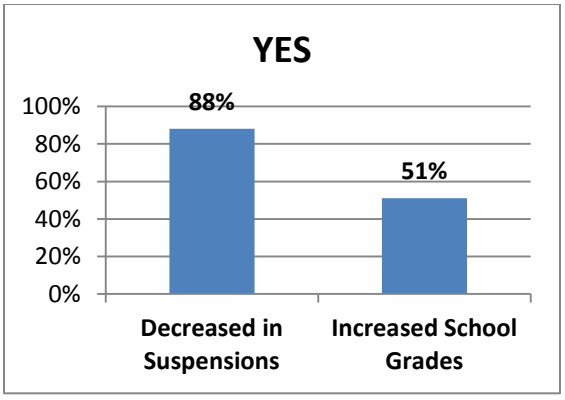
MHSA provides an opportunity to transform the mental health system in alignment with the MHSA principles. MHSA has facilitated an increase in community collaboration, as evidenced by the strong involvement in the planning processes and implementation committees. Consumers and families have been especially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

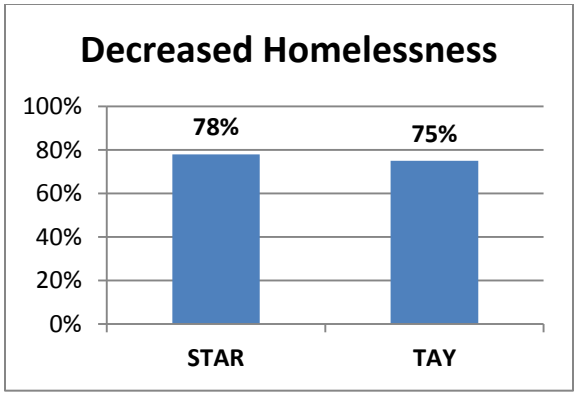
Community Services and Supports (CSS)

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

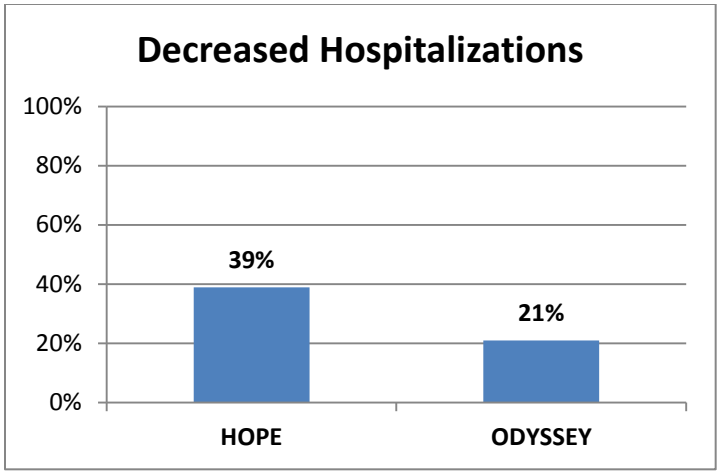
Percentages are calculated based on the number of clients within each program for whom the measure is appropriate, i.e., only those for whom there was data reported for each measure during the 12 months prior to enrollment in the program or at any time while enrolled in the program.

These charts report cumulative outcomes since the beginning of the CSS program.





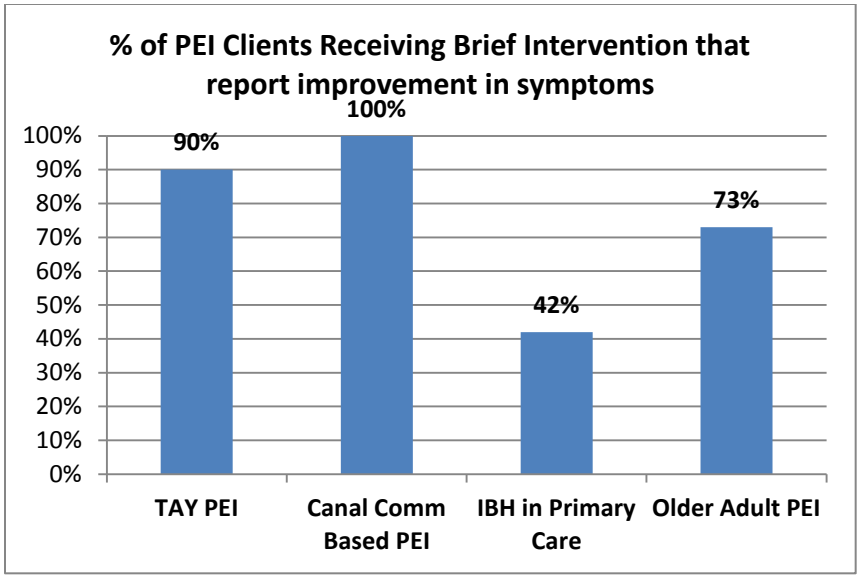
This chart reports outcomes for FY2013-14.



Further details on CSS programs are provided in the following report.

Prevention and Early Intervention (PEI)

This chart reports outcome highlights from programs providing brief intervention services for FY2013-14.



Further details on PEI programs are provided in the following report.

Innovation (INN)

Currently, Marin's Innovation Program funds are being used to develop and operate a community-based crisis service in a homelike environment that integrates crisis intervention and stabilization with wellness and recovery principles. Additional innovative project elements include integrated peer and professional staffing; use of client-driven crisis plans which provide the opportunity for consumers to have a voice and choice in determining which services and supports are most effective in times of psychiatric crisis; and use of SBIRT (Screening, Brief Intervention, and Referral for Treatment), an integrated health approach to the identification of and effective response to persons with substance use disorders, as well as those who are at risk of developing these disorders.

Workforce, Education and Training (WET)

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

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

Capital Facilities and Technological Needs (CFTN)

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

Fiscal Year 2015-16 Annual Update

For a copy of the MHSA FY2015-16 Annual Update please call: 415.473.7465 or you can find it on our website at: https://www.marinhhs.org/mhsa.

Please review the MHSA FY2015-16 Annual Update and post your comments on the website or you can mail comments or questions to: Kasey Clarke, County of Marin, Mental Health and Substance Use Services Division, 20 N. San Pedro Road, Suite 2021, San Rafael, CA 94903.

The required thirty (30) day public comment period for the MHSA FY2015-16 Annual Update begins on **Friday, May 8, 2015** and ends on **Sunday, June 7, 2015.**

A Public Hearing for the MHSA FY2015-16 Annual Update will take place at the Mental Health Board Meeting on Tuesday, June 9, 2015 at 6:00 pm at 20 N. San Pedro Road, San Rafael, CA 94903 in the Point Reyes Conference Room. The public is welcome.

MHSA Moving Forward

Marin's MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 is available to download at www.marinhhs.org/mhsa.

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

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

MENTAL HEALTH SERVICES ACT

STAKEHOLDER PROCESS

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 MHSA webpage at 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 www.marinhhs.org/mhsa.

For FY2014-15, 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 that 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.

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. (See tables below for demographic breakdown.)

For the complete report on the Community Planning input, please see Appendix A – Community Conversation Summary.

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%

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%

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%

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%

Every year, the State requires counties to develop an MHSA Annual Update that reports the program descriptions and outcomes for the reporting period, and identifies challenges and changes to programs as needed.

Ongoing Stakeholder Input

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

General:

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

MHSA Coordinator and Component coordinators and other settings as appropriate for consideration.

MHSA Component Meetings:

- The PEI Committee meets quarterly to discuss PEI Program implementation, including reviewing annual program evaluation reports. It is comprised of PEI providers, community advocates, consumers, Marin Health and Human Services representatives, Mental Health Board members, school representatives, and other community organizations.
- WET Consumer Subcommittee meets on a monthly basis. Its 6-8 members meet at the consumer run drop in center. In addition, family members, family partners and the WET consultant meet monthly as the Family Subcommittee.
- An Innovation Advisory Committee met regularly to oversee the implementation of, and discuss lessons learned, regarding the Client Choice and Hospital Prevention Program (CCHPP). The CCHPP is concluding as an Innovation program at the end of FY14-15. An Innovation Planning Process took place in FY14-15 to develop a new Innovation Plan. This included stakeholder meetings. For more details see the Innovation section of this Annual Update.
- A panel including county staff, community members, community providers and others is convened to review proposals received in response to Requests for Proposals to implement MHSA programs.

MHSA Advisory Committee:

Through January 2014, the MHSA Implementation Committee existed to review outcomes of MHSA programs and make recommendations regarding all significant changes/additions to MHSA programs. Once the MHSA Three Year Program and Expenditure Plan for FY2014-15 through FY2016-17 was completed, MHSUS decided to reformulate that committee to ensure appropriate representation and to allow for more regular meetings. MHSUS conducted an outreach and application process to develop a balanced group. See Appendix B for the complete list of the members and their representation. The new MHSA Advisory Committee has begun monthly meetings to learn about all aspects of MHSA in depth and provide ongoing recommendations regarding program implementation and outcomes. This Annual Update will be reviewed at the May meeting, at which time committee members will have an opportunity to provide input.

See table below for ongoing venues for stakeholder input into MHSA areas.

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

FY2015-16 Annual Update Process

This Annual Update does not propose any significant changes to existing programs. There are minor budgetary changes reflected for FY2015/16 period. This Annual Update was developed by MHSUS staff and agencies contracted to provide MHSA services. The Annual Update approval process includes:

The MHSA Annual Update for FY2015-16 will posted for 30-day public comment from **Friday, May 8, 2015** through **Sunday, June 7, 2015**. It will be widely distributed:

- The MHSA Annual Update will be posted for 30-day public comment on Marin County's website at www.marinhhs.org/mhsa, including instructions on how to receive a copy of the report, how to submit comments and the date of the Public Hearing.
- An announcement about the posting was placed in the local newspaper, the Marin Independent Journal, including information about getting a copy of the update, how to comment, and the date of the Public Hearing.
- Copies of the MHSA Annual Update for FY2015-16 is available at two local libraries – the main branch in San Rafael and the branch in West Marin – including how to comment and the date of the Public Hearing.
- An email with a link to the website posting was sent to all Mental Health and Substance Use Services (MHSUS) staff, contracted providers, community based organizations, Marin

Mental Health Board, Alcohol and Other Drug Board, MHSUS staff, MHSA Advisory Committee, and other MHSA related distribution lists and committees.

On Tuesday, June 9, 2015, a Public Hearing will be held at the Mental Health Board meeting at 6pm at 20 N. San Pedro Road, San Rafael, CA 94903 in the Point Reyes Conference Room. All input will be considered and substantive comments will be summarized and analyzed (see below). The final MHSA Annual Update for FY2015-16 will go before the Board of Supervisors after the public hearing.

Prior MHSA Annual Updates are available at: www.marinhhs.org/mhsa

In 2016 Marin will begin another community planning process to develop the next MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20.

Substantive Comments and Responses:

The following comments were received during the thirty (30) day public comment period and the Public Hearing:

1. **Currently the Drug Court in Marin does not accept dually diagnosed clients and the STAR Court (Support and Treatment After Release (STAR) Mental Health Court) does not accept client with substance abuse issues.**
   There are a number of programs that serve individuals with co-occurring issues in the justice system. STAR Court (Mental Health Court) serves clients with a serious mental illness, most of which also have a substance abuse or dependence problem. Currently 100% of STAR Court clients have co-occurring disorders. Unfortunately individuals with only a substance use issue, or primarily a substance use issue and mild or moderate mental health diagnosis are not eligible for STAR.

   The Marin County Adult Drug Court includes the provision of substance use and mental health services as components of the treatment service and to be eligible, clients must have a substance use disorder as a primary diagnosis. Many of the clients participating in the Adult Drug Court program also have mild to moderate mental health disorders.

   There is a Co-Occurring Disorders Committee that meets quarterly that is comprised of County Staff, CBO staff, family members, NAMI members that is tasked with identifying and implementing effective co-occurring treatment options for individuals in the MH and SUS system. This group has been in existence for at least the last 15 years.

   With the integration of the Divisions of Mental Health and Substance Use Services, we are continuing to identify areas of gaps within all of our programs, including those serving those in the justice system. MHSUS works with the justice system to continue to improve and expand available services.

2. **Individuals facing misdemeanor charges who are not competent to stand trial do not have access to treatment services in order to become competent to stand trial.**

   Under PC1370 individuals facing misdemeanor charges who are not competent to stand trial are referred to the Mental Health Director (or designee) for a recommendation on restoring the defendant to competence in either Marin County's outpatient clinic or in a state hospital. Mental Health and Substance Use Services (MHSUS) division attempts to make the best decision based

on public safety, staff safety, severity of illness and other factors. Admission into the state hospitals is outside of MHSUS control. The number of individuals who fall into this category is limited at approximately four (4) people per year.

3. **It can be very difficult for clients with severe and persistent mental illness to get treatment, especially if they do not recognize that they need treatment. Outreach and engagement has been used for many years in Marin, but it is not working. Assisted Outpatient Treatment (AB1421) could help these clients access treatment and start the recovery process. (3 comments)**

   The CARE Team provides outreach and engagement services to homeless individuals suffering from mental illness. Likewise, the newly formed Outreach and Engagement Team reaches out to those who are housed and resistant to engaging in services.

   During FY2013-14, 101 individuals received homeless outreach services from the CARE team, totaling 1,261 contacts. Statistics are not yet available for the Outreach and Engagement Team (implemented during FY2014-15) but are expected to be similar.

4. **Psychiatric Emergency Services (PES) simply turns clients and families away if the client does not want treatment, but clearly needs treatment.**

   PES recognizes that it can be very frustrating for clients and families when PES cannot provide the services requested. There are many legal limitations regarding what PES can provide. PES is required by law to follow the LPS (Lanterman Petris Short) Act. PES can involuntarily hospitalize a person after evaluation of a 5150 application if the person meets the following criteria: danger to self, danger to others, or grave disability (inability to provide food, clothing or shelter due to an acute psychiatric condition). PES does hospitalize people that meet the LPS criteria, even if the client does not want it.

   When hospitalization is not indicated, PES provides applicable information, options and resources to the client and family (with client's permission). PES has also added a Family Partner that is directly aimed at supporting families and loved ones of individuals who present to PES. This positon also helps family members understand the scope of PES and links them to resources in the community where they can find additional support.

5. **The lack of mental health supportive housing means clients end up in IMD's (lockdown facilities) or homeless shelters. Supportive housing allows clients to recover and should be a first priority for funding.**

   Ideally Marin should adopt a housing first position. Mental health supportive housing is a priority for the Mental Health and Substance Use Services division. Unfortunately it is very difficult to locate and develop such housing in Marin. As described in the "Housing" section of this MHSA FY2015-16 Annual Update, MHSUS will undertake a stakeholder process in FY2015-16 to identify a housing project that can be funded by MHSA Housing funds.

MARIN COUNTY CHARACTERISTICS

Marin County is a mid-sized county with a population of approximately 260,750 and spanning 520 square miles of land. The population is 51% female. 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. Spanish is the only threshold language, although most county documents are also available in Vietnamese.

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 2013	Medi-Cal Beneficiaries CY2011	Homeless 2013 Count	County MH Clients FY13-14
Total	**258,821**	**24,147**	**933**	**3,398**
White	86.2%	32.3%	43.4%	57.0%
African American	2.8%	7.1%	12.8%	8.0%
Native Am/ Alaska Native	1.1%	0.2%	1.4%	0.5%
Asian	6.0%	5.4%	3.2%	3.2%
Native Hawaiian/ Other Pacific Islander	0.3%	0.0%	0.3%	0.6%
Multi or Other Race	3.7%	4.3%	4.0%	26.2%
Unknown	0.0%	0.0%	14.6%	4.5%
Hispanic or Latino (of any race)	15.7%	50.6%	20.4%	23.7%
Sources:	Census estimate for 2013			Marin County records

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 2013	FY13-14 County MH Clients (N=3,398)
White	83.8%	69.5%	86.2%	57.0%
African American	2.9%	9.9%	2.8%	8.0%
Native	0.4%	0.5%	1.1%	0.5%
Asian	4.5%	3.4%	6.0%	3.2%
Pacific Islander	0.4%	0.4%	0.3%	0.6%
Multi	3.5%	0.0%	3.7%	0.0%
Other/Unknown	4.5%	16.3%	0.0%	30.7%
Hispanic	11.1%	15.7%	15.7%	23.7%
Age	**2000 Census**	**FY06-07 County MH Clients**	**2010 Census**	**FY13-14 County MH Clients**
0-17	20.3%	27.4%	20.7%	22.6%
18-25	5.5%	9.9%	5.8%	9.2%
26-59	56.1%	54.1%	49.2%	52.2%
60+	18.1%	8.4%	24.3%	16.0%
Sources:	Census data	Marin County records	Census data	Marin County records

CULTURAL COMPETENCY ADVISORY BOARD (CCAB)

Marin County's Mental Health and Substance Use Services Division (MHSUS) re-established its Cultural Competence Advisory Board (CCAB) in December 2013, after several years of inactivity. Between July-December 2013, the Interim Ethnic Services Manager (ESM) conducted targeted outreach to twenty one (21) culturally diverse division staff, service agency partners, consumers, family members and community advocates which made up the CCAB. During FY2014-15 the membership has expanded to 27 members (see Appendix C for CCAB Membership).

Upon its inception, members worked to define the overall purpose, goals and objectives of the board. Using the **California Mental Health Directors Association's Framework for Eliminating Cultural, Linguistic, Racial, and Ethnic Behavioral Health Disparities** report as the guide to the board's strategic plan, the interim ESM began to orient the board to the Marin's 2010 Cultural Competence Plan. Due to the scope and magnitude of the county plan, the board decided to structure itself by creating sub-committees, including policy, media/outreach, access and training, as well as a consumer/family member ad-hoc group. Each subcommittee was tasked to review and analyze issues and data related to the subcommittee's focus.

Purpose

The purpose of the Cultural Competence Advisory Board is to serve as advisors to MHSUS' administrators, managers and line staff. The charge of the board is to examine, analyze and make recommendations about promising and current mental health services and practices that are culturally sensitive, appropriate and responsive to our diverse consumer community. Additionally, the board shall identify barriers and challenges within MHSUS' system that prevent consumers from adequately accessing needed mental health and substance use services. Barriers may include, but are not limited to, stigma and discrimination, language and/or lack of cultural awareness.

Goals

Consistent with the state's priority to improve culturally competent mental health and substance use services, and to reduce stigma among the consumer community, the Board will identify areas of MHSUS systems, policies, procedures, service delivery and practices that can be improved upon. Priorities and recommendations will be established by the Board upon careful examination and analysis of MHSUS system.

Objectives

- The Board will meet every other month for two hours. Additional committee meetings and tasks may be established, as appropriate/necessary.
- MHSUS' Ethnic Services Manager will facilitate board meetings to ensure that the Board is working to achieve its stated goals in an efficient manner.
- The Board will rely on individual and collective expertise of its members to make informed decisions and recommendations.
- The Board will be available for community and staff input, utilizing members of the Board as liaisons to the entire stakeholder community.
- Members of the Board will work collaboratively to ensure that the interests of stakeholders are appropriately and effectively represented.

A major accomplishment of the CCAB was to plan and implement a county-wide cultural competency training. This training was unique in that it included consumer and family member voices to provide culture-specific presentations. Consumers and family members were partnered with mental health and substance use professionals to present on various topics related to the cultural issues based on race/ethnicity, gender-identity and age. The training exceeded the maximum attendees of one hundred (100) allowed, with an additional fifty (50) registrants who were placed on the waiting list. Registrants on the waiting list were given top priority to attend the subsequent cultural competency training.

The CCAB also worked to advocate for improving access to mental health and substance use services by the Latino community of Marin. This target population has continually struggled to access our county's service system, as evidenced by the low penetration rate relative to the state average and census data. The Board's advocacy resulted in a recommendation to the Division Director to increase the number of Promotoras working in the county's predominantly Latino communities such as the Canal neighborhood in San Rafael, the city of Novato, and the rural coastal area of West Marin. The recommendation was included in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

Also, the CCAB advocated for the development of a user-friendly website that consumers and family members can easily access and use to obtain information and resources about services, programs and opportunities. The MHSUS Division Director assembled a working committee within the division to begin the process of designing and developing a user-friendly website. Due to the lack of staffing resources, the development process was slowed, delaying the availability of a functional website for the public to access and use. However, aggressive efforts are under way to accomplish the development of the website in order to improve access by consumers, family members and the general public.

Lastly, the CCAB advocated for increased and improved access to services by residents who live in the county's public housing elements. The division went into a collaborative partnership with Marin Public Housing Authority by identifying the challenges and needs of its residents, particularly older adults and African American families with severe mental illness. This advocacy resulted in the procurement of the SB-82 grant which provide funding for mental health triage services to public housing residents.

Race/Ethnicity CCAB Membership			
White	7	Hispanic	6
African/American	5	Multi	
Asian	4	Other	4
Pacific Islander			
Native	1		

COMMUNITY SERVICES AND SUPPORTS (CSS) OVERVIEW

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

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

Full Service Partnerships (FSPs)

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

System Development (SD)

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

Outreach and Engagement (OE)

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

MHSA Community Supports and Services Program Outcomes

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

Since CSS has been implemented we have seen an increase in services to Latino adults and continued our relatively high level of service to Latino youth. In FY2006-07 Latinos comprised 15.7% of County mental health clients and in FY2013-14 it is 23.7%. There was not a significant change in rates for other ethnic populations. MHSA has allowed for an increase in bilingual staff across CSS and PEI programs.

The County recognizes the need to better engage and serve diverse populations, especially those identified as un/underserved. For instance, in FY2012-13 the County allocated PEI monies to three programs aimed at reaching the Latino, Vietnamese and Southern Marin populations, including the use of Community Health Advocates/Promotores, a strategy shown to develop trust and reduce barriers to accessing mental health services. Similarly, in FY2014-15 PEI expanded services in West Marin, a geographically isolated are. To some extent, the PEI-funded efforts help support the outreach to CSS and other more intensively focused service programs.

This table summarizes the individuals served by CSS programs in FY2013-14.

Total Individuals Served: 1835

Age Group	# served	% of Served
0-15 years old	130	10%
16-25 years old	171	13%
26-59 years old	730	54%
60+ years old	309	23%
Race/Ethnicity		
White	597	44%
African American	408	30%
Asian	49	4%
Pacific Islander	28	2%
Native	7	<1%
Hispanic	130	10%
Multi	78	6%
Other/Unknown	43	3%

Primary Language	# served	% of served
English	1215	91%
Spanish	73	5%
Vietnamese	6	<1%
Cantonese	6	<1%
Mandarin	5	<1%
Tagalog	1	<1%
Cambodian		
Hmong		
Russian	13	1%
Farsi	7	<1%
Arabic	6	<1%
Other	8	<1%

The demographics do not include 495 clients served by the ASOC program.

The key outcome data for each program is included in each program section of this FY2015-16 Annual Update.

YOUTH EMPOWERMENT SERVICES (YES) FULL SERVICE PARTNERSHIP

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

Marin County's Youth Empowerment Services (YES) Program is a Full Service Partnership program serving approximately 40 seriously emotionally disturbed (SED) youth at risk for high end services that are on formal probation and/or attend County Community School, an alternative high school. A Full Service Partnership is a model of 'whatever it takes' and entails a flexible approach to the child and family to meet their needs providing a range of services from case management and family therapy to medication consultation and monitoring.

Target Population

The YES program serves youth in two systems: 1) SED youth in the juvenile justice system and 2) SED youth attending County Community School. These youth typically do not have ready access to other mental health resources (i.e., underinsured or uninsured.) and are not typically motivated to seek services at outpatient mental health clinics. Latino youth continue to represent the largest group in terms of referrals from both the juvenile justice system and County Community School. The majority of clients continue to be 14 – 18 years old and around 60% self-identify as Hispanic at any given time. The YES program is equipped to serve these youth with three (3) bilingual Spanish speaking clinicians, one of whom is a Latino male working with mostly Latino male students at County Community School.

Program Description

The YES FSP is a supportive, strengths based model with the goal of meeting youth and families at school, in their homes, and in the community, both literally and figuratively with a 'whatever it takes' philosophy. This program collaborates with partner agencies (i.e., education, probation, drug court, etc.) to facilitate integrated care and ongoing family support. An important component of this program is the support from the YES team Family Partner, who provides support and guidance to parents in navigating the various systems and with parenting youth engaged in high risk behaviors. The Family Partner has lived experience with a family member who has been involved in the juvenile justice system and/or the mental health system.

The goal is to engage the youth in establishing treatment goals and interventions to ameliorate the mental health symptoms that have impacted their life negatively. YES clinicians strive to help families identify their needs and implement ways to address them successfully. The youth's mental health symptoms usually have impacted many areas of their life such as their education, family

relations and the legal system. By working together with the YES team across systems as needed and engaging the youth and family to come up with their own goals the youth is able to move forward.

Intended Outcomes 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.

Children's Mental Health has formed a taskforce which is currently researching a new outcome measure to use in all of Children's Mental Health to measure the effectiveness of services. Currently, the programs use the Child Behavioral Check List (CBCL) which many find too long and difficult to engage parents. The expectation is to select a valid instrument that will be less challenging to use and to begin implementation by the Fall of 2015.

OUTCOMES
July 2013 – June 2014

In FY2013/14 the YES Program served 38 youth as Full Service Partners (FSP) and 26 youth that received less intensive services, for a total of 64. This decrease from 91 in FY2012/13 mirrors the decrease statewide in youth involved in the juvenile justice system.

Full Service Partnership Client Demographics

Age Group	# served	% of served
0-15 years old	16	42%
16-25 years old	22	58%
26-59 years old		
60+ years old		
Unknown/No Reply		
Total	**38**	**100%**
Race/Ethnicity		
White	1	3%
African/American	3	8%
Asian		
Pacific Islander		
Native		
Hispanic	31	81%
Multi	2	5%
Other		
Unknown/No Reply	1	3%

Primary Language	# served	% of served
English	25	66%
Spanish	13	33%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Unknown/No Reply		
Gender		
Male	9	24%
Female	29	76%

Previous demographic data for the YES program (formerly Children's System of Care (CSOC)) reported in the last three Annual Updates reported a much higher total number served than in FY2013-14. Those numbers were a blend of YES Full Service Partnership (FSP) clients and non-FSP clients served in the YES program. The numbers above represent FSP clients served only.

YES program objectives included decreasing arrests, decreasing school suspensions and increasing school attendance and performance. This data is only available for those identified as Full Service Partners. Because the number of youth in this program each year is small for purposes of statistical analysis outcomes have been calculated to include all Full Service Partner participants over the course of this program, adding data in each year.

From the beginning of the YES FSP Program notable outcomes include:

- A decrease of 88% in suspension;
- A 41% improvement in attendance;
- 51% improvement in grades;
- 22% of participants experienced a decrease in incarceration during FY2013/14.

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, we are in the process of developing a three to five year strategic plan for our Children's Mental Health services. This plan will take into account the reduced number of youth in the juvenile justice system, identify gaps and needs in our system, and address strategies with the help of community based organizations, community members and clinical staff. We have a significant increase in bilingual students with monolingual parents and currently half of our clinical staff is bilingual Spanish speaking to meet that need. Our Children's Mental Health Strategic Plan is expected to be completed by the summer of 2015 and will include priority areas, goals and strategies, identified through our stakeholder process for our YES Program. It is expected our FSP will be expanded to include referrals for youth with SED from other sources beside the juvenile justice system.

In FY2015-16, we expect to begin implementation of our Strategic Plan with our finalized goals and strategies. Our top priorities have been identified broadly as 1) Increase outreach and access to services, 2) Increase staff and system capacity to meet the identified needs and, 3) Improve data collection, analysis and reporting.

YOUTH EMPOWERMENT SERVICES (YES) FULL SERVICE PARTNERSHIP

CLIENT STORY

Jaime had very poor school attendance and was caught selling marijuana at school, a fairly common picture of youth grappling with emotional difficulties. He was smoking marijuana on a daily basis and appeared to be depressed. He was very quiet, introverted, and had poor social skills. He had been expelled from his regular school and sent to County Community School where a YES clinician was assigned.

At first Jaime was not interested in "therapy" and refused to talk. He continued to smoke marijuana and his school attendance remained very poor. Jaime went to juvenile hall several times for violating probation mandates but after a lengthy stay realized he wanted to make a change in his life. The YES clinician visited him at Juvenile Hall and he began to open up during these visits. Jaime disclosed that as a young child he had witnessing domestic violence which was traumatic for him and yet suffered an even greater trauma when his father left the family without saying goodbye.

Jaime made a commitment to himself to change his behavior so he would not return to Juvenile Hall. He began by decreasing his marijuana use and attending school regularly. He was able to express how much he missed his father and through the help of his family and the YES team was able to reconnect with him and begin working through their difficult relationship. Through the YES program and his clinician he learned that talking about his problems could help relieve his depression instead of masking it with drug use. Jaime was recognized by his peers and teacher as making significant change and is on track to re-enter mainstream school and be released from probation.

TRANSITION AGE YOUTH (TAY) FULL SERVICE PARTNERSHIP

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

Marin County's Transition Age Youth (TAY) Partnership, provided by Buckelew Programs, is a Full Service Partnership (FSP) providing approximately 20 young people (16-25 year olds) with independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services. These services are strengths based, evidence based and client centered. There is an onsite psychiatrist part time and the substance use specialist provides initial assessments and meets with the youth and their family as appropriate and provides psycho-educational groups. In addition, partial services, such as drop-in hours and activities, are available to TAY clients who are not in the Full Service Partnership.

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.

Program Description

The TAY program 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. The TAY psychiatrist is available on site part time which has enabled him to follow TAY participants more closely when they are in crisis, adapting to a new medication, or needing more frequent contact to stabilize symptoms.

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 more intensive services, incarceration and homelessness.

Partial services are provided on a drop-in basis to full service 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 participants to expand their cultural horizons, and a

place to for them to practice their social skills. The iRest group continues to be well attended. It is an integrated, evidence supported practice that teaches emotional regulation and helps heal unresolved issues. The monthly TAY calendar of activities is available in English and Spanish. A bimonthly Family Support Group for families of TAY with mental health illness, whether or not they are enrolled in the TAY programs is provided by a TAY staff member.

Intended Outcomes and Evaluation

The goals of decreased incarceration, homelessness, psychiatric hospitalization from the FSP data is tracked over the years of the program and only the data of those who were hospitalized, incarcerated or experienced homelessness prior to entering the program are captured. In addition, the Program tracks those who engage in school, work or vocational training. The Program staff also wants to maintain optimum occupancy of the TAY house since housing is such a precious commodity in the Bay Area especially for TAY youth, so the occupancy of the TAY house is tracked as well.

It is planned to gather more robust feedback from the community and the youth themselves in shaping the program and addressing the needs of this group which remains a work in progress.

OUTCOMES
July 2013 – June 2014

The TAY Program objectives include decreasing hospitalizations and homelessness and increasing participation in school or work. Only those who were hospitalized, incarcerated or experienced homelessness prior to entering the program are tracked for these outcomes. Those who experienced these conditions before entering the program experienced:

- 50% reduction in juvenile hall;
- 75% reduction in homelessness;
- 60% reduction in psychiatric hospitalization after entering the program.

Additionally, the TAY house was fully occupied 91% of the time and 88% of TAY participants engaged in work, school or vocational training.

Full Service Partnership Client Demographics

Age Group	# served	% of served
0-15 years old		
16-25 years old	25	93%
26-59 years old	2	7%
60+ years old		
Unknown/No Reply		
Total	**27**	**100%**
Race/Ethnicity		
White	17	63%
African/American	1	4%
Asian	2	7%
Pacific Islander		
Native		
Hispanic	4	15%
Multi	2	7%
Other		
Unknown/No Reply	1	4%

Primary Language	# served	% of served
English	26	96%
Spanish	1	4%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Unknown/No Reply		

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, an Request for Proposal was distributed to community providers in response to stakeholder input. A different perspective on meeting the unique needs of this age group was envisioned with a focus on utilizing peer mentors, family partners and the youth themselves to build a program more engaging and more responsive to their needs. In the Fall of 2014 a new community based organization, Sunny Hills Services, was chosen to lead the TAY Program and was implemented in January 2015.

In **FY2015-16,** we will move forward with the plan as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, working closely with the new TAY provider.

SUPPORT AND TREATMENT AFTER RELEASE (STAR) PROGRAM FULL SERVICE PARTNERSHIP (FSP)

PROGRAM DESCRIPTION
July 2023– June 2014

Program Overview

The Support and Treatment After Release (STAR) Program has been an MHSA-funded Full Service Partnership (FSP) serving adults with serious mental illness who are at risk of incarceration or re-incarceration since 2006. The FSP provides culturally competent intensive, integrated services to 40 mentally ill offenders. Operating in conjunction with Marin's mental health court – the STAR Court – the program is 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.

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.

Program Description

Operating in conjunction with Marin's Jail Mental Health Team and the STAR Court (mental health court), a multi-disciplinary, multi-agency assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psycho-education, employment services and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. Program participants and their families are provided education regarding the management of health and mental health issues, with a focus on reducing stigma, restoring hope and promoting recovery of health and functioning. Recognizing the critical role that families and other natural support systems play in their family member's recovery, family members have access to an array of

family support services to assist them to develop alternative strategies and skills for coping with and addressing the effects of serious mental illness on themselves and their family member.

The team consists of three (3) mental health clinicians, one of whom is bilingual/bicultural (Spanish-speaking) and one of whom is co-located with the Jail Mental Health Team; a part-time nurse practitioner; a part-time psychiatrist; two (2) peer specialists; a deputy probation officer; an employment specialist; an Independent Living Skills specialist; and a part-time substance use specialist. Support is available to clients and their families 24 hours a day, 7 days a week.

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

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

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

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

Outcomes 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%

OUTCOMES
July 2013 – June 2014

In FY2013-14, the STAR Program served 54 individuals who had serious mental illness and significant criminal justice involvement, exceeding the program's target enrollment of 40. Of the 19 program participants referred by the team for employment services, 7 (36%) were successfully engaged in job development activities, 5 (26%) of whom were successfully placed in jobs, and 9 (47%) engaged in volunteer work. Independent Living Skills (ILS) services were provided to 9 program participants, exceeding the projected goal of 4-5 individuals, with 71% remaining engaged in ILS services at the end of this reporting period.

STAR (FSP-03)	Goal	ACTUAL FY2013-14	
		Cumulative	FY
# served	40	192	54
Decrease in homelessness	75%	78%	59%
Decrease in arrests	75%	68%	71%
Decrease in incarceration	80%	80%	75%
Decrease in hospitalization	40%	50%	15%

Annually, the STAR Program sponsors Crisis Intervention Team (CIT) Training, a 32-hour training program for police officers to enable them to more effectively and safely identify and respond to crisis situations and mental health emergencies. Approximately 30 sworn officers and dispatch staff attended the CIT Training offered during this reporting period. To date, 335 sworn officers have received CIT training with at least one CIT trained officer in every law enforcement jurisdiction in Marin.

Female offenders with mental illness have been identified to be a high risk population and, as a group, tend to be unserved or underserved. During this reporting period, 13% percent of program participants were female, as compared to the 10-11% that has constituted the Marin County Jail population.

Since individuals must be justice-involved in order to qualify for STAR Mental Health Court, and most referrals are initiated by the judicial system (judge, district attorney, and/or public defender), there is reduced opportunity for outreach and engagement with minority populations. As a result, the assertive community treatment component of the program does not serve a population representative of the jail population (see table below), for example the County Hispanic/Latino jail population is 26% compared to 13% of those served by this component of STAR.

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

Full Service Partnership Client Demographics

Age Group	# served	% of served
0-15 years old		
16-25 years old	6	11%
26-59 years old	41	76%
60+ years old	7	13%
Unknown/No Reply		
Total	**54**	**100%**
Race/Ethnicity		
White	41	75%
African/American	1	2%
Asian	2	4%
Pacific Islander		
Native		
Hispanic	7	13%
Multi	2	4%
Other		
Unknown/No Reply	1	2%

Primary Language	# served	% of served
English	47	87%
Spanish	5	9%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic	1	2%
Other	1	2%
Unknown/No Reply		
Gender		
Male	47	87%
Female	7	13%

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, the program experienced some challenges and made appropriate adjustments. As noted above, the STAR Program has had limited success with outreach to and engagement with minority populations, especially Hispanic/Latino. The program will continue to explore additional methods for improvement in this area, including a component in Marin's upcoming MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 to expand the core assertive community treatment team by one mental health clinician in order to increase enrollment in the program without the requirement for participation in STAR Mental Health Court. This would broaden the referral base and hopefully expand Hispanic/Latino access to the STAR Program. Additionally, partnering with two new Prevention and Early Intervention (PEI) projects – Community Health Advocates (CHAs) and Vietnamese Community Connection – has the potential for increasing the program's opportunities for outreach and engagement to both populations. The Adult System of Care (ASOC) CHA Liaison will be instrumental in linking these new PEI projects with STAR and other system of care programs.

Additionally, the MHSA CSS one-time expansion funding for three (3) STAR Program services – the clinician sited with the Jail Mental Health Team, the substance use specialist, and the ILS training – ended in FY2013-14. The MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 continues those expansions that provide services that are essential to serving the program's target population and have already demonstrated success.

In FY2015-16, the STAR Program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

HELPING OLDER PEOPLE EXCEL (HOPE) PROGRAM FULL SERVICE PARTNERSHIP

PROGRAM DESCRIPTION
July 2013– June 2014

Program Overview

The Helping Older People Excel (HOPE) Program is a Full Service Partnership serving older adults with serious mental illness who are at risk of homelessness, hospitalization or institutionalization since 2007. The program provides culturally competent, intensive, integrated services to 40 priority population at-risk older adults. Services include 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.

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.

Program Description

The HOPE Program is a multi-agency team, staffed by County Mental Health and Substance Use Services (MHSUS), Aging and Adult Services, and the Public Guardian's Office. The multi-disciplinary assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psycho-education, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance use disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. Program participants and their families are provided education regarding the management of health and mental health issues, with a focus on reducing stigma, restoring hope and promoting recovery of health and functioning. Recognizing the critical role that families and other natural support systems play in their family member's recovery, family members have access to an array of family support services to assist them to develop alternative strategies and skills for coping with and addressing the effects of serious mental illness on themselves and their family member.

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

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

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

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

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

Outcomes Expected and Evaluation

Listed in the following table, 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%

OUTCOMES
July 2013 – June 2014

During FY2013-14, the HOPE Program and Senior Peer Counseling provided information, referral, outreach and engagement, assessment and professional consultation to over (350) individuals, families and other treating professionals. The HOPE Program served 61 at-risk older adults who had serious mental illness and were unserved by the mental health system, exceeding the program's target enrollment of 40. An additional 41 older adults were served by the Senior Peer Counseling Program, the outreach and engagement component of the HOPE Program. Independent Living Skills services were provided to 3 program participants.

During FY2013-14, the Senior Peer Counseling Program supported a total of 37 trained older adult volunteers, 6 of whom were Spanish-speaking. Senior peer counselors visited older adults in their homes, in skilled nursing facilities, in board and care homes, and in the hospital for a total of 1,305 visits during the year. Eight (19%) of the individuals served by the senior peer counselors were Hispanic/Latino and received 14% of the total FY2013-14 visits (193).

Of the 61 at-risk older adults served by the HOPE FSP in FY2013-14, 69% experienced a decrease in homelessness, falling short of the goal of 75% decrease. The 39% decrease in acute hospital admissions also did not reach its target goal of 50%. Three program participants (7%) received assessment of their independent living skills; 2 engaged in ILS training following assessment.

Marin's older adult population, age 60 and older, is largely Caucasian (92%), with 4% Asian, 4% Hispanic/Latino, and 1% Black/African-American. African American participants in the HOPE FSP are slightly overrepresented at 7%, while 84% of participants identify as white/Caucasian. Asian and Latino older adults were underrepresented at 2% each (see table below).

Note: County older adult population data from 2010 census

Full Service Partnership Client Demographics

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old	2	3%
60+ years old	59	97%
Unknown/No Reply		
Total	**61**	**100%**
Race/Ethnicity		
White	52	84%
African/American	4	7%
Asian	1	2%
Pacific Islander		
Native		
Hispanic	1	2%
Multi	2	3%
Other	1	2%
Unknown/No Reply		

Primary Language	# served	% of served
English	55	89%
Spanish	1	2%
Vietnamese	1	2%
Cantonese		
Mandarin		
Tagalog	1	2%
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	3	5%
Unknown/No Reply		
Gender		
Male	23	38%
Female	38	62%

CHALLENGES AND UPCOMING CHANGES

In FY14-15, there were a number of challenges experienced and adjustments made. While Marin's Hispanic/Latino population has continued to increase, the growth has been less dramatic within the County's older adult population. The HOPE Program continues to experience difficulty locating and engaging this potentially underserved population, enrolling no Hispanic/Latino older adults in the assertive community treatment component of the program. ACASA conducted extensive outreach to the Latino community with a goal of increasing referrals by educating over twenty community leaders about services. Despite employing this and other creative strategies, the program appears to remain unsuccessful in this area. Unknown at this point is what proportion of Marin's older adult population is Latino and suffering from serious mental illness. Feedback received suggests that families who have migrated to Marin cannot yet afford to bring their elders to the area.

Recognizing the need for Spanish-speaking capacity in the assertive treatment component, Marin's MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 will add this

capacity. Partnering with two PEI projects implemented in FY2012-13 – Community Health Advocates (CHAs) and Vietnamese Community Connection – has the potential for increasing the program's opportunities for outreach and engagement, but has not realized this potential yet. The ASOC (Adult System of Care) CHA Liaison will be instrumental in linking these PEI projects with HOPE and other system of care programs.

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

The MHSA PEI and CSS one-time expansion funds for two (2) HOPE Program services – the ACASA clinician and ILS training – ended in FY2013-14. Despite some challenges in fully implementing the ILS training, these expansions provide services that are considered to be essential for success in serving the program's target population. Marin's MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 will continue both expansions.

In FY2015-16, the HOPE Program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

ODYSSEY PROGRAM (HOMELESS) FULL SERVICE PARTNERSHIP

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

The Odyssey (Homeless) Program is a Full Service Partnership (FSP) that provides culturally competent intensive, integrated services to clients who are homeless or at risk of homelessness. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

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.

Program Description

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

The team consists of 3 mental health clinicians, one of whom is bilingual/bicultural (Spanish-speaking); a nurse practitioner; a psychiatrist; 4 peer specialists, an employment specialist, an independent living skills specialist and a substance use specialist. Outreach and engagement services are provided by a team of 2 peer specialists. Support is available to clients and their families 24 hours a day, 7 days a week.

Funded by Community Services and Supports (CSS) FY2011-12 one-time expansion funds and continued through FY2013-14, the program provides transitional housing in a 2-bedroom apartment for program participants who are homeless, reducing the program's reliance on hotel rooms. Additionally, CSS FY2012-13 one-time expansion funds were approved through FY2013-14 to provide Independent Living Skills (ILS) training for targeted Odyssey clients.

OUTCOMES
July 2013 – June 2014

The Odyssey Program targets individuals who, by virtue of being unserved or underserved, are either homeless or at-risk of homelessness. In FY2013-14, the Program served 72 individuals, exceeding the program's target enrollment of 60. Of those served, 72% (N=52) experienced homeless or risk of homelessness prior to enrollment. The program was successful in decreasing homelessness among these participants by 77%.

Outreach and engagement services for homeless residents are provided by the Enterprise Resource Center (ERC), a mental health consumer run drop-in center, and the CARE Team (homeless mobile outreach) which works closely with the Odyssey Program and provides most of the referrals for the program's assertive community treatment component. During FY2013-14, 101 individuals received homeless outreach services from the CARE team, totaling 1,261 contacts, exceeding their target contacts by 5%. The majority of these individuals were Caucasian 74%, with African-Americans comprising 2%, Latinos 8%, and Asians 2%.

The program's transitional supportive housing component experienced significant challenges during this period. In FY2013-14, four program participants utilized the service. None of these participants were able to successfully transition to other, more permanent living arrangements. The program target of 50% was not met.

Independent Living Skills (ILS) services were provided to 7 program participants, exceeding the projected goal of 4-5 individuals, with 5 (70%) remaining engaged beyond the assessment service.

Of the 10 program participants referred by the team for employment services, 5 (50%) were successfully engaged in job development activities, and 4 (40%) were successfully placed in jobs. Three participants (30%) were placed in volunteer activities and 3 (30%) engaged in educational activities focused on academic/training goals for expanding employability.

The 14 participants with arrests prior to enrollment experienced an 83% reduction in arrests and 47% reduction in incarcerations. Similarly, acute inpatient hospitalizations decreased by 21%.

Substance Use Services

On average, 58% of participants in the Odyssey Program have presented with a co-occurring substance use disorder, putting them at even greater risk. In addition to the programs substance use specialist, in FY2013-14 the program partnered with a local organization to provide harm reduction focused engagement groups to program participants with co-occurring disorders. Groups were attended by 11 program participants, for a total of 87 services. The program will continue to explore strategies for engaging participants in this aspect of their recovery.

The program served a somewhat diverse population, with African-Americans being overrepresented at 13% compared to 3% in the County adult population (18 years and older), but consistent with the 13% reported in Marin's homeless population. Hispanics were underrepresented at 10% compared to 14% in the adult population and 20% in the homeless population. Also underrepresented were Asians at 0% compared to 6% in the adult population and 3% reported in the homeless population.

Notes: County adult population data from 2010 census; County homeless population data from Marin County Point-in-Time Homeless Count 2013

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old	56	78%
60+ years old	16	22%
Unknown/No Reply		
Total	**72**	**100%**
Race/Ethnicity		
White	49	68%
African/American	9	13%
Asian		
Pacific Islander		
Native	2	3%
Hispanic	7	10%
Multi	4	5%
Other	1	1%
Unknown/No Reply		

Primary Language	# served	% of served
English	65	90%
Spanish	4	6%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi	1	1%
Arabic		
Other	2	3%
Unknown/No Reply		
Gender		
Male	29	40%
Female	43	60%

CHALLENGES AND UPCOMING CHANGES

In FY14-15, there were a number of challenges experienced and adjustments made. Marin's Hispanic/Latino population has continued to grow and is overrepresented in the County's homeless population. The Odyssey Program continues to explore additional methods for improving outreach to/engagement with Hispanic/Latino adults. Partnering with two Prevention and Early Intervention (PEI) projects implemented in FY2012-13 – Community Health Advocates (CHAs) and Vietnamese Community Connection – have increased the program's opportunities for outreach and engagement, as demonstrated by improvements in this area since FY2012-13. The ASOC (Adult System of Care) CHA Liaison has been instrumental in linking these new PEI projects with Odyssey and other system of care programs.

During FY2013-14 60% of the Odyssey Program participants were female, while males comprised only 40%. Most studies of the homeless population show that single homeless adults are more likely to be male than female, with 68% being male. While further attention to this issue is warranted, this shows an improvement over FY2012-13, when only 32% of program participants were male. Program staff will continue to develop strategies for engaging and enrolling more males in the program.

As noted above, a substantial percentage of program participants present with co-occurring substance use disorders, putting them more at risk for suicide, aggressive behavior, homelessness, incarceration, hospitalization and serious physical health problems. Implementation of the integrated substance use services expansion has been challenging. Given the high retention rate once participants actually do access this essential service, the Odyssey Program team is exploring methods for increasing and supporting the engagement and participation of Odyssey Program clients in the program's integrated substance abuse services.

The MHSA CSS one-time expansion funds for 3 Odyssey Program services – the substance use specialist, transitional housing and ILS training have shown notable improvement in participant outcomes, and will be continued in Marin's MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

In FY2015-16, the Odyssey Program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, which includes the addition of a Step-Down component. This component will be staffed by a Support Service Worker with lived experience and a peer specialist, who will provide services to 40 participants who continue to struggle with independent community living but no longer require the support of the assertive community treatment component of the program. This will increase the availability of assertive community treatment services, in addition to providing a less abrupt transition from intensive services to independence.

ENTERPRISE RESOURCE CENTER (ERC)

PROGRAM DESCRIPTION
July 2013 – June 2013

Program Overview

Since 2006, the Enterprise Resource Center (ERC) 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 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.

Target Population

The target population of the ERC 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.

Program Description

Prior to implementation of MHSA, Marin's consumer-staffed Enterprise Resource Center had outgrown its space and management infrastructure. The ERC 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 and Human Services Health and Wellness Campus. Currently, the Enterprise Resource Center averages over 1,300 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 seven (7) days per week, as well as serving as host to such meetings as Dual Recovery Anonymous, Smokebusters, and NAMI Family Support Groups. ERC programs and services designed to provide personal support and foster growth and recovery include the Warm Line, available seven (7) days/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.

Outcomes Expected and Evaluation

Expected outcomes for the ERC Program are listed in the table below. The data for these measures are obtained from CSS logs that program staff are required to fill out and keep up-to-date.

	Goal
Number of unduplicated clients served by the ERC	200
Average daily attendance at the ERC	35
Number of Warm Line contacts	9,000
Average monthly contacts by CARE	100
Average daily attendance at Linda Reed Activities Club	12
Number of mental health clients employed or receiving stipends	65

OUTCOMES
July 2013– June 2014

The Enterprise Resource Center continues to be successful in engaging hard to reach individuals, in particular those with serious mental illness who have not engaged with MHSUS services. Outcomes for FY13-14 are listed in the table below. The ERC Expansion Program has been remarkably successful with the number of client visits per month increasing from 600 to over 1,300.

	Goal	Actual FY2013-14
Number of unduplicated clients served by the ERC	200	341
Average daily attendance at the ERC	35	45
Number of Warm Line contacts	9,000	6,878
Average monthly contacts by CARE	100	105
Average daily attendance at Linda Reed Activities Club	12	12
Number of mental health clients employed or receiving stipends	65	66

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old	47	73%
60+ years old	17	27%
Unknown/No Reply		
Total	**64***	**100%**
Race/Ethnicity		
White	39	61%
African/American	4	6%
Asian	4	6%
Pacific Islander	1	1.5%
Native	1	1.5%
Hispanic	5	8%
Multi	7	11%
Other		
Unknown/No Reply	3	5%

Primary Language	# served	% of served
English	50	78%
Spanish	7	11%
Vietnamese	1	1.6%
Cantonese	1	1.6%
Mandarin	1	1.6%
Tagalog		
Cambodian		
Hmong		
Russian	2	3%
Farsi	1	1.6%
Arabic	1	1.6%
Other		
Unknown/No Reply		
Gender		
Male	35	55%
Female	27	42%
Transgender	2	3%

** Demographic data based on a sample of 64 unduplicated ERC clients.*

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, the majority of the program was implemented as expected. The implementation of the ERC Step-Up Recovery Program has been delayed due to the need to clarify aspects of the program before releasing a Request for Proposals for implementation. This program is inctended to serve as the next step ("step down") for individuals who no longer require intensive case management services provided by the Adult System of Care (ASOC), and others actively engaged in recovery.

In FY2015-16, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014/15 through FY2016/17. In the community planning process for the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 the need to expand services for individuals actively engaged in recovery was identified. In order to ensure coordination of services, MHSA funded consumer operated wellness and recovery services will be combined into one program and a Request for Proposal (RFP) process will be released in FY2015-16.

SOUTHERN MARIN SERVICES SITE (SMSS)

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

In the original and recent MHSA community 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%.

Program Description

The Southern Marin Services Site Program (SMSS), initially implemented by Family Service Agency, which is now part of Buckelew Programs, 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, to provide psycho-education, clinical counseling and case management services, parenting support, assistance with re-entry, and goal setting. This aspect of the program was discontinued due to a loss in staffing in February 2014.

Intended Outcomes 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.

OUTCOMES
July 2013 – June 2014

SMSS has been successful in reaching its program objectives and engaging unserved/underserved populations in southern Marin. They have also created a racially diverse staff at SMSS, which includes two African American clinicians (four including the Phoenix Project therapist and consultant), an Asian clinician, a Mexican/East Indian clinician, several culturally competent Caucasian clinicians, and an African American parent aide/family advocate. SMSS has partnered with other providers in the community to increase the accessibility of the services, including providing home-visits and services within other programs and local schools.

Outcome	Goal	Actual FY2013-14
Children receiving child or family therapy that improved or were stabilized in their overall functioning as measured by one or more dimensions on the Child Outcome Survey.	70%	69% *N=25*
Adults receiving therapy that improved or were stabilize in their overall functioning as measured by one or more dimensions on the Adult Outcome Survey.	70%	80% *N=71*
Families receiving home visiting services that improved or were stabilized in their parenting/care giving abilities as measured by at least one of three parenting/care giving dimensions on the Adult Outcome Survey.	70%	100% *N=12*
Students participating in the school-based program that showed improved emotional functioning, coping skills, and/or peer/family relationships and/or decreased high-risk behavior as evidenced by pre-post counselor evaluations.	70%	95% *N=40*
Number of calls to SMS that are answered in person by the the administrative assistant.	70%	85% *N=~20/day*

Clinical Services

Age Group	# served	% of served
0-15 years old	14	15%
16-25 years old	9	10%
26-59 years old	59	62%
60+ years old	12	13%
Unknown/No Reply		
Total	**94**	**100%**
Race/Ethnicity		
White	52	56%
African/American	18	20%
Asian	2	2%
Pacific Islander	3	3%
Native		
Hispanic	5	5%
Multi	5	5%
Other	3	3%
Unknown/No Reply	6	6%

Primary Language	# served	% of served
English	87	93%
Spanish	1	1%
Vietnamese		
Cantonese	1	1%
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian	2	2%
Farsi	1	1%
Arabic		
Other	2	2%
Unknown/No Reply		

Outreach and Engagement Activities

Age Group	# served *	% of served
0-15 years old	100	18%
16-25 years old	100	18%
26-59 years old	250	46%
60+ years old	100	18%
Unknown/No Reply		
Total	**550**	**100%**
Race/Ethnicity		
White	100	18%
African/American	340	61%
Asian	20	4%
Pacific Islander	20	4%
Native		
Hispanic	40	7%
Multi	20	4%
Other	10	2%
Unknown/No Reply		

Primary Language	# served *	% of served
English	540	98%
Spanish	10	2%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Unknown/No Reply		

* Estimated number of individuals reached with outreach and engagement services

CHALLENGES AND UPCOMING CHANGES

One challenge in providing services is the stigma associated with mental health services. SMSS continues to find ways to increase referrals from and provide services in community based settings. In the next fiscal year SMSS intends to co-facilitate a DBT group for pre-teens at the MLK School. Continued attempts to outreach and engage the community will be the challenge for the coming year and strategies will be developed in collaboration with the schools and community leaders.

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

In **FY2014-15**, there were a number of staff changes that resulted in fewer clinical services being provided than in the previous year. A part-time consultant was hired to bring a holistic approach to the collaborative work with the Phoenix Project. He provided life-coaching services for 14 young men, assisting them in achieving education, employment, and other life goals. The collaboration with

Phoenix Project to work with TAY at their site ended at the end of the fiscal year due to funding changes.

In **FY2015-16,** this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. SMSS has met with community leaders to determine a more effective outreach strategy that will partner more effectively with the faith based community and the community leaders. This will include creating a Community Services Team comprised of members of the community to engage in a paid traineeship to further the development of the workforce from this community.

ADULT SYSTEM OF CARE EXPANSION (ASOC)

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

The Adult System of Care (ASOC) 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.

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.

Target Population

The target population of the ASOC 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.

Program Description

The ASOC 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 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 Youth Empowerment Services Family Partnership Program into the ASOC through the addition of a Family Partner and a part time bi-lingual Family Partner with personal experience as a family member of an adult with mental illness. The ASOC Family Partners provide 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. The family partners have worked across the case management teams in the adult system of care to support family members and assist them in navigating the mental health system.

Intended Outcomes and Evaluation

Listed in the table below, the expected outcomes for the ASOC 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 is required to fill out and keep up-to-date.

Adult System of Care (ASOC)	Goal FY2014-15	Goal FY2015-16
# Served	275	325
% Hispanic	50%	50%
# Primary Language is Spanish	100	100
# Asian	15	15
# Primary Language is Vietnamese	10	10
# Served – Outreach and Engagement Team	N/A	20
# Successfully engaged in Treatment – Outreach and Engagement Team	N/A	15

OUTCOMES
July 2013 – June 2014

During FY2013-14, the ASOC program served a total of 495 at-risk individuals who had serious mental illness and their families, well in excess of the project's goal of 275.

- The Peer Specialist provided services and supports to 10 clients of the Adult Intensive Case Management team.
- Outreach to and Engagement with Hispanic/Latino Individuals and Vietnamese Individuals was provided in part by the Community Health Advocate (CHA) Liaison, a part-time clinician. She worked with the Promotores, Vietnamese community health advocates, and other key partners, utilizing a variety of strategies intended to improve community awareness of mental health issues and resources, improve access and increase mental health related services to Hispanic/Latino and Vietnamese community members, including:
  - Training/support of **7 Latina mental health CHAs** in meetings held twice a month.
  - Training/supervision of **4 Latino Family Health and 3 Vietnamese Family Health bilingual bicultural interns** (APA-accredited pre-doctoral internship) providing culturally appropriate mental health services, including a community Holiday educational/recreational event and a weekly Vietnamese stress management and relaxation group. These interns served more than 150 individuals.
  - Provision of **information, referral, brief intervention, and linkage** to services to more than 200 Latino adults.
  - Provision of **no-cost classes** in Spanish, including 1 year-long weekly parenting class, 1 weekly psycho-educational women's group, and 5 weekly behavioral activation (walking, dancing, yoga) groups.
  - 5 **Presentations** on mental health issues in the community.
  - Emceeing/participation in 4 **community events**.

- Provision of psycho-education through **public media**, including 40 hour-long radio broadcasts, 6 television interviews and 25 (13 Spanish, 12 bilingual) newspaper articles.

In addition, the Spanish-speaking psychiatrist located at the Health and Wellness Campus provided services to 69 individuals, 18 of whom were Hispanic. The Vietnamese speaking case manager served a total of 34 Asian individuals, 28 of whom used Vietnamese as their primary language.

- Family Outreach, Engagement and Support Services

  During FY2013-14, the Family Partners in these 2 positions, who are based with the Adult Case Management Team, co-facilitated one of the weekly support meetings offered by the Adult Mental Health System for parents of adult children needing mental health services. The bi-lingual Family Partner started a support group for Spanish speaking family members. She also organized a group of Spanish-speaking family members who attended the annual NAMI fund-raiser, NAMI Walk. Her walking team (the Sunshine team) was the largest group at the walk with 33 members. The English-speaking Family Partner for the adult system provided one-on-one support to 63 parents and family members. Of these, 2 were Hispanic, 57 were Caucasian and 4 were unknown. Twenty were between the ages of 26-59 and 43 were over the age of 60. The bilingual Spanish Family Partner provided one-on-one support to 40 family members, 37 of whom were Spanish speaking.

  The PES Family Partner, newly hired in February 2014, served a total of 80 individuals from February 2014 to June 2014. The family members were 16% Hispanic, 6% African American, 5% Asian and 8% "other." Fifteen percent (15%) spoke Spanish as their primary language and 1% spoke Vietnamese. The previous PES Family Partner was out on medical leave for much of the 2013 and we were short staffed for much of the year. Given that, we were still able to serve numerous family members presenting to PES in crisis and to offer post crisis support services. Beginning in FY2014-15 the PES Family Partner position will be reported under the Crisis Continuum of Care Program.

- The ASOC Housing Assistance Fund was used to provide much needed short-term housing assistance to 9 clients of the Adult Intensive Case Management team whose community tenure was at-risk.

CHALLENGES AND UPCOMING CHANGES

In **FY2014-15**, a number of changes were implemented, as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. Approximately 30 peer specialists received a salary increase to ensure their wages are comparable to other para-professionals. An Outreach and Engagement Team has begun engaging adults 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. The challenges in the coming year will be to more effectively integrate all of these supports and services within the newly expanded Crisis Continuum of Care.

In **FY2015-16,** this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

CO-OCCURRING CAPACITY

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

In the original community planning process for Mental Health Services Act (MHSA), addressing co-occurring disorders for clients in the mental health system of care was identified as a priority. While some of the Community Services and Supports (CSS) programs incorporate co-occurring capacity to differing degrees—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 integration of Community Mental Health Services and Alcohol, Tobacco and Other Drugs into a single division of Mental Health and Substance Use Services (MHSUS) provided an opportunity to continue building capacity across the system. While enhancing co-occurring capacity is a long-term and ongoing effort, in FY2013-14, there were a number of small-scale projects that were implemented to assess and identify needs and resources for clients — and staff working with clients — who have co-occurring mental health and substance use disorders, including tobacco dependence. In addition to those described here, program specific efforts are described within the appropriate program narrative.

Co-Location of Substance Use Specialist – Recovery Connections Center

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

Peer to Peer Tobacco Cessation Services

In response to local survey data (n=47) that showed a disproportionately higher rate of smoking (72%) among Marin County mental health consumer respondents compared to the overall Marin smoking rate (7.4%) — coupled with study data showing that, with the right support, 30.5% of smokers with recent mental illness were able to remain abstinent from tobacco for one year — Bay Area Community Resources engaged peers to conduct a needs assessment to gather information on what supports or inhibits tobacco cessation for mental health consumers in Marin. Through this project, peers were trained and conducted interviews with 125 tobacco using consumers from across the continuum of services. The results provided data and actionable recommendations that have been shared with various stakeholders and were used to provide the basis for peer-to-peer smoking cessation efforts in FY2013-14.

Target Population

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.

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.

Program Description

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, including the Full Service Partnerships, Adult Case Management, Psychiatric Emergency Services, the Medication Clinic and County-contractors providing services through CSS.

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 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.

Intended Outcomes and Evaluation

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

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 individual and organizational 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 is 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.

	GOAL
Number of mental health consumers trained to provide peer-to-peer tobacco cessation support	10
Number of mental health consumers participating in tobacco education and cessation services	75
Number of County and contractor agencies that integrate tobacco cessation support into their programs	5

OUTCOMES
July 2013 – June 2014

Co-Location of Substance Use Specialist – Recovery Connections Center

The Consulting Addiction Specialist continued to provide staff consultation and direct client care at mental health sites and programs throughout the County. Through this work, the following

outcomes were achieved during the FY 2013-14 project period:

- Engaged 280 contacts with Marin County consumers and providers.
- Provided and participated in 19 informational presentations and meetings, respectively, with mental health staff from across the system of care, including Psychiatric Emergency Services, Odyssey Program, STAR Program, HOPE Program, Adult Case Management, Youth and Family Services, and other Providers such as the Casa Rene Crisis Residential program.
- Provided outreach and consultation to 37 mental health staff and programs throughout the system of care for Marin County.
- Provided direct client care to adult and adolescent Marin County residents, including assessments, case management and other support services to 21 unduplicated clients and their families (as applicable).

Age Group	# served	% of served
0-15 years old		
16-25 years old	5	23.8%
26-59 years old	14	66.7%
60+ years old	2	9.5%
Unknown/No Reply		
Total	**21**	**100%**
Race/Ethnicity		
White	13	61.9%
African/American	1	4.8%
Asian		
Pacific Islander		
Native		
Hispanic	2	9.5%
Multi	3	14.3%
Other	2	9.5%
Unknown/No Reply		

Primary Language	# served	% of served
English	21	100%
Spanish		
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Unknown/No Reply		

Peer to Peer Tobacco Cessation Services

Key program objectives were met during the FY 2013-14 project period, including:

- BACR trained nine (9) mental health peer counselors. Of those trained, seven (7) provided 77 cessation support sessions to a total of 58 mental health consumers within various programs throughout Marin County. The majority of consumers attended between 2 – 5 sessions. An additional 19 unduplicated clients participated in a four-session series held at the Enterprise Resource Center.
- Of those that attended the 77 cessation support sessions, 79% responded having reduced their tobacco consumption as a result of participating in the sessions. [*Note: There are duplicated counts from individuals attending more than one session.]*

- As a result of the BACR efforts to train and deploy mental health peer tobacco cessation counselors, nine agencies over the past year have provided cessation groups for their mental health consumers.
- Peers have provided weekly cessation support sessions at sites including: Enterprise Resource Center, Voyager Carmel, Novato House, Marin Alano Club, D Street House, Draper House and Lakeside House.

Age Group	# served	% of served
0-15 years old		
16-25 years old	4	5%
26-59 years old	57	70%
60+ years old	21	25%
Unknown/No Reply		
Total	**82**	**100%**
Race/Ethnicity		
White	63	77%
African/American	11	14%
Asian	2	2%
Pacific Islander		
Native		
Hispanic	6	7%
Multi		
Other		
Unknown/No Reply		

Primary Language	# served	% of served
English	82	100%
Spanish		0%
Vietnamese		0%
Cantonese		0%
Mandarin		0%
Tagalog		0%
Cambodian		0%
Hmong		0%
Russian		0%
Farsi		0%
Arabic		0%
Other		0%
Unknown/No Reply		0%

CHALLENGES AND UPCOMING CHANGES

In **FY2014-15**, while co-location of a consulting addiction specialist has been invaluable in terms of staff consultation services and direct client care, the staff time needed to successfully address the complex needs of the client population does not afford the additional time necessary of many mental health staff and programs to also take on the capacity building aspect of the project as originally envisioned. As described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, in the absence of additional staffing or reduced caseloads, this initiative will continue to largely focus on ancillary consultation services to mental health staff and clients, rather than on building internal staff capacity to provide comprehensive services to clients with complex co-occurring mental health and substance use disorders. As such, this has also resulted in higher than anticipated amount of time spent on direct client care activities, resulting in a smaller number of unduplicated individuals than expected served in FY2013-14.

As described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, additional outcomes will be measured in the Peer to Peer Tobacco Cessation Program, including the percentage of consumers attempting to and quitting tobacco use and the percentage of consumers maintaining their quit status at three-month follow-up.

While the co-location of a Consulting Substance Use Specialist and implementation of Peer to Peer Tobacco 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 implementing an intensive outreach and engagement program composed of staff from both the mental health and substance use systems of care. As such, an intensive outreach and engagement program for individuals with complex co-occurring mental health and substance use disorders—Alliance in Recovery—was included in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

In **FY2015-16,** we will move forward as described in MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

CRISIS CONTINUUM OF CARE

PROGRAM DESCRIPTION

Program Overview

The Crisis Continuum of Care program began in FY2014-15. It consolidates MHSA funded crisis services into one Systems Development program to enhance and streamline the crisis continuum in Marin. In FY2014-15, the Crisis Planning program moved from Prevention and Early Intervention and the Psychiatric Emergency Services (PES) located Family Partner moved from CSS Adult System of Care and Youth Empowerment Services (formerly the Children's System of Care). We anticipate moving the Crisis Residential from Innovation funding to CSS funding 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, in FY2013-14, Marin County MHSUS was awarded a grant from Mental Health Service Oversight and Accountability Commission (MHSOAC) for Triage Personnel beginning in FY2013-14 and a grant for Mobile Crisis 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 Psychiatric Emergency Services (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.

Crisis Planning

Crisis Planning began as MHSA Prevention and Early Intervention program and as a part of the Client Choice and Hospital Prevention program, under MHSA Innovation. It 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 staff 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.

OUTCOMES

This program began in FY2014-15 and therefore will begin reporting on outcomes in the next Annual Update.

CHALLENGES AND UPCOMING CHANGES

In **FY2014-15**, the Crisis Continuum of Care brought together the many components that have been initiated. In addition to MHSA funded programs and already established programs, the triage and mobile crisis teams, funded by grants from Mental Health Service Oversight and Accountability Commission (MHSOAC) and the California Health Facilities Financing Authority (CHFFA), were established.

In **FY2015-16,** this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. In response to needs expressed by families, the family partner from PES is collaborating with another family partner in our Adult System to implement a caregiver support group that provides real life skills families can use to manage their stress while caring for a loved one diagnosed with a mental illness.

HOUSING

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

FIRESIDE SENIOR APARTMENTS

PROGRAM DESCRIPTION
July 2013 – June 2014

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

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

OUTCOMES
July 2013 – June 2014

During this reporting period, all 5 Fireside Senior Apartment MHSAHP-funded units continued to be occupied, continuing to indicate that this supportive housing project has been successful in reducing homelessness and enabling older adults with serious mental illness to maintain housing in the community and live independently. Two of the occupants were able to be stepped down from intensive case management services while maintaining their independent housing.

CHALLENGES AND UPCOMING CHANGES

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. Marin has been working in collaboration with the state to determine if we can draw down our reserve funds and apply them to other projects in our community.

In FY2014-15, effective January 1, 2015, the California Housing Finance Agency (CalHFA) released a process for counties to request the return of their unspent Mental Health Services Act housing funds held by CalHFA. Marin's original MHSA Housing allocation was paid to CalHFA and we worked with them to develop the Fireside Housing project. The Fireside Housing project did not expend all the Housing funds and the unspent balance has been with CalHFA pending an appropriate housing project to be identified that would fit under the CalHFA guidelines. Many counties were challenged and limited with the CalHFA guidelines and advocated for the funds to be returned to them.

In FY2015-16, Marin will undertake a stakeholder process to determine if a housing project can be identified for the unspent funds with CalHFA. Once determined, the County will follow the process to request our funding from CalHFA.

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)	$649,227	**$649,227**	$649,227	$1,947,682
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	**$519,644**	$519,644	$1,558,933
FSP-04 Helping Older People Excel (HOPE)	$688,527	**$688,527**	$688.527	$2,065,581
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	$347,409	**$347,409**	$347,409	$1,042,227
SDOE-09 - Crisis Continuum of Care	$0	**$600,000**	$600,000	$1,200,000
Subtotal	$5,776,124	**$6,376,124**	$6,376,124	$18,528,372
MHSA Coordinator	$140,986	**$140,986**	$140,986	$422,958
Ethnic Services Manager	$88,000	**$88,000**	$88,000	$264,000
Administration and Indirect	$900,767	**$900,767**	$990,767	$2,882,301
Operating Reserve	$129,798	**$129,798**	$129,798	$389,394
Total	$7,035,675	**$7,725,675**	$7,725,675	$22,487,025

	FY14-15	**FY15-16**	FY16-17	Total	%
County	$2,673,259	**$2,718,552**	$2,718,552	$8,110,363	36%
Contract Provider	$3,331,851	**$3,886,559**	$3,886,559	$11,104,968	49%
Administration	$900,767	**$990,767**	$990,767	$2,882,300	13%
Operating Reserve	$129,798	**$129,798**	$129,798	$389,394	2%
Total	$7,035,675	**$7,725,675**	$7,725,676	$22,487,025	100%

Full Service Partnership (FSP)	64.87%	**58.77%**	58.77%
System Development Outreach and Engagement (SDOE)	35.13%	**41.23%**	41.23%
Total	100.00%	**100.00%**	100.00%

COMMUNITY SERVICES AND SUPPORTS (CSS)

NUMBERS TO BE SERVED IN FY2015-16

Program			FY2013-14 Actual	FY2015-16 Projected	FY2015-16 Cost Per person
FSP-01	Youth Empowerment Services (YES)	FSP	38	**40**	**$16,231**
FSP-02	Transition Age Youth (TAY)	FSP	27	**25**	**$17,871**
		Partial	112	**40**	
FSP-03	Support and Treatment After Release (STAR)		54	**55**	**$9,448**
FSP-04	Helping Older People Excel (HOPE)		61	**50**	**$16,970**
FSP-05	Odyssey (Homeless)		72	**90**	**$14,256**
SDOE-1	Enterprise Resource Center (ERC)		341	**430**	
SDOE-4	Southern Marin Services Site (SMSS)		644	**700**	
SDOE-7	Adult System of Care (ASOC)		495	**350**	
SDOE-8	Co-Occurring Capacity		103*	**190***	
SDOE-9	Crisis Continuum of Care			**350**	
	Housing		5	**5**	

***** Indicates number of unduplicated individuals served. While this program is also focused on capacity building efforts, the total served does not include the number of staff or organizations engaged.

PREVENTION AND EARLY INTERVENTION (PEI) OVERVIEW

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

PEI funds are intended to help prevent mental illnesses from becoming severe and disabling. This includes intervening early in the onset of symptoms; reducing risks related to mental illness; increasing recognition of signs of mental illness; reducing stigma and discrimination related to mental illness; preventing suicide; and connecting individuals to appropriate services. A minimum of 51% of PEI funds are required to be dedicated to youth and transition age youth (0-25 years old).

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

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

In addition to PEI program funds, PEI Technical Assistance funds were available through FY2013-14. These funds were designated for projects including evaluation, quality improvement, and implementation of evidence-based programs. These funds were used in Marin for:

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

The narratives in this report address program outcomes. A continuing challenge is assessing the impact of PEI as a whole. Marin has continued to work with RAND Corporation in FY2013-14 to further develop its capacity to assess and report on both the program specific outcomes and the overarching impact of PEI.

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

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

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

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

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

PEI COMMITTEE IMPACT

Recognizing that increased funding and services are not by themselves sufficient to reach PEI goals, the PEI Coordinator convenes the PEI Committee quarterly, as well as short-term work groups as needed. The PEI Committee began meeting in 2009 to facilitate the implementation of the PEI programs, review PEI program evaluations, and collaborate towards a stronger system of care. Annually, the PEI Committee completes a survey about the PEI Committee. Results about collaboration efforts include:

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

	2009	2014
Participation on the PEI Committee helps my organization to develop expertise in MH prevention and programs.	2.85	3.27
The PEI Com fosters a "culture of prevention" for mental health.	3.00	3.47
The PEI Com works collaboratively with other efforts in the community to address issues.	3.00	3.07
Participation on the PEI Com helps my organization to collaborate effectively with other organizations.	2.89	3.31
The PEI Com contributes to the development of a mental health system of care.	3.12	3.53

POPULATIONS SERVED BY PEI PROGRAMS

Total Individuals Served by PEI in past 5 years (FY09-10 through FY13-14): 44,856
** Data is not collected on most Prevention (i.e., education and screening services.)*

Age Group	# served	% served
0-15 years old	6,882	15%
16-25 years old	6,620	15%
26-59 years old	20,255	45%
60+ years old	7,441	17%
Unknown	3,658	8%
Race/Ethnicity	**# served**	**% served**
White	22,894	51%
African American	1,461	3%
Asian/Pacific Islander	1,335	3%
Native	182	<1%
Hispanic	16,411	37%
Multi	947	2%
Other/Unknown	1,626	4%

Primary Language	# served	% served
English	25,015	56%
Spanish	14,166	31%
Vietnamese	461	1%
Other/Unknown	5,214	12%

Over the life of PEI, the programs have been adjusted to increase their ability to reach underserved populations. Introducing behavioral health Community Health Advocates/Promotores has increased the number of individuals from the Latino and Vietnamese communities receiving services. Locating programs within Marin City and West Marin have increased access for African Americans and geographically isolated communities. Providing programs specifically for transition age youth (TAY) and older adults (OA) has ensured PEI services are available for residents of all ages. In addition, PEI providers consistently report that they are serving individuals and communities who prior to PEI would have not received mental health support, whether due to language, stigma, cost, or other barriers.

UPCOMING CHALLENGES AND CHANGES

PEI continues to adjust programs to ensure they are effective and reach the target populations. In the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 significant changes were made to some of the PEI programs. In this Annual Update there are minor changes included in the following programs: Triple P, Transition Age Youth PEI, Latino Community Connection, Mental Health Community Training, and Statewide PEI. Please see the program narratives for more specific information.

EARLY CHILDHOOD MENTAL HEALTH (ECMH) CONSULTATION

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

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. A team of Jewish Family and Children's Services (JFCS) mental health consultants provide training, coaching and interventions at subsidized preschools and other early childhood education sites 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 children (0-5), and their families, who attend subsidized pre-schools or other early childhood education programs. The children 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.

Program Description

- Outreach for Increasing Recognition of Early Signs of Emotional Disturbance
- Prevention: Reducing Risks Related to Emotional Disturbance

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 early childhood education programs 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 early childhood education site 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' "Parent 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.

OUTCOMES
July 2013 – June 2014

In FY2013-14 ECMH provided consultation for 18 Marin County subsidized preschools. The ECMH program is successful at providing prevention and capacity building that reaches far beyond a direct services model. By training and coaching childcare providers, many children and families will benefit for years to come, including increasing their access to services due to early identification and effective linkages. Intervening early in a child's life can reduce poor outcomes that would require more extensive services later in life.

Outcome	Goal	Actual FY2013-14
Outreach and Education		
Number of childcare staff that received ECMH consultation and/or training.	158	152
Number of children served by trained childcare staff.	800	745
Percent of children served that come from un/underserved populations (Latino, Asian, African American, West Marin).	70%	69% *N=745*
Teachers receiving ECMH Consultation that report: • increased ability to find alternative solutions to problems • increase understanding of children's experiences and feelings • increased willingness to provide care to a difficult child • increased effectiveness in communicating with parents • increased knowledge about sensory needs and environmental supports	85%	84% 90% 90% 86% 100% *N=76*
Prevention		
Children/families provided prevention services through ECMH Consultation (intervention plan, warm hand-off, case consultation, etc.).	75	84
Children in childcare setting served by ECMH consultants that were retained in their current program, or transitioned to a more appropriate preschool setting.	100%	100% *retained* *N=745*
Satisfaction		
Families receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent).	85%	100% *N=9*
Teachers receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent).	85%	99% *N=75*

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

Age Group	# served	% of served
0-15 years old	745	100%
16-25 years old		
26-59 years old		
60+ years old		
Total	**745**	**100%**
Race/Ethnicity		
White	196	26%
African/American	31	4%
Asian	33	4%
Pacific Islander	4	0.5%
Native	5	0.5%
Hispanic	426	58%
Multi	41	6%
Other/Unknown	9	1%

Primary Language	# served	% of served
English	306	41%
Spanish	426	57%
Vietnamese	2	>0.5%
Cantonese		
Mandarin	10	1%
Tagalog		
Cambodian		
Hmong		
Russian	1	>0.5%
Farsi		
Arabic		
Other		

The program reaches a diverse array of families by taking place in subsidized preschools and other early childhood education sites. PEI funding has increased the capacity of the program to provide bilingual services. All materials are available in Spanish, with an effort made to provide materials and resources in other languages as needed. Many of these families do not have other opportunities to obtain identification and intervention services for their children's behavioral issues.

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, an Occupational Therapy Consultant (OTC) continued to provide training, consultation, observation, and, as appropriate, treatment planning. The OTC has been instrumental in increasing the capacity of the ECMH consultants, childcare providers, and families to recognize and address sensory processing problems.

In Fall of 2014, ECMH began consultation services to the programs at the San Geronimo Valley Community Center that serve children age 5 and younger and their families. This community center serves a geographically isolated and historically underserved population. In addition, ECMH began services to one Early Head Start site that serves children from the community together with children of families in residence at Center Point, a rehabilitation center.

In FY2015-16, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. There may be some adjustment to tracking changes in protective factors and risk factors for children and families due to low response rate to the "Parent Questionnaire." Efforts are underway in FY2014-15 to determine the most effective way to gather that data.

EARLY CHILDHOOD MENTAL HEALTH (ECMH) CONSULTATION

CLIENT STORY

Louis was 2 years 6 months old when consultation began, six months after he entered the infant program at a local childcare center. He lives with his single mother, paternal grandmother, and teenaged uncle. His parents are separated, and his father was in a residential substance abuse treatment center.

The teachers reported that Louis was continually bumping and falling on top of children, hugging and squeezing children until they cried out, hitting himself on the head, and running around the room. He did not accept comfort, even when hurt. Other children were beginning to be afraid of him. The teachers described Louis as verbal and bright, which confused them because "…he doesn't stop when we tell him to." Louis's mom and grandma also wanted help dealing with his constant need for activity and stimulation.

Building on Louis's desire to be engaged with others, the consultant supported his attachment to all staff and created small group activities that provided Louis with attention and success. The consultant, recognizing significant sensory integration needs, continued educating the staff in this area. With Louis's mom and grandma, the consultant explored the impact on Louis of his parents' separation, helped them increase their understanding of Louis's sensory processing challenges, and taught them activities to meet his need for stimulation.

After the consultant brought Mom, Grandma, and Louis's primary caregiver together for several sessions to share ideas and increase communication, Mom and Grandma became increasingly open about changes in his life and everyone's relationship with Louis's dad. The Occupational Therapist (OT), a member of our ECMH team, was definitely an asset with this family and childcare center. The consultants have learned from the OT how to recognize sensory needs that could be driving a child's behavior. With Mom's permission, the OT observed Louis in his classroom, confirmed the consultant's observations, and created a plan to meet his needs, which the consultant reinforced in staff and parent meetings.

After a year, by the time Louis turned 3 1/2 years old and was ready to move from the infant/toddler program to the preschool program, his teachers, mother, and grandmother were all including activities with Louis that met his sensory needs, and he was settled and calm more often than not, both in childcare and at home. His primary caregiver was willing to try all activities recommended by the consultant and the ECMH Occupational Therapist, and it was arranged for her to move to the preschool room as a member of that team, which contributed to a smooth transition. Louis was part of a newly formed small group of older toddlers who played for part of the day in an adjacent room where he sustained focus on

activities and accepted guidance in appropriate social interactions without hitting, pushing, or squeezing. He also stopped hitting himself.

Nonetheless, two months into his preschool time he began to have difficulty separating from his mom at morning drop-off, and his sensory issues began to escalate. With the consistency of a consultant serving the same site on an ongoing basis, support was offered again through meetings with staff and parents, co-creating a goodbye ritual, and reinforcing with the preschool staff all that had helped in the past. At this point, Louis's mom and grandma also found a way to participate with Louis in three (3) OT sessions that reinforced what they had been hearing from the consultant and OT in the previous school year.

Thanks to this consistent and focused support, Louis is once again experiencing less distress and having greater success in preschool. His primary caregiver credits their ECMH consultant with making the difference, reporting that "[The consultant] has helped me with Louis through so much of his development. I am very close with the family now and I really feel like I can understand and work with him and his differences better."

TRIPLE P (Positive Parenting Program) MARIN: PROVIDER TRAINING and SUPPORT

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

Triple P (Positive Parenting Program) Marin is an evidence-based model for coaching and empowering parents to improve their parenting skills. It has been shown to increase parenting effectiveness and reduce child abuse. The ultimate aim is the healthy development of children and the reduction of emotional or behavioral problems. Due to its focus on assisting parents to identify their parenting goals and methods for reaching those goals, it is a culturally sensitive approach. Triple P is a multi-leveled system, which aims to tailor information, advice and support to the needs of families. Triple P Marin coordinates training and technical assistance for providers who work with families to implement Triple P with fidelity. Marin has focused on Levels 2 and 3, with some trainings provided for Levels 4 and 5.

Triple P Levels

1	Media/Information Campaign to normalize need for parenting help and inform families and providers about services.
2	Group presentations about general child development and parenting issues.
3	Individual or group, brief parent "coaching" about a specific concern the parent(s) has. Provided by a wide range of providers who work with families.
4	Individual or group parenting "coaching" over approximately 10 sessions. Usually provided by licensed mental health workers.
5	5-11 individual sessions with parents with complex issues affecting their parenting. Usually provided by licensed mental health workers.

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.

Program Description

- Outreach for Increasing Recognition of Early Signs of Emotional Disturbance

Triple P Marin increases the skills of potential responders by providing training and technical assistance for providers working with families. Technical assistance includes 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 also provides 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.

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 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. 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.

OUTCOMES
July 2013 – June 2014

Marin County Office of Education (MCOE) successfully coordinated trainings for a broad array of family providers in multiple levels of Triple P, as well as piloted a school staff training effort. These agencies serve a very diverse client base. In FY2013-14, 198 families received Level 2 or 3 services.

Outcome	Goal	Actual FY2013-14
Outreach and Education		
Number of parents that participated in Level 2 seminars.	50	100
Percent of parents participating in Level 2 seminars that report satisfaction with the services.		80% *N=90*
Number of families that received Level 3 services.		98
Providers certified in Level 2 (Brief, Teen).	40	13
Providers certified in Level 3 (Teen).	12	12
Percent of providers receiving training and technical assistance that report satisfaction with the services.		95%

Age Group	# served *	% of served
0-15 years old	97	99%
16-25 years old	1	1%
26-59 years old		
60+ years old		
Total	**98**	**100%**
Race/Ethnicity		
White	50	51%
African/American	6	6%
Asian	3	3%
Pacific Islander	1	1%
Native	1	1%
Hispanic	36	37%
Multi	1	1%
Other/Unknown		

Primary Language	# served *	% of served
English	69	70%
Spanish	29	30%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		

** Children of parents participating in Level 3 services.*

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, Triple P Marin was significantly changed to focus on supporting previously trained providers to implement the program with fidelity, providing group services in underserved communities, and assessing next steps in the development of the program. Due to this change, the contract was put out to bid through a Request for Proposal process and subsequently awarded to Jewish Family and Children's Services (JFCS).

In FY2015-16, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, with limited expansions. As requested, JFCS assessed the status of Triple P Marin implementation and provided recommendations for continued successful implementation. In alignment with the assessment, increased funds will be allocated to provide additional group services for caregivers, as well as limited individual consultations (40 additional families served). In addition, Community and Provider PEI Training program funds will be made available train additional Triple P providers.

ACROSS AGES MENTORING

PROGRAM DESCRIPTION
July 2013 – June 2014

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

OUTCOMES
July 2013 – June 2014

In FY2013-14, the goal of matching mentors and mentees was delayed until the latter part of the year, therefore there is no outcome data available regarding changes in risk and protective factors due to mentoring. Six mentor matches were made (4 boys, 2 girls) and life skills services were conducted (12 girls).

Marin City is home to primarily low-income, un/underserved populations. A high proportion of students at MLK Academy Middle are at risk for low academic achievement, substance use, and mental health issues.

Outcome	Goal	Actual FY13-14
Prevention		
Number of female students that received life skills lessons.	12	12
Percent of these students that come from un/underserved populations.	90%	100% *N=12*
Number of life skills lessons conducted.	15	16
Number of mentor matches initiated.		6
Percent of students receiving services that participated in community service.	60%	81% *N=16*

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

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

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

CHALLENGES AND UPCOMING CHANGES

During the MHSA Three-Year community planning process, school age youth in Southern Marin continued to emerge as a priority population. MHSA PEI increased the funding available for serving school age youth in Southern Marin and conducted a Request for Proposal (RFP) process under the MHSA PEI "School Age Program" described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. Funds were awarded to Marin City Community Services District to provide prevention services for K-8 students in the Sausalito Marin City School District.

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2013 – June 2014

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: screening and brief intervention for mental health concerns in teen clinics; psycho-education for TAY, parents of TAY, and providers of TAY; and group services in high schools for at-risk TAY.

In FY2013-14, skill-building workshops for high-risk teens and their caregivers were provided by LIFT-Levántate and the Center for Restorative Practice.

Target Population

The target population is 16-25 year olds from underserved populations. TAY reached 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. TAY receiving services are at risk for signs of mental illness due to adverse childhood experiences, severe trauma, poverty, racism and social inequality, as well as other concerns.

Program Description

- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Prevention: Reduce Risk Related to Mental Illness
- Intervene Early in the Onset of Mental Illness

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.

Prevention:

- 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.

  LIFT-Levántate and the Center for Restorative Practice provided stress/anxiety coping skills workshops for high-risk teens and their caregivers.

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.

OUTCOMES
July 2013 – June 2014

The TAY PEI program has been successful in reaching the intended population and the intended outcomes. Huckleberry Youth Programs (HYP) and the Novato Youth Center (NYC) have consistently adjusted the program to ensure it is providing effective and needed services.

Outcome	Goal	Actual FY2013-14
Outreach		
Percent of TAY participating in psycho-education activities that report an increase in knowledge regarding risk factors, resources and coping skills.	80%	99% *N=91*
Percent of providers completing training sessions that show an increase in knowledge about screening and referring TAY for mental health concerns.	90%	100% *N=13*
Prevention		
Number of TAY that received Prevention services from HYP/NYC.	600	514
Percent of clients from un/underserved cultural populations. *Includes those receiving prevention and/or early intervention*	65%	69% *N=818*
Number of TAY that participated in stress/anxiety coping skills workshops.	70	47
Number of TAY parents/caregivers that participated in stress/anxiety coping skills workshops.	70	46
Percent of participants in stress/anxiety coping skills workshops who reported using the skills taught in the workshop.	65%	77% *N=30*
Early Intervention		
Number of TAY that received Early Intervention services at teen clinics.	80	304
Percent of clients participating in at least three sessions of brief intervention that report improvement in well bring as measured by the Outcome Rating Scale.	65%	90% *N=88*
Percent of clients participating in at least three sessions of brief intervention that report a positive therapeutic alliance as measured by the Session Rating Scale.	75%	87% *N=99*
Satisfaction		
Clients completing stress/anxiety coping skills workshops reporting satisfaction with the services.	75%	72% *N=82*

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

Age Group	# served	% of served
0-15 years old	10	1%
16-25 years old	855	94%
26-59 years old	32	3%
60+ years old	14	2%
Total	**911**	**100%**
Race/Ethnicity		
White	316	35%
African/American	51	6%
Asian	23	2%
Pacific Islander	20	2%
Native	5	1%
Hispanic	438	48%
Multi	36	4%
Other/Unknown	22	2%

Primary Language	# served	% of served
English	557	61%
Spanish	230	25%
Vietnamese		
Cantonese		
Mandarin		
Tagalog	1	<1%
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown	123	13%
Others	**# served**	**% served**
LGBTQ	95	10%

818 clients received Prevention or Early Intervention Services from HYP/NYC.
93 TAY/ parents/caregivers received stress/anxiety coping workshops from LIFT/CRP.

All TAY PEI services have a focus on un/underserved populations. As can be seen above, the services are successfully reaching underserved populations. Many of the staff hired with MHSA funding are bilingual and bicultural. The stress and anxiety coping skills workshops were provided to high-risk TAY and their families, such as young mothers, low-income, justice system involved, and others.

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, the TAY PEI program conducted by Huckleberry Youth Programs and Novato Youth Center have continued to be successful.

While the workshops provided by LIFT/Levántate and The Center for Restorative Practice were well received, higher priority strategies for reaching this age group were identified during the community planning process, such as focusing on services in schools. The skills-building workshops were not recommended to be continued in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

In FY2015-16, the TAY PEI Program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, with a limited expansion. Due to the spike in youth immigration in 2014, there is a higher need for services for recently immigrated youth than was evident at the time of the MHSA Three-Year Plan development. Addressing these needs is in alignment with the priority of reducing mental health disparities. In addition, these individuals cannot access the expanded mental health services due to the Affordable Care Act. Increased funding will be allocated to expand the number of recently immigrated youth able to participate in the coping and problem-solving skills groups provided at high schools.

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

CLIENT STORY

"Julio," a 17-year-old teen who identifies as "gay," came to the Monday Wellness Teen Clinic to ask for HIV and other Sexually Transmitted Infections (STI) testing. He met with one of the Teen Clinic counselors after noting on his initial questionnaire that he felt "sad and hopeless." With no insurance and feeling very depressed about his mother's response to his coming out, he perked up at the offer of additional free counseling with the Wellness counselor and immediately signed up for weekly sessions. Although Julio denied feeling suicidal to the counselor, it was clear from the initial assessment that he might be at risk without additional support.

Julio responded well and quickly to a positive counseling approach that helped him recognize his strengths and better appreciate his identity while also becoming more understanding of his mother's mixed reactions and limitations. The counselor helped Julio expand his positive support system and review the best strategies for helping himself feel better on a "bad day," such as after an argument with his mom. After only three sessions, Julio already seemed happier and his self-reported "score" on the client rating scale increased dramatically from an initial 11.4 at his first session to a much healthier 30.9 at his third session. (Note: 28 is the score most teens associate with feeling good most of the time.)

"Maribel" is a 16-year-old Latina client who participated in the counseling group at San Rafael High School's Newcomer class. The Newcomers class is specifically for youth who have newly arrived to the country. While engaged in the group, Maribel was referred by the high school for individual counseling due to signs of depression and dropping grades. Maribel had recently immigrated to the country, didn't yet speak English, and was reunified here with two adult sisters whom she did not know. She came in feeling isolated, hopeless about her future, and feeling angry with her family about the lack of support. She engaged in weekly individual sessions at school and once school ended continued attending sessions throughout the summer. Counseling sessions focused on building rapport, working on expression of feelings, identifying support systems in her life, building coping skills and educating Maribel on the grieving process of leaving her home country. She was eventually willing to incorporate her sisters into family counseling sessions to increase family support. Maribel began shifting her thought process to a positive and healthy outlook on her future, especially in academics after meeting with a UC Davis counselor who told her she had "an incredible potential and it would be an honor to have her talent at their school."

CANAL COMMUNITY-BASED PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2013 – June 2014

Canal Community-Based Prevention and Early Intervention (PEI) program aims to increase wellness by increasing access to mental health prevention and intervention services for Canal's un/underserved residents at the earliest signs of mental health problems. Canal Alliance (CA) has implemented this program since July 2009. Components include:

- Training Canal Alliance front line workers to identify and refer clients in need of behavioral health support, as well as to increase their skills in supporting clients with such concerns.
- Assessment sessions to identify issues and resources for individuals and families.
- Groups for individuals who have experienced trauma for mutual support, training in individual and group tools to reduce symptoms and increase and maintain mental wellbeing.
- Individual/family problem-solving sessions.

Canal Alliance (CA) is located in the Canal neighborhood of San Rafael, comprised mostly of immigrants from Mexico and Central America dealing with extreme poverty, traumatic pasts, ongoing fears, family strife and limited mental health services within financial or linguistic reach. CA has provided a wide array of services to this community for 30 years, building a high level of respect and trust.

OUTCOMES
July 2013 – June 2014

Canal Alliance (CA) effectively adjusts its program to respond to client need, while maintaining focus on the desired mental health outcomes. Support groups have been expanded to include stress management for men, women, survivors of domestic violence, mothers with trauma, young mothers and their children, and families reunifying after separation. By providing these services in a group format it has helped build a community of support as well as contribute to de-stigmatizing the discussion of mental health concerns in the community. This program is integrated with the Mental Health and Substance Use Community Health Advocate Program and programs addressing domestic violence.

Outcome	Goal	Actual FY2013-14
Outreach		
Percent of providers receiving training in mental health issues that show an increase in knowledge about mental health, providing appropriate services, and making effective referrals	75%	100% *N=5*
Prevention		
Number of clients receiving group prevention services.	300	287
Percent of clients from un- or underserved cultural populations.	75%	99% *N=287*
Number of clients receiving individual/family prevention services.	80	163
Percent of CAPEI clients who participated in a support groups for at least 3 months that report a decreased sense of isolation and increased sense of social support.	80%	100% *N=38*
Percent of CAPEI clients who participated in a support groups for at least 3 months that report improvement in PTSD signs/symptoms as measured by the PTSD Check List.	75%	100% *N=38*
Percent of CAPEI clients who participated in a support groups for at least 3 months that report an increase in coping skills.	80%	100% *N=38*
Satisfaction		
Percent of PEI clients who participated in a support groups for at least 3 months that report satisfaction with the services.	85%	100% *N=38*

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

Age Group	# served	% of served
0-15 years old		
16-25 years old	21	7%
26-59 years old	252	88%
60+ years old	14	5%
Total	**287**	**100%**
Race/Ethnicity		
White		
African/American		
Asian		
Pacific Islander		
Native		
Hispanic	285	99%
Multi		
Other/Unknown	2	1%

Primary Language	# served	% of served
English		
Spanish	285	99%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown	2	1%

Canal Alliance (CA) is located in the Canal neighborhood of San Rafael, comprised mostly of new immigrants from Mexico and Central America. CA has provided a wide array of services to this community for 30 years, building a high level of respect and trust. Staff hired with PEI funds are bilingual/bicultural.

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, the Canal Community Based PEI program merged with the Community Health Advocates (CHA) program to create the Latino Community Connection (LCC) Program, as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. The LCC program expanded the CHA/Promotores component to West Marin. In addition, Cuerpo Corazon Comunidad, a weekly live one-hour radio show in Spanish on the health of Latino individuals, families and communities, began in October 2014.

In FY2015-16, the Latino Community Connection (LCC) program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, with a limited expansion. The Cuerpo Corazon Comunidad radio show will receive a higher allocation in order to cover the full costs of the program in FY2015-16. In FY2014-15 Public Health was able to provide a portion of the funds in order to launch the show.

CANAL COMMUNITY-BASED PREVENTION AND EARLY INTERVENTION

CLIENT STORY

"Jorge" began attending the men's group seven months ago, having lived for eight years with severe symptoms of PTSD after an unprovoked violent attack as he came home from work one night. A formerly friendly and happy man who participated regularly in sports, church and social activities, Jorge's life had now shrunk down to work and watching television in his room. He rarely talked about what happened to him, after a "friend" had responded by mocking him for calling the police rather than "fighting to the end like a man."

One day someone mentioned that he might talk to someone at Canal Alliance. He began attending the men's group regularly and participated fully in the stress reduction exercises, story-telling, mutual support and psycho-education regarding PTSD. Jorge sat like a stone, barely moving, for the first three months. He gradually began to relax both in body and mental state, and his activities began to expand – he is now playing soccer weekly and attending church, and has expressed interest in becoming a "Promotor" regarding prevention of domestic violence, working with men and boys. Jorge repeatedly says, "This is the only place we can talk about these things."

INTEGRATED BEHAVIORAL HEALTH (IBH) IN PRIMARY CARE

PROGRAM DESCRIPTION
July 2013– June 2014

Program Overview

In 2009, MHSA PEI began "Integrated Behavioral Health (IBH) 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. Marin Community Clinics (MCC) and Coastal Health Alliance (CHA) have received Mental Health Services Act (MHSA) funds since July 1, 2009 to improve health outcomes by providing services for un/underserved populations at the earliest signs of mental health problems. In FY2012-13 and FY2013-14, Marin City Health and Wellness Center and Ritter Center received MHSA funds to expand their IBH programs. In addition, Sutter Health Access to Care funds were provided through Marin Community Foundation to expand IBH services. These sites provide screening and brief intervention for mental health and substance use issues.

Target Population

In FY2013-14, the target population for this program was individuals accessing primary care at community clinics that may be experiencing onset of serious psychiatric illness, and/or risk factors for mental illness, such as low-income, trauma exposure, and underserved cultural populations.

Program Description

- Intervene Early in the Onset of Mental Illness

There are many models for integrating mental health and substance use services into primary care sites. PEI has supported Marin Community Clinics, Coastal Health Alliance, Marin City Health and Wellness Center and Ritter Center to build their capacity to provide:

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

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.

OUTCOMES
July 2013 – June 2014

	MCC		CHA		MCHWC	
Outcome	**Goal**	**Actual FY2013-14**	**Goal**	**Actual FY2013-14**	**Goal**	**Actual FY2013-14**
Outreach						
Number of clients screened for behavioral health concerns. *(PHQ2 at a minimum)*	30%	27% *N=10,943*	75%	87% *N=4,377*	70%	80%
Early Intervention						
Number of clients that received brief intervention services.	300	369	180	274	25	55
Percent of clients completing brief intervention experiencing a decrease of at least 50% in depression symptoms or a reduction of symptoms to below significant levels (below 10 on PHQ9).	50%	40% *N=104*	50%	43% *N=215*	50%	60%
Satisfaction						
Percent of clients receiving brief intervention reporting satisfaction with behavioral health services.	75%	95% *N=379*				
Percent of clients receiving brief intervention that report a positive therapeutic alliance. *(Session Rating Scale)*			75%	92% *N=78*		

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

Ritter Center has a different model of IBH than the other clinics due to the fact that they serve very low-income/homeless clients, often with co-occurring and complex concerns. In FY2013-14 they provided 214 walk-in visits, group or individual brief intervention for depression and/or anxiety for 26 clients, and achieved a reduction in depression for 46% (N=15) and a reduction in anxiety for 60% (N=15) of clients receiving multiple brief intervention services.

The clinics serve primarily low-income residents. IBH is implemented at three (3) MCC locations in Central Marin, two (2) CHA locations in West Marin, one (1) Marin City location a the Marin City Health and Wellness Center, and one (1) central San Rafael location at the Ritter Center. Most staff hired with MHSA funds are bilingual and culturally competent. MCC has Spanish speaking behavioral health and clinic staff, Vietnamese speaking clinic staff, and use translation services when needed. CHA has Spanish speaking behavioral health and clinic staff. Marin City Health and Wellness Center is well integrated into the diverse area it serves. Ritter Center serves very low-income, precariously housed, and homeless Marin residents. Ritter provides a range of free services, including case management, primary health care, food and clothing, emergency financial assistance, and substance use services.

Marin Community Clinics (MCC)

Age Group	# served	% of served
0-15 years old	178	9%
16-25 years old	260	13%
26-59 years old	1226	62%
60+ years old	306	16%
Total	**1970**	
Race/Ethnicity		
White	970	49%
African/American	89	4%
Asian	62	3%
Pacific Islander	5	<1%
Native	15	1%
Hispanic	774	39%
Multi	14	1%
Other/Unknown	41	2%

Primary Language	# served	% of served
English	1310	66%
Spanish	616	31%
Vietnamese	11%	<1%
Cantonese	3	<1%
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian	3	<1%
Farsi	10	<1%
Arabic		
Other	17	1%
Others	**# served**	**% served**
Homeless	70	4%
Veterans	16	1%

2,955 clients were screened for behavioral health concerns.
1,970 clients received behavioral health services.
369 received MHSA PEI funded brief intervention.

Coastal Health Alliance (CHA)

Age Group	# served	% of served
0-15 years old	58	1%
16-25 years old	349	9%
26-59 years old	2266	60%
60+ years old	1132	30%
Total	**3805**	**100%**
Race/Ethnicity		
White	2695	71%
African/American	27	<1%
Asian	14	<1%
Pacific Islander	5	<1%
Native	5	<1%
Hispanic	1013	27%
Multi	24	<1%
Other/Unknown	22	<1%

Primary Language	# served	% of served
English	2786	73%
Spanish	1010	26%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian	4	<1%
Farsi		
Arabic		
Other	5	<1%
Others	**# served**	**% served**
Homeless	38	<1%
Veterans	23	<1%

3,805 clients were screened for behavioral health concerns.
274 received brief intervention.

Marin City Health and Wellness Center (MCHWC)

Age Group	# served	% of served
0-15 years old	39	71%
16-25 years old		
26-59 years old	16	29%
60+ years old		
Total	**55**	**100%**
Race/Ethnicity		
White	12	22%
African/American	26	47%
Asian		
Pacific Islander		
Native		
Hispanic	17	31%
Multi		
Other/Unknown		

Primary Language	# served	% of served
English	55	100%
Spanish		
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Others	**# served**	**% served**
Homeless	16	29%

55 clients received brief intervention.

Ritter Center

Age Group	# served	% of served
0-15 years old		
16-25 years old	61	8%
26-59 years old	529	75%
60+ years old	117	17%
Total	**707**	
Race/Ethnicity		
White	369	52%
African/American	104	14%
Asian	20	3%
Pacific Islander	8	1%
Native	15	2%
Hispanic	100	14%
Multi	47	7%
Other/Unknown	44	7%

Primary Language	# served	% of served
English	637	90%
Spanish	70	10%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Others	**# served**	**% served**
Disabled	156	22%
Homeless	370	52%
Veterans	23	3%

707 clients were screened for behavioral health concerns.

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, this program was significantly changed in part due to the Affordable Care Act (ACA). PEI now focuses on increasing access to Integrated Behavioral Health services for uninsured primary care clients. From July through December 2014 PEI funding continued at a lower rate for all four clinics while a Request for Proposal (RFP) process was conducted. In January 2015 new contracts were awarded to Coastal Health Alliance and Ritter Center. Behavioral health services at all four clinics are currently expanding due to federal funds. In addition MCC, CHA and Ritter Center are implementing the Suicide Prevention in Primary Care program developed with CalMHSA PEI funds.

In FY2015-16, IBH programs are expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

CLIENT STORY

"Rita" is an 18-year-old young woman who was referred to a psychiatric nurse practitioner (PNP) at MCC after her primary care provider (PCP) discovered she had been cutting herself for the past couple of years. When she and the PNP started work together, Rita's chief concern was, "I don't like myself." Her PHQ-9 was 17, indicating moderately severe depression. She reported depressed mood, overwhelming moods, low energy, psychomotor slowing, detachment, headaches, and poor self-esteem nearly every day for the past two years, but was not suicidal. She felt guilty that she was sad because she felt others had it worse than her. She had difficulty talking about how she felt. Rita's parents had separated three years ago, which was the most identifiable stressor, but she had felt anxious and stressed prior to her parents separating.

Rita was referred to an LCSW in the community who began therapy with her, beginning with relaxation approaches. Her PCP felt it was best to keep her psychiatric services in-house for better coordination. Both the therapist and the PNP reinforced relaxation strategies and replacement behaviors for cutting, including listening to music and using elastic bands instead of a razor. The PNP discussed treatment with fluoxetine and through weekly and bi-weekly visits after starting the medication, Rita was coached through initial side effects of agitation, slight hand tremor, and GI upset. With encouragement she was able to get through the side effects, which passed, and get to a stable dose of 40 mg. She has not cut since starting work with the PNP, and has begun to gain insight, energy, and confidence in the coping skills she has acquired. At Rita's last behavioral health visit, her PHQ-9 was 8 for mild depression, and she was transferred back to her PCP for ongoing medication management.

"Miguel" is a soft-spoken, 26 year old, Latino male who has lived in this country for several years. His primary language is Spanish, and he can converse in English. He was very tentative about coming to therapy, however, he found his anxiety and PTSD were interfering in his daily life. He was screened positive in the health clinic for depression and was referred to the behavioral health program. He began seeing a psychology intern who immediately diagnosed his PTSD and began working on coping skills with him to manage his anxiety. He attended regularly and was able to process the trauma that he had experienced prior to coming to this county and since being here. He was able to work through some of the difficult feelings that were impairing his ability to function. He came to rely on his therapist and went from being reluctant to come into session to seeking her out for advice and support. The therapist was able to provide support for on-going legal issues that prior to services threatened to be overwhelming. At the termination of therapy, Miguel had reduced anxiety and depressive symptoms, he was able to articulate a plan to move his life forward, and he was excited again about his future.

OLDER ADULT PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2013 – June 2014

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.

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, people with disabilities, and geographically isolated. Spanish Speaking older adults are primarily served by a peer-counseling program provided by Mental Health and Substance Use Services.

Program Description

- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Intervene Early in the Onset of Mental Illness

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 educated 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 short-term problem-focused treatment (Cognitive Behavioral Therapy) along with care management, referrals for medication evaluation, and behavioral activation (Healthy IDEAS). 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. Outreach, education and brief intervention 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 education 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.

OUTCOMES
July 2013 – June 2014

With PEI funding, Jewish Family and Children's Services expanded their existing older adult intervention services to address depression, substance use and other behavioral health concerns, including an evidence-based approach to depression, Healthy IDEAS. The Older Adult PEI program has been very successful at adapting to meet the needs of the clients. The Spanish-speaking peer provider program, Amigos Consejeros a su Alcance (ACASA), continues to increase access to services and continuity of care for Spanish speaking older adults.

Outcome	Goal	Actual FY2013-14
Outreach		
Number of clients, community members or providers receiving outreach and education presentations.	300	480
Percent of those receiving educational presentations from un/underserved populations (Latino, African-American, Asian, LGBTQ, ESL).	20%	21% *N=480*
Number of Seniors At Home clients screened for depression and substance use.	150	167
Early Intervention		
Number of low-income clients receiving early intervention services, including care management, depression care, and linkages to services.	30	40
Percent of those receiving early intervention from un/underserved populations (Latino, African-American, Asian, LGBTQ, ESL).	20%	20% *N=40*
Percent of older adults receiving brief intervention for depression or anxiety experiencing a clinically significant reduction in symptoms. *(PHQ9, GDS, GAD7)*	75%	73% *N=30*
Percent of older adults receiving brief intervention that successfully addressed one or more client goals in their care plan.	75%	90% *N=30*
Satisfaction		
Percent of clients receiving brief intervention reporting satisfaction with services.	75%	100% *N=15*

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old	2	4%
60+ years old	54	96%
Total	**56**	**100%**
Race/Ethnicity		
White	46	82%
African/American	1	2%
Asian	4	7%
Pacific Islander		
Native	1	2%
Hispanic		
Multi	3	5%
Other/Unknown	1	2%

Primary Language	# served	% of served
English	52	92%
Spanish		
Vietnamese	1	2%
Cantonese	2	4%
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	1	2%
Others		
LGBTQ	3	5%
Disabled	22	39%
Veterans	1	2%

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, Jewish Family and Children's Services initiated a volunteer peer visitor program for clients who have achieved stability during early intervention services, but would benefit from more extended support. Ten volunteers have been trained and will begin providing home and community visits with supervision and support from JFCS clinical staff.

In FY2015-16 we expect this program to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

OLDER ADULT PREVENTION AND EARLY INTERVENTION

CLIENT STORY

"Joan," a 75-year-old divorced woman living alone in subsidized senior housing, self-referred after a traumatic fall and leg injury. She was depressed for several months after recovery and could not find energy to re-engage in the activities she previously enjoyed. A survivor of metastasized colon cancer, Joan was very concerned that she might be suffering from a cancer relapse. After Joan's physician ruled out any physical causes for her fatigue and negative moods, the facility's social worker suggested counseling.

Joan initially appeared to be very self-isolating and rarely left her apartment. Though Joan said she enjoyed reading and painting, she was unable to find energy to do either. We discussed some of the tools she could learn to manage her depression, including behavioral activation – starting with incremental steps to engage in activities that Joan wanted. She succeeded in attending a support group for residents. We used CBT to identify Joan's negative automatic core belief of being worthless, and discussed more balanced thoughts that explained why she felt excluded by the other participants. In time, Joan gained more self-confidence in changing her emotional and behavioral responses. Joan recently described how she was taking little walks, joining more support groups, and enjoying painting and reading again. As Joan stated, "This program helped me set realistic goals as something positive to work towards and actually gave me a sense of hope for the first time since my fall. While I felt much better than when I started, I still have a way to go, but felt that I'm at least headed in the right direction."

"Cristina" is a 66 year old, monolingual Spanish speaking woman from El Salvador. She lives in a small apartment with her daughter, son in law, and her two grandchildren. Cristina is diagnosed with Bipolar disorder and is being treated with medication. She has no education and had a very difficult upbringing. She lost her mother early in life and her father abandoned the family. Growing up she lived with an aunt and sold food on the streets for money and was never able to attend school. Her husband was an alcoholic and abused her physically and emotionally. Cristina has diabetes, problems with her knees and back and difficulty walking. She lives up a steep hill, making her isolated and unable to leave the house without her daughter in the car. She is alone all day and spends most of her time cleaning and watching television. Cristina misses her country and is having trouble adjusting to this new culture. She feels depressed and lonely.

Senior Peer Counselor, Roberta, has worked with Cristina over the past year. Roberta has helped to ease the loneliness in Cristina's life in several ways. Cristina looks forward to her weekly visits with Roberta and finally has a person with whom she can speak to about her fears and problems. She never felt comfortable speaking to her daughter and the

relationship in the house is already strained as her son-in-law does not want her living with his family. She has opened up to Roberta about much of her life and reports feeling happier and lighter since the visits began. Roberta has also helped Cristina gain much more independence and to begin socializing in the community. She connected Cristina to Marin Access Catch-A-Ride. Cristina now leaves the house once a week and she either attends Mass or Corazon Latino meetings at Whistlestop. She is meeting people and doing something she loves which is attending church. Roberta has introduced Cristina to books on tape which she enjoys very much. She now has her own library card and knows how to check the books out on her own after visiting the library with Roberta. Roberta describes Cristina as a person who "suddenly seems more awake and less a stranger in this world." Cristina's new independence has built a new self-confidence and she is overall much happier and at peace.

CLIENT CHOICE AND HOSPITAL PREVENTION CRISIS PLANNING

PROGRAM DESCRIPTION
July 2013 – June 2014

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

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

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

OUTCOMES
July 2013 – June 2014

The Crisis Planning program has established strong working relationships with key partners including clients, County Mental Health case managers, and Psychiatric Emergency Services (PES). This included working with the Family Partner at PES and accessing individuals at risk of losing housing. In FY2013-14, in addition to the ongoing client base, the program focused on working with clients of the crisis residential services launched by Innovation funds to support stabilization and averting future crises. Crisis Planning services and written materials are available in English and Spanish.

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

Outcome	Goal	Actual FY2013-14
Prevention		
Number of clients and/or families that received Crisis Planning services.	75	Outreach Svcs. 800 Planning Svcs. 57
Percent of clients receiving planning services that file a completed Crisis Plan in their medical records.	50%	47% *N=57*
Percent of clients and/or families completing a Crisis Plan that report increased understanding of the community resources available to them.	60%	74% *N=27*
Percent of clients completing a Crisis Plan that report increased awareness of their individual symptoms and supports.	60%	48% *N=27*
Percent of clients reporting that Crisis Planning decreased their need to psychiatric emergency services 6 months after completing the plan.	35%	76% *N=21*
Percent of clients that accessed PES reporting that having a Crisis Plan improved their experience at PES.	35%	33% *N=6*
Satisfaction		
Percent of clients completing a Crisis Plan that report satisfaction with the services.	75%	92% *N=27*

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

Age Group	# served	% of served
0-15 years old		
16-25 years old	5	9%
26-59 years old	46	81%
60+ years old	6	10%
Total	**57**	**100%**
Race/Ethnicity		
White	48	83%
African/American	3	5%
Asian	2	4%
Pacific Islander		
Native		
Hispanic	2	4%
Multi		
Other/Unknown	2	4%

Primary Language	# served	% of served
English	57	100%
Spanish		
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown		
Others		
LGBTQ	1	2%
Homeless	10	18%

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, the Crisis Planning program was moved to the MHSA Community Services and Supports (CSS) component to increase its integration with the continuum of crisis services, as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

VIETNAMESE COMMUNITY CONNECTION

PROGRAM DESCRIPTION
July 2013 – June 2014

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, education and prevention. 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. 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. Most of the Prevention and Early Intervention (PEI) programs do not have the capacity to serve the monolingual Vietnamese community or to do effective outreach into the Vietnamese community.

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.

Program Description

- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Prevention: Reduce Risk Related to Mental Illness

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.

Prevention:

- 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 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.

OUTCOMES
July 2013 – June 2014

Community Action Marin's Marin Asian Advocacy Program has trained Community Health Advocates to provide outreach at community events, including hosting "field trips" to get isolated older adults together. A bilingual, bicultural mental health worker has assessed and provided individual and group support for clients referred from the CHA's, as well as other sources.

Outcome	Goal	Actual FY2013-14
Prevention		
Individuals that participated in outreach and engagement events.	100	180
Individuals that received Community Health Advocate services (education, assistance with accessing services, etc).	30	100
Individuals that participated in support group or home visiting services.	50	77
Percent of those receiving support group or home visiting services that show an improvement in mental health status.	80%	80% *N=77*

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

Age Group	# served	% of served
0-15 years old	22	12%
16-25 years old	18	10%
26-59 years old	40	22%
60+ years old	100	56%
Total	**180**	**100%**
Race/Ethnicity		
White	1	1%
African/American		
Asian	179	99%
Pacific Islander		
Native		
Hispanic		
Multi		
Other/Unknown		

Primary Language	# served	% of served
English	2	1%
Spanish		
Vietnamese	176	98%
Cantonese	1	<1%
Mandarin	1	<1%
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, efforts have been made to formalize the training and assessment aspects of the program, such as providing consistent supervision time for CHAs, defining and assessing the CHAs skills, and measuring changes in mental health risks and protective factors for clients participating in support groups and home visits.

In FY2015-16, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

VIETNAMESE COMMUNITY CONNECTION

CLIENT STORY

"An" is a 60 year-old female who emigrated to the U.S from Vietnam with her husband in 2007. She has four children but none live with her or near her. She lives with her husband in "affordable housing" and is a caretaker for her husband who has physical disabilities.

An describes her life prior coming to the U.S. as very distressing on multiple levels due to poverty, marital discord, prejudice, violence, and that she had to work very hard to raise her children. Soon after moving here, her husband became "lost" due to severe stress and started to experience mood and psychotic symptoms, including leaving home and ending up on the street every day. He is currently psychiatrically stable. However, due to physical disabilities, he has to stay at home and be taken care of by An. An and her husband were very isolated for many years, preferring to not get involved with the community due to the fear of being judged and gossiped about by others. An describes her life as "very sad, depressing, and lonely."

An was introduced to the Vietnamese Community Connection program in Spring 2013 after she was battered by another community member who was known as a violent person. She was badly hurt physically and mentally and didn't know how to deal with the situation. The PEI mental health worker visited her home, talked to her, provided psychological support, and helped sort through different options for dealing with the crisis physically, psychologically, and legally. An said she felt understood, empathized with, and that the PEI mental health worker was very helpful for her as well as the person who hurt her. She gained a lot of trust in the program staff, allowing her to get involved in the community.

The PEI mental health worker offered to refer An to the medication clinic to receive additional counseling services along with medication. However, she declined and expressed that she would rather go to PEI groups and classes. She has been an active member in the PEI support groups, skills classes, and other community events this past year. She was the "student of the year" who never failed to show up to PEI weekly support groups and skills classes. When in class or group, she appeared very happy, motivated to learn, and share her thoughts and feelings with others. She also invited other members to come and often cooked for the whole class. She reports that her health has been drastically improved, physically and mentally, and that she appreciates what the program has done for her: "I'm very busy these days. I love it. I have so much fun. I go to different groups, events, and classes offered by PEI and other programs pretty much every day. I would not want to miss any group. I have many friends. Other community ladies and I visit each other often too and we go to each others houses to cook and hang out. My husband is very happy for me. I think our community is getting stronger." An says that her husband and she are looking forward to the next community field trip this summer. Her health and mood have been improved greatly through this program, as well as her husband who has been watching her progress and began participating in program events with her throughout the year.

MENTAL HEALTH COMMUNITY TRAINING

PROGRAM DESCRIPTION
July 2013 – June 2014

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

Mental Health First Aid (MHFA) is an evidenced based training that has been shown to:

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

OUTCOMES
July 2013 – June 2014

California Institute for Mental Health began provided trainings in July 2012. All trainings were no-cost to the participants and efforts were made to ensure a broad array of participants enrolled.

Outcome	Goal	Actual FY2013-14
Prevention		
Individuals completing the training.	100	108
Percent of participants reporting an increase in their ability to recognize the signs that someone may be dealing with a mental health problem or crisis.	80%	98% *N=108*
Percent of participants reporting an increase in ability to speak to somebody in a crisis.	80%	80% *N=10*
Percent of participants reporting an increase in awareness of available resources.	80%	80% *N=10*

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

Age Group	# served	% of served
0-15 years old		
16-25 years old		
26-59 years old		
60+ years old		
Total		
Race/Ethnicity		
White	68	63%
African/American	4	4%
Asian	1	1%
Pacific Islander		
Native	1	1%
Hispanic	22	20%
Multi		
Other/Unknown	12	11%

Primary Language	# served	% of served
English	78	73%
Spanish	11	10%
Vietnamese	9	8%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other	10	9%
Others	**# served**	**% served**
LGBTQ	15	14%

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, this program became the Community and Provider Prevention and Early Intervention Training including Mental Health First Aid, as well as other trainings and conferences regarding evidence based and best practices, stigma and discrimination reduction, and other skills needed for implementing PEI programs successfully.

In FY2015-16, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, with a limited expansion. The Triple P Program initially focused on training providers who work with families. In FY2014-15 the allocation was significantly reduced and the contract provider was requested to assessed the status of Triple P Marin implementation and provided recommendations for continued successful implementation. In alignment with the assessment, increased funds will be allocated to train existing Triple P providers in additional levels of Triple P, as well as train additional providers in Triple P. This will ensure that Triple P services are more available for the target population.

TEEN SCREEN

PROGRAM DESCRIPTION
July 2013 – June 2014

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

OUTCOMES
July 2013 – June 2014

Beginning July 2012, Prevention and Early Intervention (PEI) funds were provided to Family Service Agency (FSA) to increase participation in the existing Teen Screen program, especially among un/underserved youth, as well as expand follow-up services. A total of 561 students participated in Teen Screen in FY2013-14.

Outcome	Goal	Actual FY2013-14
Prevention		
Number of additional teens participating in Teen Screen as compared to FY12-13.	75	201
Number of additional teens receiving follow-up services as compared to FY12-13.	25	43
Percent of youth participating in Teen Screen that report an increase in knowledge of mental health resources.	50%	98% *N=500*
Percent of youth participating in Teen Screen that report an increase in knowledge of resilience/protective factors.	50%	88% *N=500*
Percent of youth participating in Teen Screen that are from un/underserved populations.	30%	37% *N=500*

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

Age Group	# served	% of served
0-15 years old	391	70%
16-25 years old	170	30%
26-59 years old		
60+ years old		
Total	**561**	**100%**
Race/Ethnicity		
White	381	68%
African/American		
Asian		
Pacific Islander		
Native		
Hispanic	78	14%
Multi		
Other/Unknown	102	18%

Primary Language	# served	% of served
English		
Spanish		
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown	561	100%

CHALLENGES AND UPCOMING CHANGES

In **FY2014-15,** PEI funds were not provided for this program, as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

MENTAL HEALTH COMMUNITY COALITIONS

PROGRAM DESCRIPTION
July 2013 – June 2014

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

OUTCOMES
July 2013 – June 2014

In FY2013-14 PEI funds supported PEI providers to participate in existing community coalitions, as well as staff time for the Novato coalition to expand their work into mental health.

- The Novato Blue Ribbon Coalition integrated mental health prevention with their existing substance use prevention efforts.
- Three PEI providers participated in the Community Coalitions, leading to increased collaboration and understanding of prevention approaches.

CHALLENGES AND UPCOMING CHANGES

In **FY2014-15,** PEI funds were not provided for this program, as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

MENTAL HEALTH COMMUNITY HEALTH ADVOCATES

PROGRAM DESCRIPTION
July 2013 – June 2014

For hard to reach populations, trusted community members provide an effective cultural and linguistic bridge to information and services. This project provides training, supervision and stipends for Community Health Advocates (CHAs) in mental health and substance use. This program increases the efficacy of existing mental health programs by reducing the barriers for accessing those services. In addition it creates a culture shift in the target communities that reduces stigma and increases the support available within the community.

OUTCOMES
July 2013 – June 2014

In July 2012, Canal Alliance began this program, focusing on Spanish-speaking CHAs in the Canal and Novato communities. This program is coordinated with Prevention and Early Intervention (PEI) and other programs that provide early intervention for mental health and substance use issues for the Latino community. Seven (7) CHAs – Promotores – have been trained and actively providing services in the community.

Outcome	Goal	Actual FY2013-14
Prevention		
Number of underserved community members receiving behavioral health information and education from CHA's.	250	547
Number of underserved community members receiving behavioral health support from CHA's.	50	94
Number of CHA's trained in behavioral health skills.	8	7
Number of CHA's reporting an increase in knowledge and skills regarding behavioral health issues. • Ability to recognize signs/symptoms of mental health and substance use issues • Knowledge of services to refer clients to • Confidence to help people facing mental health issues	8	7

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

Age Group	# served	% of served
0-15 years old	87	16%
16-25 years old	140	26%
26-59 years old	300	55%
60+ years old	20	3%
Unknown		
Total	**547**	**100%**
Race/Ethnicity		
White	97	18%
African/American	24	4%
Asian	32	6%
Pacific Islander		
Native		
Hispanic	392	72%
Multi		
Other/Unknown	2	<1%

Primary Language	# served	% of served
English	121	22%
Spanish	385	70%
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown	41	8%

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, the Community Health Advocates (CHA) program was merged with the Canal Community Based PEI program as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. Promotores have been expanded into West Marin.

LEGAL ASSISTANCE

PROGRAM DESCRIPTION
July 2013 – June 2014

In the original Prevention and Early Intervention (PEI) community planning process, it was recognized that economic stressors can have negative mental health consequences. Over time, PEI has explored ways to address this. An example is providing mental health services at sites that also provide linkages to food, housing, and other necessities. Legal assistance at key times, such as divorce, eviction, foreclosure, or bankruptcy, can reduce the mental health consequences of these stressors. This program provided legal services for existing PEI and Mental Health System of Care clients whose mental health is affected by legal issues.

OUTCOMES
July 2013 – June 2014

In December 2012, Legal Aid of Marin (LAM) began providing legal services for clients referred from Mental Health System of Care and PEI programs. Most clients referred for services received advice or brief services, five (5) of the cases resulted in a negotiated settlement. Of these, four (4) had favorable outcomes for the clients.

Outcome	Goal	Actual FY2013-14
Number of MHSA clients receiving legal services.	50	20
Percent of clients receiving legal assistance that report reduced stress.	50%	96% *N=20*
Percent of clients receiving legal assistance that report satisfaction with services.	75%	92% *N=20*

Age Group	# served	% of served
0-15 years old	2	10%
16-25 years old		
26-59 years old	15	75%
60+ years old	3	15%
Total	**20**	**100%**
Race/Ethnicity		
White	12	60%
African/American	2	10%
Asian	2	10%
Pacific Islander		
Native		
Hispanic	4	20%
Multi		
Other/Unknown		

Primary Language	# served	% of served
English	15	75%
Spanish	4	20%
Vietnamese		
Cantonese	1	5%
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Others	**# served**	**% served**
Disabled	5	25%

15 PEI clients served.
5 Mental Health System of Care clients served.

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, PEI funds were not provided for this program, as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

SOUTHERN MARIN COMMUNITY CONNECTION

PROGRAM DESCRIPTION
July 2013 – June 2014

In the original Mental Health Services Act (MHSA) planning processes in Marin, African Americans were identified as "inappropriately served." The fact that they are over-represented among County Mental Health clients indicates that they may not be receiving services that could help prevent the need for such intensive services. Prevention and Early Intervention (PEI) has successfully reached many of the underserved populations identified, but has further work to do regarding the African American community. The goal of this program is to reach high-risk residents of Marin City, including those living in subsidized housing or with no permanent residence, providing assessment and services to promote protective factors and reduce the need for more intensive services. Services are provided in the home or in the community, including street-based outreach.

OUTCOMES
July 2013 – June 2014

In December 2012, the Southern Marin Multidisciplinary Team (MDT) began receiving PEI funds to provide brief intervention and case management services for Marin City residents. The majority of their clients are living in subsidized housing or with no permanent residence. Assistance is provided regarding mental health, parenting, housing, economics, medical services and education. In FY2012-13 the MDT worked with the California Reducing Disparities Project (CRPD) to develop data collection and analysis methods, using the *Family Functioning Scale*.

Outcome	Goal	Actual FY2013-14
Individuals receiving early intervention services.	60	53
Percent of clients/families receiving services that had significant improvement in their goal areas as measured by the Family Functioning Scale.	50%	50% *N=53*

Age Group	# served	% of served
0-15 years old	5	9%
16-25 years old	8	15%
26-59 years old	39	74%
60+ years old	1	2%
Total	**53**	**100%**
Race/Ethnicity		
White	14	26%
African/American	17	32%
Asian	1	2%
Pacific Islander	1	2%
Native		
Hispanic	5	9%
Multi	12	23%
Other/Unknown	3	6%

Primary Language	# served	% of served
English	43	81%
Spanish	5	9%
Vietnamese	1	2%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown	4	8%
Others	**# served**	**% served**
LGBTQ	2	4%
Homeless	15	28%
Veterans	1	2%
Disabled	4	8%

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, PEI funds were not provided for this program, as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

SCHOOL AGE PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

In the community planning process for the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, the need for services for school age youth was a high priority. In FY2014-15, MHSA PEI began funding this program to provide 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) from underserved populations. The current projects focus on San Rafael City Schools, Shoreline School District and Sausalito Marin City School District. Initially a higher portion of funding targets 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.

Program Description

- Prevention: Reducing Risks Related to Mental Illness

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.

In each target district the services are tailored to that location, including what services already exist and where the key gaps are:

San Rafael City Schools - Seneca

- Train school staff and parents regarding identifying risk and signs/symptoms of emotional disturbance, how to respond, and how to refer for further services
- Provide training, consultation and coaching for school staff on preventing and responding to behavioral health concerns in the school setting
- Provide evidence-based therapeutic and social emotional skills groups for students identified by a school screening process as at-risk for emotional disturbance

Sausalito Marin City School District – Marin City Community Services District

- Train community providers regarding identifying risk and signs/symptoms of emotional disturbance, how to respond, and how to refer for further services
- Provide community connector services for students and families identified referred by the school or community providers who are eligible for PEI. The community connectors will provide assistance, advocacy and coordination to help ensure families successfully follow-through on SST/SARB action plans
- Provide weekly "Girl Power" groups to increase protective factors among 5-14 year old girls

Shoreline School District – Bay Area Community Resources

- Train school staff and parents regarding identifying risk and signs/symptoms of emotional disturbance, how to respond, and how to refer for further services
- Provide evidence-based risk reduction services, individual and group, for students and families referred by the schools who eligible for PEI services

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.

OUTCOMES
July 2013 – June 2014

This program began in FY2014-15.

CHALLENGES AND UPCOMING CHANGES

In FY2015-16, the School Age PEI Program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

VETERANS COMMUNITY CONNECTION

PROGRAM DESCRIPTION

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. In FY2014-15, MHSA PEI began funding 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.

Program Description

- Prevention: Reduce Risk Related to Mental Illness

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.

OUTCOMES
July 2013 – June 2014

This program began in FY2014-15.

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, this program began implementation. Staff hiring took place later than planned and therefore number of clients served is expected to be lower than projected in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

In FY2015-16, the Veterans Community Connection Program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

STATEWIDE PREVENTION AND EARLY INTERVENTION

PROGRAM DESCRIPTION

Marin County assigned a portion of MHSA PEI funds to a statewide effort. 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.

OUTCOMES
July 2013 – June 2014

Statewide program outcomes are tracked and reported by CalMHSA. See Appendix D for a brief overview of the impact of Statewide efforts on Marin County.

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, Marin allocated funds to CalMHSA, focusing on the regional Suicide Prevention Hotline. In addition, funds were provided directly to Marin County Office of Education (MCOE) to continue staff training efforts begun under PEI Statewide efforts.

In FY2015-16, CalMHSA has revised their focus. Marin will provide some funding to CalMHSA to continue their efforts in Suicide Prevention, Student Mental Health and Stigma and Discrimination Reduction. In addition, funds will be provided directly to support Suicide Prevention Hotline services, as those services are no longer within the CalMHSA scope of work. The funding allocated for this program will increase from the FY2014-15 allocation.

MHSA Prevention and Early Intervention (PEI)

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

Program	FY14-15 (Estimated Actual)	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	**$62,000**	$62,000	$179,000
PEI-4 Transition Age Youth (TAY) PEI	$140,000	**$160,000**	$160,000	$460,000
PEI-5 Latino Community Connection	$199,000	**$204,000**	$204,000	$607,000
PEI-6 Integrated 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	$45,000	**$95,000**	$95,000	$235,000
PEI-18 School Age Prevention and Early Intervention Programs	$205,000	**$310,000**	$310,000	$825,000
PEI-19 Veteran's Community Connection	$25,000	**$60,000**	$60,000	$145,000
PEI-20 Statewide Prevention and Early Intervention	$111,536	**$175,000**	$175,000	$461,536
Subtotal	$1,343,536	**$1,629,000**	$1,629,000	$4,601,536
Evaluation	$0	**$40,000**	$40,000	$80,000
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**	$36,871	$92,469
Total	$1,680,500	**$2,005,964**	$2,015,036	$5,701,500

	FY14-15	FY15-16	FY16-17	Total	%
County	$25,000	**$60,000**	$60,000	$145,000	2.5%
Contract Provider	$1,383,436	**$1,673,900**	$1,673,900	$4,731,236	83%
Administration	$244,265	**$244,265**	$244,265	$732,795	13%
Operating Reserve	$27,799	**$27,799**	$36,871	$92,469	1.5%
Total	$1,680,500	**$2,005,964**	$2,015,036	$5,701,500	100%

PREVENTION AND EARLY INTERVENTION

NUMBERS TO BE SERVED IN FY2015-16

Program	Type of Service	Individuals					Family Members	Providers
		0-15	16-25	26-59	60+	Total		
Early Childhood Mental Health	Outreach							**130**
	Prevention	100				**100**	**100**	
Triple P Marin	Outreach						**140**	**15**
Transition Age Youth PEI	Outreach	50	350			**400**		**15**
	Prevention	15	65			**80**		
	Early Intervention	50	250			**300**	**30**	
Latino Community Connection	Outreach							**15**
	Prevention		20	60	20	**100**	**20**	
Integrated Behavioral Health	Early Intervention		50	200	50	**300**	**30**	
Older Adult PEI	Outreach							**100**
	Prevention				50	**50**	**15**	
Vietnamese Community Connection	Outreach							**5**
	Prevention		10	15	25	**50**	**10**	
PEI Training	Outreach		10	80	30	**120**		
School Age PEI	Outreach							**20**
	Prevention	100				**100**	**60**	
Veterans Community Connection	Prevention		20	80	20	**120**	**20**	
Statewide PEI	CalMHSA					**TBD**		
	Suicide Prevention Hotline						**8000**	

Outreach: *Increasing Recognition of Early Signs of Mental Illness/Emotional Disturbance*
Prevention: *Reducing Risks Related to Mental Illness/Emotional Disturbance*
Early Intervention:
Individuals: Individual identified for services.
Family Members: Family members or caregivers of the individuals who participate in services.

CLIENT CHOICE AND HOSPITAL PREVENTION PROGRAM (CCHPP)

PROGRAM DESCRIPTION
July 2013 – June 2014

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.

Marin's first Innovation project was the Client Choice and Hospital Prevention Program (CCHPP). This consisted of developing recovery oriented, less restrictive approaches to responding to adults experiencing a psychiatric crisis. The CCHPP was the result of a diverse and collaborative community planning process conducted in Marin County. While the Innovation 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 Innovation project was 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. Innovation funding for this project will draw to a close at the end of FY2014-15 when it will move under Community Services and Supports (CSS) funding.

Target Population

The population served by the Client Choice and Hospital Prevention program includes adults 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	FY2014-15
Crisis Planning	80
Crisis Residential	120
SBIRT (Screening, Brief Intervention, Referral to Treatment)	120

Program Description

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

Marin's 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 to 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 were used to develop and operate a community-based crisis service in a homelike environment that integrates crisis intervention and stabilization with wellness and recovery principles. Additional innovative project elements include integrated peer and professional staffing; use of client-driven crisis plans (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 E – CCHPP Description and Brochure and Appendix F – CCHPP Logic Model.

Intended Outcomes 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 was developed and 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 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.

FY2013-14 has been a pivotal year for CCHPP which has included an enormous amount of growth, learning and systems adjustment. As stated in the previous MHSA FY2014-15 Annual Update, FY2013-14 is the year where all the pieces come together. These pieces include: the opening of the crisis residential unit; hiring of all staff for all components of this project; pulling together key partners who are champions of partnership; development of a common language/understanding of the overarching goals of this project and the individualized clinical goals of the consumers who are at risk and/or are experiencing a mental health crisis; finalizing all customized evaluation tools; implementation of evaluation; and data analysis.

Marin County's crisis residential unit, Casa René, opened its doors on February 4, 2014. Weeks prior to the opening of Casa René the public was invited to tour the location. The intention of the invitation was to help neighbors, community members, family members, first responders, and others understand that there are alternatives to treating psychiatric crises, and that people who experience these crises can stabilize and recover in a home-like voluntary setting. In the weeks leading up to the opening of the unit, Casa René received a lot of attention and praise for its thoughtful, recovery oriented design of the home. Casa René is unarguably a beautiful setting that is conducive to healing and respite. Many commented that the home felt like a high-end bed & breakfast. While the praise was welcomed, the message conveyed was that people who are experiencing a psychiatric crisis deserve quality services and support, including a respectful and thoughtful setting. An unexpected outcome of the beautiful home-like setting has been a subtle but powerful message that those who experience a psychiatric crisis deserve quality care thus chipping

away at some long-held beliefs that feed into stigma and discrimination. It also demonstrated that the Casa René staff and management are willing and wanting to "partner well" with folks far outside the target population of this project.

Also in the weeks that led to the opening of Casa René, once all staff were hired, key partners were identified so they could begin to operationalize this concept of "partnership". Again, the working hypothesis being tested is "When we partner well, the quality of our work and the outcomes for all will improve". This group of people consisted of peer professionals, family partners, substance abuse staff, Casa René staff, psychiatric emergency services staff, and medical staff. These staff members are contract providers as well as county staff. While this may not seem like an unusual group of professionals to pull together, something unusual did happen that has fundamentally shaped the outcome of this project. Early in the development of this group, the group decided it was best to meet at Casa René. It was clear that a big point of meeting was to coordinate care of those who are admitted to Casa René. When clinical conversations began to happen, the peer professional members were asked to leave the meeting, citing HIPPA/confidentiality regulation. The peer professionals left the meeting and the meeting continued. The peer professionals were left feeling excluded, defeated and upset.

This most unfortunate event has turned out to be a profound learning point of this project. Had it not been for the courage and strength of the peer professionals to come forward and express their thoughts and views on being excluded, the exact dynamic this project is trying to prevent would have been recreated and would have negatively impacted the outcomes for everyone, including those in crisis. People who are in crisis often feel unheard, minimized and excluded from their care. Their rights are taken away from them, others begin to make choices for them, and they end up involuntarily hospitalized. This is exactly what this project is trying to remedy. By asking the peer professionals to leave the meeting the unintentional message to this group was that peer professionals don't get to have a voice in care of those who need help.

What came after this event were several very hard conversations, the types of conversations most groups try to avoid because they are uncomfortable. Yet sticking with the difficult conversations proved to be the correct thing to do. It was never anyone's intention to hurt another's feelings, or to exclude anyone. The group was committed to partnering well and they did not cut the process short by trying to create a simple solution (i.e., having signed releases of information for all members of the group). Rather they took the time to hear each other's perspective and expertise. They learned more about each other and their style of communication. They looked at their own preconceived notions of choice, treatment, and partnership. Through the difficult conversations they humbly and genuinely reflected on the institutional stigma and discrimination that so easily get played out especially when delivering crisis services. Through the difficult, yet honest conversations, they discovered what it means to partner and to partner well. They were reminded that the consumer voice is a powerful voice and that when the consumer voice, whether it be a client or a peer professional, is present at the table the outcomes for everyone dramatically improves. When the client voice is being heard it gives everyone more hope and reminds all that recovery is possible.

As previously stated, evaluation tools were finalized and implemented during this time. Work on the evaluation tools started in the previous fiscal year, however, the difficult conversations and subsequent positive outcomes of these conversations further helped to shape the types of evaluation questions that were being asked. Not only do we want to capture "partnering well" in real-time

situations, we want to be able to quantify partnership as it relates to positive outcomes. To this end, partner surveys were finalized, base-line data was captured, and an additional evaluation cycle was completed during this time period. Additionally, through the partnership conversations it was discovered that there were different ideas and definitions of what quality crisis care means. Via the CCHPP Advisory Board, the partnership surveys and discussions with other key players responsible for the expanding crisis continuum of care services, a definition of "Quality Crisis Care" see Appendix G was developed. This definition complements the CCHPP and Crisis Planning Logic Models that were created in the previous year. These tools and documents are being used to not only shape the CCHPP, but also the larger crisis continuum of care.

OUTCOMES
July 2013 – June 2014

Casa René Numbers

Age Group	# served	% of served
18-23 years old	2	3%
24-28 years old	14	21%
29-38 years old	11	17%
39-47 years old	10	15%
48-52 years old	5	8%
53-57 years old	11	16%
58-62 years old	9	14%
63-67 years old	4	6%
Total	**66**	**100%**
Race/Ethnicity	**# served**	**% of served**
White	41	62.5%
African/American	2	3%
Vietnamese	1	1.5%
Pacific Islander	1	1.5%
Native		
Hispanic	10	15%
Multi		
Other	11	16.5%
Unknown/No Reply		

Primary Language	# served	% of served
English	55	83.5%
Spanish	10	15%
Vietnamese	1	1.5%
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other		
Unknown/No Reply		
Gender	**# served**	**% of served**
Female	36	55%
Male	30	45%

Crisis Planning Numbers

Age Group	# served	% of served
0-15 years old		
16-25 years old	5	9%
26-59 years old	46	81%
60+ years old	6	10%
Total	**57**	**100%**
Race/Ethnicity		
White	48	83%
African/American	3	5%
Asian	2	4%
Pacific Islander		
Native		
Hispanic	2	4%
Multi		
Other/Unknown	2	4%

Primary Language	# served	% of served
English	57	100%
Spanish		
Vietnamese		
Cantonese		
Mandarin		
Tagalog		
Cambodian		
Hmong		
Russian		
Farsi		
Arabic		
Other/Unknown		
Others		
LGBTQ	1	2%
Homeless	10	18%

CHALLENGES AND UPCOMING CHANGES

In FY2014-15, this project will conclude as an Innovation project. Data analysis will peak during this year, allowing all involved partners to determine and refine what is being learned. Positive key learning elements will greatly contribute to the expansion and development of Marin's Crisis Continuum of Care which now includes the Investment in Wellness Act funded Crisis Triage and Crisis Mobile response teams.

Additionally, in FY2014-15 Marin County conducted a stakeholder planning process in order to determine the next MHSA Innovation project(s). It is hoped that key learning elements of the CCHPP will help shape the hard to solve problem of reducing disparities.

In **FY2015-16,** the data findings will be finalized and the CCHPP "Lessons Learned" report will be written. This report will be included in the MHSA FY2016-17 Annual Update. As stated, funding for key aspects of this project will shift away from Innovation to Community Support Services (CSS). The coordination, evaluation and responsibility of managing the partnership will shift from the MHSA Innovation Coordinator and will be assigned to the Mental Health and Substance Use Program Manager who oversees the Crisis Continuum of Care.

WORKFORCE, EDUCATION AND TRAINING

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

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

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

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, community based organizations (CBO's), 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

1. Training Coordinator

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

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

2. Peer Consultation Network

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

In FY2013-14 we continued to build the Peer Consultation Network, with ongoing consultation and training groups for the "Train the Trainers" series in Nonviolent Communication, LEAP, Motivational Interviewing, and Group Facilitation. (See the **Consumer** and **Family Focused Trainings** sections below for the specifics on trainings.)

Two training groups have concluded and as of early 2014 had newly "graduated" trainers who were to offer services via the Warm Line, a phone line for support for people and their families living with mental illness, run by Community Action Marin. One of the concluding groups agreed to continue to meet monthly without the original trainer, and to schedule quarterly consultations with that original trainer.

In addition, with the aim of continuing to build the Peer Consultation Network, two new Nonviolent Communication training series were completed, in the same Train the Trainer format of a weekly series followed by monthly consultation and training groups for one year.

One trained a cohort of members of the Southern Marin Multidisciplinary Team, a coalition of peer and professional community mental health and social service workers who work in partnership with CSS' Southern Marin Services, the Marin City Community Development Corporation, and the Marin City Network. This is an especially important development considering the ongoing need to broaden the areas in which WET Program services are offered, as this group's members have strong links to underserved communities with ethnically diverse populations in Southern Marin County.

The other training series, NVC in Spanish, was held in San Rafael for the largely Latino and Latin immigrant community of the Canal district, in our continuing effort to engage everyone in the County including monolingual people and families. At the end of the FY this group was in the process of scheduling the follow-up monthly consultation groups, which will continue for at least one year, during which the members will be bridged into a training role to bring this work to more people and families in the community.

We have developed a cohort of 20 Motivational Interviewing (MI) champions. These champions have met with our MI consultant on a monthly basis for the past year expanding their personal skills and ability to provide trainings to our internal and contract provider staff. The focus of this group has changed from that of supporting further learning in MI to how to begin to teach MI to the larger system. The consultant has brought forth training on coding MI sessions, how to lead brief trainings, and support for developing curriculum.

3. Targeted Training in Evidence Based Practices

This action item is to administer a flexible fund designed to support the delivery of a range of training in evidence-based practices. In FY2013-14 we delivered the following:

- Trauma Informed Care Conference: In October 2013 we planned and conducted a 2-day conference on trauma informed care. This included the culturally relevant breakout sessions on the impact of trauma on Latino, African American, Vietnamese and LGBTQ populations. The conference also provided sessions on evidence-based practices with different populations spanning children through adults. There were a total of 78 attendees at this, ranging from county staff, CBO staff, and peer providers. Participants were able to bring important new trauma informed care skills and knowledge to their work, including trauma awareness, assessment, cultural sensitivity, community-based responses, referrals and treatment options, and many others.
- In April 2014 we conducted two half-day workshops for Marin County PES, in conjunction with San Francisco General PES, for 50 people. These workshops were targeted specifically to medical staff but were attended by others involved in psychiatric emergency services.
- The WET program continued the Essential Learning contract which is utilized by the staff of Psychiatric Emergency Services as they are not able to attend many of the WET funded trainings given the nature of the 24/7 facility.

4. Consumer Focused Training

This action item is to increase consumers' capacity to advocate for consumers, qualify for employment within the mental health system, and participate in planning and policy within the system. An additional goal is to increase the capacity of providers to include consumers in treatment and planning processes. A consumer subcommittee has met monthly in FY2013-14 to identify specific training needs of consumers and to review and agree upon training initiatives.

- **WRAP – Wellness Recovery Action Plan**: We cultivated the use of the WRAP model, essentially a mental health crisis prevention and management program that is very "user-friendly". Two peer volunteer staff were interested in becoming certified as WRAP facilitators. They completed a week-long WRAP Facilitation Training in San Francisco in Spring of 2014 and became certified. Working with WET staff, they are currently in the process of developing a series of mobile "Train the Trainers" workshops to bring to places in the County with less accessibility to the Enterprise Resource Center, such as Novato, Marin City, and West County.

- **Dual Diagnosis:** A monthly Dual Diagnosis consultation group was conducted for peer providers in our system to assist them in working with individuals who present with co-occurring disorders. A total of 12 sessions were offered.

- **Group Leadership:** A monthly peer group leader facilitation group was held in FY2013-14 at the Enterprise Resource Center, led by a peer expert, again continuing to move in the direction of having consumers leading groups relevant for them.

5. Family Focused Training

This action item is to increase family member's capacity to support consumers, qualify for employment within the mental health system, and participate in planning and policy within the system. In addition it is to increase the capacity of providers to include families in treatment and planning processes. A family subcommittee has been meeting on a monthly basis to bring ideas and determine the trainings relevant for them.

Two training groups concluded in FY2013-14, and as of early 2014 had newly "graduated" trainers to offer services via the Warm Line, a phone line for support for people and their families living with mental illness, run by Community Action Marin. One of the concluding groups agreed to continue to meet monthly without the original trainer, and to schedule quarterly consultations with that original trainer.

- **Listen Empathize Agree Partner (LEAP)**: The monthly Training of Trainers consultation group that began in FY2012-13 concluded its activities in Fall of 2013, with the next goal of having trained group members making themselves available through the "Warm Line." Members were offered ongoing support on an as-needed basis with the group facilitator.

- **Nonviolent Communication:** In FY2013-14, we completed two new Trainings of Trainers series in Nonviolent Communication. Continuing to utilize the services of Bay Area Nonviolent Communication, we conducted one training series in Marin City and the other in San Rafael, both in the same Train the Trainer format of a weekly series followed by monthly consultation and training groups for one year.

  - One trained a cohort of members of the Southern Marin Multidisciplinary Team, a coalition of peer and professional community mental health and social service workers who work in partnership with CSS' Southern Marin Services, the Marin City Community Development Corporation, and the Marin City Network. This is an especially important development considering the ongoing need to broaden the areas in which WET Program services are offered, as this group's members have strong links to underserved communities with ethnically diverse populations in Southern Marin County.

  - The other training series, NVC in Spanish, was held in San Rafael for the largely Latino and Latin immigrant community of the Canal district, in our continuing effort to engage everyone in the County including monolingual people and families. At the end of FY2103-14 this group was in the process of scheduling the follow-up monthly consultation group schedule, which will then continue for at least one year, during which the members will be bridged into a training role to bring this work to more people and families in the community.

  - In addition, arrangements were made for the "graduates" of the previous NVC training held in San Rafael to attend the Marin City ongoing consultation group, for ongoing support for these new NVC peer/family trainers.

6. Systems Wide Integrated Dual Disorders Training

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

7. Clinical Practice Forums

This action item is to institute ongoing learning groups to support and expand the learning provided by WET trainings.

- **Harm Reduction and Dual Dual Diagnosis** consultation group meets on a monthly basis and includes CBO's, county staff and peer providers. This group has been co-facilitated by our WET consultant and has begun to self -govern with the expertise and confidence of the members growing throughout the year. The total number of attendees in this is 15 and the group averages 5-8 attendees each month. 10 sessions were held in FY2013-14.
- The **Group Therapy** supervision series was offered monthly throughout the year to support the integration of knowledge learned in the previous immersion trainings. This group was co-facilitated by two experienced group therapists. There were 7 members of this group. 10 sessions were held in FY2013-14.

8. MH Directors Leadership Institute Training

This action item was created to send current and future leaders from Marin to the California Institute of Mental Health (CIMH) Leadership Training each year. This action item was deliberate and focused on strengthening leadership to manage system transformation in the public mental health system. In FY2013-14 one staff was sent to the Leadership training.

9. Intern Stipend System

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

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

Buckelew	**$9,000**	**6 Occupational Therapist interns targeting Asian bilingual/bicultural**
Family Service Agency	**$8,000**	**6 MFT interns Spanish- Speaking/ African American**
Huckleberry Youth Programs	**$5,400**	**2 interns Spanish-speaking and Lived experience**
Catholic Charities CYO	**$9,000**	**3 interns Spanish-speaking**
Community Institute for Psychotherapy	**$5,000**	**1 full time intern working at Homeless Resource Center- Ritter**

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

This action item is to provide scholarships for consumers, family members and members of under-represented populations when the educational program will result in possible entry to or advancement within the public mental health system. The Consumer and Family WET subcommittees have been identifying prospective students for scholarships.

FY2013-14 was the third year of our scholarship process. The recommendations from the consumer and family subcommittees were to offer $2,000 per individual to support their education towards working in the public mental health system. This year we were able to offer scholarships to 4 separate individuals in both the fall and spring semesters. These individuals attended College of Marin, Dominican University, and Coastline Community College. Two of the stipends went to peer providers who currently work in the public mental health system and want to further their ability to advance. Two stipends went to consumers pursuing psychology and social work degrees and two to consumers wanting to gain the education needed to work in the public mental health system. The stipends were utilized to offset commuting costs and the purchase of books and technology needed to participate in courses.

In the spring of 2014, Marin partnered with San Francisco, Alameda, and the City of Berkeley to partner in a regional state grant - Bay Area Peer and Professional Network. This program is a grant from the OSHPD which promotes the effective training, hiring and support of peer professionals in the mental health system.

Intended Outcomes and Evaluation

Each year goals are set regarding what trainings are to be held and how to distribute stipend funds to best meet existing needs. The completion of these tasks is tracked, as well as number of participants. In some cases individual trainings have conducted course evaluations and assessments. The feasibility of analyzing and reporting on the course evaluations and assessments will be assessed.

CHALLENGES AND UPCOMING CHANGES

In **FY2014-15**, MHSUS expanded the role and duties of the newly created permanent full-time position of Ethnic Services Manager (ESM) by including the responsibilities of coordinating WET. Therefore, the position was renamed Ethnic Services and Training Manager (ESTM) as of January 2015. The ESTM analyzed the strengths and challenges of the WET system by reviewing existing reports, data, past and current training offerings and practices, interviews with stakeholders and consulting with CIBHS' Senior Associate and regional WET cohorts to determine if the existing WET's strategic plan is consistent to the MHSA's overall goals, objectives and principles. While the ESTM determined that MHSUS is making progress to meeting many of its strategic plan's goals and objectives, certain parts of the plan and system required minor adjustments for the purpose of expanding the capacity of WET, consistent to the county's workforce and consumer needs.

One of the many successful examples of WET's accomplishment during FY2014-15 is its ongoing progress to integrate mental health and substance use programs and services into a more coordinated system of care. Led by MHSUS' hired consultant organization, Harm Reduction Therapy Center (HRTC), the Co-Occurring Disorders Collaborative has been working steadily towards an enhanced integration and collaboration among mental health and substance use services. HRTC has begun to work closely with senior management staff of MHSUS this fiscal year to begin operational planning and implementation.

Another example of success is the recent completion of a 3-day Interpreters' Training by seven (7) bilingual/bicultural staff; four (4) Latino/a staff and three (3) Vietnamese staff. Participating staff are commonly used to improve communication and access among monolingual Spanish and Vietnamese speaking consumers. Based on written evaluations submitted, all staff reported feeling more confident and skilled to interpret between/for consumers and MHSUS staff. Marin County was the host site for this multi-county collaborative, which included Sonoma and Napa counties.
Some of the challenges identified by the ESTM included the lack of cultural diversity and low participation of consumers/family members among and within existing steering committees that are supported through the WET system; inadequate outreach to the diverse consumer/family member communities to promote and encourage behavioral health as a vocational and/or career option for people with lived experiences; lack of a system for consumers/family members/peers to adequately access funding opportunities who are interested in a vocation/career in the behavioral health field; and lack of a diverse peer counselor labor pool.

In FY2015-16, one of the major shifts that WET will undertake is to expand on its Peer Mentoring program. This includes improving outreach and engagement efforts in ethnic and low-income communities of the county for the purpose of promoting and encouraging consumers and family members' of color to consider a vocation/career in behavioral health. So far this has resulted in the submissions of twenty two (22) applications from culturally diverse backgrounds throughout the county. Of the 22 applicants, sixteen (16) were awarded scholarship funds to get trained as either peer counselors, drug/alcohol counselors, and/or in domestic violence counseling.

In order to reduce the risks of the applicants from dropping out from their chosen vocational training fields, a diverse pool of peer mentors will be assigned to all applicants to provide them with

ongoing emotional support and career/vocational coaching. Once applicants begin their respective vocational training instructions, the peer mentors will work to provide ongoing support groups to the applicants for the purpose of building a community of support, and to eventually become the next generation of peer mentors once they have completed their training programs.

Funding will be re-aligned from WET coordination staff time, Clinical Practice forums and Family Focused training to support the expansion of Peer Mentoring.

Lastly, the ESTM will establish a formal system with a set of policies and guidelines which will serve as standard operating procedures to ensure that there are mechanisms in place at every key decision point related to scholarship awards and supports, training needs and requests, and workforce development.

WORKFORCE, EDUCATION AND TRAINING

CLIENT STORY

One of the Consumer Educational Stipend applicants exemplifies the potential of WET Programs to help someone progress in their career path one step at a time, with beneficial results.

"Sharon", at the time a peer volunteer staff member, was present at one of the Marin WET Dual Diagnosis trainings. After engaging with Marin WET Program staff there, she attended the monthly Dual Diagnosis Group, aimed at providing peer staff a place to consult on clients and learn more about working with dual diagnosis. She became a core member of that group and participated in other MHSA groups.

In the Dual Diagnosis Group, program staff observed Sharon's astute thinking and mindfulness with regard to mental health and substance use issues, as well as her gregarious and compassionate nature. Staff encouraged her to apply for a Consumer Educational Stipend. She applied and was awarded. It turned out, she'd already started working on a degree in psychology at College of Marin, and the stipend would help further her studies. She brings the skills and experience of her educational work to her community mental health work in Marin every day she is on the job, and in turn her studies seem to inspire and energize her to continue serving the people.

MHSA Workforce, Education and Training (WET)

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

Program	FY14-15 (Estimated Actual)	FY15-16	FY16-17	Total
1) System-wide Dual Diagnosis Training	$8,320	**$121,000**		$129,320
2) Family Member Focus Training	$5,000			$5,000
3) Scholarships for Underserved Consumers & Family Members	$5,000	**$45,000**	$45,000	$95,000
4) Community Based Organization (CBO) Intern Stipends	$0	**$25,000**	$25,000	$50,000
5) Training Initiatives	$4,000	**$25,000**	$25,000	$54,000
6) Peer Mentoring	$5,766	**$85,000**	$85,000	$175,766
7) MHSUS Intern Stipends	$152,000	**$152,000**	$152,000	$456,000
8) WET Coordination	$30,000	**$0**	$0	$30,000
9) California Institute for Mental Health-Training	$0	**$10,500**	$10,500	$21,000
Total	**$210,086**	**$463,500**	**$342,500**	**$1,016,086**

One-Time Funding Sources:	
Prior Year Unspent WET Funds (Actual)	**$164,086**
Prior Year Unspent CSS Funds	**$852,000**
TOTAL	**$1,016,086**

CAPITAL FACILITIES/TECHNOLOGICAL NEEDS

PROGRAM DESCRIPTION
July 2013 – June 2014

Program Overview

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

CFTN projects must support the goals of the Mental Health Services Act (MHSA) and the provision of MHSA services. The use of CFTN funds should produce long-term impacts with lasting benefits that move the mental health system towards goals of wellness, recovery, resiliency, cultural competence, prevention and early intervention. An additional goal is to promote reduction in disparities for underserved groups by expanding opportunities for accessible community-based services for clients and their families.

CAPITAL FACILITIES (CF)

Capital Facilities allows counties to acquire, develop or renovate buildings to house and support MHSA programs. Funds may also be used to develop less restrictive community-based settings that will reduce the need for incarceration or institutionalization. Marin County has not identified appropriate capital facilitates projects that fit within State parameters for MHSA Capital Facilities funding.

TECHNOLOGICAL NEEDS (TN)

Technological Needs supports counties in modernizing clinical and administrative information systems, as well as increasing consumer and family members' access to health information within a variety of public and private settings. This plan is based upon the foundation developed by the original CFTN plan.

Program Description

In Marin County, our goals have focused on technological improvements that support the development of an Electronic Health Record (EHR), enabling the advancement towards a paperless record. This included, implementation of an e-Prescribing system and upgrading and modernizing the legacy billing system (INSYST). In 2011/12, the upgrade to replace the INSYST system was expected to include all of the existing billing and reporting functionality, including managed care, as well as being able to interface with our hybrid EHR, Clinicians Gateway. The Practice Management project constituted the most complicated component of Marin's TN plan. After extensive review of existing systems in California, Echo Consulting Services, Inc. (Echo) was selected as the vendor to provide the system upgrade to ShareCare, a web-based state of the art software system. The contract

with Echo was approved in late January 2011 with a target implementation go-live date of July 1, 2011. Project implementation focused on the completion of intensive tasks essential for a successful system conversion, including purchase of hardware, data clean up, crosswalk set-up, ShareCare system set up and preparation for integration with our EHR, Clinicians Gateway. In June of 2011, in preparation for the July go-live, Echo provided System Administrator core training, Train-the-Trainer training, and Managed Care training for key staff.

Marin County's CFTN Plan also funded relevant training, updating/upgrading equipment, and scanning equipment including, but not limited to, local and remote desktop computers, server equipment, scanning equipment, and signature pad devices in order to further the goals of the MHSA and the expansion of mental health services.

Technological Needs in Marin County consist of the following components:

- Practice Management Upgrade
- e-Prescribing
- Electronic Health Record and Emergency Back-up
- Scanning Project
- Consumer Empowerment

Practice Management

Echo's ShareCare system was implemented in the summer of 2011. Continued enhancements to the system allow for analytics, which extend the functionality of the system to meet federal and state reporting requirements.

Echo also supports Rapid Insight, a unique software tool for performing data analyses, ad hoc reporting, and managing analytic data sets, and developing predictive models. Veera is a companion system attached to Rapid Insight that provides a user-friendly interface to produce easily read and presentation quality reports from data extrapolated from Rapid Insight.

Marin continues to search for a full data warehouse analytics system which interfaces with and extracts data from ShareCare to provide data on service and claim level information. Securing an analytics system will enable Marin County to accurately track and monitor our service delivery outcomes, cost report support, and to develop tools for identifying challenges and changes needed to system of care.

e-Prescribing

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

Electronic Health Record (EHR)

A fully functioning EHR allows for greater integration as well as smoother secure access to health information. Marin's mental health staff and select contract providers have used Clinicians Gateway since 2006 to write electronic progress notes. This component proposed to move the medical record further towards a more complete EHR by adding 10-15 key forms to Clinicians Gateway. The project also included the provision for an expanded hardware configuration to provide for emergency backup in case of power or system failures.

Marin continues to make progress towards system enhancement and upgrades to our EHR to meet Meaningful Use (MU) and Physicians Quality Reporting System (PQRS) documentation, data collection capability and reporting requirements. Additionally, the project proposed to add digital signature pads as new operational components of the EHR, so that clinicians would be able to record client signatures on documents in the field or office.

In late FY2013-14 Marin County began the process of developing the capacity for a Health Information Exchange (HIE). The goal of HIE is to facilitate access to, clinical data to provide safer and more timely, efficient, effective, and equitable patient-centered care. This aspect is essential to treating the "whole health" of consumers and continuity of care between primary care and behavioral health care. Additionally, HIE will reduce expenses to the County associated with the manual printing, scanning and faxing of documents, reduce ink and paper costs, reduce time and effort spent copying large volumes of client documents when released to other providers, etc.

Integrating our billing/claiming and EHR, is vital to the integration of Mental Health and Alcohol and Other Drugs. The behavioral health crosswalk furthers the integration efforts by reducing duplication and improving care coordination and interoperability between systems within our EHR and data sharing capabilities. This project will include a one-time crosswalk to integrate Clinicians Gateway and the FIE WITS system, which is the EHR being used by Alcohol and Other Drugs contracted service providers.

Scanning

This component involves the implementation and interface of Platton Technologies IMAVISER, which is a scanning application fully integrated with Clinicians Gateway. Adding scanning capabilities to the EHR would incorporate the paper documentation which continues to be part of the medical record. IMAVISER would allow authorized clinical staff to electronically access key documents necessary in caring for their clients.

Consumer Empowerment

This component proposed to dedicate funding for the purchase of desk top computers and internet access for the use of consumers living in county-contracted residences with six or more people. Additionally, this component proposed to expand on existing resources at the Enterprise Resource Center, Marin's consumer-operated drop-in center, by providing funding for additional computer desktops and dedicated paid consumer staff time for computer training and IT expertise.

OUTCOMES
July 2013 – June 2014

e-Prescribing: Full implementation of this component continues to be delayed. Pharmacies widely used by the clients of MHSUS have not received certification to receive controlled/scheduled II-V, medication prescriptions electronically through the Electronic Prescribing of Controlled Substances (EPCS) system. We expect this to be resolved in FY2014-15 and until that time there will continue to be a limited number of hand-written prescriptions.

Electronic Health Record: The component goal continues to support system enhancements and upgrades. In 2012 Marin's EHR vendor began the process of upgrading the system to meet the Meaningful Use (MU) objectives and measures first year of participation where providers can attest that they have "adopted, implemented, and upgraded" certified EHR technology. As a result in 2013, Marin was able to register all medical providers as eligible providers under Meaningful Use guidelines with both the Federal and State governments. The system upgrade for Stage 1 & 2 MU objectives, include measures such as a laboratory interface, and a consumer portal which allows clients access to information about their treatment, as well as the ability to communicate online directly with their medical providers is planned. Electronic signature pads were purchased and software upgraded in the confirmation section of Clinicians Gateway in order to electronically capture client signatures on treatment plans.

Scanning Project: During FY2010-11 the software and hardware necessary for implementation was purchased. Additional system upgrades occurred in FY2013-14 as well as the purchase of additional hardware to include all clinic medical records sites. This is an on-going project and Platton Technologies is working with MHSUS to have this fully implemented in FY2014-15 with only annual maintenance in FY2015-16 and FY2016-17.

Consumer Empowerment: Beginning FY2011-12 Marin has provided computer kiosks solely for client use in Medication Sites for client use. In FY2013-14 discussions began to hire a Peer Provider to support the training of clients at consumer sites on computer skills, including software training.

Practice Management: During FY2011-12, continued implementation of ShareCare remained the primary focus of the TN project, and by April 2012, Marin was able to successfully bill all major third party payers. In FY2012-13 client invoices began being generated from our ShareCare system. In addition to system upgrades and enhancements, ShareCare Managed Care module upgrades were completed in FY2013-14. Echo, Inc. also supports the addition of Rapid Insight; a unique software tool for performing data analyses, ad hoc reporting, and managing analytic data sets, and developing predictive models. Veera is a companion system attached to Rapid Insight that provides a user-friendly interface to produce easily read and presentation quality reports from data extrapolated from Rapid Insight. In 2013 testing of the Rapid Insight analytics was completed and licenses were purchased and installed on 7 staff computers in FY2013-14.

CHALLENGES AND UPCOMING CHANGES

ICD-10 Implementation – On May 1, 2014 the Center for Medicare and Medicaid Services (CMS) issued an interim final rule that set the new compliance date for ICD- 10, to October 2015. ICD-10-International Classification of Diseases – Tenth Edition is a set of diagnosis and inpatient procedure codes used in the health care system. In FY2013-14 the major system upgrade began to implement and transition to ICD-10 codes, as required by Health Insurance Portability and Accountability Act of 1996 (HIPAA). The project will provide Mental Health and Substance Use services with coding analysis and crosswalk, impact analysis, implementation and training. The implementation will include both county and contract operated services. Marin will be contracting with Julie Larish, a national consultant for ICD-10 transition, to provide support for the implementation and crosswalk support.

IT Security Risk Assessment – An IT security risk assessment was conducted in FY2013-14 as a result of the standards of the HIPAA Security Rule which is a function of the Meaningful Use requirements of the Medicare and Medicaid EHR Incentive Programs. This assessment was done to ensure the privacy and security of clients protected health information. This assessment must be completed for both Stage 1 and Stage 2 of meaningful use. Marin successfully completed this Assessment and is working diligently to resolve the items in the remediation work plan.

Reportal – It was a goal of the Practice Management component to purchase and implement the ShaRP (Reportal) System, also supported by Echo's ShareCare. Unfortunately, due to the untimely death of the developer, Reportal System is no longer available. Marin continues its search for a system that will interface with our Practice management system to accurately track and monitor our service delivery outcomes, cost report support, and to develop tools for identifying challenges and changes needed to system of care.

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

Emergency Backup – Expanding hardware configuration to provide for emergency backup continues to be delayed due to the limited County IT resources being directed to higher priority components of CFTN including EHR and Practice Management components.

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	$151,252	**$66,507**	$68,011	$285,770	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	$69,507	**$55,968**	$56,230	$181,705	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	$40,400	**$37,343**	$37,735	$115,478	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	$298,091	**$185,344**	$73,286	$556,721	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	$149,221	**$72,055**	$73,494	$294,770	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	$142,081	**$20,494**	$20,494	$183,069	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	**$850,552**	**$437,711**	**$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**

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)	$1,680,500	**$2,005,964**	$2,015,036	$5,701,500	b)
Workforce Education and Training (WET)	$210,086	**$463,500**	$342,500	$1,016,086	c)
Capital Facilities and Technological Needs (CFTN)	$850,552	**$437,711**	$329,250	$1,617,513	d)
Innovation (INN)	$621,055	**$621,055**	$621,055	$1,863,165	e)
Total MHSA Funds Allocated	**$10,397,868**	**$11,253,905**	**$11,033,516**	**$32,685,289**	

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

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%

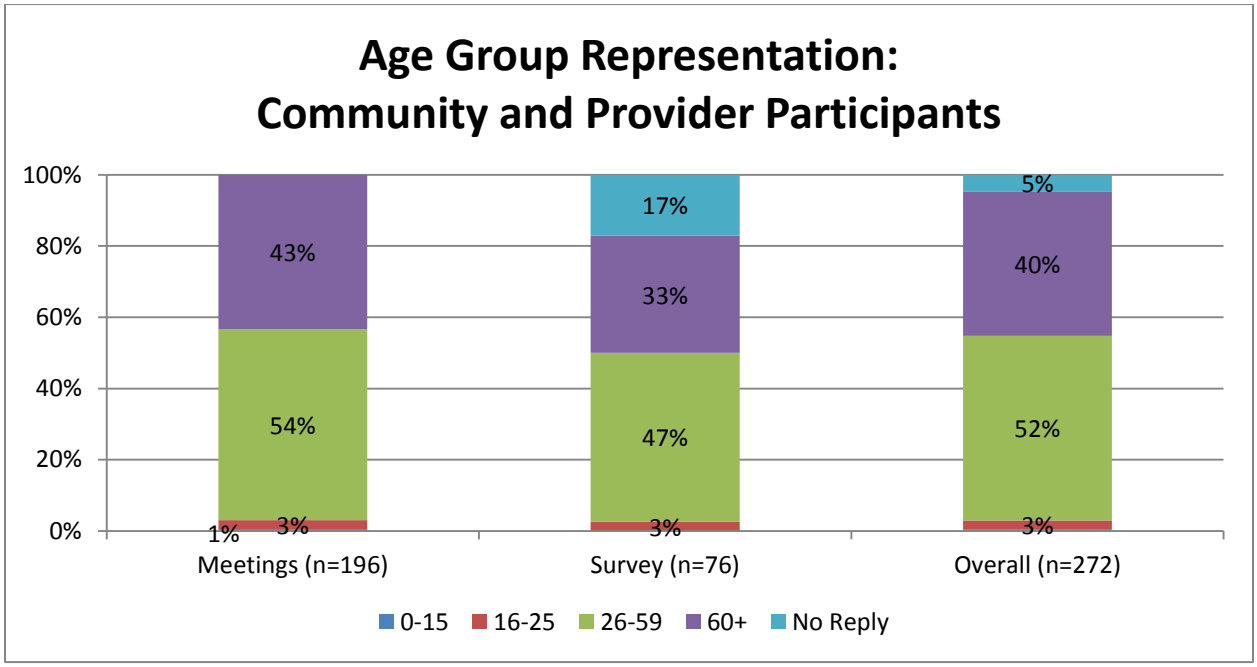
Further information

- 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%

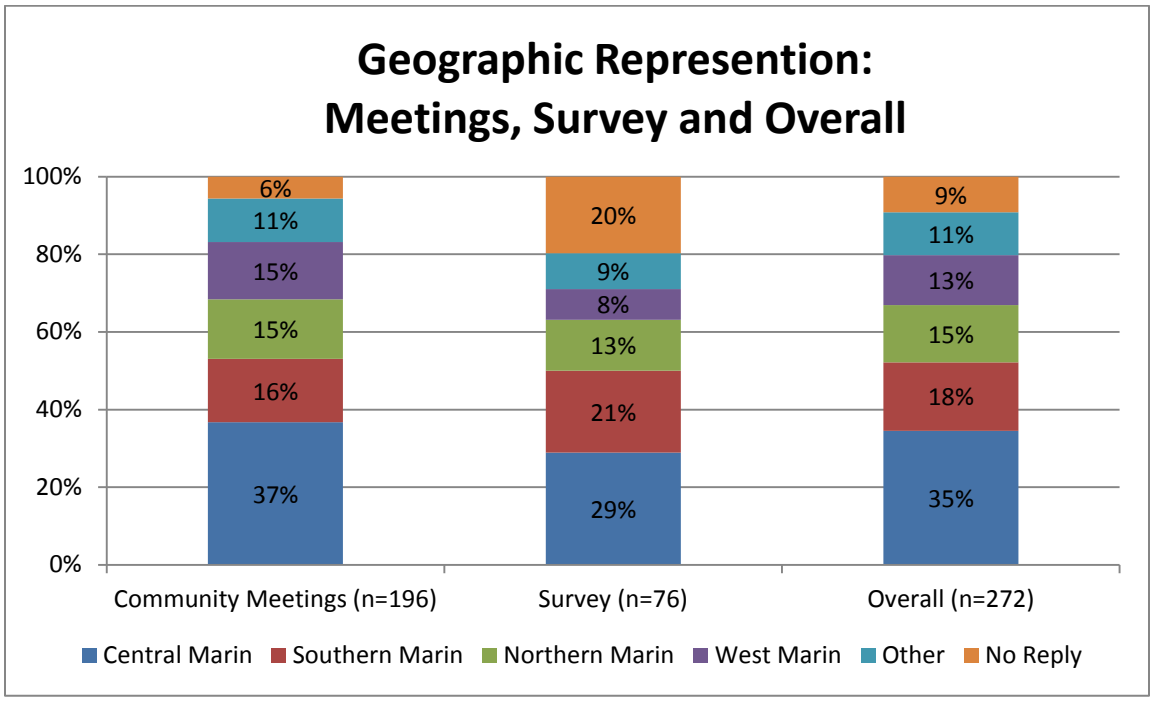
Further Information

- 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%

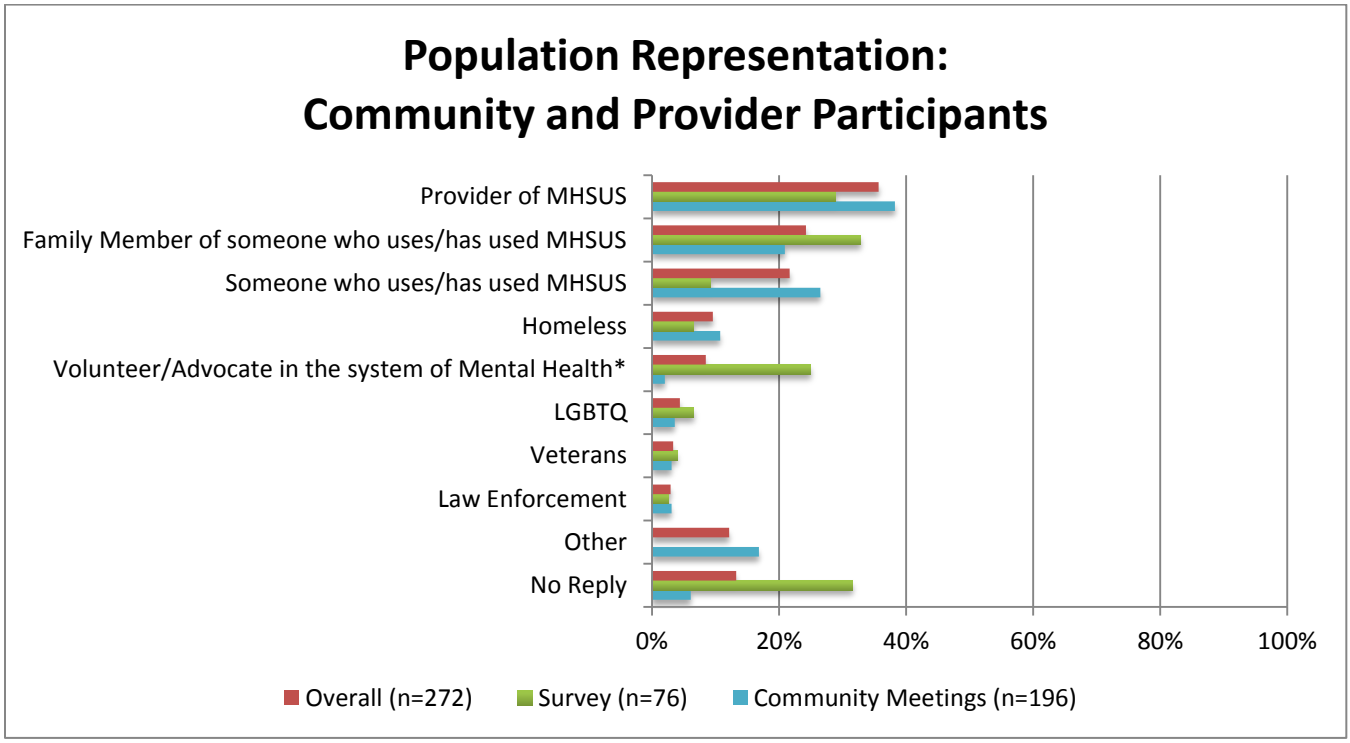
Further Information

- 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.

APPENDIX B

MHSA Advisory Committee Membership

Appendix B
MHSA Implementation Committee Members

Member Name	Affiliation	Representation	Ethnicity
Nick Avila	HHS-CalWORKS	Social Services	Latino/Hispanic
Julie Baker	Ritter Center	FQHC	White
Alison Buck	Homeward Bound of Marin	Homeless	White
Brian Hyun Cho	College of Marin	Student	Asian/Pacific Islander
Barbara Coley	Community Action Marin	Consumer/ Family Member	White
Steve Eckert	Buckelew Programs	Contracted Provider	White
Sandra Fawn	Mental Health Board	Consumer/ Fam. Member	Multi Race
Maya Gladstern	Peer Advocate	Consumer/ Fam. Member	White
Brook Hart	Consumer	Family Member	White
Laura Kantorowski	Bay Area Community Resources	Contracted Provider	White
Carol Kerr	HHS-Intern Program	Education	White
Vihn Q. Luu	Marin Asian Advocacy Project	Social Services	Asian/Pacific Islander
Janice Mapes	Phoenix Project	Family Resource Center	African American
Marvin Mars	Retired	Older Adult	White
Maria Patricia Niggle	West Marin Collaborative	Promotores	Latino/Hispanic
Kerry Peirson	Client Advocate	Southern Marin	African American
Sandra Ponek	Canal Alliance	Latino Community	White
Robert Powelson	Transitional Age Youth	Consumer/ Family Member	White
Sandra Ramirez Griggs	HHS-Youth & Family	Early Childhood	Latino/Hispanic
Robert Reiser	NAMI	NAMI	White
Suzanne Sadowsky	San Geronimo Valley Community Center	West Marin	White
Victoria A. Sanders	Veteran	Veterans Organizations	White
Maritza Saucedo	Marin Community Clinics	Latino Community	Latino/Hispanic
Brian Slattery	Marin Treatment Center	Co-Occurring/ LGBTQ	White
Jasmine Stevenson	Huckleberry Youth Programs	Youth	White
Gail Theller	Retired	Older Adult/ LGBTQ	White
Teresa Torrence-Tillman	Probation-Adult Services	Law Enforcement	African American

APPENDIX C

Cultural Competency Advisory Board Membership

CULTURAL COMPETENCY ADVISORY BOARD (CCAB)

APPENDIX C
CCAB MEMBERSHIP ROSTER

Mental Health and Substance Use Services Staff

1. Darby Jaragosky – HHS Planner/Evaluator – **Caucasian**
2. Marisol Munoz-Kiehne – Promotores Coordinator, (Adult Team) – **Latina**
3. Brian Robinson – Supervisor (Child Team) – **Caucasian, LGBTQ**
4. Cesar Lagleva – Ethnic Services Manager/ Mental Health Practitioner (Child Team) – **API**
5. Laurie Hunt – Mental Health Practitioner, HOPE Program, (Adult Team) – **Caucasian**
6. Kristen Gardner – MHSA/PEI Coordinator – **Caucasian**
7. Jessica Diaz – Mental Health Practitioner, Adult Case Management, (Adult Team) – **Mixed Heritage**
8. Cecilia Guillermo – Bilingual Mental Health Practitioner, Adult Case Management (Adult Team) – **Latina**
9. Robert Harris – Mental Health Practitioner, Adult Case Management (Adult Team) – **African American**
10. Maria Abaci – Mental Health Practitioner, Adult Case Management (Adult Team) – **African American**
11. Ngoc Loi – Mental Health Practitioner, (Adult Team) – **API**
12. Kristine Kwok – Supervisor (Adult Team) – **API**
13. Rafael Tellez – Office Assistant III (MHSUS) – **Latino, LGBTQ**
14. Sadegh Nobari – Licensed Mental Health Practitioner – **Middle Eastern**

Agency Partners

15. Leticia McCoy – Family Partner, Community Action Marin – **African American, Former Consumer – Consumer Advocate**
16. Vinh Luu – Coordinator, Asian Advocacy Project, Community Action Marin – **API, Consumer Advocate**
17. Douglas Mundo – Executive Director, Canal Welcome Center – **Latino, Consumer Advocate**
18. Robbie Powelson – Board member, Marin Mental Health Board – **Caucasian, Former Consumer, Consumer Advocate, LGBTQ**
19. Sandy Ponek – Program Director, Canal Alliance – **Caucasian**
20. David Escobar-District 5 – Aide to Supervisor Steve Kinsey – **Central American Indian, Consumer Advocate**

Community Volunteers

21. Gustavo Goncalves – San Rafael – **Latino, Community Volunteer**
22. Leah Fagundes – San Rafael – **Caucasian, Former Consumer, Consumer Advocate**
23. Cat Wilson – San Rafael – **Jewish, Consumer**
24. Cheryl August – San Rafael – **Jewish, Former Consumer, Consumer Advocate**
25. Kerry Peirson – Mill Valley – **African American, Consumer Advocate, Older Adult, African American**
26. John Ortega – **San Rafael – Latino, Consumer Advocate**
27. Cameron "Cammie" Duvall – **San Rafael – Caucasian, LGBTQ, Consumer Advocate**

APPENDIX D

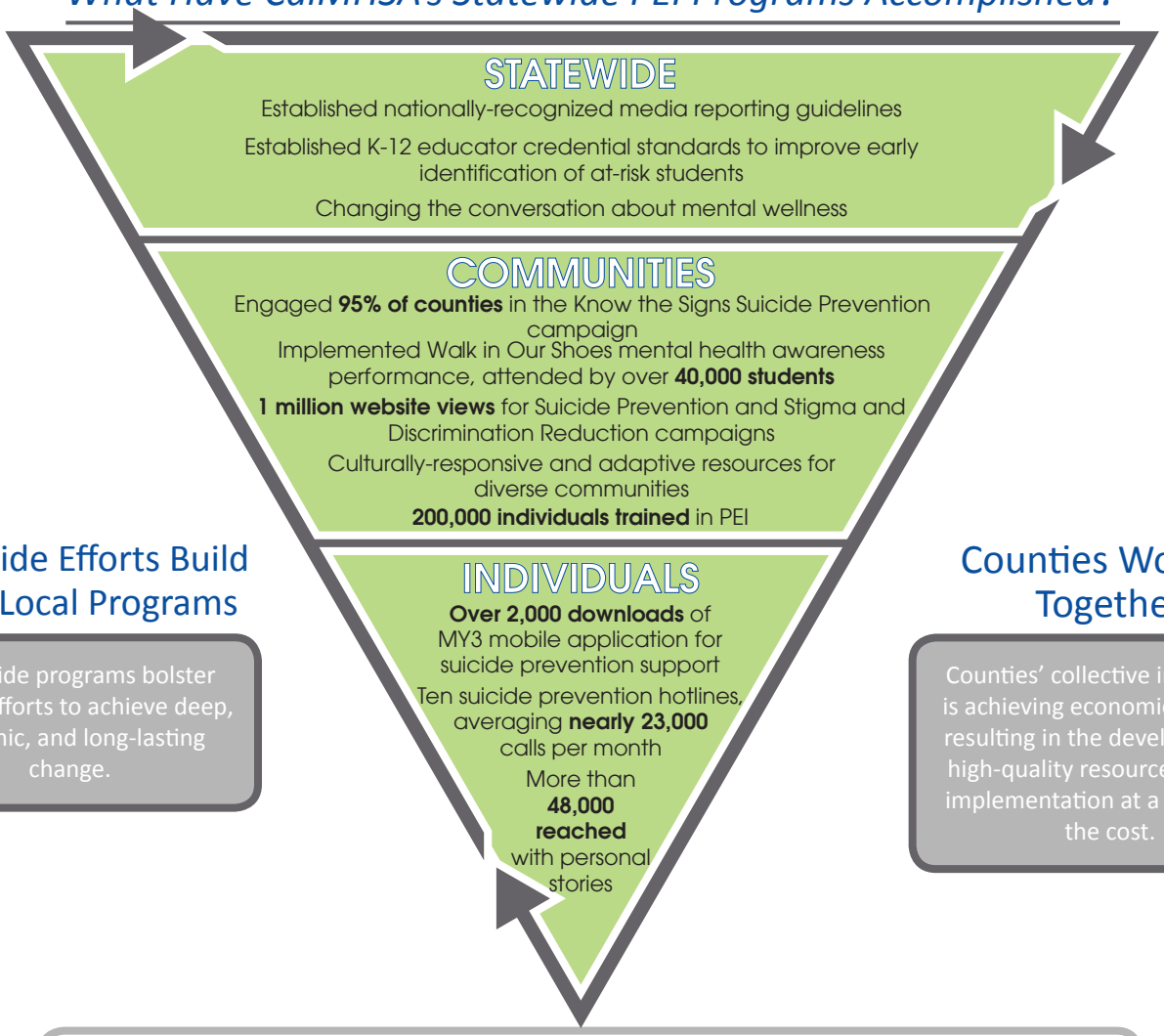
CalMHSA Statewide PEI Overview

Marin County & The California Mental Health Services Authority:
Supporting Mental Health Through Statewide Prevention and Early Intervention Programs

Affirming that Each Mind Matters in California

Through the *California Mental Health Services Authority* (**CalMHSA**), counties are leveraging their *Proposition 63* (**Mental Health Services Act**) resources to support Prevention and Early Intervention (**PEI**) statewide programs that are preventing suicide, improving student mental health, and reducing stigma and discrimination.

What Have CalMHSA's Statewide PEI Programs Accomplished?



Statewide Efforts Build Upon Local Programs

Statewide programs bolster county efforts to achieve deep, systemic, and long-lasting change.

Counties Working Together

Counties' collective investment is achieving economies of scale; resulting in the development of high-quality resources for local implementation at a fraction of the cost.

RESULTING IN **WELLNESS** & RECOVERY

Research demonstrates that PEI programs effectively reduce the risk of consequences related to untreated mental illness. PEI programs address multiple levels of prevention, focusing on improving the overall health and wellness of whole populations, changing knowledge, attitude and awareness of mental health conditions, and encouraging and facilitating help-seeking among those who are experiencing mental health challenges.

A California Legacy

A unique spotlight is on California as one of the most innovative states implementing programs to promote mental health at an unprecedented scale. The Phase Two Plan continues this legacy. California's collective commitment to mental wellness thrives outside of California, as other states and counties adopt and benefit from these locally-developed programs.

EACH MIND MATTERS
California's Mental Health Movement

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

WELLNESS • RECOVERY • RESILIENCE

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

Funded by counties through the voter-approved Mental Health Services Act (Prop 63).

Prevention & Early Intervention Strategies working in Marin County

Marin County has benefited from statewide efforts: CalMHSA's multi-faceted PEI statewide projects are designed to complement local activities. Here are a few examples of the local impact of statewide PEI programs on Marin County residents.

Marin County's **communities** are **becoming more aware and responsive** to individuals with mental health challenges or thoughts of suicide

Relationships in Marin County are becoming **more compassionate and supportive**

Individuals in Marin County have improved **access to crisis support services**

The ***Know the Signs*** Suicide Prevention Campaign informs Californians of 3 things: The warning signs for suicide, how to talk to someone about suicide, and how to identify helpful resources. In California, 40-45% of households have seen the Know the Signs Suicide Prevention Campaign. According to a RAND evaluation, Californians who have seen the Know the Signs messages have higher confidence they can intervene to stop suicide.

Directing Change is a statewide contest that engages students in creating videos about suicide prevention and stigma and discrimination reduction. In Marin County, **7** Directing Change submissions were received in the last two years, and participating schools received stigma and discrimination reduction and suicide prevention programs. The 2014 high school statewide winning video in the eliminating stigma category was from Marin County.
Novato High School: Spencer Wilson and Bradley Virshup for "Bouy"

Student feedback on the Directing Change contest: *"The topic of suicide hits close to home for our school; we have had two students die by suicide, causing our school to change entirely. The Directing Change student video contest was a great way for us to get involved with suicide prevention. We hope that through the video we can give others hope and encourage them to reach out."*

Each Mind Matters, California's mental health movement is a community of individuals and organizations dedicated to a shared vision of mental wellness and equality. Since May 2013, there have been more than **600** website visits from Marin County residents to *EachMindMatters.org* demonstrating the county's strong interest and support for this mental health movement.

Mental Health First Aid (MHFA) educates individuals on how to assist someone experiencing a mental health related crisis. In the MHFA course, participants learn risk factors and warning signs for mental health and addiction concerns, strategies for how to help someone in both crisis and non-crisis situations, and where to turn for help. Since 2012, over **200** people in Marin have been trained and there are at least **6** MHFA trainings being offered in FY2014-15.

Regional K-12 Student Mental Health Initiative builds the capacity of schools and communities to implement prevention and early identification strategies that promote student mental health. From July 2012 to June 2014, **89** trainings were held in Marin County, with nearly **3,000** individuals trained in mental health topics, such as suicide prevention and bullying prevention.

Kognito Interactive is an online interactive gatekeeper training that uses virtual students and role-playing simulations to prepare learners to recognize when a student is exhibiting signs of psychological distress, and manage a conversation with the student with the goal of connecting them with the appropriate support service**.** Through the California Community Colleges Student Mental Health Program, *Kognito Interactive* training is available to faculty, staff, and students at the College of Marin.

CalMHSA has expanded the reach of 24/7 crisis hotline services as well as the types of community support services they provide. Suicide Prevention & Community Counseling of Family Service Agency of Marin receives **4,000** calls (on average) each year from Marin County residents and over **12,000** crisis calls annually. With CalMHSA's additional support, FSA Marin has also trained over **1,000** Marin County residents in suicide prevention.

Do you have questions or want more information? info@calmhsa.org
Visit www.calmhsa.org or email
Version created: 12/9/14

APPENDIX E

Client Choice and Hospital Prevention Program Description and 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.

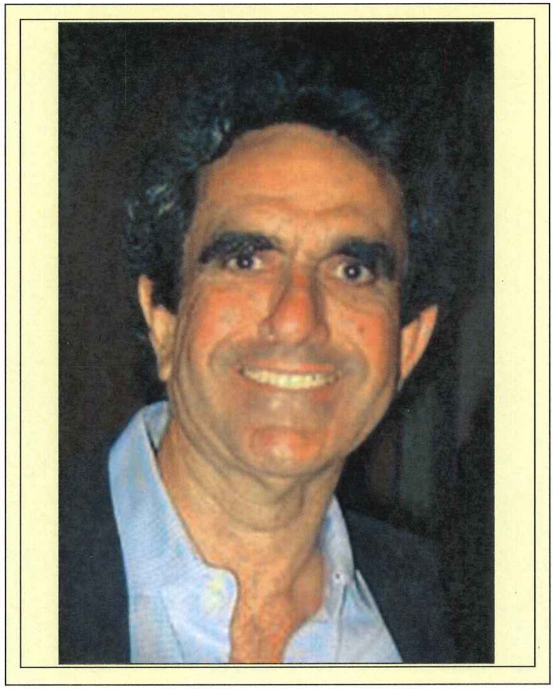
Crisis Planning (partnerships between providers and clients): Offered by Community Action Marin (CAM), peer staff helps individuals articulate and document their support options to prevent a crisis as well as their support preferences during a time of crisis. A person can name the individuals he or she 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.



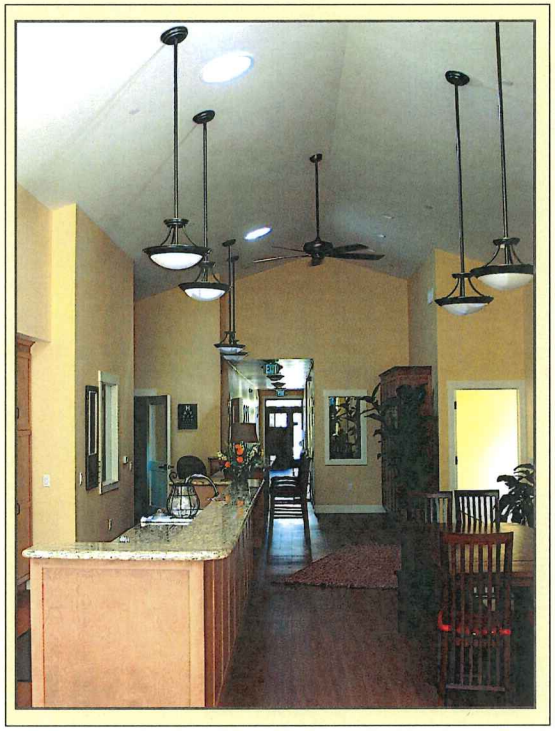
Casa René

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

APPENDIX F

Client Choice and Hospital Prevention Program Logic Model

CCHPP: Crisis Residential Logic Model

Resources

Partners

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

Referral System

House for Program

Activities

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

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

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

Outputs

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

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

Number of program staff trained to use SBIRT model

Number of substance use screenings completed by program residents

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

Outcomes: Short Term *(knowledge/attitudes)*

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

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

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

Outcomes: Intermediate /Long Term *(behavior)*

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

Peer and professional program staff report working as equal partners

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

Changes are made to improve quality of crisis system

Partners report that the quality of crisis services is improved.

The number and percentage of involuntary and voluntary hospitalizations is reduced

Individuals with co-occurring disorders have improved outcomes

Individuals who are served at the house for the program demonstrate better illness self-management (MH and SU)

Impact

System transformation in response to mental health crisis

TRANSFORM MENTAL HEALTH SYSTEM

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

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

APPENDIX G

Client Choice and Hospital Prevention Program Defining Quality Crisis Mental Health Services

Defining Quality Crisis Mental Health Services

In June and July 2014, nine providers involved in the CCHPP were interviewed and asked to define Quality Crisis Mental Health Services, and the Advisory Committee was asked to review their responses. Below is the resulting description:

Elements of Quality Crisis Mental Health Services
The current crisis mental health system is working toward these elements.

- **Client Treated as a Whole Person:** Listening to and understanding the client and family members' stories is an important element of quality services and reduces stigma about the use of crisis mental health services. The client is treated as a whole person with many types of needs.
- **Strong Partnerships**: The crisis mental health system understands and accommodates complexity with strong partnerships and inclusion of service providers, peer providers, substance use providers, primary care providers, family members and community resources.
- **Accessible Services:** Clients, family members and service providers know how to use and navigate the crisis mental health service system.
- **Timely, Thorough Assessments**: Assessments are thorough and occur as early as possible. Time is taken to understand client's needs, perspective and goals. Clients feel heard.
- **Service Options and Client Choice:** Client has access to many programs/different options/different modalities and has a choice of services in their own community.
- **Increased Connections:** The client develops relationships and connections to aid in moving away from crisis.
- **Support to Prevent Mental Health Crisis:** Quality crisis services continue after the crisis to prevent the next crisis by providing support to reduce isolation, obtain/maintain housing, encourage relational support and gain employment.

Other terms that were used in describing quality crisis mental health included: Least restrictive, dignity, respect, feel safe, empowered, quality setting, compassion, reducing isolation

Quotes

- "Quality is when clients feel good about being there and providers feel good about working there"
- "Quality is not just handing our resources in a packet. It is in sharing their story and holding their fears while they move out of crisis."