December 6, 2016

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

SUBJECT: Department of Health and Human Services, Division of Behavioral Health and Recovery Services: Approve the Mental Health Services Act (MHSA) FY 2016-17 Annual Update.

Dear Supervisors:

RECOMMENDATION: Authorize the President to approve the Mental Health Services Act (MHSA) FY 2016-17 Annual Update.

SUMMARY: In FY 2016-17, approximately $11,314,518 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 setting and youth activities ($2,091,015);
- 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 (INN) 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 ($329,250); 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 ($547,523).

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 2015-16 are included in the MHSA FY 2016-17 Annual Update.
This Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations Section 330, Community Planning Process. The draft Mental Health Services Act (MHSA) FY 2016-17 Annual Update was circulated to representatives of stakeholder interest and a legal notice ran in the Marin Independent Journal (IJ) seeking public comments from interested parties for thirty (30) days on the Marin County MHSA webpage beginning Friday, June 10, 2016 and ending on Sunday, July 10, 2016. On Tuesday, July 12, 2016, the Mental Health Board provided its recommendations and feedback as well. All input has been considered and appropriate adjustments have been incorporated into the MHSA FY 2016-17 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.

FISCAL IMPACT: Funds for on-going costs in the MHSA FY 2016-17 Annual Update are included in the existing Behavioral Health and Recovery Services budget in the Mental Health Prop 63 Fund. 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

**County/City:** Marin  
- Three-Year Program and Expenditure Plan   
- Annual Update  
- Annual Revenue and Expenditure Report

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<tr>
<th>Local Mental Health Director</th>
<th>County Auditor-Controller / City Financial Officer</th>
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<tbody>
<tr>
<td>Name: Suzanne Tavano</td>
<td>Name: Roy Given</td>
</tr>
<tr>
<td>Telephone Number: (415) 473-6809</td>
<td>Telephone Number: (415) 473-3736</td>
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<tr>
<td>E-mail: <a href="mailto:STavano@marincounty.org">STavano@marincounty.org</a></td>
<td>E-mail: <a href="mailto:RGiven@marincounty.org">RGiven@marincounty.org</a></td>
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<td>Local Mental Health Mailing Address:</td>
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<tr>
<td>Behavioral Health and Recovery Services</td>
<td></td>
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<tr>
<td>20 North San Pedro Road, Suite 2028</td>
<td></td>
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<tr>
<td>San Rafael, CA 94903</td>
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I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the MHSA. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

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

_Suzanne Tavano_  
Local Mental Health Director (PRINT)  
Signature  
Date 9-15-16

I hereby certify that for the fiscal year ended **June 30, 2015**, 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, **February 1, 2016** for the fiscal year ended **June 30, 2015**. I further certify that for the fiscal year ended **June 30, 2015**, 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.

_Roy Given_  
County Auditor-Controller / City Financial Officer (PRINT)  
Signature  
Date 10-26-16

---

1 Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)  
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)
MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES
MENTAL HEALTH AND SUBSTANCE USE SERVICES DIVISION

MENTAL HEALTH SERVICES ACT

FY2016-2017 ANNUAL UPDATE
REPORTING FY2014-2015
SERVICES AND OUTCOMES

Year 1 of the
MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN
for FY2014-15 through FY2016-17
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Director’s Introduction

Dear Community Members,

I would like to thank you for your interest in the first year of implementation of Marin’s Mental Health Service Act Three Year Program and Expenditure Plan for FY2014-15 through FY2016-17. The advancement of programs and initiatives within the plan would not have been possible without the involvement and support of the Marin Mental Health Services Act Advisory Committee, Mental Health Board, Cultural Competence Advisory Board, and County Board of Supervisors, and of course the many program staff who worked with commitment and passion in delivering the services. A great deal of effort by these entities not only went into the planning and development of services, but also their ongoing monitoring, evaluation and enhancement. These activities were conducted in the spirit of quality assurance and improvement and with focus on program outcomes and effectiveness. This empirical data was used to determine continuation, modification or discontinuance of initiatives.

The first year of the MHSA Three-Year Plan, FY2014-15, was one of significant growth and development in the Marin continuum of community mental health and substance use services, ranging from robust population-based Prevention and Early Intervention initiatives to expansion of intensive “whatever it takes” Full Service Partnerships for adults diagnosed with serious mental illness and youth with serious emotional disturbances. Particularly notable throughout the delivery system was the growing emphasis on integration of mental health and substance use services. Promotores made important advancement in engaging Latino residents in rural and agricultural regions of the county. The Latino Family Health project was very successful in providing culturally and linguistically appropriate early intervention services and health promotion to primarily Spanish speaking members of our central region. In addition to these and many other very successful programs and services, the Mental Health Services Act funded our internship program for psychologists, which is accredited by the American Psychological Association (APA), clinical social workers and marriage and family therapists. These interns greatly contributed to expanding the racial and cultural diversity of our workforce and to implementing a variety of evidence based practices.

Community involvement was essential in designing the wide array of services provided under the Mental Health Services Act in FY2014-15, as was the on-going evaluation and monitoring conducted by our advisory boards. We look forward with gratitude to your on-going participation in our efforts.

With warm regard,

Suzanne Tavano, Ph.D.
Director, Mental Health and Substance Use Services
FY2016-2017 MHSA Annual Update Stakeholder Review

We welcome feedback on the FY2016-2017 MHSA Annual Update. The required thirty (30) day public comment period for the MHSA Annual Update begins on Friday, June 10, 2016 and ends on Sunday, July 10th, 2016.

For a copy of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 or a copy of the FY2016-2017 MHSA Annual Update, please call: 415.473.7465 or you can find it on our website at: https://www.marinhs.org/mhsa.

A Public Hearing for the FY2016-2017 MHSA Annual Update will take place at the Mental Health Board Meeting on Tuesday, July 12, 2016 at 6:00 pm at 20 N. San Pedro Road, San Rafael, CA 94903 in the Point Reyes Conference Room. The public is welcome.

To get involved with MHSA in Marin County, please contact:

Dr. Suzanne Tavano, Director
Department of Health and Human Services
Mental Health and Substance Use Services Division
20 N. San Pedro Road, Suite 2021
San Rafael, CA  94903
415-473-6809 phone
stavano@marincounty.org email
MHSA Annual Update FY2016-17 Executive Summary

The FY2016-17 MHSA Annual Update provides an opportunity to report on outcomes and activities from FY2014-15, an update on the programs for FY2015-16, and changes expected in FY2016-17. FY2014-15 is the first year of implementation of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 and this report contains information about the new and changed programs described in the MHSA Three-Year Plan.

For the most part, the programs have rolled out as expected for year 1 of the MHSA Three-Year Plan. There are a few programs that experienced delayed implementation and a few that have been adjusted along the way. All changes to programs have been reported in this MHSA Annual Update for FY16-17 or through a previous MHSA Three-Year Plan amendment in June 2015. All MHSA related Annual Updates and the MHSA Three-Year Plan Amendment can be found at: www.marinhhs.org/mhsa.

The MHSA programs continue to result in very positive outcomes – reaching underserved populations, decreasing negative outcomes associated with mental illness, and furthering our understanding of the community’s needs. Data gathering, reporting and analysis continues to be improved, although changes in local programs and providers, as well as State systems and requirements, provide ongoing challenges to providing consistent data. The program narratives provide details about each program, including program descriptions, outcomes and expected changes. Many of the programs include a client story to illustrate the work and outcomes supported by MHSA.

Community Services and Supports (CSS)

CSS programs have overall led to very positive outcomes for participants. The charts shown in the report highlights outcomes for Marin’s CSS Full Service Partnerships (FSPs).

Outcomes data 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 while enrolled in the program.

Prevention and Early Intervention (PEI)

Prevention and Early Intervention (PEI) continues to expand its efforts to reach un/underserved communities. In FY14-15, promotores were established in West Marin, programs in diverse school districts were initiated, and TV shows about mental health were produced in English and Spanish. Services are continuously adjusted to best serve the clients, identifying and responding to their varied needs.

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

Innovation (INN)

Marin concluded its first Innovation Plan in FY2014-15 – the Client Choice and Hospitalization Prevention Program (CCHPP). The Plan developed a community-based residential crisis service in a
homelike environment that integrates crisis intervention and stabilization with wellness and recovery principles. The Plan resulted in increased partnership among agencies and with peer providers, decreased use of locked crisis facilities, and increased client participation in preventing and handling crisis events.

Stakeholder meetings were held in FY2014-15 to develop the new Innovation Plan – Growing Roots: The Young Adult Services Project. The Plan will focus on reducing disparities by working closely with the Transition Age Youth (TAY), 16-25 year olds, from un/underserved populations who are at risk for or experiencing a mental illness and informal providers who successfully engage them. The Innovation Plan was approved by the Mental Health Services Oversight and Accountability Commission on April 28, 2016 and implementation has already begun.

Workforce Education and Training (WET)

The goal of Marin’s MHSUS Workforce Education and Training Program is to develop a workforce that is culturally competent, linguistically and culturally reflective of the communities that are served, and able to offer integrated treatment for co-occurring disorders. Some of the key strategies have included training and mentoring to assist consumers and family members to enter the public mental health workforce; providing stipends for bilingual and bicultural interns through partner CBOs and MHSUS’ APA accredited internship program; and providing training for mental health and substance use providers in identifying and responding to clients with complex conditions.

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 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 handwriting prescriptions, and the legacy billing system (INSYST) needed upgrading and modernization.

Mental Health Services Act Principles

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

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

The MHSA has five (5) components:

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

B. Prevention & Early Intervention (PEI)
   PEI funds are intended to prevent mental illness from becoming severe and disabling. It aims to reduce risk factors for mental illness as well as increase access to services for underserved populations by reducing stigma, providing accessible services and linking people to appropriate services.

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

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

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

Mental Health Services Act (MHSA) Background

In November 2004 California voters approved Proposition 63, the Mental Health Services Act (MHSA), intended to expand and transform community mental health services throughout California. While the proposition passed with 54% of the vote statewide, Marin County residents voted 63% in favor. The MHSA raises additional taxes for the State, which are then allocated to respective county mental health programs under extensive regulations developed by the then State Department of Mental Health, now known as the Department of Health Care Services. WIC § 5891 states that MHSA funds may only be used to pay for MHSA programs.

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

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

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

WIC § 5484 states that Three-Year Plan and Annual Update drafts must be posted for a thirty (30) day Public Comment period and the Mental Health Board shall conduct a public hearing on them at the close of the comment period. MHSA Three-Year Program and Expenditure Plans and MHSA Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within thirty (30) days after Board of Supervisor adoption.

The MHSA Three-Year Program and Expenditure Plan is different than an MHSA Annual Update. CCR § 3310 states that a county shall update the MHSA Three-Year Plan annually. An MHSA Annual Update includes an update to the MHSA Three-Year Plan addressing the elements that have changed, the service outcomes for the reporting year and the coming year’s expenditure plan.
CULTURAL COMPETENCY ADVISORY BOARD (CCAB)

Overview

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 Ethnic Services Manager (ESM) conducted targeted outreach to culturally diverse division staff, service agency partners, consumers, family members and community advocates to develop the CCAB membership. A list of current members can be found in Appendix A.

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 ESM oriented the Board to 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.

Actual Outcomes

MHSUS’ Cultural Competence Advisory Board (CCAB) continued to play an active role in many activities and initiatives to reduce stigma and to improve culturally competent mental health and substance use services. In addition, MHSUS developed a full-time permanent position for an Ethnic Services Manager, whose responsibility was later expanded to include managing Marin’s MHSA Workforce Education and Training (WET) program. Accomplishments of the CCAB are as follows:

- Planned and implemented a second one-day, countywide cultural competency training. Due to the popularity of the last year’s one-day cultural competency training, CCAB duplicated its effort by mobilizing nearly the same resources and subject matter/cultural experts which 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 cultural issues related to race/ethnicity, sexual
orientation, gender-identity and age. The training served ninety (90) participants and evaluations by participants indicated an average score of “very good” on a 1-5 scale (poor to excellent).

- Due to the popularity of the ongoing cultural competency trainings, CCAB conducted a series of 3-hour culture-specific trainings and monthly introductory cultural competency trainings. Culture-specific trainings included working with the LGBTQ and Vietnamese cultures. Also, a training in Culturally and Linguistically Appropriate Services (CLAS) Standards was offered to provide staff an opportunity to understand the value and importance of language in accessing care and services.

- Eight (8) MHSUS staff went through an intensive 2-day Interpreter Training where they learned strategies and techniques to provide effective interpreter services for other staff and their consumers. Spanish and Vietnamese were the focus languages for the trainings.

- CCAB continued to advocate for improving access to mental health and substance use services by the Latino community of Marin. Through the use of PEI funds, the promotores program expanded to include West Marin. Additionally, a school-age resource specialist was hired through a PEI contract with Bay Area Community Resources (BACR) to provide education, prevention and service linkages for students and families who are at risk for or experiencing mental health and/or substance use concerns.

- CCAB’s Media and Outreach committee advocate for and participated in the production of six (6) public education/awareness TV shows. Three (3) of the shows were produced in Spanish titled “Latinos en la Casa” and three (3) in English entitled “Meaningful Mental Health.” The shows feature community leaders, consumers and professionals addressing a range of topics related to mental health and substance use services, and resources.

**Challenges and Upcoming Changes**

In **FY2015-16**, CCAB is conducting research and analysis of AB1421 also known as Laura’s Law or Assisted Outpatient Treatment (AOT). Consumers and family members of CCAB expressed concerns about the possible misapplication of AOT as it may disproportionately target people of color and impinge on people’s civil rights if adopted by the county’s Board of Supervisors.

The persistent lack of racial/ethnic diversity, particularly African American clinicians, in MHSUS’ staffing composition, negatively impacts access to and delivery of culturally competent and responsible services and interventions. CCAB is analyzing MHSUS applicant recruitment, screening, interviewing and hiring practices in order to make recommendations to the director regarding any areas for improvement. CCAB will hopefully engage and partner with the county’s Human Resources Department to analyze past demographic data of applicants to determine if the system and practice of hiring may suggest implicit biases of hiring authorities.

Also, CCAB will analyze existing MHSUS programs and agency partner contracts to determine the penetration rate of racially/ethnically un/underserved communities in accessing services and care. If programs and/or contracts demonstrate poor penetration rates by underserved communities, CCAB will develop its findings and make recommendations for improvements to the MHSUS Director.
Lastly, CCAB will engage ethnic communities who conduct community-defined or informal practices that address mental illness and substance use disorders to possibly collaborate with MHSUS. CCAB values the role and importance of community, faith and spirituality in consumers’ and family members’ lives. CCAB will investigate the complementary roles of evidenced-based and community-defined practices in the treatment and care of un/underserved communities.
**PREVENTION AND EARLY INTERVENTION**

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

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

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

Recognizing that increased funding and services are not 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.
Prevention and Early Intervention (PEI)  
Prevention and Early Intervention Overview

Annually, the PEI Committee completes a survey about the PEI Committee. Results about collaboration efforts include:

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<td>Participation on the PEI Committee helps my organization to develop expertise in MH prevention and programs.</td>
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<td>3.29</td>
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<td>The PEI Com works collaboratively with other efforts in the community to address issues.</td>
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<td>3.31</td>
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<tr>
<td>Participation on the PEI Com helps my organization to collaborate effectively with other organizations.</td>
<td>2.89</td>
<td>3.29</td>
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<td>The PEI Com contributes to the development of a mental health system of care.</td>
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<td>3.35</td>
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</table>

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

The rating about working collaboratively with other efforts in the community increased significantly this year, likely due to conducting a series of Resource Roundtables to provide information and connections to PEI providers to increase their ability to refer clients to needed services.

Clients Served

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.
Prevention and Early Intervention (PEI)

Prevention and Early Intervention Overview

PEI 14/15: Age Group

- 0-15: 1179 (30%)
- 16-25: 299 (8%)
- 26-59: 1048 (26%)
- 60+: 1443 (36%)
- Unknown: 10 (0.3%)

PEI 14/15: Race/Ethnicity

- Hispanic: 2204 (56%)
- White: 1165 (29%)
- Asian: 210 (5%)
- African American: 149 (4%)
- Multi: 138 (4%)
- Native American: 89 (2%)
- Pacific Islander: 134 (4%)
- Not Reported: 1577 (40%)

PEI 14/15: Primary Language

- Spanish: 1577 (40%)
- English: 1523 (38%)
- Not Reported: 138 (4%)
- Vietnamese: 730 (18%)
- Chinese (0.1%)
- Russian (0.02%)
- Farsi (0.02%)

PEI 14/15: Gender

- Male: 1613 (41%)
- Female: 2335 (59%)
- Transgender/Other: 4 (0.1%)
- Unknown: 22 (0.6%)
The narratives in this report include program descriptions, outcomes, and upcoming changes.

Upcoming Changes

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, including ending some and starting new ones. In addition, the previous Annual Update and the June 16, 2015 MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 Amendment include limited changes to existing programs. This Annual Update does not contain significant changes to PEI programs.

During FY2015-16, the State approved revised PEI Regulations. The regulations include changes to program categorization, types of required programs, required demographic data, and reporting on referrals and duration of untreated mental illness. Marin’s PEI component will begin implementation of these changes in FY2016-17. We expect to complete implementation in FY2017-18 by bringing programs in compliance with the regulations during the development and implementation of the next MHSA Three-Year Program and Expenditure Plan FY2017-18 through FY2019-20.
EARLY CHILDHOOD MENTAL HEALTH (ECMH) CONSULTATION

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 pre-school students (0-5), and their families, who attend subsidized pre-schools. These students are approximately 60% Latino and/or Spanish speaking, 5% Asian, 3% African American, and 10% multi-racial. The majority of families are low-income. The children and families face risk factors including poverty, racism, social inequality, trauma, adverse childhood experiences, substance use, and others. In addition, the staff at the subsidized pre-schools are the target population for the training in recognizing and responding to risk factors and signs of emotional disorders.

Program Description

- Prevention: Reducing Risks Related to Emotional Disturbance

Early Childhood Mental Health Consultation (ECMH) is promoting the mental health of children 0-5 by helping teachers and parents to observe, understand, and respond to children’s emotional and developmental needs. Childcare providers’ skills are expanded by receiving training and ongoing
coaching to integrate evidence based practices and best practices into their daily interactions with children and families. Practices include “Powerful Interactions,” “Social and Emotional Foundations for Early Learning,” and “Triple P.” These increase the provider’s ability to reduce behavioral issues in the classroom, increase the social-emotional skills of the students, and identify and respond to behaviors that may be due to mental or emotional difficulties.

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

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

Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by ECMH consultants, who are licensed mental health providers. They make the referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the “Access and Assessment 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.

**Expected Outcomes**

Early Childhood Mental Health Consultation is intended to:

- **Reduce Prolonged Suffering** for those at significantly higher risk or mental illness by increasing protective factors and reducing risk factors.
- JFCS’ “Consultation Questionnaire” is completed by pre-school staff to track changes in relevant knowledge and skills. The “Parents’ 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 for the target population:

- Early Childhood Mental Health Consultation (ECMHC) is a practice-based method that is emerging as an effective strategy for supporting young children's social and emotional development and addressing challenging behaviors in early care and education settings (Gilliam & Shahar, 2006). ECMHC aims to strengthen the capacity of staff, families, programs, and systems to promote positive social and emotional development as well as prevent, identify, and reduce the impact of mental health problems among children from birth to age 6 (Kaufman et. al., 2012). As a result, more and more states and communities are investing in ECMHC programs. Georgetown University Center for Child and Human Development (GUCCHD) faculty are nationally-recognized leaders in the field of early childhood mental health consultation, and have drawn on their expertise to help states and programs across the country build their capacity for delivering and evaluating ECMHC services for young children and their caregivers.
- The Devereaux Early Childhood Assessment-Clinical (DECA-C) is an evidenced based practice (Devereaux Foundation and the Devereaux Early Childhood Initiative). The use of the DECA-C as a tool to assess at-risk children ages 3-5 provides us with a valuable framework for working with parents and teachers on a specific child’s behavior with emphasis on the child’s protective factors and best ways to build resilience.

Actual Outcomes

In FY2014-15 ECMH provided consultation for 14 Marin County subsidized preschools and one community playgroup. 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.

In addition to serving the preschools and playgroup, the program collaborated with Early Head Start to institute a system for identifying and referring all children in Early Head Start in the case of mental health concerns. ECMH continues to collaborate with the County Office of Education to implement the California Teaching Pyramid (evidence based) to provide mental health promotion and early intervention services for students in pre-school through 3rd grade.
Prevention and Early Intervention (PEI)
Early Childhood Mental Health (ECMH) Consultation

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of childcare staff that received ECMH consultation and/or training.</td>
<td>160</td>
<td>129</td>
</tr>
<tr>
<td>Number of children served by trained childcare staff.</td>
<td>800</td>
<td>661</td>
</tr>
<tr>
<td>Percent of children served that come from un/underserved populations (Latino, Asian, African American, West Marin).</td>
<td>70%</td>
<td>82%             N=661</td>
</tr>
<tr>
<td>Childcare providers receiving ECMH Consultation that report:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• increased ability to find alternative solutions to problems</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>• increased understanding of children’s experiences and feelings</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>• increased willingness to provide care to a difficult child</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>• increased effectiveness in communicating with parents</td>
<td>81%</td>
<td></td>
</tr>
<tr>
<td>• increased knowledge about sensory needs and environmental supports</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td>Parents/primary caregivers that received education about their child’s emotional development, individually or in workshops.</td>
<td>200</td>
<td>204</td>
</tr>
<tr>
<td>Children/families provided prevention services through ECMH Consultation (intervention plan, warm hand-off, case consultation, etc.).</td>
<td>75</td>
<td>110</td>
</tr>
<tr>
<td>Children in childcare setting served by ECMH consultants that were retained in their current program, or transitioned to a more appropriate preschool setting.</td>
<td>100%</td>
<td>100% retained N=661</td>
</tr>
</tbody>
</table>

Satisfaction

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent).</td>
<td>75%</td>
<td>100%   N=17</td>
<td></td>
</tr>
<tr>
<td>Childcare providers receiving ECMH Consultation services that report satisfaction with the services (rating overall quality of services as Good or Excellent).</td>
<td>75%</td>
<td>94%    N=67</td>
<td></td>
</tr>
</tbody>
</table>

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

In FY2014-15, ECMH was discontinued in a few pre-schools with lower rates of underserved populations in order to expand services to non-pre-school settings that were lacking services, such as a playgroup in West Marin. This meant that fewer people were served overall, but a higher proportion of children from underserved populations was reached. 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 **FY2015-16**, the program was implemented as expected. There are continued efforts to increase the evaluation response rate from parents.

In **FY2016-17**, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.
EARLY CHILDHOOD MENTAL HEALTH CONSULTATION – CLIENT STORY

Mark was 4.5 years old when he was enrolled in his current preschool. This was his third preschool - the last school required his parents to provide a 1:1 aid, which resulted in them leaving the program. Given the history of school “failure,” an ECMH consultant immediately began services for this child, his parents and the school staff. Mark’s behaviors observed by the consultant in the classroom included an extremely loud voice, running throughout the school, and knocking over children. Mom reported that Mark often hit her. The consultant met with the teachers and parents several times in the next month and the ECMH Occupational Therapist (OT) also observed him in the classroom. It became clear that the parents were struggling with differences in parenting styles, so they were guided back to a Kaiser specialist with whom they had previously consulted. OT sessions were provided. A DECA-C was completed and a support plan created by the primary teacher and consultant built on his strengths as identified in the assessment, such as his ability to start and engage in play with other children. The teachers also provided Mark with tools to deal with frustration and provided Mark with a “chill space” in the classroom. Regular meetings were convened to coach the primary teacher and the entire staff on the implementation of the support plan. The consultant also referred the parents to the school district to assess for any delays that would benefit from early intervention services. After several months of coaching, Mom called the school district psychologist who determined from the brief conversation that he did not qualify for an assessment. After placing her own call to the district psychologist, the consultant referred the family to Matrix for help in knowing their rights and the parents now have a plan to work with the school district once Mark enters kindergarten.

As Mark’s behavior vacillated between improvement and regression, the consultant continued to meet with his parents individually and together. Mark’s mother started to reveal mental health issues that plagued her family growing up and followed her into her young adult life. Seven months into consultation Mark came to school very upset, sucking his thumb and told a teacher that his parents had a really bad fight and that they were “wrestling.” The ECMH consultant was called and immediately spoke with the teachers at a staff meeting and a report was made to Children and Family Services. The consultant contacted Mom who revealed further details of domestic violence. This provided an additional perspective to Mark’s out of control behavior as a witness to trauma in an out-of-control home environment. The consultant facilitated a warm hand off for Mark’s mother to the Center for Domestic Peace (CDP). Following their expert advice, Mom presented Dad with an ultimatum and he began therapy. With the help of the consultant, mom was able to talk openly with the site supervisor about the unrest at home, which helped the supervisor better understand Mark’s challenges. Mom was also able to express her appreciation for the school’s support.

The Consultant worked with the teachers to create safety for Mark at school so that possible triggers for his out of control behavior could be avoided. The consultant educated mom about the connection between Mark’s witness of the violence and his hitting her. Mother was referred to parent child therapy to increase her capacity to set limits with Mark while maintaining and improving a healthy attachment. Although Mom did not follow through with this referral, she did return to therapy for herself with a previous therapist. Mark’s mother shared the following on her program evaluation: “(The consultant) helped my family through not only our son’s transitions but the parents too. She gave us great referrals and taught us to be good advocates to our son going to kindergarten. It’s been a wonderful experience. I can only say that the consultant went above and beyond. Our family is eternally grateful for her time and efforts.” Mom is poised to be an effective advocate for her son and work in partnership with school professionals to give Mark the best chance of success.
TRIPLE P (POSITIVE PARENTING PROGRAM) MARIN

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 effective 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. In addition, the program provides parent workshops and individual consultations. Marin has focused on Levels 2 and 3, with some Levels 4 and 5 provider trainings.

Triple P Levels

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Media/Information Campaign to normalize need for parenting help and inform families and providers about services.</td>
</tr>
<tr>
<td>2</td>
<td>Group presentations about general child development and parenting issues.</td>
</tr>
<tr>
<td>3</td>
<td>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.</td>
</tr>
<tr>
<td>4</td>
<td>Individual or group parenting “coaching” over approximately 10 sessions. Usually provided by licensed mental health workers.</td>
</tr>
<tr>
<td>5</td>
<td>5-11 individual sessions with parents with complex issues affecting their parenting. Usually provided by licensed mental health workers.</td>
</tr>
</tbody>
</table>

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 Mental Illness
- Prevention: Reducing Risks Related to Emotional Disturbance

Triple P Marin reduces children’s risk for emotional disturbance, such as likelihood of adverse childhood experiences, by increasing their connection to supportive and skilled caregivers. Triple P provides 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 P 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 direct services for families including Triple P Level 2 and 3 group and individual 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 and Assessment 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.
Expected Outcomes

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.

- Reduce Prolonged Suffering for those at significantly higher risk of mental illness by increasing protective factors and reducing risk factors
  The number and demographics of the families participating in group services will be tracked, as well as outcome data. 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 Triple P, an evidence-based practice (SAMHSA, NREPP) that has been validated for the target populations. Triple P Marin ensures fidelity by providing certification courses, as well as ongoing trainings and technical assistance to support implementation with fidelity. In addition, the Triple P Marin Program Coordinator participates in regional meetings regarding implementation of Triple P.

Actual Outcomes

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 assessing the next steps for the program, it was determined that strategically expanding the pool of trained providers and providing brief intervention services for individual families are priorities.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal FY2014-15</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Triple P providers that received additional training and technical assistance.</td>
<td>12-15</td>
<td>14</td>
</tr>
<tr>
<td>Percent of participating providers indicating that they are skilled in identifying, responding to, and effectively referring at-risk families.</td>
<td>80%</td>
<td>83% N=12</td>
</tr>
<tr>
<td>Number of parents that participated in Triple P seminars and discussion groups.</td>
<td>135</td>
<td>173 unduplicated</td>
</tr>
<tr>
<td>Percent of parent seminars and discussion groups provided in Spanish.</td>
<td>33%</td>
<td>50% N=22</td>
</tr>
</tbody>
</table>
Prevention and Early Intervention (PEI)
Triple P (Positive Parenting Program) Marin

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of parents participating in Triple P seminars and discussion</td>
<td>80%</td>
<td>89% N=258 not unduplicated</td>
</tr>
<tr>
<td>groups reporting satisfaction with the services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of parents that received individual brief intervention.</td>
<td>N/A</td>
<td>54</td>
</tr>
</tbody>
</table>

The target population of Triple P Marin is children 0-15 years old, so the demographics reflect the children of parents participating in Triple P Marin sponsored group or individual services.
Challenges and Upcoming Changes

In FY2015-16, funding was allocated to meet the needs identified during the program assessment in FY2014-15. Access to individual consultations for families who attend group services was expanded. In addition, the pool of trained providers was strategically expanded, including increasing the levels that existing providers are certified in, through targeted trainings. Two refresher trainings are scheduled for May 2016, focusing on fidelity to the evidence based model and addressing implementation issues that providers experience after achieving certification.

In FY2016-17, 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 the expansions described in the paragraph above.
TRIPLE P (POSITIVE PARENTING PROGRAM) MARIN – CLIENT STORY

Sarah is a mother working part time and living in Forest Knolls. She lives with her husband and two children, ages 2 ½ and 6. Sarah came to the San Geronimo Playgroup with her younger child. She described herself as a thoughtful parent who sometimes struggles to set clear limits. Sarah described her issues with being firm about limits as a reaction to how rigid her parents were when she was growing up. This has resulted in some behavioral issues in her children including defiance and intense struggles around completing homework.

Bonnie, a Parent Educator, began monthly visits to the playgroup last October. Sarah asked questions about her toddler and her kindergartener. Bonnie offered some Triple P strategies in a 1:1 format, and when the Triple P Seminar Series was offered in January she invited Sarah to attend. Sarah attended with her husband and two friends to whom she had recommended Triple P. At the most recent playgroup Sarah described the usefulness of the Triple P principles to other parents in the group, reflecting her increased confidence in effectively addressing challenging situations. That started a conversation regarding Triple P and other strategies offered. When the Parent Educator next attends the playgroup, she will bring some tip sheets related to the interests expressed by the group (i.e., aggression, discipline, homework and positive parenting).
TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

Program Overview

In 2009, MHSA PEI funds began the Transition Age Youth (TAY) Prevention and Early Intervention (PEI) program, provided by Huckleberry Youth Programs (HYP) and Novato Youth Center (NYC). TAY PEI provides screening and brief intervention for behavioral health concerns in teen clinics, psycho-education for TAY and community members, which often include parents and providers of TAY, and group services in high schools for at-risk TAY.

Target Population

The target population is 16-25 year olds from underserved populations. 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.

Program Description

- **Prevention:** Reduce Risk Related to Mental Illness
- **Early Intervention:** Intervene Early in the Onset of Mental Illness
- **Access and Linkage to Treatment for those with Serious 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.

**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.
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.

Access and Linkage to Treatment:

- Mental health and substance use screening is conducted for all clients of the teen health clinic. Clients screening positive are then assessed by a clinician and, if identified as experiencing serious mental illness, linked to medically necessary services.

The program improves timely access to services for underserved populations by being located within health 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 and Assessment 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.

Expected Outcomes

Transition Age Youth (TAY) PEI is intended to:

- 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 practices that have been shown to achieve positive impacts with the target population:

- The Global Appraisal of Individual Needs (GAIN-SS) is a validated tool used to screen clients at the Teen clinics for psychosocial concerns.
- The Partners for Change Outcome Measurement System (PCOMS), is both an evaluation and an intervention (evidence based, SAMHSA NREPP). The system consists of two tools, the Outcomes Rating Scale (ORS) and the Session Rating Scale (SRS). The ORS is administered each session to measure progress over time. The SRS is conducted at the end of each session and measures the “therapeutic alliance,” which, based on overwhelming evidence, is directly tied with the progress a client makes in counseling. Counseling staff receive annual training in implementation, as well as a review of scores at monthly supervision meetings to ensure the tools are being properly administered.
- Interventions use evidence based and promising practices, such as Motivational Interviewing (evidence based, SAMHSA NREPP). Counseling staff receives annual training.
- A practice based curriculum is used for school-based groups. An appropriate existing curriculum was not found that addresses acculturation, coping skill development and exploration of social norms to meet the needs of the groups in the schools. Counselors worked with school administrators and community agencies to put together a curriculum that addresses acculturation, coping skills, and exploration of social norms based on Seeking Safety. Curriculum activities and planning have been standardized in available modules; all sessions are reviewed by the Counseling Coordinator.

Actual Outcomes

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. By integrating behavioral health screening into confidential reproductive health services, many youth have both identified issues and received help they would have not otherwise.
## Prevention and Early Intervention (PEI)

**Transition Age Youth Prevention and Early Intervention**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outreach</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of TAY providers trained in recognizing and responding to behavioral health concerns.</td>
<td>10</td>
<td>36</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of TAY participating in psycho-education workshops that show a base level of knowledge regarding risk factors, resources and coping skills.</td>
<td>80%</td>
<td>93% N=79</td>
</tr>
<tr>
<td>Number of TAY attending psycho-education workshops.</td>
<td>50</td>
<td>79</td>
</tr>
<tr>
<td>Number of students participating in at least 5 sessions of school-based groups.</td>
<td>50</td>
<td>55</td>
</tr>
<tr>
<td>Percent of students participating in at least 5 sessions of school-based groups that report an improvement in well-being as measured by the Outcome Rating Scale.</td>
<td>65%</td>
<td>82% N=55</td>
</tr>
<tr>
<td><strong>Early Intervention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of TAY that received Early Intervention services at teen clinics or in school setting. (Range: 1-41 sessions. Average: 4.7)</td>
<td>180</td>
<td>398</td>
</tr>
<tr>
<td>Number of families that engage in Early Intervention services in support of TAY.</td>
<td>30</td>
<td>61</td>
</tr>
<tr>
<td>Percent of clients participating in at least three sessions of brief intervention that report improvement in well being as measured by the Outcome Rating Scale.</td>
<td>65%</td>
<td>84% N=117</td>
</tr>
<tr>
<td>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.</td>
<td>75%</td>
<td>83% N=115</td>
</tr>
<tr>
<td><strong>Access and Linkage to Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of clients screened for behavioral health concerns (GAIN-SS).</td>
<td>550</td>
<td>498</td>
</tr>
</tbody>
</table>

*N = the total number in the sample (i.e. total number who received services or completed a survey)*
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 with both personal experience and understanding of the challenges that youth in our community face. All services are tailored to meet the individual needs of adolescents and support the family unit in increasing communication and functionality.
Challenges and Upcoming Changes

In FY2015-16, there was an expansion of group services in schools to address the increased need for services for recently immigrated youth in two high schools. The groups offer trauma informed counseling and psych-education around issues of acculturation, family dynamics and facing new social norms.

In FY2016-17, 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 the expansion noted in the paragraph above.
TRANSITIONAL AGE YOUTH PEI – CLIENT STORY

Marty is an 18-year-old female who came to Teen Clinic because she was worried about her depression and anxiety, her suicidal ideation, her grades, and a developing eating disorder. Marty initially reported very low self-esteem and strong negative beliefs about herself and relationships. The therapist soon learned that these negative messages had come from a very troubled family in which Marty was treated as a scapegoat and had come to believe that she was the problem. While immediately working with Marty’s beliefs, the therapist also attempted to intervene with the family to help them see Marty in a different way and to address the real issue: a mother with mental illness and her father’s and sisters’ refusal to acknowledge this.

Despite several attempts, however, Marty and the therapist realized that her family was not willing to do anything differently. So the therapist and Marty re-focused on changing Marty’s learned beliefs and behaviors. Fortunately, Marty realized that she was both capable of and very much wanting change for herself. As she continued to work with the therapist, she began developing new and much more positive beliefs about herself and her relationships.

Marty came to see that, in many ways, she is the healthiest member of her family and the most able to have good relationships. As a result she stopped having suicidal ideation, her mood, self-esteem, and eating habits improved, and she began dating—which in the past had seemed unthinkable to her. Marty also worked on what she called her “escape plan”—including getting her driver’s license, improving her grades, and moving forward on plans for college—to help her create her own idea of a healthy family, career, and home.
LATINO COMMUNITY CONNECTION

Program Overview

Latino Community Connection is a multi-layered program to provide behavioral health outreach, engagement, and prevention services in the Latino community. Canal Alliance, a trusted multi-service agency, partners with Novato Youth Center and services in West Marin to train and support Promotores throughout the county. Promotores are trusted community members trained in identifying and responding to behavioral health concerns, including providing peer support and linkages to services. A bilingual behavioral health provider provides brief interventions for individuals, couples and families including psycho-education, coping skills, communication skills, and referrals to appropriate behavioral health services. Clients may also be referred to trauma and stress management groups at Canal Alliance that help them develop coping and stress reduction strategies. In addition, PEI funds co-sponsor a radio show in Spanish on health issues, including mental health and substance use.

Target Population

The target population is Latinos throughout the County, especially newer immigrants facing many stressors and barriers to access of services. The Latino population faces a number of significant risk factors for mental illness including severe trauma, ongoing stress, poverty, family conflict or domestic violence, racism and social inequality, and traumatic loss.

Program Description

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

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

- **Radio Show:** A licensed mental health provider will host a weekly live one-hour radio show in Spanish on the health of Latino individuals, families and communities, in particular mental health topics. It will be broadcast from stations in central Marin, West Marin and other regions in California. A similar program focused on parenting was well received.

- **Promotores Training and Support:** For hard to reach populations, trusted community members provide an effective cultural and linguistic bridge to information and services. This project provides training, supervision and stipends for Promotores to provide mental health and substance use education, identification of risk and signs, and linkages to services. This program increases the efficacy of existing mental health programs by reducing the barriers for accessing those services. In addition it creates a culture shift in the target communities that reduces stigma and increases the natural supports available within the community. MHSUS provides staff time in-kind for training, supervision, and program development by a licensed mental health practitioner.

Prevention:

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

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

Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by the program’s behavioral health provider. Promotores, family advocates and others are trained to identify signs and symptoms and refer clients to the behavioral health provider as needed. The behavioral health provider makes referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the “Access and Assessment 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.
Expected Outcomes

Latino Community Connection is intended to:

- Train Promotores and other front-line workers to recognize and respond to early signs of mental illness.
  The number and type of providers trained will be tracked. Participant surveys are conducted to track changes in knowledge and skill.

- Reduce Prolonged Suffering for those at significantly higher risk of mental illness by increasing protective factors and reducing risk factors.
  The Posttraumatic Stress Disorder Checklist will be completed by group participants upon entry to and exit from the program. Changes for individuals will be tracked and then reported in aggregate.

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

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

- The Promotores program is a practice-based model with a long history. It has been described and studied in many articles, including “The Promotor Model: A Model for Building Healthy Communities” (The California Endowment) and “Promotores: Vital PRC Partners Promote Nutrition and Physical Activity” (Center for Disease Control).

- Promotores and other providers in this program receive training in Motivational Interviewing and trauma informed care as a basis for all of their work.

- The Posttraumatic Stress Disorder Checklist (PCL-C) is a validated tool for assessing symptoms of trauma.

Actual Outcomes

This program is a successful model of behavioral health support for the low-income, Spanish speaking community. Services are accessed quickly, often within the same day. Services are also embedded in a community resource center that provides many other services, so stigma is reduced. Brief interventions are focused on solutions to problems and learning healthy coping strategies. Services are provided by staff that reflect the culture, language and life experience of the community being served. In FY2014-15, four Promotores in West Marin were trained to expand services to their geographically isolated community.

Cuerpo Corazón Comunidad is a weekly radio program in Spanish on topics related to the wellness of Latino individuals, families and communities. It website is: www.cuerpocorazoncomunidad.org. In FY2014-15, 39 programs were aired, with an emphasis on behavioral health knowledge, skills, and community resources.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outreach</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Promotores receiving training about identifying and responding to mental health concerns.</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Number of Family Resource Advocates receiving training about identifying and responding to mental health concerns.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Number of community members receiving behavioral health information/support from Promotores and Family Resource Advocates.</td>
<td>450</td>
<td>1320</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of participants in support groups or individual/family services. (Range of sessions: 1-7. Average: 4)</td>
<td>100</td>
<td>171</td>
</tr>
<tr>
<td>Percent of participants attending a support groups for at least 3 months that experienced improvement in symptoms as measured by the PTSD Checklist (at least 5 point improvement).</td>
<td>80%</td>
<td>100% N=24</td>
</tr>
<tr>
<td>Percent of participants in individual/family sessions reporting improvement in wellbeing.</td>
<td>80%</td>
<td>95% N=140</td>
</tr>
<tr>
<td>Number of family members participating in family sessions in support of the client.</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals receiving prevention services reporting satisfaction with the services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• would use the services again in the future</td>
<td>80%</td>
<td>95%</td>
</tr>
<tr>
<td>• would be very or somewhat likely to recommend the services</td>
<td></td>
<td>94%</td>
</tr>
<tr>
<td>• agree or strongly agree staff were culturally sensitive</td>
<td></td>
<td>92%</td>
</tr>
<tr>
<td>• report services were very or somewhat helpful in addressing their problems</td>
<td></td>
<td>89% N=122</td>
</tr>
</tbody>
</table>

The demographics represent individuals who received individual, group, or family services from Promotores, Family Resource Advocates, or Behavioral Health Coordinators.
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. They have partnered with Novato Youth Center and West Marin county services to implement Promotores in North and West Marin. Staff hired with PEI funds are bilingual/bicultural.

Challenges and Upcoming Changes

In FY2015-16, one of the challenges experienced is the high need for the individual and family services provided by the Behavioral Health Coordinator. There are very limited counseling services available in Spanish or at no- or very low-cost. MHSUS continues to work with the community and existing providers to identify and address services gaps. The West Marin Promotores has been a successful expansion, although due to the large area the four Promotores serve, it can be challenging to meet all of the needs.

In FY2016-17, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.
LATINO COMMUNITY CONNECTION – CLIENT STORY

A Promotora was dropping her kids off at school when she noticed that a 6 year-old boy was crying. He told her he was afraid he was never going to see his father again, due to his arrest by immigration officials that morning. The Promotora asked school officials for permission to talk to the child and she comforted him. The next day, the Promotora talked to the child’s mother, and arranged for her to meet with the program’s Behavioral Health Coordinator for emotional support. She also referred the family to immigration services at Canal Alliance, and helped her call for an appointment. A few days later, the child ran over to the Promotora when he saw her to hug her and let her know that his father was back at home and everything was back to normal. The family often expresses their appreciation for the emotional support and referrals given to them.

Quotes from Promotores regarding the program and their personal growth:

- Being a Promotora motivates me to make changes, to keep educating myself and helping people who are going through difficult moments. We all have problems and sometimes we are not aware that there is help.
- To be a Promotora is a privilege. I have learned to help the community a lot. I have helped them to seek help. I also lead the Zumba groups that we offer to the community, to help them to de-stress, because in these times with so much work, so many children, and so many problems, they need something to relax. That is why we have the Zumba, yoga, and walking groups.
- Being a mental health Promotora has impacted me, I can see the community people as my family and help them regarding the health of the mind. (The Coordinators) have given us gigantic support, classes about how to manage emotional education, and preparing us so that we can always be ready to offer our support to people. It has impacted me very, very much, so I keep on going forward helping people from my heart!
INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

Program Overview

In 2009, MHSA PEI began “Integrated Behavioral Health in Primary Care” to support the integration of mental health and substance use services into primary care clinics serving underserved populations. These programs have served thousands of clients that likely would not have otherwise accessed these services. In FY2014-15, this program significantly changed, in part due to the Affordable Care Act (ACA). The ACA provides for increased mental health and substance services for insured clients, as well as increasing the number of individuals with insurance. PEI will focus on ensuring un- and under-insured individuals can access the behavioral health services provided in primary care settings.

Target Population

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

Program Description

- Intervene Early in the Onset of Mental Illness
- Access and Linkage to Treatment for those with Serious Mental Illness

The ACA provides screening and intervention services for mild to moderate mental health and substance use concerns in primary care settings. PEI provides support to primary care settings to ensure un- and under-insured clients, who often have increased barriers, are able to access those services.

The most common concerns presenting in the primary care setting include depression, anxiety, substance use, and PTSD. If a client screens positive, they are further assessed during the primary care visit, or are referred to on-site behavioral health providers, depending on the clinic. Assessments may include PHQ9, GAD7, or other validated tools. Clients are offered on-site services as appropriate. If an individual is identified as experiencing serious mental illness, they are linked to medically necessary services. On-site providers are trained in evidence-based practices, such as Problem Solving Treatment.
The program improves timely access to services for underserved populations because the target population already accesses the community clinics for primary care. The screening and interventions offered are culturally and linguistically appropriate, utilizing Spanish speaking staff and interpretation for other languages as needed. Due to federal guidelines regarding client copays, the cost of the services can be a barrier for the target population, therefore PEI funds assist in reducing the costs to the client. In addition, PEI supports the Latino Community Connection program, which provides similar services for free in a community-based setting. These two programs work together to assist clients in receiving the most appropriate services available. Services are non-stigmatizing by being offered through sites clients are already accessing and by focusing on issues like stress and wellness rather than “mental health.”

Individuals/families at risk or showing signs of developing mental illness or emotional disturbance are provided risk reduction and early intervention services, or linked other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is provided through assessment and referral by licensed mental health providers in the primary care setting. They make the referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the “Access and Assessment 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.

Expected Outcomes

Integrated Behavioral Health in Primary Care is intended to:

- Screen clients for an array of mental health and substance use issues at primary care clinics for early identification of mental health issues and linkages to appropriate services. Number of clients screened will be tracked.
- Reduce Prolonged Suffering by reducing symptoms and improving mental, emotional and related functioning. Primary care clients are screened for behavioral health concerns. Numbers screened are tracked. Those screening positive are further assessed. If they participate in early intervention the assessment is repeated periodically throughout services. Change in status is measured for each client, then reported in aggregate. Providers track the number and demographics of the clients/families served.

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 by implementing a variety of evidence-based models and tools shown to have positive impact for the target population. Initially the program followed two evidence-based models: IMPACT (SAMHSA NREPP) and SBIRT (SAMHSA NREPP). Some adjustments have been made in consultation with best practices and emerging practices in IBH. Interventions incorporate a number of evidence-based practices, including Problem Solving Treatment with Behavioral Activation (Day A., Baker F., Gath DH,

Actual Outcomes

Fortunately the Affordable Care Act and other federal funds have enabled the four Federally Qualified Health Centers (FQHC) in Marin to significantly expand their behavioral health services. PEI funds are focused on increasing access to these services for the un- and underinsured who often have increased financial and other barriers. Coastal Health Alliance and Ritter Center implement a variety of strategies to reduce these barriers, including drop-in appointments, combining physical and behavioral health services in a single visit, and reduced copays.

The previous IBH programs were continued through December 2014, providing early intervention services for 191 clients. The revised IBH programs were implemented January 1, 2015, so the results represented here are for six (6) months. Due to this, meaningful outcome data is not available at this time.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access and Linkage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of un- and underinsured clients screened for depression (PHQ2).</td>
<td>400</td>
<td>1015</td>
<td>300</td>
<td>326</td>
</tr>
<tr>
<td>Number of un- underinsured clients screened for substance use concerns.</td>
<td>250</td>
<td>179</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Early Intervention</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of behavioral health services provided for un- or underinsured clients. (Range: 1-14 sessions. Average: 2. Total clients: 66)</td>
<td>225</td>
<td>130</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of uninsured clients receiving brief intervention. (Range: 1-11 sessions. Average: 2.5)</td>
<td></td>
<td></td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Number of uninsured clients receiving medication management. (Range: 1-7 sessions. Average: 1.5)</td>
<td></td>
<td></td>
<td>45</td>
<td>66</td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of clients receiving brief intervention reporting satisfaction with behavioral health services.</td>
<td>75%</td>
<td>90% N=10</td>
<td>75%</td>
<td>95% N=59</td>
</tr>
</tbody>
</table>

N = the total number in the sample (i.e. total number who received services or completed a survey)
Integrated Behavioral Health in Primary Care

**IBH 14/15: Age Group**
- 954 (77%)
- 145 (12%) 0-15
- 140 (11%) 16-25
- 6 (0.5%) 26-59
- 11 (1%) 60+
- Unknown

**IBH 14/15: Race/ Ethnicity**
- Hispanic: 598 (48%)
- White: 523 (42%)
- Asian: 49 (4%)
- African American: 23 (2%)
- Multi: 29 (2%)
- Native: 11 (1%)
- Pacific Islander: 6 (0.5%)
- Not Reported: 11 (1%)

**IBH 14/15: Primary Language**
- Spanish: 638 (51%)
- English: 606 (49%)
- Vietnamese: 23 (2%)
- Chinese: 56 (4%)
- Not Reported: 11 (1%)

**IBH 14/15: Gender**
- Male: 556 (45%)
- Female: 689 (55%)
- Transgender/Other: 23 (2%)
- Not Reported: 11 (1%)
Challenges and Upcoming Changes

In FY2015-16, the clinics have continued to refine their expected outcomes based on changes in the uninsured population and workflow to meet federal requirements. They have implemented the Suicide Prevention in Primary Care training and protocols.

In FY2016-17, 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

Mr. Bell self-referred to behavioral health services with multiple problems: obsessive-compulsive disorder, online gaming addiction, homelessness, and poverty. He is well-educated and understands the benefits of counseling services. He is extremely intelligent and is able to be of great benefit to others; he is specifically expert in “non-violent communication” and is able to teach others these difficult to master skills. He has been consistent about attending psychotherapy; however, when he engages in online gaming, it is compulsive and he will go for many weeks with minimal sleep and poor self-care. The goals of psychotherapy have been to support his efforts to remain employed, cope with chronic anxiety associated with his multiple disorders, and provide reality testing and linkage to additional supportive services.
OLDER ADULT PREVENTION AND EARLY INTERVENTION

Program Overview

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

Target Population

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

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 trained to recognize signs of depression and other mental health concerns among older adults and how to get appropriate help.

Early Intervention:

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

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

Individuals at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness is achieved through assessment and referral by JFCS licensed mental health providers. They make the referrals to County Mental Health and Substance Use (MHSUS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County MHSUS go to the “Access and Assessment 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.

**Expected Outcomes**

Older Adult PEI is intended to:

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

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

The program achieves the intended results due to implementing a combination of clinical approaches and program practices that have been shown to achieve positive impacts in older adults. Healthy IDEAS (Identifying Depression, Empowering Activities for Senior) (https://www.ncoa.org/resources/program-summary-healthy-ideas/) is evidence based and a core...
program model. Cognitive Behavioral Therapy is also an evidence-based treatment practice (http://www.currentpsychiatry.com/home/article/how-to-adapt-cognitive-behavioral-therapy-for-older-adults/99ca3de03d6ed62b20b672dce4e56c.html). In addition, commonly used tools are validated, including PHQ9 and GAD7. Providers are trained in the practices and receive follow-up training as needed.

**Actual Outcomes**

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. In FY2014-15 the program launched Caring Connection Volunteers, providing training and supervision for ten (10) volunteers to provide ongoing support to clients who “graduated” from the counseling services.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of clients, community members or providers receiving outreach and educational presentations.</td>
<td>200</td>
<td>251</td>
</tr>
<tr>
<td>Percent of those receiving educational presentations from un/underserved populations (Latino, African-American, Asian, LGBTQ, ESL).</td>
<td>20%</td>
<td>21% N=251</td>
</tr>
<tr>
<td>Number of Seniors At Home clients screened for depression and substance use.</td>
<td>150</td>
<td>168</td>
</tr>
<tr>
<td>Early Intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of low-income clients receiving early intervention services, including care management, depression care, and linkages to services. (Range: 1-38 sessions. Average: 7)</td>
<td>35</td>
<td>49</td>
</tr>
<tr>
<td>Percent of those receiving early intervention from un/underserved populations (Latino, African-American, Asian, LGBTQ, ESL).</td>
<td>20%</td>
<td>20% N=49</td>
</tr>
<tr>
<td>Percent of older adults completing a treatment protocol experiencing a clinically significant reduction in symptoms, as evidenced by a decrease of at least on category of severity: Depression (PHQ) Anxiety (GAD7)</td>
<td>60% 66% N=35 N=30</td>
<td>77% 88% N=35 N=30</td>
</tr>
<tr>
<td>Percent of older adults receiving brief intervention that successfully addressed one or more client goals in their care plan.</td>
<td>75%</td>
<td>88% N=32</td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of clients receiving brief intervention reporting satisfaction with services.</td>
<td>75%</td>
<td>100% N=21</td>
</tr>
</tbody>
</table>
Challenges and Upcoming Changes

In FY2015-16, the mean age of clients was 81 with a range of 65 to 98. For many, the fact that depression is not a normal part of aging was a new idea to them, and this was their first experience with counseling. With this population it often took a number of sessions of psycho-education and relationship building before actual counseling work could proceed. Length of treatment was also impacted by the health status of these clients. Over 90% of the clients have some medical challenges with 40% of the clients having a serious medical condition with related functional, psychological and spiritual impacts. These changing circumstances presented a challenge to the therapy process and often required a flexible treatment plan and revision of client priorities. It was interesting to note that 56% of clients required some form of family involvement, such as collateral services to families and joint counseling sessions. Many of the clients were also provided ancillary services such as senior companions or palliative care.

In FY2016-17 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 PEI – CLIENT STORY

Robert was only 69 but presented as much older and frailer. He went from a robust man of 185 pounds to 125 pounds in one year. Robert had been away from home for 4 months due to cancer surgery, repeat hospitalizations, and rehabilitation hospital stays. He was having a difficult time recovering both physically and emotionally. He was in constant pain, and felt hopeless, depressed and lacked motivation or interest in daily activities. Most of the time he stayed in bed and worried about his current situation and future uncertainties.

Over a period of three years, Robert lost his wife to cancer and his home and business to economic recession. As a single father raising two teenagers, he had struggled to make sure his son and daughter could have as normal life as possible. Then Robert came down with aggressive cancer in late 2014, could no longer live independently, and moved to a senior group home. Robert was referred to the Older Adult PEI program by a home health social worker due to his rapid physical and psychological decline.

At our first visit, Robert expressed how lonely, anxious, and totally discouraged he felt most of the time. Through weekly sessions, a referral to our psychiatrist for a medication evaluation, and through his friendship with a Caring Connection volunteer, Robert’s depression began to lift. He agreed to go out to lunch with the volunteer and started to contemplate the idea of moving near his brother out of state.

Robert was unsure if his physical and emotional challenges could be barriers to the move. He worked hard to come to a decision and a viable plan. Then Robert, with a new-found sense of confidence, made the move to start a new life. As Robert expressed his heartfelt gratitude for his therapist’s “ability to listen and to provide the hope” when he felt so lost, he described his relationship with therapist as “the plug that kept the water in the tub” and “safe haven in the storm.” Robert stated how he felt he “was a drowning man when we started to work together and now I feel as if I have a new lease on life.”
VIETNAMESE COMMUNITY CONNECTION

Program Overview

In 2011, MHSA PEI began the Vietnamese Community Connection program to implement effective ways of engaging the Vietnamese community in behavioral health outreach, education and prevention efforts. The program consists of outreach by Community Health Advocates (CHAs), community events to reduce isolation and increase self-care, and individual/family problem solving sessions. CHAs are trusted community members trained in identifying and responding to behavioral health concerns, including peer support and linkages to services.

Target Population

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

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.
Reducing Risk:

- Building Protective Factors: CHA’s and the program coordinator conduct community activities, such as field trips, walking groups, and discussion groups, to reduce isolation, build social support, and increase self care behaviors. The program coordinator also provides individual and family consultations to assist with problem solving and linkages to other needed 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 and Assessment 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.

Expected Outcomes

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 regarding the impact of the services.

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. CHA’s attended Mental Health First Aid (SAMHSA NREPP) and received training based on Marin’s promotores program model. The group and individual
services incorporate evidence based practices including Dialectical Behavioral Therapy, Cognitive Behavioral Therapy, and Motivational Interviewing.

Actual Outcomes

In FY2014-15, Community Action Marin’s Marin Asian Advocacy Program trained five (5) Community Health Advocates to provide outreach, including hosting community events 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.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outreach</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Community Health Advocates (CHAs) that participated in Mental Health First Aid.</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of individuals that participated in outreach and engagement events.</td>
<td>120</td>
<td>140</td>
</tr>
<tr>
<td>Individuals that participated in support group or home visiting services. (Support groups – Range: 8-40 sessions. Average: 20. Home visits – Range 1-12. Average: 6)</td>
<td>50</td>
<td>60</td>
</tr>
<tr>
<td>Percent of those receiving support group or home visiting services that report an improvement in coping skills.</td>
<td>70%</td>
<td>100% N=28</td>
</tr>
<tr>
<td><strong>Satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of clients participating in support group or home visiting reporting satisfaction with services.</td>
<td>80%</td>
<td>100% N=30</td>
</tr>
</tbody>
</table>

*N = the total number in the sample (i.e. total number who received services or completed a survey)*
Challenges and Upcoming Changes

In FY2015-16, significant changes were made to the Vietnamese Community Connection (VCC) program. MHSUS hired more Vietnamese speaking staff, enabling VCC to focus more on peer outreach and prevention and discontinue the clinical assessment aspect of the program. The new program coordinator is not clinically trained, but is taking the Peer Counseling course provided at the consumer-run Enterprise Resource Center.

In FY2016-17, 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 the adjustments noted above.
VIETNAMESE COMMUNITY CONNECTION – CLIENT STORY

Mai is a middle age woman who moved to the US almost 10 years ago. She is a caretaker for her husband who was involved in the War of Vietnam. She has 3 children living far from her. Mai experienced many traumatic events in Vietnam and also during her first five years in the US. She has experienced symptoms of depression and anxiety, and is a client of MHSUS. Although she has been a county patient, she has not been provided with psychotherapy due to the lack of staff and also due to her fear of “bothering people, and being seen as crazy.” Mai has been coming to psycho-education groups and individual therapeutic contacts provided by this program and attended all the field trips these past two years. She reported, “I really enjoy being out, learning coping skills, and connecting with others in a friendly environment. It’s so fun and I look forward to it every time.” She said her symptoms of depression and anxiety have improved greatly. She has also recruited a few others to join the program and brought her husband out to community events a couple of times.
COMMUNITY AND PROVIDER PREVENTION AND EARLY INTERVENTION TRAINING

Program Overview

In order to support MHSA PEI goals including increasing recognition of mental illness, stigma and discrimination reduction, and implementing effective practices, Marin has designated funds to implement outreach, training and education. A central component is Mental Health First Aid (MHFA). In addition, funds are used for other strategies, such as training in other evidence-based practices; outreach to those who could recognize and respond to mental illness, including individuals who may have signs of mental illness and their families; sending providers, consumers, families and others to conferences related to PEI efforts; and more.

Target Population

The target population for this program is:

- Providers, consumers, family members and other community members who may be in a position to recognize and respond to early signs of mental illness. These include school staff, front-line workers in health and human service agencies, community health advocates/promotores, family members, probation staff, security guards, librarians, and others.

- Providers, consumers, family members and other community members who are in a position to implement stigma and discrimination reduction activities. These include community leaders, peer providers, appropriate county staff, and others.

- PEI providers.

Program Description

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

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

- increases understanding of mental health and substance use disorders;
- increases knowledge about signs and symptoms of issues such as depression, anxiety, psychosis, and substance abuse;
- reduces negative attitudes and beliefs about people with symptoms of mental health disorders;
- increases skills for responding to people with signs of mental illness and connecting individual to services;
- increases knowledge of resources available.
MHFA trainings are offered throughout the community. In the past, three to five trainings have been offered per year. Trainings include standard, youth, and Spanish. The type of trainings, locations, and frequency depend on the demand for the trainings.

Additional trainings on recognizing and responding to signs of mental illness, implementing PEI evidence based practices, suicide prevention, and other related topics are scheduled as needed. In addition, funds support attendance at conferences on PEI issues and outreach opportunities.

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

**Expected Outcomes**

Community and Provider Trainings are intended to:

- Train community members to recognize signs/symptoms of mental health and substance use disorders and to respond, including linking individuals to services.

  The number and type of individuals participating will be tracked. Every six months, this data will be analyzed to ensure that target numbers and representation are being reached. In addition, MHFA conducts pre and post surveys to assess change in knowledge and behavior.

- Reduce stigma and discrimination

  The number and type of individuals participating will be tracked. In addition, MHFA conducts pre and post surveys to assess change in knowledge and behavior.

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

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

<table>
<thead>
<tr>
<th>Numbers to be served in FY2014-15</th>
<th>Community Member and Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach to Increase Recognition and Stigma and Discrimination Reduction</td>
<td>100</td>
</tr>
</tbody>
</table>
Actual Outcomes

<table>
<thead>
<tr>
<th>Mental Health First Aid Outcomes for FY2014-15</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Marin County community members that participated in MHFA.</td>
<td>127</td>
</tr>
<tr>
<td>Participants reporting increased knowledge about mental illness signs/symptoms. (0-5 scale)</td>
<td>4.5</td>
</tr>
<tr>
<td>“As a result of this training, I feel more confident I can recognize the signs that someone may be dealing with a mental health problem or crisis.”</td>
<td></td>
</tr>
<tr>
<td>Participants reporting feeling able to offer a distressed person basic “first aid” information and reassurance about mental health. (0-5 scale)</td>
<td>4.4</td>
</tr>
<tr>
<td>Participants reporting ability to assisting somebody experiencing a mental health problem or crisis to seek appropriate professional help.</td>
<td>4.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Participants in MHFA</th>
<th>Number Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (target client)</td>
<td>1</td>
</tr>
<tr>
<td>Family Member</td>
<td>1</td>
</tr>
<tr>
<td>Providers</td>
<td></td>
</tr>
<tr>
<td>County Mental Health and Substance Use Services</td>
<td>7</td>
</tr>
<tr>
<td>Community-based Mental Health and/or Substance Use Provider</td>
<td>19</td>
</tr>
<tr>
<td>Education</td>
<td>18</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>6</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>5</td>
</tr>
<tr>
<td>Senior Centers/Services</td>
<td>6</td>
</tr>
<tr>
<td>Social Services</td>
<td>28</td>
</tr>
<tr>
<td>Veterans</td>
<td></td>
</tr>
<tr>
<td>Faith-based</td>
<td>1</td>
</tr>
<tr>
<td>Shelters/Homeless Services/Public Housing</td>
<td>6</td>
</tr>
<tr>
<td>Libraries</td>
<td>1</td>
</tr>
<tr>
<td>Public Transit</td>
<td></td>
</tr>
<tr>
<td>Other – List: DV, BOS, Parks Svcs, PH</td>
<td>15</td>
</tr>
<tr>
<td>Security, Emergency Svcs</td>
<td>13</td>
</tr>
</tbody>
</table>

Other Outreach and Training Activities in FY14-15

- Sponsored four (4) attendees at the “Together Against Stigma Conference” and two (2) attendees at the “Latino Behavioral Health Conference”
- Production of three (3) English and three (3) Spanish 30-minutes video segments which are available on the MHSUS website at: www.marinhhs.org/mhsus
- Two (2) events for consumers and families regarding handling holiday stress
- Each Mind Matters and May is Mental Health Month materials

Challenges and Upcoming Changes

In **FY2015-16**, nine (9) MHFA trainings were offered. While the wait list for standard MHFA courses is dwindling, there is an increased request for targeted trainings – Spanish, youth, and faith communities.

In **FY2016-17**, we expect this program will continue to be implemented as described.
SCHOOL AGE PREVENTION AND EARLY INTERVENTION

Program Overview

In the community planning process for the MHSA Three-Year Plan, the need for services for school age youth was a high priority. Beginning in FY2014-15, MHSA PEI provided funding for increased services for students in 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) who may be experiencing emotional disturbance or are at significantly higher risk due to adverse childhood experiences, severe trauma, poverty, family conflict or domestic violence, racism and social inequality or other factors. Classrooms and students may be referred for services through school staff, Success/Study Teams (SST), or Student Attendance Review Teams (SART) and Boards (SARB). They will then be assessed to determine whether they are appropriate for PEI services or are linked to other services. The program is targeting three areas of Marin County at this point:

<table>
<thead>
<tr>
<th>Target Schools</th>
<th>Latino</th>
<th>American Indian</th>
<th>Asian</th>
<th>African American</th>
<th>Multiple Races</th>
<th>English Learners</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Rafael City Schools</td>
<td>60%</td>
<td>1%</td>
<td>4%</td>
<td>1%</td>
<td>2%</td>
<td>43%</td>
</tr>
<tr>
<td>West Marin Schools</td>
<td>40%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>35%</td>
</tr>
<tr>
<td>Sausalito/Marin City Schools</td>
<td>25%</td>
<td>10%</td>
<td>30%</td>
<td>7%</td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>

*Percentages are approximate.

Program Description

- Prevention: Reducing Risks Related to Mental Illness
- Outreach for Increasing Recognition of Early Signs of Mental Illness
The primary objective of this program is to reduce risks related to emotional disturbance and prevent further impairment in functioning. In addition, programs provide training for parents, school staff and community providers to identify and respond to signs for mental illness.

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

Once a student has been identified as eligible, services will be provided with the goal of increasing protective factors and reducing risk factors for developing signs of emotional disturbance. Each school district has a different service provider with a program, designed based on community needs and existing gaps. Program descriptions by school district are provided below.

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 and Assessment 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.

**San Rafael City Schools**
Saneca Family of Agencies provides a multi-leveled program: It creates a school culture that supports wellness by conducting a comprehensive assessment (School Climate Assessment Instrument) and using it to identify strengths to build upon and challenges to address through school community training and development of protocols and procedures to address behavioral health related issues. It provides training and coaching to increase school staff capacity to address needs within the classroom. And it provides group therapy, short-term case management, family engagement and psycho-education.

The program incorporates a number of models shown to achieve positive results. School climate is assessed using the School Climate Assessment Instrument (SCAI), analyzing ratings of various dimensions by school staff, parents and students. This survey is based on the Alliance for the Study of School Climate and the average overall score of this survey has been shown to have a strong correlation with student achievement (Academic Performance Index, CA Department of Education). The school climate – student achievement connection has been well established in the research (Freiberg, Driscoll, & Knights, 1999; Hoy, & Hannum, 1997; Kober, 2001; Loukas, & Robinson, 2004; Norton, 2008; Shindler, et al., 2004). Work with school staff and students integrates
an array of practices, including Second Step (evidence based, SAMHSA NREPP), I Can Problem Solve (evidence based, SAMHSA NREPP), Cognitive Behavioral Intervention for Trauma in Schools (evidence based, SAMHSA NREPP), and Zones of Regulation (promising practice, www.zonesofregulation.com), mindfulness (promising practice, http://www.mindfullivingprograms.com/whatMBSR.php), and others. PEI staff receives relevant training through Seneca’s Institute for Advanced Practice to implement practices with fidelity. She receives regular clinical supervision where time is set aside to discuss the implementation of curricula and make plans to mitigate any challenges that arise.

Sausalito Marin City School District
Marin City Community Services District (MCCSD) has implemented a Community Connector program. Schools or community providers can refer students to the Community Connectors who then work with the student and families to determine what they need and how to access needed services, including client advocacy and care coordination. They work with the SARB to help develop and implement action plans with families, helping the family complete the goals of the plan. They also train community providers in identifying and responding to mental health needs, as well as provide a “Girl Power” group to increase protective factors among 5-14 year old girls.

The program incorporates a number of models shown to achieve positive results in underserved communities. The Community Connectors are a combination of promotores (“The Promotor Model: A Model for Building Healthy Communities,” The California Endowment) and navigators (“The role of patient navigators in eliminating health disparities,” Natale-Pereira A, Enard KR, Nevarez L, Jones LA). They have received training in Mental Health First Aid (evidence-based, SAMHSA NREPP) and will continue to receive training in evidence-based practices. The individuals hired as Community Connectors are long-time, trusted members of the community they serve. The “Girl Power” group was previously implemented in this community under the Integrated Behavioral Health program and showed positive outcomes: the percent of participants with positive self-esteem increased from 51% to 85% and 79% of participants reported improvement in coping skills (N=39).

Shoreline School District
Bay Area Community Resources (BACR) provides an array of services: Stigma reduction is addressed through education for school staff, students and families about mental health and available resources. Self-regulation classes are provided in the classroom to build resiliency skills. And individual services are provided for students and families at school and through home visits.

The program incorporates a number of models shown to achieve positive results. The classroom self-regulation sessions are taken from Zones of Regulation (promising practice, www.zonesofregulation.com). While the entire curriculum is not used, each session that is used is implemented with fidelity based on the manual. The PEI staff person receives training in additional practices, such as restorative practices.

Expected Outcomes
School Age PEI is intended to:

- Educate school staff and parents to recognize and respond to early signs of mental illness through providing training and written materials.

  The numbers and types of individuals trained will be tracked.
Reduce prolonged suffering for those at significantly higher risk of mental illness 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, promising or community practices shown to achieve positive results with the target population. Specific models and tools are indicated in the descriptions by school district above.

### Actual Outcomes

The School Age PEI program began in FY2014-15 with three different models of service in three different school districts, depending on the local needs. A total of 1365 teachers, parents and students participated in psycho-education or intervention services. In the first year of implementation there were a number of refinements made to service models and evaluation processes, resulting in limited data for this report. There has been an effort to have all programs use the same core methods for assessing outcomes: the Strengths and Difficulties Questionnaire (SDQ) (validated) and school attendance and performance records. The school districts have different procedures regarding releasing that data, and therefore might not be a viable measure for some programs.

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach</td>
<td>Percent of school staff attending school site trainings.</td>
<td>75%</td>
<td>86%&lt;br&gt;N=66</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention</td>
<td>Number of students that received individual or group prevention services.</td>
<td>96</td>
<td>22</td>
<td>12</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of families that received individual or group prevention services.</td>
<td>70</td>
<td>73</td>
<td>20</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>
## Prevention and Early Intervention (PEI)

### School Age Prevention and Early Intervention

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Seneca</th>
<th>MCCSD</th>
<th>BACR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of students (11-14 y.o.) receiving prevention services reporting statistically significant improvement in risks factors and/or behavior. (SDQ)</td>
<td>80% (N=18)</td>
<td>60%</td>
<td>Not Available</td>
</tr>
<tr>
<td>Percent of families receiving prevention services reporting statistically significant improvement in student's risks factors and/or behavior. (SDQ)</td>
<td></td>
<td>80% (N=17)</td>
<td></td>
</tr>
</tbody>
</table>

### Satisfaction

Parents receiving counseling services reporting satisfaction with the services:
- would use the services again in the future
- would be very or somewhat likely to recommend the services
- will agree or strongly agree staff were culturally sensitive
- will report services were very or somewhat helpful in addressing their problems

<table>
<thead>
<tr>
<th></th>
<th>Seneca</th>
<th>MCCSD</th>
<th>BACR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
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<tr>
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<td>100%</td>
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<td>100%</td>
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<tr>
<td></td>
<td>100%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>N=5</td>
<td></td>
<td>N=11</td>
</tr>
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</table>

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

### SA 14/15: Age Group

- 0-15: 214 (99%)
- 16-25: 3 (1%)
- 26-59: 4 (2%)
- 60+: 18 (8%)
- unknown: 2 (1%)

### SA 14/15: Race/ Ethnicity

- Hispanic: 65 (30%)
- White: 127 (59%)
- Asian: 18 (8%)
- African American: 4 (2%)
- Multi: 2 (1%)
- Native: 3 (1%)
- Pacific Islander: 1 (1%)
- Not Reported: 0
Challenges and Upcoming Changes

In FY2015-16, the MHSA PEI Committee established a School Age PEI subcommittee. It has allowed the three School Age PEI providers to share insights, especially regarding best practices for working with schools and implementation of evaluation tools.

In FY2016-17, the School Age PEI Program is expected to be implemented as described above. Evaluation methods will continue to be refined.
SCHOOL AGE PEI – CLIENT STORY

Jonathon is a fifth grade student who entered his current school in fourth grade. Jonathon’s father died a few years ago and he currently lives with his mother and siblings. His mother has struggled to hold a consistent job and intermittently collects unemployment. Historically, Jonathon has struggled with running away from campus when frustrated, not completing his school work, engaging in physical fights with other peers, verbal provoking of other peers, and isolating/shutting down when upset or frustrated.

Four months before Jonathon was to graduate from the fifth grade (another possible trigger of loss), Jonathon’s behaviors began to deteriorate. Presenting concerns included: running off campus when frustrated, allegedly stealing money from a classroom community money jar, bullying other students during recess, occasionally throwing items at other students, and struggling to track and complete homework assignments.

The Seneca clinician provided PEI services on several levels. She spoke with Jonathan and his mother, as well as staff, to understand what strategies had worked in the past to support periods of success. To address his runaway behaviors, the clinician consulted with administration and staff to implement a response that would begin to extinguish his behavior, rather than reinforce it. Both Jonathon and staff were taught about safety contracts and Jonathon was supported in the process of “taking space” when he was experiencing high levels of stress. When Jonathan did leave the classroom impulsively, the clinician worked with him to build the skills to self-soothe and reflect on his behavior before integrating back into the classroom environment. To address the allegations of stealing, the clinician worked with involved staff on how to respond to both Jonathan and the class at large. The possible underlying motivation for stealing the money was explored, and a restorative justice approach was implemented. To address Jonathan’s social challenges, the clinician worked with both school staff and Jonathan’s mother to create a behavioral incentive plan by which Jonathan could earn rewards, such as individual time with his favorite teacher, for exhibiting positive, pro-social behaviors. The clinician also worked with Jonathon to explore his triggers and to learn replacement behaviors.

The above plans were all shared with mother who was initially reticent about meeting with this clinician. Over time however, the mother became actively engaged with the clinician. The clinician worked with mom to build her capacity and confidence in providing clear and logical consequences at home. The clinician also worked with mom to create strategies for successfully monitoring Jonathan’s homework completion. The clinician explored with mom the possible drivers of her son’s behaviors, and supported mom in considering and accessing mental health treatment for her son.

By the end of the year, Jonathan had made great strides in his ability to form and sustain positive relationships with peers, and his ability to manage his attention and impulsivity. He was also better able to receive and follow-through with directions from staff, as well as complete classroom assignments. Though his behaviors did not completely subside, he no longer left campus when upset and he was completing his classwork both in and outside the classroom. His bullying behaviors on the playground decreased in frequency. During the last week of school, he asked this clinician if she would come to his 5th grade graduation.
**VETERANS COMMUNITY CONNECTION**

**Program Overview**

Veterans are recognized as being at high risk for mental illness, without adequate access to necessary care. While there are efforts on a Federal level to address this need, there is much that can be done on a local level to prevent prolonged suffering, as well as a need for more intensive services. 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.

**Target Population**

The target population is United States veterans involved in the criminal justice system who have a treatment plan for mental illness developed by Veterans’ Affairs (VA) or who are exhibiting symptoms of mental illness. Most of the target population may be experiencing Post Traumatic Stress Disorder (PTSD), while some may experience depression or other concerns.

**Program Description**

- Access and Linkage to Treatment for those with Serious Mental Illness

This program does active outreach and support for Veterans, particularly those who are homeless or involved in the criminal justice system, to link them to medically necessary mental health services. Many of the Veterans are provided the support they need, such as transportation and entry into housing and Veterans Administration (VA) benefits, to access needed mental health services. Some are already connected to the VA and have a mental health treatment plan. The VA usually 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.

A part-time case manager is dedicated to this program. Clients are identified through outreach, in-reach and referrals from the VA. The case manager provides:

- Outreach and engagement.
- Case management, linking clients to housing, behavioral health services, and more.
 Assistance with logistical barriers to completing a treatment plan.

 Ongoing contact to increase likelihood of engaging with services.

 Services for significant support people, such as family.

 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 are provided by a veteran who 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 case manager or the VA.

 Expected Outcomes

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

 Reduce Prolonged Suffering by ensuring veterans experiencing symptoms of mental illness engage in services expected to reduce their symptoms and increase their functioning.

 The Veterans’ Services case manager will maintain records on contacts with participating veterans, engagement with behavioral health services, and rate of completion of treatment plans.

 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 is expected to achieve the intended results by providing case management and increasing completion of treatment plans developed by the VA.

 Actual Outcomes

 This program began later than expected, impacting the total number of clients served. Since starting in February 2015, the program has worked with many veterans with mental illness ensuring they completed mental health treatment plans and linking them to other support services to reduce prolonged suffering. In particular, clients were successfully linked to housing, employment assistance, and substance use services.
Outcome | Goal | Actual FY2014-15
--- | --- | ---
**Prevention**
Number of veterans that received support services to increase likelihood of completing the veteran’s mental health treatment plan. (Average number of services: 8) | 40 | 36
Number of family members that received services to increase their capacity to support the client. | 7 | 10
Percent of veterans receiving support that complied with their mental health treatment plan. | 80% | 94%\(N=36\)

**Satisfaction**
Clients receiving support services reporting satisfaction with the services:
- would use the services again in the future | 75% | 75%
- would be very or somewhat likely to recommend the services | 86% | 86%
- agree or strongly agree staff were culturally sensitive | 75% | 75%
- report services were very or somewhat helpful in addressing their problems | N=36 | 

VETS 14/15: Age Group

- 0-15: 22 (61%)
- 16-25: 12 (33%)
- 26-59: 2 (6%)
- 60+: 4 (11%)

VETS 14/15: Race/ Ethnicity

- Hispanic: 4 (11%)
- White: 26 (72%)
- Asian: 2 (6%)
- African American: 4 (11%)
- Multi: 2 (6%)
- Native: 12 (33%)
- Pacific Islander: 2 (6%)
- Not Reported: 4 (11%)
VETS 14/15: Primary Language

- Spanish: 36 (100%)
- English: 0
- Vietnamese: 0
- Chinese: 0
- Not Reported: 0

VETS 14/15: Gender

- Male: 18 (50%)
- Female: 16 (44%)
- Transgender/Other: 2 (6%)
- Not Reported: 0

PEI: Veterans' Community Connection

- San Rafael: 31
- Novato: 3
- West Marin: 1
- Fairfax: 1
- San Geronimo Valley: 1
- San Anselmo: 1
- Larkspur: 1
- Mill Valley: 1
- Sausalito/Marin City: 0
- Corte Madera: 0
- Greenbrae/Kentfield/Ross: 0
- Belvedere/Tiburon: 0
- Not Reported: 0

COUNTY OF MARIN • MENTAL HEALTH AND SUBSTANCE USE SERVICES DIVISION
MHSA FY2016-2017 ANNUAL UPDATE 76
Challenges and Upcoming Changes

In FY2015-16, the program continues to serve individuals with complex conditions and situations, including serious mental illness, incarceration, chronic homelessness, and substance dependency. Through ongoing outreach within jails and prisons, on the street, and in homeless encampments, the case manager has been able to engage individuals in services who have previously refused services.

In FY2016-17, 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, with a change in the target population to include individuals with mental illness not only on probation or parole, but also those with any criminal justice involvement.
VETERANS COMMUNITY CONNECTION – CLIENT STORIES

One Sunday our County Veterans Services Officer (VSO) received a phone call from Marin General Hospital because a young, post 911 veteran had tried to commit suicide by jumping off the Golden Gate Bridge. The VSO immediately went to the hospital to speak to the young veteran and assure him our office was there to help him. This veteran did not qualify for VA health benefits; which means he had to use Medi-Cal.

He had a bi-polar diagnosis and it was decided to release him to the Veterans Community Connection case manager on Tuesday. The case manager met the veteran at the hospital and the he agreed to be medication compliant. The case manager immediately secured him temporary housing through the use of the REST Program administered by St. Vincent De Paul (at almost 5PM), ensured he had food, took him to pick up his medication at a pharmacy - as Marin General is not allowed to give needed mental health medications upon release - and introduced him to REST staff.

He stabilized with the PEI program, REST, and Marin General all playing a part in his success. The case manager wrote him a new resume and within two (2) months of his suicide attempt he started a full time job with a major corporation and is now seeking permanent housing.

On the case managers first day, the VSO informed her that he had a very tough case. A 100% service connected veteran with no limbs, who was a registered sexual predator, was living in an outhouse (the only one wheelchair accessible) a few feet from a public school with children in attendance (illegal by law). The case manager visited the veteran, who insisted he did not want housing. It took about 6 weeks, but through consistent engagement and extensive partnership with the VA and non-profit VA housing partners, he did move into legal housing - where he is to this day. He is still not exactly happy - but after being homeless for over five (5) years and living in an illegal status by the school - this is a huge success.
STATEWIDE PREVENTION AND EARLY INTERVENTION

Program Overview

Marin County assigned a portion of MHSA PEI funds to a statewide effort. Those funds, mostly managed by California Mental Health Services Authority (CalMHSA) through FY2014-15, have supported:

- **Suicide Prevention:** This includes Statewide efforts, such as the Know the Signs campaign, as well as a regional effort led by 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. Locally there are efforts to implement mental health related training for school staff.

- **Stigma and Discrimination Reduction (SDR):** This includes Statewide efforts such as the Reach Out Here and Walk In Our Shoes campaigns.

Actual Outcomes

Statewide program outcomes are tracked and reported by CalMHSA. See Appendix B for a brief overview of the impact of Statewide efforts on Marin County. In addition, FSA’s Suicide Prevention and Crisis Hotline numbers served are shown below.

The local Student Mental Health Initiative, coordinated by Marin County Office of Education (MCOE), has assisted with engaging school staff in Mental Health First Aid and identifying priorities for additional mental health training.

<table>
<thead>
<tr>
<th>Numbers served in FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of calls to hotline from Marin County</td>
</tr>
</tbody>
</table>

Challenges and Upcoming Changes

In FY2015-16, Marin, and other participating counties, began funding the Suicide Prevention Hotline directly due to changes in CalMHSA’s scope of work. Marin continued to work with MCOE to determine opportunities for training school staff. Currently a number of schools are interested in Positive Behavioral Interventions and Supports (PBIS), a multi-layered evidence based model for prevention and intervention in schools.

In FY2016-17, PBIS training will be implemented if at least five (5) schools commit to participating.
PREVENTION AND EARLY INTERVENTION FUNDING

<table>
<thead>
<tr>
<th>Program</th>
<th>Funding FY2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Childhood Mental Health Consultation</td>
<td>$230,000</td>
</tr>
<tr>
<td>Triple P (Positive Parenting Program)</td>
<td>$62,000</td>
</tr>
<tr>
<td>Transition Age Youth PEI</td>
<td>$160,000</td>
</tr>
<tr>
<td>Latino Community Connection</td>
<td>$204,000</td>
</tr>
<tr>
<td>Integrated Behavioral Health in Primary Care</td>
<td>$180,000</td>
</tr>
<tr>
<td>Older Adult PEI</td>
<td>$100,000</td>
</tr>
<tr>
<td>Vietnamese Community Connection</td>
<td>$53,000</td>
</tr>
<tr>
<td>PEI Community and Provider Training</td>
<td>$95,000</td>
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<tr>
<td>School Age PEI</td>
<td>$310,000</td>
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<tr>
<td>Veterans Community Connection</td>
<td>$60,000</td>
</tr>
<tr>
<td>Statewide</td>
<td>$175,000</td>
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</table>

<table>
<thead>
<tr>
<th>Program</th>
<th>FTE*</th>
<th>P</th>
<th>EI</th>
<th>O</th>
<th>SDR</th>
<th>A&amp;L</th>
<th>SP</th>
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<tbody>
<tr>
<td>Early Childhood Mental Health Consultation</td>
<td>2.6</td>
<td>100%</td>
<td></td>
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<tr>
<td>Triple P (Positive Parenting Program)</td>
<td>0.5</td>
<td>100%</td>
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<tr>
<td>Transition Age Youth PEI</td>
<td>1.7</td>
<td>30%</td>
<td>60%</td>
<td></td>
<td>10%</td>
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<tr>
<td>Latino Community Connection</td>
<td>2.5</td>
<td>65%</td>
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<td>35%</td>
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<tr>
<td>Integrated Behavioral Health in Primary Care</td>
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<td>85%</td>
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<td>Older Adult PEI</td>
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<td>80%</td>
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<td>0.8</td>
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<tr>
<td>PEI Community and Provider Training</td>
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<td></td>
<td></td>
<td>50%</td>
<td>50%</td>
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<tr>
<td>School Age PEI</td>
<td>3.8</td>
<td>90%</td>
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<tr>
<td>Veterans Community Connection</td>
<td>0.6</td>
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<td>100%</td>
</tr>
<tr>
<td>Statewide</td>
<td>NA</td>
<td></td>
<td>40%</td>
<td></td>
<td></td>
<td>10%</td>
<td>50%</td>
</tr>
</tbody>
</table>

* FTE = Full Time Equivalent indicates the number of staff hours (100% = 40 hours/week)

PEI Programs

Prevention: Reduce risk factors and increase protective factors.

**Examples:** support groups, peer support, pro-social activities.

Early Intervention: Promote recovery and functional outcomes.

**Examples:** clinical services.

Outreach: Increase ability to recognize and respond to potentially severe mental illness.

**Examples:** Mental Health First Aid, provider training.

Stigma and Discrimination Reduction: Reduce negative attitudes relating to having a mental illness.

**Examples:** campaigns, speaker’s bureaus, education, efforts to increase self-acceptance.

Access and Linkage: Link individuals with serious mental illness to medically necessary treatment.

**Examples:** screening, assessment, referral, help lines.

Suicide Prevention (optional): Prevent suicide as a consequence of mental illness.

**Examples:** campaigns, hotlines, training, screening.
## Prevention and Early Intervention

### Numbers to be served in FY2016-17

<table>
<thead>
<tr>
<th>Program</th>
<th>Type of Service</th>
<th>Individuals</th>
<th>Family Members</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>0-15</td>
<td>16-25</td>
<td>26-59</td>
</tr>
<tr>
<td>Early Childhood Mental Health</td>
<td>Outreach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention</td>
<td>700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triple P</td>
<td>Prevention</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Transition Age Youth</td>
<td>Prevention</td>
<td>10</td>
<td>40</td>
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<td></td>
<td>Early Intervention</td>
<td>75</td>
<td>325</td>
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<td></td>
<td>Access &amp; Linkage</td>
<td>100</td>
<td>400</td>
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<tr>
<td>Latino Community Connection</td>
<td>Outreach</td>
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<tr>
<td></td>
<td>Prevention</td>
<td>30</td>
<td>100</td>
<td>30</td>
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<tr>
<td>Integrated Behavioral Health</td>
<td>Early Intervention</td>
<td>30</td>
<td>140</td>
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<tr>
<td></td>
<td>Access &amp; Linkage</td>
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<tr>
<td>Older Adult PEI</td>
<td>Outreach</td>
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<tr>
<td></td>
<td>Early Intervention</td>
<td></td>
<td></td>
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<tr>
<td>Vietnamese Community Connection</td>
<td>Outreach</td>
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<tr>
<td></td>
<td>Prevention</td>
<td>15</td>
<td>75</td>
<td>60</td>
</tr>
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<td>PEI Training</td>
<td>Outreach</td>
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<td>70</td>
<td>15</td>
</tr>
<tr>
<td>School Age PEI</td>
<td>Outreach</td>
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<td></td>
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<tr>
<td></td>
<td>Prevention</td>
<td>150</td>
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<td></td>
</tr>
<tr>
<td>Veterans Community Connection</td>
<td>Prevention</td>
<td>20</td>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>PEI Statewide</td>
<td>CalMHSA</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Suicide Prevention</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Individuals:** Individual identified for services.  
**Family Members:** Family members or caregivers of the individuals who participate in services.
# Prevention and Early Intervention (PEI)  
*Prevention and Early Intervention – Component Budget*

MHSA Prevention and Early Intervention (PEI)  

<table>
<thead>
<tr>
<th>Program</th>
<th>FY14-15</th>
<th>FY15-16</th>
<th>FY16-17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI-1 Early Childhood Mental Health Consultation - ECMH</td>
<td>$230,000</td>
<td>$230,000</td>
<td>$230,000</td>
<td>$690,000</td>
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<tr>
<td>PEI-2 Triple P (Positive Parenting Program) Marin</td>
<td>$55,000</td>
<td>$62,000</td>
<td>$62,000</td>
<td>$179,000</td>
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<tr>
<td>PEI-4 Transition Age Youth (TAY) PEI</td>
<td>$140,000</td>
<td>$160,000</td>
<td>$160,000</td>
<td>$460,000</td>
</tr>
<tr>
<td>PEI-5 Latino Community Connection</td>
<td>$199,000</td>
<td>$204,000</td>
<td>$204,000</td>
<td>$607,000</td>
</tr>
<tr>
<td>PEI-6 Integrated Behavioral Health in Primary Care</td>
<td>$180,000</td>
<td>$180,000</td>
<td>$180,000</td>
<td>$540,000</td>
</tr>
<tr>
<td>PEI-7 Older Adult Prevention and Early Intervention</td>
<td>$100,000</td>
<td>$100,000</td>
<td>$100,000</td>
<td>$300,000</td>
</tr>
<tr>
<td>PEI-11 Vietnamese Community Connection</td>
<td>$53,000</td>
<td>$53,000</td>
<td>$53,000</td>
<td>$159,000</td>
</tr>
<tr>
<td>PEI-12 Community and Provider PEI Training</td>
<td>$45,000</td>
<td>$95,000</td>
<td>$85,000</td>
<td>$225,000</td>
</tr>
<tr>
<td>PEI-18 School Age Prevention and Early Intervention Programs</td>
<td>$205,000</td>
<td>$310,000</td>
<td>$310,000</td>
<td>$825,000</td>
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<tr>
<td>PEI-19 Veteran's Community Connection</td>
<td>$25,000</td>
<td>$60,000</td>
<td>$60,000</td>
<td>$145,000</td>
</tr>
<tr>
<td>PEI-20 Statewide Prevention and Early Intervention</td>
<td>$111,536</td>
<td>$175,000</td>
<td>$205,000</td>
<td>$491,536</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>$1,343,536</td>
<td>$1,629,000</td>
<td>$1,649,000</td>
<td>$4,621,536</td>
</tr>
<tr>
<td>Evaluation</td>
<td>$0</td>
<td>$0</td>
<td>$40,000</td>
<td>$40,000</td>
</tr>
<tr>
<td>PEI Coordinator</td>
<td>$64,900</td>
<td>$64,900</td>
<td>$74,000</td>
<td>$203,800</td>
</tr>
<tr>
<td>Administration and Indirect</td>
<td>$211,265</td>
<td>$254,085</td>
<td>$264,450</td>
<td>$729,800</td>
</tr>
<tr>
<td>Operating Reserve</td>
<td>$27,799</td>
<td>$15,000</td>
<td>$63,565</td>
<td>$106,364</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,647,500</td>
<td>$1,962,985</td>
<td>$2,091,015</td>
<td>$5,701,500</td>
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</tbody>
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<table>
<thead>
<tr>
<th>County</th>
<th>FY14-15</th>
<th>FY15-16</th>
<th>FY16-17</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>$25,000</td>
<td>$60,000</td>
<td>$60,000</td>
<td>$145,000</td>
<td>2.5%</td>
</tr>
<tr>
<td>Contract Provider</td>
<td>$1,383,436</td>
<td>$1,673,900</td>
<td>$1,673,900</td>
<td>$4,731,236</td>
<td>83%</td>
</tr>
<tr>
<td>Administration</td>
<td>$244,265</td>
<td>$244,265</td>
<td>$244,265</td>
<td>$732,795</td>
<td>13%</td>
</tr>
<tr>
<td>Operating Reserve</td>
<td>$27,799</td>
<td>$27,799</td>
<td>$36,871</td>
<td>$92,469</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,680,500</td>
<td>$2,005,964</td>
<td>$2,015,036</td>
<td>$5,701,500</td>
<td>100%</td>
</tr>
</tbody>
</table>
COMMUNITY SERVICES AND SUPPORTS (CSS)

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 funding is 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. MHSA has enabled an increase in services targeted at Latinos, older adults, and specific geographic parts of the County, as well as other expansions and improvements.

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. In addition to PEI-funded efforts that increase engagement of underserved populations, CSS continues efforts to hire bilingual and bicultural staff and other strategies to better serve diverse populations. In addition, the Southern Marin Services Site (SMSS) Program is being closed at the end of FY2015-16 in order to work with the community on designing a service that will better meet their needs.

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 Overview

Marin County’s Youth Empowerment Services (YES), formerly known as the Children’s System of Care (CSOC), is a Full Service Partnership program serving 40+ seriously high risk youth through age 21 who are involved with Juvenile Probation and/or attend Marin Community School, an alternative high school for students at risk educationally.

This program was originally implemented as a Children’s System of Care grant in the late nineties. In FY2005-06 the Mental Health Services Act began supporting a major portion of the program, enabling the program to expand and hire Family Partners with lived experience with children who had been in the mental health system and/or juvenile justice system.

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

Target Population

YES serves seriously high-risk youth through age 21 who are involved with Probation and/or attend Marin Community School, an alternative high school. The majority of clients in this program are between ages 13-18 (N=38, 79% < 17 years old) and male (74%). Latino youth in particular make up the majority of the YES clients (81%).

Program Description

The YES model is a supportive, strengths based model with the goal of meeting youth and families in their homes and in the community. The YES program provides culturally appropriate mental health services, intensive case management, and psychiatric care, as well as collaboration with
partner agencies (i.e., education, probation, drug court, etc.) to facilitate integrated care and ongoing family support. The Full Service Partnership (FSP) model includes a ‘whatever it takes’ philosophy which includes creative strategizing to maintain stability for clients and their families which is supported by flex funding which can be used to support the family in addressing important needs. Flex fund decisions are made by the wraparound team and must be in support of the mental health goals of the child and family as described in the client’s treatment plan.

Young Latino males continue to be the largest group served by the YES program. YES staffing consists of three (3) bilingual clinicians, one of whom is a Latino male working with students at Marin Community School.

The YES program utilizes family partners, parents who have had a child in the mental health or juvenile justice system, who are able to engage and support the parent in a unique manner because of their life experience. Family partners provide support and guidance to parents in navigating the various systems and with parenting youth engaged in high-risk behaviors.

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

**Expected Outcomes**

YES program objectives include serving 40+ youth per fiscal year, decreasing arrests and days in juvenile hall, decreasing school suspensions and increasing school attendance and performance. YES services also aim to assist youth in decreasing substance use, develop better coping skills to manage daily stresses and increase pro-social activities in the community.

In the MHSA Three-Year MHSA Program and Expenditure Plan, there were three outcomes identified. During FY2014-15 it became clear that there is not sufficient school related data, and therefore the outcomes were revised. In FY2015-16 the YES Program will better capture individual outcomes along these dimensions by collecting all “actionable items” on the Child Adolescent Needs and Strength (CANS) instrument administered on admission and then every six (6) months, tracking any changes. Items in the CANS cover legal issues, school attendance and many other salient aspects of a child’s functioning. By analyzing actionable items we will be able to focus on those that are most challenging and track effectiveness of our program in specific domains.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal FY2014-15</th>
<th>Revised Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in School Suspensions</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Increase in School Attendance</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Decrease in Arrests</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Decrease days in juvenile hall</td>
<td></td>
<td>20%</td>
</tr>
</tbody>
</table>

**Actual Outcomes**
In FY2014-15, the YES program served 38 clients, but with the loss of 2 staff mid-year it was unable to meet its goal of serving 40 youth. Services provided to the 38 youth (total # of services = 1124) included assessment, case management and individual/family therapy, as well as family partner support and medication services. In response to the fact that a high proportion of YES clients present with substance use issues, staff has been trained to utilize harm reduction and motivational interviewing techniques to assist clients with substance use issues.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in Arrests</td>
<td>25%</td>
<td>52%</td>
</tr>
<tr>
<td>Decrease days in juvenile hall</td>
<td>20%</td>
<td>increase</td>
</tr>
</tbody>
</table>

By Age Group
- Child (<17): 8 (21%)
- Adult (18 to 22): 30 (79%)

By Race/ Ethnicity
- Caucasian or White: 31 (81%)
- Hispanic: 6 (16%)
- Black or African American: 1 (3%)
- Other/ Unknown: 1 (3%)

In response to the fact that a high proportion of YES clients present with substance use issues, staff has been trained to utilize harm reduction and motivational interviewing techniques to assist clients with substance use issues.
YES services resulted in 87% decrease in arrests, so the program exceeded its goal of 25% noted above. The YES program also maintained 100% prevention of emergency events from the year prior to entry into YES compared with the first year of services.

Services in the YES program did not result in decreased days in juvenile hall when compared to pre-FSP data. For FY14-15, FSP clients in the YES program spent 10% fewer days with parents and more days in juvenile hall during the first year of service. One explanation for this is that clients often begin YES services at the onset of probation, and emotional/behavioral improvements do not always occur immediately. Thus, the number of days the youth spends in juvenile hall may initially increase as the youth struggles to cope differently.

**Challenges and Upcoming Changes**

In **FY2015-16**, MHSUS’ Children’s Mental Health is conducting a strategic planning process to address changes occurring, including a reduction in referrals to YES due to a decrease in number of youth on probation. In addition, YES will recruit to fill two (2) vacant bilingual clinician positions.

In **FY2016-17**, in accordance with the new Children’s Mental Health strategic plan, YES will be restructured to serve a wider range of clients with high risk needs and behaviors.
YOUTH EMPOWERMENT SERVICES – CLIENT STORY

John is a 16 year old Latino male who was referred by juvenile probation to receive services as part of his probation mandates. He was placed on probation after assaulting his mother and pushing her to the ground.

John developed severe behavioral problems from age 5 after his parents’ divorce and, through time, his anger turned into uncontrollable rage as he felt displaced and rejected. He began to smoke marijuana by age 13 and started getting into trouble with the law due to his aggression and defiance towards authority.

Through YES services, John learned to take responsibility for his displaced anger, his disrespect and defiance towards authority, and to apologize for his actions. He also learned to differentiate between people who are on his side and people who do not care about him. He still gets into power struggles with authority figures, but his overall adjustment improved significantly.
TRANSITION AGE YOUTH (TAY) FULL SERVICE PARTNERSHIP

Program Overview

Marin County’s Transition Age Youth (TAY) Program is a Full Service Partnership (FSP) providing young people (16-25) with serious emotional disturbance or emerging mental illness with independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services. These services are strengths based, evidence based and client centered. A multi-disciplinary team provides assessment, individualized treatment plans and linkages to needed supports and services, as well as coordinated individual and group therapy and psychiatric services for TAY participants. There is also a well-attended partial program for youth who can take advantage of the group activities and ongoing social support. This program was started by Buckelew in partnership with Family Service Agency (FSA) in FY2006-07. In January 2015 the TAY Program transitioned to a new agency when Sunny Hills Services was awarded the contract through a competitive process.

Target Population

The priority population is transitional age youth, 16-25 years of age, with serious emotional disturbances/serious mental illness. These youth may be aging out of the children’s system, child welfare and/or juvenile justice system or may be experiencing new mental health challenges that are seriously impacting their ability to function appropriately in their home and community. Priority is also given to TAY who are experiencing first-episode psychosis and need access to developmentally appropriate mental health services.

In the past years, Latino youth, 18 years of age and over, were underrepresented in the TAY Program, but this last year there were eight youth self-identified as Hispanic which is 29% of the TAY clients. The TAY Program has three bilingual Spanish speaking staff out of five, so they have the needed capacity to work with Latino families. Parent support groups are offered in Spanish and English at the TAY offices.
Program Description

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

There is a two-bedroom apartment available to FSP clients in the TAY Program, recognizing that stable housing is important in maintaining mental health. Due to the TAY Program’s very limited housing capacity, other housing programs available for those 18 years and over are also utilized by TAY participants as appropriate, and many still live with their family which will continue to be their main source of support.

This program provides ‘whatever it takes’ with the goal of providing treatment, skills and the level of self-sufficiency necessary to TAY to manage their illness and accomplish their goals, avoiding deep end services, incarceration and homelessness. In addition, partial services, such as drop-in hours and activities, are available to all TAY clients as well as those who are not in the full service partnership. Often this welcoming approach is effective in engaging youth experiencing serious mental health challenges that are open to dropping by and engaging in social activities before committing to joining the program.

Partial and drop in services offer a range of activities from art activities and movies to mindfulness. There are frequent outings to local recreational areas that are very accessible in Marin. These activities provide a forum for healthy self-expression, an opportunity for participants to expand their cultural horizons, and a place to for them to practice their social skills. Specific groups on gardening, employment, budgeting and nutrition round out the offerings. The monthly TAY
calendar of activities is available in English and Spanish. A bi-monthly Family Support Group for families of TAY with mental health illness and substance use, whether or not their child is enrolled in the TAY program, is provided by a TAY staff.

**Expected Outcomes**

The broad goals of the TAY Program, including decreasing hospitalization and homelessness and increasing attendance at school or work, have not changed and are evident in the chart on the previous page. Additionally, specific goals targeting vocational support and independent living skills that support such outcomes were monitored closely with the new agency, Sunny Hills Services, starting January 2015. Specific objectives were set for Sunny Hills for the six months remaining in FY2014-15 as they began with building up the program under new leadership.

**Actual Outcomes**

In FY2014-15, sixteen (16) TAY FSP clients were transferred from the Buckelew Program to the Sunny Hills Program and four (4) new clients were admitted to the program, exceeding their goal for number of clients served. The TAY Program reported that four of twenty FSP clients participated in one or more of activities designed to improve independent living skills. The plan is to assess how these activities address the needs of the FSP clients and work on engagement and outreach to reach at least 50% participation. A Sunny Hills staff member completed the CAADAC substance use counselor training, allowing for those services to start in FY2015-16.*

<table>
<thead>
<tr>
<th>Outcomes (6 months)</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients served:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• FSP</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>• Partial/drop-in</td>
<td>25</td>
<td>27</td>
</tr>
<tr>
<td>FSP clients engaged in work, vocational training or school.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>FSP clients engaged in activities designed to improve independent living skills.</td>
<td>50%</td>
<td>20%</td>
</tr>
<tr>
<td>FSP clients screened for substance use.</td>
<td>100%</td>
<td>*</td>
</tr>
<tr>
<td>Clients identified as having substance use issues that receive substance use services.</td>
<td>50%</td>
<td>*</td>
</tr>
</tbody>
</table>
By Age Group

- Child (<17): 1 (4%)
- Adult (18 to 26): 27 (96%)

By Race/Ethnicity

- Caucasian or White: 13 (46%)
- Hispanic: 8 (29%)
- Black or African American: 3 (11%)
- Other/Unknown: 4 (14%)

By Preferred Language

- English: 26 (93%)
- Spanish: 1 (3.6%)
- Vietnamese: 1 (3.6%)

By Gender

- Female: 17 (61%)
- Male: 11 (39%)
Challenges and Upcoming Changes

In FY2015-16, substance use screening and services for TAY FSP clients were initiated. The challenge in finding a qualified and certified substance use counselor was addressed by having an existing TAY staff become a certified CAADAC counselor during the first six (6) months of the Sunny Hills Services contract (January-June 2015). In FY2015-16, 100% of clients will be screened by the substance abuse counselor and appropriate interventions such as groups for youth and families will be provided in a manner that engages the youth and addresses where they are in terms of stages of change. This substance abuse counselor will provide needed services for youth with co-occurring disorders who need support in recognizing the impact of substance abuse on their mental health as well as support comprehensive services that promote recovery and self-sufficiency.

Many of the clients seen in the TAY Program suffer with serious mental illness which impacts their ability to function in their daily lives. In FY2015-16 a post doc intern interested in work with First Episode Psychosis has been providing groups and individual therapy to a few of those clients in the TAY Program. The plan is to explore developing a track or program for these clients based on the research data collected through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant currently being researched by a MHSUS staff in collaboration with the county Quality Improvement management and Sunny Hills management.

In FY2016-17, we expect to continue implementing the TAY program 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) FULL SERVICE PARTNERSHIP

Program Overview

The Marin County 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 STAR Program was originally implemented in 2002 through a competitive Mentally Ill Offender Crime Reduction Grant (MIOCRG) awarded by the California Board of Corrections. Upon the conclusion of that grant, the STAR Program was approved as a new Full Service Partnership, providing culturally competent, intensive, integrated services to 40 mentally ill offenders. Operating in conjunction with Marin’s mental health court – the STAR Court – the program was designed to provide comprehensive assessment, individualized client-centered service planning, and provision of or linkages to all needed services and supports. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce incarceration, and reduce hospitalization.

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), the FSP is a multi-disciplinary, multi-agency assertive community treatment team comprised of professional and peer specialist staff. The Team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psycho-education, employment services and provision of or linkages to all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. The program also has a volunteer family member who brings the voice and perspective of families to the program and is available to provide outreach to family members of STAR Program participants.

The team consists of two (2) mental health practitioners, one of whom is bilingual/bicultural Spanish speaking, two (2) peer specialists, a mental health nurse practitioner and a psychiatrist, an independent living skills specialist, an employment specialist and a substance use specialist. Support is available to participants and their families 7 days a week, 24 hours a day.

Integral to the team, the nurse practitioner provides medical case management, health screening/promotion and disease prevention services, coordinates linkage to community-based physical health care services, and is able to furnish psychiatric medications under the supervision of the team psychiatrist. The employment specialist provides situational assessments, job development and job placement services, 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 independent living skills counselor is available to support participants with development of skills needed to obtain and maintain independence in the community. The substance abuse counselor provides appropriate group and individual counselling to participants as needed.

CSS one-time expansion funds were approved beginning in FY2011-12 through FY2013-14 to provide Crisis Intervention Training, a 32-hour training program for police officers to enable them to more effectively and safely identify and respond to crisis situations and mental health
emergencies. Because earlier trainings were successful and popular, the program was extended into FY2014-2015, and we anticipate continuing through FY2016-17. Funds are used for stipends to local law enforcement jurisdictions to enable them to send officers to the training, support their ongoing participation in the monthly meetings of the county-wide problem-solving Forensic Multi-Disciplinary Team (FMDT), and help pay for the cost of the training. This training is provided to 25-30 sworn officers annually.

Expected Outcomes

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.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in homelessness</td>
<td>75%</td>
</tr>
<tr>
<td>Decrease in arrests</td>
<td>75%</td>
</tr>
<tr>
<td>Decrease in incarceration</td>
<td>80%</td>
</tr>
<tr>
<td>Decrease in hospitalization</td>
<td>40%</td>
</tr>
</tbody>
</table>

Actual Outcomes

In FY2014-15, the STAR Program engaged 54 individuals who had serious mental illness and significant criminal justice involvement, exceeding the program’s target enrollment of 40. Of those served, homeless days were reduced by 93%, arrests decreased 87%, and hospitalizations by 70%, all far exceeding program goals. Participant incarceration decreased by 74% and the program saw a 73% reduction in mental health emergencies. The team nurse practitioner saw 43 of the enrolled participants, for a total of 1153 medication-related services.

Of the 16 program participants referred for employment services, 10 (63%) were successfully engaged in job development. Eight (50%) were placed in jobs, and an additional 5 (31%) were engaged in volunteer work. Independent Living Skills (ILS) Services were provided to 7 participants, exceeding the annual goal of 4-5, and 5 (71%) remained engaged in ILS services at the end of this reporting period.
Challenges and Upcoming Changes

In FY2015-16, the program began recruiting for an additional bilingual Spanish speaking mental health practitioner. Recruitment for this position has been challenging, and the position is expected to be filled in the near future. The addition of this position will allow the program to expand capacity by an additional 15 participants without the requirement of participation in STAR Court, and will allow the program to engage and enroll a more diverse participant population. This will bring the program total to 60 participants.

A significant challenge in this fiscal year has been the retirement of the two core, long-term mental health practitioners, as well as the resignation of the program supervisor. At this point all of these positions have been filled.

In FY2016-17, we anticipate having all of the current positions filled, and the services up to the anticipated levels. Once the program has stabilized we will begin to explore enhanced services for families of program participants, understanding that natural supports are an integral part of the recovery process.
STAR FULL SERVICE PARTNERSHIP – CLIENT STORY

Joseph has been diagnosed with schizoaffective disorder, panic disorder and poly substance use disorder. Joseph has a long history of legal entanglements, psychiatric hospitalizations, and chronic substance use. Joseph is a participant in STAR court for the second time. During his first attempt he was derailed in his efforts to succeed by relapse and new drug charges. In this attempt to complete STAR court he has really been engaged with the treatment and services that the STAR team provides and has been extraordinarily successful at meeting his own goals and fulfilling the mandates of the court. Using the therapeutic tools and psycho-education he works to master with STAR providers, Joseph has a better understanding of his diagnosis and how to overcome the barriers it can create, and has had huge success in reducing the frequency and severity of his symptoms. Joseph is deeply engaged in his recovery, and has maintained sobriety for over 9 months! Joseph has worked with STAR providers to secure permanent affordable housing and to enroll in classes at College of Marin, where he just scored a 96% (highest in the class) on his most recent intermediate algebra exam. Joseph attributes his success in taking on and managing these new challenges in his treatment, housing, sobriety, and education in part to the support and skills he gets from the STAR, and says that STAR has helped him understand that he is deserving of the success he is working hard for.
HELPING OLDER PEOPLE EXCEL (HOPE) PROGRAM

Program Overview

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

Prior to implementation of MHSA, Marin County did not operate a comprehensive integrated system of care for older adults with serious mental illness. Of all the age groups served by Marin’s public mental health services, older adults had received the least services and had the lowest penetration rates, despite the fact that they constituted the fastest growing age cohort in Marin. Key stakeholders and community partners consistently agreed that Marin needed to comprehensively address the needs of older adults who have serious mental illness, and they strongly supported the creation of a new full service partnership as a critical step toward an integrated system of care for this population.

In 2006, Marin’s HOPE Program was approved as a new MHSA-funded full service partnership providing culturally competent, intensive, integrated services to 40 priority population at-risk older adults. The HOPE Program was designed to provide community-based outreach, comprehensive geropsychiatric assessment, individualized client-centered service planning, and provision of or linkages to all needed services and supports by a multi-disciplinary, multi-agency team.

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

The HOPE Program’s multi-disciplinary assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psycho-education, assistance with money management, and provision of or linkages to 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.

Integral to the team, the mental health nurse practitioner provides medical case management, health screening/promotion and disease prevention services, coordinates linkage to community-based physical health care services, and is able to furnish medications under the supervision of the psychiatrist. The independent living skills counselor is available to support participants with development of skills needed to maintain independence in the community. The substance abuse counselor provides appropriate group and individual counseling to participants as needed.

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 individuals 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 provide supervision and support, has been integrated into the team and provides outreach, engagement, and support services.
Expected Outcomes

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

<table>
<thead>
<tr>
<th>Outcome</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in homelessness</td>
<td>75%</td>
</tr>
<tr>
<td>Decrease in hospitalization</td>
<td>50%</td>
</tr>
</tbody>
</table>

Actual Outcomes

In FY2014-15 the HOPE Program engaged 54 individual older adults, exceeding the program goal of 40. Of those served, homeless days were decreased by 68%, and hospitalization by 14%, but shy of their goals of 75% and 50% respectively. Alternately, mental health emergencies requiring services at the Crisis Stabilization Unit decreased by 47%.

Outreach and engagement services by the Senior Peer Counseling program staff conducted 31 face-to-face assessments that either resulted in the client receiving a Senior Peer Counselor, declining services or referring out.
Challenges and Upcoming Changes

In FY2015-16, a prominent challenge was the lack of available housing and placement options for older adults who suffer from chronic and persistent mental illness. As the population of Marin ages, so does the population of older adults who have mental illness, medical comorbidities and cognitive decline. This profile makes psychiatric hospitalizations and medical hospitalizations very challenging. The larger health care system is in the process of becoming more integrated, and when psychiatric illness intertwines with complex medical issues, longer term care options are limited.

In FY2016-17, the HOPE Program and Senior Peer Counseling will explore options for better integrating primary care, mental health and substance use treatment services, as well as, additional options for older adult housing and appropriate placements.
HOPE FULL SERVICE PARTNERSHIP – CLIENT STORY

“If there’s one significant thing you take away from this conversation, I want you to know that the HOPE Program saved my life” she exclaimed vehemently over the phone. This opening statement captured the vivid theme of one woman’s life journey; a snapshot of despair, grace and humility. These emotions are captured through the lived experience of the HOPE Program and Senior Peer Counseling Program client ‘Nancy’.

Nancy, in her mid-60’s, spent her childhood years as the only child of a single mother. She lived on the east coast for 8 years until moving to LA with her single mother. As a child she was rambunctious and loved life. As an adult, Nancy suffered her first mental health crisis in her 30’s and as a result spent years homeless. In Los Angeles, to support herself between jobs as a “cosmetologist for the stars”, she lived on meager Social Security and Disability; regularly turning tricks to fund her drug habit that developed to help manage her symptoms. Nancy’s struggle with housing and maintaining employment was symptomatic of and exacerbated by an untreated mental illness: bipolar disorder. Abusing substances was Nancy’s coping mechanism to combat feelings of loneliness, inadequacy and invisibility. Eventually, Nancy lost her sparkle. “I’m a very competent person. Homelessness is right up there with rape. It’s degrading and demeaning, and when you’re homeless, you learn how to survive.”

After her first hospitalization, Nancy experienced the rag-doll effect of being homeless, then securing a safe place to live, only to become homeless again. Never really finding terra firma, Nancy slowly became isolated; without a sense of community or village, lost was the supportive loving environment she blossomed in while she was a child and living with her mother. Luckily, her best friend Leslie has been her security and constant emotional support. “We talk almost every day”.

After relocating from Oregon in 2014, Nancy was living on the streets in San Rafael, California, eventually being swept up by the HOPE Program, in an attempt to save one more person. After another hospitalization, and reluctantly agreeing to take medication, Nancy became more willing to consider medication and support from the HOPE Program. Nancy began to find that stabilization and sense of trust she had as a child. On January 22nd, 2015, Nancy was supported to move into her own apartment at the Fireside Apartment in beautiful Mill Valley, California; thus beginning the end of a full-circle roller coaster ride. The Fireside Apartments are funded by the Mental Health Services Act and this housing has afforded the dignity and independence to several older adults who suffer from mental illness.

Riding on the secure and stable high, Nancy has now settled in the safe environment provided through collaboration of HOPE Program providers, including but not limited to her psychiatrist, nurse practitioner, and case manager, and support from In Home Supportive Services (IHSS). Nancy is finally able to find peace of mind and be of service to others. “I am very blessed and thankful, because I have not had personal control taken away; I have power over my life now.”

This personal power is evidenced by Nancy’s being of service to others. Just the other day she was able to provide a donation of food to someone she cares about. “I know what it’s like to be hungry.” Now with a sense of independence, and growing social competency, Nancy is considering dating, but with humility and grace, also states “I am very blessed and grateful, and I don’t need any more than this.”
ODYSSEY PROGRAM (HOMELESS) FULL SERVICE PARTNERSHIP

Program Overview

The Odyssey Program is a Full Service Partnership (FSP) that provides culturally competent intensive, integrated services to adults with serious mental illness who are either homeless or at risk for 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, and to reduce rates of homelessness, hospitalization and incarceration.

Target Population

The target population of the Odyssey Program is adults, age 18 and over, with serious mental illness, who are homeless or at-risk of becoming homeless. Priority is given to individuals who are unserved or underserved by the mental health system. Participants may or may not have a co-occurring substance abuse disorder and/or serious health conditions.

Program Description

A multi-disciplinary, multi-agency assertive community treatment team comprised of mental health practitioners and peer specialists provides comprehensive assessment, individualized client-centered service planning, crisis management, and other supportive services as indicated, including support to obtain/maintain housing, crisis planning, peer counselling and support, employment services, money management, support for development of independent living skills, psycho-education, access to medication services and management support, substance abuse services as indicated, and medical case management when needed. The program has a pool of flexible funding to purchase needed goods and services that cannot be otherwise obtained, including time-limited emergency housing, medications and transportation. A limited amount of supportive housing is provided through partnerships with the Marin Housing Authority’s Shelter Plus Care Program, and other community partners. Recognizing the critical role natural support systems play in participant’s recovery, friends and family members have access to an array of 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. 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.

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

Integral to the team, the nurse practitioner provides medical case management, health screening/promotion and disease prevention services, coordinates linkage to community-based physical health care services, and is able to furnish medications under the supervision of the psychiatrist. The employment specialist provides situational assessments, job development and job placement services, 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 independent living skills counselor is available to support participants with development of skills needed to maintain independence in the community. The substance abuse counselor provides appropriate group and individual counselling to participants as needed.

Implemented in 2015, the program also now includes a “step-down” component, for program participants who are no longer in need of assertive community treatment, but who continue to struggle with independent community living and are not yet able to rely on natural supports to maintain health and well-being. Program services are provided by a para-professional with lived experience and a peer specialist.
Expected Outcomes

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

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>GOAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in homelessness</td>
<td>80%</td>
</tr>
<tr>
<td>Decrease in arrests</td>
<td>50%</td>
</tr>
<tr>
<td>Decrease in incarceration</td>
<td>60%</td>
</tr>
<tr>
<td>Decrease in hospitalization</td>
<td>40%</td>
</tr>
</tbody>
</table>

Actual Outcomes

The Odyssey Program targets individuals who, by virtue of being unserved or underserved, are either homeless or at-risk of homelessness. In FY2014-15, the program engaged 80 individual participants, exceeding the program goal of 60. Of those served, homeless days were decreased 74%, falling short of the goal of 80%. This will be discussed further in the Challenges section of this report. While days spent incarcerated decreased by 70% exceeding the 60% goal, frequency of arrests was decreased by 32% vs. the goal of 50%. Hospitalization rates were minimally effected this year, with only a 2% decrease. This may be attributable to a notable increase in the acuity of clients, but also may be a factor of some significant staffing changes. Crises requiring evaluation by the Crises Stabilization Unit decreased by 54%.

Outreach and engagement services to homeless individuals are provided by the CARE Team and supported by the Enterprise Resource Center, a peer operated drop-in center. The CARE Team works closely with Odyssey and is the primary source of referrals for the program. In FY2014-15 the CARE Team provided 1397 service contacts in the field, exceeding their annual goal of 1200 visits by 16%.

Independent Living Skills services were provided to 11 participants, exceeding the goal of 4-5. Of those 11, 100% remained engaged following assessment. Vocational Rehabilitation Services were offered to 21 Participants: 9 (43%) engaged in job development, 5 (24%) were placed in employment and 6 (28%) were placed in volunteer positions.

On average, 58% of Odyssey program participants present with a co-occurring substance use disorder, putting them at even greater risk. Odyssey’s low-barrier harm-reduction based substance group provided services to 18, demonstrating a significant increase from the previous year’s 11 participants. A total of 43 groups were provided throughout the year. The program will continue to explore strategies for engaging participants in this aspect of their recovery.
By Age Group
- Child (<18): 5, 6%
- Adult (18 - 64): 76, 94%

By Race/Ethnicity
- Caucasian or White: 59, 73%
- Hispanic: 7, 9%
- Black or African American: 9, 11%
- American Indian: 4, 5%
- Other/Unknown: 2, 2%

By Preferred Language
- English: 71, 88%
- Spanish: 6, 7%
- Farsi: 3, 3%
- Other/Unknown: 3, 3%

By Gender
- Female: 46, 57%
- Male: 43, 43%
Challenges and Upcoming Changes

As our primary provider of services to homeless individuals, the Odyssey Program has been particularly struggling with the nation-wide housing crisis. In Marin County, affordable housing has become exceptionally challenging. While Odyssey has a well-established partnership with the Marin Housing Authority, it is becoming more and more common for individuals in possession of Section 8 vouchers through the Shelter Plus Care Program to remain homeless due to lack of availability of units where vouchers are accepted. MHSUS will continue to collaborate with other county divisions as well as community partners to find housing solutions for Marin’s homeless who suffer from mental illness.

Challenges and Upcoming Changes

In FY2015-16, the Odyssey Program is being 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 supporting smooth transitions from intensive services to independence.

In FY2016-17, we anticipate further expansion of the Odyssey Program by adding two (2) additional mental health practitioners. With this added capacity, the Program will be able to provide services for an additional 30 individuals. Including the Step-Down component, this program will be providing services to a total of 120 participants. Vocational Rehabilitation and Independent Living Skills Supports will be expanded to meet the needs of this enhanced service as well. We will also increase collaborative efforts with Marin Housing Authority to provide additional services and supports to assist program participants to obtain and maintain housing.
ODYSSERY FULL SERVICE PARTNERSHIP – CLIENT STORY

“I have been waiting for you,” says Peter. I follow him inside as he shows me his clean apartment. Peter is in his mid-fifties and lives near downtown San Rafael. Every weekday Peter wakes up at 4:30 a.m. to take a bus to work. Peter is a crossing guard, and commutes back and forth on the city bus to attend sobriety meetings between his shifts. Earlier in Peter’s life he owned his own ceramic tiling business in Novato and worked hard to provide for his family.

Over a decade ago Peter experienced the traumatic death of his family. Peter explains that he became depressed and was self-medicating with alcohol and drugs to such an extent that he lost his business and home. “I was homeless and living on a dock. I would dig through the dumpsters of restaurants for food.” Peter met a county employee that recruited him for a group and connected him to the Odyssey Team. “People don’t realize it, but once you are on the streets it is almost impossible to get off alone.”

Peter has spent the last 13 years working with the Odyssey Team. “They have helped me with everything: getting me off the street, budgeting, keeping my social security, and getting a job,” he says. Peter has lived in a variety of county placements over the past decade and has been working with the same case manager for the past nine years. The structure and consistency in Peter’s day remain an important aspect of his recovery. He regularly attends church, sobriety meetings, and case management appointments. He reliably contacts his Odyssey Team Case Manager and maintains his employment. Over the past thirteen years, the continuity of services provided by the Odyssey Team has been invaluable for Peter.

A demonstration of this value can be seen in Peter’s abstinence from substances over the past decade. He attributes this sobriety to his community, church, and case manager. He is currently reworking his sobriety program and making amends with some of his extended family. He tells me of a niece he has in Vallejo and how they “talk sometimes.” Peter is an active member in his local community: he attends two churches, serves food to the homeless, and assists in other charitable activities.

Peter’s gratitude can be felt in each story he shares, especially when describing the Odyssey Team, “They have seen me through some hard times and I am a different person now,” he says. They are one of the few things in Peter’s life that has remained consistently supportive.
ENTERPRISE RESOURCE CENTER (ERC) EXPANSION

Program Overview

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

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

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

Program Description

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 builds trust, maximizes opportunities for collaboration and increasingly engages clients in their own recovery process. Managed and staffed entirely by mental health consumers, the center promotes a strengths-based, harm-reduction approach and offers clients a one-stop central location to access and receive services such as socialization activities, peer counseling, mentoring, psycho-educational activities, and support groups. Consumers working to assist other consumers serve as role models and a message of hope that further promotes wellness and recovery.

ERC offers a full schedule of activities, classes and groups 7 days per week, as well as serving as host to meetings such as Dual Recovery Anonymous, Smokebusters, and NAMI Family Support Groups. Programming and services are designed to provide personal support and foster growth and recovery,
Community Services and Supports (CSS)
Enterprise Resource Center (ERC) Expansion

and include the Warm Line, available 7 days/week, 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. The ERC also provides Peer Specialist training programs and on-the-job internships for consumers seeking to work as service providers in the public mental health system. Overseen by the ERC, outreach and engagement services for the County’s homeless individuals with mental illness are provided by the CARE team (homeless mobile outreach) which works closely with Marin’s Odyssey Program for adults with serious mental illness who are also homeless. The CARE team has been expanded with ongoing funding to provide a second full-time Peer Specialist, plus a small flexible fund to support outreach and engagement efforts.

Expected Outcomes

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

<table>
<thead>
<tr>
<th>Goal</th>
<th>Goal</th>
<th>FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td># served - ERC</td>
<td>200</td>
<td>228</td>
</tr>
<tr>
<td>Average daily attendance</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td># Warm Line contacts</td>
<td>6800</td>
<td>6797</td>
</tr>
<tr>
<td>Average monthly contacts - CARE</td>
<td>100</td>
<td>116</td>
</tr>
</tbody>
</table>

Actual Outcomes

As in previous years, the ERC continues to exceed the goals of the program. In FY2014-15, there were a total of 13,400 consumer visits to the ERC, with an average daily attendance of 37. A total of 228 unique individuals were registered, exceeding the program goal by 14%. This year the program also established a membership option that provides members with additional privileges such as computer use. At the close of the year 287 consumers had elected to become members. The Linda Reed Activities Club continues to be popular and had a cumulative attendance of 1,234 throughout the year. The Warmline was able to assist callers with 6,797 contacts, just short of the goal of 6800. Additionally, the ERC launched the 1108 Gallery, and Art Gallery showcasing consumer Artwork. Two modules of Peer Specialist courses were held, for a total of 3 courses. Of 39 total enrollees, 31 were able to successfully complete the course.
Challenges and Upcoming Changes

In FY2015-16, with the retirement of staff from key management and administrative positions, the ERC has begun to explore opportunities for internal development, particularly as the new leadership begins to shape the future of the programs. Additionally, the implementation of the ERC Step-Up Recovery Program continued to be delayed. This program is intended to serve as the next step 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 order to ensure coordination of services, it was decided to combine existing and new MHSA funded consumer operated wellness and recovery services. During the past year, the existing provider of these services went through major changes. In addition, it has become increasingly difficult to locate services in centralized areas that are easily accessible to consumers. Due to these factors, MHSUS is waiting for a more strategic time to implement this expansion.

In FY2016-17 the program will continue self-evaluation and explore opportunities for organizational development. We will also continue to explore opportunities to implement the Step-Up Recovery Program.
SOUTHERN MARIN SERVICES SITE (SMSS) PROGRAM

Program Overview

In the original and recent MHSA planning processes, community members identified reaching unserved and underserved populations as a high priority, in line with the MHSA principles. In 2007, the Southern Marin Services Site Program (SMSS) was developed as an outreach and engagement program that targets unserved and underserved children with serious emotional disturbance and adults with serious mental illness living in the Southern Marin area.

Target Population

Children, adults and older adults with serious emotional disturbance or serious mental illness, with special attention paid to providing services to ethnic minorities in Southern Marin. Approximately one third of Marin’s Medi-Cal beneficiaries live in Southern Marin. The program specifically outreaches to Marin City, the most diverse region in Marin County 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, has with an 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 Willow Creek school 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. They provide psycho-education, clinical counseling and case management services, parenting support, assistance with re-entry, and goal setting.

Expected Outcomes

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.

**Actual Outcomes**

In FY2014-15, SMSS conducted extensive outreach and engagement services, including community trainings, Teen Screen, and psycho-education about domestic violence in collaboration with a representative from Center for Domestic Peace. In addition, SMSS reached a total of 617 residents and service providers as follows:

- **Outpatient Services**: 84 children and adults
- **Home Visiting by Family Advocate/Parent Aide**: 42 children and parents
- **School-based Services by BACR**: 53 youth
- **Community Education**: 254 youth and adults
- **Psycho-Education and Outreach**: 120 adults
- **Center for Domestic Peace**: 64 individuals

<table>
<thead>
<tr>
<th>Outpatient Services</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients that received outpatient behavioral health services</td>
<td>84</td>
</tr>
<tr>
<td>Clients from un-served and under-served populations</td>
<td>100%</td>
</tr>
<tr>
<td>Percent of clients on MediCal</td>
<td>79%</td>
</tr>
<tr>
<td>Percent of clients that are uninsured</td>
<td>19%</td>
</tr>
<tr>
<td>Percent of clients experiencing serious emotional disturbance/mental illness</td>
<td>100%</td>
</tr>
<tr>
<td>Percent of clients that are residents of Southern Marin</td>
<td>100%</td>
</tr>
</tbody>
</table>
SMSS 14/15: Age Group
- Child and Youth, 0-15 yrs.: 10%
- Transitional Age Youth, 16-25 yrs.: 17%
- Adults, 26-59 yrs.: 58%
- Older Adults, 60+ yrs.: 15%

SMSS 14/15: Race/ Ethnicity
- Caucasian: 62%
- African American: 18%
- American Indian: 8%
- Native Hawaiian: 5%
- Asian: 1%
- Other or Two or More Races: 6%
- Not reported: 7%

SMSS 14/15: Hispanic/ Non Hispanic
- Identified as Hispanic: 23%
- Identified as Non-Hispanic: 70%
- Not reported: 7%

SMSS 14/15: Gender
- Male: 76%
- Female: 24%
SMSS Program Outcomes | Goal | Actual FY2014-15
--- | --- | ---
Percent of children experiencing improvement or stabilized in one or more dimension on the Child Outcome Survey. | 70% | 100%
Percent of adults experiencing improvement or stabilized in one or more dimension on the Adult Outcome Survey. | 70% | 72%
Percent of families receiving home visiting services experiencing improvement or stabilized in one or more parenting/caregiving dimension on the Adult Outcome Survey. | 70% | 100% N=15
Percent of participants in community education programs that show an increase in knowledge of behavioral health information and resources. | 75% | NA*

* Southern Marin Services provided community education in these areas: Suicide Prevention, Teen Resilience and Teen Screen. There is no measured outcome for TeenScreen at this time, other than the number of students referred for further treatment.

Challenges and Upcoming Changes

In FY2015-16, Marin City leaders and residents requested to receive more culturally appropriate, responsive and appropriate services. SMSS and MHSUS met to discuss a more effective outreach and engagement strategy that would improve the penetration rate of, and access to services by, community residents. Some changes were made to the existing program. In February 2016, MHSUS decided to close the existing program at the end of FY2015-16. Drawing from a strength-based approach, MHSUS recognizes the importance of establishing and maintaining positive relationships with historically un/underserved communities in the county, particularly African Americans and the Latino communities. MHSUS plans to involve all Southern Marin leaders and residents to inform MHSUS of their current needs and to work towards developing and implementing a more culturally responsive program.

In FY2016-17, the existing program will be closed as of end of FY2015-16. A planning process will be conducted to determine the needs of the community, bridge services for FY2016-17, and services to be included in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20.
ADULT SYSTEM OF CARE (ASOC) EXPANSION

Program Overview

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

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

The ASOC Expansion Program was approved as a General System Development/Outreach and Engagement project designed to expand and enhance supports and services available in Marin’s system of care for priority population adults and their families through the implementation of 5 components: peer specialist services; outreach to Hispanics/Latinos; outreach and support to Vietnamese; family outreach, engagement and support services; and short-term housing assistance. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, reduce isolation, and provide low-barrier access which welcomes unserved clients of Vietnamese and Hispanic/Latino origin.

Target Population

The target population of the ASOC Expansion Program is transition age youth (18+), adults and older adults who have serious mental illness and their families who are at risk of hospitalization, institutionalization, incarceration, homelessness, frequent emergency medical care or other long-term adverse impacts of mental illness. Priority is given to individuals who are currently 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 Expansion Program is a general system development/outreach and engagement project designed to expand and enhance supports and services available in Marin’s system of care for adults with serious mental illness and their families by 1) increasing peer specialist services on the Adult Intensive Case Management team, 2) providing outreach and engagement services to Hispanics/Latinos, 3) increasing Vietnamese outreach and engagement services, and 4) adding family outreach, engagement and support services to the ASOC at large.

Increased Peer Specialist Services
An MHSA-funded full-time peer specialist provides services and supports to clients of the Adult Intensive Case Management team that focus on recovery and illness self-management strategies for individuals whose symptoms have begun to stabilize. This program component promotes the concepts of wellness, recovery and self-help within the county-operated core non-FSP intensive case management team serving adults who have serious mental illness.

Provide Outreach to and Engagement with Hispanic/Latino Individuals
Marin has a well-documented need to increase mental health services for un/underserved Hispanics/Latinos. MHSA funding was used to add a part-time bilingual (Spanish-speaking) psychiatrist to provide medication support services. MHSA funding was also used to fund a part-time bilingual (Spanish-speaking) mental health clinician to provide targeted outreach and engagement to Hispanics/Latinos. In FY2012-13, the ASOC Spanish-speaking staff position was restructured to function as Community Health Advocate (CHA) Liaison to the evidence-based MHSA-funded PEI CHA project designed to increase the capacity of CHAs to address mental health and substance abuse concerns of Hispanics/Latinos in their communities. The CHA Liaison provides training, supervision and support to the Spanish-speaking CHAs, as well as assistance in linking community members to public mental health services.

Increased Outreach and Engagement to Vietnamese-Speaking Individuals
The Vietnamese population in Marin County has also been un/underserved. By using MHSA-funding to increase a part-time bilingual Vietnamese speaking clinician to full-time, Marin expanded capacity to incorporate the language and culture of the underserved Vietnamese population through the provision of linguistically and culturally competent services. This position provides mental health outreach and engagement to Vietnamese-speaking individuals, as well as translation of language and cultural issues to ensure that staff psychiatrists can accurately provide medication support to monolingual Vietnamese clients.

Additionally, MHSA PEI funds were approved to support the development of a CHA model for the Vietnamese community. The MHSA-funded Vietnamese-speaking clinician and MHSA-funded Spanish-speaking CHA Liaison will partner with this CHA project to provide support and assistance, as well as promote opportunities for the two CHA projects to collaborate.

Family Outreach, Engagement and Support Services
This program component expanded the operations of the existing Children’s System of Care Family Partnership Program into the ASOC through the addition of a part-time Family Partner with personal experience as a family member of an adult with mental illness. The ASOC Family Partner provides outreach and engagement services to families of adults with serious mental illness, as well as family-to-family case management services, including provision of support and advocacy, assistance with service plan development and implementation, information and referral to NAMI-Marin and other local community resources, and co-facilitation of family support group
Expected Outcomes

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

<table>
<thead>
<tr>
<th></th>
<th>Goal</th>
<th>FY1415</th>
</tr>
</thead>
<tbody>
<tr>
<td># Served</td>
<td>325</td>
<td>232</td>
</tr>
<tr>
<td>% Hispanic</td>
<td>50%</td>
<td>27%</td>
</tr>
<tr>
<td># Primary language-Spanish</td>
<td>100</td>
<td>14</td>
</tr>
<tr>
<td># Asian</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td># Primary language-Vietnamese</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td># Served – Outreach &amp; Engagement team</td>
<td>20</td>
<td>142</td>
</tr>
</tbody>
</table>

Actual Outcomes

In FY2014-15 ASOC has seen a significant increase in the number of people needing an intensive level of services. It is likely that this is attributable to increased outreach efforts and development of a cohesive Crisis Continuum of Care, which is appropriately identifying and engaging new consumers into planned (non-crisis based) services. Due to demand for intensive services, ASOC was not able to serve the number of people traditionally served by the same staffing levels: 232 unique individuals, compared to the goal of 325. In response, we will be expanding all of our services to accommodate this increased demand. We will also continue to evaluate effectiveness of getting the right consumers into the right programs based on each person’s individual needs.

Family Outreach, Engagement and Support Services continue to provide invaluable support to families, particularly in times of crisis. With the addition of a part-time Spanish speaking Family Partner, the team provides support to families with loved ones in PES as well as those engaged in planned services through ASOC. Family Partners facilitate support and psycho-educational groups for family members; organize activities focused on health and wellness, one-to-one support, and crisis planning services. These services will be further outlined in the Crisis Continuum of Care section of this report.

Outreach and Engagement with Hispanic/Latino and Vietnamese Individuals continues to develop and build a strong component of the ASOC. Services are provided in part by the Community Health Advocate (CHA) Liaison, a part-time clinician who works with the Promotores, Vietnamese CHA’s 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 and resources for Hispanic/Latino and Vietnamese community member, including:

- Training and support for Latina mental health CHA’s through meetings 2 times a month
- Training and supervision of bilingual and bicultural interns who support the Latino and Vietnamese Family Health programs by providing culturally appropriate mental health services such as community educational/recreational events and stress management groups.
The interns serve more than 150 individuals throughout the year.

- Provision of information, referral, brief interventions and linkage to services for more than 200 Latino adults
- Provision of no-cost classes in Spanish, including parenting classes, psychoeducational groups for women, and behavioral activation groups
- Provision of multiple presentations to the community about a variety of mental health issues, including organized community events and through public media including radio broadcasts, television interviews and newspaper articles.

**Equity Adjustment for Community Action Marin (CAM) ASOC Peer Specialists** – In FY2014-15 Marin was able to use MHSA funds for an equity adjustment to realign the salaries of ASOC Peer Specialists to be comparable with other para-professional positions. This adjustment affected approximately thirty (30) ASOC positions and will ensure that Peer Specialist salaries continue to meet the Marin County Living Wage Ordinance minimum compensation requirements.

**ASOC Outreach and Engagement Team** newly launched in FY2014-15, this mobile team had contact with 142 individuals in the first year of operations. The team consists of a full-time mental health clinician and a full-time peer specialist. The target population for this program is adults (18+) who have a serious mental illness with symptoms that contribute to serious functional impairments in activities of daily living, social relations, and/or ability to sustain housing, but who are not in crisis; are not current clients of the public mental health system; and are unwilling or unable to engage in treatment. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition. The team responds to calls for assistance and provides outreach services in-home and in the community. This program will also be further outlined in the Crisis Continuum section of this report.

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**ASOC FY 14/15: Age Group**

- 83% <18 (Child)
- 17% 18-64 (Adult)

**ASOC FY 14/15: Race/ Ethnicity**

- 59% Caucasian or White
- 15% Vietnamese
- 12% Other Asian
- 1% Unknown / Not Reported
- 1% Native Hawaiian
- 1% Japanese
- 1% Other
- 1% Hispanic
- 1% Black or African American
- 1% Unknown / Not Reported
Challenges and Upcoming Changes

In FY2015-16, the ASOC programs will be challenged once again by retirements and reassignments of key leadership staff. The primary focus of the year will be stabilization of staffing, increasing bilingual/bicultural staff to better reach our Spanish and Vietnamese speaking consumers.

In FY2016-17, we will be integrating what is currently known as the Adult Case Management Team and our two Medication Clinics into one, interdisciplinary team serving clients at two locations, the Kerner Campus and at Bon Air. It is our belief that this integrated model will allow for more continuity of care, and allow all consumers to access the services they need when they need them. We will also be exploring tools for evaluating fluctuations in consumer needs, developing a more flexible system, enhancing care, and expanding the amount of services available.
CO-OCCURRING CAPACITY

Program Overview

In both the original and recent MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 planning processes, effectively identifying, engaging and treating clients with complex co-occurring mental health and substance use disorders continues to be identified as a priority. In the last few years, some of the CSS programs have increased their capacity to address co-occurring disorders, and significant progress has been made in increasing coordination and integration of mental health and substance use services and administration. The MHSA Three-Year plan presents the opportunity to expand and institutionalize these efforts in order to effectively and seamlessly serve clients with co-occurring mental health and substance use disorders, including tobacco dependence.

Target Population

**Alliance in Recovery (AIR) Program**
The target population of the Alliance in Recovery (AIR) Program is for adults (18+) with co-occurring substance use and mental health disorders—referred from either system of care—who are not being adequately served through the programs currently available in the mental health and/or substance use services system of care.

**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.

**Peer to Peer Tobacco Cessation Services**
The target populations of the Peer to Peer Tobacco Cessation Services program are mental health consumers and agency staff working with consumers with serious and persistent mental illness.

Program Description

**Alliance in Recovery (AIR) Program**
The AIR Program provides intensive outreach and engagement services for adults whose co-occurring mental health and substance use disorders have resulted in unsuccessful treatment outcomes in one or both treatment systems. Staffed by a County mental health clinician, a contracted substance use counselor, and a contracted peer specialist—all who are a co-located team—the goal of the program is to provide flexible outreach and support services that build trust and relationships with these difficult-to-engage individuals, increase their motivation to change, and support them to access and participate in formal treatment services. Services provided will vary on the client’s needs, strengths and stage of readiness, and may include services such as outreach, individual counseling, group counseling, case management and linkage to other supportive services. The capacity of the AIR program is 20 clients at any given time, with an estimated 40 individuals served annually.
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.

Peer to Peer Tobacco Cessation Services
This program trains and supervises peer cessation specialists 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.

Expected Outcomes

Alliance in Recovery (AIR) Program
The goals initially established for the AIR Program are to reduce hospital days, Psychiatric Emergency Services admissions, homelessness and criminal justice involvement. Specific goals are listed in the FY2014-15 Outcomes section. Although this is not a Full Service Partnership, it is intended that the data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the AIR Program staff on a daily basis. Program staff will continue to explore methods for measuring engagement.

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, such as number of clients served and change in provider skills. A follow-up survey also collects data on change in substance use for clients. Data is being collected and reported through a combination of Marin WITS—the substance use electronic health record—and service logs.

Peer to Peer Tobacco Cessation Services
As the project focuses on both client services and capacity building, the expected outcomes include both outcome measures, such as reduction in tobacco use, and performance measures, such as integrating tobacco cessation into other substance use programs. Supervised by an independent external evaluator, data is being collected and reported through a combination of training logs, group sign-in sheets, key informant interviews with County and contractor staff, and an analysis of intake, completion and follow-up survey data with consumers to assess their smoking status. Data will also be collected on methods used to assist in smoking cessation efforts, including, but not limited to: participation in peer-led cessation groups and/or peer-led individual motivational interventions; use of a nicotine patch, gum or nasal spray; Bupropion; and/or other supports.
Actually Outcomes

Alliance in Recovery
In addition to hiring a Peer Specialist in FY14-15, AIR provided 36 outreach, information and engagement group sessions at community agencies, including Homeward Bound Voyager, Buckelew Programs Supported Housing, Casa Rene Crisis Residential, and Helen Vine Recovery Center. Of the 35 clients served, 37% were transferred or discharged from AIR. Of the clients transferred or discharged from AIR, 46% successfully achieved AIR goals, including engaging in either the formal treatment system or natural community supports. Given that AIR serves among the most complex clients, all of whom historically have not engaged in the formal treatment system, this represents a significant success.

There is no FY2014-15 data to report for reduced hospital days, homeless days, Psychiatric Emergency admissions and criminal justice involvement as the data was not entered into Clinician's Gateway due to the impact it has on the FSP dataset. The AIR team is exploring whether the measures identified during the three-year planning process sufficiently capture the intended outcomes of the program. As such, the FY2014-15 outcome measures are focused on a key goal of AIR, which is to successfully engage the target population with formal treatment or natural community supports.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Goal</th>
<th>FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients with mental health and substance use disorders</td>
<td>40</td>
<td>35</td>
</tr>
<tr>
<td>Reduced hospital days</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Reduced Psychiatric Emergency Services admissions</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Reduced homeless days</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Reduced criminal justice involvement</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Demographics

Age Group:
- 0-15: 31 (88%)
- 16-25: 2 (6%)
- 26-59: 2 (6%)
- 60+: 2 (6%)

Race/Ethnicity:
- White: 24 (68%)
- African American: 2 (6%)
- Asian: 2 (6%)
- Native: 4 (11%)
- Hispanic: 1 (3%)
- Multi: 1 (3%)
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 FY14-15 project period:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of mental health County and contractor staff/providers (Psychiatric Emergency Services, MHSUS medical providers, HHS Division of Children and Family Services, Casa Rene Crisis Residential program and others) receiving case consultation and staff training/presentations</td>
<td>50</td>
<td>54</td>
</tr>
<tr>
<td>Number of mental health clients receiving substance use assessment, care management and other support services</td>
<td>75</td>
<td>69</td>
</tr>
<tr>
<td>Staff receiving consultation report increase in ability to address substance use issues</td>
<td>80%</td>
<td>96% N=25</td>
</tr>
</tbody>
</table>
| Clients served will take recommended action in relationship to reducing substance use and/or related problems. Upon follow-up clients reported:  
  • No substance use  
  • Reduced substance use  
  • Institutionally clean and sober  
  • No change in substance use | 50%  | 63% 28% 6% 3% N=35 |

In addition, staff provided 43 group education and counseling sessions to 294 (duplicated) clients engaged at the Casa Rene Crisis Residential program. Of the clients that participated in a follow-up
survey (n=273 / 92.9% response rate), 79% reported that the substance use knowledge learned will assist them following discharge from Casa Rene.

Demographics

Peer to Peer Tobacco Cessation Services
Most program objectives were met during the FY14-15 project period, including 75% of clients participating in peer-led cessation services reporting reducing their tobacco use. The number of agencies integrating tobacco cessation support into their programs exceeded the FY14-15 goal, with peer-led cessation services being delivered at: 1) Bridge the Gap, in Marin City; 2) Homeward Bound
Residential Program, in San Rafael; 3) Enterprise Resource Center; 4) Casa Rene; 5) Draper House; and 6) Marin Treatment Center.

Below is a summary of outcomes that were achieved during the FY2014-15 project period:

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>GOAL</th>
<th>Actual FY2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of peers receiving training and supervision to provide peer to peer smoking cessation services</td>
<td>10</td>
<td>N/A in FY 14-15</td>
</tr>
<tr>
<td>Number of mental health clients participating in smoking cessation services</td>
<td>75</td>
<td>79</td>
</tr>
<tr>
<td>Percentage of clients participating in peer-led cessation services who report reducing their tobacco use</td>
<td>60%</td>
<td>34% N=59</td>
</tr>
<tr>
<td>Percentage of clients participating in peer-led cessation services who report attempting to quit smoking</td>
<td>75%</td>
<td>75% N=59</td>
</tr>
<tr>
<td>Percentage of clients participating in peer-led cessation services who maintained their quit status at 3-month follow-up</td>
<td>30%</td>
<td>Not Collected in FY 14-15</td>
</tr>
<tr>
<td>Number of County and contractor agencies that integrate tobacco cessation support into their programs</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Demographics

**Age Group**

- 0-15: 8 (12%)
- 16-25: 17 (25%)
- 26-59: 43 (62%)
- 60+: 1 (1%)
- unknown: 1 (1%)

**Race/Ethnicity**

- White: 50 (73%)
- African American: 6 (9%)
- Asian: 3 (4%)
- Native: 1 (1%)
- Hispanic: 1 (1%)
- Multi: 1 (1%)
Challenges and Upcoming Changes

In FY2015-16, data reporting for the Alliance in Recovery program has remained a challenge. Although AIR staff continue to collect Full Service Partnership (FSP) data, it is not being entered into Clinician’s Gateway due to the impact it has on the FSP dataset. The Alliance in Recovery team also has continued to explore whether the measures identified during the three-year planning process sufficiently capture the intended outcomes of the program. As such, the FY14-15 outcome measures are focused on a key goal of the AIR program, which is to successfully engage individuals with complex co-occurring mental health and substance use conditions with formal treatment or natural community supports.

Similar to FY2014-15, co-location of a consulting addiction specialist has been invaluable in terms of staff consultation services and direct client care. However, 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. In order to better meet the demand for services, in FY15-16 the Division of Mental Health and Substance Use Services allocated substance use services funding to make the consulting addiction specialist a full-time position.

In FY2016-17, the Alliance in Recovery Program will explore a different integration and staffing approach to delivering services and will identify additional outcome measures to track and report on that more closely align with the goals and objectives of the program. The Division of Mental Health and Substance Use Services also intends to continue augmenting the consulting addiction specialist position with substance use funding in order to provide full-time support for this work.
CRISIS CONTINUUM OF CARE

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). Crisis Residential moved from Innovation funding to Community Services and Supports (CSS) funding in FY2015-16. The theory behind these changes is that having crisis services coordinated into a clear continuum will enable these services to provide a smooth flow that reduces barriers to access. In addition, Marin County MHSUS was awarded a grant from Mental Health Service Oversight and Accountability Commission (MHSOAC) for Triage Personnel 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. Current approaches to care clearly demonstrate 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 levels of services such as Psychiatric Emergency Services (PES), hospitalization and/or time spent in jail can be avoided or drastically reduced. Additionally, individuals are empowered to make choices for themselves before a crisis hits, when judgement and decision making is most impaired, forcing others to make decisions about their care such as law enforcement, PES, or jail personnel.

Target Population

The target population is individuals currently experiencing a psychiatric crisis, including individuals who are unserved or underserved, and those who have recently experienced a crisis and are in need of immediate follow-up care. Priority is given to MediCal recipients at highest risk for requiring higher levels of intervention, such as police, acute hospitalization or jail.

Crisis Planning

Program Description

The Crisis Planning program consists of specially trained Peer Specialists who assist individuals at risk of psychiatric crises to create a plan for treatment should they experience future crises (a “crisis plan”). This team collaborates closely with PES, Crisis Residential, treatment providers and others to engage individuals. They meet with people in the community to create a realistic plan for care 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. The crisis planning staff are integral members of the Crisis Continuum, participating in weekly Crisis Residential meetings.
Crisis Planning aims to (1) increase clients’ knowledge, skills and network of support to avoid crises or resolve them quickly when they do happen; (2) to inform Psychiatric Emergency Services of client’s wishes, particularly around treatment choices and family involvement when faced with a crisis; and (3) to engage and support clients who are residing in the Crisis Residential in the completion of a crisis plan. Developing and using crisis plans allows for a more recovery-oriented focus, supporting individuals in choosing how they want to engage in their recovery.

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.

Expected Outcomes and Evaluation

Listed in the table below, the expected outcomes for the Crisis Planning Program are based on the goals of the program and remain unchanged. The crisis planning team gathers these data points as they work with clients.

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

Actual Outcomes

Over the course of the year, Crisis Planning Counselors conducted outreach and discussed crisis planning services with 120 individuals, far exceeding their goal of 80. Crisis Planning and follow up services were provided to 65 individuals and family members. Aftercare group services were provided to 12 individuals. Of those completing crisis plans, 23 consumers agreed to have their crisis plan permanently entered into their mental health record for use in case of future crises. Following accessing crisis planning services, 27 people completed program surveys. Of those 27, 30% indicated that their symptoms are not interfering as much with their daily activities and over
40% reported the crisis plan helped them reach out to their supports to avert a crisis. Almost half (45%) agreed that crisis planning reduced their need for psychiatric emergency services. Program plans for the future include expanding program capacity by integrating existing peer providers embedded in county programs to create crisis plans with their clients who have received services at PES or the Crisis Residential Unit.

**PES Family Partner**

Program Description

The family partner is an integral member of the PES team. They are on site 11am-7pm, five days a week, and work closely with PES staff when a family arrives with a loved one in crisis. The family partner assists families in navigating the mental health system and advocating for families to access needed resources. The family partner also co-facilitates a family support group to facilitate support among families struggling with mental illness. This role also has the capability of meeting families in the community to create family crisis plans and help families following a crisis to access needed resources and support. If the family is found to need longer term supports, the PES family partner may refer to the family partners integrated into 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 one hundred (100) family contacts.

Actual Outcomes

The family partner served a total of one hundred seventeen (117) family members, exceeding the goal of 100. Of these family members, ninety-six (96) spoke English, five (5) Spanish, two (2) Vietnamese, and fourteen (14) spoke other languages. Ninety-two (92) were White, ten (10) African American/Black, seven (7) Asian, seven (7) Latino, and one (1) Other/Unknown.

**Crisis Residential – Casa René**

Program Description

Casa René is a 10-bed Crisis Residential facility currently administered by Buckelew Programs. The program aims to reduce unnecessary acute psychiatric hospitalizations by providing a home-like setting where individuals can resolve crises in the community and re-stabilize for up to thirty (30) days. The program integrates peer and professional staffing as well as client centered programing focused on principles of wellness and recovery. Crisis residential staff works with each individual’s circle of support: family, friends, treatment professionals, substance abuse counselors, 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.

Currently all referrals to Casa Rene are directly from Marin County Psychiatric Emergency Services (PES). The program is a collaborative effort between many community partners, especially between Buckelew Programs, Community Action Marin and County Mental Health and Substance Use
Services. Buckelew Programs provide the facility and staffing; MHSUS provides nurse practitioner care for residents while at Casa René; and Community Action Marin provides crisis planning services.

The target population is individuals, age 18 and above, experiencing a psychiatric crisis and who are able to voluntarily agree to stay at Casa René in lieu of a hospitalization. Priority is given to Medi-Cal recipients experiencing a psychiatric crisis.

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.

For FY2014-15 outcomes see the Innovation component of this report and Appendix C. 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.

Challenges and Upcoming Changes

In FY2015-16, MHSUS began the implementation of the Mental Health Service Oversight and Accountability Commission (MHSOAC) grant for Triage Personnel as well as the implementation of the Mobile Crisis services funded by the California Health Facilities Financing Authority (CHFFA).

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

Program Overview

In August 2007, the State Department of Mental Health released the guidelines for the Mental Health Services Act (MHSA) Housing Program (MHSAP), a collaborative program administered by the California Housing Finance Agency and the State Department of Mental Health. MHSAP 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. MHSAP 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. MHSAP 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 MHSAP, an individual/family/household must also be homeless or at risk of becoming homeless, as defined by MHSAP 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.

Program Description – Fireside Senior Apartments

In FY2008-09, Marin County received approval of our proposal to use MHSAP 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 MHSAP 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 MHSAP-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 MHSAP-funded units opened on December 3, 2009. The first MHSAP-funded unit was occupied on January 25, 2010 and all five (5) units were occupied as of June 6, 2010.
Actual Outcomes

During this reporting period, all five (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.

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 despite the January 2015 changes with the California Housing Finance Agency (CalHFA) which allows counties to request the return of their unspent CalHFA Mental Health Services Act housing funds.

In FY2015-16, the MHSA Advisory Committee convened a meeting on September 2, 2015 that included participants with housing development experience in Marin to educate the committee on the challenges and recommendations from experts familiar with housing projects in Marin. The experts that participated were: Marc Rand, Marin Community Foundation; Craig Meltzner, Craig S. Meltzner & Associates; Roy Bateman, Marin County Community Development. During FY2015-16 MHSUS will seek the Board of Supervisors support to approve the withdrawal of Marin’s funds with CalHFA through a board action so that when a development is identified, we are ready to withdraw our funds.

In FY2016-17, the MHSUS Director will continue to explore development partnership opportunities in Marin
## COMMUNITY SERVICES AND SUPPORTS (CSS)

### Numbers to be Served in FY2016-17

<table>
<thead>
<tr>
<th>Program</th>
<th>FY2014-15 Actual</th>
<th>FY2015-16 Projected</th>
<th>FY2015-16 Cost Per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSP-01 Youth Empowerment Services (YES)</td>
<td>FSP 38</td>
<td>20</td>
<td>$16,231</td>
</tr>
<tr>
<td>FSP-02 Transition Age Youth (TAY)</td>
<td>FSP 20</td>
<td>25</td>
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<tr>
<td>FSP-03 Support and Treatment After Release (STAR)</td>
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<td>FSP-04 Helping Older People Excel (HOPE)</td>
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<tr>
<td>FSP-05 Odyssey (Homeless)</td>
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<tr>
<td>SDOE-1 Enterprise Resource Center (ERC)</td>
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<tr>
<td>SDOE-4 Southern Marin Services Site (SMSS)</td>
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<td>SDOE-7 Adult System of Care (ASOC)</td>
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<td>SDOE-8 Co-Occurring Capacity</td>
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<tr>
<td>SDOE-9 Crisis Continuum of Care</td>
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<td>Housing</td>
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</table>

*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.

**Southern Marin Services Site (SMSS) ended June 30, 2016.
# Community Services and Supports (CSS)
## Community Services and Supports – Component Budget

### COUNTY OF MARIN
#### MENTAL HEALTH AND SUBSTANCE USE SERVICES DIVISION

#### MHSA FY2016-2017 ANNUAL UPDATE

## MHSA Community Services and Support (CSS)
### Three-Year Plan (FY2014-2015 through FY2016-2017)

<table>
<thead>
<tr>
<th>Program</th>
<th>FY14-15</th>
<th>FY15-16</th>
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<th>Total</th>
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<td><strong>Total</strong></td>
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<td>$7,725,675</td>
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<table>
<thead>
<tr>
<th>FY14-15</th>
<th>FY15-16</th>
<th>FY16-17</th>
<th>Total</th>
<th>%</th>
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<td>Operating Reserve</td>
<td>$129,798</td>
<td>$129,798</td>
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<td>$389,394</td>
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<tr>
<td><strong>Total</strong></td>
<td>$7,035,675</td>
<td>$7,725,675</td>
<td>$7,725,675</td>
<td>$22,487,025</td>
</tr>
</tbody>
</table>

| 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% |
CLIENT CHOICE AND HOSPITAL PREVENTION PROGRAM (CCHPP)

Program Overview

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

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

- Introduces new, never-before-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 concluded at the end of FY2014-15 when it moved under Community Services and Supports (CSS) funding.

Target Population

The population served by the Client Choice and Hospital Prevention program are adults at risk for or experiencing severe mental illness and who are experiencing a psychiatric crisis.

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.

**Expected Outcomes**

This project was intended 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.
Actual Outcomes

Marin County’s crisis residential unit, Casa René, opened its doors on February 4, 2014. A full evaluation report was conducted by a neutral contracted evaluator, looking at how all of the components of the Innovation Plan worked together, what was achieved, and what we learned from implementing the Plan that can be applied to other efforts. See Appendix C for the full report.

Key findings:

Crisis Residential

Partnerships with mental health providers and peer professionals:

- **Marin County partners and staff understand collaboration and its importance.** Partners and staff reported consistent and high levels of agreement with statements related to their knowledge and understanding of the importance of collaboration among providers, integration of peer professionals/family partners and inclusion of substance use services.

- **Really involving people in ongoing decision making works.** Partners and staff increased in their agreement that they influenced program design and implementation decisions. Participants on the Advisory Committee increased their ratings by more than 20%.

- **Peer providers and family partners are involved in the crisis mental health system in meaningful ways and clients notice.** When asked whether or not peers employed in crisis services are treated as equal partners, peer providers and family partners increased their agreement by 25% from January 2014 to January 2015. In client interviews, clients noticed that staff and peers were working together and appreciated the coordinated services.

Partnerships with Substance Use Services:

- **Integrating mental health and substance use services is a long process with ongoing challenges; clients have already noticed the changes and are satisfied with the shifts in collaboration.** There is continued work to be done to address long-standing system barriers between substance use and mental health and to ensure that the needed substance use services are available to clients in Marin County. Currently peer providers/family partners and substance use providers are not connected, though they are serving the same clients at Casa René. When compared to June 2014, partners and staff decreased their agreement that changes have been made in the mental health system and/or in the substance use system to prevent and treat psychiatric crisis. In the client interviews, clients praised the substance use services at Casa René.

Improved Client Outcomes:

- **Clients’ perspectives about crisis mental health services are a key component of understanding quality.** Clients rated the quality of the crisis mental health system based on the definition developed in July 2014 (see page 18). They were most likely to indicate that they had experienced strong partnerships and increased connections, but also reported frustration in obtaining high quality mental health services and supports.
➢ The availability of Crisis Residential/Casa René keeps clients out of locked facilities. For the period of February 2014 to June 2015, there were 229 referrals to crisis residential: 50 individuals (22%) were diverted from a locked unit and 78 clients (34%) were stepped-down from a locked unit to crisis residential.

Crisis Planning

Partnerships with Crisis Planning/Improved Client Outcomes:

➢ Crisis Planning encourages clients to develop and use their own supports. After reviewing the program strengths and outcomes in July 2014, CCHPP staff agreed that the focus of crisis planning was moving to PREVENT crisis rather than change the experience of individuals at PES. To this end, of the survey respondents with a crisis plan indicated the plan helped them reduce their symptoms (30%), reach out to supports (41%) and decrease their need for psychiatric emergency services (44%). Clients praised crisis planning as a support to improve their social supports and to help them navigate the systems of care to get connected to ongoing services.

➢ Crisis Planning helps clients feel like they can partners with the mental health system and participate in their own recovery. In the post survey, crisis planning participants were twice as likely to agree that crisis planning helped them feel like they can partner with the mental health system and that having a crisis plan makes them feel like they can participate in their own recovery. More than one-third of the individuals who had a crisis plan and returned to PES for services reported that the crisis plan improved their overall experience with PES.

➢ Clients who participated in crisis planning needed relatively less care on subsequent visits than those who did not participate. The clients who participated in Crisis Planning services and Crisis Residential were about twice as likely to have a second visit to Crisis Residential, but only increased their time in care by 10%. The clients who participated in only Crisis Residential services (without any participation in Crisis Planning), were less likely to return to Crisis Residential, but stayed an average of 36% longer on their second visit when compared to their first visit.

Upcoming Changes

When concluding an Innovation Plan a county must determine if they will continue the services funded by it. In this case all components of the Plan were considered successful and important to continue. Innovation funding for Casa Rene concluded at the end of FY2014-15 when it moved under Community Services and Supports (CSS) funding. The Crisis Planning Services also shifted from MHSA PEI funds to CSS funds.
GROWING ROOTS: THE YOUNG ADULT SERVICES PROJECT

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 is initiating its second Innovation Plan in Summer of 2016. The Plan focuses on reducing disparities by working closely with the transition age youth from un/underserved populations who are at risk for or experiencing a mental illness and informal providers who successfully engage them. By engaging their expertise in conducting a needs assessment, developing an action plan, and implementing new or expanded services and strategies, we aim to:

reduce disparities in access to culturally competent behavioral health services for TAY from un/underserved populations (i.e.: race, ethnicity, language, sexual orientation, gender identity, geographic isolation, experiencing complex conditions) who are at risk for or experiencing a mental illness by building on the strengths of the informal system of care.

Target Population

This Innovation Plan focuses on transition age youth (16-25) from un/underserved populations (i.e.: race, ethnicity, language, sexual orientation, gender identity, geographic isolation) who are at risk for or experiencing a mental illness. In Marin the specific populations identified as underserved by the County mental health services include: Latinos (18+), Asian Pacific Islanders, African Americans (inappropriately served), persons living in West Marin, and Spanish and Vietnamese speaking persons. Additionally, this Plan targets those experiencing complex conditions and TAY who are currently engaging in informal services, but not the formal behavioral health system of care.

Program Description

The core challenge identified in Marin, during the development of the MHSA Three-Year Program and Expenditure Plan for FY14-15 through FY16-17, was how to reduce disparities for un/underserved populations in the mental health system. Efforts to reduce disparities can address increasing access to services for those who are underserved, as well as improving quality of services.
to reduce disparities in outcomes. Currently a number of populations in Marin are defined as un/undeserved due to accessing county mental health services at lower rates than expected, including adult Latinos, African Americans (inappropriately served), older adults, transition aged youth (16-25 years old), and persons living in West Marin.

During Innovation community meetings in late 2014 and early 2015, the role of the informal system of care was identified as a key to addressing existing disparities. Informal providers - such as grassroots, faith and peer led organizations - provide a number of behavioral health - mental health and substance use - services for those at risk for or experiencing mental illness who may not be engaged with the formal system of care. Services include outreach, engagement, prevention, intervention, resiliency, recovery and community integration.

In addition, transition age youth from 16-25 years old (TAY) were identified as an un/underserved population that continues to be hard to reach. TAY at risk for or experiencing mental illness are less likely to engage in formal mental health services than other age groups. At the same time, an individual's initial episode of severe mental illness usually occurs in the late teens or early twenties, suicide is the third leading cause of death for youth ages 15-24, and youth ages 15 to 21 have the highest prevalence of co-occurring substance use and mental disorders. Youth with unaddressed mental health problems are highly likely to drop out of school, go to jail as adults, and suffer other negative outcomes. Given this, it is imperative that we support services that this population will engage with.

Plan Components:

TAY Advisory Council

- Develop a TAY Advisory Council to participate in the implementation of the INN Plan.
- Include TAY in the needs assessment and evaluation to ensure the Action Plan and evaluation of the Plan are based on their needs.
- Provide opportunities and support for TAY to participate in stakeholder processes.

Joint Learning Process

- Engage County and community providers in a joint learning process to strengthen the system of care.
- This project recognizes that all partners bring something valuable to the table. For example, informal providers are successful in providing prevention and recovery services that are engaging for underserved communities; more established organizations generally have more capacity for providing clinical services, securing funding and conducting evaluations; and TAY and their families are essential to developing client centered services and systems.

Phase 1 Needs Assessment

- Gather existing data including from the census, homeless survey, agencies serving TAY and literature.
- Release a Request for Proposals (RFP) to identify providers serving TAY from underserved populations to participate in and assist in conducting focus groups, key informant interviews,
and surveys with TAY and their families. The aim is to understand their perspective on effective access to services, challenges, and other factors that will assist with understanding what an improved system of care would look like.

- The Needs Assessment will break down needs based on age and other demographics.

**Phase 2 Action Plan**

- Based on the Needs Assessment, develop an Action Plan for making changes to the system of care.
- Release a Request for Proposals (RFP) to identify providers to implement changes to their services and systems as prioritized in the Action Plan.
- Participating agencies implement changes that may include changes to policies and procedures; locations or modes of services; types or quantity of services available; coordination of services; and evaluation of services, among others.
- Implement trainings, technical assistance, and evaluation as needed.

**Evaluation**

- The evaluator will develop and implement a complete evaluation plan based on this INN Plan and the Needs Assessment.

**Expected Outcomes**

The Innovation Plan aims to reduce disparities in access to culturally competent behavioral health services for TAY from un/underserved populations (i.e.: race, ethnicity, language, sexual orientation, gender identity, geographic isolation, experiencing complex conditions) who are at risk for or experiencing a mental illness by building on the strengths of the informal system of care. By learning from and integrating the expertise of TAY themselves and providers who reflect TAY in terms of culture, language and lived experience, we hope to:

- Increase our understanding of the behavioral health needs of un/underserved TAY in Marin;
- Increase access to, quality of, range of, and cultural competency of services available to TAY;
- Increase the number of TAY receiving services and achieving positive behavioral health outcomes.

What we learn about increasing access and providing effective services will be incorporated into MHSUS’ work going forward. This may mean changes to MHSUS policies, services, and/or funding priorities.

To review the complete Innovation Plan go to www.marinhhs.org/innovation.
WORKFORCE, EDUCATION AND TRAINING

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. The focus is on developing and maintaining a more diverse workforce, including individuals with personal experience of mental illness and their family members. State requirements include:

1. Expand capacity of postsecondary education programs.
2. Expand forgiveness and scholarship programs.
3. Create new stipend programs.
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.

The goal of Marin’s MHSUS Workforce, Education and Training Program is to develop a workforce that is culturally competent, linguistically and culturally reflective of the communities that are served, and able to offer integrated treatment for co-occurring disorders. Some of the key strategies have included providing stipends, training and mentoring to assist consumers to enter the public mental health workforce; providing stipends for bilingual and bicultural interns through partner CBOs and MHSUS’ APA accredited internship program.

Target Population

WET programs are designed to increase the number of peer and family providers, as well as culturally and linguistically competent providers. In Marin this includes Spanish speaking, Latino, African Americans, Vietnamese speaking, Asian, LGBTQ and other providers that reflect our client population. WET partners with county divisions and community-based organizations, including primary care providers, to support the development and employment of a diverse workforce. The programs are targeted toward the current workforce in addition to reaching out to future workforce members.

Trainings are open to all county, CBO, peer and family member providers. 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 create trainings for their respective populations and fully participate in the process.
Program Description and FY14-15 Activities

1. System-wide Dual Diagnosis Training

Marin Mental Health and Substance Use Services system underwent an integration process to bring together the two previously separate divisions of Mental Health and Alcohol and Other Drugs. The goal of this component is that every member of the workforce will be provided training to identify and respond to clients with dual diagnosis. The training model will include workshops, followed by ongoing coaching and consultation to integrate and maintain practice change. MHSUS hired a consultant organization, Harm Reduction Therapy Center (HRTC) to coordinate this process. HRTC established the Co-Occurring Disorders Collaborative to enhance integration and collaboration between mental health and substance use services. HRTC is working closely with MHSUS senior management staff to plan and implement this component.

The trainings that took place in FY14-15 include:

**Dual Diagnosis training for the Alliance in Recovery (AIR) Team**

The two members of the team received ten trainings, resulting in increased ability to implement new skills and engage with clients effectively.

**Harm Reduction and Dual Diagnosis**

This training group for MHSUS and contracted case managers and therapists met ten times. A total of twelve providers participated, with an average of 6 people attending each group. The group demonstrated increased skill by becoming more active, relative to the consultant, in advising each other about working with complex clients.

**Training for Consumers and Peer Counselors**

Dual Diagnosis training group for peer counselors at the Enterprise Resource Center (ERC). This training met eleven times during the fiscal year. A total of nine people attended, with an average of five people per training.

**Provider Trainings**

The Motivational Interviewing training of trainers process concluded, resulting in MHSUS having the capacity to deliver MI training without hiring outside trainers. MI training will be built into the Dual Diagnosis training in FY15-16 fiscal year with county employees providing the MI training.

2. Family Member Focus Training

This component aims to enhance the skills of family members to provide support to other families who have loved ones with mental illness. In addition it is to increase the capacity of providers to include families in treatment and planning processes.

3. Scholarships for Underserved Consumers and Family Members

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. Scholarship opportunities will enable qualified Marin residents with lived experience to enroll in vocational mental health, drug and alcohol, and/or
domestic violence peer provider programs. Twenty-one (21) scholarships were awarded in FY14-15 since the program began in April 2015. The majority of awardees decided to pursue a certificate in drug and alcohol counseling. It is expected that all awarded students will successfully complete their chosen vocational education programs. Upon completion, they are expected to volunteer, intern and/or find gainful employment in their respective fields at a public service agency.

In addition, two consumers were funded to attend a 5-day WRAP Certification training. There are plans to have the newly certified WRAP group leaders “take WRAP on the road” to parts of the County with less access to WRAP, such as Marin City, West Marin, and Novato.

4. Community Based Organizations (CBO) Intern Stipends

This component aims to support CBO interns to fill hard-to-fill positions. 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.

In FY2015-16 the stipends will be shifted to support individuals who have completed vocational counseling programs in order to create parity and promote Peer Specialists in the county’s behavioral healthcare system.

5. Training Initiatives

This component provides workshops, courses and ongoing coaching in evidence-based, promising practices, and community-defined practices.

In FY14-15, MHSUS’ Cultural Competence Advisory Board implemented a series of cultural competency trainings including:

- A one-day training on October 2014 that included consumers and family members as subject matter experts. Approximately 100 participants attended the training.
- Six (6) 3-hour cultural competency trainings between April-June 2015.

Graduates of the Group Therapy Training Program met monthly from July through December of 2014. This group had 7 members and an average of 4 people attended each session. The group leaders facilitated 2 members of that group to attend at the American Group Psychotherapy Association Annual Meeting in February 2015. They assisted 1 member to present a workshop at the Annual Meeting. That workshop was entitled “Adapting Group Psychotherapy to Work with Marginalized People.” 40 participants attended the workshop.

6. Peer Mentoring

This component provides support for people to mentor consumers who are entering the MHSUS workforce. Peers and behavioral healthcare professionals play a vital role in the success of students with lived experience who are entering into the workforce. MHSUS dedicated funds to develop a
program that would match mentors with scholarship awardees to support them in their pursuit of obtaining a vocational degree in behavioral health counseling. Participating peers and professionals all have lived experiences, providing support to students to reduce the risk of dropping out. In addition to providing ongoing emotional support and encouragement to students, they are also responsible for addressing barriers (i.e. basic living needs) that may prevent the student (mentee) from successfully completing the vocational training program.

7. MHSUS Intern Stipends

This component provides stipends for behavioral health graduate, doctoral and post-doctoral students to participate in Marin’s APA accredited internship program. This is an effective strategy for increasing the number of diverse interns providing services in Marin.

In FY14-15, there were thirteen (13) psychology interns and two (2) social work interns in the Graduate Clinical Training Program. With the help of MHSA funding we were able to offer competitive stipends to bilingual applicants that have many opportunities in the Bay Area. Nine were bilingual/bicultural (6 fluent in Spanish, 2 in Vietnamese). Two (2) are family members of consumers, seven were first or second year immigrants and two identified as part of the LGBT community.

The interns provided individual outpatient psychotherapy, group psychotherapy, psycho-diagnostic assessment, case management, brokerage and rehab services, psycho-educational groups and community outreach and engagement, including bilingual broadcast and print media. They provided these services in the Latino Family Health, Supported Treatment After Release (STAR), Vietnamese Family Health, Adult Case Management and West Marin programs. They participated in Prevention and Early Intervention outreach and engagement such as the Cuerpo, Corazan and Communidad Radio Program, which is presented weekly by a county bilingual psychologist, a truly unique experience for those interns who are interested. Four interns were subsequently hired by MHSUS or community providers.

8. WET Coordination

In FY14-15, the Ethnic Services Manager became the WET Coordinator. He is working closely with the Harm Reduction Therapy Center to ensure coordination of all components of the WET Plan.

9. California Institute for Behavioral Health – Leadership Institute Training

This action item was created to send current and future leaders from Marin to the California Institute of Behavioral Health (CIBH) 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 FY14-15 no staff was sent to the training due to turn-over in a number of key positions. One staff member is expected to participate in FY15-16.
Highlights from FY2014-15

MHSUS redesigned the two WET steering committees (consumer and family member) into one committee, and added MHSUS staff and agency partners. This was done in order to promote inclusion and greater collaboration among a wider and more culturally diverse stakeholder community. The purpose of the newly designed committee has remained the same in that it continues to advise the ESTM and MHSUS senior management about emerging workforce, education and training trends and needs of the behavioral health workforce.

In addition to the many initiatives described above, seven bilingual/bicultural MHSUS staff attended a 3-day Interpreters’ Training (four Latino/a, three Vietnamese). Participating staff are commonly used to improve communication and access for monolingual Spanish and Vietnamese speaking consumers. Based on written evaluations submitted, all staff reported feeling more confident and skilled to interpret between consumers and MHSUS staff. Marin County was the host site for this multi-county collaborative, which included Sonoma and Napa counties.

Challenges and Upcoming Changes

In FY2015-16, MHSUS’ WET program is experiencing a robust year, filled with requests for new evidenced-based and community-defined practice trainings for the county and contracted workforce. Also, the redesign of the WET system expects to improve engagement of consumers and family members as newly incentivized opportunities will be offered. The Scholarships for Underserved Consumers and Family Members and the expanded Peer Mentoring programs expect to see a continued increase in interest and participation.

Community-Based Organization Intern Stipends will also be revised to provide stipends for consumers and family members upon completion of their vocational program courses. Also, an interest in system-wide cultural competency training will likely result in hiring trainers and consultants similar to the function and purpose of the Harm Reduction Therapy Center.

Lastly, due to the consolidation of the WET Consumer and Family Steering committees into one WET Steering committee, Family Member Focus Trainings will be eliminated. However, family members who request family-focused training opportunities can request training funds through the Training Initiatives component of the overall WET program.
### MHSA Workforce, Education and Training (WET)


<table>
<thead>
<tr>
<th>Program</th>
<th>FY14-15</th>
<th>FY15-16</th>
<th>FY16-17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) System-wide Dual Diagnosis Training</td>
<td>$7,472.00</td>
<td>$24,310.00</td>
<td>$54,654.71</td>
<td>$86,436.71</td>
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<td>2) Family Member Focus Training</td>
<td>$3,900.00</td>
<td>$0</td>
<td>$0</td>
<td>$3,900.00</td>
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<tr>
<td>3) Scholarships for Underserved Consumers &amp; Family Members</td>
<td>$7,586.22</td>
<td>$68,719.00</td>
<td>$78,000.00</td>
<td>$154,305.22</td>
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<tr>
<td>4) Community Based Organization (CBO) Intern Stipends</td>
<td>$0</td>
<td>$0</td>
<td>$50,000.00</td>
<td>$50,000.00</td>
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<tr>
<td>5) Training Initiatives</td>
<td>$5,281.00</td>
<td>$23,099.07</td>
<td>$80,000.00</td>
<td>$108,380.07</td>
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<td>6) Peer Mentoring</td>
<td>$8,982.00</td>
<td>$22,234.00</td>
<td>$80,000.00</td>
<td>$111,216.00</td>
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<td>7) MHSUS Intern Stipends</td>
<td>$109,632.00</td>
<td>$152,000.00</td>
<td>$194,368.00</td>
<td>$456,000.00</td>
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<td>8) WET Coordination</td>
<td>$30,000.00</td>
<td>$0</td>
<td>$0</td>
<td>$30,000.00</td>
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<tr>
<td>9) California Institute for Mental Health-Training</td>
<td>$0</td>
<td>$5,348.00</td>
<td>$10,500</td>
<td>$15,848.00</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$172,853.22</strong></td>
<td><strong>$295,710.07</strong></td>
<td><strong>$547,522.71</strong></td>
<td><strong>$1,016,086.00</strong></td>
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#### One-Time Funding Sources:

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Year Unspent WET Funds (Actual)</td>
<td>$164,086</td>
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<tr>
<td>Prior Year Unspent CSS Funds</td>
<td>$852,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$1,016,086</strong></td>
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</table>
CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS

Electronic Health Record (EHR)

In FY2014/15 Marin continues to make progress toward systems enhancement and upgrades to our electronic health record, Clinicians Gateway. Additional Meaningful Use and Physicians Quality Reporting System (PQRS) documentation, data collection capability, forms, and reporting upgrades were made to the system. This includes the following:

- Clinical Decision Support modules for Meaningful Use certification requirements were added by enhancing the Metabolic Monitoring form to include smoking status, adding the PHQ-9 and SBQ-R form for completion electronically. Alerts will be set up in 14/15 in the EHR to include: PES admission alerts, Laboratory alerts (when labs are due, lab results and abnormal lab values), no-show alerts, Medication alerts, etc. Patient Specific education modules and Patient Portal will be developed in FY2014/15.

- Electronic signature pad functionality and software upgrades were made to the confirmation section in Clinicians Gateway in order to electronically capture client signatures. Signature pads were installed on service provider computers and lap tops. Tablets with signature capability were purchased for Case Management teams treating clients in the field.

- Small desk top printers were purchased and installed for medical providers. With Patient-Specific Education Resources capacity being added to our EHR, for Meaningful Use certification requirements; the ability to print out education resources and medication specific patient handouts for discussion during the visit enhances the quality of care for Marin clients.

- Marin is currently embarking on a Health Information Exchange (HIE) project to improve the coordination, quality and cost-effectiveness of care delivered to the citizens of Marin. The goal of this project is to implement a data sharing and integration service with HHS, Community Clinics and other external partners securely through our electronic health record, Clinicians Gateway. In April of 2015, an RFI will be announced in order to begin the process to select a vendor to implement this data sharing and integration service.

Practice Management Upgrades

Marin has continued to upgrade ShareCare to further meet State and Federal reporting requirements, as well as enhance billing and claiming functionality. Marin amended the CFTN Practice Management budget to reflect changes in personnel. In lieu of positions previously budgeted, we added a 1.0 FTE of Technology Specialist II who started employment in January 2015. Primary focus will be Practice Management and EHR technology. With this additional fixed term staff member, Marin has the increased capability to be able to further develop state and federal reporting, develop or purchase and implement a data warehouse system which interfaces with ShareCare to generate customizable financial and clinical reports, more efficiently and accurately track and monitor service delivery outcomes, and financial trends. As well as increase support for data analysis and quality improvement efforts.
As required by HIPAA, ICD-10 implementation requires a major system upgrade to be fully implemented by the Department of Health Care Services deadline of October 2015. Julie Larish, a national consultant for ICD-10 transition was contracted to provide support for the implementation and crosswalk for our practice management system. In September of 2014 Marin established an implementation steering committee lead by Quality Management and Julie Larish to plan for coding analysis and crosswalk, impact analysis, implementation and training for both county and contracted operated services.

E-Prescribing

Full implementation of this component continues to be delayed. Once a sufficient number of local pharmacies obtain certification to receive controlled or scheduled medication prescriptions electronically, Marin proposes to use MHSA funds to expand use of RxNT to include this functionality and eliminate all hand written prescriptions.

Scanning Project

This component involves the implementation of IMAVISER, a scanning application fully integrated with Clinician’s Gateway. Adding scanning capabilities to the EHR to incorporate the paper documentation will allow authorized clinical staff at any workstation to access key documents necessary for their work electronically. During FY2010-11, the software and hardware necessary for implementation was purchased; In FY2012/13 the software was updated and installed in a testing environment however, further implementation has been delayed by focus on other, higher priority components of CFTN.

Behavioral Health Crosswalk

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

Emergency Backup

Expanding hardware configuration to provide for emergency backup continues to be delayed due to limited County IT resources being directed to higher priority components of this project, including practice management, and EHR enhancements.
## Capital Facilities and Technological Needs (CFTN)
### Capital Facilities and Technological Needs – Component Budget

### MHSA Capital Facilities and Technological Needs (CFTN)

<table>
<thead>
<tr>
<th>Program</th>
<th>FY14-15</th>
<th>FY15-16</th>
<th>FY16-17</th>
<th>Total</th>
<th>Description of Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Management</td>
<td>$151,252</td>
<td>$66,507</td>
<td>$68,011</td>
<td>$285,770</td>
<td>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.</td>
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<tr>
<td>Scanning</td>
<td>$69,507</td>
<td>$55,968</td>
<td>$56,230</td>
<td>$181,705</td>
<td>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 have access to documentation necessary for quality care.</td>
</tr>
<tr>
<td>E-Prescribing</td>
<td>$40,400</td>
<td>$37,343</td>
<td>$37,735</td>
<td>$115,478</td>
<td>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.</td>
</tr>
<tr>
<td>Electronic Health Record Upgrade</td>
<td>$298,091</td>
<td>$185,344</td>
<td>$73,286</td>
<td>$556,721</td>
<td>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</td>
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<tr>
<td>Consumer Family Empowerment</td>
<td>$149,221</td>
<td>$72,055</td>
<td>$73,494</td>
<td>$294,770</td>
<td>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.</td>
</tr>
<tr>
<td>Behavioral Health Information Crosswalk</td>
<td>$142,081</td>
<td>$20,494</td>
<td>$20,494</td>
<td>$183,069</td>
<td>Further 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.</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$850,552</td>
<td>$437,711</td>
<td>$329,250</td>
<td>$1,617,513</td>
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</table>

### One-Time Funding Sources

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Year Unspent CFTN Funds</td>
<td>$709,500</td>
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<tr>
<td>Prior Year Unspent CSS Funds</td>
<td>$908,013</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$1,617,513</strong></td>
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</tbody>
</table>
Total MHSA Funds Allocation


<table>
<thead>
<tr>
<th>Components</th>
<th>FY14-15</th>
<th>FY15-16</th>
<th>FY16-17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services and Support (CSS)</td>
<td>$7,035,675</td>
<td>$7,725,675</td>
<td>$7,725,675</td>
<td>$22,487,025</td>
</tr>
<tr>
<td>Prevention and Early Intervention (PEI)</td>
<td>$1,647,500</td>
<td>$1,962,985</td>
<td>$2,091,015</td>
<td>$5,701,500</td>
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<tr>
<td>Workforce Education and Training (WET)</td>
<td>$172,853</td>
<td>$295,710</td>
<td>$547,523</td>
<td>$1,016,086</td>
</tr>
<tr>
<td>Capital Facilities and Technological Needs (CFTN)</td>
<td>$850,552</td>
<td>$437,711</td>
<td>$329,250</td>
<td>$1,617,513</td>
</tr>
<tr>
<td>Innovation (INN)</td>
<td>$621,055</td>
<td>$621,055</td>
<td>$621,055</td>
<td>$1,863,165</td>
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<tr>
<td><strong>Total MHSA Funds Allocated</strong></td>
<td><strong>$10,327,635</strong></td>
<td><strong>$11,043,136</strong></td>
<td><strong>$11,314,518</strong></td>
<td><strong>$32,685,289</strong></td>
</tr>
</tbody>
</table>

| Components                                |          |          |          |          |
| Community Services and Support (CSS) - Housing |          |          |          | **$1,400,000** |
| Local Prudent Reserve Available Balance    |          |          |          | **$2,175,490** |

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 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.
STAKEHOLDER PROCESS IN MARIN COUNTY

Background

In 2004, before the first Mental Health Services Act (MHSA) funds were provided to counties, Marin conducted an extensive community stakeholder process to identify unmet needs and strategies for addressing those needs. Over 1,000 people participated in that planning process, including clients, their families, diverse community members, providers, and other sectors of the community. (For a copy of the original Community Services and Support Plan, visit the 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. Demographics were not collected for all of the Board and Committee meetings.

This MHSA Annual Update for FY2016-17 reports on the first year of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

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.

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 Steering Committee 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 convened to review proposals received in response to Requests for Proposals to implement new or changed MHSA programs in FY2014-15.

New Innovation Project Stakeholder Process

Marin’s first Innovation project: Client Choice and Hospital Prevention Program concluded at the end of FY2014-15. Based on the outcomes of the community stakeholder process that was done to create the MHSA Three-Year Program and Expenditure Plan for FY2014-15 thought 2016-17, the Ethnic Services Manager and the MHSUS Director agreed that the focus of the next project should to be targeted at Reducing Disparities.

A community meeting was held on October 28, 2014 which over 40 community members and providers attended to see a presentation by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on MHSA Innovation Promise and Potential, Primary Purposes and MHSA General Standards, understand the Reducing Disparities theme for the projects and how to submit ideas and recommendations.

During the meeting, community stakeholders expressed concerns around the proposed process of submitting or talking about ideas for Reducing Disparities projects with others in the room because they didn’t want their ideas to be funded by other individuals or organizations in the room, many of them were unfamiliar with each other. There was a sense of distrust among the attendees. Mental Health and Substance Use Services (MHSUS) facilitators acknowledged the feedback from the participants and agreed to pause and re-strategize next steps.
On January 9, 2015, a second Innovation Planning stakeholder meeting was held and was attended by 48 community stakeholders. At the meeting MHSUS provided more detail and definition to the Reducing Disparities theme and held breakout discussion groups.

Innovation idea submissions were received from community stakeholders and in an effort to keep their idea confidential, but still give the community a sense of what was submitted we posted a summary of target population or geographical area and what the “hard to solve problem” was.

All meeting materials and the summary of idea submissions can be found in Appendix D.

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 E 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.

During FY2014-15 the new MHSA Advisory Committee started meeting in March 2015 and below is an overview of the meeting dates during FY2014-15:

- March 20, 2015
- April 3, 2015
- May 13, 2015
- June 10, 2015
- June 24, 2015

The committee continues to meets on the 4th Wednesday of each month for 1.5 hours. Information and data related to this MHSA Annual Update for FY2016-17 was present to the MHSA Advisory Committee during Winter/Spring of 2016 and the committee member provided their recommendations and feedback which have been incorporated into this report as much a possible.

All MHSA Advisory Committee meeting agenda and minutes can be found on the web at: https://www.marinhhs.org/mhsa-advisory-committee
See table below for ongoing venues for stakeholder input into MHSA areas.

<table>
<thead>
<tr>
<th>Stakeholder Involved</th>
<th>Policy</th>
<th>Program Planning and Implementation</th>
<th>Monitoring</th>
<th>Quality Improvement</th>
<th>Evaluation</th>
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<td>Alcohol &amp; Other Drug Advisory Board</td>
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<td>Board of Supervisors</td>
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FY2016-17 Annual Update Process

This Annual Update is reporting on the first year of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2015-16. This Annual Update was developed by MHSUS staff, the MHSA Advisory Committee 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, June 10, 2016 through Sunday, July 10, 2016. It will be widely distributed:

- The MHSA Annual Update will be posted for 30-day public comment on Marin County’s website at www.marinhhss.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.
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 and MHSUS related distribution lists and committees.

On Tuesday, July 12, 2016, a Public Hearing was 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 was considered and substantive comments are summarized and analyzed (see below). The final MHSA Annual Update for FY2016-17 will go before the Board of Supervisors after the public hearing.

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

In Fall 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:

During the Public Comment period no online or written feedback was received. The following comment was received during the Public Hearing:

1. A request was made to include the funding allocations on each program narrative, in addition to the budget summary at the end of each component section.

This recommendation will be implemented in the next Annual Update report for FY2015-16 outcomes.
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.

The following charts provide information on Marin’s 2014 population by race/ethnicity and age group, Medi-Cal population and County mental health clients.
Race/ Ethnicity

<table>
<thead>
<tr>
<th>Race/ Ethnicity</th>
<th>Total Population 2014</th>
<th>Medi-Cal Beneficiaries 2014</th>
<th>County MH Clients FY 14/15</th>
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<tbody>
<tr>
<td>White</td>
<td>30%</td>
<td>57%</td>
<td>72%</td>
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<tr>
<td>African American</td>
<td>6%</td>
<td>7%</td>
<td>8%</td>
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<tr>
<td>Native Am/ Alaska Native</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Asian/ / Other Pacific Islander</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
</tr>
<tr>
<td>Multi or Other Race</td>
<td>3%</td>
<td>7%</td>
<td>7%</td>
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<tr>
<td>Hispanic or Latino (of any race)</td>
<td>16%</td>
<td>23%</td>
<td>51%</td>
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Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Population 2014</th>
<th>Medi-Cal Beneficiaries 2014</th>
<th>County MH Clients FY 14/15</th>
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<tbody>
<tr>
<td>0-17</td>
<td>21%</td>
<td>18%</td>
<td>46%</td>
</tr>
<tr>
<td>18-59</td>
<td>46%</td>
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</tr>
<tr>
<td>60+</td>
<td>14%</td>
<td>17%</td>
<td>19%</td>
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## CULTURAL COMPETENCY ADVISORY BOARD (CCAB) MEMBERSHIP ROSTER – APPENDIX A

### Mental Health and Substance Use Services Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Representation</th>
<th>Ethnicity</th>
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<tbody>
<tr>
<td>Darby Jaragosky</td>
<td>HHS Senior Program Coordinator</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Marisol Munoz-Kiehne</td>
<td>Promotores Coordinator, (Adult Team)</td>
<td>Latina</td>
</tr>
<tr>
<td>Brian Robinson</td>
<td>Supervisor (Child Team)</td>
<td>Caucasian, LGBTQ</td>
</tr>
<tr>
<td>Cesar Lagleva</td>
<td>Ethnic Services Manager/ Mental Health Practitioner (Child Team)</td>
<td>API</td>
</tr>
<tr>
<td>Laurie Hunt</td>
<td>Mental Health Practitioner, HOPE Program, (Adult Team)</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Kristen Gardner</td>
<td>MHSA/PEI Coordinator</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Jessica Diaz</td>
<td>Mental Health Practitioner, Adult Case Management, (Adult Team)</td>
<td>Mixed Heritage</td>
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<tr>
<td>Cecilia Guillermo</td>
<td>Bilingual Mental Health Practitioner, Adult Case Management (Adult Team)</td>
<td>Latina</td>
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<tr>
<td>Robert Harris</td>
<td>Mental Health Practitioner, Adult Case Management (Adult Team)</td>
<td>African American</td>
</tr>
<tr>
<td>Maria Abaci</td>
<td>Mental Health Practitioner, Adult Case Management (Adult Team)</td>
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<tr>
<td>Ngoc Loi</td>
<td>Mental Health Practitioner, (Adult Team)</td>
<td>API</td>
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<tr>
<td>Kristine Kwok</td>
<td>Supervisor (Adult Team)</td>
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<tr>
<td>Cammie Duvall</td>
<td>Mental Health Practitioner</td>
<td>Caucasian, LGBTQ, Consumer Advocate</td>
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<tr>
<td>Sadegh Nobari</td>
<td>Licensed Mental Health Practitioner</td>
<td>Middle Eastern</td>
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<td>Marta Flores</td>
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<tr>
<td>Ellie Boldrick</td>
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<td>Caucasian</td>
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### Agency Partners

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<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Leticia McCoy</td>
<td>Family Partner, Community Action Marin</td>
<td>African American, Former Consumer – Consumer Advocate</td>
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<tr>
<td>Vinh Luu</td>
<td>Coordinator, Asian Advocacy Project, Community Action Marin</td>
<td>API, Consumer Advocate</td>
</tr>
<tr>
<td>Douglas Mundo</td>
<td>Executive Director, Canal Welcome Center</td>
<td>Latino, Consumer Advocate</td>
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<tr>
<td>Robbie Powelson</td>
<td>Board member, Marin Mental Health Board</td>
<td>Caucasian, Former Consumer, Consumer Advocate, LGBTQ</td>
</tr>
<tr>
<td>Sandy Ponek</td>
<td>Program Director, Canal Alliance</td>
<td>Caucasian</td>
</tr>
<tr>
<td>David Escobar</td>
<td>District 5 – Aide to Supervisor Steve Kinsey</td>
<td>Central American Indian, Consumer Advocate</td>
</tr>
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<td>Name</td>
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<tr>
<td>Gustavo Goncalves</td>
<td>San Rafael</td>
<td>Latino, Community Volunteer</td>
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<tr>
<td>Leah Fagundes</td>
<td>San Rafael</td>
<td>Caucasian, Former Consumer, Consumer Advocate</td>
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<tr>
<td>Cat Wilson</td>
<td>San Rafael</td>
<td>Jewish, Consumer</td>
</tr>
<tr>
<td>Cheryl August</td>
<td>San Rafael</td>
<td>Jewish, Former Consumer, Consumer Advocate</td>
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<tr>
<td>Kerry Peirson</td>
<td>Mill Valley</td>
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<tr>
<td>John Ortega</td>
<td>San Rafael</td>
<td>Latino, Consumer Advocate</td>
</tr>
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Marin County

6,929
Suicide Prevention Materials

Know the Signs materials in English, Spanish, Khmer, Vietnamese, Tagalog, Hmong, Lao, Korean and Chinese were provided to two organizations in Marin County. (July 2014-June 2015)

85
85 students from 1 school were reached through Walk in Our Shoes Program. (2013 and 2014 school tours)

The Know the Signs campaign is a statewide suicide prevention effort with the goal to empower Californians to know the warning signs for suicide, find the words to offer support to someone they are concerned about and to reach out to resources. All campaign materials refer individuals to the campaign websites:

suicideispreventable.org elsuicidioesprevenible.org

In addition, funds were available to Marin County through Each Mind Matters (administered by RSE) to support the use of statewide resources at the local level. In Marin County, the funds were used to implement an English and Spanish transit media buy that included five WhistleStop bus ads and seven Golden Gate transit shelters.

Each Mind Matters: California’s Mental Health Movement serves as the megaphone to amplify the voices of all people who want to put an end to stigma related to mental health and create a community where everyone feels comfortable reaching out for the support they deserve.

eachmindmatters.org sanamente.org

These activities are not inclusive of all statewide efforts.
Marin County

Dissemination of Suicide Prevention Outreach Materials

- Between July 2014 and June 2015, a total of 6,929 suicide prevention outreach materials were provided at no cost to the county behavioral health agency and a community based organization. Materials included posters, brochures, toolkits, and many other educational materials in English, Spanish and several other languages.
  - 2,214 outreach materials were in English
  - 501 in Spanish
  - 4,214 in other languages including Khmer, Vietnamese, Tagalog, Hmong, Lao, Korean and Chinese.
- Materials were mailed at no cost to the county behavioral health agency and the Family Service Agency of Marin.

Suicide Prevention Technical Assistance, Presentations, Trainings and Outreach

County behavioral health agencies and their community partners were provided with support from the Know the Signs team in the form of outreach, presentations, trainings and technical assistance throughout the year.

County Behavioral Health Agency:

- Most engagement was with the primary KTS contact Kristen Gardner, PEI Coordinator for Marin County. KTS provided assistance to the North Bay Suicide Prevention Project for a media interview. Answered follow-up questions regarding Star Behavioral Health Providers that was referenced in the monthly content email on the topic of resources to veterans.
- KTS assisted with engagement information on implementing MY3 with local crisis line staff and others that can use the app. In addition, provided additional information on MY3, such as the PowerPoint that highlights useful information on the app.
- The KTS team provided information with the KTS resource online advertisement to reach helpers of LGBTQ youth at risk for suicide.

Suicide Prevention Stakeholders:

- Technical assistance was provided to Melissa Ladrech from Family Service Agency of Marin. Melissa was responding to a request from a magazine writer, working on a feature article about suicides in Marin County. KTS followed up with feedback and information to the article author.

Marketing and Media

Through the Each Mind Matters campaign (administered by RSE) Marin County was given $5,000 in marketing funds to support use of statewide resources at the local level. The funds were used to implement an English and Spanish transit media buy that included 5 WhistleStop bus ads and 7 Golden Gate Transit Shelters from May 4—31, 2015.
Directing Change
For the past three years, 7 films from three high schools in Marin County were submitted: Redwood High School, Novato High School and Marin Catholic High School.

In 2015, one film was submitted from Redwood High School from Marin County.

All participating schools were offered suicide prevention programs and an Ending the Silence presentation from NAMI California.

In addition, in 2015, two people from Marin County judged films and participated in a one-hour training on appropriate messaging about suicide prevention and mental health.

Walk In Our Shoes
Walk In Our Shoes is an integrated communications campaign that reaches out to youth ages 9 – 13 to introduce the topic of mental health through a variety of mediums, such as an interactive website and musical school performance. The goal of this campaign is to educate youth about mental illness and promote understanding and empathy towards individuals experiencing a mental health challenge.

One of the ways in which this targeted age group was reached in Marin County, was through a live school play that was produced and performed at Bolinas-Stinson Unions School. This performance reached 85 students and enabled them to learn about empathy towards people with mental health challenges and allowed for an interactive Q&A to further strengthen their knowledge of mental health.
Marin MHSA Innovation: Client Choice and Hospital Prevention Program (CCHPP)

Evaluation Summary

Project Background
In 2004, California voters passed the Mental Health Services Act (MHSA). This act created new funding to improve and expand mental health services. There are five key components to MHSA, including “Innovation”.

The Mental Health Services Oversight and Accountability Commission’s (MHSOAC) Innovation Committee defines innovative programs “as novel, creative, ingenious mental health approaches developed within communities in ways that are inclusive and representative, especially of unserved, underserved, and inappropriately served individuals.”

Community Planning
To determine how to use the funds, a comprehensive community planning process with diverse stakeholders was undertaken in Marin County. Stakeholders highlighted the need to use MHSA Innovation funds “to increase the quality of services, including better outcomes”, as it relates to the systems’ response to psychiatric crisis.

The Marin County stakeholders identified the lack of treatment options in the crisis mental health system as an area for further learning and focus. The existing Marin County mental health system offered 23 hours of crisis stabilization services to adults who experienced a psychiatric crisis. If the individual’s crisis did not resolve within that time, the next option was inpatient hospitalization in a locked setting, sometimes in an out-of-county facility. Individuals whose crises were not severe enough to justify hospitalization were returned to the care of outpatient/community providers, family, and friends who expressed that they often did not have the skills, resources or resiliency to provide sufficient support.

The lack of treatment options led to a repetitive series of crisis visits until (1) the individual’s crisis eventually resolved or (2) the crisis did not resolve and the individual’s condition deteriorated to the point of requiring hospitalization. This scenario often left clients, families, friends, providers and key partners feeling drained, discouraged, and disempowered.
Learning Goals

An Advisory Committee was convened at the onset of the project. The committee was comprised of representatives from a range of stakeholder groups, including: Clients and Family Members, Community-Based Mental Health Providers, Community-Based Substance Abuse Providers, County-Based Mental Health Providers, and the Public Guardians Office. The Advisory Committee began to see that in order to learn how to transform the crisis system of care all involved would need to partner well together. This clarity shaped the working hypothesis of the project:

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

Learning is the focus of MHSA Innovation funding. The Advisory Committee identified the following learning areas for the Marin County crisis mental health system, based on the community planning process:

- **Partnerships with mental health providers and peer professionals**: How does partnering with peer professionals, family advocates, community mental health providers and county mental health services affect the delivery of crisis services and contribute to the project’s primary goal of transforming the crisis mental health system?
- **Partnerships with Crisis Planning**: Does the use of client-driven crisis plans result in better illness self-management and/or improved partnerships between staff providing crisis services and individuals who use the services?
- **Partnerships with Substance Use Services**: How does the integration of a substance use Screening, Brief Intervention, and Referral to Treatment (SBIRT) in a crisis residential home change the treatment planning and outcomes for individuals using the crisis mental health services? How does it change the collaboration with specialized substance use treatment services in the community?
- **Improved Client Outcomes**: Do individuals who participate in the Client Choice and Hospital Prevention Program (CCHPP) experience improved outcomes?

Strategies

The Client Choice and Hospital Prevention Program (CCHPP) was designed to provide recovery-oriented, community-based resources for adults experiencing psychiatric crises. The following three strategies were chosen to support the learning goals and to improve partnerships, improve response to mental health needs and improve mental health outcomes for those at risk of or diagnosed with mental illness.

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

*This strategy included promoting partnerships with crisis planning peer staff,*
APPENDIX C

CCHPP Evaluation Summary

Community mental health providers and county mental health services to design, implement and operate the CCHPP.

- **Train mental health and community providers** to listen and respond to mental health needs. *Included in this strategy is the integrated peer professional staffing at the crisis residential home, and staff training on the use of crisis plans and how to screen for co-occurring disorders*

- **Provide integrated mental health services and supports** to individuals at risk of or diagnosed with mental illness. *This strategy brings client-driven crisis plans and the focus on the least-restrictive, recovery-oriented treatment options for individuals using mental health services.*

To put these strategies in place, funds were used to develop and operate a community-based crisis residential home to provide crisis intervention and stabilization, to integrate peer and professional staffing in crisis mental health services, to encourage clients and providers to use crisis plans developed by clients to determine the most effective services and supports, and to begin the use of SBIRT (Screening, Brief Intervention, and Referral for Treatment) in crisis mental health services to provide early intervention and treatment services for persons with co-occurring substance use disorders, as well as those who are at risk of developing these disorders.
APPENDIX C
CCHPP Evaluation Summary

Report Organization
This report begins with a summary of the findings to briefly highlight the areas where the biggest changes and/or the most learning occurred. This section is followed by a review of the methods used to capture the outcomes.

The bulk of the report addresses the logic models for two programs: Crisis Residential and Crisis Planning. These sections are organized to align with the logic models found in Appendix A.

The final section addresses the overall learning from this project and a review of the key components that led to the project’s success. It also includes recommendations for adjustments if the project was to be replicated.

Partners
The partners who participated in this project are noted throughout the report. For clarity they are also described here:

Advisory Committee: The Advisory Committee for this project included representatives from Buckelew Programs, Community Action Marin, Psychiatric Emergency Services, County of Marin Mental Health and Substance Use Services, Marin County Health and Human Services Public Guardian, Recovery Connection Center, and National Alliance on Mental Illness (NAMI).

Casa René: The Crisis Residential home designed to facilitate recovery from a psychiatric crisis. Casa René is run by Buckelew Programs, a community-based organization.

Crisis Planning Program: A project of Community Action Marin (a community-based organization) offered to individuals with experience at Psychiatric Emergency Services (PES). The program is run by peer providers who develop crisis plans and assist clients in preventing future mental health crises. This project is funded by MHSA Prevention and Early Intervention.

Recovery Connections Center (RCC): A community-based organization that provides drug and alcohol screening and brief intervention on site to clients with co-occurring disorders at Casa René and follows clients in the community to support recovery.

Family Partner: A program of Community Action Marin that provides support to the family members of individuals who experience a mental health crisis. Individuals employed as family partners are family members of people who have used the mental health system.

Psychiatric Emergency Services (PES): PES provides services to individuals experiencing a mental health crisis. Every client undergoes a detailed psychiatric assessment, nursing assessment, and screening for drug and alcohol use. Clients who are served at Casa René are often screened by PES. PES can provide up to 23 hours of care. The service is operated by the County of Marin: Mental Health and Substance Use Services.
“Thursday Group”: This is the name adopted by the group of providers and partners who meet each Thursday at Casa René to discuss client care and to continually evaluate the quality of the partnerships. The partners who attend include: Program managers, supervisors and staff from Casa René, Psychiatric Emergency Services, Crisis Planning and Recovery Connections Center, Family Partners, Hospital Liaisons, Mental Health Nurse Practitioners and Case Managers.

Summary of Evaluation Findings
The Client Choice and Hospital Prevention Program (CCHPP) is fully implemented and this evaluation summary describes the program outcome data. Key findings include:

Crisis Residential
Partnerships with mental health providers and peer professionals:

- **Marin County partners and staff understand collaboration and its importance.** Partners and staff reported consistent and high levels of agreement with statements related to their knowledge and understanding of the importance of collaboration among providers, integration of peer professionals/family partners and inclusion of substance use services.
- **Really involving people in ongoing decision making works.** Partners and staff increased in their agreement that they influenced program design and implementation decisions. Participants on the Advisory Committee increased their ratings by more than 20%.
- **Peer providers and family partners are involved in the crisis mental health system in meaningful ways and clients notice.** When asked whether or not peers employed in crisis services are treated as equal partners, peer providers and family partners increased their agreement by 25% from January 2014 to January 2015. In client interviews, clients noticed that staff and peers were working together and appreciated the coordinated services.

Partnerships with Substance Use Services:

- **Integrating mental health and substance use services is a long process with ongoing challenges; clients have already noticed the changes and are satisfied with the shifts in collaboration.** There is continued work to be done to address long-standing system barriers between substance use and mental health and to ensure that the needed substance use services are available to clients in Marin County. Currently peer providers/family partners and substance use providers are not connected, though they are serving the same clients at Casa René. When compared to June 2014, partners and staff decreased their agreement that changes have been made in the mental health system and/or in the substance use system to prevent and treat psychiatric crisis. In the client interviews, clients praised the substance use services at Casa René.

Improved Client Outcomes:
**CCHPP Evaluation Summary**

- **Clients’ perspectives about crisis mental health services are a key component of understanding quality.** Clients rated the quality of the crisis mental health system based on the definition developed in July 2014 (see page 18). They were most likely to indicate that they had experienced strong partnerships and increased connections, but also reported frustration in obtaining high quality mental health services and supports.

- **The availability of Crisis Residential/Casa René keeps clients out of locked facilities.** For the period of February 2014 to June 2015, there were 229 referrals to crisis residential: 50 individuals (22%) were diverted from a locked unit and 78 clients (34%) were stepped-down from a locked unit to crisis residential.

**Crisis Planning**

**Partnerships with Crisis Planning/Improved Client Outcomes:**

- **Crisis Planning encourages clients to develop and use their own supports.** After reviewing the program strengths and outcomes in July 2014, CCHPP staff agreed that the focus of crisis planning was moving to PREVENT crisis rather than change the experience of individuals at PES. To this end, of the survey respondents with a crisis plan indicated the plan helped them reduce their symptoms (30%), reach out to supports (41%) and decrease their need for psychiatric emergency services (44%). Clients praised crisis planning as a support to improve their social supports and to help them navigate the systems of care to get connected to ongoing services.

- **Crisis Planning helps clients feel like they can partners with the mental health system and participate in their own recovery.** In the post survey, crisis planning participants were twice as likely to agree that crisis planning helped them feel like they can partner with the mental health system and that having a crisis plan makes them feel like they can participate in their own recovery. More than one-third of the individuals who had a crisis plan and returned to PES for services reported that the crisis plan improved their overall experience with PES.

- **Clients who participated in crisis planning needed relatively less care on subsequent visits than those who did not participate.** The clients who participated in Crisis Planning services and Crisis Residential were about twice as likely to have a second visit to Crisis Residential, but only increased their time in care by 10%. The clients who participated in only Crisis Residential services (without any participation in Crisis Planning), were less likely to return to Crisis Residential, but stayed an average of 36% longer on their second visit when compared to their first visit.
APPENDIX C
CCHPP Evaluation Summary

Methods
The following methods were used to collect data for this summary report.

Provider Survey: A provider survey was sent to all crisis mental health providers and partners in Marin County in January and June 2014, and again in January 2015. The response rate was 70% in January 2014, 59% in June 2014, and 48% in January 2015. The text of the provider survey is included in Appendix B for reference.

Definitions:
- **Partners** are defined as individuals who work within the crisis mental health system but do not provide direct services.
- **Staff** is defined as individuals who provide direct services within the crisis mental health system.

Scale:
All provider questions were rated on a scale of one to ten where “1” represented Strongly Disagree and “10” represented Strongly Agree.

Provider Interviews: To better understand the changes in the quality of crisis mental health service, the partnership between peer professionals/family partners and licensed staff, the integration of substance use service and the improvements in client care, nine providers were interviewed in June and July 2014. Providers included representatives from Psychiatric Emergency Services, Buckelew Programs, Community Action Marin and Marin County Mental Health and Substance Use Services. The provider interview protocols are included in Appendix C.

Client Survey: Two types of client surveys were used in this summary. A client survey is given to participants in the Crisis Planning program after a crisis plan is completed, and then after they have returned for care in the Crisis Mental Health System. The surveys were distributed by crisis planning staff during client visits from 2010-2013, and during the client event in December 2014. The client event brought individuals who had used crisis planning services and crisis residential services together to talk about their experiences with the program. An additional client survey was used at the event to ask for client input about the quality of care they received. The client surveys are included in Appendices D and E.

Client Interviews: During the client event in December 2014, clients where offered the opportunity to participate in interviews with MHSUS staff about their experiences in the CCHPP. The client interview protocols are included in Appendix F.

Program Records:

Psychiatric Emergency Services, Client Tracking Spreadsheet: PES provided information from clinicians who referred clients to Crisis Residential in order to determine where the client would have been referred if Crisis Residential was not available and whether or not the client had an AOD diagnosis.
Psychiatric Emergency Services, Active Client Data (2014): Marin County Mental Health and Substance Use Services provided demographic and diagnosis data for clients who were seen at Psychiatric Emergency Service and/or Crisis Residential between January 1, 2014 and December 31, 2014.

Crisis Planning Program, Demographic Data and Program Records: Demographic data was provided by Community Action Marin to describe new clients who met with Crisis Planning staff since the program’s inception in 2010. Additionally, data was provided to indicate the types of services clients participated in with Crisis Planning staff.

Crisis Residential
The first client was referred from Psychiatric Emergency Services to Crisis Residential on February 4, 2014. From the date it opened until December 31, 2014, the Crisis Residential program received 137 referrals. This represents 12% of all visits to Psychiatric Emergency Services. The demographics for the referrals are shown in the chart below. Note that this represents 103 unduplicated clients referred to Crisis Residential of the 757 unduplicated clients served at PES (14% of unduplicated clients) from February to December 2014.

When the demographics of the referrals to the crisis residential program are compared the demographics of PES overall, most variation is within 10%. Clients served by Crisis Residential were more likely to report living in supported housing and less likely to have a house or apartment (47% compared to 62% of all PES visits), more likely to report they were not Hispanic (80% vs 62% of PES visits) and less likely to have an AOD diagnosis (23% vs 37% of PES visits).

### Demographic Information for All PES visits and Crisis Residential Referrals from 2/4/14 to 12/31/14

<table>
<thead>
<tr>
<th></th>
<th>Overall Visits and Referrals (PES and CR) (n=1,156)</th>
<th>PES Visits (n=1,019)</th>
<th>Crisis Residential (CR) Referrals (n=137)</th>
<th>Difference between CR Referrals &amp; PES Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>50%</td>
<td>51%</td>
<td>46%</td>
<td>-5%</td>
</tr>
<tr>
<td>Female</td>
<td>49%</td>
<td>49%</td>
<td>54%</td>
<td>5%</td>
</tr>
<tr>
<td>Other or Unknown</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Housing Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House or Apartment</td>
<td>62%</td>
<td>63%</td>
<td>47%</td>
<td>-16%</td>
</tr>
<tr>
<td>Homeless</td>
<td>21%</td>
<td>20%</td>
<td>24%</td>
<td>4%</td>
</tr>
<tr>
<td>House or Apt. with Support</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
<td>1%</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>3%</td>
<td>2%</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>Adult Residential Facility</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>House or Apt. with Supervision</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)/Intermediate Care Facility (ICF)</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>-1%</td>
</tr>
<tr>
<td>Institute of Mental Disease (IMD)</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>
## CCHPP Evaluation Summary

<table>
<thead>
<tr>
<th>Overall Visits and Referrals (PES and CR) (n=1,156)</th>
<th>PES Visits (n=1,019)</th>
<th>Crisis Residential (CR) Referrals (n=137)</th>
<th>Difference between CR Referrals &amp; PES Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Hospital</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Board and Care</td>
<td>2%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>MH Rehab Center (24 Hour)</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Other or Unknown</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
</tr>
</tbody>
</table>

### Military Status

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>PES Visits</th>
<th>Crisis Residential</th>
<th>Difference between CR Referrals &amp; PES Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>Inactive</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Veteran</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Not Applicable or Unknown</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

### Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Overall</th>
<th>PES Visits</th>
<th>Crisis Residential</th>
<th>Difference between CR Referrals &amp; PES Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian or White</td>
<td>66%</td>
<td>65%</td>
<td>74%</td>
<td>9%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>6%</td>
<td>6%</td>
<td>2%</td>
<td>-4%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>American Indian</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Asian Indian</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Cambodian</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Mixed Race</td>
<td>11%</td>
<td>11%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown / Not Reported</td>
<td>5%</td>
<td>6%</td>
<td>0%</td>
<td>-6%</td>
</tr>
</tbody>
</table>

### Hispanic

<table>
<thead>
<tr>
<th>Hispanic</th>
<th>Overall</th>
<th>PES Visits</th>
<th>Crisis Residential</th>
<th>Difference between CR Referrals &amp; PES Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12%</td>
<td>13%</td>
<td>11%</td>
<td>-2%</td>
</tr>
<tr>
<td>No</td>
<td>64%</td>
<td>62%</td>
<td>80%</td>
<td>17%</td>
</tr>
<tr>
<td>Unknown / Not Reported</td>
<td>24%</td>
<td>25%</td>
<td>9%</td>
<td>-16%</td>
</tr>
</tbody>
</table>

### Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Overall</th>
<th>PES Visits</th>
<th>Crisis Residential</th>
<th>Difference between CR Referrals &amp; PES Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>17%</td>
<td>18%</td>
<td>15%</td>
<td>-2%</td>
</tr>
<tr>
<td>26-59</td>
<td>61%</td>
<td>61%</td>
<td>71%</td>
<td>10%</td>
</tr>
<tr>
<td>60+</td>
<td>11%</td>
<td>11%</td>
<td>14%</td>
<td>3%</td>
</tr>
</tbody>
</table>

### AOD Diagnosis at Admission

<table>
<thead>
<tr>
<th>AOD Diagnosis at Admission</th>
<th>Overall</th>
<th>PES Visits</th>
<th>Crisis Residential</th>
<th>Difference between CR Referrals &amp; PES Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>36%</td>
<td>37%</td>
<td>23%</td>
<td>-14%</td>
</tr>
</tbody>
</table>

1 The number of clients referred to Crisis Residential from PES who had an AOD diagnosis was reported by PES staff separately at the time of referral (instead of the time of admission to PES). Of the 137 referrals tracked, 34% of clients referred to Crisis Residential were reported to have an AOD diagnosis.
Outcomes: Short Term (knowledge/attitudes)

The following section outlines the short term outcomes that are expected as a result of the full implementation of the CCHPP which occurred when the Crisis Residential Program opened. Many of these outcomes were first measured in January 2014 as a baseline prior to the program opening. The same questions were asked again in June 2014 and January 2015 to record any changes in knowledge and/or attitudes among direct service providers and partners. For ease of interpretation and review, the results are reported for the first and last data collection period for each item.

Outcome: 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

Between January 2014 and January 2015, the staff knowledge and attitudes about collaboration declined slightly, but overall remained firmly on the side of agreement with average scores over 7.5 on a scale of one to ten where 1= Strongly Disagree and 10=Strongly Agree. All variation was within 10%.

**Provider Survey Responses, January 2014 and January 2015**
*(Scale: Strongly Disagree=1, Strongly Agree=10)*

<table>
<thead>
<tr>
<th>Statements</th>
<th>January 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand my role in improving the quality of crisis services in Marin County.</td>
<td>8.5</td>
<td>8.1</td>
<td>-6%</td>
</tr>
<tr>
<td>I understand how to work together (collaborate) with other people/agencies involved in improving crisis services in Marin County.</td>
<td>8.6</td>
<td>8.2</td>
<td>-3%</td>
</tr>
<tr>
<td>I believe that working together (collaboration) is an effective way to improve crisis mental health services in Marin County.</td>
<td>9.3</td>
<td>9.2</td>
<td>0%</td>
</tr>
<tr>
<td>I believe that using PEER PROFESSIONALS is an effective way to improve crisis mental health services in Marin County.</td>
<td>8.3</td>
<td>8.4</td>
<td>5%</td>
</tr>
<tr>
<td>I believe that using FAMILY PARTNERS is an effective way to improve crisis mental health services in Marin County.</td>
<td>9.0</td>
<td>9.2</td>
<td>3%</td>
</tr>
</tbody>
</table>
APPENDIX C
CCHPP Evaluation Summary

<table>
<thead>
<tr>
<th>Statements</th>
<th>Overall Average (n=49)</th>
<th>Partner Average (n=15)</th>
<th>Staff Average (n=34)</th>
<th>Overall Average (n=33)</th>
<th>Partner Average (n=13)</th>
<th>Staff Average (n=20)</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe that serving individuals with co-occurring disorders is an effective way to improve crisis mental health services in Marin County.</td>
<td>9.2</td>
<td>9.8</td>
<td>8.9</td>
<td>9.3</td>
<td>9.6</td>
<td>9.1</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2%</td>
</tr>
</tbody>
</table>

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

Staff and partners responded to questions about the change in their knowledge in June 2014 and January 2015. Partners were less likely to agree they had increased knowledge about how to prevent or respond to a psychiatric crisis in the second data collection period. The staff responses remained stable.

**Provider Survey Responses, June 2014 and January 2015**

<table>
<thead>
<tr>
<th>As a result of the Client Choice and Hospital Prevention Program, ...</th>
<th>June 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Overall Average (n=40)</td>
<td>Partner Average (n=15)</td>
<td>Staff Average (n=25)</td>
</tr>
<tr>
<td>I have more knowledge about how to help PREVENT a psychiatric crisis.</td>
<td>7.5</td>
<td>8.1</td>
<td>7.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have more knowledge about how to RESPOND to a psychiatric crisis.</td>
<td>7.8</td>
<td>8.2</td>
<td>7.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

After introducing a definition of quality crisis mental health services in July 2014, partners and staff reported increases in their understanding of the components of quality crisis services.

Both respondent groups reported declines in their willingness to make changes to improve quality. This is an area that should be explored further; it was not clear why this area declined.
CCHPP Evaluation Summary
Provider Survey Responses, January 2014 and January 2015

<table>
<thead>
<tr>
<th></th>
<th>January 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Overall</td>
<td>Partner</td>
<td>Staff</td>
</tr>
<tr>
<td>Overall Average (n=49)</td>
<td>8.1</td>
<td>7.2</td>
<td>8.5</td>
</tr>
<tr>
<td>Partner Average (n=15)</td>
<td>8.3</td>
<td>7.8</td>
<td>8.6</td>
</tr>
<tr>
<td>Staff Average (n=34)</td>
<td>8.0</td>
<td>7.8</td>
<td>8.1</td>
</tr>
</tbody>
</table>

Staff respondents were slightly more likely to indicate that training in the areas of learning for this project would be useful. The biggest change was seen in the Peer Professional Staffing. All changes were less than 10%.

|                                | January 2014 | January 2015 | Change |
|                                | Overall      | Partner      | Staff  |
| I understand the components of quality crisis services. | 8.1          | 7.2          | 8.5    |
| I am willing to make changes to improve the quality of crisis services in Marin County. | 9.2          | 9.5          | 9.1    |

Outcomes:

Intermediate /Long Term (behavior)
Long term outcomes for the CCHPP are defined as changes that indicate that HOW someone does something has changed.

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

The way that decisions are made in the CCHPP is different than in other programs. This program set out to include partners and staff in program design and implementation decisions. Since January 2014, both partners and staff report being more involved in these decisions. Partners were more likely to agree that they reviewed the decisions, and staff was more likely to report influencing the decisions.
Recall that the scale of the survey is from one to ten with “1”=Strongly Disagree and “10”= Strongly Agree. The scores that are less than or equal to 4.5 show the respondents were on the “Disagree” side of the scale and are marked in pink.

Generally, partners were more likely to agree that they had a role in program design and implementation decisions as the program progressed. Staff increased their ratings for influencing program design and implementation, but declined in their rating of reviewing implementation decisions. This is an area that needs further discussion.

<table>
<thead>
<tr>
<th>Provider Survey Responses, January 2014 and January 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>January 2014</strong></td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td><strong>Overall Average</strong> (n=47)</td>
</tr>
<tr>
<td><strong>Partner Average</strong> (n=13)</td>
</tr>
<tr>
<td><strong>Staff Average</strong> (n=34)</td>
</tr>
<tr>
<td>I reviewed program design decisions</td>
</tr>
<tr>
<td>I reviewed implementation decisions</td>
</tr>
<tr>
<td>I influenced program design decisions</td>
</tr>
<tr>
<td>I influenced implementation decisions</td>
</tr>
</tbody>
</table>

A variety of partners and staff participated in the provider survey, and representatives from each of these groups participated more intensively in the Advisory Committee. When the data is reviewed to see the changes in the ratings for the members of the Advisory Committee, the changes are more positive and more dramatic. Note that the sample size is small, but the trend is encouraging. The ratings are higher than the partners and staff overall in both data collection periods, and show an overall increase of 21-27% in the level of agreement.

<table>
<thead>
<tr>
<th>Provider Survey Responses, January 2014 and January 2015: Advisory Committee Only</th>
<th>January 2014 (n=9)</th>
<th>January 2015 (n=9)</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>I reviewed program design decisions</td>
<td>7.4</td>
<td>9.3</td>
<td>24%</td>
</tr>
<tr>
<td>I reviewed implementation decisions</td>
<td>7.3</td>
<td>9.1</td>
<td>25%</td>
</tr>
<tr>
<td>I influenced program design decisions</td>
<td>6.9</td>
<td>8.8</td>
<td>27%</td>
</tr>
<tr>
<td>I influenced implementation decisions</td>
<td>7.0</td>
<td>8.5</td>
<td>21%</td>
</tr>
</tbody>
</table>
APPENDIX C
CCHPP Evaluation Summary

Peer and professional program staff report working as equal partners

In the two data collection periods, staff and partners remained fairly stable in their assessment of the relationships between peer professionals and providers.

### Provider Survey Responses, June 2014 and January 2015

<table>
<thead>
<tr>
<th></th>
<th>June 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Average (n=41)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Average (n=15)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Average (n=26)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Average (n=33)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Average (n=13)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Average (n=20)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Peers employed in crisis services are treated as equal partners.

<table>
<thead>
<tr>
<th></th>
<th>June 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Average (n=41)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer Average (n=15)</td>
<td></td>
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<tr>
<td>Staff Average (n=26)</td>
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<tr>
<td>Overall Average (n=33)</td>
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<td></td>
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<tr>
<td>Peer Average (n=13)</td>
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<tr>
<td>Staff Average (n=20)</td>
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</table>

Though the sample size is very small, the biggest change was seen in the ratings by peers and family partners, which showed a 25% increase in their agreement that they are treated as equal partners.

### Provider Survey Responses, June 2014 and January 2015

Peer Professional, Family Partners and Advisory Committee Members Responses

<table>
<thead>
<tr>
<th></th>
<th>June 2014</th>
<th>January 2015</th>
<th>Change</th>
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<tbody>
<tr>
<td>Overall Average (n=41)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Peers and Family Partners (n=6)</td>
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<tr>
<td>Advisory Committee Members (n=9)</td>
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</tr>
<tr>
<td>Overall Average (n=41)</td>
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<tr>
<td>Peers and Family Partners (n=5)</td>
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<tr>
<td>Advisory Committee Members (n=7)</td>
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</table>

Peers employed in crisis services are treated as equal partners.

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<tr>
<th></th>
<th>June 2014</th>
<th>January 2015</th>
<th>Change</th>
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</thead>
<tbody>
<tr>
<td>Overall Average (n=41)</td>
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<tr>
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<tr>
<td>Advisory Committee Members (n=9)</td>
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</tr>
<tr>
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<tr>
<td>Peers and Family Partners (n=5)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Advisory Committee Members (n=7)</td>
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</table>

Once again, the data was examined to see if the changes were more dramatic for the Advisory Committee Members, those who were most involved in the implementation and oversight of the project. Advisory Committee Members reported a higher average than the overall provider group in each of the data collection periods. Again, the sample size is small, and caution should be used in generalizing the results.
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Client Interviews: In the client interviews in December 2014, clients who have stayed at Casa René and/or participated in Crisis Planning were asked how the peer professionals and the family partners work with licensed staff in the Client Choice and Hospital Prevention Program. The clients noticed that the staff and the peer professionals were working together and appreciated the coordinated services. Comments included:

- “It seemed to me that the peers and all other staff worked together professionally and directly. I think the licensed staff could use more training to do what the peer professional does about SSI and GA”
- “[I] didn’t know who was a peer and who wasn’t a peer”
- “It seemed to me that all staff and the many people who came to help out, all cooperated with each other. [The peer professional] was very good.”
- “[It] feels really good when all the treatment providers get together and try to problem solve.
- “It felt like everything was being coordinated.”

Provider Interviews: In July 2014, partners were asked during the interviews to comment on how peer professionals/family partners and licensed staff work together in the Client Choice and Hospital Prevention Program.

Several providers spoke of an incident that occurred just after Casa René opened. During a discussion of client needs, there was uncertainty about confidentiality and a peer provider was asked to leave the partner meeting. The incident was described as a “guffaw at first, but now it is a milestone, something we worked on and got past” and “definitely a turning point...the rest of the team was kind of floored.”

When asked about the response after the incident occurred, partners described that the peer professionals/family partners were supported and it shifted how the group thought about their role. “It’s come from a rigid, licensing state to ‘let’s do what we need to do to make this work.’”

Partners noted that the incident has not been repeated and a peer professional/family partners noted “my experience has been positive since then.” One interview observed: “It is in the conflict that the relationships get stronger. The proof is that now the doors of Casa René are wide open to the peers.”

All interviewees noted that the perspective of peer professionals/family partners was valuable and valued. They were described by the partners as full participants and peer professionals/family partners noted their ideas were sought out and they were listened to. “The partnership seems interested in incorporating what I know.”

The partnership between peer professionals/family partners and providers in the CCHPP “exceeds all the other programs in terms of equality, but it is not perfect.” There has been impressive integration in the four months the crisis residential has been open, “the difference in unbelievable, I feel heard and the partnership feels genuine.”

Providers praised the peer professional/family partner ideas and the ways they are supporting the clients. It was noted that “a couple of the clients have opened up to the peer providers first.” Several
interviewees noted the peer professional/family partner’s ability to work with the clients about services and supports they will need after leaving crisis residential. The addition of the laptops to the house allows for clients to connect with the outside world and apply for benefits even before they have left treatment. This was described as keeping the client moving toward recovery. Many noted the development of the aftercare groups as another option for clients to continue to build relationships and connections toward recovery.

Overall the peer professional/family partner’s partnership in the CCHPP changed how peers/family partners and professionals interacted and worked together. One provider noted: “I got more flexible, and it is all working.” Another praised the peer professionals/family partners for being “articulate and [sticking] with the hard conversations.” Both peer professionals/family partners and providers noted the “reciprocity of getting to hear each other’s voice” as a key to improving the working relationships.

When asked how the peer professional/family partner staffing could be improved, some interviewees (both peer professionals/family partners and providers) described a need to continue to monitor the relationship between peer professionals/family partners and providers. “Sometimes there is a subtle (and sometimes not so subtle) elitism with the licensed staff...this is an area where there needs to be some strengthening.” Another interviewee noted: “There is a pecking order at the table...the peers’ power is less.”

Suggestions to address this area included (1) addressing pay inequities “If they are equal at the table, there should be equal/comparable pay” and (2) continuing to listen to and value the peer professional/family partners’ experiences working with clients “If there was some way to listen to peer professionals...where they could highlight areas we could all learn from. It is very helpful to know what is working and where the problems are. Peers really are on the front lines...what are the patterns and the obstacles they see?”
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Outcome: Changes are made in mental health system and substance use system, to prevent and treat psychiatric crisis.

Overall, both staff and partners declined in their agreement about changes being made to specifically prevent and treat psychiatric crisis. This was true for both the mental health and the substance use systems. Though the averages declined, all averages remained on the “Agree” side of the scale. Changes of more than 10% are bolded in the table below.

<table>
<thead>
<tr>
<th>Provider Survey Responses, June 2014 and January 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2014</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Overall Average</td>
</tr>
<tr>
<td>Mental Health System</td>
</tr>
<tr>
<td>Changes have been made to the mental health system to PREVENT psychiatric crisis.</td>
</tr>
<tr>
<td>Changes have been made to the mental health system to TREAT psychiatric crisis.</td>
</tr>
<tr>
<td>Substance Use System</td>
</tr>
<tr>
<td>Changes have been made to the substance use system to PREVENT psychiatric crisis.</td>
</tr>
<tr>
<td>Changes have been made to the substance use system to TREAT psychiatric crisis.</td>
</tr>
</tbody>
</table>

Client Interviews: Clients were also asked to comment on the coordination with Substance Use Services during client interviews in December 2014. Of the 13 interviews, seven clients (54%) discussed their substance use and how it was addressed during treatment at Casa René. Five clients noted they met with the substance use support person or had been referred to her during treatment. Three clients noted they continued to follow-up with her after their mental health treatment at Casa René has concluded.

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2 Recall that the scale used in all provider survey questions was 1=Strongly Disagree, 10=Strongly Agree. Responses above 4.5 are on the “Agree” side of the scale.
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- “[The substance use support staff person] is awesome. I started seeing her at Casa René. I see her regularly. She is overseeing what is going on with me... [she] has many great analogies that help me understand with is going on with me.”
- “At Casa René I met with [the substance use support staff person]. We have ongoing 1:1 meetings. She wants me to go to dual-recovery, because of my past with alcohol and marijuana. I’m trying to get the courage.”

Changes are made to improve quality of crisis system

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. The resulting definition has been adopted by the Advisory Committee as a guide for improving crisis mental health services.

<table>
<thead>
<tr>
<th>Elements of Quality Crisis Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current crisis mental health system is working toward these elements.</td>
</tr>
<tr>
<td>- <strong>Client Treated as a Whole Person:</strong> 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.</td>
</tr>
<tr>
<td>- <strong>Strong Partnerships:</strong> 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.</td>
</tr>
<tr>
<td>- <strong>Accessible Services:</strong> Clients, family members and service providers know how to use and navigate the crisis mental health service system.</td>
</tr>
<tr>
<td>- <strong>Timely, Thorough Assessments:</strong> Assessments are thorough and occur as early as possible. Time is taken to understand client’s needs, perspective and goals. Clients feel heard.</td>
</tr>
<tr>
<td>- <strong>Service Options and Client Choice:</strong> Client has access to many programs/different options/different modalities and has a choice of services in their own community.</td>
</tr>
<tr>
<td>- <strong>Increased Connections:</strong> The client develops relationships and connections to aid in moving away from crisis.</td>
</tr>
<tr>
<td>- <strong>Support to Prevent Mental Health Crisis:</strong> 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.</td>
</tr>
</tbody>
</table>
Client Survey: At the client event in December 2014, participants were asked to rate the current mental health system using the quality definition.

The fourteen clients who completed a survey indicated that they were more likely to have experienced the elements pertaining to Strong Partnerships, Client Treated as a Whole Person and Increased Connections. Clients were less likely to report experiencing Service Options and Client Choice and Support to Prevent Mental Health Crisis.

Comments made by clients indicated that there are still frustrations in obtaining high quality mental health services and supports.

- “It seems to be ‘tough’ for the groups to work together.”
- “Clients still aren’t being objectively asked where they want to go and aren’t then being given the wheel”
- “…the process (post PES) should be accelerated i.e. the treatment team meeting should have happened sooner than 2+ weeks and greater emphasis should be placed on self-reliance, i.e. don’t count on your case manager for everything.”
- “All the support is great. I feel frustrated with any type of action plan what to do where to go how to be successful. There is no housing in Marin.”
CCHPP Evaluation Summary

- “Housing is probably the biggest issue and help/assistance for gaining resources there hasn’t been stable housing, its all shelter short term.”

**Provider Interviews:** Using the quality definition, providers were asked if the quality of crisis mental health services had improved, stayed the same or declined with the addition of the Client Choice and Hospital Prevention Program (June/July 2014). All nine providers indicated that the program has improved quality. The responses centered around two themes:

**Another Option for Clients:** Of the nine interviews, five providers (56%) noted that simply adding another option to crisis services increased the quality of the system. Now there is another choice.

**Improved Partnerships between Providers:** Seven of the nine interviews (78%) noted they were surprised at how quickly the partnerships formed and how effective the partnerships have been in improving services.

- “[The partners] come every week, they keep their word, they show up, they problem solve...They are very good at hearing what I am saying.”
- “People who are involved are motivated and willing to champion this cause.”
- “The fact that there are three organizations coming together to discuss quality is an improvement.”
- “I am surprised by the trust that has been built and how quickly it happened. The collaborative and the relationships have been strong enough to withstand bumps.”

**Provider Survey:** Additionally, providers were surveyed about changes in the quality of crisis mental health services in Marin County. From June 2014 to January 2015, the ratings declined slightly. This may be due to a better understanding of quality and a higher standard for indicating change. Note at all average ratings are firmly on the “agree” side of the scale.

**Provider Survey Responses, June 2014 and January 2015**

<table>
<thead>
<tr>
<th></th>
<th>June 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes have been made to improve the quality of the crisis system.</td>
<td>8.4</td>
<td>8.6</td>
<td>-6%</td>
</tr>
<tr>
<td></td>
<td>8.2</td>
<td>7.9</td>
<td>-8%</td>
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<tr>
<td></td>
<td>7.9</td>
<td>7.8</td>
<td>-5%</td>
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</table>
When the data for the Advisory Committee specifically was reviewed, the ratings were overall higher than the averages for partners and staff, but also showed a slight decline.

**Provider Survey Responses, June 2014 and January 2015—Advisory Committee Only**

<table>
<thead>
<tr>
<th>Changes have been made to improve the quality of the crisis system.</th>
<th>June 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.2</td>
<td>8.3</td>
<td>-9%</td>
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</table>

**Outcome:** Partners report that the quality of crisis services is improved.

As described above, during provider interviews, the partners reported that quality of crisis service is improved (see previous section).

While considering quality, the providers were asked what could be done to improve quality even further. Five providers offered suggestions:

- Open up Casa René to more clients. This included offering crisis mental health services to youth and those with other co-occurring disorders and changing referral processes and requirements
- More training for partners to strengthen communication and reporting: writing notes, completing paperwork, using Gateway Notes
- Shifting discussion of clients’ needs to a focus on what all the partners can do to move people away from crisis instead of clients’ shortcomings.

**Provider Survey:** On average, partners expressed more confidence than staff that the quality of the crisis system is improving. Overall there was a decline in the average agreement rating for this area from June 2014 to January 2015. Again this may be due to the more specific definition of quality that was introduced in July 2014, raising the standard for what it would mean to improve quality.

**Provider Survey Responses, June 2014 and January 2015**

<table>
<thead>
<tr>
<th></th>
<th>June 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>The quality of the crisis system has improved.</td>
<td>8.2</td>
<td>8.5</td>
<td>-7%</td>
</tr>
<tr>
<td></td>
<td>8.1</td>
<td>7.9</td>
<td>-7%</td>
</tr>
<tr>
<td></td>
<td>7.6</td>
<td>7.3</td>
<td>-10%</td>
</tr>
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</table>

The ratings for the Advisory Committee members reflect the previous pattern. The ratings are overall higher in both data collection periods and show the same decline.
APPENDIX C
CCHPP Evaluation Summary

Provider Survey Responses, June 2014 and January 2015—Advisory Committee Only

<table>
<thead>
<tr>
<th>The quality of the crisis system has improved.</th>
<th>June 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
</table>

The number and percentage of involuntary and voluntary hospitalizations is reduced

Program Records: From February to December 2014, the 137 referrals to Crisis Residential were tracked to determine where they would have gone if Crisis Residential was not available. Additionally, Psychiatric Emergency Services (PES) reported on the additional 92 referrals received between January and June 2015 for a total of 229 referrals. Working with the referring clinicians, the following data was reported:

Client Placement if Crisis Residential was not available (n=229)

- Discharged back to community: 39%
- Admitted to an acute unit (like Unit A): 22%
- Spent more days in an acute unit (like Unit A): 32%
- Stayed in an IMD longer (like Creekside): 2%
- Unknown: 5%

This data shows that with the availability of Crisis Residential, 90 of the individuals referred (39%, dark blue) received further treatment instead of being released to the community, 50 clients (22%, red) were...
diverted from a locked unit, and 78 clients (34%, green, purple, light blue) were stepped-down from a locked unit to crisis residential.

Of those referred to Crisis Residential who would have had more inpatient days if Crisis Residential was not available, the referring clinician estimated between 1-9 days of inpatient treatment, with an average of 3.3 days. Of the five referrals who would have been released to spend more time in IMD, the range was 14-38 days with an average of 28 days.

**Outcome:** Individuals who are served at the house for program are screened for substance use, and those with co-occurring disorders receive improved interventions

**Provider Interviews:** Substance use services were planned from the inception of the project, but the resources and personnel to integrate substance use services into the programs were not added until the program began. Partners noted that the substance use resources at Case René have been fantastic--particularly the quick and helpful responses to questions and concerns and the willingness to provide service at Casa René.

The approach to clients with co-occurring disorders was described as a team approach that is just getting started. “Substance use services need to be at the table from the get-go. It is a reflection of where we are as a system. It took us awhile to get there.” Another provider described, “Crisis residential had been very open to taking people with substance use disorders…. It is happening in other mental health services, but it can really be SEEN in crisis residential.”

A situation recently occurred where a client with a co-occurring disorder was having increasing mental health symptoms which were putting the client at risk of using. Using substances would increase the mental health symptoms. The client was admitted to Casa René. “With multiple programs involved, both mental health and alcohol and drug symptoms were further addressed and stabilized.”

Among the providers there was some uncertainty about the availability and the sustainability of the current substance use services at Casa René and in the community. “It is hard to open up the door (to assessing substance abuse) when there are limited treatment centers… I think there needs to be more clear direction and resources before there is more screening.” There is also a perception by some of the providers that the substance use service “isn’t sustainable.” Other providers noted that the substance use provider is spread thin and has limited time.

The peer professionals and family partners reported that they had not worked with or met with the substance use provider, though two peer provider/family partners reported that they had heard of her work and clients spoke highly of the support and resources. “It is hard to provide relational support for substance use as a peer in a client choice program. In trying to meet the client where they are at, if they tell me that marijuana and alcohol improve the symptoms that could lead to a crisis, I’m not in the position to challenge their assertion.”
Several providers, including peer professionals and family partners noted a need for further training to improve the understanding of how to work together to best meet the needs of the clients. One provider noted that time and training were the keys to promoting the integration of substance use screening. “It took a lot of reminding about the focus on co-occurring disorders and the need to take away the judgment—to be more open-minded. Being able to talk about it, and participate in the tremendous amount of training available gave staff a better understanding.”

Several providers commented on the legislative barriers that exist in the integration of mental health and substance use services. 42-R limits the substance use providers’ ability to discuss client’s substance use with other providers. There is more work to be done to continue to include substance use services in the weekly partner meetings and to develop a role for a substance use content expert while still respecting the legislation. “The barriers between substance use services and mental health are entrenched and are really hard to shift. It is hard to tell what is an actual barrier and what is a habit.”

Program Records: Program records were reviewed for the clients referred to Casa René by PES and for all PES clients.

- In August 2014, PES began tracking AOD diagnosis for clients referred to Casa René. Over half of the referrals between August 25, 2014 and June 30, 2015 had an AOD diagnosis (59%).
- Overall, 36% of PES visits in 2014 included an AOD diagnosis (411 of 1156 client visits).
- Data from the provider interviews in July 2014 cited a study done in PES that estimated the incidence of co-occurring disorders among PES clients at 85%.
- Data was not available on how many of the clients who were referred to Crisis Residential received an AOD diagnosis as a result of the screening and substance use services available at the facility.

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

Client Interviews: In the client interviews, the majority of participants noted their stay at Casa René (the crisis residential facility) was “a refuge from the real world”, and that “everyone there was really helpful.” Their comments related to the care they received at the site, including the groups, the food, and the staff. Generally, it was deemed a “great experience.” One client described: “It was calming to me. It was an opportunity to take a second sober look at my life”

- “The space is great! Really clean, the staff accommodating and the food is really good.”
- “At Casa René, if you have a problem they listen. There is openness in groups.”
- “Casa René helped me calm down, to take the edge off.”
- “Casa René was terrific, nice staff, good groups.”

In terms of better illness self-management, clients who were interviewed noted that they wanted more guidance and structure, more housing and employment assistance, and more emphasis on self-reliance.
“There is not really a lot of structure during the day. Daily meetings may or may not happen, due to staffing; therefore we are not driven to make progress. I spent too much time in my bedroom not knowing what is happening next.”

“It was very helpful for me (to have been at Casa René), but, the planning we made, for after Casa René, did not work out. I still need help with housing and employment.”

“A greater emphasis upon self-responsibility and personal acceptance of the need to be reliable for one self (i.e., staff not do it all).”

**Provider Interviews:** Providers were asked if client care was improved as a result of the implementation of the CCHPP. All providers interviewed agreed that the care had improved. Below are the reasons cited for the positive changes:

**Weekly Partnership Meetings (5 of 9 providers, 56%):** The weekly partnership meetings strengthen the trust and improve the working relationships between providers: “The key is the integrated, once a week meeting. People are talking honestly and sharing information. The team is starting to accept that the other team members have their back. If they take a risk, someone will back them up. They don’t have to carry the burden of care for the client all by themselves.” The meetings also provide an avenue for exchanging information to improve care: “Consulting with [other providers] has been helpful. I consult with them to understand what is happening with the Affordable Care Act and other system changes. Their experience provides a lot of wisdom and practical talking points that improves communication with clients when discussing options and resources.” The client care is improved by the partnerships: “The plans have more footing because all the partners are at the table and we take the client’s perspective. The client’s voice is at the table and this empowers the group to see it from that point of view.” The meetings also provide access to more service providers and services, including “concurrent treatment of co-occurring symptoms”.

An example of client care at a weekly meeting:

*Today the team was discussing a well-known client. In other places, the focus would have been on what’s wrong. The discussion today was about how to best serve this person. One provider noticed a subtle detail, a small step the client had made. The detail was shared and the group was reminded to remember the feeling of the small step and to continue to hope for the client...hope that the small steps would lead to something better for him. So far the frustration of doing crisis services has not infiltrated this group.*

**More Time (4 of 9 providers, 44%):** Having more time to work with the client, consult with partners and make a better plan results in better client care and more options at discharge. “The extra time opens up the door to housing in some places because the client is stable enough to return to a placement they lost, or are now stabilized enough to qualify for the housing option.”

**Relationships (3 of 9 providers, 33%):** Providers noted that clients are given more time to develop relationships. The relationships that are enhanced include other clients, staff and the system of crisis mental health services. “I was surprised by how clients have begun to use each other as support once
APPENDIX C
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they are out. They are following up with the relationships that have starting in the program. That feels to me like something that is working."

Program Setting (3 of 9 providers, 33%): The neighborhood and the crisis residential home are described as beautiful and an important component of client care. “We are fortunate to have built a beautiful home. Really recovering in a beautiful, respectful environment allows people to relax and really sink in.” One provider noted that client care was improved in part because “the facility is in the nice part of town; they can go for walks and get out of the facility.”

Crisis Planning
The Crisis Planning Program provides crisis planning services to individuals at Casa René and other clients who use the crisis mental health system. Data collection consists of a demographic form that is completed at one of the first visits, an initial survey that is completed once the crisis plan is done, and a follow-up survey for distribution after six months or after the client has experienced a mental health crisis.

In January 2014, Community Action Marin submitted demographic information and surveys for all clients that had been seen during the three years the program has been in operation. In June 2014, CAM staff submitted demographic data for the clients that had begun a crisis plan in 2014. In December 2014, clients who had participated in Crisis Planning came to a client event and surveys were collected from those who attended.

A comparison of the demographics from 2010-2013 and from January to June 2014 shows the following:

- The screening for veteran status has improved
- In 2014, Crisis Planning staff assisted more individuals age 50-64 and less individuals age 35-49.
- Crisis Planning was more likely to serve individuals with more stable housing in 2014. Specifically those who had been in the same housing for 3 months or more.
- In 2014, there was an increase in the percentage of clients working toward a crisis plan who have a co-occurring substance use disorder.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>57</td>
<td>46%</td>
<td>41 51%</td>
<td>16 37%</td>
</tr>
<tr>
<td>Female</td>
<td>57</td>
<td>46%</td>
<td>35 44%</td>
<td>22 51%</td>
</tr>
<tr>
<td>Transgender</td>
<td>1</td>
<td>1%</td>
<td>0 0%</td>
<td>1 2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing Status at First Contact</th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outdoors (e.g., street, abandoned building, automobile)</td>
<td>8</td>
<td>7%</td>
<td>1 1%</td>
<td>7 16%</td>
</tr>
<tr>
<td>Own or someone else’s apartment, room or house</td>
<td>65</td>
<td>53%</td>
<td>47 59%</td>
<td>18 42%</td>
</tr>
<tr>
<td>Halfway House, Residential treatment</td>
<td>13</td>
<td>11%</td>
<td>8 10%</td>
<td>5 12%</td>
</tr>
</tbody>
</table>
# APPENDIX C
## CCHPP Evaluation Summary

<table>
<thead>
<tr>
<th>program</th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Shelter</td>
<td>2 2%</td>
<td>2 3%</td>
<td>0 0%</td>
<td>-3%</td>
</tr>
<tr>
<td>Hotel</td>
<td>2 2%</td>
<td>1 1%</td>
<td>1 2%</td>
<td>1%</td>
</tr>
<tr>
<td>Institution (psychiatric, other hospital, nursing home, etc.)</td>
<td>14 11%</td>
<td>6 8%</td>
<td>8 19%</td>
<td>11%</td>
</tr>
<tr>
<td>Jail</td>
<td>2 2%</td>
<td>1 1%</td>
<td>1 2%</td>
<td>1%</td>
</tr>
<tr>
<td>Long-term Shelter</td>
<td>3 2%</td>
<td>3 4%</td>
<td>0 0%</td>
<td>-4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 2%</td>
<td>1 1%</td>
<td>1 2%</td>
<td>1%</td>
</tr>
<tr>
<td>Other (Mail Program)</td>
<td>2 2%</td>
<td>1 1%</td>
<td>1 2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Veteran Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veteran</td>
<td>1 1%</td>
<td>1 1%</td>
<td>0 0%</td>
<td>-1%</td>
</tr>
<tr>
<td>Non-Vet</td>
<td>80 65%</td>
<td>40 50%</td>
<td>40 93%</td>
<td>43%</td>
</tr>
<tr>
<td>Unknown</td>
<td>42 34%</td>
<td>39 49%</td>
<td>3 7%</td>
<td>-42%</td>
</tr>
</tbody>
</table>

### Race/Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>93 76%</td>
<td>60 75%</td>
<td>33 77%</td>
<td>2%</td>
</tr>
<tr>
<td>Asian</td>
<td>4 3%</td>
<td>2 3%</td>
<td>2 5%</td>
<td>2%</td>
</tr>
<tr>
<td>Black / African American</td>
<td>4 3%</td>
<td>3 4%</td>
<td>1 2%</td>
<td>-1%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>3 2%</td>
<td>1 1%</td>
<td>2 5%</td>
<td>3%</td>
</tr>
<tr>
<td>American Indian / Alaskan Native</td>
<td>2 2%</td>
<td>2 3%</td>
<td>0 0%</td>
<td>-3%</td>
</tr>
<tr>
<td>Native Hawaiian / Other Pacific Islander</td>
<td>2 2%</td>
<td>2 3%</td>
<td>0 0%</td>
<td>-3%</td>
</tr>
<tr>
<td>Other (Arab, Persian)</td>
<td>2 2%</td>
<td>1 1%</td>
<td>1 2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

### Age

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-34</td>
<td>40 33%</td>
<td>24 30%</td>
<td>16 37%</td>
<td>7%</td>
</tr>
<tr>
<td>35-49</td>
<td>29 24%</td>
<td>24 30%</td>
<td>5 12%</td>
<td>-18%</td>
</tr>
<tr>
<td>50-64</td>
<td>39 32%</td>
<td>22 28%</td>
<td>17 40%</td>
<td>12%</td>
</tr>
<tr>
<td>65-74</td>
<td>9 7%</td>
<td>7 9%</td>
<td>2 5%</td>
<td>-4%</td>
</tr>
</tbody>
</table>

### Primary Language

<table>
<thead>
<tr>
<th>Language</th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>112 91%</td>
<td>71 89%</td>
<td>41 95%</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>2 2%</td>
<td>2 3%</td>
<td>0 0%</td>
<td>-3%</td>
</tr>
</tbody>
</table>

### Length of Time in Housing

<table>
<thead>
<tr>
<th>Length of Time</th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2 days</td>
<td>14 11%</td>
<td>14 18%</td>
<td>0 0%</td>
<td>-18%</td>
</tr>
<tr>
<td>2 days to 30 days</td>
<td>7 6%</td>
<td>7 9%</td>
<td>0 0%</td>
<td>-9%</td>
</tr>
<tr>
<td>31 days to 90 days</td>
<td>2 2%</td>
<td>2 3%</td>
<td>0 0%</td>
<td>-3%</td>
</tr>
<tr>
<td>91 days to 1 year</td>
<td>17 14%</td>
<td>7 9%</td>
<td>10 23%</td>
<td>15%</td>
</tr>
<tr>
<td>Over one year</td>
<td>59 48%</td>
<td>35 44%</td>
<td>24 56%</td>
<td>12%</td>
</tr>
<tr>
<td>Unknown</td>
<td>8 7%</td>
<td>4 5%</td>
<td>4 9%</td>
<td>4%</td>
</tr>
</tbody>
</table>

### Mental Illness Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>37 30%</td>
<td>22 28%</td>
<td>15 35%</td>
<td>7%</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>3 2%</td>
<td>2 3%</td>
<td>1 2%</td>
<td>0%</td>
</tr>
<tr>
<td>Other Psychotic Disorder</td>
<td>6 5%</td>
<td>2 3%</td>
<td>4 9%</td>
<td>7%</td>
</tr>
</tbody>
</table>
### APPENDIX C

**CCHPP Evaluation Summary**

<table>
<thead>
<tr>
<th></th>
<th>Overall</th>
<th>2010-2013</th>
<th>Jan-Jun 2014</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Serious Mental Illness</td>
<td>2</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Affective Disorder</td>
<td>57</td>
<td>46%</td>
<td>36%</td>
<td>49%</td>
</tr>
<tr>
<td>Unknown or Undiagnosed Mental Illness</td>
<td>9</td>
<td>7%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Co-Occurring Substance Use Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Co-Occurring Substance Use Disorder</td>
<td>37</td>
<td>30%</td>
<td>19%</td>
<td>42%</td>
</tr>
<tr>
<td>No Co-Occurring Substance Use Disorder</td>
<td>40</td>
<td>33%</td>
<td>26%</td>
<td>33%</td>
</tr>
<tr>
<td>Unknown Substance Use Disorder</td>
<td>21</td>
<td>17%</td>
<td>11%</td>
<td>23%</td>
</tr>
<tr>
<td>Not Completed, Refused</td>
<td>1</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total Respondents</strong></td>
<td>123</td>
<td>80</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

In 2014, Crisis Planning staff offered several types of services to Crisis Residential clients. Of the 103 clients served by Crisis Residential, 73 (71%) participated in Crisis Planning services. The types of services and the number of participants are noted in the table below:

### Participation in Crisis Planning Services, 2014 (Program Records)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met with Crisis Planning Staff (information)</td>
<td>71</td>
<td>97%</td>
</tr>
<tr>
<td>Met with Crisis Planning Staff (planning)</td>
<td>49</td>
<td>67%</td>
</tr>
<tr>
<td>Filed Crisis Plan with MHSUS</td>
<td>26</td>
<td>36%</td>
</tr>
<tr>
<td>Support to Access Community Resources</td>
<td>33</td>
<td>45%</td>
</tr>
<tr>
<td>Attended Alumni Group</td>
<td>7</td>
<td>10%</td>
</tr>
<tr>
<td>Attended Substance Use Support</td>
<td>5</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Total Individuals Served by Crisis Planning in 2014</strong></td>
<td>73</td>
<td>100%</td>
</tr>
</tbody>
</table>

### Outcomes: Short Term (knowledge/attitudes)

The following section outlines the short term outcomes that are expected as a result of the implementation of the Crisis Planning Program. The client surveys used to report these outcomes were analyzed in January 2014 and January 2015. The January 2015 analysis was based on the surveys collected during the client event in December 2014.
Clients

Mental health clients understand choices available to them in crisis situations and the purpose of crisis planning (knowledge)

Over half of the Crisis Planning clients who completed a survey agreed that the crisis plan increased their awareness of symptoms (57%), and that having a crisis plan increased their understanding of the choices available in a crisis situation (60%). Though there were many who were neutral or did not respond to these questions, only one respondent indicated they disagreed with one of the statements.

Client Surveys, January 2014 and January 2015 (n=54)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of individual symptoms</td>
<td>24%</td>
<td>33%</td>
<td>30%</td>
<td>2%</td>
<td>11%</td>
<td>5%</td>
</tr>
<tr>
<td>Understanding of choices</td>
<td>19%</td>
<td>41%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Clients, who responded to the questions about the purpose of Crisis Planning, generally agreed that that they understood that crisis planning was intended to avert a crisis and to improve their experience if they had a crisis. Two clients indicated that they were neutral and majority of clients did not respond to these questions.
Mental health clients report that crisis planning helped them partner with the mental health system (attitude)

In the post surveys, individuals were more than twice as likely to agree or strongly agree that crisis planning helped them feel like they can partner with the mental health system (20% initial, 48% post) and that having a crisis plan makes them feel like they can participate in their own recovery (20% initial, 56% post). Up to 20% of the respondents disagreed with these statements on the post test, and over one third did not respond.
## Partnering and Participation in Recovery, Client Survey

<table>
<thead>
<tr>
<th></th>
<th>Initial (n=54)</th>
<th>Post (n=27)</th>
<th>Initial (n=54)</th>
<th>Post (n=27)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a crisis plan makes me feel like I can partner with the mental health system</td>
<td>76% 4% 37% 9% 11%</td>
<td>37% 30% 15% 9% 11%</td>
<td>37% 4% 2% 33% 22%</td>
<td></td>
</tr>
<tr>
<td>Having a crisis plan makes me feel like I can participate in my own recovery</td>
<td>9% 19% 11%</td>
<td>9% 2% 33% 7% 4%</td>
<td>15% 9% 11% 30% 7%</td>
<td></td>
</tr>
</tbody>
</table>

Legend:
- No response
- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree
**APPENDIX C**  
**CCHPP Evaluation Summary**

**Staff**

**PES and crisis residential services staff understand the purpose of crisis planning**

Understanding crisis planning and the barriers clients experience using a crisis plan remained relatively stable for staff and partners from January 2014 to January 2015. This may be due to the early implementation of the program (prior to the first provider survey) and the work of the Crisis Planning staff in informing the providers and partners about the program as the services began. All averages are relatively high (over 8.5) on the scale of 1= Strongly Disagree and 10= Strongly Agree.

<table>
<thead>
<tr>
<th>Statement</th>
<th>January 2014</th>
<th>January 2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand that one purpose of Crisis Planning is to avert a crisis.</td>
<td>9.2</td>
<td>9.5</td>
<td>2%</td>
</tr>
<tr>
<td>I understand that another purpose of Crisis Planning is to improve a client’s experience if they do have a crisis.</td>
<td>9.5</td>
<td>9.7</td>
<td>-2%</td>
</tr>
<tr>
<td>I understand the barriers to utilizing a crisis plan.</td>
<td>--</td>
<td>8.5</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Outcomes:**

**Intermediate /Long Term (behavior)**

Long term outcomes for the CCHPP are defined as changes that indicate that HOW someone does something has changed.

**Clients**

**Mental health clients have Crisis Plans as part of their permanent mental health record and update them as needed. (behavior)**

**Program Records:** 26 of the 73 Crisis Planning clients (36%) have signed off to include crisis planning documentation as part of their MHSUS record.
Client Survey: Of the ten individuals who indicated they had a crisis plan on file and completed a post survey, three indicated they did not update their plan, and six indicated they update their plan as needed. One client did not indicate yes or no.

Mental health clients report the use of support and self-care identified in Crisis Plan to avert a crisis. (behavior)

Overall, 30-44% of the respondents who completed a post survey agreed or strongly agreed that the crisis plan had helped them reduce symptoms (30%), reach out to supports (41%) and/or decrease their need for psychiatric emergency services (44%).

Staff

Outcome: PES and crisis residential services staff reviews the Crisis Plans when a mental health client is in crisis

After reviewing the findings from the provider survey and the client surveys in June 2014, it became evident that the Crisis Planning program was finding a niche PREVENTING crisis and helping people remain stable by identifying their supports and making plans about how to respond if clients began having symptoms again. To this end, the outcomes related to how the crisis plan is utilized in the care of the client at PES became less of a focus and the goal of keeping clients from needing PES services became more of a focus.
This change in the focus of the program is likely reflected in the decline in the report of providers reviewing the crisis plans.

**Percentage of Respondents indicating “Do Not Know”**

There was a decrease in the percentage of providers reporting that they did not know if the providers use the crisis plans, so this may indicate that staff and partners are now aware of how the plan could be used, but are not utilizing it in crisis care. *(Note that a negative percentage change indicates an increase in provider knowledge for the following table.)*

**Outcome: Something from plan is used in client’s care**

**Client Survey:** Though the focus of crisis planning shifted to PREVENT crisis rather than to specifically address the care received at PES, 52% of the post survey respondents (14 of 27), completed the
questions relating to how the crisis plan was used. This was only for clients who had been to PES since making their crisis plan.

For these 14 clients:

- Half reported that they remembered their crisis plan before their visit to PES, and none of them indicated that PES staff discussed the crisis plan with them at admission.
- Two individuals noted that at least one of their treatment preferences from the crisis plan was used during their stay, and four indicated that PES staff allowed them to contact their supports during their PES visit.
- Five of the 14 individuals (36%) agreed that having the crisis plan improved their overall experience with PES.

**Outcome:** The client’s outcome is better than previous crisis treatment

**Client Interviews:** Eight of the thirteen clients interviewed mentioned crisis planning and the assistance they received to (1) improve their social supports, and (2) navigate the systems and appointments to get connected to ongoing services (particularly social security benefits, medication management, and ongoing mental health care).

- “[Seth] is what helps save me—check in regularly”
- “I prepared my Crisis Plan at Casa René. It was helpful to get the phone numbers to call if things get shitty. It [The Crisis Plan], helped for me to get my sister’s phone number. “

**Program Records:** To better understand clients’ outcomes with the existing PES data, the length of the visits at Casa René were compared for clients who participated in Crisis Planning, and those who did not participate in Crisis Planning.

**Crisis Residential Services Only:** There were 34 clients who only received Crisis Residential Services and did not participate in any Crisis Planning. Six of these clients returned to Crisis Residential before December 31, 2014. One was still staying at Casa René when the data was collected. For the five clients who had been discharged:

- The first visit averaged 12.2 days and
- The second visit averaged 16.6 days, a 36% increase.

**Crisis Planning AND Crisis Residential Services:** There were 69 clients who stayed at Crisis Residential and participated in at least one contact with Crisis Planning. Of these clients, 22 returned for a second visit before December 31, 2014. Twenty one clients had been completed their stay by the time the data was collected. For those who came for a second visit:

- The first visits averaged 19.3 days
- The second visits averaged 21.3 days, a 10% increase.
In summary, the clients who participated in Crisis Planning services were about twice as likely to have a second visit, but only increased their time by 10%. The clients who participated in only Crisis Residential services were less likely to return to crisis residential, but stayed an average of 36% longer than their first visit.
Learning and Recommendations

As stated throughout this report the Client Choice and Hospital Prevention Program began as a way to experiment and learn from a different way of partnering to improve client outcomes. The idea for the project was developed as the mental health department began discussing how to move their programs toward their working hypothesis: “When we partner well, the quality of our work and the outcomes for all will improve.” The partnerships began with a series of Advisory Committee meetings to discuss how to add a crisis residential facility in Marin County that included partnerships with crisis planning services and peer providers, substance use staff and mental health providers.

Partnerships with Crisis Planning

Learning: Crisis Planning is most effective when the clients are NOT in crisis. A focus on client choice in crisis prevention was more effective than a focus on client choice in crisis treatment.

When the planning began, Psychiatric Emergency Services (PES) and Crisis Planning were just beginning to work together. The peer provider providing crisis planning services started working with clients at PES to develop a crisis plan to detail the type of support and interventions the client preferred if a crisis occurred. The idea was to keep the crisis plan at PES so the PES staff could reference it if the client returned. This initial partnership and process of integrating crisis planning at PES was deemed both successful in building awareness and relationships and difficult to fit the two systems and services together. The clients were getting services during an active crisis or just after which was deemed a difficult time by both partners: the PES staff was concerned about how to integrate a crisis plan in a crisis situation and the crisis planning staff was concerned about the usefulness of the plan if it is not used to change the client’s subsequent visits to PES and ultimately does not keep the client OUT of crisis.

The initial experience of working on Crisis Planning at PES led the crisis planning staff to modify the focus for their efforts. The staff began to focus on crisis prevention, and began to work with individuals to help them prevent a crisis from occurring.

Preliminary data collection shows that the clients who participate in crisis planning are more likely to return to Casa Rene (likely because they have more complex risks), but when they do, their subsequent stays are shorter than the clients who do not participate in crisis planning. The current sample is too small to draw conclusions, but this is a promising trend (see pages 38-39).

Partnering with Substance Use Services and Staff

Learning: The integration of substance use systems and crisis mental health services was challenging. Long-standing legislative barriers prevented true coordinated services. A focus on substance use screening did improve the identification of substance use concerns for clients seeking mental health services, and the partnership resulted in more substance use services support for individuals as they began recovery from a crisis mental health situation. The inclusion of substance use providers at the beginning planning stages of the project is recommended.
The partners were somewhat self-selected as they developed the project idea and the partnership component of the idea. The new leaders and staff who joined the project once it began to be implemented came in with an understanding of the project’s learning goals. The original Advisory Committee consisted of partners from Community Action Marin, Buckelew, Marin County Mental Health, and NAMI. In hindsight, the group noted they would have included the substance use staff earlier in the process. During the planning for implementation, the Marin County Mental Health department was merging with the Marin County Substance Use Services (SUS) department. Staff from the SUS department attended some meetings, but did not stay directly involved during the implementation. Several administrative staff on the project were from Substance Use Services and brought that perspective, but Substance Use Services practitioners were not involved until after implementation.

There are long-standing barriers to collaboration between mental health services and substance use services. The partners are working to creatively problem solve how to work together despite federal legislation that prevents talking about clients who receive substance use services.

“Substance use services need to be at the table from the get-go. It is a reflection of where we are as a system. It took us awhile to get there.” Another provider described, “Crisis residential had been very open to taking people with substance use disorders…. It is happening in other mental health services, but it can really be SEEN in crisis residential.”

The clients who use the crisis mental health system are frequently diagnosed with substance use issues as well. When clients were tracked for substance use diagnosis prior to being referred to Casa René, 59% of the referrals had an AOD diagnosis in addition to their mental health crisis (see page 27).

There is more work to be done to continue to include substance use services in the weekly partner meetings and to develop a role for a substance use content expert while still respecting the legislation. “The barriers between substance use services and mental health are entrenched and are really hard to shift. It is hard to tell what is an actual barrier and what is a habit.”

Partnerships with mental health providers and peer professionals

Learning: The key to the partnerships with mental health providers and peer professionals was a face to face weekly meeting at the crisis residential home. Issues were discussed and resolved each week and in person.

Once the crisis residential facility was built, PES and Buckelew (the community mental health program operating the crisis residential facility) began working on the process for referring clients to Casa René. This included how to get clients from one facility to another as well as how to transfer records and information. Additionally, time was spent determining what types of needs Casa Rene’s programs could meet. Just as with the partnership with Crisis Planning and PES, this work began to highlight the tension between mandates and regulations and the vision for the program of being as flexible as possible to meet the clients’ needs.
APPENDIX C
CCHPP Evaluation Summary

One of the partners reported, “We all came from the perspective of wanting the same thing and that was choices, alternatives for clients, to be able to have something different than they’ve been offered in the past. Something more preventable and more proactive and inclusive of them in their treatment and I think we all brought that vision to the table and that’s what worked.”

The providers from the Advisory Group began to meet at Casa René as services began. The group continues to meet every Thursday on site, face to face. This component is transformative. As one member of the Thursday meeting explained:

[The key is] having a lot of stakeholders here at the table every Thursday. Not only operational questions, but the day to day can be dealt with and issues weren’t deferred through email chains. We’ve created a really supportive environment to hash stuff out on the go, in the moment. There is very little deferring or putting things off. I had a chance to work as a team; to work together to instill what the vision is for Casa René...to decide who is an acceptable or appropriate client and who is not and the reasons why. We’re still working that out but being be able to reach out to [other members of the team] or anyone else and say “here are my concerns, can you bring it back to our team?” It makes the thing much more successful and avoided road blocks. That was one of the most successful pieces.

The Thursday meetings meant that the issues were resolved in the room, in real time, together. A pivotal event occurred early in the Thursday meetings. There was uncertainty about how to discuss clients when peer providers were present. The uncertainty initially resulted in the peer providers being asked to leave the meeting.

[It was] an odd break. We all felt weird about it. Thankfully, we were able to recognize, “wait a minute; this is exactly what the problem is. We won’t be able to do this program successfully without [the peer provider’s voice].” Because by erecting these divisions, that section was separated. This group was able to overcome that and move past it. And then give a big sigh of relief “oh thank god, we got [the peer provider’s] perspective”. [The client situation] isn’t something that needed to be watered down and then provided to him after the fact or as if he wasn’t a provider. That’s a really concrete example of us working together.

This collaborative problem solving toward the common goal of partnering well led to additional changes in the Crisis Residential Program. The program began to reach out to the programs they were referring clients to after they completed their stay at Casa René. They invited staff from PES and the programs to visit Casa René, and Casa René staff began to visit PES and the outside programs. This changed how successful the referrals were for clients and improved their anxiety about transitioning.

It’s like, “Hey! Six heads are better than one!” We were having an issue with folks who are really anxious about going to shelters. At that time, we didn’t know enough about it to be helpful to them, so we said, “Let’s pull them in, let’s have a meeting, let’s talk about it. How can we partner?” and so forth. There’s been enormous growth. Now the staff at Casa René feels much more knowledgeable about where they are sending folks to and can work with the clients who
have anticipatory anxiety about it. Just having that knowledge has made the referral more successful.

The providers who participate in the project noted that this flexibility in partnering leads to better client outcomes. Not just through more successful treatment planning and more successful referrals, but also through the flexibility in the programming at the site.

... the program has changed to fit the population of the people who are here. It’s not a set-in-stone curriculum that happens every single day. Groups are changed or there’s flexibility and choice in the activities and programming that occurs from week to week here at Casa René to reflect the needs of the clientele. It isn’t simply, “Well, it’s Tuesday, we’ll do this.” and I think that’s very important and I would like to make it easier for other programs to build in that flexibility.

Improved Client Outcomes

*Learning: Client outcomes were improved by building trust and connection between the service providers.*

When asked to describe how the partnerships and flexibility change client care, the partners described four client situations.

**Situation One: Partnering to address client’s needs in the least restrictive setting**

One of the strategies to transform the mental health system is to provide the least-restrictive, recovery-oriented treatment environment. One client who needed mental health care had a medical condition. Without Casa René and the partnership, this client would have been placed on 51-50 and brought to PES. What was different is that he did not come to PES. The PES staff and the Crisis Residential staff worked with the referring psychiatrist and the homeless outreach team and “Everyone figured out what was needed... the medications, the PPD... and put the details together to make it happen. That was a first time thing.” The ability to address the complexity of the situation and for each of the partners to trust each other to make it happen was new and very successful.

**Situation Two: Partnering to develop treatment plans for clients with complex needs**

As a result of the length of the stays at Casa René and the partnerships between the service providers and Psychiatric Emergency Services, the decisions about how to serve clients with complex needs are shared. One provider described a client who had multiple substance use, mental health and physical health concerns. She was unable to complete her first stay because of her unwillingness to manage her physical health. On her next referral, the crisis residential staff brought the decision about her admission to the Thursday meeting for discussion. The team worked out a plan that made her physical health her responsibility and as long as she took responsibility for that, they were able to focus on treating her mental health crisis and providing substance use support. After her second visit, she is doing much better. She was able to manage her physical health needs during her stay at Casa René.
This showcases the flexibility of the admission process and the ability to provide mental health services and supports to individuals who have multiple complex needs. It also demonstrates how client choice improves outcomes.

**Situation Three: Partnering to address the services and support client’s need to stay out of crisis**

Integrating crisis planning into the crisis residential services meant more support for clients to plan how to prevent their next crisis. The difficulty that arose again and again was housing. As clients began to recover, they also began to exhibit anxiety about housing. For one client, the peer providers were able to get their Medi-Cal active, help them qualify for disability, and arrange mental health support and medication services in the community. All of these services helped the client be stable enough to qualify for housing. “The client said therapy was going to be the biggest part of recovery. A lot of good things the client said were going to help in recovery were followed through on by a lot of different players. He’s currently housed and just got disability .... All those connections were made through Casa René. He was very clear about what he needed.” The flexibility to adapt the services and supports to reflect what the client needed are a hallmark of the Client Choice and Hospital Prevention Program.

**Situation Four: Partnering to empower clients to choose recovery**

A client came to Casa René and left the facility after one day and before he had completed treatment. The next day he went back to PES and returned to Casa René to try again. The following morning, “he really tried again, but he just couldn’t do it and it was like ‘ok, see you later, good bye’ and so, what a relief, if it doesn’t work, goodbye. And that’s just a wonderful part. It is the client’s choice, and that way he tried and he may come back.” Another provider continued, “Sometimes we’re helping to empower them to decide to leave here. It doesn’t sound like that would be very therapeutic, but the other side would be that if we tried to convince them to stay here and they are very agitated, in some cases even hostile and angry, that they start to feel like they can’t leave, that they feel trapped.” This client is able to have a choice about continuing treatment and the partners are working together to allow the client to return to treatment when they choose.

In conclusion, the partners and providers who participated in the CCHPP commented frequently on the importance of the weekly face to face meeting and the value of flexibility.

There was an unspoken agreement that [the CCHPP] was going to be different. It became different and I think when there were opportunities to get pulled back into the usual ways of doing business there were some brave people in the room who challenged it, and in part that was [the peer providers]. When barriers were getting put up because that’s how usual business goes, there was willingness and a sense of trust ultimately to work it out differently and get through the hard conversation.
Appendix A:

Logic Models
APPENDIX C
CCHPP Evaluation Summary
MHSA Innovation: Client Choice and Hospital Prevention Program

**Strategies**

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

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

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

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

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

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

**Outcomes**

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

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

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

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

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

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

**Impact**

TRANSFORM THE MENTAL HEALTH SYSTEM

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

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

**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
CCHPP: Crisis Planning Logic Model

**Resources**
- Advisory Committee
- Peer Providers
- Family Partners
- Clients
- CBO Mental Health Staff (Buckelev)
- Crisis Planning Staff (CAM)
- Psychiatric Emergency Services staff (PES)
- County Mental Health and Substance Use Services staff

**Partners**
- Advisory Committee
- Peer Providers
- Family Partners
- Clients
- CBO Mental Health Staff (Buckelev)
- Crisis Planning Staff (CAM)
- Psychiatric Emergency Services staff (PES)
- County Mental Health and Substance Use Services staff

**Referral System**

**Outputs**
- Number of mental health clients, family members and providers who receive education
- Number of clients who develop or update a crisis plan
- Number of meetings with Psychiatric Emergency Services (PES), crisis residential services and mental health providers serving stable, sub-acute and acute populations to identify clients and address barriers to crisis planning as they emerge
- Number of clients identified
- Number/type of barriers to crisis planning that emerge

**Outcomes: Short Term (knowledge/attitudes)**

**Clients**
- Mental health clients understand choices available to them in crisis situations and the purpose of crisis planning (knowledge)
- Mental health clients report that crisis planning helped them partner with the mental health system (attitude)

**Outcomes: Intermediate /Long Term (behavior)**

**Clients**
- Mental health clients have Crisis Plans as part of their permanent mental health record and update them as needed. (behavior)
- Mental health clients report the use of support and self-care identified in Crisis Plan to avert a crisis. (behavior)

**Staff**
- PES and crisis residential services staff understand the purpose of crisis planning (knowledge)
- PES and crisis residential services staff reviews the Crisis Plans when a mental health client is in crisis.

**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 B:

Provider Survey

The text and questions of the provider survey are provided here for reference. The survey was completed online.
Welcome!
Thank you for your work with the Client Choice and Hospital Prevention Program (CCHPP).

This survey asks about your experiences working and/or advocating in the Marin County Crisis Mental Health System.

YOUR RESPONSES ARE CONFIDENTIAL.

Your name is required to be sure that everyone has responded to the survey and to assign a survey respondent number.

Once the survey is completed and the respondent number assigned, YOUR NAME WILL BE STRIPPED FROM THE DATA.

Your honest and thoughtful responses will be used to understand what is working and what needs to be changed. Thank you for your time.

If you have questions about the survey, please contact Patty Lyons, MFT at PLyons@marincounty.org.

1. Your name is required so we can be sure that everyone has responded to the survey. It will be stripped from the data prior to analysis. *(This question was required)*

   Your email is requested in case we have questions about your responses.
   
   Name:
   
   Email:

Demographics

2. How long have you worked in the field of mental health?
   - I do not work in the field of mental health
   - Less than one year
   - 1 to 5 years
   - 6 to 10 years
   - 11 to 15 years
   - More than 15 years

3. How long have you worked in the field of crisis mental health?
   - I do not work in the field of crisis mental health
   - Less than one year
   - 1 to 5 years
   - 6 to 10 years
   - 11 to 15 years
   - More than 15 years

4. How long have you been an advocate for mental health services?
   - I am not an advocate for mental health services
   - Less than one year
   - 1 to 5 years
   - 6 to 10 years
   - 11 to 15 years
   - More than 15 years
Your Role

5. What is your role in providing Crisis Mental Health Services? Please check ALL that apply.
   - I am a member of the Client Choice and Hospital Prevention Advisory Committee
   - I am a Peer Provider
   - I am a Family Partner
   - I am a staff person at Buckelew
   - I am a staff person at CAM
   - I am a staff person at PES or MHSUS
   - I am a line staff person
   - I am a manager or supervisor
   - I am an administrator
   - Other (please specify):

6. Do you provide DIRECT crisis mental health services in Marin County? (Those who answered “yes” to this question were considered Direct Service Staff for the purposes of this survey—This question was required)
   - Yes
   - No

7. Thinking about Crisis Services in Marin County, please rate the following statements: (Statements were rated from 1-10 with 1=Strongly Disagree and 10=Strongly Agree. Do Not Know was also a response option)
   - I understand the components of quality crisis services.
   - I understand my role in improving the quality of crisis services in Marin County.
   - I am willing to make changes to improve the quality of crisis services in Marin County.
   - I understand how to work together (collaborate) with other people/agencies involved in improving crisis services in Marin County.
   - I believe that working together (collaboration) is an effective way to improve crisis mental health services in Marin County.
   - I believe that using PEER PROFESSIONALS is an effective way to improve crisis mental health services in Marin County.
   - I believe that using FAMILY PARTNERS is an effective way to improve crisis mental health services in Marin County.
   - I believe that serving individuals with co-occurring disorders is an effective way to improve crisis mental health services in Marin County.
   - I understand that on purpose of Crisis Planning is to avert a crisis
   - I understand that another purpose of Crisis Planning is to improve a client’s experience if they do have a crisis

(The remaining statements were asked of Direct Service Staff Only)
   - I understand the barriers to utilizing a crisis plan.
   - I believe I am part of a trusting team providing crisis mental health services
   - I believe that wellness and recovery are possible
   - I believe that a focus on wellness and recovery is an effective way to improve crisis mental health services
   - I enjoy working as part of a team that believes in wellness and recovery.
APPENDIX C
CCHPP Evaluation Summary

Training
(This question was asked of Direct Service Staff Only)

8. Thinking about your role in providing crisis mental health services, please indicate the usefulness of the following potential training topics. (Statements were rated from 1-10 with 1=Not at all Useful and 10=Very Useful. Do Not Know was also a response option)
   - Crisis Planning
   - Peer Professional Staffing
   - Integrating Substance Use and Mental Health Services
   - Other (Please specify):

Changes in Crisis Mental Health System

9. Thinking about Crisis Services in Marin County, please rate the following statements: (Statements were rated from 1-10 with 1=Strongly Disagree and 10=Strongly Agree. Do Not Know was also a response option)
   - Peers employed in crisis services are treated as equal partners
   - Providers review the crisis plan with a mental health client in a crisis
   - Providers address the barriers to using the crisis plan as they emerge

10. Thinking about Crisis Services in Marin County, please rate the following statements about prevention and treatment: (Statements were rated from 1-10 with 1=Strongly Disagree and 10=Strongly Agree. Do Not Know was also a response option)
    - Changes have been made to the mental health system to PREVENT psychiatric crisis.
    - Changes have been made to the mental health system to TREAT psychiatric crisis.
    - Changes have been made to the substance use system to PREVENT psychiatric crisis.
    - Changes have been made to the substance use system to TREAT psychiatric crisis.

11. Overall, as a result of the Client Choice & Hospital Prevention Program (CCHPP): (Statements were rated from 1-10 with 1=Strongly Disagree and 10=Strongly Agree. Do Not Know was also a response option)
    - Changes have been made to improve the quality of the crisis system.
    - The quality of the crisis system has improved.

12. As a result of the Client Choice & Hospital Prevention Program (CCHPP): (Statements were rated from 1-10 with 1=Strongly Disagree and 10=Strongly Agree. Do Not Know was also a response option)
    - I have more knowledge about how to help PREVENT a psychiatric crisis.
    - I have more knowledge about how to RESPOND to a psychiatric crisis.

Decision Making
One of the goals of the Client Choice & Hospital Prevention Program is to involve all partners in decisions that shape the program. The following questions ask about your experiences reviewing and influencing decisions about program design and implementation. The decisions can be either programmatic or clinical.

PROGRAM DESIGN refers to the policies and procedures used to operate the programs, and program development.

IMPLEMENTATION refers to the quality improvement efforts and the use of evaluation findings to adjust the program and increase the effectiveness.
13. I REVIEWED...

Reviewed means that during the program development and/or implementation, the decisions have been shared with you.

(Statements were rated from 1-10 with 1=Strongly Disagree and 10=Strongly Agree. Do Not Know was also a response option)

- Program Design Decisions
- Implementation Decisions

14. I INFLUENCED...

Influenced means that you actively participated in discussion before the decisions were made.

(Statements were rated from 1-10 with 1=Strongly Disagree and 10=Strongly Agree. Do Not Know was also a response option)

- Program Design Decisions
- Implementation Decisions

Thank You!
Thank you very much for taking the time to complete the survey.

15. Additional Comments about the Client Choice and Hospital Prevention Program:

16. If you would like to be contacted about your comment(s), please leave your name and contact information below. NOTE: Your name will not be kept with your survey responses, but it will be kept with your comment(s) so you can be contacted.

☐ YES, I would like to be contacted about my comment(s) from above question:

Name:

Contact Information:

If you have questions about the Client Choice and Hospital Prevention Program, please contact Patty Lyons at Plyons@marincounty.org.
Appendix C:

Provider Interview Protocol
1. Quality:
   a. From your perspective, define quality crisis mental health services
   b. Given this definition, do you think that the quality of crisis mental health services has improved, stayed the same or declined since the implementation of the Client Choice and Hospital Prevention Program? Why?
      i. Different?
      ii. Surprised you?
      iii. Could be changed?

2. Peer-Professional Staffing:
   a. This project aims to implement and operate integrated peer professional staffing.
      i. What is different from your previous experiences with peer professional staffing?
      ii. What surprised you about the peer professional staffing?
      iii. What could be changed about peer professional staffing?

3. Substance Use Services:
   a. This project aims to strengthen the partnerships between substance use services and crisis mental health (increased SUS screening, improved attitudes about serving individuals with co-occurring disorders, changing systems to prevent and treat psychiatric crisis)
      i. What is different from your previous experiences with partnerships between SUS and MH?
      ii. What surprised you about partnerships between SUS and MH in this project?
      iii. What could be changed about partnerships between SUS and MH in this project?

4. Client Care:
   a. Thinking about the peer, SUS and MH interventions in the CCHPP, in your opinion, are clients receiving improved interventions? Why or why not?
      i. Different?
      ii. Surprised you?
      iii. Could be changed?
Appendix D:

Crisis Planning Client Surveys, Initial and Post
### INITIAL SURVEY (to be completed after Crisis Plan is finished)

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<tr>
<th>Date:</th>
<th>strongly agree</th>
<th>agree</th>
<th>neutral</th>
<th>disagree</th>
<th>strongly disagree</th>
<th>don't know or n/a</th>
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<tbody>
<tr>
<td>1 I like the Crisis Planning services that I received here.</td>
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<td>2 If I had other choices, I would still get services from CAM's Crisis Planning Program.</td>
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<td>3 I would recommend this agency, CAM's Crisis Planning Program, to a friend or family member.</td>
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<td>4 Having a Crisis Plan increased awareness of my individual symptoms.</td>
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<td>5 Having a Crisis Plan increased my understanding of the types of choices available to me in a crisis situation.</td>
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<td>6 After meeting with crisis planning staff, I understand the purpose of crisis planning is to avert crisis</td>
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<td>7 Having a crisis plan makes me feel like I can partner with the mental health system</td>
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<td>8 Having a crisis plan makes me feel like I can participate in my own recovery</td>
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<td>9 I have a crisis plan as part of my permanent mental health record</td>
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POST SURVEY (to be completed 6 months after crisis plan is completed, or after a crisis visit)

Today's Date:
My Crisis Plan was competed ____months ago.

<p>| 1 | Having a Crisis Plan increased my understanding of the types of choices available to me in a crisis situation. |
| 2 | Having a Crisis Plan makes me feel like I can partner with the mental health system |
| 3 | Having a crisis plan makes me feel like I can participate in my own recovery |
| 4 | I have a crisis plan as part of my permanent mental health record |
| 5 | I update my crisis plan as needed |
| 6 | Since developing my Crisis Plan, my symptoms are not interfering as much with my daily activities. |
| 7 | Having a Crisis Plan increased my awareness of community supports. |
| 8 | Having a Crisis Plan helped me reach out to my supports (family, friends, peers services and clinicians) to avert a crisis. |
| 9 | Using the Crisis Plan made me more engaged in my recovery process |</p>
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<th></th>
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<th>strongly agree</th>
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<th>disagree</th>
<th>strongly disagree</th>
<th>don't know or n/a</th>
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<tr>
<td>10</td>
<td>As a result of Crisis Planning I was able to decrease my need for psychiatric emergency services.</td>
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*Please complete these questions if you have used Crisis Mental Health Services since making your Crisis Plan*

My visit to PES was ___ months ago

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<th>strongly agree</th>
<th>agree</th>
<th>neutral</th>
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<th>strongly disagree</th>
<th>don't know or n/a</th>
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<tr>
<td>11</td>
<td>I remembered my Crisis Plan before my visit to PES</td>
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<td>12</td>
<td>PES and/or Crisis Residential staff discussed my Crisis Plan with me when I was admitted.</td>
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<td>13</td>
<td>PES and/or Crisis Residential staff used at least one of my treatment preferences from my Crisis Plan.</td>
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<td>14</td>
<td>Having a Crisis Plan improved my overall experience with PES services.</td>
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<td>PES staff allowed me to contact my supports to provide additional assistance during my last visit.</td>
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Would you like additional Crisis Planning Services? ☐Yes ☐No
Appendix E:

Client Survey: Quality Rating

The following survey was distributed to clients of crisis residential and crisis planning at a client event to get their opinion of the quality of crisis mental health services in Marin County.
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.

**Thinking about your experiences with crisis mental health, are clients treated as a whole person?**

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<th>Always</th>
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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.

**Thinking about your experience with crisis mental health, are there strong partnerships?**

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Accessible Services: Clients, family members and service providers know how to use and navigate the crisis mental health service system.

**Thinking about your experience with crisis mental health, are there accessible services?**

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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.

**Thinking about your experience with crisis mental health, are the assessments timely and thorough?**

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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.

**Thinking about your experience with crisis mental health, are there service options for clients?**

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APPENDIX C
CCHPP Evaluation Summary

**Increased Connections:** The client develops relationships and connections to aid in moving away from crisis.

*Thinking about your experience with crisis mental health, are there service options for clients?*

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**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.

*Thinking about your experience with crisis mental health, are there service options for clients?*

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*Your comments about Quality Crisis Mental Health Services in Marin County:*
Appendix F:

Client Interview Protocol
APPENDIX C
CCHPP Evaluation Summary

Overview/Introduction: We want to understand your experience with the Client Choice and Hospital Prevention Program and to hear whether it has changed how you manage your mental health.

The Client Choice and Hospital Prevention Program has four parts: Crisis Planning, Crisis Residential (Casa Rene), Peer Professional Staffing and Substance Use Services.

Questions:

Crisis Planning: One part of the program is Crisis Planning.
- Have you used Crisis Planning? What did you think? Did it help you have more choices to manage your mental health? Why or why not?

Crisis Residential: Another part of the program is the Crisis Residential Home, Casa Rene. Casa Rene opened in February 2014.
- Have you used the services at Casa Rene? What did you think? Did it help you have more choices? Did it help you to manage your mental health? Why or why not?

Peer Professionals: The Client Choice and Hospital Prevention Program employs peer professionals and licensed mental health staff who work together to meet clients mental health needs.
- Have you noticed the peer professionals and the licensed staff working together? What do you think? Did it help you have more choices? Did it help you to manage your mental health? Why or why not?

Substance Use Services: The Client Choice and Hospital Prevention Program brings mental health providers and substance use providers together to coordinate services for individuals who need both types of support.
- Have you used substance use services as well as mental health services? (if no, do you have a friend who has used both services?) What did you think? Were the services coordinated? Did it help you have more choices? Did it help you to manage your mental health?

Overall:
- Please share any stories that explain how the Client Choice and Hospital Prevention Program did or did not change how you manage your own mental health and avoid crisis.
Marin County Mental Health and Substance Use Services Division

*Mental Health Services Act (MHSA)*

INNOVATION STAKEHOLDER MEETING

AGENDA

Innovation in Marin
*Chris Kughn*

Mental Health Services Oversight and Accountability Commission (MHSOAC)
*Deborah Lee*

Marin’s Innovation Theme:
Reducing Disparities
*Cesar Lagleva*

Summary and Next Steps:
Submitting your Ideas
*Chris Kughn*
*Kasey Clarke*

All documentation provided at this meeting are available on our website at: [www.marinhhs.org/mhsa](http://www.marinhhs.org/mhsa)
GUIDING PRINCIPLES FOR THE DEVELOPMENT
OF CULTURALLY COMPETENT SERVICES

The following guiding principles have been developed as a tool for counties in creating a culturally and linguistically sensitive system of care. They are intended to clarify the activities required in the implementation and oversight of this task. Identification, development, promulgation, and adoption of culturally competent best practice guidelines for care must be an integral part of ongoing culturally competent systems of care. Cultural competence is a means to eliminating cultural, racial and ethnic disparities. Cultural competence enhances the ability of the whole system to incorporate the languages, cultures, beliefs and practices of its clients into the service. In this way all clients benefit from services that address their needs from the foundation of their own particular culture.

1. Mental health and substance use service disparities for cultural, racial and ethnic populations must be identified throughout the system of care. Subsequently, strategies for elimination of these disparities must be developed and implemented.

2. Cultural competence must be supported at all levels of the system including policy, programs, operations, treatment, research and investigation, training and quality improvement.

3. Oversight of cultural competence activities is provided by the Cultural Competence/Ethnic Services Manager who functions as an expert advisor to the leadership body of the organization.

4. Monitoring and evaluation of Cultural Competence Plans and activities must be an integral component of quality improvement.

5. A process must be established and implemented for obtaining client, community, and staff input related to cultural competence planning, implementation, monitoring and evaluation.

6. Ongoing training to professional, administrative, and support personnel must be culturally competent in order to effectively address the needs of cultural, racial and ethnic populations.

7. Commitment to cultural competence must be evident in mental health and substance use strategic planning and budgeting. Allocations that support cultural competence activities must be included in annual budgets.

8. Human Resource recruitment strategies must be established in order to ensure adequate levels of staff from diverse populations in the workforce. Educational opportunities and other retention efforts must be emphasized.
9. Mental health services must be responsive to the numerous stressors experienced by cultural, racial and ethnic populations that have a negative impact on the emotional and psychological state of individuals.

10. Professional, administrative, and support staff should reflect the diversity of the populations served.

11. Cultural, racial and ethnic populations must participate as active partners in all aspects of the services they are receiving, including outreach and engagement, assessment, plan development and treatment.

12. Services to cultural, racial and ethnic populations must include the family, a natural resource, when working with individuals experiencing emotional difficulties.

13. Formal and informal relationships with the community and other partners must be developed to address cultural competence issues, and delivery of culturally competent care.

14. Services must be culturally and linguistically appropriate with sensitivity to historical, cultural and religious experiences of diverse populations.

15. Treatment interventions, engagement strategies, and outreach services must be culturally and linguistically appropriate to engage and retain cultural, racial and ethnic populations and prevent hospitalization.

16. Mental health and substance use service systems must have policies, workplace design, and mechanisms in place to promote engagement of staff of diverse backgrounds.

17. Services must be accessible on a timely basis, and geographically convenient for all diverse populations.
MHSA Innovation Promise and Potential

Why Innovation?
- What we don’t know exceeds what we know
- Creativity of community
- Transformation: develop and evaluate new mental health practices, encourage adoption throughout California

Challenge to public sector innovation
- Every county creates, innovates
- Some Innovative Programs won’t work
- Change is challenging
- Sustaining Innovative Projects
- Getting the song out of our heads (for awhile)
MHSOAC and Innovation

- Counties’ Three-Year Program and Expenditure Plans and Annual Updates, including programs for innovations, shall be submitted to the MHSOAC within 30 days of adoption by boards of supervisors.

- County mental health programs shall expend funds for their innovation programs upon approval of the MHSOAC.

Innovation to Date

- 55 of 59 counties: at least one approved Innovative Program.

- 172 Innovative Programs approved to date:
  - 105 approved by MHSOAC
  - 67 Approved Locally

- Average time from submission by county to MHSOAC approval (post-AB 1467): 24 business days.
MHSA Definition: Innovation

■ Introduces new mental health practices/approaches including prevention and early intervention or
■ Changes an existing mental health practice/approach, including adaptation for a new setting or community or
■ Introduces a new application to the mental health system of a promising community-driven practice/approach that has been successful in non-mental health contexts or settings

Innovation Trends

■ Serious mental illness or emotional disturbance: 70%
■ Treatment: 55%
■ System changes: 45%
■ Early intervention: 37%
■ Crisis response: 32%
■ Prevention: 23%
Innovation Trends

- Peer Support
  - Riverside: Recovery Learning Center
  - LA: Integrated Peer-Run Model
  - Contra Costa: Promoting Wellness, Recovery, and Self-Management through Peers
  - Humboldt: Adaptation to Peer Transition-Age Youth
  - Lake: Peer-Informed Access
  - San Diego: Peer and Family Engagement Project
  - San Francisco: Peer-Led Hoarding and Cluttering Support Team
  - Marin: Client Choice and Hospital Prevention Program
  - Trinity: Respite Support Project
  - San Joaquin: Adapting Functional Family Therapy

Innovation Trends

- Physical-Behavioral Integrated Health
  - Ventura: Healthcare Access and Outcomes Project
  - Tuolumne: Wellness: One Mind One Body
  - Tulare: Integrated Clinic with Pharmaceutical Case Management
  - Tri-City: Integrated Services
  - Stanislaus: Integrated Innovations
  - Sonoma: Integrated Health Team
  - San Mateo: Total Wellness
Innovation Trends

■ Physical-Behavioral Integrated Health
  ▪ San Diego: Physical Health Integration Project
  ▪ San Benito: Primary Care Integration Project
  ▪ Orange: Integrated Services
  ▪ Nevada: Integrated Healthcare
  ▪ Modoc: Taking Integration Personally
  ▪ Madera: Development of Model of Integrated Peer Support and Clinical Services
  ▪ LA: Integrated Clinic Model and 3 others
  ▪ Inyo: Coordinated Care Collaborative

■ La Cultura Cura
  ▪ Monterey: Alternative Healing and Promotores de Salud
  ▪ Napa: The Collaborative Project
  ▪ San Bernardino: Holistic Campus
  ▪ Santa Clara: Multi-Cultural Center Project
  ▪ Sonoma: Reducing Disparities Community Fund Initiative
  ▪ Sutter-Yuba: A Culturally Competent Collaboration to Address Serious Mental Illness in the Traditional Hmong Population
  ▪ Tehama: Drumming for Health
  ▪ Stanislaus: Families in the Park
Innovation Trends

- **La Cultura Cura**
  - Berkeley: African-American Community Empowerment Academy
  - Butte: A Community-Based Treatment for Historical Trauma to Help Hmong Elders (The Happy Program)
  - Fresno: Holistic Culturally Competent Wellness Center
  - Kings: Native American Youth Equine-Facilitated Psychotherapy Program
  - LA: Community-Designed Integrated Service Management Model
  - Merced: Strengthening Families Project

Mental Illness/Mental Health

- Innovation may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges.
Primary Purposes

- Increase access to services
- Increase access to services for underserved groups
- Improve the quality of services, including measurable outcomes
- Promote interagency and community collaboration

MHSA General Standards

- Community collaboration
- Cultural competence
- Client-driven
- Family-driven
- Focused on wellness, recovery, and resilience
- Integrated service experience for clients and their families
Time-Limited Pilot Projects

- If an innovative project has proven to be successful and a county chooses to continue it, the project work plan shall transition to another category of funding as appropriate
  - Timeline
  - Evaluation
  - Budget

Timeline

- Timeline with sufficient opportunity for learning, testing, making decisions, and disseminating
  - Maximum five years (proposed regulations)
  - Key activities and milestones
    - Implementing and refining
    - Evaluating
    - Making decisions
    - Communicating successes and lessons learned
Evaluation

- Plan to evaluate whether/how Innovative Project has proven to be successful
- Expected outcomes of Innovation
- How and at what frequency outcomes will be measured
- How outcomes relate to Innovation’s primary purpose
- How county will assess which elements of Innovation contributed to positive outcomes, especially whatever is new or changed

Budget

- Includes anticipated future Innovation funds
- County provides budgets for each fiscal year and total budget, specifying MHSA Innovation funds
- Budget is consistent with a time-limited pilot; county has option to provide narrative with brief rationale for budget
Change

- Expected to learn and change as you go along
- Evaluation is ongoing, not just at the end
- Participants and community members have lots to contribute to evaluation
- Changes that require community participation and MHSOAC approval
- Implementing change as a result of Innovation learning

MHSOAC Support for Counties on Innovation

- Partnership with community members
- Pre-submission technical assistance and support, if county requests
- Review of submitted plan for consistency with MHSA requirements using MHSOAC review tool
- Phone conference with county
- Support and review county’s revisions
- Submit to MHSOAC
- Support for Innovation evaluations
- Support for telling the story and sharing successes
We want your ideas to Reduce Disparities in Marin County!

Idea Submission Instructions

*Mental Health Services Act (MHSA)*
Innovation FY2014-2017

A key element to Innovation is *learning* how to solve a challenging problem in our community. Our hard to solve problem in Marin County is engaging, and supporting diverse populations in order to reduce disparities.

You will need to include the following information in your one-page summary:

- Please include your name, phone number and email address.
- Description and Purpose of your Innovation idea, including what you think we will *learn* about reducing disparities?
- How your idea will address reducing disparities?
- Target population you will reach (ethnicity, culture, age, gender/identity)?
- Number of clients you think your idea will reach?
- How is this idea “innovative” (refer to *Innovation Defined* document)?
- Annually, how much do you think your idea will cost (estimate)?

Submit your written idea no later than: **Friday, December 12, 2014 by 5 p.m.**

You can U.S. Mail, email or drop off your idea to:

Kasey Clarke  
MHSA Coordinator  
Mental Health and Substance Use Services Division  
20 N. San Pedro Road, Suite 2021  
San Rafael, CA 94903  
kclarke@marincounty.org - email
Definition of Reducing Disparities

In order to reduce disparities, we must improve our system of care to better support our diverse community. Diversity includes cultural, ethnicity, race, age, and/or gender/identity. Culturally competent systems enhance the ability to incorporate the cultures, beliefs, practices and languages of its diverse consumers into services (concept taken from the Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities: Guiding Principles).

Some Barriers that Lead to, or Maintain, Disparities in our System of Care

- Traditional access to services is difficult due to language, lack of cultural understanding and/or lack of culturally competent services, especially where there is a high concentration of hard-to-serve/hard-to-reach populations.
- Lack of culturally and linguistically appropriate treatment interventions and approaches.
- Lack of culturally and linguistically competent professionals and para-professional staff in our community and programs.
- Lack of cultural competency trainings for the workforce.
- Literatures and educational/informational tools are not linguistically appropriate

Population that MHSA Innovation Ideas Can Positively Impact

Un-served, Under-served, Inadequately and/or Inappropriately served, including:

- African Americans
- Asian/Pacific Islanders
- Latinos
- Children
- Transition Aged Youth
- Adults
- Older Adults
- Families
- U.S. Veterans
- LGBTQ
- Uninsured
- Low Income
- Undocumented
- Rural / West Marin
- Institutions
Mental Health Services Act (MHSA)
INNOVATION STAKEHOLDER MEETING

AGENDA

10:00 Welcome and Introductions
Meeting Purpose and Goals

10:15 Review Innovation Guidelines and Marin’s Reducing Disparities Theme

10:30 Breakout Discussion Groups
Reports from Groups

11:45 Closing / Next Steps

All documentation provided at this meeting are available on our website at: www.marinhhs.org/mhsa
INNOVATION DEFINED

The MHSA Oversight and Accountability Commission’s Innovation Committee defines Innovative Programs as novel, creative, or ingenious mental health and substance use service approaches developed within communities that are inclusive and representative, especially of underserved, 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 and substance use service practices or approaches.
- Makes a change to an existing mental health and substance use system practice or approach including adaptation for a new setting.
- Introduces a new application to the mental health and substance use service system of a promising community-driven practice or approach that has been successful in a non-mental health setting.

INNOVATION NEEDS

Needs to…contribute to learning;
Needs to…try new things out (vs. doing things that are already accepted practices);
Needs to…Include one or more of the MHSA Essential Elements listed below:

- Increase access to underserved groups;
- Increase the quality of services with better outcomes;
- Promote interagency collaboration;
- Increase access to services.

INNOVATION CLARIFICATIONS

Innovation may introduce a novel, creative ingenious approach to a variety of mental health and substance use practices, but is not limited to direct mental health services. As long as the Innovation contributes to learning and maintains alignment with the MHSA Essential Elements it may affect any aspect of mental health and substance use service practices or assess a new application of a promising approach to solving persistent seemingly intractable mental health and substance use challenges.

These approaches can include the following:

- Administrative/governance/organizational practices, processes or procedures;
- Advocacy;
- Education and training for service providers, including non-traditional mental health practitioners;
Outreach, capacity building and community development;
Planning;
Policy and system development;
Prevention and early intervention;
Public education efforts;
Research;
Services and/or treatment intervention.

A practice or approach that has been successful in one community mental health and substance use service setting cannot be funded as an Innovative Program in a different community even if the practice or approach is new to that community, UNLESS it is changed in a way that contributes to the learning process.

Addressing an unmet need is not sufficient to receive funding under this component.

By their very nature, not all Innovative projects will be successful and can be terminated.

No time limit on projects. If the project is successful it could potentially be sustained through the CSS or PEI funding.

An innovative project can add a learning strategy to a currently approved CSS or PEI plan.

Innovation projects are similar to pilot projects or demonstration projects in that they are time-limited (three (3) year limit).

Leveraging with collaborative partnership is encouraged.

Projects can involve regional collaboration with other counties.

Analysis of effectiveness and reporting of progress is required.

**INNOVATION POSSIBILITIES**

 ✓ Can be based on what has been learned during large community planning processes for CSS, PEI or WET.
 ✓ Can be informed by lessons learned during the implementation of CSS.
 ✓ Can focus on innovative co-occurring disorder treatment.
 ✓ Can measure outcomes and effectiveness of PEI Project Community Capacity Building (evaluation).
 ✓ More than one project can be created.

*Marin County Innovation Resources can be found at www.marinhhs.org/mhsa*

*Innovation resources can be found at http://mhsoac.ca.gov/Counties/Innovation/Innovation.aspx*
We want your ideas to Reduce Disparities in Marin County!

Idea Submission Instructions
Mental Health Services Act (MHSA)
Innovation FY2014-2017

A key element to Innovation is learning how to solve a challenging problem in our community. Our hard to solve problem in Marin County is engaging, and supporting diverse populations in order to reduce disparities.

You will need to include the following information in your one-page summary:

- Please include your name, phone number and email address.
- Description of your Innovation idea, including:
  - What strategies, activities or services would be conducted;
  - How your idea will reduce disparities;
  - What you think we will learn about reducing disparities.
- Target population you will reach (ethnicity, culture, age, gender/identity)?
- How is this idea “innovative” (refer to Innovation Defined document at www.marinhhs.org/mhsa)?

Submit your written idea no later than:  Wednesday, January 21, 2015 by 5pm

You can U.S. Mail, email or drop off your idea to:

Kasey Clarke
MHSA Coordinator
Mental Health and Substance Use Services Division
20 N. San Pedro Road, Suite 2021
San Rafael, CA  94903
kclarke@marincounty.org - email
APPENDIX D

Definition of Reducing Disparities

In order to reduce disparities, we must improve our system of care to better support our diverse community. Diversity includes cultural, ethnicity, race, age, and/or gender/identity. Culturally competent systems enhance the ability to incorporate the cultures, beliefs, practices and languages of its diverse consumers into services (concept taken from the Framework for Eliminating Cultural, Linguistic, Racial and Ethnic Behavioral Health Disparities: Guiding Principles).

Some Barriers that Lead to, or Maintain, Disparities in our System of Care

- Traditional access to services is difficult due to language, lack of cultural understanding and/or lack of culturally competent services, especially where there is a high concentration of hard-to-serve/hard-to-reach populations.
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- Lack of culturally and linguistically competent professionals and paraprofessional staff in our community and programs.
- Lack of cultural competency trainings for the workforce.
- Literatures and educational/informational tools are not linguistically appropriate

Population that MHSA Innovation Ideas Can Positively Impact

Un-served, Under-served, Inadequately and/or Inappropriately served, including:

- African Americans
- Asian/Pacific Islanders
- Latinos
- Children (0-18)
- Transition Aged Youth (16-25)
- Adults (18-59)
- Older Adults (60+)
- Families
- U.S. Veterans
- LGBTQ
- Uninsured
- Low Income
- Undocumented
- Rural / West Marin
- Institutionalized
- Incarcerated Adults
- Homeless
- Middle School Students
- Older Adults (60+)
- Families
- U.S. Veterans
- LGBTQ
- Uninsured
- Low Income
- Undocumented
### MHSA INNOVATION FUNDING
#### PLANNING PROCESS OVERVIEW (TENTATIVE)

**Goal:** Produce an MHSA Innovation Plan for FY2014/15 through FY2016-17 by bringing together stakeholder input, MHSA Innovation requirements, and County Mental Health and Substance Use Services (MHSUS) priorities.

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<th>Event/Deadline</th>
<th>Description</th>
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<tr>
<td>MHSA Innovation Meeting 10.28.2014</td>
<td>First meeting to give overview of MHSA Innovation component and guidelines</td>
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<tr>
<td>MHSA Innovation Meeting 1.9.2015</td>
<td>Second meeting to gather stakeholder input what reducing disparities means to the community and what are Marin’s priority populations needing services.</td>
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<tr>
<td>Additional Input 1.12.15 thru 1.21.15</td>
<td>January 9th meeting input posted for reference and the ability to add to this input for those unable to attend.</td>
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<tr>
<td>Submission of Written Ideas Deadline 1.21.2015</td>
<td>Stakeholders submit written ideas with strategies no later than 5 pm on January 21, 2015.</td>
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<td>Identify Themes/Priorities Late January-Early February</td>
<td>Review Written ideas received by the deadline and align with stakeholder priorities identified through the public process to share with the MHSUS Director.</td>
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<tr>
<td>MHSUS Director Input 2.9.2015</td>
<td>Project Themes and direction will be determined by the Director</td>
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<td>Draft INN Plan Mid-February – March 2015</td>
<td>Based on the Director’s determination(s), Innovation plan(s) will be drafted, technical assistance provided by the MHSOAC.</td>
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<td>Thirty (30) Day Public Comment Period April 2015</td>
<td>Proposed Innovation Plan(s) will be posted for public review and comment.</td>
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<td>Board of Supervisor Approval Spring 2015</td>
<td>With the public comments included, the Board will review proposed Innovation plan(s) for approval.</td>
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<tr>
<td>Submit Innovation Plan(s) to the MHSOAC Spring 2015</td>
<td>MHSOAC will review / approve Plan(s).</td>
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<tr>
<td>Draft RFP(s) Spring 2015</td>
<td>Draft Innovation RFP(s) based on approved Plan(s).</td>
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<td>RFP’s (subject to change) Summer 2015</td>
<td>Release RFP(s). Technical Assistance available for RFP applicants.</td>
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<tr>
<td>Target Population/Geographic Area/etc.</td>
<td>Hard to solve Problem</td>
</tr>
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<td>--------------------------------------</td>
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</tr>
<tr>
<td>Unhoused, West Marin - Bolinas</td>
<td>Unhoused people challenged with mental health and addiction issues, yet unable to access needed services and supports.</td>
</tr>
<tr>
<td>Seniors</td>
<td></td>
</tr>
<tr>
<td>Probation Youth 18-25</td>
<td>Probation youth not going to high school or college nor have the skills for securing jobs and at risk of eventual incarceration.</td>
</tr>
<tr>
<td>K-12 age group</td>
<td>Socially constructed messages limit people's self-empowerment.</td>
</tr>
<tr>
<td>Seriously mentally ill clients</td>
<td>People initially engaged with the treatment system leaving early.</td>
</tr>
<tr>
<td>San Geronimo Valley and West Marin communities</td>
<td>Isolation for both adults and youth in the rural West Marin area with limited access to health and social services.</td>
</tr>
<tr>
<td>LGBTQ Latino Youth</td>
<td>Counseling/therapy is a high need area identified in the report <em>First, Do No Harm, Reducing Disparities for LGBTQ populations in California.</em></td>
</tr>
<tr>
<td>Youth or Seniors</td>
<td>Large-scale social change requires broad cross-agency, cross-sector coordination.</td>
</tr>
<tr>
<td>Residents of Marin</td>
<td>Complex problems require wrap-around approach.</td>
</tr>
<tr>
<td>Low income Spanish speaking community</td>
<td>Need non-clinical environments to service this population differently than the traditional western therapy models.</td>
</tr>
<tr>
<td>Transition-aged youth with co-morbid psychosis and substance misuse disorders and family members</td>
<td>This population constitutes a “hard-to-serve/hard-to-reach” community that is poorly engaged through traditional treatment and case management services.</td>
</tr>
<tr>
<td>Seriously mentally ill</td>
<td>People living with SMI are at higher risk for negative health consequence.</td>
</tr>
<tr>
<td>Middle school youth in Novato, particularly Latino.</td>
<td>Much of the time youth-in-need do not receive mental health services unless an adult recognizes they are struggling and makes a referral.</td>
</tr>
<tr>
<td>Latino males, 13-18, who are at risk of negative outcomes</td>
<td>There is a dearth of effective interventions aimed at acculturation stress.</td>
</tr>
<tr>
<td>Parents of color who are involved with the criminal justice system and their children</td>
<td>Intergenerational cycles of criminal justice involvement for families of color due to mental health and substance abuse issues</td>
</tr>
<tr>
<td>Formerly incarcerated adults and children (14-20 years old) of incarcerated adults.</td>
<td>Significantly underserved population that is at high-risk.</td>
</tr>
</tbody>
</table>
# MHSA ADVISORY COMMITTEE MEMBERS

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