

DEPARTMENT OF  
**HEALTH AND HUMAN SERVICES**

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



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September 19, 2017

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) Three-Year Program and Expenditure Plan for FY 2017-18 through FY 2019-20 and the Mental Health Services Act (MHSA) FY 2016-17 Annual Update.**

Dear Supervisors:

**RECOMMENDATIONS:**

1. Authorize the President to approve the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for FY 2017-18 through FY 2019-20.
2. Authorize the President to approve the Mental Health Services Act (MHSA) Annual Update for FY 2017-18 reporting on FY 2015-16 outcomes.

**SUMMARY:** For FY 2017-18 through FY 2019-20, \$40,126,000 in Mental Health Services Act (MHSA) funds are proposed for a broad range of community-based and County operated programs to provide a variety of mental health and substance use services, including:

- Prevention and Early Intervention (PEI) activities such as parenting programs, screening for mental health and substance use issues in primary care settings, or youth activities (\$6,888,000);
- Community Services and Supports (CSS) programs such as case management for older adults, homeless individuals or the Support and Treatment After Release (STAR) program focusing on alternatives to incarceration (\$28,907,000);
- Innovation services including crisis planning and Casa Rene, a crisis residential home-like facility (\$1,551,000);
- Capital Facilities and Technological Needs (CFTN) programs such as an electronic health record, scanning capability and other practice management programs (\$1,700,000); 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 (\$1,080,000).

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.

This MHSA Three-Year Program and Expenditure Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft MHSA Three-Year Program and Expenditure Plan for FY 2017-18 through FY 2019-20 was circulated to representatives of stakeholder interest and posted for any interested party for thirty (30) days on the Marin County Mental Health Services Act webpage for public comment and feedback beginning on Friday, June 9, 2017 and ending on Sunday, July 9, 2017. A legal notice ran in the Marin Independent Journal seeking public comment and feedback as well. On Tuesday, July 11, 2017, the Mental Health Board hosted a Public Hearing for the MHSA Annual Update for FY 2017-18 and the MHSA Three-Year Program and Expenditure Plan for FY 2017-18 through FY 2019-20 and provided their feedback and recommendations. All input has been considered with adjustments made, as appropriate and incorporated into the MHSA Annual Update for FY 2017-18 and MHSA Three-Year Program and Expenditure Plan for FY 2017-18 through FY 2019-20 as appropriate.

In addition to the \$28,907,000 in funds included in the plan for CSS programs, there remains approximately \$1.4 million of CSS Housing funds, administered by the County of Marin, that are still available for future planning.

The local MHSA Prudent Reserve available balance is \$2,175,490. Welfare and Institutions Code 5847 (b)(7) requires Counties to establish and maintain a Prudent Reserve to ensure the County programs will continue to be able to serve those currently being served should MHSA revenues decline.

The Mental Health Services Act (MHSA) Annual Update for FY 2017-18 provides information on the MHSA funded programs and service outcomes for the FY 2015-16 reporting period, the second year of Marin's MHSA Three-Year Program and Expenditure Plan for FY 2014-15 through FY 2016-17. Each program narrative in the Annual Update includes the annual program budget allocation and describes the program, the target population served, and the actual outcomes achieved.

**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:** There will be no increase to the General Fund Net County cost as a result of your Board's approval, as the proposed Expenditure Plan will be fully covered by MHSA revenues. The total Three-Year MHSA funding of \$40,126,000 is allocated as follows:

FY 2017-18: \$13,398,534  
FY 2018-19: \$13,378,533  
FY 2019-20: \$13,348,933.

These amounts include existing previously approved funds, and expansion/growth funds. The Department will work with the County Administrator's Office to make the necessary budget adjustments to reconcile the annual funding allocation with the funds already budgeted in the MHSA program baseline budgets.

<b>REVIEWED BY:</b>	<input checked="" type="checkbox"/>	County Administrator	<input type="checkbox"/>	N/A
	<input type="checkbox"/>	Department of Finance	<input checked="" type="checkbox"/>	N/A
	<input type="checkbox"/>	County Counsel	<input checked="" type="checkbox"/>	N/A
	<input type="checkbox"/>	Human Resources	<input checked="" type="checkbox"/>	N/A

Respectfully submitted,



Grant Nash Colfax, MD  
Director

# MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION<sup>1</sup>

County/City: Marin County

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

<p><b>Local Mental Health Director</b></p> <p>Name: Suzanne Tavano</p> <p>Telephone Number: 415.473.7595</p> <p>E-mail: STavano@MarinCounty.org</p>	<p><b>County Auditor-Controller / City Financial Officer</b></p> <p>Name:</p> <p>Telephone Number:</p> <p>E-mail:</p>
<p>Local Mental Health Mailing Address:</p> <p>County of Marin                  Department of Health and Human Services                  Behavioral Health and Recovery Services Division                  20 N. San Pedro Road, Suite 2021                  San Rafael, CA 94903</p>	

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

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

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

*Suzanne Tavano* 8/24/17  
 Signature Date

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

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

N/A  
 County Auditor Controller / City Financial Officer (PRINT)

\_\_\_\_\_  
 Signature Date

<sup>1</sup>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)

## MHSA COUNTY COMPLIANCE CERTIFICATION

County: Marin County

Local Mental Health Director	Program Lead
Name: Suzanne Tavano	Name: Kasey Clarke
Telephone Number: 415.473.7595	Telephone Number: 415.473.7465
E-mail: STavano@MarinCounty.org	E-mail: KClarke@MarinCounty.org
County Mental Health Mailing Address:  <div style="text-align: center;">             County of Marin              Department of Health and Human Services              Behavioral Health and Recovery Services Division              20 N. San Pedro Road, Suite 2021              San Rafael, CA 94903           </div>	

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

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on 9/12/2017.

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

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

Suzanne Tavano, Ph.D.  
Local Mental Health Director/Designee (PRINT)

*Suzanne Tavano* 8/24/17  
Signature Date

County: Marin County

Date: \_\_\_\_\_

MARIN COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES  
BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION

# MENTAL HEALTH SERVICES ACT

## THREE-YEAR PROGRAM & EXPENDITURE PLAN



FY 2017-18 THROUGH FY 2019-20

20 NORTH SAN PEDRO RD, SUITE 2021 \* SAN RAFAEL \* CA \* 94903

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## INTRODUCTION

Dear Residents of Marin,

Thank you for your interest in Marin County's Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20. We are especially appreciative of the many contributions the MHSA Advisory Committee made by diligently reviewing performance and outcome data about existing programs, making recommendations about current and future projects, and assisting in constructing Marin County's MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20. We also would like to thank the many individuals who served as Key Informants, participated in Community forums, or were members of Focus Groups. In total, over 375 individuals provided observations, perspectives and opinions about existing Behavioral Health and Recovery Services (BHRS) and helped identify sections or members of the community that have been un-served or under-served, or ways in which we can provide better services. This very comprehensive planning process was inclusive of the delivery system as a whole.

As it might be recalled, MHSA is the result of Proposition 63, a California state initiative which added a 1% tax on individuals earning over \$1 million dollars. It is these resulting funds that have helped stabilize community mental health during economically challenging times, allowed expansion of services, supported necessary program activities not reimbursed through Medi-Cal, and promoted system redesign that emphasizes client-centered and client-driven care. The MHSA moved community mental health from the "illness and deficit" model created by Medi-Cal to one of hope and the belief that treatment does work and recovery is possible. MHSA also advanced thinking that persons who have received behavioral health services have unique perspectives and expertise to contribute to the behavioral health delivery system. Additionally, it provided funding for the training and certification of these persons with lived experience so they could prepare to enter the workforce. The resulting contributions from this have been many: a more diverse workforce that reflects the communities served, employment for those in recovery, and a reduction in stigma and discrimination against persons with behavioral health issues.

As in past years, our goal has been to incorporate the voices of clients, family members, providers, and other community stakeholders into the BHRS planning process so we are more responsive to community needs and work toward a more effective, culturally sensitive and inclusive system of care.

Again, thank you for interest and participation.



My best regards,

Suzanne Tavano, Ph.D.  
Director, Behavioral Health and Recovery Services

## Mental Health Services Act Principles

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

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

## Mental Health Services Act Components

The MHSA has five (5) components:

### A. Community Services and Supports (CSS)

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

### B. Prevention & Early Intervention (PEI)

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

### C. Innovation (INN)

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

### D. Workforce Education & Training (WET)

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

### E. Capital Facilities & Technology Needs (CF/TN)

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

## Mental Health Services Act (MHSA) Background

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

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

## Three-Year Program and Expenditure Plan

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates for Mental Health Services Act programs and expenditures. Marin County created their first MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 which will end as of June 30, 2017. This MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 will begin as of July 1, 2017.

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

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

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

For a copy of the current MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, or for a copy of this new MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 please call: Kasey Clarke at 415.473.7465 or email her at [KClarke@marincounty.org](mailto:KClarke@marincounty.org) or you can find all MHSA Plans on our website at: <https://www.marinhhs.org/mhsa3year>.

Please review the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 and post your comments on the website or you can mail comments or questions to:

Kasey Clarke  
 MHSA Coordinator  
 County of Marin  
 Behavioral Health and Recovery Services Division  
 20 N. San Pedro Road, Suite 2021  
 San Rafael, CA 94903

The required thirty (30) day public comment period for the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 began on **Thursday, June 8<sup>th</sup>, 2017** and ended on **Sunday, July 9<sup>th</sup>, 2017**.

A Public Hearing for the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 and the MHSA Annual Update for FY2017-18 was held at the Mental Health Board Meeting on **Tuesday, July 11<sup>th</sup>, 2017** at 6:00 pm at 20 N. San Pedro Road, San Rafael, CA 94903 in the Point Reyes Conference Room.

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

Dr. Suzanne Tavano, Director  
 County of Marin  
 Department of Health and Human Services  
 Behavioral Health and Recovery Services Division  
 20 N. Redwood Drive, Suite 2021  
 San Rafael, CA 94903

# STAKEHOLDER PROCESS IN MARIN COUNTY

## BACKGROUND

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

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

Beginning in FY2014-15 the State required that all counties develop a MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 that included all five (5) MHSA components. Marin's current MHSA Three-Year Plan will remain active until June 30, 2017 and can be found online at [www.marinhhs.org/mhsa](http://www.marinhhs.org/mhsa).

In May of 2016 Marin County began a new in-depth community planning process for our new MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 which includes all five (5) MHSA components.

This MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 was developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, community-based providers of mental health and alcohol and other drug services, law enforcement agencies, education, social services, veterans, health care organizations, representatives and families of unserved and/or underserved and other important interests. Also included were stakeholders that reflect the diversity of the demographics of Marin, including, but not limited to, geographic location, age, gender and race/ethnicity.

## ONGOING STAKEHOLDER INPUT

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

Behavioral Health and Recovery Services Division (BHRS) representatives regularly discuss MHSA services and supports with individuals, the Mental Health Board, MHSA Advisory Committee, Alcohol and Other Drug Advisory Board, the Quality Improvement Committee, Probation and other forums. Input received in these settings is brought to BHRS Senior Management, the MHSA component coordinators, and as appropriate, to the MHSA Advisory Committee, 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. PEI Committee Meeting Notes can be found at [www.marinhhs.org/mhsa](http://www.marinhhs.org/mhsa).
- WET Steering Committee meets on a monthly basis. Its members meet at the Marin Health and Wellness Campus. In addition, family members, family partners and the WET consultant meet monthly as the Family Subcommittee.
- Quality Improvement/Quality Management (QI/QM) Committee meets quarterly. The participants are a mix of county staff, community based providers and other community partners
- The new MHSA Innovation Project: *Growing Roots: The Young Adult Services Project* was approved by the MHSOAC on April 28, 2016 and is supported by a Transition Age Youth (TAY) Advisory Committee. The committee meets monthly. See the Innovation Component section of this report for more details.

## MHSA ADVISORY COMMITTEE

The MHSA Advisory Committee (formerly known as the MHSA Implementation Committee) was reformulated in FY2014-15 after the arrival of Marin's new Behavioral Health and Recovery Services Director to ensure compliance with WIC § 5848 and CCR § 3320. The MHSA Advisory Committee is a body of MHSA stakeholders established to review outcomes of MHSA programs and make recommendations regarding all significant changes/additions to MHSA programs. See Appendix I – MHSA Advisory Committee Members which lists the members, affiliations and their representation.

During the FY2014-15 through FY2016-17 the committee met on the follow dates:

3/20/2015	12/2/2015	9/28/2016
4/3/2015	1/27/2016	10/26/2016
5/13/2015	2/24/2016	11/15/2016
6/10/2015	3/23/2016	12/13/2016
6/24/2015	4/27/2016	1/25/2017
8/26/2015	5/25/2016	2/22/2017
9/2/2015	6/22/2016	3/29/2017
9/23/2015	7/27/2016	4/26/2017
10/28/2015	8/24/2016	6/28/2017

The MHSA Advisory Committee meets the 4<sup>th</sup> Wednesday of each month at 20 N. San Pedro Road, San Rafael, CA in the Point Reyes Conference Room. All meeting agendas and minutes can be found on the web at: <https://www.marinhhs.org/mhsa-advisory-committee>

## **MHSA THREE-YEAR PLANNING PROCESS FOR FY2017-18 THROUGH FY2019-20**

The Behavioral Health and Recovery Services (BHRS) Senior Management Team served as the MHSA Planning Committee internally for the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20. The Senior Management Team includes the BHRS Director, the MHSA Coordinator and the MHSA Component Coordinators for Prevention and Early Intervention (PEI), Community Services and Supports (CSS), Workforce, Education and Training (WET), Capital Facilities and Technological Needs (CFTN) and Innovation (INN), the Ethnic Services Coordinator, fiscal representatives, and the consultant hired to support the Community Planning Process, Mary Roy Michaels. Senior Management met regularly throughout the process. See the MHSA Three Year Planning Meeting chart on page 20 for specific meeting dates.

### Program Evaluations

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

### Planning Steps

The BHRS Senior Management team wanted to take a new approach with the outreach to stakeholders by having a variety of Focus Groups and Key Informant Interviews, as well as the open Community Meetings throughout Marin County.

Over the course of the first MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 BHRS compiled various recommendations and feedback from the current plan to review and consider for the next Three-Year Plan as appropriate. These recommendations were reviewed and, as appropriate, incorporated into the community planning process to get stakeholder feedback on them.

### Community Input Process

During Marin's initial Three Year Planning process in FY2014-15, Behavioral Health and Recovery Services was under the direction and guidance of the Interim Mental Health Director. With this Three Year Planning Process we were able to structure our process with the direct guidance and recommendations from our Behavioral Health Director, Dr. Suzanne Tavano.

- While the first MHSA planning process in FY2005-06 was focused on how to apply a new funding source, and the first Three Year Planning process for the FY2014-15 through FY2016-17 Plan focused on feedback about the existing MHSA services and gaps, as well as seeking recommendations for new programs, the planning process for this FY2017-18 through FY2019-20 Community Planning Process focused more on getting feedback and

recommendations from consumer and family members through Focus Groups and Key Informant Interviews, as well as through local community meetings.

- In July 2016, Marin County Mental Health and Substance Use Services (MHSUS) Division was renamed to align with other county and state entities and became the Behavioral Health and Recovery Services (BHRS) Division. This supports the focus and need to provide co-occurring competent services in Marin County.
- MHSA funding interacts with a variety of other funding and policy factors, including the Affordable Care Act, Medi-Cal, Grants, and Substance Abuse Treatment funding.
- Clients and families experience services throughout the continuum of care, usually without knowledge of the funding source and related regulations.

In all meetings addressing the development of the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20, an overview of MHSA's history and transformational concepts was provided, as well as an overview of MHSA including the core purposes:

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

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

## COMMUNITY PLANNING PROCESS

Between May 5, 2016 and May 2, 2017, Marin County hosted seventy three (73) separate meetings: four (4) community meetings, twenty three (23) Key Informant Interviews, twenty five (25) Focus Groups, three (3) internal Policy Group meetings, nine (9) MHSA Advisory Committee meetings, one (1) Cultural Competence Advisory Board (CCAB) meeting and eight (8) BHRS Senior Management meetings to support the stakeholder input for the MHSA Three Year Program and Expenditure Plan for FY2017-18 through FY2019-20. (See charts on pages 13-17)

The four (4) Community Meetings were held throughout Marin to gather input from all sectors of the community, two (2) in Southern Marin (Mill Valley and Marin City), one (1) in Novato and one (1) in San Rafael (see Appendix III – Community Meeting Flyers). Context for the meetings was a brief PowerPoint presentation to give the history and an overview of MHSA's purpose and the five (5) MHSA Components, it also included an overview of the MHSA Funding Estimates so stakeholders could see what the estimated MHSA revenue projections for the Three-Year Planning period were, what the cost of the currently funded MHSA programs were, and what funding would be available for expansion of existing programs and/or new program recommendations.

After the presentation, Community Meeting attendees participated in two breakout sessions:

*Break Out Session I* focused on five (5) questions: 1) strengths, 2) needs, 3) barriers, and 4) recommendations for new services or activities for the mental health and substance use system, as well as, 5) what services or activities could be provided which would assist individuals before these problems became severe and disabling.

The second *Break Out Session II* focused on Reaching Underserved Cultural Communities, Integrating Mental Health and Substance Use Services, Housing for Individuals with Mental Illness, Crisis Services and Suicide Prevention, and First Episode Psychosis (see Appendix IV – Break Out Session I and II Content).

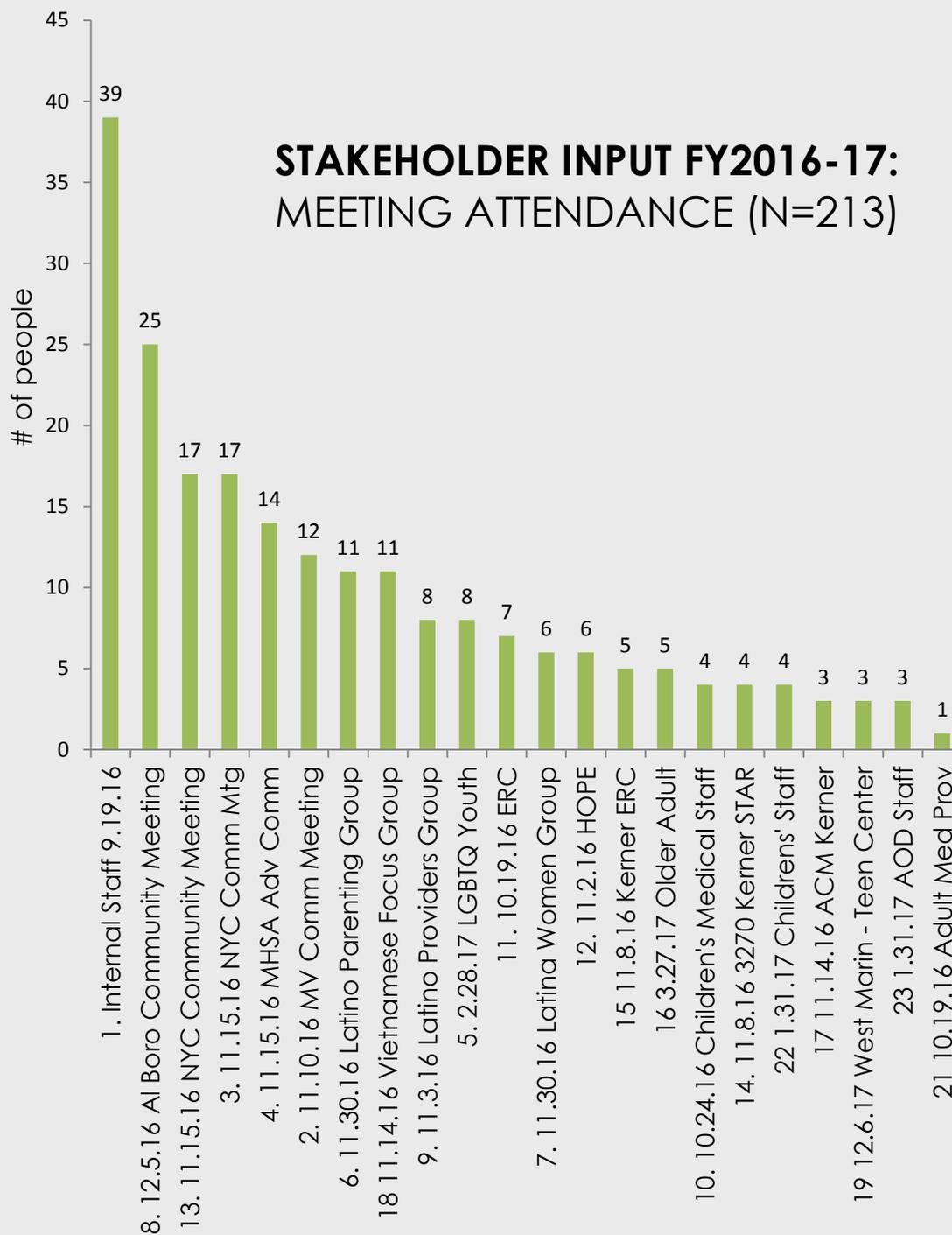
Community meetings were conducted throughout the County and included translation and interpretation in Spanish and/or Vietnamese, transportation, refreshments, and child supervision. Invitations were distributed to BHRS staff, BHRS contractors, all MHSA related committees, including the MHSA Advisory Committee, the Mental Health Board, the Alcohol and Other Drug Advisory Board, BHRS Stakeholder contact list, NAMI, Board of Supervisors and other interested parties. Flyers were displayed at BHRS services, community services, libraries, stores and other locations throughout the community. Community-based organizations and providers were asked to personally invite clients and other providers. In addition, Marin hosted an All BHRS Staff Policy Group meeting to provide a Community Input presentation and gather feedback from staff.

The Consultant, Mary Roy Michaels, summarized all of the input from the community meetings, focus groups, key informant interviews, Policy Group, CCAB, BHRS Senior Managers, and the MHSA Advisory Committee to inform what changes should be made to existing MHSA programs, what additional MHSA programs are needed, and what needs should be addressed through other programmatic and funding resources. For the complete report on the Community Planning Process, please see Appendix V – Marin County Community Planning Process Report.

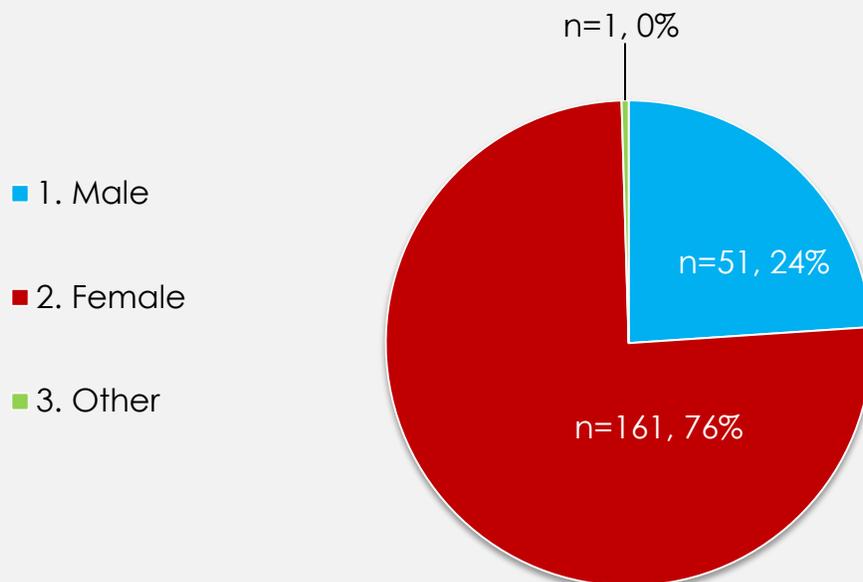
### **THREE-YEAR PLAN STAKEHOLDER PARTICIPATION**

Overall, 375 community members, consumers, families, BHRS staff, providers of service, law enforcement/criminal justice, LGBTQ, Veterans, and other interested parties attended the community meetings or participated in a focus group or key informant interview. Of these 375 participants, 213 completed a demographic form. We did not collect demographic forms from the Senior Management, Policy, Board and Committee meetings.

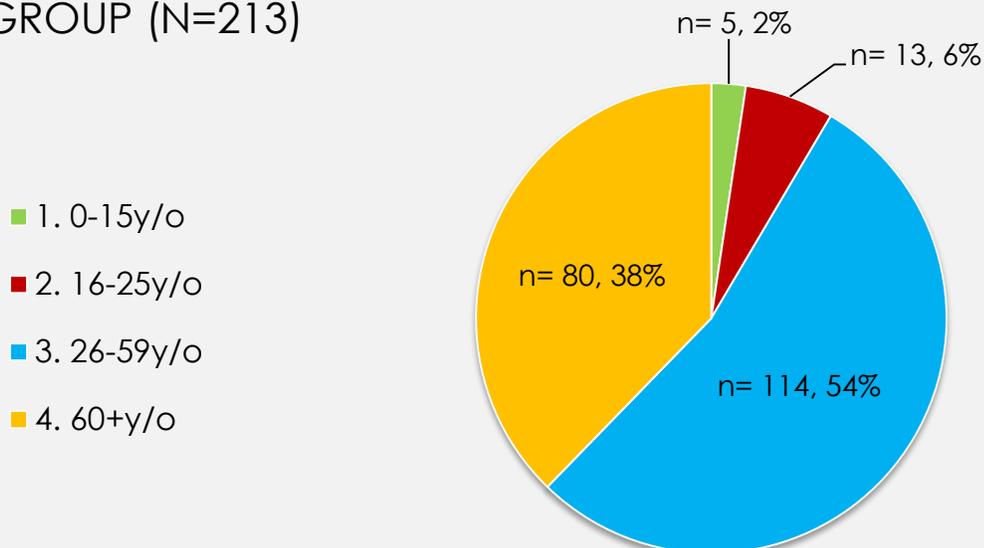
A summary of the representation and demographic information from the 213 participants that completed a demographic form from the community, key informant and/or focus group meetings is below.



**STAKEHOLDER INPUT FY2016-17:  
GENDER (N=213)**

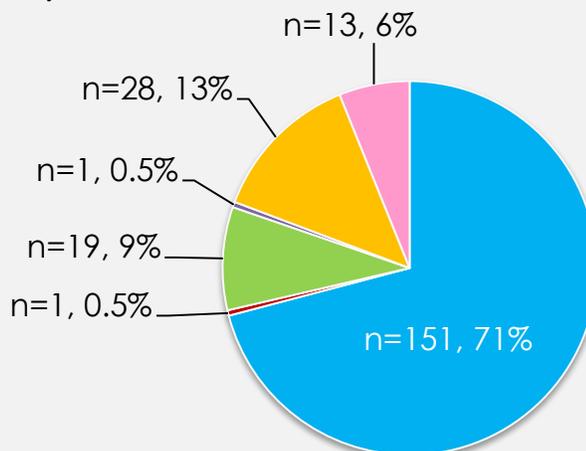


**STAKEHOLDER INPUT FY2016-17:  
AGE GROUP (N=213)**



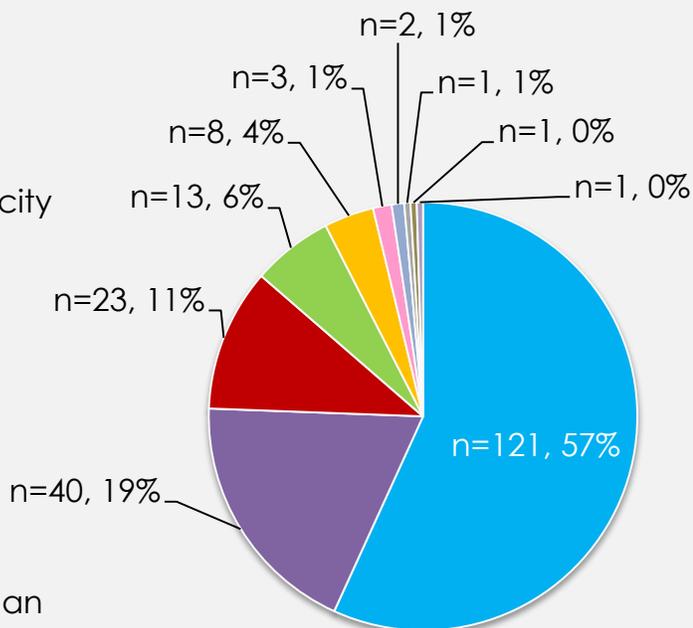
**STAKEHOLDER INPUT FY2016-17:  
PRIMARY LANGUAGE (N=213)**

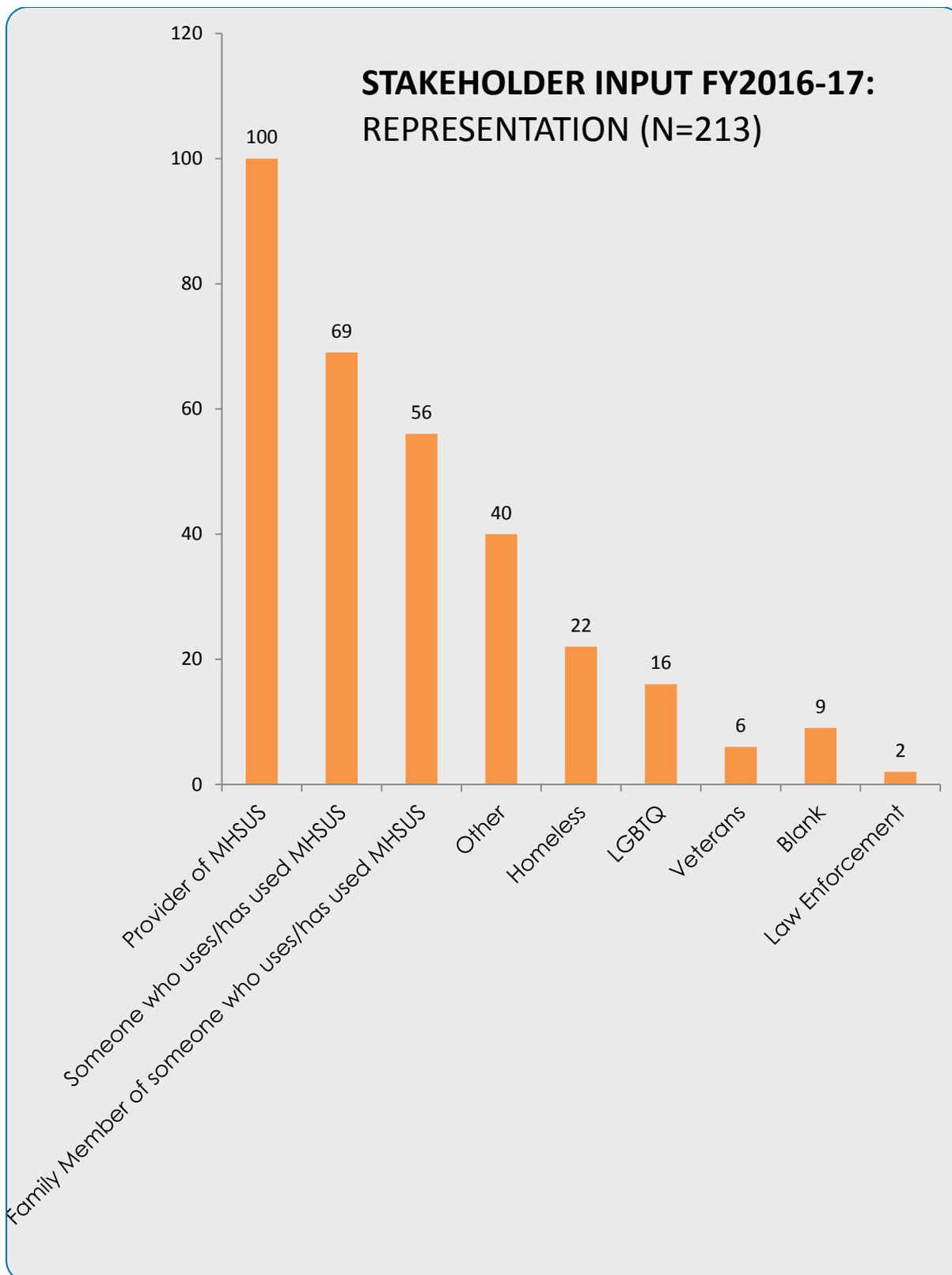
- English
- Other
- More than one
- Tagalog
- Spanish
- Vietnamese



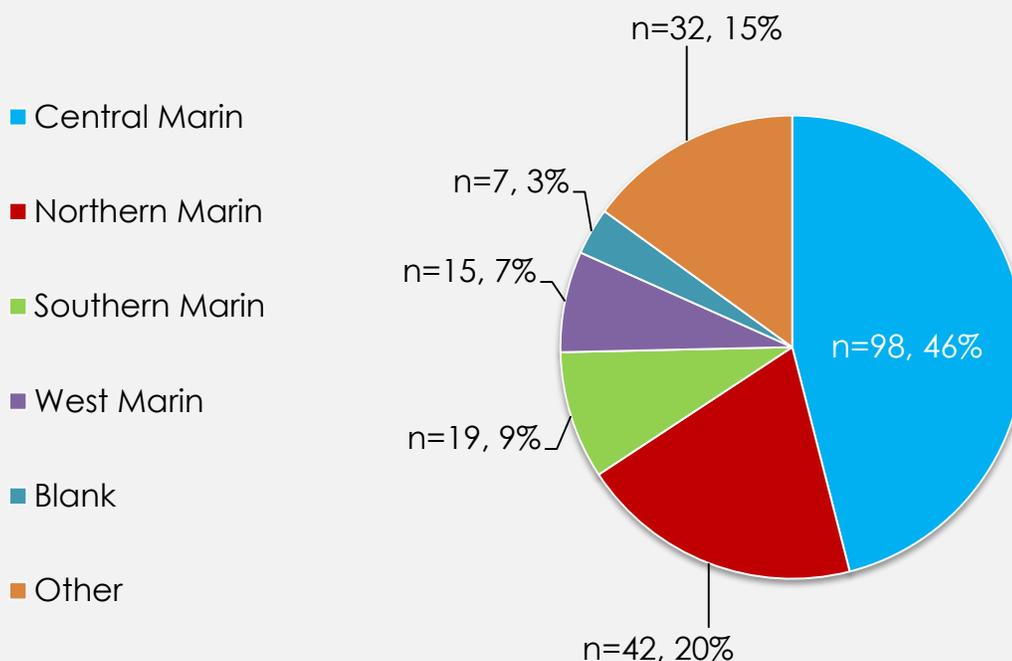
**STAKEHOLDER INPUT FY2016-17:  
RACE/ETHNICITY (N=213)**

- White
- Hispanic/Latino
- Asian
- More than one race/ethnicity
- African/American
- Other
- Blank
- Pacific Islander
- Hispanic
- Other: Euro/Native American





## STAKEHOLDER INPUT FY2016-17: GEOGRAPHIC LOCATION (N=213)



The MHSA Advisory Committee met on March 29, 2017 to review the MHSA Three Year program budgets and to review the recommendation outcomes now that the Community Planning Process has been completed. Committee members were given spreadsheets for each of MHSA Component's which included a detail of the existing programs and their associated budgets that were being recommended to continue and the programs that were being recommended to be discontinued in the new MHSA Three-Year Plan based on stakeholder feedback. Committee members were given a copy of the Marin County Community Planning Process Report and an MHSA Handbook to reference during the discussion. Priorities were reviewed and discussed at length and there was not time to have the committee give their formal recommendations at the meeting. Please see Appendix VI – 3.29.17 MHSA Advisory Committee Handouts to review the meeting documents.

On April 29, 2017 the committee met again to finalize their MHSA Three-Year Program Plan recommendations. To refresh the members, a PowerPoint presentation was provided which reviewed the Committee's Purpose, Role and Responsibilities and that the plan was to be built on Client Driven Programs and Services. For each MHSA Component, members were reminded what programs would continue, what programs were being proposed to be discontinued, and what new programs and services were being recommended to be added. The Component Spreadsheets that

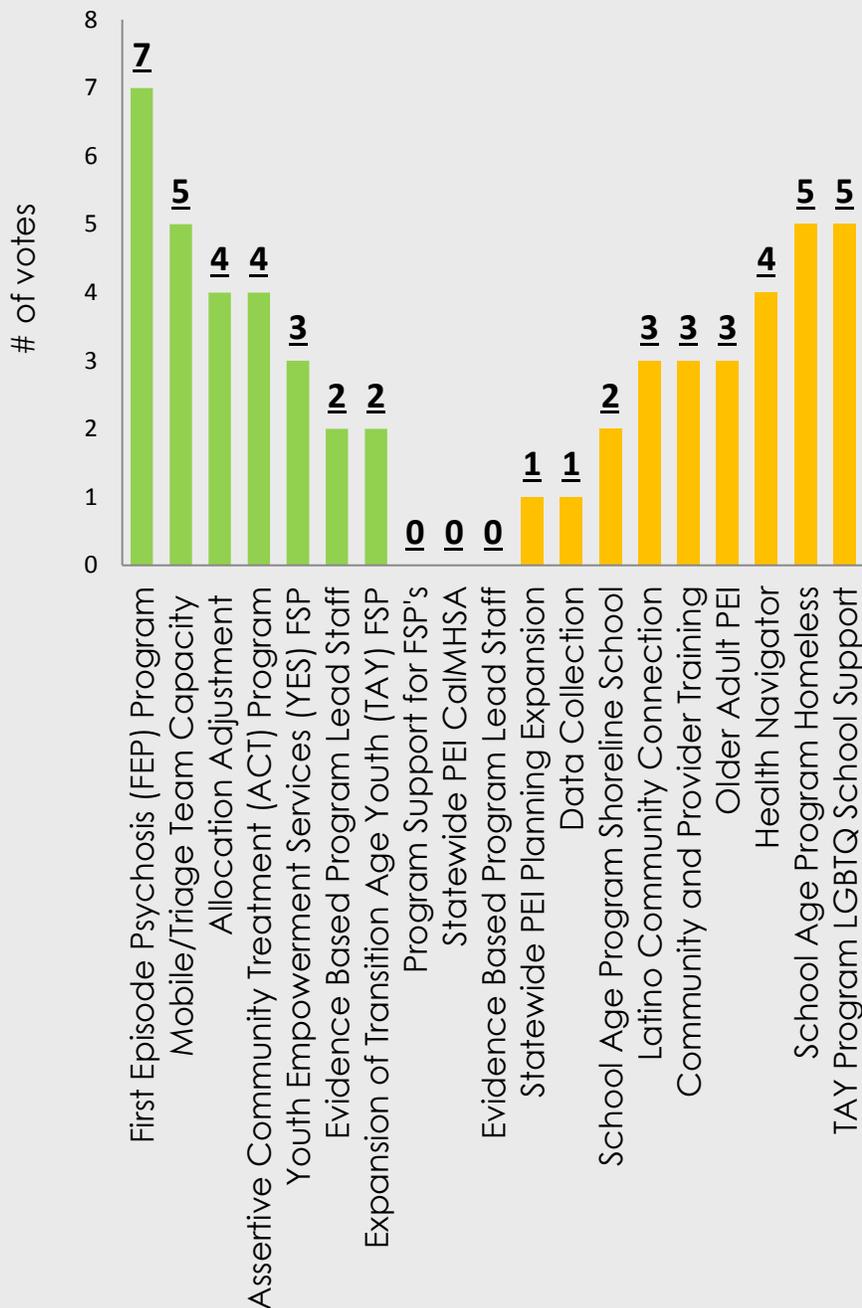
were handed out at the March 29, 2017 meeting were updated before this meeting with the actual funding required for the programs that would be continuing, for the programs being discontinued, and the costs projected for the proposed new or enhanced programs.

Verbal support was received from the membership for the proposed WET and CFTN Component changes and additions. The Innovation funding for the FY2017-18 through FY2019-20 period requires a new stakeholder process so there was no action required from the members at this time for this component.

For the proposed new programs and enhancements for the PEI and CSS Components wall charts with each of the program names were put around the room. The committee members were given three (3) green stickers for CSS and three (3) yellow stickers for PEI. Members went to the wall chart for the CSS or PEI program enhancement or program expansion to show their priority recommendations by putting their stickers on the wall charts. Please see Appendix VII – 4.28.17 MHSA Advisory Committee Handouts to review the meeting documents.

On the next page is a graph of the program recommendations for both PEI and CSS from the April 28, 2017 MHSA Advisory Committee meeting.

### 4.26.17 MHSAAAC MEETING RECOMMENDATION: (NUMBER OF VOTES = 54)



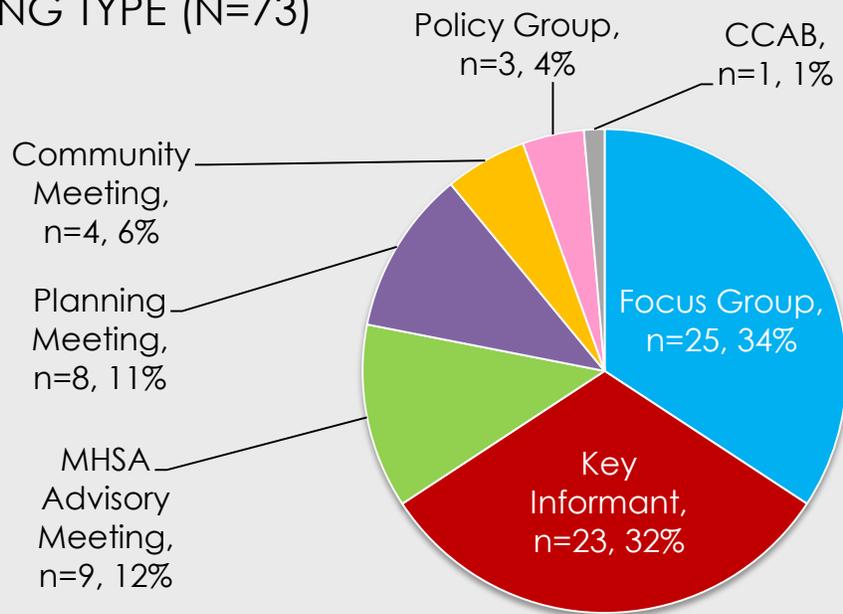
## MHSA THREE-YEAR PLANNING MEETING OVERVIEW (FY2017-18 THROUGH FY2019-20)

Date	Meeting Description
May 5, 2016	Latino Services Sub-Group Meeting
June 3, 2016	Cultural Competence Advisory Board Meeting
June 14, 2016	Ethnic Services Manager/WET Coordinator Key Informant Interview
June 20, 2016	Community Meeting – Margarita C. Johnson Senior Center, Marin City
June 22, 2016	MHSA Advisory Committee Meeting
July 1, 2016	LGBTQ Community Needs Key Informants Interview
July 7, 2016	LGBTQ Youth Key Informant Interview
July 7, 2016	PEI Coordinator Key Informant Interview
July 25, 2016	MHSA Advisory Committee Member Planning Input
August 7, 2016	Canal Alliance Key Informant Interview
August 8, 2016	Behavioral Health and Recovery Services Policy Group Meeting
August 9, 2016	Family Member Key Informant Interview
August 9, 2016	Consumer Key Informant Interview
August 17, 2016	Law Enforcement School Partnership Focus Group
August 23, 2016	Latina Provider Key Informant Interview
August 29, 2016	Juvenile Probation Key Informant Interview
August 30, 2016	Access Team Supervisor Key Informant Interview
September 2, 2016	Older Adults Key Informant Interview
September 6, 2016	Triple P Key Informant Interview
September 7, 2016	West Marin Key Informant Interview
September 7, 2016	Marin Advocates for Mental Health Focus Group
September 8, 2016	Youth Leadership Institute Key Informant Interview
September 19, 2016	Behavioral Health and Recovery Services Policy Group Meeting
September 21, 2016	First Episode Psychosis Focus Group
October 3, 2016	Latino Providers Focus Group
October 10, 2016	LGBTQ Youth Outreach Key Informant Interview
October 10, 2016	West Marin Service Center Key Informant Interview
October 11, 2016	Sr. Management Planning Meeting
October 19, 2016	Medical Staff Focus Group
October 19, 2016	Enterprise Resource Center Consumer Volunteers Focus Group
October 24, 2016	Children's Mental Health Staff Focus Group
October 26, 2016	Veteran's Services Key Informant Interview
October 26, 2016	QI/QM Key Informant Interview

Date	Meeting Description
October 25, 2016	Sr. Management Planning Meeting
October 26, 2016	MHSA Advisory Committee Member Planning Input
November 1, 2016	Adult Case Management Kerner Focus Group
November 2, 2016	HOPE Program Focus Group
November 3, 2016	Latino Provider Focus Group (need meeting notes)
November 8, 2016	Enterprise Resource Center Staff Focus Group
November 8, 2016	STAR Full Service Partnership Focus Group
November 10, 2016	Community Meeting – Mill Valley Community Center, Mill Valley
November 14, 2016	Vietnamese Adult Case Management Focus Group
November 14, 2016	Vietnamese Focus Group
November 15, 2016	City of Novato Key Informant Interview
November 15, 2016	MHSA Advisory Committee Meeting – Community Process
November 15, 2016	Community Meeting – Novato Youth Center, Novato
November 29, 2016	Adult Services Key Informant Interview
November 30, 2016	Latino Women’s Focus Group
November 30, 2016	Latino Parent’s Focus Group
December 1, 2016	Odyssey Full Service Partnership Focus Group
December 1, 2016	West Marin Focus Group
December 5, 2016	Community Meeting – Al Boro Community Center, San Rafael
December 6, 2016	West Marin Focus Group
December 13, 2016	Adult Case Management Bon Air Focus Group
December 13, 2016	MHSA Advisory Committee Member Planning Input
January 25, 2017	MHSA Advisory Committee Member Planning Input
January 25, 2017	Vietnamese Provider Key Informant Interview
January 31, 2017	Children’s Lead Staff Focus Group (need meeting notes)
January 31, 2017	Substance Use Services Staff Focus Group
February 14, 2017	Sr. Management Planning Meeting
February 22, 2017	MHSA Advisory Committee Member Planning Input
February 28, 2017	Drake High Gay Straight Alliance Youth Focus Group
March 2, 2017	Spahr Center Key Informant Interview
March 7, 2017	Sr. Management Planning Meeting
March 16, 2017	Older Adult Key Informant Interview
March 27, 2017	Older Adult Focus Group
March 29, 2017	MHSA Advisory Committee Member Planning Input
April 4, 2017	Sr. Management Planning Meeting
April 10, 2017	Policy Group Update on Planning Process

Date	Meeting Description
April 18, 2017	Sr. Management Planning Meeting
April 25, 2017	Sr. Management Planning Meeting
April 26, 2017	MHSA Advisory Committee Member Planning Input
May 2, 2017	Sr. Management Planning Meeting

**STAKEHOLDER INPUT FY2016-17:**  
MEETING TYPE (N=73)

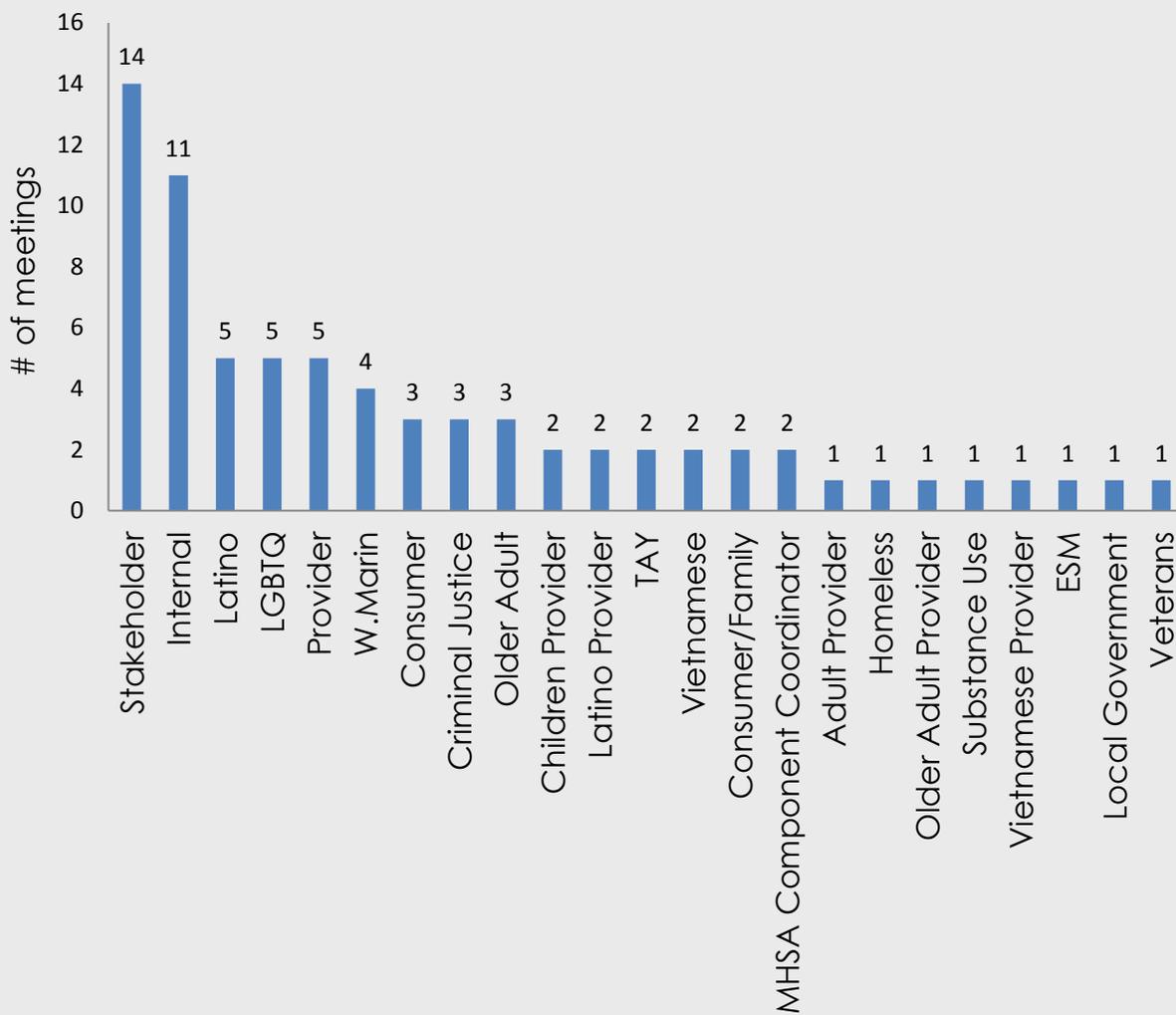


**COMMUNITY BOARDS, COMMISSIONS, AND  
COMITTEES SECTOR REPRESENTATION**

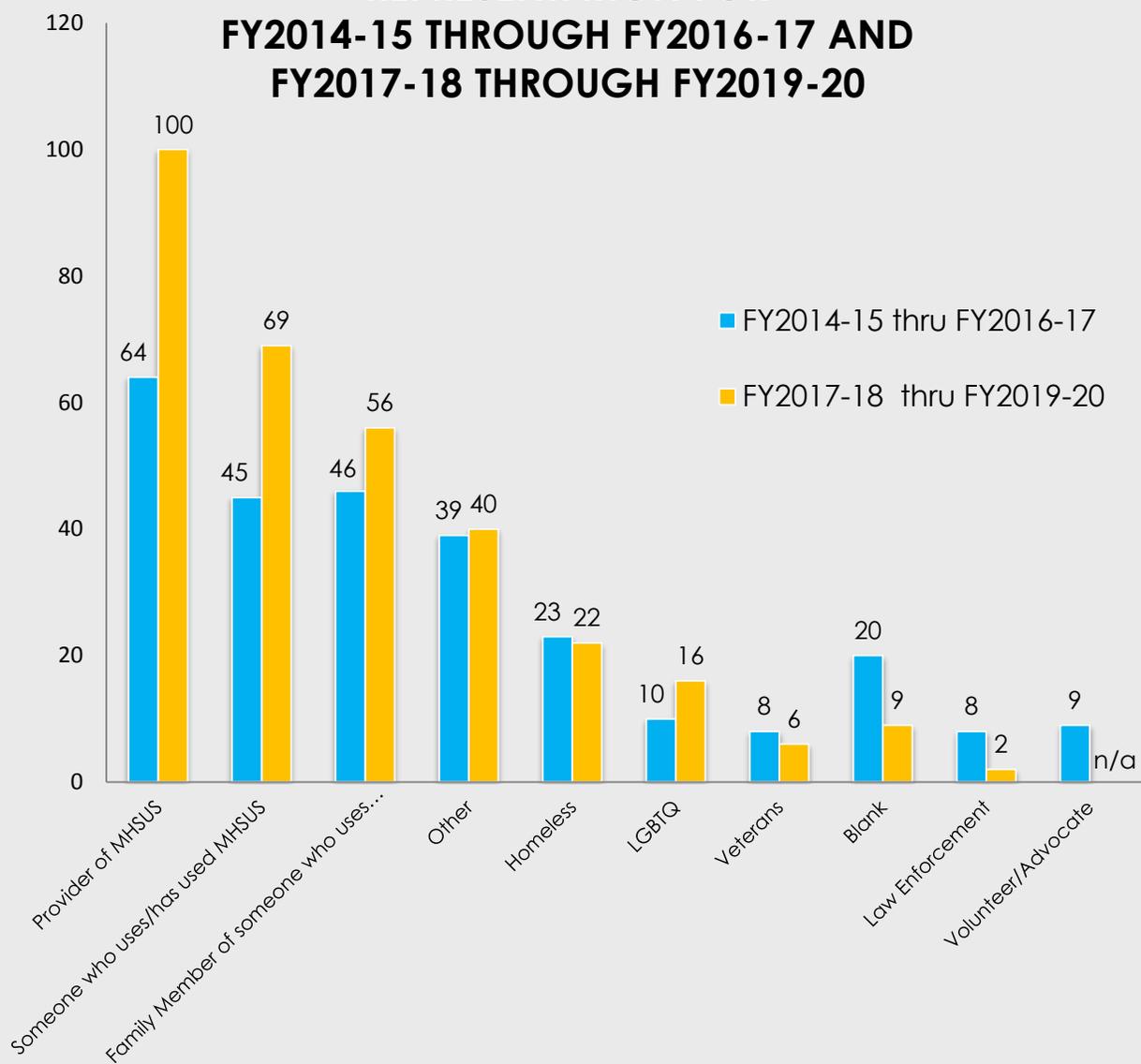
Sector	Representation
County Behavioral Health and Recovery Services (BHRS)	<ul style="list-style-type: none"> <li>❖ Senior Management</li> <li>❖ Supervisors</li> <li>❖ All-Staff meeting</li> <li>❖ Mental Health Board</li> <li>❖ Alcohol and Other Drug Advisory Board</li> </ul>
Community-based Mental Health Providers	<ul style="list-style-type: none"> <li>❖ County Contractors</li> <li>❖ Additional agencies</li> </ul>
Community-based Substance Use Services Providers	<ul style="list-style-type: none"> <li>❖ County Contractors</li> <li>❖ Additional agencies</li> </ul>
Health Care Services	<ul style="list-style-type: none"> <li>❖ Community Clinics</li> <li>❖ Teen Clinics</li> </ul>
Social Services	<ul style="list-style-type: none"> <li>❖ Children &amp; Family Services</li> <li>❖ Aging and Adult Services</li> <li>❖ Employment Services</li> </ul>
Education	<ul style="list-style-type: none"> <li>❖ Marin County Office of Education</li> <li>❖ Early Childhood Education</li> <li>❖ School Districts</li> </ul>
Law Enforcement	<ul style="list-style-type: none"> <li>❖ Sheriff</li> <li>❖ Police Departments</li> </ul>
Veterans/Veterans Orgs	<ul style="list-style-type: none"> <li>❖ Marin County Veterans’ Services</li> </ul>
Community-Family Resource Centers	<ul style="list-style-type: none"> <li>❖ Community-Based Organizations</li> </ul>

Stakeholders Involved	Policy	Program Planning and Implementation	Monitoring	Quality Improvement	Evaluation	Budget Allocations
Mental Health Board	X	X	X			
MHSA Advisory Committee	X	X	X			X
PEI Committee		X	X	X	X	
WET Committees		X	X	X	X	X
Policy Committee	X					
Alcohol & Other Drug Advisory Board	X	X	X			
Quality Improvement/Management (QI/QM) Committee	X			X		
Cultural Competency Advisory Board	X	X	X	X	X	
BHRS Contractor Meetings			X	X		
Board of Supervisors	X		X			X

### STAKEHOLDER INPUT FY2016-17: MEETING REPRESENTATION TYPE (N=73)



### MHSA THREE YEAR PLANNING PROCESS REPRESENTATION FOR FY2014-15 THROUGH FY2016-17 AND FY2017-18 THROUGH FY2019-20



## MHSA FY2017-18 THROUGH FY2019-20 FUNDING

The funding required for all of the proposed CSS new programs and expansions exceeded the amount of MHSA funds available. There was enough WET, CFTN and PEI funding to support the priority community recommendations.

New programs and expansion under CSS that will not be funded through this MHSA Plan will be funded by other county funding or through a Whole Person Care grant that is expected to be awarded to Marin County.

## ADDITIONAL STAKEHOLDER PARTICIPATION EFFORTS

### Innovation Planning Process

A community planning process will be conducted in FY2017-18 to further define the next Innovation Project using the project Innovation funding for the FY2017-18 through FY2019-20 period.

## FINAL MHSA PLAN APPROVAL PROCESS

The MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 was posted for 30-day Public Comment beginning on **Thursday, June 8<sup>th</sup>, 2017** through **Sunday, July 9<sup>th</sup>, 2017**. It has been widely distributed:

- The MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 was posted for thirty (30) day public comment on Marin County's website at, [www.marinhhs.org/mhsa](http://www.marinhhs.org/mhsa) and on the BHRS website banner at, [www.marinhhs.org/bhrs](http://www.marinhhs.org/bhrs) including instructions on how to receive a copy of the report, how to submit comments and the date of the Public Hearing.
- On June 9-10, 2017 an announcement about the posting was placed in the local newspaper, the Marin Independent Journal, including information about getting a copy of the update, how to comment, and the date of the Public Hearing.
- Copies of the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 were available at three local libraries – the main branch in San Rafael, the branch in Inverness, and the branch in West Marin – including instructions on how to receive a copy of the report, how to submit comments and the date of the Public Hearing.
- Copies of the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 were available at the Marin City Health and Wellness Clinic, 20 N. San Pedro Administration office, Enterprise Resource Center, and BHRS Integrated Clinics on the Marin Health and Wellness Campus and 250 Bon Air Campus. These copies included 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 Behavioral Health and Recovery Services (BHRS) staff, contracted providers, community based organizations, Marin Mental Health Board, Alcohol and Other Drug Board, BHRS staff, MHSA

Advisory Committee, and other MHSA and BHRS related distribution lists and committees.

On **Tuesday, July 11, 2017** 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 received was considered and any substantive comments are summarized below. The final MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 will likely go before the Board of Supervisors in September of 2017.

Prior MHSA Annual Updates are available at: [www.marinhhs.org/mhsa](http://www.marinhhs.org/mhsa)

## **SUBSTANTIVE COMMENTS AND RESPONSES:**

### ***Implement one of three CDC recommended Evidence Based Practices (EBP) – IMPACT, PEARLS, Healthy IDEA***

The MHSA Older Adult PEI program incorporates evidence-based practices, including Healthy IDEAS and Cognitive Behavioral Therapy in the BOOST program at Jewish Family and Children Services. BOOST is intended to serve older adults experiencing depression, anxiety, adjustment disorders, and isolation. They serve about 35-40 individuals a year. In addition, in the initial PEI Plan, funds were allocated for training Marin Community Clinics, Coastal Health Alliance, and other community provider staff in IMPACT. Additional funds were allocated to provide technical assistance to the community clinics to implement IMPACT. Their current programs incorporate IMPACT to differing degrees. PEI funds will continue to support the implementation of evidence based programs as appropriate.

### ***Develop an experience multi-disciplinary professional Geriatric team within Behavioral Health and Recovery***

The HOPE Program is the Older Adult Specialty Multi-Disciplinary team. The team consists of 10 gerontology-trained individuals including a Psychiatrist, NP, RN, and six (6) licensed mental health clinicians. We focus on working to serve the unique and diverse needs of the older adult population who need mental health services. We examine the social, cultural and economic factors that influence treatment. We meet weekly to discuss complex mental and medical issues affecting our clients. At HOPE, we provide in-home comprehensive assessments, behavioral health diagnostic evaluations, intense case management, psychiatric medication, family consultation and on-going collaboration with other treating professionals. Outside of the HOPE Intensive Case Management program, we also have the Senior Peer Counseling Program (SPC). The SPC counselors are a group of trained older adult volunteers who meet with clients in their homes once a week to provide one on one peer counseling services. SPC clients primarily present with depression, isolation, grief, loss of identity and other stage of life issues. HOPE team staff offer consultation to other professionals and multi-disciplinary case conferences and coordinates with other community agencies. Services are provided in English, Spanish and Vietnamese.

### ***Develop an Older Adult Mental Health cultural competence training program for staff of behavioral health and community care providers which includes, demographics, key risk factors and intervention models***

We will work with our training committee to ensure all county providers and clinicians have access to older adult trainings. We see older adults as a diverse population. A population that is

underserved and undervalued. With increased awareness comes improved services. Trainings would focus on the biological aspects of aging, different psychological theories of aging with a focus on current research, and how political issues relating to advocacy, public policy and long-term care can affect the lives of older adults.

### ***PEI Services focused on Older Adults***

MHSA supports the Older Adult PEI program, implemented by Jewish Family and Children's Services under the program BOOST. BOOST serves older adults with mild to moderate symptoms of depression, isolation, anxiety, adjustment disorders and other mood disorders. BOOST's approach is a blend of CBT and Healthy IDEAS. They provide brief therapeutic interventions in client's homes, ranging from 8 months to a year and a half.

In addition, all PEI programs that serve adults, serve older adults. For example, the Vietnamese Community Connection program includes a focus on reducing isolation among the older adult Vietnamese population.

In FY2015-16, older adults made up 3% of individuals who received risk reduction or symptom reduction services from PEI programs. While this is lower than would be expected, it is in part due to the fact that a few years ago PEI changed the Older Adult program from one that served more older adults, but less intensively, to one that serves less individuals, but provides more robust services for their complex needs. This MHSA Plan proposes to increase the funding for the PEI Older Adult program to increase the number of older adults served.

### ***Increased Mental Health Services for TAY in West Marin***

During the remodeling of the West Marin Service Center in Point Reyes Station, specialty mental health services for clients in that region will be provided in the field as the interim center has limited capacity. Once the renovation is complete in 2018, the new facility will allow for expanded behavioral health services in West Marin.

The School Age PEI program includes funding for work in the Shoreline School District. That funding enables Bay Area Community Resources (BACR) to provide a range of prevention services within the schools, including linking students and families to additional services as needed. This Plan proposes increased funding for this program. We will work with BACR to expand their services, taking into account input from students, families and school staff.

The current Innovation project – Growing Roots: The Young Adult Services Project – aims to increase access to services for underserved Transition Age Youth (TAY, 16-25 years old). West Marin is considered a geographically underserved area, and therefore is a target population for the project.

### ***Increase support for Older Adult during life changing events. – Loss of loved ones, depression, isolation, downsizing, financial trouble.***

The Senior Peer Counseling Program through HOPE provides individual emotional support to older adults who are experiencing a transition in their lives. This transition can be triggered from a recent retirement, loss of a loved one, decreased financial income, loss of independence and control, declining physical health, onset of depression and/or anxiety, and a change of location (house to retirement facility). Senior Peer Counseling is a free service for any older adult who lives in Marin. There is no exclusion criterion (income, insurance, family support, etc.) except for age.

Counselors provide tools and resources for clients to deal with change, remain independent as long as possible, and cultivate a positive approach to aging. SPC has four supervision groups led by a licensed mental health clinician, from West Marin, to Novato to San Rafael. SPC also runs ACASA, a Spanish-speaking group that provides culturally and linguistically appropriate support services to native Spanish speakers. FY16-17 so far we have made 1425 client visits by our SPC volunteers.

***Opportunities to partner with the Buck Institute***

BHRS supports the recommendation to partner with the Buck Institute which is also located in Marin County. We will seek to strengthen our relationship and determine areas for collaboration, idea sharing and future partnership opportunities.

***Increase Co-Occurring treatment options for complex issues***

Although expansion of co-occurring treatment options for complex issues is included within the Co-Occurring and Community Services and Supports sections of the Three-Year Plan, additional expansion efforts are taking place outside of the MHSA funding and planning processes. With the implementation of the Drug/Medi-Cal Organized Delivery System Waiver in April 2017, behavioral health integration efforts will continue to expand, largely within the outpatient setting. The Division of Behavioral Health and Recovery Services continues to explore the feasibility of additional local Residential treatment facilities to serve individuals with complex co-occurring mental health and substance use issues.

***Expand PEI School age program to support children and youth exposed to domestic violence and their non-abusing parent***

Trauma, due to a variety reasons including domestic violence, is a significant issue for many PEI clients. BHRS is committed to providing trauma informed care in all of its programs. Trainings to increase trauma informed care skills are offered and a number of PEI contracts specifically include trauma services, in particular for the TAY PEI program. This Plan includes funding for a new School Age PEI project that will focus on trauma services. The development of that program will take into account the role of domestic violence and appropriate services. In addition, this Plan includes funding for an Evidence Based Programs Lead Staff, which is expected to increase the efforts to incorporate trauma informed care in all programs.

***Employ Peer Counselors with lived experience and provide a career ladder for them.***

The County has created classified Peer Counselor positions I and II. There are peer classified positions included in this MHSA Three Year Plan which are expected to be implemented upon Board of Supervisors approval of the Plan. Career ladder opportunities beyond the Peer Counselor position are already established, such as Support Service Workers, Sr. Support Service Workers, etc.

***Increase the number of African American Providers with County BHRS services***

Through MHSA's Workforce Education and Training (WET) component, which includes the APA Clinical Graduate Intern Program, applicants of these initiatives increase the overall diversity of our system of care and upon completion of these initiatives, many of these interns apply and are hired as regular employees to continue providing culturally competent services to our diverse community.

## MARIN COUNTY CHARACTERISTICS

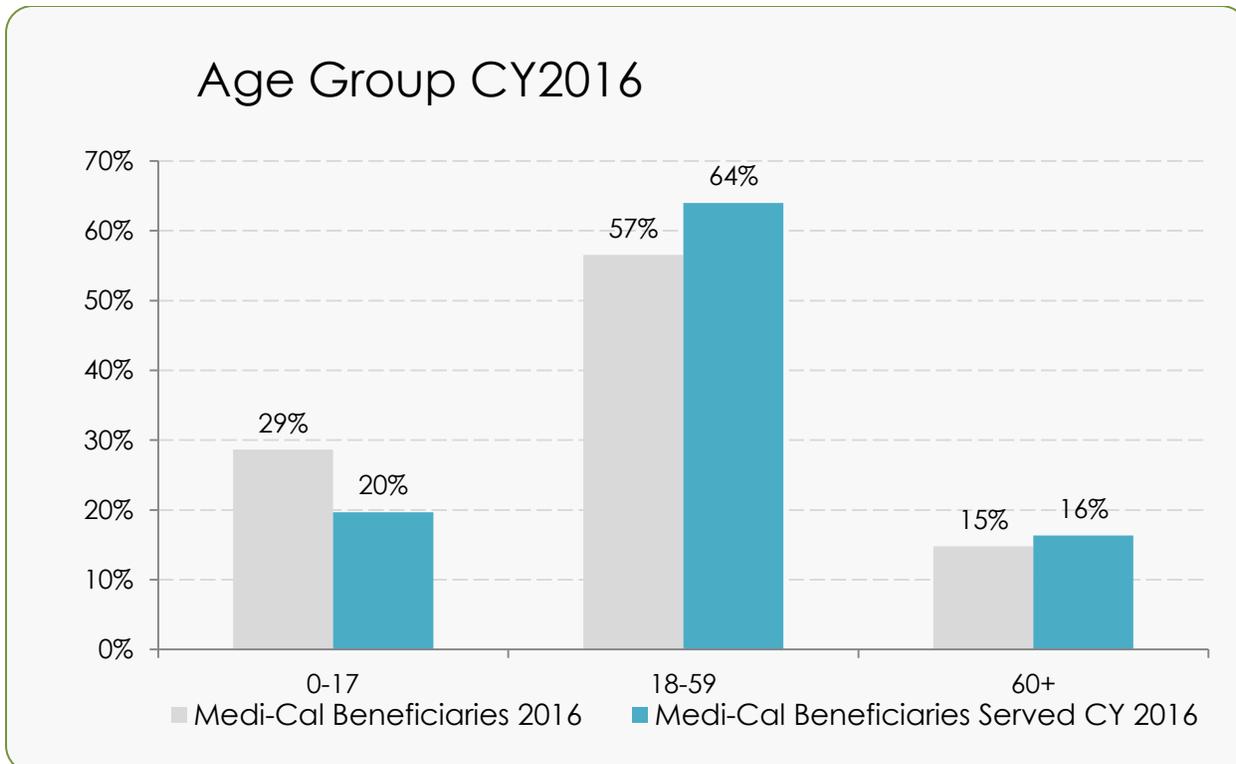
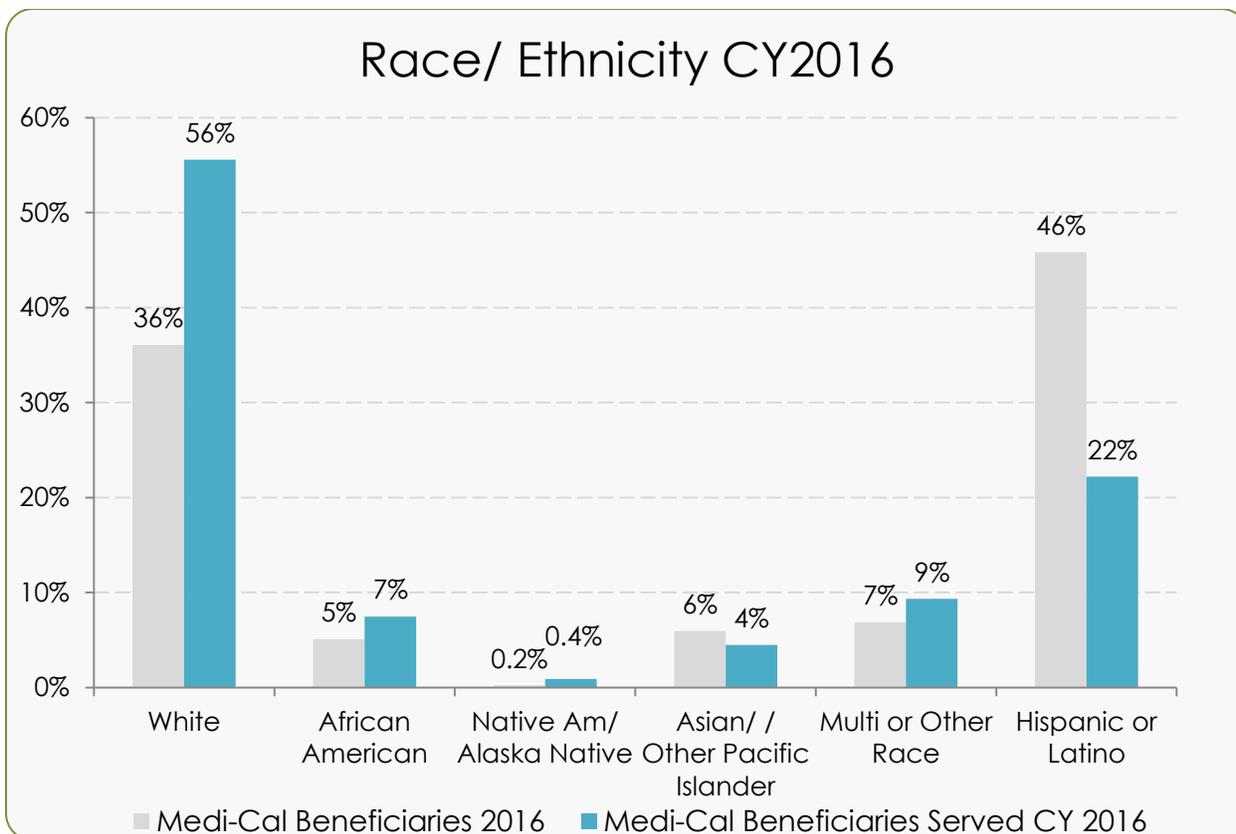
Marin County is a mid-sized county with a population of approximately 260,750 and spanning 520 square miles of land. The population is 51% female. The majority of residents live in the eastern region of the county, along the Highway 101 corridor. Ranching and dairying are major features of the rural 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 2015 population by race/ethnicity and age group, Medi-Cal population and County mental health clients.



# CULTURAL COMPETENCE ADVISORY BOARD (CCAB)

## PURPOSE

The purpose of the Cultural Competence Advisory Board is to serve as advisors to BHRS 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. See Appendix VIII – Cultural Competence Advisory Board Members. Additionally, the Board shall identify barriers and challenges within BHRS’ 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. Lastly, the board shall advocate for the rights of consumers and/or family members, when needed and appropriate, to ensure that consumers’ civil rights are respected and protected.

## GOALS

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

## OBJECTIVES

- The board will meet every other month for two hours. Additional subcommittee/ad-hoc meetings and tasks may get established, as appropriate/necessary, based on identified topics or issues addressed
- BHRS’ Ethnic Services and Training Manager will facilitate board meetings to ensure that the board are working to achieve its stated goals in an efficient manner
- The board will rely on individual and collective expertise of its members to make informed decisions and recommendations
- The board will be available for community and staff input, utilizing members of the board as liaisons to the entire stakeholder community
- Members of the board will work collaboratively to ensure that the interests of stakeholders are appropriately and effectively represented

## MHSA 3 YEAR PLAN

CCAB will continue to focus its work and efforts in four (4) broad areas of the county’s behavioral healthcare system—**Access, Outreach and Training, Policy and Service Delivery**—which will be examined through a diverse cultural lens. The underlying goals of the plan are to reduce

disparities in access to care and to reduce stigma and discrimination. CCAB will carefully identify key barriers or challenges in each of the four areas of the system that counters the spirit and intent of working towards an inclusive, diverse and equitable behavioral healthcare system such as **workforce staffing, culturally appropriate trainings, outreach efforts in un/underserved cultural communities, culturally appropriate/responsive treatment interventions, and policies and procedures.**

CCAB will gather existing and relevant data information to analyze emerging or current trends and practices which results in poor outcomes for un/underserved and inappropriately served populations, and to make direct recommendations to BHRS' Director, as appropriate or needed. The methods used to arrive at key recommendations will rely on the subject matter expertise of CCAB' diverse and skilled members, existing data and information gathered by board members from its outreach and engagement efforts throughout the community.

## PREVENTION AND EARLY INTERVENTION (PEI) OVERVIEW

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).

Recognizing that increased funding and services are not in themselves sufficient to reach PEI goals, the PEI Coordinator convenes the **PEI Committee** on quarterly basis to facilitate the implementation of the PEI programs, review PEI program evaluations, and collaborate towards a stronger system of care. In addition, short-term workgroups are convened to identify and address gaps in existing systems of care. In FY2017-18 one of the focuses of the committee will be implementing the revised PEI Regulations that require a change in data reporting. This includes collecting increased demographic data, tracking whether referrals to other services resulted in client services, and aligning the programs and data collected with the new program categories. In addition, Marin BHRS will work with PEI providers serving youth to implement a client assessment and outcome monitoring tool, the Child and Adolescent Needs and Strengths (CANS), which BHRS uses, in order to better coordinate services.

PEI programs are an important component for increasing services for **underserved communities**. By locating services within trusted community sites, hiring culturally and linguistically competent staff, and employing strategies such as Promotores/Community Health Advocates, PEI increases timely access for populations that have cultural and linguistic barriers to services. While PEI programs are reaching target populations, more needs to be done regarding some populations. The PEI overview in the FY2017-18 Annual Update details the demographics of PEI clients.

### PEI PROGRAMS FOR FY2017-18 THROUGH FY2019-20

Many of the existing PEI programs have been successful in reaching underserved communities and achieving mental health related goals (see FY2017-18 Annual Update) and therefore will be continued in this Three Year Plan. In response to stakeholder input, evaluations of existing PEI programs, and gaps identified, some of the ongoing programs will be changed or expanded, a couple will be concluded, and a few new programs will be started in FY2017-18. The programs that will be concluded are:

- Triple P (Positive Parenting Program): While the existing Level 2 and 3 services were well received, in order to effectively implement the model the program would have needed to be significantly expanded to include Levels 1, 4, and 5. It was determined that there were other services that were in higher demand. Some of the services will continue without PEI funding due to the existence of Triple P trained providers within BHRS and community organizations.
- Integrated Behavioral Health (IBH): IBH was one of PEI's first programs. It helped establish behavioral health services within the Federally Qualified Health Centers (FQHCs) in Marin.

Since then, the Affordable Care Act and HRSA funds have helped to support these services. PEI funds will be directed to other needed services.

<b>Program Name</b>	<b>Program Overview</b>
<b>Early Childhood Mental Health Consultation PEI-1</b>	<i>Target Population: 0-5 year olds and their families, underserved</i> Continue training for staff and parents at subsidized childcare sites to support the emotional well-being of children and recognize mental health issues. Provide assessment, brief intervention, and linkage to services.
<b>Transition Age Youth PEI PEI-4</b>	<i>Target Population: 16-25 years old, underserved</i> Continue screening and brief intervention in Teen Clinics. Expand groups in schools for at-risk students, including Newcomers and LGBTQ.
<b>Latino Community Connection PEI-5</b>	<i>Target Population: Latino</i> Expand linguistically and culturally competent outreach, including via Promotores; support groups and individual/family counseling; and linkage to services.
<b>Older Adult PEI PEI-7</b>	<i>Target Population: 60+ years old, underserved</i> Expand screening, brief intervention for depression and anxiety, and linkage to services. Expand outreach and education for providers, gatekeepers and older adults.
<b>Vietnamese Community Connection PEI-11</b>	<i>Target Population: Vietnamese</i> Continue providing linguistically and culturally competent outreach, risk reduction, and linkage to services.
<b>Community &amp; Provider PEI Training PEI-12</b>	<i>Target Population: Providers, consumers, family members, community members</i> Provide PEI related trainings, such as Mental Health First Aid. Expand training and technical assistance for implementing best practices.
<b>School Age PEI PEI-18</b>	<i>Target Population: K-8 students (5-15), underserved</i> Continue to provide services for youth in Sausalito Marin City School District and West Marin. New: Provide services for high-risk youth throughout the county, such as homeless youth.
<b>Veteran's Community Connection PEI-19</b>	<i>Target Population: Veterans</i> Continue to provide peer support for veterans experiencing mental illness, homelessness, and/or justice system involvement.
<b>Statewide PEI PEI-20</b>	<i>Target Population: Community</i> Continue providing funding to Statewide PEI efforts including policy efforts, Each Mind Matters campaign, and statewide coordination of PEI.
<b>Suicide Prevention PEI-21</b>	<i>Target Population: Community</i> Continue providing 24/7 suicide prevention hotline. New: Conduct a strategic planning process.
<b>Health Navigator PEI-22</b>	<i>Target Population: Individuals eligible for BHRS services</i> New: Provide a BHRS clinician to facilitate linkage of clients from PEI to BHRS services.

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## EARLY CHILDHOOD MENTAL HEALTH (ECMH) CONSULTATION

### PROGRAM OVERVIEW

In 2009, MHSA PEI funds expanded an existing “Early Childhood Mental Health Consultation” program provided by Jewish Family and Children’s Services (JFCS). This has been a very successful program, reaching subsidized pre-schools and child care sites that serve over 600 children. Training, coaching and interventions are provided by a team of JFCS consultants who are licensed mental health providers. The program aims to increase the skills of teachers and parents to observe, understand and respond to children’s emotional and developmental needs to:

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

### TARGET POPULATION

The target population is pre-school students (0-5), and their families, who attend subsidized pre-schools or other childcare settings. These students are 64% Latino, 19% White, 7% Asian, 5% African American, and 5% 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 child care sites are the target population for the training in recognizing and responding to risk factors and signs of emotional disorders.

Numbers to be served in FY2017-18	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Outreach to Increase Recognition (staff training)							130
Prevention (family consultation)	80				80	100	

*Individuals: Individual identified for services.*

*Family Members: Family members or caregivers of the individuals who participate in services.*

### PROGRAM DESCRIPTION

- Outreach: Increasing recognition of and response to early signs of mental illness
- Prevention: reduce risk factors and build protective factors associated with mental illness

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, such as "Powerful Interactions" and "Social and Emotional Foundations for Early Learning." 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 the Child and Adolescent Needs and Strengths (CANS), parental depression screening and/or a validated social-emotional screening for children aged 3-5 (DECA-C: Devereux Early Childhood Assessment-Clinical Form). Classroom behavior that indicates eligibility for intervention include, but are not limited to, withdrawn, aggressive, prolonged sadness, obvious delay in social, emotional and/or play skills, overly affectionate with new adults in the room, and other signs of non-"age appropriate development." Family risk factors that indicates eligibility for family/parent intervention includes, but is not limited to, intimate partner violence (IPV), depression, divorce/separation, immigration status, incarcerated parent, deported parent, poverty related stressors, unrealistic expectations and/or fears for their child, and need for positive discipline help.

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 the 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.

Children or family members at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. At the time of referral, families are informed about Medi-Cal, Early Periodic Diagnosis Screening and Treatment (EPDST), or private benefits and, when applicable, provided a needs-based assessment regarding eligibility. 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 Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to County BHRS go to Access, enabling the County to track referrals, timeliness of services, and services received. Information on clients referred to Access will

be recorded and submitted to BHRS in order for tracking referral outcomes as required under Access and Linkage. PEI staff maintains relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, BHRS, clients, families, and other key agencies in order to facilitate successful collaboration.

**EXPECTED OUTCOMES**

Early Childhood Mental Health Consultation is intended to:

- Educate and engage pre-school staff to recognize and respond to early signs of significant risk for emotional disturbance.  
The number, demographics, and setting/type of responder of those trained will be tracked.
- Reduce Prolonged Suffering by increasing protective factors and reducing risk factors. JFCS’ “Consultation Questionnaire” is completed by staff and families receiving training or consultation to track changes in skills in working with children. A DECA-C pre and post-test is completed by teacher to track changes in the child’s behavior in the preschool setting. Or a CANS will be completed pre and post by the consultant as appropriate for children receiving individual/family services to monitor outcomes of services.

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. Objective in FY2016-17 included, but were not limited to:

Outcomes	Goal
<b>Children and Families Receiving Services</b>	
Children receiving prevention services.	670
Percent of these children that come from un/underserved cultural populations (Latino, Asian, African American, West Marin).	70%
Children/families identified for enhanced intervention (through observation or validated screening tools for child behavior or family caregiver depression) and provided services through ECMH Consultation.	75
Children in childcare settings served by ECMH Consultants retained in their current program, or transitioned to a more appropriate setting. <i>Case notes</i>	100%
Parents/primary caregivers of families receiving intensive services that report increased understanding of their child’s development and improved parenting strategies. <i>JFCS multi-county parent questionnaire</i>	85%
Families receiving ECMH Consultation services that report satisfaction with the services (would use again, would recommend, were helpful). <i>PEI survey</i>	75%
<b>Early Childhood Education Sites Receiving Services</b>	
Childcare staff that received additional consultation and/or training	130
Childcare staff receiving ECMH Consultation that report increased ability to identify, intervene with, and support children in their care with emotional/behavioral issues. <i>JFCS multi-county provider questionnaire</i>	85%
Staff receiving ECMH Consultation services that report satisfaction with the services (would use again, would recommend, were helpful). <i>PEI survey</i>	75%

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 (ECMH) 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). ECMH 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 ECMH 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 ECMH services for young children and their caregivers.
- Training models for childcare workers include “Powerful Interactions” (practice based, Coaching with Powerful Interactions), Social and Emotional Foundations for Early Learning (practice based, <http://csefel.vanderbilt.edu/>), and Triple P (evidence based, SAMHSA NREPP).
- The Devereux Early Childhood Assessment-Clinical (DECA-C) is an evidenced based practice (Devereux Foundation and the Devereux 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.
- The Child and Adolescent Needs and Strengths (CANS) has demonstrated reliability in measuring clinical and psychosocial needs and strengths; assessing types and severity of problem presentation, risk behaviors, and functioning; and monitoring outcomes. In addition, reliability at the item level has been demonstrated. (Anderson et. al., 2002).

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

# TRANSITIONAL AGE YOUTH PREVENTION AND EARLY INTERVENTION

## PROGRAM OVERVIEW

In 2009, MHSA PEI funds began the Transition Age Youth (TAY) Prevention and Early Intervention (PEI) program, provided by Huckleberry Youth Programs (HYP) and Novato Youth Center (NYC). TAY PEI provides behavioral health screening and early intervention for mental health concerns in teen clinics, as well as individual and group services in middle and high schools for at-risk students. This has been a very successful program, reaching over 500 TAY and 50 families per year. In response to needs identified during the community planning process, TAY PEI will expand services provided in schools to newly arrived Spanish speaking students and LGBTQ students.

## TARGET POPULATION

The target population is 16-25 year olds from underserved populations. TAY reached are approximately 55% Latino, 30% Spanish speaking, 2% Asian, 4% African American, and 5% multi-racial. Many of the TAY are unlikely to receive services through other routes due to lack of insurance, lack of parental connection, unfamiliarity with navigating the service systems, concern about cost of services, or lack of linguistically accessible services.

Numbers to be served in FY2017-18	Individuals					Family Members
	0-15	16-25	26-59	60+	Total	
Prevention (school groups)	20	80			100	
Early Intervention (counseling)	50	200			250	50
Access and Linkage (screening)	50	300			350	

*Individuals: Individual identified for services.*

*Family Members: Family members or caregivers of the individuals who participate in services.*

## PROGRAM DESCRIPTION

- Prevention: reduce risk factors and build protective factors associated with mental illness
- Early Intervention: promote recovery and functional outcomes early in emergence 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 services for those with signs of emotional disturbance or mental illness.

#### Prevention

- **Skill Building Groups:** Multiple session groups are held at high schools to promote coping and problem-solving skills for at risk students, such as students who have recently immigrated to the US, are at risk for dropping out of traditional school settings, or are members of the LGBTQ community.

#### Early Intervention

- Youth screening positive for signs of emotional disturbance/mental illness in the teen health clinics, identified through the school groups or personnel, 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 for those with Serious Mental Illness

- **Mental Health Screening:** Teen health clinic clients complete a validated screening (GAIN Short Screen) for an array of mental health and substance use issues. Those screening positive for signs of emotional disturbance/mental illness are linked to behavioral health services.

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

Individuals at risk or showing signs of developing emotional disturbance are linked to additional risk reduction services, early interventions, and other resources as needed. At the time of referral, families are informed about Medi-Cal, Early Periodic Diagnosis Screening and Treatment (EPDST), or private benefits and, when applicable, provided a needs-based assessment regarding eligibility. 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 Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to BHRS go to Access, enabling the County to track referrals, timeliness of services, and services received. PEI staff maintains relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, BHRS, clients, families, and other key agencies in order to facilitate successful collaboration.

## PROPOSED EXPANSION

In response to needs identified during the community planning process, TAY PEI will expand services provided in schools to newly arrived Spanish speaking students and LGBTQ students. The program currently provides prevention groups at schools for “newcomers.” An increased number of groups will be provided under this expansion. The program will work with Gay Straight Alliances and others at the schools to identify the services to be provided for LGBTQ students, such as outreach and engagement, support groups, individual therapy, or other modes of service.

## 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. Information on clients referred to BHRS for treatment will be recorded and submitted to BHRS in order for tracking referral outcomes as required under Access and Linkage.

- 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. The Child and Adolescent Needs and Strengths (CANS) will also be implemented.

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. Objective in FY2016-17 included, but were not limited to:

Outcomes	Goal
TAY screened for behavioral health concerns.	450
TAY participating in at least 5 sessions of school-based skill building groups.	80
TAY participating in at least 5 sessions of school-based skill building groups showing statistically significant improvement in client well-being. <i>PCOMS: Outcome Rating Scale</i>	65%
TAY participating in individual counseling.	180
Family members participating in TAY counseling in support of the client.	30
TAY participating in at least 3 sessions of counseling showing statistically significant improvement in client well-being. <i>PCOMS: Outcome Rating Scale</i>	65%
TAY participating in at least 3 sessions of counseling showing a validated positive therapeutic alliance, a significant predictor of clinical outcomes. <i>PCOMS: Session Rating Scale</i>	75%
TAY participating in at least 3 sessions of counseling that report satisfaction with the services (would use again, were helpful). <i>PEI survey</i>	80%

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.
- The Child and Adolescent Needs and Strengths (CANS) is used to assess clients receiving early intervention services. It has demonstrated reliability in measuring clinical and psychosocial needs and strengths; assessing types and severity of problem presentation, risk behaviors, and functioning; and monitoring outcomes. In addition, reliability at the item level has been demonstrated. (Anderson et. al., 2002).
- Interventions use evidence based and promising practices, such as Motivational Interviewing (evidence based, SAMHSA NREPP). Counseling staff receives annual training and all HYP and NYC counseling staff is trained in the PCOMS evaluation and intervention system, as well as trauma-informed care.
- 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.

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

## LATINO COMMUNITY CONNECTION

### PROGRAM OVERVIEW

In FY2014-15, PEI combined the Canal Community-Based Prevention and Early Intervention program and the Community Health Advocates (Promotores) program to create the Latino Community Connection program. The purpose is to provide mental health outreach, engagement, and early intervention services for Latino communities throughout the County. This includes Promotores, trusted community members trained in identifying and responding to behavioral health concerns, including peer support and linkages to services; training front-line workers in identifying and responding to signs of mental health risks and symptoms; and providing clinical interventions. In addition, PEI co-sponsors a radio show in Spanish on health issues, including mental health and substance use. This program will change approaches by focusing clinical staff time on early intervention (symptom reduction and increasing function), rather than prevention (risk reduction and skill building), activities. In addition, this program will expand to increase the number of people receiving early intervention services by increasing the clinical staff time.

### TARGET POPULATION

The target population is Latinos throughout the County, especially newer immigrants facing many stressors and barriers to access of services.

Numbers to be served in FY2017-18	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Outreach to Increase Recognition (community, providers)		200	700	100	<b>1000</b>		<b>15</b>
Early Intervention (group, individual, family)		40	150	10	<b>200</b>	<b>20</b>	

*Individuals: Individual identified for services.*

*Family Members: Family members or caregivers of the individuals who participate in services.*

### PROGRAM DESCRIPTION

- Outreach: increase recognition of and response to early signs of mental illness
- Early Intervention: promote recovery and functional outcomes early in emergence of 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 providing early intervention services, as well as linkages to other services.

#### Outreach for Increasing Recognition:

- **Radio Show:** A licensed mental health provider will hosts a weekly live one hour radio show in Spanish on the health of Latino individuals, families and communities, in particular mental health topics. It is broadcast from stations in central Marin, West Marin and other regions in California.
- **Promotores:** 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 and front-line staff to provide mental health and substance use education, identification of risk and signs, and linkages to services. This program reduces the barriers for accessing behavioral health services including knowledge of services and stigma regarding accessing services. It also increases the natural supports available within the community. BHRS provides staff time in-kind for training, supervision, and program development by a licensed mental health practitioner within the CSS ASOC program.

#### Early Intervention:

- Mental health providers conduct support groups and individual/family counseling. Individuals seeking these services are assessed for depression (PHQ9), anxiety (GAD7) and PTSD (Posttraumatic Stress Disorder Checklist-PCL-C). Services are available to clients assessed as having mild to moderate symptoms of depression, anxiety, and or PTSD.

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 other resources as needed. At the time of referral, families are informed about Medi-Cal benefits and, when applicable, provided a needs-based assessment regarding eligibility. 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 mental health providers. Promotores, family advocates and others are trained to identify signs and symptoms and refer clients to the mental health provider as needed. The mental health provider makes referrals to County Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to BHRS go to Access, enabling the County to track referrals, timeliness of services, and services received. Information on clients referred to Access will be recorded and submitted to BHRS in order for tracking referral outcomes as required under Access and Linkage. PEI staff maintains relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, BHRS, clients, families, and other key agencies in order to facilitate successful collaboration.

## PROPOSED EXPANSION

In the past, the support groups and individual services were limited and focused on prevention (risk reduction and skill building). In the last couple of years, with changes in staff and in response to client need, these services have focused more on early intervention (symptom reduction and increasing function). That change will be reflected in the program design and evaluation going forward. In addition, this program will expand to increase the number of people receiving early intervention services by increasing the clinical staff time.

## 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, demographics, and setting/type of responder of those trained will be tracked.
- Outreach to the Latino community to increase recognition of mental illness.  
The number of community members reached will be tracked.
- Reduce Prolonged Suffering for those experiencing signs of mental illness.  
The Posttraumatic Stress Disorder Checklist will be completed by group participants upon entry to and exit from the program. Those receiving individual services will complete PHQ9, GAD7 or PCL-C, as appropriate, upon entering services and upon completing three (3) sessions and six (6) sessions. 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. Objectives in FY2016-17 included, but were not limited to:

Outcomes	Goal
Individuals receiving health information and support from Promotores or Family Resource Advocates.	640
Individuals participating in support groups or individual/family sessions.	100
Family members participating in support of the client.	20
Support group participants attending for at least 3 months.	65%
Individuals participating in a support group for at least 3 months reporting statistically significant improvement in PTSD symptoms. <i>PCL-C 5 pt change</i>	80%
Individuals participating in support groups or individual/family sessions reporting an increased ability to address their problems. <i>PEI Survey</i>	80%
Individuals participating in support groups or individual/family sessions reporting satisfaction with the services (would use again, would recommend). <i>PEI Survey</i>	80%

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.
- CalMHSA outreach, education and stigma reduction materials are used.
- The Posttraumatic Stress Disorder Checklist (PCL-C) is a validated tool for assessing symptoms of trauma.
- A number of models are used for addressing trauma, depression or anxiety in the group or individual services: Cognitive Behavioral Therapy (EBP), Exposure Therapy (EBP), Motivational Interviewing (EBP), Meditation (Goyal, 2014), and art therapy.

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

# OLDER ADULT PREVENTION AND EARLY INTERVENTION

## PROGRAM OVERVIEW

Older adults represent a growing percentage of the population of Marin and face many risks for mental illness. In 2009, MHSA PEI funds began a program targeting older adults receiving Meals on Wheels services. Due to feedback that these services needed to be available to older adults not enrolled in Meals on Wheels and that older adults needed more intensive services, in 2011 this program was revised into its current version now provided by Jewish Family and Children’s Services (JFCS). This program provides community education about mental health concerns in older adults and early intervention services for depression and anxiety. In FY2017-18, this program will be expanded to increase the number served by increasing the staff time for outreach and early intervention and focusing on reaching the LGBT community.

## 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. In FY2015-16 clients were 82% White, 8% Asian, 5% Latino, and 5% multi-racial. The program provides ongoing outreach to diverse communities to increase their access to these services. Spanish Speaking older adults are primarily served by a peer-counseling program provided by the Senior Peer Counseling Program associated with the HOPE Full Service Partnership.

Numbers to be served in FY2017-18	Individuals					Family Members	Community Members
	0-15	16-25	26-59	60+	Total		
Outreach to Increase Recognition							100
Early Intervention				50	50	20	

*Individuals: Individual identified for services.*

*Family Members: Family members or caregivers of the individuals who participate in services.*

## PROGRAM DESCRIPTION

- Outreach: increase recognition of and response to early signs of mental illness
- Early Intervention: promote recovery and functional outcomes early in emergence 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 or anxiety 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. At the time of referral, individuals are informed about Medi-Cal and Medi-Care benefits and, when applicable, provided a needs-based assessment regarding eligibility. 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 Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to BHRS go to Access, enabling the County to track referrals, timeliness of services, and services received. Information on clients referred to Access will be recorded and submitted to BHRS in order for tracking referral outcomes as required under Access and Linkage. PEI staff maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, BHRS, clients, families, and other key agencies in order to facilitate successful collaboration.

### **PROPOSED EXPANSION**

In recognition of the growing older adult population, as well as the complex needs of older adults which require a more intensive approach to services, this program will add clinical staff time to increase the number of clients that can be served. In addition, outreach activities will be increased, including outreach to the LGBT population.

## 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, demographics, and settings/types of individuals trained will be tracked.
- 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 (or GDS) and GAD7s 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. Objective in FY2016-17 included, but were not limited to:

Outcomes	Goal
Individuals receiving education regarding behavioral health signs and symptoms in older adults.	100
Individuals receiving education that are from an underserved population or primarily serving underserved populations (race, ethnicity, language, LGBTQ).	20%
Seniors at Home clients screened for behavioral health concerns. <i>PHQ9, substance use</i>	150
Low income clients receiving brief intervention services.	35
Low income clients receiving brief intervention services that are from underserved populations.	20%
Clients with family members participating in brief intervention services in support of the client.	30%
Clients completing a short-term treatment protocol for depression or anxiety.	70%
Clients completing a short-term treatment protocol for depression or anxiety experiencing a decrease of at least on category of severity (i.e.: moderate to mild). <i>PHQ9, GDS, GAD7</i>	60%
Clients receiving brief intervention reporting satisfaction with services (would use again, recommend). <i>PEI Survey</i>	75%

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 Seniors) (<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/99ca3dc03cddedc62b20b672dcc4e56c.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.

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

# VIETNAMESE COMMUNITY CONNECTION

## PROGRAM OVERVIEW

In 2011, MHSA PEI began the Vietnamese Community Connection program to implement effective ways of engaging the Vietnamese community in mental health outreach and education efforts, risk reduction, and intervention. The program includes: Community Health Advocates (CHAs), trusted community members providing outreach, engagement, peer support and linkages to services; group activities to reduce isolation; and individual/family problem solving services to build skills and ensure linkages to needed services.

## TARGET POPULATION

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

Numbers to be served in FY2017-18	Individuals					Family Members	Providers
	0-15	16-25	26-59	60+	Total		
Outreach (CHA outreach)	0	30	75	45	150		5
Prevention (activities, problem solving)		15	50	35	100	10	

*Individuals: Individual identified for services.*

*Family Members: Family members or caregivers of the individuals who participate in services.*

## PROGRAM DESCRIPTION

- Outreach: increase recognition of and response to early signs of mental illness
- Prevention: reduce risk factors and build protective factors associated with 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 reducing risk factors 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. BHRS provides staff time in-kind for training, supervision, and program development by a licensed mental health practitioner.

#### Prevention:

- The program reduces risk through group activities designed to build social support and reduce isolation; problem-solving services for individuals and families; and linkages to other services as needed. Eligible clients are those with significantly higher risk of mental illness, such as prolonged isolation, trauma, or social inequality. In addition, CHAs may provide life skill support for BHRS clients to increase functioning and reduce relapse.

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 isolation, community engagement, and 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. At the time of referral, individuals are informed about Medi-Cal and Medi-Care benefits and, when applicable, provided a needs-based assessment regarding eligibility. CHAs and others front-line workers are trained to identify signs and symptoms and refer clients to County Behavioral Health and Recovery Services (BHRS), private health coverage, and primary care and assist with making an initial appointment as needed. Referrals to BHRS go to Access, enabling the County to track referrals, timeliness of services, and services received. PEI staff maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, BHRS, 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) and front-line staff to recognize and respond to early signs of mental illness.  
The number, demographics, and setting/type 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.  
The number and demographics of those participating will be collected. A survey will be completed by participants at the end of services regarding risk and protective factors. Results will be reported in aggregate.

This data is 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. The PEI coordinator provides problem solving services and is

trained in Mental Health First Aid (EBP, SAMHSA NREPP) and the Co-Occurring Peer Education program (COPE). The CHA program is based on the Promotores practice-based model 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). CHA’s attend Mental Health First Aid and receive training based the promotores program model. In addition, CalMHSA outreach, education and stigma reduction materials are used.

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

# COMMUNITY AND PROVIDER PREVENTION AND EARLY INTERVENTION TRAINING

## PROGRAM OVERVIEW

The Community and Provider PEI Training Program provides training and events to support increasing recognition and response to signs of mental illness, reducing stigma and discrimination, and the use of effective practices. This includes Mental Health First Aid (MHFA), trainings for PEI providers to meet program and reporting requirements, and sending providers, consumers, families and others to conferences related to PEI efforts. This program is being expanded to include: supporting a speaker’s bureau to reduce stigma and discrimination, training to implement a First Episode Psychosis program within BHRS, and partial funding of a staff position to facilitate the implementation of evidence based practices with fidelity.

## 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/promotors, family members, probation staff, security guards, librarians, and others.
- Providers, consumers, family members and other community members who are in a position to implement stigma and discrimination reduction activities. These include community leaders, peer providers, appropriate county staff, and others.
- PEI providers.

Numbers to be served in FY2017-18	Community Member and Providers
Outreach to Increase Recognition (MHFA)	<b>100</b>
Stigma and Discrimination Reduction (MHFA, Speaker’s Bureau)	<b>200</b>
Evidence Based Practice Implementation (First Episode Psychosis, other TBD)	<b>10</b>

## PROGRAM DESCRIPTION

- Outreach: increase recognition of and response to early signs of mental illness
- Stigma and Discrimination Reduction

**Mental Health First Aid (MHFA)** trainings are offered throughout the community in English, Spanish and Vietnamese. MHFA is an evidenced based training that:

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

In addition, funds will continue to support other events, trainings, and participation of consumers, family members, and providers in activities that contribute to outreach, stigma and discrimination reduction, and the implementation of effective practices.

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 BHRS through Access, enabling the County to make appropriate assessments and referrals, and to track that process.

## PROPOSED EXPANSION

**Evidence Based Practice** support will be enhanced by hiring a staff person to ensure they are implemented effectively. While core practices are being implemented, including Motivational Interviewing, Cognitive Behavioral Therapy and others, there is a recognition that sustaining these evidence-based practices (EBP) requires clinical leadership and oversight. To this end, an EBP Lead Staff position will fill the role of training, coaching and evaluating the implementation of practices to ensure that they are implemented and maintained with maximum effect. The position will dedicate a portion of their time to PEI and therefore will be supported in part by PEI funds.

A **Speaker's Bureau** will be initiated to develop a team of people with lived experience who can provide presentations to schools, providers, and other groups to reduce stigma and discrimination. A Request for Proposals will be issued, and the specific form of the project will be developed in collaboration with the agency selected to provide it.

Training to support the **First Episode Psychosis (FEP)** program will be provided. This may include training for BHRS and TAY FSP staff in best practices, as well as training for TAY PEI staff, school staff, and others in a position to educate parents and refer clients to the program.

Including the training component within PEI facilitates the coordination of outreach and education aspect of FEP efforts with similar PEI efforts.

**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, demographics, and setting/type of individuals participating will be tracked. In addition, MHFA conducts post surveys to assess change in knowledge and attitude.
- Reduce stigma and discrimination. The number, demographics, and setting/type of individuals participating will be tracked. In addition, MHFA conducts post surveys to assess change in knowledge and attitude.
- Implement Effective Practices. The number, demographics, and setting/type of individuals participating will be tracked.

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. Outcomes tracked for MHFA included, but were not limited to:

<b>Mental Health First Aid Outcomes</b>
Number of Marin County community members that participated in MHFA. Portion attending MHFA in Spanish.
Participants reporting increased knowledge about mental illness signs/symptoms. (0-5 scale) “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.”
Participants reporting feeling able to offer a distressed person basic “first aid” information and reassurance about mental health. (0-5 scale)
Participants reporting ability to assisting somebody experiencing a mental health problem or crisis to seek appropriate professional help. (0-5 scale)

The program is expected to achieve the intended results due to implementing MHFA, an evidence-based practice; a speaker’s bureau; and training and technical assistance to implement effective practices.

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## SCHOOL AGE PREVENTION AND EARLY INTERVENTION

### PROGRAM OVERVIEW

The School Age PEI program is aimed at providing prevention and linkages to services for students at significantly higher risk for mental illness, or experiencing signs of mental illness. The services provided differ depending on the location, based on the needs and existing resources. 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 public school students 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. Programs are located in school districts with a high proportion of students who are low-income and from underserved populations. In FY2015-16, the students served were 40% Latino, 28% White, 12% African American, 2% Multi-racial, 1% Asian/Pacific Islander, and 17% other/unknown.

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

- Identifying high risk students:  
Student Success/Study Teams (SST), and Student Attendance Review Teams (SART) and Boards (SARB) identify students at risk of school failure. School counselors, teachers, and others may identify individuals to be assessed based on indicators other than attendance, such as emotional and behavioral factors evidenced in the classroom.
- Assessment:  
Referred students have been assessed using the Strengths and Difficulties Questionnaire (SDQ). In the future they will be assessed using the Child and Adolescent Needs and Strengths (CANS) tool.

Numbers to be served in FY2017-18	Individuals				Total	Family Members
	0-15	16-25	26-59	60+		
Outreach (education, referrals)	150		100		<b>250</b>	
Prevention (student services)	170				<b>170</b>	<b>70</b>

*Individuals: Individual identified for services.*

*Family Members: Family members or caregivers of the individuals who participate in services*

## PROGRAM DESCRIPTION

- Outreach: increase recognition of and response to early signs of mental illness
- Prevention: reduce risk factors and build protective factors associated with mental illness

This program improves 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 are 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 are linked to services as needed. At the time of referral, families are informed about Medi-Cal, Early Periodic Diagnosis Screening and Treatment (EPDST), or private benefits and, when applicable, provided a needs-based assessment regarding eligibility. These services may be provided by the PEI program, the school, community based organizations, or other available providers. Individuals experiencing symptoms of serious mental illness or emotional disturbance will be referred to Marin County Behavioral Health and Recovery Services (BHRS), private health coverage or primary care. Families will be provided assistance with making an initial appointment as needed. Referrals to County BHRS go to Access, enabling the County to track referrals, timeliness of services, and services received. Information on clients referred to Access will be recorded and submitted to BHRS in order for tracking referral outcomes as required under Access and Linkage. PEI staff maintains relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, BHRS, clients, families, and other key agencies in order to facilitate successful collaboration.

### 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 (navigators) 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. The program also supports mental health provider interns to work within the school, including with the Student

Study Team. The interns and Community Connectors together ensure families get the clinical services and other supports they need. In addition, the program ensures community providers are trained in identifying and responding to mental health needs.

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), restorative justice, anger management, non-violent communication, and one of the Community Connectors participated in a school team trained in Positive Behavioral Interventions and Supports (PBIS) (Evidence-based, SAMHSA NREPP). The individuals hired as Community Connectors are long-time, trusted members of the community they serve.

### **Shoreline School District**

Bay Area Community Resources (BACR) provides an array of services. Outreach to increase recognition of mental health issues is addressed through education for school staff, students and families about mental health and available resources. Evidence based social emotional class lessons are provided to each kindergarten through eighth grade class to build coping and resiliency skills. And individual services are provided for students and families at school and through home visits.

A student becomes eligible for individual/family services if their teacher or parent identifies behavioral concerns at school or family circumstances that could adversely affect the student’s attendance, academic success, social relationships or behavior. For example, inability to manage emotions at school, bullying, self-injury, not attending school, domestic violence, family history of mental illness or substance use.

The program incorporates a number of evidence based and age appropriate models that are proven to achieve effectiveness. The curriculums used include Zones of Regulation (promising practice, [www.zonesofregulation.com](http://www.zonesofregulation.com)) and Strong Start/Strong Kids (evidence based practice, [strongkids.uoregon.edu](http://strongkids.uoregon.edu)). The Strong Kids curriculum for grades 3-8 offers a symptoms checklist to identify at risk students, who are then referred by the PEI specialist and teacher for individual intervention. The curriculum also offers a post knowledge test conducted at the conclusion of the lesson to measure success. All of the lessons are used in most classes and all lessons are implemented with fidelity to the manual. The PEI specialist incorporates additional practices including restorative justice, conflict resolution skills, anger management skills and substance use prevention education.

## **PROPOSED EXPANSION**

In the previous MHS A Three Year Plan, a School Age PEI program was also located in the San Rafael City Schools (SRCS). While the services were well-received, there was a consensus that more intensive services addressing very high-risk students is a higher priority. In this Plan, the SRCS project is discontinued and a new project will be initiated to focus on identifying and serving very high-risk students, such as students who have experienced trauma or are homeless. The specifics of the project will be determined through a Request for Proposal process.

In addition, the Shoreline School District project will be increased through additional staff time to provide additional services and coordination of services in West Marin.

## EXPECTED OUTCOMES

School Age PEI is intended to:

- Educate students, parents, school staff, and community providers to recognize and respond to early signs of mental illness through education on signs, symptoms and resources.  
The number, demographics, and settings/types of individuals trained will be tracked.
- Reduce prolonged suffering by increasing protective factors and reducing risk factors  
The program has been collecting pre and post data on students receiving individual/family services using the Strengths and Difficulties Questionnaire (SDQ). This will be replaced with the Child and Adolescent Needs and Strengths (CANS), to 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. Demographics and results data for all clients will be aggregated and reported.

This data 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, providers work with the schools to provide data on student attendance and grades for each student prior to entering the program and after completion of the program to assist with determining efficacy of the program.

Objectives for FY2016-17 for the Shoreline School District include, but are not limited to:

Outcomes	Goal
Students with mild to moderate mental health concerns receiving at least 3 sessions of individual or group counseling.	40
Students (or parents of) receiving at least 3 sessions reporting improvement in emotional problems, conduct problems, hyperactivity problems, peer problems and/or socialization (SDQ)	65%
Students completing at least 3 sessions showing improved attendance or improved school performance.	65%
Parents completing at least 3 sessions family counseling.	20
Parents receiving at least 3 sessions reporting a reduction in family stress and/or children's difficulties in one or more of the following areas: emotional problems, conduct problems, hyperactivity problems, peer problems, and/or socialization (SDQ)	65%
Parents receiving 3 or more counseling services reporting satisfaction with the PEI services (would recommend, use again, etc). <i>PEI Survey</i>	75%

The program is expected to achieve the intended results by implementing evidence-based, promising or community defined practices shown to achieve positive results with the target population. Specific models and tools are indicated in the descriptions by school district above.

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

## VETERAN’S COMMUNITY CONNECTION

### PROGRAM OVERVIEW

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

### TARGET POPULATION

The target population is United States veterans who are exhibiting symptoms of mental illness, are involved in the criminal justice system, or are homeless. Most of the target population may be experiencing Post Traumatic Stress Disorder (PTSD), while some may experience depression or other concerns.

Numbers to be served in FY2017-18	Individuals					Family Members
	0-15	16-25	26-59	60+	Total	
Access and Linkage		20	80	20	120	20

*Individuals: Individual identified for services.*

*Family Members: Family members or caregivers of the individuals who participate in services.*

### PROGRAM DESCRIPTION

- 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 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. 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.

## 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 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. Objectives for FY 2016-17 included, but were not limited to:

Outcomes	Goal
Number of veterans that received support services to increase likelihood of accessing mental health services. (Average number of services: 8)	120
Number of family members that received services to increase their capacity to support the client.	20
Percent of veterans receiving support that complied with their mental health treatment plan.	80%
Clients receiving support services reporting satisfaction with the services (would use again, would recommend). <i>PEI Survey</i>	75%

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

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

# STATEWIDE PREVENTION AND EARLY INTERVENTION

## PROGRAM OVERVIEW

The California Mental Health Services Authority (CalMHSA), a joint powers authority, represents county behavioral health agencies working to improve mental health outcomes for the state's individuals, families, and communities. On behalf of counties, CalMHSA has implemented statewide prevention and early intervention programs since 2011 to reduce negative outcomes for people experiencing mental illness and prevent mental illness from becoming severe and disabling. The Statewide PEI Project accomplishes population-based public health strategies to reach its goals of mental health promotion and mental illness prevention. These strategies include:

- Statewide social marketing educational campaigns including the *Each Mind Matters* stigma reduction campaigns and the *Know the Signs* suicide prevention campaign with an emphasis in reaching diverse communities throughout California
- Community engagement programs including the *Walk In Our Shoes* stigma reduction programs for middle school students, and the *Directing Change* stigma reduction and suicide prevention program for high schools and higher education
- Technical assistance for counties and community based organizations to integrate statewide social marketing campaigns into local programs, and to provide support to counties in addressing county-specific stigma reduction and suicide prevention concerns
- Networks and collaborations such as community-based mini grants to support dissemination of educational outreach materials

Marin County provides a percentage of its annual PEI allocation to CalMHSA to participate in the Statewide efforts.

## TARGET POPULATION

All California residents.

## EXPECTED OUTCOMES

The RAND Corporation, a nonprofit institution that helps improve policy and decision making through research and analysis, is evaluating the impact of the Statewide PEI Project. The most recent evaluation report highlights positive findings, including:

- Social Marketing Campaigns Were Associated with Reduced Mental Illness Stigma and Increased Confidence to Intervene
- Trainings Increased Knowledge and Improved Attitudes Toward Mental Illness
- PEI Programs Had a Positive Return on Investment

- Evaluation Findings Enhanced Understanding of California's Mental Health PEI Needs and Priorities for Ongoing Intervention

See Appendix VIII – “On the Road to Mental Health”: Highlights from Evaluations of California’s Statewide Mental Health Prevention and Early Intervention Initiatives, to review the full report. ([www.rand.org/pubs/research\\_briefs/RB9917.html](http://www.rand.org/pubs/research_briefs/RB9917.html))

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

## SUICIDE PREVENTION

### PROGRAM OVERVIEW

Suicide Prevention efforts have been addressed within the Statewide Prevention and Early Intervention Program (PEI-20) through CalMHSA since the inception of PEI. For Marin this included a public campaign, printed materials and support for the Suicide Prevention Hotline provided by Buckelew Programs/Family Service Agency. In FY2015-16, CalMHSA reduced its scope, resulting in the end of funding for suicide prevention hotlines. Most of the counties supporting the local Suicide Prevention Hotline continued to fund it directly. Due to this, Suicide Prevention is now an independent program.

Buckelew’s North Bay Suicide Prevention Program provides a Suicide Prevention Hotline for Marin, Sonoma, Mendocino and Lake Counties. The hotline is answered 24/7 by a team of staff and volunteers trained to assist those in crisis. This may mean speaking with the person or somebody who is supporting them. Services are available in a wide range of languages through a phone interpreter service.

### TARGET POPULATION

The program aims to serve callers with suicidal ideation or experiencing a crisis that might escalate to self-harm. In FY2015-16, unduplicated callers were 0-15 (5%), 16-24 (23%), 25-34 (17%), 35-44 (13%), 45-54 (14%), 55-64 (18%), 65-74 (8%), and 75+ (2%).

Numbers to be served in FY2017-18	Goal
Suicide Prevention Hotline calls originating in Marin County	8,000

### PROGRAM DESCRIPTION

- Suicide Prevention

The North Bay Suicide Prevention Program provides 24/7 suicide prevention and crisis telephone counseling to Marin County residents through a regional hotline. Highly trained and supervised phone counselors provide crisis prevention and intervention to people in distress and/or their family and friends. Counselors help to enhance the callers’ coping and problem-solving skills, providing alternatives to harm toward themselves or others and relief from the profound isolation of crisis, loss, and/or chronic mental illness. It serves as a vital link to mental health resources and referrals throughout Marin County.

The program improves timely access to services for underserved populations by providing free and accessible help 24/7 which allows access for people of all ages and socioeconomic status. It is accessible by anyone who has access to a telephone including those who may have limited access to services due to geographic location or mobility issues. The translation services used by the program

offer translation for over 200 languages allowing individuals whose primary language is not English to access the hotline. In addition, the Hotline has an ongoing contract with the National Suicide Prevention Lifeline to answer calls from Veteran's who prefer not to call the Veteran's Lifeline or other Veteran resources due to stigma around mental health issues.

The Hotline collaborates with Marin County's Crisis Stabilization Unit (CSU) and refers individuals needing face-to-face crisis evaluation and intervention to County Behavioral Health and Recovery Services (BHRS) crisis services. Likewise, CSU staff frequently refer people to the Hotline in order to help prevent a crisis from escalating and to keep them safe and at a lower level of care. In addition, the Hotline maintains ongoing collaboration with Marin County law enforcement, who are a primary resource used by phone counselors in managing suicidal emergency calls, and Federally Qualified Health Clinics (Marin Community Clinics, Ritter Center, Coastal Health Alliance and Marin City Health and Wellness Center), primary health clinics serving low and moderate income residents, who distribute Hotline resource materials.

Callers are routinely referred to BHRS Access Line for appropriate assessment and referral. Information on clients referred to Access will be recorded and submitted to BHRS in order to track referral outcomes as required under Access and Linkage. PEI staff maintains relationships with referral sites and participates in the PEI Committee that includes representatives from all PEI programs, BHRS, clients, families, and other key agencies in order to facilitate successful collaboration.

## PROPOSED EXPANSION

In addition to providing the 24/7 hotline, in FY2017-18 a Suicide Prevention Strategic Plan process will be conducted to determine gaps in existing suicide prevention services and the highest priorities for the PEI funds. These priorities will be implemented in FY2018-19 and FY2019-20.

## EXPECTED OUTCOMES

The Suicide Prevention Hotline is intended to reduce the rate of suicide. Over 50% of callers are assessed for level of suicidal intent at the beginning and end of the call, using a tool developed by Didi Hirsch. The current objectives for the program are:

Outcomes	Goal
Calls to hotline originating in Marin County	6-8000
Callers who express a reduction in level of suicidal intent by 1 level or maintain Low (Low, Medium, High)	80%
Agencies receiving suicide prevention campaign materials	20

This program is expected to be effective by implementing best practices. The Hotline is accredited by the American Association of Suicidology ([www.suicidology.org](http://www.suicidology.org)). In addition, as a member of the Bay Area Suicide and Crisis Intervention Alliance (BASCIA), the Hotline collaborates with other members to discuss best practices and other issues relevant to managing a crisis call center.

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

## HEALTH NAVIGATOR

### PROGRAM OVERVIEW

During the community planning process for this Plan, there was a concern that clients who are referred from PEI programs to BHRS have difficulty enrolling in services, especially Spanish speaking and uninsured clients. While the BHRS Access Line has increased its accessibility by hiring bi-lingual staff, holding drop-in hours for assessments, and collaborating with referring agencies, there are still individuals and families who have barriers that Access cannot address.

A Health Navigator would be a licensed mental health practitioner hired by BHRS to bridge the gap between community-based services and BHRS services. They would provide active outreach and support to clients, and their families as appropriate, who are likely eligible for BHRS services, but who are not accessing the services. This includes community outreach, individual outreach, assessments, and system navigation until the client is successfully being served by BHRS.

### TARGET POPULATION

The target population is individuals experiencing serious mental illness or emotional disturbance who are identified by PEI and other community programs as appropriate for referral to BHRS for services.

Numbers to be served in FY2017-18	Individuals					Family Members
	0-15	16-25	26-59	60+	Total	
Access and Linkage		15	25	10	50	15

*Individuals: Individual identified for services.*

*Family Members: Family members or caregivers of the individuals who participate in services.*

### PROGRAM DESCRIPTION

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

During the community planning process for this Plan, there was a concern that clients who are referred from PEI programs to BHRS have difficulty enrolling in services, especially Spanish speaking and uninsured clients. While the BHRS Access Line has increased its accessibility by hiring bi-lingual staff, holding drop-in hours for assessments, and collaborating with referring agencies, there are still individuals and families who have barriers that Access cannot address. For example, clients from underserved populations are unlikely to access a service when they have not met the providers. In response to this, one BHRS staff person who works extensively with the Spanish speaking community keeps pictures of the bi-lingual Access staff on her phone so she can show them to clients when she refers them to Access. In addition, it is easy for clients to not follow-through the multiple steps required, including phone assessment, in person assessment, and initial appointments.

A Health Navigator would be a licensed mental health practitioner hired by BHRS to bridge the gap between community-based services and BHRS services. For example, they would participate in community events so they become a known and trusted provider. One PEI provider works within a school district and has been encouraging a few students and their families to access BHRS services. Having a Health Navigator provide presentations in the classroom or attend an event where the parents are present would help the families be open to making an appointment with the Health Navigator for an assessment.

Once a client contacts BHRS the Health Navigator can help ensure that they follow-through on assessment and initial treatment appointments. This may require contacting them if they miss an appointment, helping them obtain transportation, and other tasks required. The Health Navigator can also help problem-solve when there are barriers within BHRS to serving a client, such as miscommunication, confusing protocols, and other challenges that discourage clients.

This program does active outreach and support to clients, and their families as appropriate, who are likely eligible for BHRS services, but who are not accessing the services. This includes community outreach, individual outreach, assessments, and system navigation until the client is successfully being served by BHRS.

The program will improve timely access to services for underserved populations by providing the support services needed to access treatment that is available. It will reduce stigma by developing relationships with hard-to-reach communities and providing initial services in community settings.

## EXPECTED OUTCOMES

The Health Navigator Program is intended to achieve the following outcomes:

- Reduce Prolonged Suffering by ensuring individuals experiencing serious mental illness or emotional disturbance engage in medically necessary services.

The Health Navigator will maintain records on outreach activities, individuals/families engaged, rates of success, time from referral to access of services, duration of untreated mental illness, and barriers to access.

This data, and client 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.

## MHSA PREVENTION AND EARLY INTERVENTION (PEI) MHSA THREE YEAR PLAN (FY2017-18 THROUGH FY2019-20)

Program	FY2017-18	FY2018-19	FY2019-20	Total
PEI-01 Early Childhood Mental Health Consultation - ECMH	\$230,000	\$230,000	\$230,000	\$690,000
PEI-04 Transition Age Youth (TAY) PEI	\$193,000	\$193,000	\$193,000	\$579,000
PEI-05 Latino Community Connection	\$313,000	\$313,000	\$313,000	\$939,000
PEI-07 Older Adult Prevention and Early Intervention	\$156,000	\$156,000	\$156,000	\$468,000
PEI-11 Vietnamese Community Connection	\$56,000	\$56,000	\$56,000	\$168,000
PEI-12 Community and Provider PEI Training	\$80,000	\$80,000	\$80,000	\$240,000
PEI-18 School Age Prevention and Early Intervention Programs	\$346,000	\$346,000	\$346,000	\$1,038,000
PEI-19 Veteran's Community Connection	\$63,000	\$63,000	\$63,000	\$189,000
PEI-20 Statewide Prevention and Early Intervention	\$80,986	\$80,986	\$80,986	\$242,958
PEI-21 Suicide Prevention	150,000	150,000	150,000	\$450,000
PEI-22 Health Navigator	\$138,074	\$138,074	\$138,074	\$414,222
<b>Subtotal Direct Services</b>	<b>\$1,806,060</b>	<b>\$1,806,060</b>	<b>\$1,806,060</b>	<b>\$5,418,180</b>
PEI Coordinator	\$74,000	\$74,000	\$74,000	\$222,000
Evidence Based Practice (EBP) Lead Staff	\$52,374	\$52,374	\$52,374	\$157,122
Administration and Indirect	\$344,400	\$344,400	\$344,400	\$1,033,200
Operating Reserve	\$19,166	\$19,166	\$19,166	\$57,498
<b>Total</b>	<b>\$2,296,000</b>	<b>\$2,296,000</b>	<b>\$2,296,000</b>	<b>\$6,888,000</b>

	FY2017-18	FY2018-19	FY2019-20	Total	%
<b>County</b>	\$253,448	\$253,448	\$253,448	\$760,344	11%
<b>Contract Provider</b>	\$1,678,986	\$1,678,986	\$1,678,986	\$5,036,958	73%
<b>Administration</b>	\$344,400	\$344,400	\$344,400	\$1,033,200	15%
<b>Operating Reserve</b>	\$19,166	\$19,166	\$19,166	\$57,498	1%
<b>Total</b>	<b>\$2,296,000</b>	<b>\$2,296,000</b>	<b>\$2,296,000</b>	<b>\$6,888,000</b>	<b>100%</b>

## COMMUNITY SERVICES AND SUPPORTS (CSS) OVERVIEW

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

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

### **Full Service Partnerships (FSPs)**

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

### **System Development (SD)**

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

### **Outreach and Engagement (OE)**

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

Marin recognizes the need to continue to expand efforts to reduce ethnic disparities and increase services for those who are un/underserved. Efforts to address disparities are described in the previous section (Improvement Plan to Reduce Stigma and Enhance Penetration Rates). CSS aims to increase the number of linguistically and culturally competent providers, provide outreach and engagement services, develop programs responsive to needs of specific target populations, and partner with Prevention and Early Intervention (PEI) programs to increase timely access to services. The CSS overview in the FY2017-18 MHSA Annual Update reports on the effect of these strategies, and program-specific strategies for reducing disparities are discussed in each program narrative.

## **CSS PROGRAMS FOR FY2017-18 THROUGH FY2019-20**

In developing the CSS component of the MHSA Three-Year Program and Expenditure Plan (Plan) for FY2017-18 through FY2019-20, many factors were taken into consideration, including: input from an extensive community planning process, evaluations of existing CSS programs, and the changing environment and evolving needs of the community. Existing CSS programs have been successful in reaching and serving priority populations and achieving program-specific goals. In

addition, a few new program expansions and one new adult CSS FSP will be started in FY2017-18 to target those who do not necessarily fall into the one of the target populations of the current Full Service Partnerships: homeless (Odyssey), Older Adults (HOPE), or involved with the criminal justice system (STAR). Marin will continue to make adjustments to the Plan as available funding changes, programs are implemented, and additional community needs emerge.

All existing CSS programs with ongoing funding that are being continued in FY2017-18, with the exception of the MHSA Housing Program, will receive an allocation adjustment of 3% funded by MHSA CSS funds to address increases in the costs of operating these programs and other expenses. We are also expanding FSP program administrative support capacity.

Program Name	Program Overview
<b>Youth Empowerment Services (YES) FSP-01</b>	YES, formerly known as the Children’s System of Care (CSOC), is a full service partnership program serving seriously high-risk youth through age 18 who are involved with Probation and/or attend County Community School, an alternative high school.
<b>Transition Age Youth (TAY) FSP-02</b>	TAY is a full service partnership providing young people (16-25) with serious emotional disturbance or emerging mental illness with independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services.
<b>Transition Age Youth (TAY) FSP-02</b>	The recent trend of referrals of 17 and 19-year olds immediately following a First Psychotic Episode (FEP), require an extraordinary amount of coordination and delivery of services. In order to provide the core functions of a Coordinated Care Model in collaboration with the county FEP Project a .50 FTE Clinical Case Manager would be added.
<b>Support and Treatment after Release (STAR) Program FSP-03</b>	STAR is a FSP serving adults with serious mental illness who are at risk of incarceration or re-incarceration. 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. This program incorporates substance use specialist services, independent living skills training, and Crisis Intervention Team Training.
<b>Helping Older People Excel (HOPE) Program FSP-04</b>	HOPE is a FSP serving older adults with serious mental illness who are at risk of homelessness, hospitalization or institutionalization. This program includes outreach to Latino older adults and independent living skills training.
<b>Odyssey Program (Homeless) FSP-05</b>	Odyssey is a FSP serving adults with serious mental illness who are homeless or at-risk of homelessness. This program will include substance use specialist services, transitional housing, and independent living skills training. It will also develop a bridge into less intensive services.
<b>Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT) FSP-06 (NEW PROGRAM)</b>	The IMPACT FSP will provide culturally competent intensive, integrated services to thirty (30) priority population at-risk adults. The program will be 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

Program Name	Program Overview
	independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.
<b>Enterprise Resource Center (ERC) SDOE-01</b>	ERC is an outreach and engagement project serving adults with serious mental illness who are reluctant to become involved in the public mental health system. This program will continue supporting the CARE Team, providing outreach to homeless individuals, and open a second site to provide recovery support for individuals no longer requiring intensive case management.
<b>Adult System of Care (ASOC) Expansion – SDOE-07</b>	ASOC Expansion is a system development program to increase services for adults with serious mental illness who are unserved or underserved. This program will support family outreach, client support, housing assistance, and outreach and engagement services.
<b>Co-Occurring Capacity SDOE-08</b>	Co-Occurring Capacity is a systems development program intended to further develop the capacity to effectively serve individuals with co-occurring disorders. The programs included in the Three-Year plan represent multiple approaches to increasing co-occurring capacity. Program specific efforts are described within the appropriate program narrative.
<b>Crisis Continuum of Care SDOE-09</b>	Crisis Continuum of Care is a systems development program intended to reduce acute crises and increase client choice by developing and coordinating a full continuum of crisis services. Programs within this include crisis planning, crisis residential, crisis triage staff, and a CSU family partner.
<b>First Episode Psychosis (FEP) Program SDOE-10</b>	The FEP is a systems development program that will target individuals who are experiencing their first psychotic episode and are between the ages of 15-30 years old. Transitional age youth (TAY) experiencing first psychotic episodes may be referred to our TAY full service partnership program or seen in our outpatient county mental health Systems of Care in the youth system or adult system.
<b>Consumer Operated Wellness Center SDOE-11</b>	The center will be consumer staffed and operated and provide an array of classes, peer support, skill-building, and activities focused on recovery, illness self-management, and self-sufficiency. It must be accessibly located and meet Americans with Disabilities Act accessibility standards. The target population of the center is transition-age youth (18+), adults and older adults who have serious mental illness. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.
<b>MHSA Housing Program</b>	Fireside Apartments were developed for low-income older adults with serious mental illness. There are ongoing efforts to identify further housing projects that fit within the funding guidelines.

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## YOUTH EMPOWERMENT SERVICES (YES) FULL SERVICE PARTNERSHIP

### PROGRAM OVERVIEW

Marin County's Youth Empowerment Services (YES) is a Full Service Partnership program (FSP) serving 40+ seriously high risk youth up to their twenty first birthday.

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

From beginning of the YES FSP program, notable outcomes include:

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

### TARGET POPULATION

YES serves youth up to age 21 who present with significant mental health issues that negatively affect their education, family relationships, and psychiatric stability which can often result in substance use. In FY2015-16 there were 43 unduplicated clients and most were under 18 (N=38, 88%) and male (N=25, 58%). Latino youth in particular made up the majority of the YES clients (N=35, 82%) followed by Caucasian/white (N=7, 16%). English was the preferred language for 88% of clients (N=37), while a large proportion of the parents preferred Spanish. Since FY2014-15 the YES Program has broadened the referral base beyond the original juvenile justice system to

include any seriously emotionally disturbed child or youth at risk for high end mental health services regardless of the system that originally served them.

## PROGRAM DESCRIPTION

The YES model is a MHSA CSS strengths based model with the goal of meeting youth and families in their homes and in the community, in both the literal and figurative sense. The services incorporate a wraparound philosophy, utilizing a team approach to help families identify their needs and implement ways to address them successfully with on-going collaboration between clinicians, Family Partners and the child and family. Family Partners are parents who have had a child in the mental health or juvenile justice system and are able to engage and support the parent in a unique way because of their life experience, which a professional cannot. These partners provide support and guidance to parents in navigating the various systems and with parenting youth engaged in high-risk behaviors.

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 FSP model includes the ‘whatever it takes’ philosophy which includes creative strategizing to maintain stability for clients and their families which may be supported by Flex Funds, to be used, for example, to support stable housing during a short term emergency. 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 Treatment Plan.

Latino youth continue to be over-represented in the juvenile justice system and at County Community School and in our Medi-Cal beneficiary population as a whole. Such clients with high needs are referred from schools or clinics or self-referred by a parent through our Access line. In FY2015-16 only two of the three clinical positions were filled so capacity was reduced. In FY2016-17 YES staffing consists of three (3) bilingual clinicians, one of whom is a Latino male working with students at Marin Community School, an alternative high school. 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. These clients have complex mental health issues on top of poverty, assimilation challenges, and the immigration status of other family members. However, the need for specialty mental health services for these children and youth with complex needs still outpaces the current staff resources.

## PROPOSED PROGRAM EXPANSION

**Goal:** Expand the Youth Empowerment Services (YES) Full Service Partnership Program by 12 slots, from 40 to 52, by hiring an additional LMHP and a supervisor to accommodate the increasing need for intensive services for youth up to age 21 who present with significant mental health issues. Since these youth are not motivated to seek services in traditional mental health clinics a ‘whatever it takes’ individualized flexible treatment plan is at the heart of the approach for these youth. In addition some of these youth are experiencing first psychotic episodes and require intensive services early on with sufficient support of a full time supervisor in supporting evidenced based treatments for this vulnerable population. Since 82% of the YES youth identified as Hispanic in FY2015-16 it is highly desirable to provide increased cultural and linguistic capability when hiring an additional

LMHP and a supervisor to support these youth most effectively who face many challenges and environmental stressors.

**Mental Health Practitioner:** A clinician experienced in providing direct mental health services in a clinic or program with youth of color who are often marginalized and in need of a supportive, intensive, trauma focused model of treatment, especially those experiencing a first psychotic episode. This is a very challenging population and depending on their age and development require a clinician who understands the unique challenges in successfully engaging them.

**Mental Health Unit Supervisor:** An experienced clinician who has had experience in providing direct services to youth at risk and is able to plan, oversee, review and evaluate the YES Program and YES staff on a full time basis (currently there is only a part time supervisor). This supervisor would serve as a resource and consultant on daily activities as well as provide long term planning for the program, including outcome measures, in collaboration with the other Children's Mental Health supervisors and the Division Director.

## EXPECTED OUTCOMES

In FY2015-16, the YES program served 43 clients with only 2 of the 3 clinical staff positions filled as noted above. Services provided to the 43 youth included assessment, case management and individual/family therapy, as well as family partner support and medication services. YES services helped prevent several youth from becoming homeless and also supported many clients to avoid psychiatric hospitalization. Because many YES clients present with significant emotional/behavioral challenges, at times resulting in psychiatric hospitalization, YES clinicians are available to provide intensive support during crises, as well as aid in discharge planning from the hospital.

To support our larger objective of decreasing barriers to service, most of the YES services were provided in schools and in clients' homes rather than in an outpatient office setting. Services were also provided at alternative sites like Marin Community School (a school for students at risk of academic failure) as well as in the community as appropriate.

The YES program also supports our outreach efforts to reach unserved and underserved communities. 82% of YES clients identify as Hispanic, with 12% (N=5) reported as primarily Spanish speaking. The YES program also serves clients who are newcomers or who immigrated to the US within the past few years. These clients often experience educational disruption, trauma, separation and significant loss, all the while having to navigate a new culture. In many cases, YES clients are bilingual, but family based services to parents often require a bilingual clinician in order to engage parents successfully.

Three areas of focus during FY2015-16 included identifying early psychosis, substance use and trauma for YES clients. Specific issues of trauma such as exposure to domestic violence, the experience of immigration trauma, and sexual abuse were salient issues in the YES client population. In FY2015-16 the YES staff began using the Child Adolescent Needs and Strengths tool (CANS) to assess and monitor specific areas of concern that should be the focus of clinical intervention. In FY2016-17, the CANS ratings for these factors will be monitored at regular intervals to assess individual progress and overall effectiveness of the program in addressing these needs.

## PROGRAM CHALLENGES

**In FY2015-16**, The YES program remained understaffed for much of the year, at times with only one staff other times with two staff.

**In FY2016-17**, with a full complement of staff the YES program will serve at least 40 unduplicated clients and track the most frequent actionable items on the CANS to align training needs of staff with the clinical needs of the client. Staff has been trained in a software program that can show client progress, clinical areas of focus and the effectiveness of treatment. Staff has required and will continue to require ongoing support and consultation so as to effectively use this tool for the benefit of the client and program.

Currently, the YES Program has only a part time supervisor so the ability to monitor the quality and effectiveness of the program and provide timely consultation to staff in utilizing the CANS as effectively as possible in determining level of care and treatment planning and overall effectiveness of the program is challenging.

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

## TRANSITIONAL AGE YOUTH (TAY) FULL SERVICE PARTNERSHIP

### PROGRAM OVERVIEW

Marin County's Transition Age Youth (TAY) Program, provided by Sunny Hills Services is a full service partnership (FSP) for young people (16-25) with serious emotional disturbance or emerging mental illness. The TAY program provides independent living skills workshops, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services. There is also a well-attended Partial program for youth who can take advantage of the group activities and ongoing social support. This Partial Program may be used as a step down for FSP participants on their way to a more independent path as well as outreach to youth who are just realizing the importance of connection and support in dealing with emerging mental illness.

### TARGET POPULATION

The priority population is transitional age youth, 16-25 years of age, with serious emotional disturbances/serious mental illness which is newly emerging or for those who are aging out of the children's system, child welfare and/or juvenile justice system. Priority is also given to TAY who are experiencing first-episode psychosis and need access to developmentally appropriate mental health services. Research has shown there are significant benefits from early intervention with this high risk population. There is increased awareness that young people experiencing first episode psychosis symptoms should be engaged early and provided with a collaborative, recovery oriented approach through a multidisciplinary team Coordinated Specialty Care model. Untreated psychosis has been associated with increased risk for delayed or missed developmental milestones resulting in higher rates of unemployment, homelessness, reduced quality of life and a higher risk for suicide. First episode psychosis has become an area of focus across the mental health system of which TAY is an important partner.

### Full Service Partnership Client Demographics FY2015-16

Age Group	# served	% of served
0-15 years old		
16-25 years old	28	100%
26-59 years old		
60+ years old		
<b>TOTAL</b>	<b>28</b>	<b>100%</b>
Race/Ethnicity		
White	13	
African American	3	
Asian	2	
Pacific Islander		
Native		
Hispanic	10	
Multi		
Other/Unknown		

Primary Language		
Spanish	2	
Vietnamese	1	
Cantonese		
Mandarin		
Russian		
Farsi		
Arabic		
English	25	
Other		

### PROGRAM DESCRIPTION

The TAY Program is a Full Service Partnership (FSP) providing young people (16-25 yr. old) with ‘whatever it takes’ to move them toward their potential for self-sufficiency and appropriate independence, with their natural supports in place from their family, friends and community. Initial outreach and engagement is essential for this age cohort who is 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.

This goal of the program is to provide treatment, skills-building and a level of self-sufficiency needed to manage their illness and accomplish their goals, thus avoiding high end services, incarceration and homelessness. In addition, partial services, such as drop-in hours and activities, are available to TAY FSP as well as those not yet a full service partner who are given the opportunity to explore how a program such as TAY could support them.

Partial services are provided on a drop-in basis to full and partial clients. These services include an Anxiety Management Group, cooking groups, no cost physical activities such as hikes led by staff and job support and coaching. 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. A regular Family Support Group for families of TAY with mental health illness and substance use, whether or not their child is enrolled in the TAY programs is provided by a TAY staff in both Spanish and English. The monthly TAY calendar of activities is available in English and Spanish.

## EXPECTED OUTCOMES

In FY2015-16, there were 28 unduplicated FSP clients in the TAY Program. Currently 14 of the FSP's receive psychiatric medication support directly through the TAY Program and 25% receive individual therapy (N=7). Approximately 70% attended independent living skills activities.

Outcomes	Goal
Number of clients served:	
• FSP	24
• Partial/drop-in	60
FSP clients engaged in work, vocational training or school.	55%
FSP clients engaged in activities designed to improve independent living skills.	60%
FSP clients screened for substance use.	100%
Clients identified as having substance use issues that receive substance use services.	50%

Only three clients were identified as having substantial risk for alcohol and drugs which is 11% and two of the three or 66% accepted substance use services but the number is so small that the percentage is meaningless. However, one of the two clients worked with an AA sponsor outside of TAY and the other collaboratively developed a plan with their individual case manager. It is believed that many denied use and/or under reported, specifically the use of marijuana/medical marijuana which was frequently explored in drop in activities and groups utilizing Motivational Interviewing (MI) techniques. The challenge, through MI and Seeking Safety groups, will be to increase awareness of the impact alcohol and drug use has on their lives and wellbeing and to support these youth through the stages of change as appropriate.

## PERFORMANCE GOALS

- The TAY program will maintain 95% capacity (19 clients) or higher of FSP clients by active outreach and engagement, in collaboration with the BHRS TAY liaison.
- The program will have served at least 45 unduplicated clients in the drop in center with active outreach and engagement by TAY Program staff. at least 60% of FSP will have participated in at least one drop in activity.
- 70% of Full Service TAY members will have engaged in either work, vocational training or school.
- 50% of FSP will have attended two or more activities designed to improve their independent living skills.
- Ongoing assessment and interventions related to clients' needs/issues with substance use and safety. 100% of FSP clients will receive alcohol and drug screening. Clients identified

with possible substance use issues will receive further assessment, and when indicated, intervention and treatment services.

- Maintain full occupancy (two FSP) 80% of the time.

## PROPOSED EXPANSION

The recent trend of referrals of 17 and 19-year olds immediately following a First Psychotic Episode (FEP), require an extraordinary amount of coordination and delivery of services. In order to provide the core functions of a Coordinated Care Model in collaboration with the county FEP Project a (0.5 FTE) Clinical Case Manager would need to be added. This increased staffing resource would also allow an increase of four FSP slots in the TAY Program. The TAY Program is often at capacity and therefore the proposed expansion of four new slots would increase capacity to 24 FSPs, to better meet client need pending approval of the MHSA Three Year Plan.

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

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

### PROGRAM OVERVIEW

The Marin County Support and Treatment After Release (STAR) Program has been an MHSA-funded Full Service Partnership serving adults with serious mental illness who are at risk of incarceration or re-incarceration since 2006. The 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.

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

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

The re-design of the program incorporated the valuable experiences and lessons learned from the MIOCRG-funded services and in 2006, the STAR Program was approved as a new full service partnership providing culturally competent intensive, integrated services to 40 mentally ill offenders. Operating in conjunction with Marin's mental health court – the STAR Court – the program was

designed to provide comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports.

A substantial percentage of program participants present with co-occurring substance use disorders, increasing the risk for suicide, aggressive behavior, homelessness, incarceration, hospitalization and serious physical health problems. Studies have documented the effectiveness of an integrated approach to individuals with co-occurring psychiatric and substance use disorders, in which the mental illness and substance use disorder are treated by the same clinician or team. In 2011 the program added a part-time substance use specialist who provides assessments and consultation to the team, as well as facilitates a weekly treatment group for program participants with co-occurring substance abuse disorders. This position is expected to provide integrated substance use services to 15-20 program participants annually.

Originally all program enrollees were required to agree to participate in STAR Court. This presented an obstacle to enrollment for some individuals who would clearly benefit from the program's services. In 2011 the program expanded to serve an additional 15 clients without the requirement of participation in STAR Court. Hopefully removing the court requirement will also allow the STAR Program to engage and enroll a more diverse participant population.

In 2012 the program added Independent Living Skills (ILS) training for targeted STAR clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training is expected to be provided to 4-5 program participants annually.

Beginning in 2011, the program began providing CIT Training, a 32-hour training program for police officers to enable them to more effectively and safely identify and respond to crisis situations and mental health emergencies. Through MHSA CSS funds this training is provided to 25-30 sworn officers annually.

## 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 use disorder and/or other serious health condition.

## PROGRAM DESCRIPTION

The STAR Program is a Full Service Partnership providing culturally competent intensive, integrated services to 60 mentally ill offenders. As stated above, the goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce incarceration, and reduce hospitalization.

Operating in conjunction with Marin's Jail Mental Health Team and the STAR Court (mental health court), a multi-disciplinary, multi-agency assertive community treatment team comprised of professional and peer specialist staff provides comprehensive assessment, individualized client-

centered service planning, crisis management, therapy services, peer counseling and support, psychoeducation, employment services and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained. The team’s mental health nurse practitioner furnishes psychiatric medication to program participants under the supervision of the team psychiatrist. The team’s mental health nurse practitioner also provides participants with medical case management, health screening/promotion and disease prevention services, and coordinates linkage to community-based physical health care services. The program also has a volunteer family member who brings the voice and perspective of families to the program and is available to provide outreach to family members of STAR Program participants.

**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.

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

**PROPOSED CHANGES**

This plan proposes an increase in administrative staffing. In recent years Behavioral Health and Recovery Services has expanded dramatically, and current resources are inadequate to provide prompt and reliable customer service and leads to inefficiencies in staffing patterns.

Additional support staffing would also allow for increased accuracy and consistency of data collection, and is expected to have a measureable impact on data quality and timeliness of reporting.

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## HELPING OLDER PEOPLE EXCEL (HOPE) FULL SERVICE PARTNERSHIP

### PROGRAM OVERVIEW

The HOPE Program has been an MHSa-funded Full Service Partnership serving older adults with serious mental illness who are at risk of homelessness, hospitalization or institutionalization since 2007. The program is designed to provide community-based outreach, comprehensive geropsychiatric assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports by a multi-disciplinary, multi-agency team. The over-arching vision of the HOPE Program is “*Aging with dignity, self-sufficiency and in the life style of choice*”. The goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.

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

Key stakeholders and community partners had consistently agreed that Marin needed to more comprehensively address the needs of older adults who have serious mental illness, and they strongly supported the creation of a new full service partnership as a critical step toward an integrated system of care for this population. In 2006, Marin’s HOPE Program was approved as a new MHSa-funded full service partnership providing culturally competent, intensive, integrated services to 40 priority population at-risk older adults. Older adults were identified to be Marin’s fastest growing population and comprise 24% of the total population. By 2014, demand for HOPE Program services had exceeded its capacity, and MHSa funding was used to add a full-time Spanish speaking clinician to the assertive community treatment team. This enabled the program to enroll an additional 15 individuals, bringing the capacity of the Full Service Partnership to 50.

In 2014 the program was also expanded to provide increased outreach to at-risk Hispanic/Latino older adults by increasing the hours of the Spanish-speaking mental health clinician supporting and supervising the Amigos Consejeros a su Alcance (ACASA) component of the Senior Peer Counseling Program. These additional hours are used to outreach into the community to increase awareness of the mental health needs of Hispanic/Latino older adults and their families, and the services that ACASA and the HOPE Program offer. ACASA is expected to identify and engage with 5 new monolingual community liaisons annually. It is also anticipated that the addition of Spanish-speaking capacity to the Full Service Partnership will facilitate the identification, engagement, and enrollment of at-risk Hispanic/Latino older adults who have serious mental illness and have been unserved or underserved by the Older Adult System of Care.

Also in 2014, the program was also expanded to provide Independent Living Skills (ILS) training for targeted HOPE clients. These services facilitate independence and recovery by providing training in

specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training is expected to be provided to 4-5 program participants annually.

## 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 50 priority population at-risk older adults. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. As stated above, the goals of the program are to promote recovery and self-sufficiency, maintain independent functioning, reduce isolation and avoid institutionalization.

The HOPE Program's multi-disciplinary assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psychoeducation, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained.

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

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

**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.

Outcomes	GOAL
Decrease in homelessness	75%
Decrease in hospitalization	50%

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## ODYSSEY PROGRAM (HOMELESS) FULL SERVICE PARTNERSHIP

### PROGRAM OVERVIEW

The Odyssey Program has been an MHSA-funded Full Service Partnership serving adults with serious mental illness who are homeless or at-risk of homelessness since 2008. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

Following the loss of AB2034 funding for Marin's Homeless Assistance Program which had been in operation since 2001, key stakeholders and community partners fully supported the creation of a new Full Service Partnership, the Odyssey Program, to continue serving the AB2034 target population. Over the course of its existence, Marin's AB2034 program demonstrated significant success in assisting adults with serious mental illness who were homeless to obtain and maintain housing, despite the County's very challenging housing environment, and to avoid incarceration and hospitalization. The design of the new program incorporated the valuable experiences and lessons learned from the AB2034-funded services and in 2007, the Odyssey Program was approved as a new MSHA-funded CSS Full Service Partnership providing culturally competent intensive, integrated services to 60 priority population adults who were homeless or at-risk of homelessness. The Odyssey Program was designed to provide comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports by a multi-disciplinary, multi-agency team.

A substantial percentage of program participants present with co-occurring substance use disorders, increasing the risk for suicide, aggressive behavior, homelessness, incarceration, hospitalization and serious physical health problems. Studies have documented the effectiveness of an integrated approach to individuals with co-occurring psychiatric and substance use disorders, in which the mental illness and substance use disorder are treated by the same clinician or team. In 2011 the program added a part-time substance use specialist who provides assessments and consultation to the team, as well as facilitates a weekly treatment group for program participants with co-occurring substance abuse disorders. This position is expected to provide integrated substance use services to 15-20 program participants annually.

In 2012 the program added Independent Living Skills (ILS) training for targeted ODYSSEY clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training is expected to be provided to 4-5 program participants annually.

Beginning in 2011 MHSA funds were used to fund emergency housing in a 2-bedroom apartment for program participants who are homeless to provide a safe place for residents to live while seeking permanent housing. While in the emergency housing, program participants are able to save money for security and rent deposits and can work closely with program staff to develop budgeting and

living skills needed for a successful transition to independent living. Emergency housing serves 5-10 program participants annually.

In 2014 Odyssey implemented a “Step-Down” component, staffed by a Social Service Worker with lived experience and a Peer Specialist and targeting individuals already enrolled in the program who no longer need assertive community treatment services, but continue to require more support and service than is available through natural support systems. This program did not achieve the intended outcomes. Since implementation, the team has been challenged by needing to provide frequent transfers between this component and the assertive community treatment component of the team. Marin proposes to re-structure both components by integrating the two services in support of participants being able to access services at different intensities, depending on their needs, without the need to transfer between two separate FSP components.

## TARGET POPULATION

The target population of the Odyssey Program is adults, transition age young adults and older adults with serious mental illness, ages 18 and older, who are homeless or at-risk of homelessness due to their mental health challenges. Priority is given to individuals who are unserved by the mental health system or are so underserved that they end up homeless or at risk of becoming homeless. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

## PROGRAM DESCRIPTION

The Odyssey Program is a Full Service Partnership that provides culturally competent intensive, integrated services to 80 priority population at-risk adults. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. As stated above, the goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

A multi-disciplinary, multi-agency assertive community treatment team comprised of professional, para-professional and peer specialist staff provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psychoeducation, employment services, independent living skills training, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained.

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

The program’s part-time employment specialist provides situational assessments, job development and job placement services for program participants, and coordinates services with other vocational rehabilitation providers in the county. Where appropriate, participants are assisted to enroll in the

Department of Rehabilitation to leverage funding for additional vocational services, including job coaching.

### 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.

Outcomes	GOAL
Decrease in homelessness	80%
Decrease in arrests	50%
Decrease in incarceration	60%
Decrease in hospitalization	40%

### PROPOSED CHANGES

This plan proposes an increase in administrative staffing. In recent years Behavioral Health and Recovery Services has expanded dramatically, and current resources are inadequate to provide prompt and reliable customer service and leads to inefficiencies in staffing patterns. Additional support staffing would also allow for increased accuracy and consistency of data collection, and is expected to have a measureable impact on data quality and timeliness of reporting.

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

## **INTEGRATED MULTI-SERVICE PARTNERSHIP ASSERTIVE COMMUNITY TREATMENT (IMPACT) FULL SERVICE PARTNERSHIP**

### **PROGRAM OVERVIEW**

In recent years, the Marin County Adult System of Care has struggled with an increasing number of individuals with serious mental illness who are in need of more intensive services than those offered by either of the integrated clinics. This plan proposes the addition of a Full Service Partnership specifically targeting those who do not necessarily fall into the one of the target populations of the current Full Service Partnerships: homeless (Odyssey), Older Adults (HOPE), or involved with the criminal justice system (STAR). The goals of the Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT) Full Service Partnership will be to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

### **PROGRAM DESCRIPTION**

The IMPACT FSP will provide culturally competent intensive, integrated services to thirty (30) priority population at-risk adults. The program will be strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. As stated above, the goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

Following the Assertive Community Treatment model, a diverse multi-disciplinary team will be developed to provide comprehensive “wrap-around” services for individuals in need of the highest level of outpatient services. Staffing will be comprised of mental health clinicians, Peer Specialists, Family Partners, para-professionals, psychiatry and Nurse Practitioners. Services will include comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psycho-education, employment services, independent living skills training, assistance with money management, and linkages to/provision of all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and will be provided on a case-by-case basis. The team will have a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained.

### **TARGET POPULATION**

The target population of the proposed program is adults, transition age young adults and older adults with serious mental illness, ages 18 and older, which are un-served by the mental health system or are so underserved that they are unable to stabilize in the community without additional

support. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

**EXPECTED OUTCOMES**

Listed in the table below, the expected outcomes are based on the goals of the program. We expect to serve up to forty (40) 18+ year old adults. 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 program staff on a daily basis. Program staff will explore methods for measuring self-sufficiency and recovery that will permit the program to evaluate its success in these key areas.

Outcomes	Goal
Decrease in homelessness	25%
Decrease in arrests	50%
Decrease in incarceration	60%
Decrease in hospitalization	40%

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## ENTERPRISE RESOURCE CENTER (ERC) EXPANSION

### PROGRAM OVERVIEW

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

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

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

The ERC Expansion Program has been remarkably successful with the number of client visits per month increasing from 600 to over 1,500; its average daily attendance goal has been met with consistent gains each year.

### 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, such as supported housing and employment services, builds trust, maximizes opportunities for collaboration and increasingly engages clients in their own recovery process. Managed and staffed entirely by mental health

consumers, the center promotes a strengths-based, harm-reduction approach and offers clients a one-stop central location to access and receive services such as socialization activities, peer counseling, mentoring, psycho-educational activities, and support groups. Consumers working to assist other consumers serve as role models and a message of hope that further promotes wellness and recovery.

ERC offers a full schedule of activities, classes and groups 7 days per week, as well as serving as host to such meetings as Dual Recovery Anonymous, Smokebusters, and NAMI Family Support Groups. ERC programs and services designed to provide personal support and foster growth and recovery include the Warm Line; the Linda Reed Activities Club; specialty groups and classes; supportive counseling with trained Peer Counselors; and a Peer Companion Program that outreaches to individuals who tend to isolate. Outreach and engagement services for the County's homeless individuals with mental illness are provided by ERC and its CARE team (homeless mobile outreach) which works closely with Marin's Odyssey Program for homeless adults who have serious mental illness. The ERC also provides Peer Counseling and Case Management training programs and on-the-job internships for consumers seeking to work as service providers in the public mental health system.

## 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. The data for these measures are obtained from CSS logs that program staff are required to fill out and keep up-to-date.

Outcomes	Goal
# Served - ERC	200
Avg daily attendance	35
# ERC first time visitors	200
# Warm Line contacts	6500
# Served - CARE	180
Avg monthly contacts - CARE	100

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## ADULT SYSTEM OF CARE (ASOC) EXPANSION

### PROGRAM OVERVIEW

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

The overarching vision of Marin's system of care for adults who have serious mental illness is "*A Home, Family & Friends, A Job, Safe & Healthy.*" 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.

Prior to MHSA, Marin's Adult System of Care (ASOC) consisted of 3 intensive community treatment teams which were responsible for providing and connecting clients to a broad continuum of services including supported housing, employment services, Peer Specialist services, medication support, residential care services, integrated physical-mental health care, jail mental health services and crisis stabilization, in addition to traditional outpatient mental health treatment. 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 project was created to make additions/enhancements to the ASOC that would further its existing efforts at system transformation.

The ASOC Expansion 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.

With the implementation of the MHSA-funded PEI Community Health Advocate (CHA) Hispanic/Latino and Vietnamese projects, development of new partnerships and related strategies greatly increases the ASOC Expansion Program's ability to engage with these underserved populations.

### TARGET POPULATION

The target population of the ASOC Expansion Program is transition-age youth (18+), adults and older adults who have serious mental illness and their families, and are at risk of hospitalization, institutionalization, incarceration, homelessness, frequent emergency medical care or other long-term adverse impacts of mental illness. Priority is given to individuals who are currently un/underserved by the mental health system, especially Latino (Spanish-speaking) and Vietnamese (Vietnamese-speaking) individuals. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

## 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 within the integrated clinics, 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.

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. An MHSA-funded full-time Peer Specialist provides services and supports to that focus on recovery and illness self-management strategies for individuals enrolled in the adult integrated care teams.

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.

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

Family Outreach, Engagement and Support Services have been expanded through the addition of Family Partners with personal experience as a family member of an adult with mental illness. The ASOC Family Partners provide outreach and engagement services to families of adults with serious mental illness, as well as family-to-family care management services including provision of support and advocacy, assistance with service plan development and implementation, information and referral to NAMI-Marine and other local community resources, and co-facilitation of family support groups. One of these positions is designated as Spanish Speaking to further support Hispanic/Latino families who's loved ones are engaged services through the adult integrated care teams. This position is expected to serve 75 monolingual family members annually.

Beginning in 2011, CSS funds were approved to create a Housing Assistance Fund for the ASOC to provide short-term housing assistance funding to assist at-risk clients of the Adult Intensive Care Management team to successfully access and/or maintain appropriate housing in the community. Experience with this funding over the past 2-3 years has revealed the need to broaden its use to address other, equally critical client needs. The Adult Integrated Care Management Teams will use this funding as a pool of flexible funds to support clients and purchase needed goods and services,

including emergency and short-term transitional housing, medications, and transportation, that cannot be otherwise obtained. This fund will be used to assist 40 clients annually.

### 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. The data for these measures are obtained from documents that program staff are required to complete and keep up-to-date.

Outcomes	Goal
# Served	1200
% Hispanic	10%
# Primary language-Spanish	120
# Asian	60
# Primary language-Vietnamese	30

### PROPOSED EXPANSION

As the understanding that providing quality services continues to expand beyond providing accessible, timely and culturally responsive services to providing the services that adhere with fidelity to an evidence-based model, a two-fold approach has emerged. While core practices are being implemented, including Motivational Interviewing, Cognitive Behavioral Therapy for Psychosis, Trauma Informed Cognitive Behavioral Therapy and others, there is a recognition that sustaining these evidence-based practices (EBP) requires clinical leadership and oversight. To this end, an EBP Lead Staff position will fill the role of training, coaching and evaluating the implementation of practices to ensure that they are implemented and maintained with maximum effect.

This plan also proposes an increase in administrative staffing. In recent years Behavioral Health and Recovery Services has expanded dramatically, and current resources are inadequate to provide prompt and reliable customer service and leads to inefficiencies in staffing patterns. Additional support staffing would also allow for increased accuracy and consistency of data collection, and is expected to have a measureable impact on data quality and timeliness of reporting.

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## CO-OCCURRING CAPACITY

### PROGRAM OVERVIEW

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

Although the initiatives designed to increase system and service co-occurring capacity remain the same, some of the intervention approaches and service partners have evolved due to a combination of availability of new services and a review of prior outcomes. Programs included in the Three-Year Plan focus on co-occurring capacity workforce development, expansion of engagement and treatment services for individuals with complex co-occurring substance use disorder and Serious Mental Illness, and Peer-to-Peer smoking cessation services.

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

### TARGET POPULATION

#### Co-Occurring Capacity Workforce Development

The target populations of the services provided by the Contracted Addiction Psychiatrist (Chief, Addiction Services) are County and County-contracted mental health staff/providers and other stakeholders serving individuals with complex co-occurring disorders, such as Federally Qualified Health Centers and local law enforcement. The demographics may vary and are not focused on or limited to any particular population.

The expected annual numbers served are as follows:

- Clinical consultation to at least 20 County, contractor and key stakeholder behavioral health staff/providers
- Provide trainings/presentations to at least 50 County, contractor and key stakeholder behavioral health staff/providers

Expanded Engagement and Treatment Services

The target population for the expanded engagement and treatment services that will be provided through the Road to Recovery Program is Marin adults (18+ years) with co-occurring substance use disorders and Serious Mental Illness. Participants receiving treatment services shall be engaged in specialty mental health services and participants receiving engagement services may be currently enrolled in services—or have a recent history of repeated episodes—but for which services are not adequately addressing their needs.

The projected caseload for expanded services is 25 at any given time, with an estimated 50 individuals served annually. The demographics may vary and are not focused on or limited to any particular population.

Peer to Peer Tobacco Cessation Services

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

The expected numbers served annually are as follows:

- Train and supervise 10 peers to provide peer to peer smoking cessation services
- Provide tobacco cessation education and support services to 150 mental health consumers
- Work with five County and/or contractor agencies and clinics providing services to County mental health clients to integrate comprehensive, sustainable cessation support into their programs

**PROGRAM DESCRIPTION**Co-Occurring Capacity Workforce Development

In order to increase co-occurring capacity across the behavioral health system of care, an Addiction Psychiatrist, contracted with the County Division of Behavioral Health and Recovery Services, offers staff consultation and training directed at increasing the competency of the behavioral health workforce to effectively identify and treat individuals with complex co-occurring mental health and substance use disorders. Trainings may include, but are not limited to: assessment and diagnosis, Medication Assisted Treatment, and effective treatment of co-occurring disorders. Clinical consultation and training services are provided at various locations, including Community Services and Supports (CSS) programs in the behavioral health system of care.

Although previous co-occurring capacity workforce development activities were highly successful in providing direct services to clients engaged in the behavioral health system of care, the demand for client care resulted in a less than anticipated focus on staff capacity building. With additional services now available through the County-operated Road to Recovery Program, workforce development initiatives will now exclusively focus on staff and service co-occurring capacity building.

### Expanded Engagement and Treatment Services

The County-operated Road to Recovery Program opened in November 2016 and is certified to provide General Outpatient and Intensive Outpatient substance use treatment services. In order to provide a continuum of services for individuals with complex co-occurring disorders—as well as advance system and service integration efforts—engagement services previously offered through the Alliance in Recovery Program will be continued and expanded within the Road to Recovery program.

The Road to Recovery program will provide engagement and treatment services for adults whose co-occurring mental health and substance use disorders have not been effectively addressed in one or both treatment systems. The goal of the program is to provide flexible outreach and support services that build trust and relationships, 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.

### Peer to Peer Tobacco Cessation Services

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

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

Since the program's inception in June 2013 to June 30, 2016, 18 peers have been trained as tobacco cessation specialists and 258 consumers have engaged in peer-led cessation groups and/or adjunct cessation support at sites including: Enterprise Resource Center, Voyager Carmel, Lakeside House, Draper House, Marin Alano Club, D Street, Case Rene, Marin Treatment Center, and Bridge the Gap.

## EXPECTED OUTCOMES

### Co-Occurring Capacity Workforce Development

As this project focuses on staff capacity building, the expected outcomes associated with this project are largely process-oriented. Data is being collected through training and service logs. Expected outcomes include:

Outcomes	GOAL
Clinical Consultation provided to behavioral health staff/providers/stakeholders	20
Number of trainings/presentations to behavioral health staff/providers/stakeholders	10
Number of staff/providers/stakeholders participating in trainings/presentations	50
Number of sites serving mental health consumers that have ability to provide Medication Assisted Treatment (e.g. Buprenorphine, Vivitrol, Naloxone, etc.)	3
Number of new mental health providers DEA X-Waivered to prescribe or dispense Buprenorphine	5

### Expanded Engagement and Treatment Services

Below are preliminary expected outcomes for the expanded services offered through Road to Recovery Program. As the program design evolves, additional outcomes will be identified and measured.

Outcomes	GOAL
Engagement Services: Percent of clients that have at least four clinical contacts in the first 30 days	30%
Engagement Services: Percent of clients that meet criteria for substance use treatment and/or specialty mental health services that transition to formal mental health or substance use treatment	30%
Treatment Services: Reduced hospitalizations	30%
Treatment Services: Reduced criminal justice involvement	30%
Treatment Services: Reduced substance use	30%

### Peer to Peer Tobacco Cessation Services

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

Outcomes	Goal
Number of peers receiving training to provide peer to peer tobacco cessation education and support services	10
Number of mental health clients participating in tobacco cessation education and support services	150
Percentage of clients participating in peer-led tobacco cessation education and support services who report reducing their tobacco use	40%
Percentage of clients participating in peer-led tobacco education and cessation support services who report attempting to quit using tobacco	50%
Percentage of clients who quit tobacco in peer-led cessation services and maintained their quit status at 30-day follow-up	25%
Number of County and contractor agencies that integrate tobacco cessation education and support into their programs	5

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## CRISIS CONTINUUM OF CARE

### PROGRAM OVERVIEW

The Crisis Continuum of Care consolidates MHSA funded crisis services into one Systems Development program to enhance and streamline the crisis continuum in Marin. The Crisis Planning program will be moved from Prevention and Early Intervention; the Crisis Stabilization Unit (CSU, previously known as PES) located Family Partner will be moved from CSS Adult System of Care and Children's System of Care (Youth Empowerment Services); the Crisis Residential Unit from Innovation, and the Outreach and Engagement Program from ASOC. The goal of these changes is that having a crisis continuum more clearly outlined will enable these services and the individuals receiving them to experience them as more fluid and not as barriers to access.

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. History has shown that if crises can be detected early on and the individual can be linked to appropriate services, such as crisis planning, crisis residential, or other support services, then higher level services such as CSU or acute inpatient hospitalizations can be avoided or drastically reduced. Additionally, individuals are empowered to make choices for themselves on a voluntary basis, rather than involuntary services when the crisis escalates to the level of requiring involuntary hospitalization.

#### Crisis Planning Services

Crisis planning is part of the Client Choice and Hospital Prevention program, originally funded under MHSA Innovation, and later incorporated into the Prevention and Early Intervention component of MHSA funded services. Planning services work closely with CSU and the Crisis Residential Unit. Crisis Planning aims to (1) increase clients' knowledge, skills and network of support to decrease crises; (2) provide crisis plans to The Crisis Stabilization Unit that increase the role of the client and their network of support in case of a crisis; and (3) to engage and support clients who are residing in the Crisis Residential Unit in the completion of a crisis plan. Moving this program to CSS has facilitated the coordination of crisis services in Marin. Developing and using crisis plans allows for a more recovery-oriented focus, supporting individuals in choosing how they want to engage in their recovery.

**EXPECTED OUTCOMES**

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

CSU Family Partner

CSS FY2012-13 expansion funding was approved to expand services to families of mental health clients, particularly by assisting family members of individuals evaluated at The Crisis Stabilization Unit (CSU). In partnership with the Children's System of Care, the ASOC jointly added one full-time Family Partner position to complement the work of the CSU staff, so that discharge plans can be developed with the family as a full partner. Family Partners are particularly helpful in assisting families to navigate multiple services, as well as advocating for support for the entire family. As time permits, this Family Partner will also be available to families engaged with any of the Full Service Partnerships.

**TARGET POPULATION**

The target population consists of families referred by or coming to The Crisis Stabilization Unit or Crisis Residential.

**PROGRAM DESCRIPTION**

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

## EXPECTED OUTCOMES

The family partner will track number of contacts with family members and the language in which the service was provided. The target number for each fiscal year is 100 family contacts.

### Crisis Residential – Casa René

The Crisis Residential program was initially funded under MHSA Innovation through FY2014-15 and was continued under CSS beginning in FY2015-16. The program is a 10-bed Crisis Residential program that aims to reduce unnecessary 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 offers client centered programming focused on the principles of wellness and recovery. This program is a key component of the crisis continuum of care in that it offers clients a voluntary recovery-focused residential option for crisis resolution.

## TARGET POPULATION

The target population is Medi-cal recipients, age 18 and older, experiencing a psychiatric crisis and who are able to voluntarily agree to Crisis Residential services in lieu of hospitalization.

### Outreach and Engagement

The Outreach and Engagement 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 a serious impairment in activities of daily living, social relations, and/or ability to sustain housing, but are not in crisis, are not current clients of the public mental health system; and are unwilling or unable to engage in treatment. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

The team responds to calls for assistance and provides outreach services in-home and in the community. Calls from family members are given priority. The team works closely with the County Mobil Crisis Team to ensure collaboration and avoid duplication of services. Where time permits, the team will also conduct proactive outreach to organizations, providers, and community members who may have access to and/or have knowledge about potential clients. A pool of flexible funding is available to the team members in order to purchase services and supports needed at this community-based street-level engagement phase. An important function of the team will be the provision of support and education to family members and friends of adults referred to the team.

## EXPECTED OUTCOMES

Outcomes	Goal
# Served – Outreach & Engagement team	20
# Successfully engaged in treatment –Outreach & Engagement Team	15

### Mobile Crisis Response Team

The Mobile Crisis Response Team (MCRT) was implemented in FY2015-16, supported by funding from SB82, and administered by the California Health Facilities Financing Authority. MCRT supports wellness and recovery by increasing availability and utilization of voluntary supports and services in the community. The program aims to decrease the need for law enforcement involvement in mental health and/or substance use crises as well as decreasing the need for involuntary interventions when voluntary services would be equally effective. The program currently consists of two teams, composed of clinicians and Peer Specialists, and provides crisis support seven days a week from 1-9pm.

### Transitions Team

The Transitions Team was also implemented in FY2015-16, likewise supported by funding from SB82, administered by the Mental Health Services Oversight and Accountability Commission. The team provides short-term intensive services to individuals experiencing crises in development in the community. The team also provides intensive services immediately following a crisis to support re-stabilization without further need for emergency services or involuntary treatment. The program is staffed with mental health clinicians, Peer Specialists and Family Partners. A voluntary service, the team is able to provide support, education and linkages to community services. The team is mobile and able to respond wherever needed within the county. Team staff maintains up-to-date information about community resources available to consumers and families, and provides outreach to crisis services to assure awareness of the resources available.

## **PROPOSED EXPANSION**

Both the Mobile Crisis and the Transitions teams have been well received by the community, and the need is greater than the resource as it is currently designed. This plan proposes adding two additional clinicians who are cross-trained to work for either/both of these teams, to allow for maximization of resources based on demand.

# FIRST EPISODE PSYCHOSIS PROGRAM (FEP)

## PROGRAM OVERVIEW

A Coordinated Specialty Care team for First Episode Psychosis (FEP) that emphasizes a collaborative, recovery-oriented approach between individuals who receive services (target age 15 to 30), treatment team members, and when appropriate, family members and others who can provide support. Treatment planning is collaborative, involving shared decision making and addressing the following key areas: psychotherapy, pharmacotherapy, case management, supported education and employment, coordination with primary care, and family education and support.

## TARGET POPULATION

The FEP efforts target individuals who are experiencing their first psychotic episode and are between the ages of 15-30 years old. Transitional age youth (TAY) experiencing first psychotic episodes may be referred to our TAY full service partnership program or seen in our outpatient county mental health Systems of Care in the youth system or adult system.

## PROGRAM DESCRIPTION

In order to deliver the core functions of the Coordinated Specialty Care model the team will include a team leader (1 FTE), a dedicated prescribing psychiatrist (0.2 FTE), current county staff working with these clients (0.5 FTE each, depending on need) , along with a supported education and employment specialist (0.5FTE), peer specialist, (0.5 FTE) and a family partner, (0.5 FTE).

The team leader would be an experienced clinician who will be the primary contact person for clients and families and will spearhead efforts to engage clients in treatment. Primary goals are to build a positive relationship with participants and assist them in developing their abilities for illness self-management using a shared decision making process to develop and modify treatment plans. This position would provide support, outreach, education, consultation, and basic services to participants and their families as well as possess the ability to identify primary psychosis and perform differential diagnoses for psychosis in consultation with the Access Team and the county Crises Stabilization Unit (CSU). This team leader would also monitor, oversee, and supervise the team-based process.

The two part time Mental Health Practitioners/case managers would be current staff working in the Children's mental health and Adult mental health systems identified as part of this FEP team so as to coordinate and consult with the team. They would use evidenced based practices such as CBT for psychosis and help clients clarify goals, cope with stressful situations, interact more effectively with other people, and in general, overcome barriers to their recovery using case management interventions as needed. The Supported Education and Employment Specialist, (0.5 FTE) would focus on assisting participants to continue, resume, or adapt their academic or vocational activities successfully. The TAY Peer Specialist, (0.5 FTE) with lived experience with mental health services and would help carry out recovery support functions, treatment, and treatment planning and meet regularly with the team, provide one-on-one counseling/support, and lead one or more peer support and/or family psycho-education groups. The Family Partner, (0.5 FTE) would help in navigating the

mental health system for a loved one and help carry out recovery support functions, treatment, and treatment planning and provide education, support, and liaison services for families, and lead family psycho-education groups.

## **EXPECTED OUTCOMES**

Develop the Coordinated Specialty Care Team and establish regular meetings, consultation and channels of communication between the team members working with FEP clients in at least three of the following settings by June 30, 2018: Children's Mental Health System, Adult Mental Health System, Sunny Hills TAY Program, Access Team and CSU.

The Child, Adult, TAY Program, Crises Stabilization Unit and Access teams will be trained and able to screen as appropriate those suspected of a FEP within the specified age range to increase positive identification of psychosis and facilitate connection to county mental health services as evidenced by at least two or more contacts beyond the diagnostic assessment.

# CONSUMER OPERATED WELLNESS CENTER

## PROGRAM OVERVIEW

Since 2006, the Enterprise Resource Center (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 had outgrown its space and management infrastructure. MHSA funding has supported adding new consumer management positions, locating the ERC at the Health & Human Services Health and Wellness Campus, and increasing consumer staffing to enable the ERC to increase its hours of operation to seven (7) days a week. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, increase social supports and reduce isolation.

Since the ERC Expansion, the number of client visits per month has increased from 600 to over 1,500. 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.

The MHSA Three Year Plan (FY2014-17) established funding to develop a Wellness and Recovery Program to serve individuals who are actively working on their recovery, including those who no longer require intensive case management services provided by Marin's Adult System of Care (ASOC).

## TARGET POPULATION

The target population of the center is transition-age youth (18+), adults and older adults who have serious mental illness. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

## PROGRAM DESCRIPTION

The center will be consumer staffed and operated and provide an array of classes, peer support, skill-building, and activities focused on recovery, illness self-management, and self-sufficiency. It must be accessibly located and meet Americans with Disabilities Act accessibility standards.

The program design should:

1. Meet or substantially meet the definition of a consumer-operated service (COS): "a peer-run program or service that is administratively controlled and operated by the mental health consumers and emphasizes self-help as its operational approach" (U.S. Department of Health and Human Services, 1998). See "Consumer-Operated Services: The Evidence"

(<http://store.samhsa.gov/product/SMA11-4633CD-DVD>) for further discussion of key components of a COS, such as:

- Consumer control
- Member-run activities
- Participatory leadership
- Voluntary participation
- Peer support
- Experiential learning
- Recovery orientation
- Culturally competent, safe, non-judgmental services

2. Operate under, or incorporate key elements of, the International Center for Clubhouse Development (ICCD) model. Details about the model can be found on the ICCD website (<http://www.iccd.org>) and SAMHSA's NREPP website ([www.http://www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov)). Key elements include:

- Participants operate as “members” with rights and responsibilities
- “Work-ordered day” that structures the daily activities and participation
- Day to day operation is the responsibility of members and staff who work side by side in a rehabilitative environment
- Access to transitional, supported and independent employment
- Access to community support, such as housing and medical services
- Assistance in accessing educational resources
- Ongoing outreach to maintain contact with active members
- Participation in program decision-making and governance
- Evening, weekend and holiday social programs

The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, increase social supports and reduce isolation. The program will have access to ASOC resources and staff as needed for consultation and assistance. In addition, the center should provide Peer Case Management services.

**EXPECTED OUTCOMES FY2017-18**

The program is expected to serve at least 50 individuals each year.

Individuals participating in the center are expected to show an increase in wellness and recovery, such as:

- Increased access to employment and volunteer activities
- Reduced use of more intensive services, including hospitalization
- Reduced homelessness
- Reduced arrests and incarceration
- Improved quality of life
- Increased resiliency factors, such as social support

# HOUSING

## PROGRAM OVERVIEW

In August 2007, the State Department of Mental Health released the guidelines for the Mental Health Services Act (MHSA) Housing Program (MHS AHP), a collaborative program administered by the California Housing Finance Agency and the State Department of Mental Health. MHS AHP funds can be used to build or renovate rental housing or shared housing. Rental housing developments are defined as, apartment complexes with five (5) or more units, where each person or household has his/her own apartment. Shared housing is defined as; each resident has a lockable bedroom in a house or apartment that is shared with other housemates. MHS AHP housing must be permanent supportive housing. 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. MHS AHP funds must be used for housing adults with serious mental illness or children with severe emotional disorders and their families. In order to qualify for MHS AHP housing, an individual/family/household must also be homeless or at risk of becoming homeless, as defined by MHS AHP regulations. The household must be able 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 MHS AHP funds to leverage a set-aside of five (5) furnished housing units (studio and one-bedroom) for seniors in the Fireside Apartments. Fireside Apartments are a 50-unit affordable housing development for low-income families and seniors located in Mill Valley. The MHS AHP 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 identified as traditionally unserved or underserved by the mental health system. Many of whom have a co-occurring substance use disorder, as well as complex and often untreated physical health disorders. Individuals may have negative background information and poor tenant histories as a result of their disability and lack of access to services. 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. The tenants of the MHS AHP-funded units are eligible to participate in community activities offered at the Fireside Apartments by Homeward Bound of Marin. Homeward Bound of Marin is a community-based non-profit organization that is the main provider of shelter and support services for families and individuals who are homeless or at-risk of homelessness in Marin County.

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

## **ACTUAL OUTCOMES – Fireside Senior Apartments**

During FY2015-16, all five (5) Fireside Senior Apartment MHS AHP-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.

## **CALIFORNIA HOUSING FINANCE AGENCY (CalHFA) – Unspent Housing Funds**

Since the completion of the Fireside Senior Apartment project in 2010, the unspent housing funds of approximately \$1,400,000 remained with CalHFA pending identification of a new housing project. Since any proposed housing project had to follow CalHFA requirements as well as be feasible in Marin’s high-cost housing market, it has been very difficult to find a project to fit the available funding.

In January of 2015 the Department of Health Care Services (DHCS) released Information Notice No. 15-004 which allowed each County the option to request the release of unspent MHSA Housing Program funds back from CalHFA. Counties must spend the released MHSA Housing Program funding to provide “housing assistance” to the target populations identified in W&I Code Section 5600.3 (W&I Code Section 5892.5 (a) (1)). Housing assistance is defined as rental assistance or capitalized operating subsidies; security deposits, utility deposits, or other move-in cost assistance; utility payments; moving cost assistance; and capital funding to build or rehabilitate housing for persons who are seriously mentally ill and homeless or at risk of homelessness (W&I Code Section 5892.5 (a)(2)).

Now that the County could request the funding be returned and used for housing outside of the CalHFA requirements, the MHSA Advisory Committee convened a meeting in September of 2015 that included participants with housing development experience in Marin to educate the committee on the challenges and recommendations from experts who were familiar with successful 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.

The overall feedback from the experts was that housing projects are very difficult in Marin and while \$1.4 million may seem like a lot of money, it doesn’t buy much in Marin County. The MHSA Advisory Committee agreed that the preference would be to use the funds for a permanent housing project versus using it for subsidies or rental assistance at this time.

In May 2016 at the direction of the Behavioral Health and Recovery Services Director, and with the support of the MHSA Advisory Committee, the Board of Supervisors approved the release of unencumbered Mental Health Services Act Housing Program funds held by CalHFA to be returned to the County of Marin.

In October 2016 Marin County submitted the necessary paperwork and a copy of the May 2016 Board of Supervisors approval to release and return the CalHFA funds. In late December 2016 the County was notified that funds totaling \$1,493,655.94 were being sent overnight to Marin County.

Upon receipt of the funds, Marin County has three (3) years to spend the funding before it would revert back to the State.

## **PROGRAM CHALLENGES**

While Marin's housing market continues to be extremely challenging to penetrate, we continue to look for creative housing solutions/projects for the MHSA Housing funds. By having the funding available with the County we will be better positioned to use the funds should a housing development opportunity present itself.

**In FY2016-17**, Behavioral Health and Recovery Services will continue to look for permanent housing project opportunities to use the MHSA Housing funds.

**In FY2017-18**, if by the end of FY2017-18 a housing project has not been identified; Behavioral Health and Recovery Services will begin discussing with the MHSA Advisory Committee what other housing options may need to be reviewed if a permanent housing option is still unidentified to ensure use of the funding before reversion occurs in December 2019.

## MHSA COMMUNITY SERVICES AND SUPPORTS (CSS) MHSA THREE YEAR PLAN (FY2017-18 THROUGH FY2019-20)

Program	FY2017-18	FY2018-19	FY2019-20	Total
FSP-01 Youth Empowerment Services (YES)	\$668,704	\$668,704	\$668,704	\$2,006,111
FSP-02 Transitional Age Youth (TAY) Program	\$550,176	\$550,176	\$550,176	\$1,650,529
FSP-03 Support and Treatment After Release (STAR)	\$535,233	\$535,233	\$535,233	\$1,605,700
FSP-04 Helping Older People Excel (HOPE)	\$873,973	\$873,973	\$873,973	\$2,621,918
FSP-05 Odyssey	\$1,321,526	\$1,321,526	\$1,321,526	\$3,964,578
FSP-06 Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT)	\$691,702	\$691,702	\$691,702	\$2,075,106
SDOE-01 Enterprise Resource Center (ERC)	\$357,809	\$357,809	\$357,809	\$1,073,426
SDOE-07 Adult System of Care (ASOC)	\$825,504	\$825,504	\$825,504	\$2,476,511
SDOE-08 Co- Occurring Capacity	\$326,734	\$326,734	\$326,734	\$980,201
SDOE-09 Crisis Continuum of Care	\$1,101,325	\$1,101,325	\$1,101,325	\$3,303,975
SDOE-10 First Episode Psychosis (FEP) - NEW	\$159,763	\$159,763	\$159,763	\$479,289
SDOE-11 Consumer Operated Wellness Center (Step Up)	\$262,591	\$262,591	\$262,591	\$787,774
<b>Subtotal</b>	<b>\$7,675,040</b>	<b>\$7,675,040</b>	<b>\$7,675,040</b>	<b>\$23,025,120</b>
MHSA Coordinator (Coordinator and Ethnic Services Manager)	\$235,852	\$235,852	\$235,851	\$707,555
FSP Program Support - NEW	\$229,425	\$229,425	\$229,425	\$688,275
Administration and Indirect	\$1,495,350	\$1,495,350	\$1,495,350	\$4,486,050
Operating Reserve	\$0	\$0	\$0	\$0
<b>Total</b>	<b>\$9,635,667</b>	<b>\$9,635,667</b>	<b>\$9,635,667</b>	<b>\$28,907,000</b>

	FY2017-18	FY2018-19	FY2019-20	Total	%
<b>County</b>	\$4,468,311	\$4,468,311	\$4,468,311	\$13,404,933	46%
<b>Contract Provider</b>	\$3,672,006	\$3,672,006	\$3,672,006	\$11,016,018	38%
<b>Administration and Indirect</b>	\$1,495,350	\$1,495,350	\$1,495,350	\$4,486,050	16%
<b>Total</b>	<b>\$9,635,667</b>	<b>\$9,635,667</b>	<b>\$9,635,667</b>	<b>\$28,907,000</b>	<b>100%</b>

<b>Full Service Partnership (FSP)</b>	50.55%	50.55%	50.55%
<b>System Development Outreach and Engagement (SDOE)</b>	49.45%	49.45%	49.45%
<b>Total</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>

## MHSA THREE YEAR PLAN (FY2017-18 THROUGH FY2019-20) NUMBERS TO BE SERVED IN FY2017-18

	Program		FY2017-18 Projected	FY2017-18 Cost Per Person
FSP-01	Youth Empowerment Services (YES)	FSP	40	\$16,718
FSP-02	Transition Age Youth (TAY)	FSP	25	\$22,007
		Partial	90	
FSP-03	Support and Treatment After Release (STAR)	FSP	60	\$8,921
FSP-04	Helping Older People Excel (HOPE)	FSP	60	\$16,649
FSP-05	Odyssey (Homeless)	FSP	60	\$14,566
FSP-06	Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT)	FSP	40	\$17,293
SDOE-01	Enterprise Resource Center (ERC)	SDOE	200	\$1,789
SDOE-07	Adult System of Care (ASOC)	SDOE	1,200	\$688
SDOE-08	Co-Occurring Capacity			
SDOE-09	Crisis Continuum of Care	SDOE		
SDOE-10	First Episode Psychosis (FEP)	SDOE	25	\$6,391
SDOE-11	Consumer Operated Wellness Center	SDOE	50	\$5,252
	Housing		5	
PEI-1	Early Childhood Mental Health Consultation (ECMH)	O	130	\$846
		P	80	\$1500
PEI-4	Transition Age Youth (TAY) PEI	P	100	\$700
		EI	250	\$400
PEI-5	Latino Community Connection	AL	400	\$58
		O	1015	\$95
PEI-7	Older Adult Prevention and Early Intervention	EI	200	\$1000
		O	100	\$300
PEI-11	Vietnamese Community Connection	EI	50	\$2520
		O	155	\$103
PEI-12	Community and Provider PEI Training	P	100	\$400
		O	310	\$427
PEI-18	School Age Prevention and Early Intervention Programs	O	490	\$135
		P	330	\$848
PEI-19	Veteran's Community Connection	AL	120	\$500
PEI-20	Statewide PEI (CalMHSA)	SDR	NA	NA
PEI-21	Suicide Prevention	SP	8000	\$19
PEI-22	Health Navigator	AL	50	\$2964

**FSP** = Full Service Partnership    **SDOE** = System Development Outreach and Engagement

**P** = Prevention    **EI** = Early Intervention    **AL** = Access and Linkage    **SP** = Suicide Prevention

**O** = Outreach to Recognize Signs and Symptoms    **SDR** = Stigma and Discrimination Reduction

PROGRAM CONTINUATION

PROGRAM EXPANSION

NEW PROGRAM

## WORKFORCE EDUCATION AND TRAINING (WET)

### 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:

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

In Marin some of the key strategies have included providing stipends, training and mentoring to assist interested consumers and family members to enter the public behavioral healthcare workforce; providing stipends for bilingual and bicultural interns through partner CBOs and BHRS' 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 provider, family members. The intent is to be inclusive and to reach beyond the traditional training of the “professional” staff in the public mental health system. The Consumer and Family Sub-committees guide and direct and create trainings for their respective populations and fully participate in the process.

## PROGRAM DESCRIPTION

The WET Plan was amended in FY2015/16 to better align and reflect its strategies based on BHRS' identified workforce education and training needs and goals. The amended goal of WET 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”**. A set of tactics has been implemented which includes:

1. Graduate Clinical Internship Program- Recruit and retain culturally/linguistically diverse interns to provide clinical services throughout the division, especially in program areas where there is persistent under-penetration of un/underserved racial/ethnic communities such as the Latino population.
2. Scholarships for Consumers and Family Members-Offer scholarships to culturally diverse consumers/family members to complete a vocational/certificate course in mental health, substance use and/or domestic violence peer counseling.
3. Peer Mentoring- Recruit and retain peer mentors with lived experience to provide support to scholarship recipients who are attending vocational/certificate courses in mental health, AOD and/or domestic peer counseling to ensure that recipients successfully complete their coursework.
4. Peer Specialist, domestic violence and substance use Intern Stipend Program- Offer internship stipends to mental health, substance use and domestic violence peer counselor graduates who are placed in public behavioral healthcare settings.
5. Consumer-Focused Trainings- Develop and implement advocacy training course for un/underserved racially/ethnically and culturally diverse peer specialists/counselors and adult BHRS consumer populations. Also, implement WRAP program that will be taught by former consumers who have completed WRAP certification program.
6. System-wide Dual Diagnosis Training- Develop a comprehensive system-wide substance use training and consultation plan for BHRS clinical staff and its agency partners. Also, develop and implement a co-occurring peer education certification course for consumers/family members interested in becoming mental health peer counselors/specialists.
7. Development of BHRS Peer Counselor classified positions- In collaboration with Human Resources, develop Peer Counselor I, II and Peer Supervisor job classifications and positions. Also, develop a collaborative pilot project with the department's Human Resources that will enhance recruitment, application reviews, interview and hiring processes and practices that will increase a culturally diverse applicant pool to compete for available BHRS job opportunities.
8. Training/Workshop Initiatives- Provide a series of introductory-level course/trainings on culture-specific topics. Also, continue to provide evidenced-based trainings such as Motivational Interviewing, Non-Violent Crisis Intervention and Trauma Informed System, Interpreter and the Use of Interpreter trainings, and Mental Health First Aid, all of which includes cultural competency principles.

9. Team Development- Contract with an organizational consultant/trainer/facilitator with cross-cultural expertise to engage staff throughout the organization on team building-related activities, discussions and planning related to diversity for the purpose of fostering, promoting and creating an inclusive organizational work culture and environment.

10. Curriculum Development- Participate in a Bay Area Workforce Co-Learning Collaborative (WCC) to develop a training curriculum for employers to support consumers and family members in the workplace.

11. State-wide WET Collaboration and Partnership- Continue to attend and participate in regional and state-wide WET-related policy, program and planning through the California Institute for Behavioral Health Solutions (CIBHS).

12. Advisory Committee- Continue to meet with WET Steering Committee monthly and to ensure fair and equitable representative voices from BHRS, agency partners and consumers/family members. See Appendix X – Workforce Education and Training (WET) Steering Committee Members.

**EXPECTED OUTCOMES**

- To sustain current level of outreach, recruitment, placement and retention of culturally diverse pool of approximately 12-15 graduate interns annually.
- To continue to offer scholarship awards to approximately 75 consumers and family members with lived experience to enter into the behavioral healthcare workforce as certified mental health peer specialists/family partners, substance use counselors and/or domestic violence counselors.
- To continue to provide mentoring support to awarded scholarship recipients to ensure successful completion of their coursework by maintaining 5-7 mentors with lived experience each fiscal year.
- To increase the number of internship and employment sites to five (5) by promoting the value and effectiveness of peer counseling programs among BHRS’ contract agency partners. Interns will be incentivized by BHRS’ continued offering of internship stipends to approximately 50 qualifying students.
- To establish a consumer/peer-operated, run and administered consumer advocacy course and system in BHRS.
- To provide a combination of 10-15 culturally appropriate, evidenced-based and community-defined best practice trainings annually for BHRS staff, contract agency partners, consumers and family members.
- To provide 2-3 co-occurring-related trainings for BHRS clinical staff and its contract agency partners

- To continue to support Integrated Community Services' Co-occurring Peer Education (COPE) and Community Action Marin's Peer Counseling certification course programs for interested consumers/family who are interested in entering the county's behavioral healthcare workforce as peer specialists/family partners. Approximately 50 enrolled students will successfully graduate from one of the course programs and advance into a volunteer, internship or paid employment opportunities.
- Fully implement BHRS' first-ever classified peer counselor positions within the organization by recruiting, hiring and retaining qualified consumers/family members to work in identified service programs and work units as Peer Counselor I and II.

**MHSA WORKFORCE EDUCATION AND TRAINING (WET)  
MHSA THREE YEAR PLAN (FY2017-18 THROUGH FY2019-20)**

Program	FY2017-18	FY2018-19	FY2019-20	Total
Scholarships for Underserved Consumers & Family Members	\$40,000	\$40,000	\$40,000	\$120,000
Consumer/Family Member Training Initiatives	\$55,000	\$55,000	\$55,000	\$165,000
Peer Mentoring	\$50,000	\$30,000	\$10,000	\$90,000
BHRS Intern Stipends	\$203,200	\$203,200	\$203,200	\$609,600
Peer Specialist and AOD Intern Stipend Program	\$35,000	\$35,000	\$25,400	\$95,400
<b>Total</b>	<b>\$383,200</b>	<b>\$363,200</b>	<b>\$333,600</b>	<b>\$1,080,000</b>

One-Time Funding Sources:	
Estimated Prior Year Unspent WET Funds	\$80,000
From CSS Funds	\$1,000,000
<b>TOTAL</b>	<b>\$1,080,000</b>

PROGRAM CONTINUATION  PROGRAM EXPANSION  NEW PROGRAM

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

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

Marin’s second Innovation Plan was approved by the MHSOAC on April 28, 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 LGBTQ TAY, TAY 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 FY2014-15 through FY2016-17, 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.

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 BHRS' work going forward. This may mean changes to BHRS policies, services, and/or funding priorities. To review the complete Innovation Plan go to [www.marinhhs.org/innovation](http://www.marinhhs.org/innovation).

Program Continuation  Program Expansion  New Program

## CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

### PROGRAM OVERVIEW

In 2008, the State Department of Mental Health released the guidelines for the MHSA Capital Facilities and Technology Component (CFTN). CFTN goals and projects are essential in supporting the development of an integrated infrastructure to modernize clinical and administrative systems, which in turn increases operational efficiency, cost effectiveness, and coordination of client care. Capital Facilities allows counties to acquire, develop or renovate buildings to house and support MHSA programs. Funds may also be used to develop community-based, less restrictive settings that will reduce the need for incarceration or institutionalization. Technological Needs supports counties in transforming and modernizing clinical and administrative information systems as well as increasing consumer and family member's access to health information within a variety of public and private settings. The planned use of the Capital Facilities and Technological Needs funds should produce long-term impacts with lasting benefits that move the mental health system towards MHSA goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups. Marin's initial CFTN planning process did not identify any capital improvement projects, so focus was placed on identifying and addressing growing technology needs.

### PROGRAM DESCRIPTIONS

#### Capital Facilities

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

#### Technological Needs

Our Technological (TN) goals for this three year planning cycle are to implement the software tools needed to be responsive to the enhanced data collection requirements and oversight by Federal and State entities.

With the TN Project, Marin County will continue to improve the flexibility of our electronic medical record system to have relevant and meaningful data accessible when working with and preparing for their consumers best outcomes. Marin County will also be improving the effectiveness of our practice management system to ensure that we are prepared for the upcoming shift to value based payments and improve the effectiveness, and efficiency of our claims.

Marin's TN Project is designed to use technological resources and strategies to increase consumer and family member' access to health information and records electronically in public and private

settings and modernize and transform clinical and administrative information systems through the follow components:

- 1) Implement Disaster recovery preparedness plan;
- 2) Perform any necessary Electronic Health Record (EHR) upgrades to remain compliant with current and future services standards such as MIPS, value based billing;
- 3) Perform any necessary upgrades to produce claims that meet all billing requirements in a timely and efficient manner; and
- 4) Participation in the HIE (Health Information Exchange) for consumers who opt into this network to support integrated care.

## **PROGRAM EXPANSION**

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

### ***Electronic Health Record and Disaster Recovery***

In the course of maintaining our existing infrastructure we are moving to a Virtualized environment to host our existing systems. This will modernize our server infrastructure and provide better backups with a quicker recovery timeline as well as a more robust disaster recovery plan allowing us to host our systems from multiple sites in the event of a disaster.

### ***Practice Management Upgrade***

Marin is looking for a complete, responsive, and efficient billing system. One that handles California Medi-Cal billing rules at the County level with the ability to process claims for Managed Care and Mental Health as well as the current and future billing trends value based payment methodologies.

We are hoping to find software that can provide our functional billing requirements within the software itself, and will respond quickly to bugs and new features that aid in compliance, timeliness, and tracking efforts.

### ***Electronic Health Record Upgrade***

We are preparing for the most current and future clinical requirements so that we can take as many opportunities to best serve our consumers in efforts such as Whole Person Care activities. Marin County will continue to focus on supporting our clinician's at the point of care with improved decision support for our providers to have relevant and meaningful data accessible when working with and preparing for their consumers best outcomes. We are looking for an EHR software program that is flexible, efficient, and modern.

### ***Integration of Practice Management and Electronic Health Record Software***

Marin will be evaluating and pursuing an integrated Practice Management and Electronic Health Record suite of software to improve the quality and operational efficiencies of our documentation and claiming processes as well as deliver actionable information at the point of care in an efficient and effective manner to support our clinical staff in providing the best care.

## EXPECTED OUTCOMES

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

- Improve integration of our Practice Management and Electronic Health Record systems.
- Capture all records in a digital format to make all current records entirely electronic including client signatures, information exchanges, and reports.
- The implementation of electronic transfer of information, including: laboratory information, medication information, and participation in the health information exchange, for consumers who opt into this network, to improve integrated care.
- Moving toward field capable service delivery, possibly mobile solutions.
- Staying current with Federal clinical quality documentation and reporting standards.
- Participation in the Health Information Exchange for consumers who opt into this network.

**MHSA CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)  
MHSA THREE YEAR PLAN (FY2017-18 THROUGH FY2019-20)**

Program	FY2017-18	FY2018-19	FY2019-20	Total	Description of Project
Practice Management	\$261,356	\$261,356	\$261,355	\$784,067	For implementation of a new Practice Management and Billing system to meet federal and state requirements and increase system capability for analytics, data outcome reports, and interoperability.
Electronic Health Record System Enhancements	\$305,311	\$305,311	\$305,311	\$915,933	System enhancements 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
<b>Total</b>	<b>\$566,667</b>	<b>\$566,667</b>	<b>\$566,666</b>	<b>\$1,700,000</b>	

One-Time Funding Sources	
<b>Estimated Prior Year Unspent CFTN Funds</b>	<b>\$1,200,000</b>
<b>One-time MHSA Accrued Interest</b>	<b>\$ 500,000</b>
<b>Total</b>	<b>\$1,700,000</b>

## TOTAL MHSA FUNDING ALLOCATION MHSA THREE-YEAR PLAN (FY2017-2018 through FY2019-2020)

Components	FY2017-18	FY2018-19	FY2019-20	Total	
Community Services and Support (CSS)	\$9,635,667	\$9,635,667	\$9,635,667	\$28,907,000	a)
Prevention and Early Intervention (PEI)	\$2,296,000	\$2,296,000	\$2,296,000	\$6,888,000	b)
Workforce Education and Training (WET)	\$383,200	\$363,200	\$333,600	\$1,080,000	c)
Capital Facilities and Technological Needs (CFTN)	\$566,667	\$566,667	\$566,666	\$1,700,000	d)
Innovation (INN)	\$517,000	\$517,000	\$517,000	\$1,551,000	e)
<b>Total MHSA Funds Allocated</b>	<b>\$13,398,534</b>	<b>\$13,378,537</b>	<b>\$13,348,933</b>	<b>\$40,126,000</b>	

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

- a) Increase in funding for CSS is from MHSA CSS growth funds.
- b) Increase in funding for PEI is from MHSA estimated prior year unspent PEI funds.
- c) Increase in funding for WET is from CSS funds and estimated prior year unspent WET funds.
- d) Increase in funding for CFTN is from estimated prior year unspent CSS funds and one-time MHSA accrued interest.
- e) These INN funds have not been allocated for community planning through this plan submission. Community planning for these funds will start in FY2017-18. These funds do not include INN funds already allocated for existing programs.
- f) Approximately \$1.4m of CSS Housing funds are still available.
- g) Local Prudent Reserve are funds that have been set aside for use when MHSA funds are below recent averages adjusted by changes in the State population and the California Consumer Price Index, pursuant to WIC section 5847, subdivision (b)(7). Use of the funds requires State approval.

## APPENDIX I

### MHSA ADVISORY COMMITTEE MEMBERS

First Name	Last Name	Agency/Affiliation	Committee Representation
Nick	Avila	BHRS - Odyssey FSP	Social Services
Kay	Browne	Family Member	Family Member
Brian Hyun	Cho	Provider for Developmentally Disabled	Asian/Pac. Islander
Barbara	Coley	Community Action Marin	Family Member Consumer Peer Advocacy
Sandra	Fawn	Consumer/Family Member Mental Health Board	Consumer Family Member
Maya	Gladstern	Community member	Consumer MH Clients Peer Advocacy
Karin	Jinbo	Novato Unified School District	Education
Laura	Kantorowski	Bay Area Community Resources	Substance Use Mental Health Provider
Carol	Kerr	Intern Program	Education Family Member Substance Use Mental Health Workforce Dev.
Vinh Q.	Luu	Marin Asian Advocacy Project	Asian Community Social Services
Amira	Mostafa	Tam High School	Education
Lynn	Murphy	San Rafael Police Department	Law Enforcement LGBTQ
Mark	Parker	Community Action Marin	Consumer
Lisa	Peacock Compton	Enterprise Resource Center	Consumer Peer Advocacy
Sandra	Ponek	Canal Alliance	Low Income Latino Community Provider
Sandra	Ramirez Griggs	BHRS - Youth and Family Services	Early Childhood Youth
Robert	Reiser	NAMI	NAMI
Heather	Richardson	San Geronimo Valley Community Center	Family Member West Marin
Victoria A.	Sanders	Veterans	Veterans Veterans Organizations Sexual Trauma Victims Northern Marin
Brian	Slattery	Marin Treatment Center	Co-Occurring MH/SUS LGBTQ
Marisa	Smith	Community Action Marin - WRAP	Consumer
Jasmine	Stevenson	Huckleberry Youth Programs	Youth Education
Gail	Theller	Community member	LGBTQ Client Family Older Adult

## APPENDIX - II

# Mental Health Services Act Three Year Planning

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San Rafael Community Meeting  
December 5, 2016  
10:00 a.m. to 12:00 p.m.

### Agenda

10:05 Welcome

10:10 MHSA Overview

10:30 Break Out Session I

- Consumers
- Family Members
- Community Members
- Providers

11:00 Report out

11:15 Break Out Session II

- Reaching Underserved Cultural Communities
- Integrating Mental Health and Substance Abuse Services
- Housing for individuals with mental illness
- Crisis Services/Suicide Prevention
- First Episode Psychosis

11:35 Report out

11:45 Thank you and next steps

12:00 Adjourn

# Ley de Servicios de Salud Mental Planificación de Tres Años

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Reunión Pública de Marin

Agenda

Bienvenidos

MHSA Visión de Conjunto- Mary Roy

Sesión I

- Consumidores
- Familiares
- Miembros de la Comunidad
- Providers

Relato

Sesión II

- Alcanzar a las Comunidades Culturales Marginadas
- Integración de Servicios de Abuso de Sustancias y Salud Mental
- Vivienda para las Personas con Enfermedad mental
- Servicios de Crisis / Prevención del Suicidio
- Psicosis Primer Episodio

Relato

Gracia y próxima etapas

Aplazar

## APPENDIX - II

### Mental Health Services Act (MHSA) Three-Year Planning Al Boro Community Center December 5, 2016

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

**Your Gender:**

1. Female       2. Male       3. Other

**Your Age:**

- 0 – 15 years old     16 – 25 years old  
 26 – 59 years old    60+ years old

**Your Primary Language:**

1. English       2. Spanish       3. Cantonese       4. Arabic  
 5. Farsi       6. Hmong       7. Mandarin       8. Russian  
 9. Cambodian     10. Tagalog       11. Vietnamese  
 12. More than one language       Other (please specify) \_\_\_\_\_

**Your Race / Ethnicity:**

1. White       2. Hispanic/Latino     3. Asian       4. Native  
 5. Pacific Islander     6. African/American     7. More than one race/ethnicity  
 8. Other (please specify) \_\_\_\_\_

**Where do you live in Marin County?**

1. Central Marin     2. Northern Marin     3. Southern Marin  
 4. West Marin       5. Other (please specify) \_\_\_\_\_

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

1. Homeless       2. Law Enforcement     3. LGBTQ       4. Veterans  
 5. Someone who uses/has used Mental Health and/or Substance Use Services  
 6. Family Member of someone who uses/has used Mental Health and/or Substance Use Services  
 7. Provider of Mental Health and/or Substance Use Services  
 8. Other (please specify) \_\_\_\_\_

## APPENDIX - II

Ley de Servicios de Salud Mental (MHSA)  
Reunión Pública  
December 5, 2016

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

Su sexo:

1. Femenino       2. Masculino       3. Otro

Su edad:

- 0 – 15 años de edad       16 – 25 años de edad  
 26 – 59 años de edad       60 años de edad o mayor

Su idioma principal:

1. Inglés       2. Español       3. Cantonés       4. Árabe  
 5. Farsi       6. Hmong       7. Mandarín       8. Ruso  
 9. Camboyano       10. Tagalog       11. Vietnamita  
 12. Más de uno Idioma       Otro \_\_\_\_\_

Su raza / origen étnico:

1. Blanco       2. Hispano/Latino       3. Asiático       4. Nativo  
 5. Isleño del Pacífico       6. Afroamericano       7. Más de una raza/etnia  
 8. Otra (por favor especifique) \_\_\_\_\_

¿Dónde vive usted en el Condado de Marin?

1. Centro de Marin       2. Norte de Marin       3. Sur de Marin  
 4. Oeste de Marin       5. Otro (por favor especifique) \_\_\_\_\_

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

1. Sin hogar       2. Cuerpos policiales       3. LGBTQ       4. Veteranos  
 5. Alguien que usa/ha usado servicios de salud mental y/o contra abuso de sustancias  
 6. Familiar de alguien que usa/ha usado servicios de salud mental y/o contra abuso de sustancias  
 7. Proveedor de servicios de salud mental y/o contra abuso de sustancias  
 8. Otro (por favor especifique) \_\_\_\_\_

## APPENDIX - II

**Đạo luật về Dịch vụ Y tế Tâm thần (Mental Health Services Act (MHSA))**  
**Buổi họp Công cộng tại Trung tâm Albert J. Boro Community Center, San Rafael, CA**  
**December 5, 2016**

Quận Marin cam kết sẽ nói chuyện với tất cả những người dân trong khắp quận hạt. Những câu trả lời của các bạn sẽ giúp chúng tôi biết là đã được nghe từ những ai và cần phải tiếp cận đến những ai.

**Giới phái của bạn:**

- Nam  Nữ

**Tuổi của bạn:**

- 0 – 15 tuổi  16 – 25 tuổi  
 26 – 59 tuổi  60 tuổi hoặc hơn

**Ngôn ngữ chính của bạn:**

- Ả rập  Chăm bốt  Quảng đông  Anh ngữ  
 Farsi  H' Mông  Quan thoại  Nga ngữ  
 Tây ban nha  Phi luật tân  Việt nam  
 Ngôn ngữ khác (xin nói rõ) \_\_\_\_\_

**Chủng tộc của bạn:**

- Mỹ gốc Châu Phi  Á đông  Tây ban nha  Thổ dân  
 Thái bình dương  Da trắng  Lai  
 Chủng tộc khác (xin nói rõ) \_\_\_\_\_

**Bạn sống ở vùng nào trong Quận Marin?**

- Trung Marin  Bắc Marin  Nam Marin  
 Tây Marin  Vùng khác (xin nói rõ) \_\_\_\_\_

**Bạn thuộc bất cứ nhóm nào sau đây trong cộng đồng của chúng ta? (đánh dấu tất cả những gì áp dụng)**

- Vô gia cư  Thi hành Luật Pháp  Đồng giới, Chuyển giới  Cựu chiến binh  
 Một người đang/đã sử dụng Dịch vụ Y tế Tâm thần và/hoặc Dịch vụ Cai nghiện  
 Thành viên gia đình của một người đang/đã sử dụng Dịch vụ Y tế Tâm thần và/hoặc Dịch vụ Cai nghiện  
 Nhà Cung cấp Dịch vụ Y tế Tâm thần và/hoặc Dịch vụ Cai nghiện  
 Khác (xin nói rõ) \_\_\_\_\_

**APPENDIX - II**

**Marin County MHSA  
Three-Year Community Planning  
Process  
FY2017-FY2020**



WELLNESS • RECOVERY • RESILIENCE

# Mental Health Services Act

## Historical Overview

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- Local systems stretched beyond capacity
- Consumers and family members without adequate care
- Need for mental health to be addressed with the same urgency as health care

# Proposition 63

## The Mental Health Services Act

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- Grassroots advocates statewide gathered signatures for an initiative on the November 2004 ballot
- The proposition passed, and became the Mental Health Services Act (MHSA)
- 1% tax on income over \$1 million

# Mental Health Services Act: Transformational Concepts

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- Community Collaboration
- Cultural Competence
- Client and family-driven programs and interventions
- Specific attention to individuals from underserved communities
- Integrated service experience for individuals and their families
- Wellness recovery and resilience
- Outcomes-based program design

# Client Driven Programs and Services

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- Client driven programs and services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and definition and determination of outcomes

# Mental Health Services Act:

## The Purpose

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- Define serious mental illness as a condition deserving priority attention
- Reduce long-term adverse impact on individuals resulting from untreated mental illness
- Expand successful innovative services, including culturally and linguistically competent approaches for underserved populations
- Provide funds to adequately meet needs of children/adults /older adults who can be identified/enrolled in programs under this measure
- Ensure funds expended in the most cost-effective manner and services provided in accordance with recommended best practices

# Mental Health Services Act

## Components

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- Community Services & Supports (CSS)
  - Full Service Partnerships (FSP)
  - Systems Development
  - Outreach and Engagement
  - MHSA Housing Program
- Prevention & Early Intervention (PEI)
- Workforce Education & Training (WET)
- Capital Facilities & Technology Needs (CFTN)
- Innovation (INN)

# Community Supports and Services

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- Target populations:
  - Seriously Emotionally Disturbed Children and Youth
  - Adults and Older with a Serious mental disorder, which is severe in degree and persistent in duration examples include: schizophrenia, bi-polar disorder and major affective disorder

Full Service Partnerships

# Doing “Whatever it Takes”

## Full Service Partnerships

---

- 282 consumers served FY2015/16
  - o Five Full Service Partnerships now fully staffed
    - Two additional BOS-approved positions in recruitment
    - New positions will increase Full Service Partnership capacity by 30 treatment slots
    - New clinic site opening in Novato to house Full Service Partnership teams
  - o Thirty Seven (37) new consumers entered Full Service Partnership services since February 2016

282

Consumers served  
FY2015-16

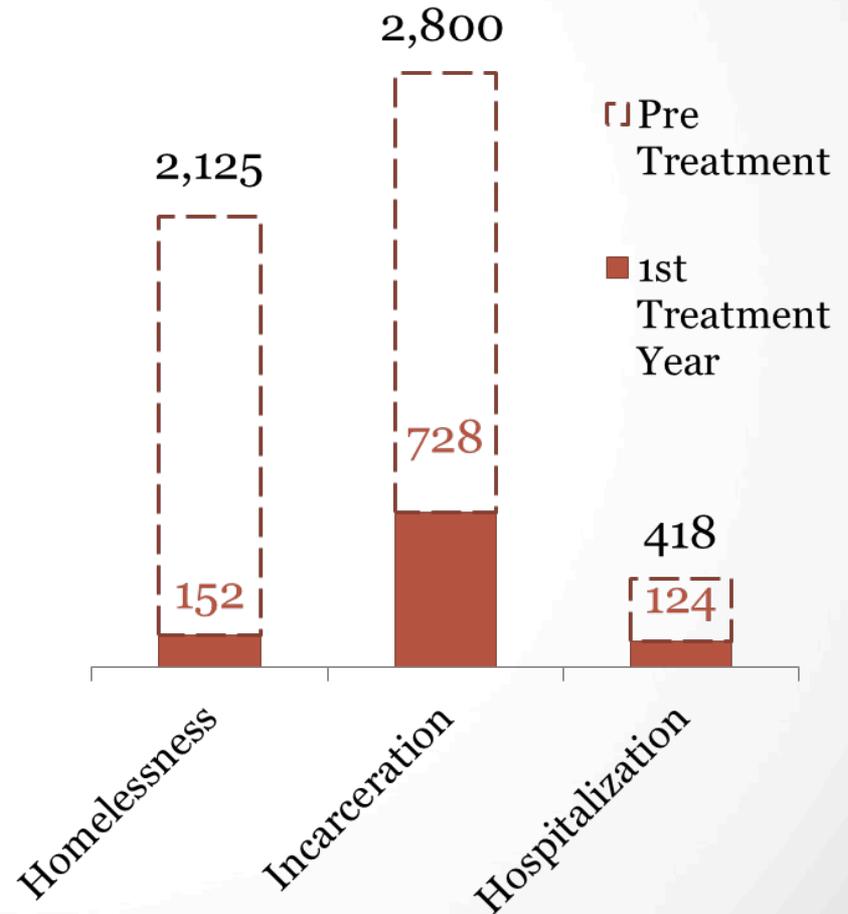
37

New Consumers  
entered Full Service  
Partnership services  
since Feb. 2016

## APPENDIX - II

# Support and Treatment After Release (STAR) Outcomes - Residential Status Full Service Partnerships

- N=54
- Increased housing
  - -1,973 days homelessness
- Increased community living
  - -2,072 days incarcerated
- Increased outpatient treatment
  - -294 days hospitalization

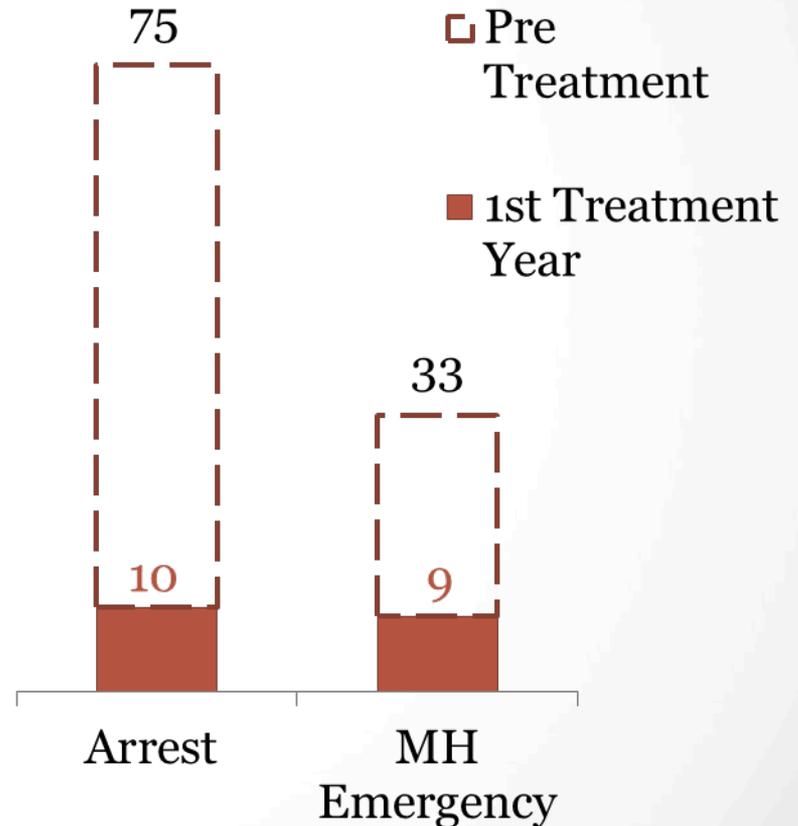


## APPENDIX - II

# Support and Treatment After Release (STAR) Outcomes – Emergency Events Full Service Partnerships

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- N=54
- Fewer arrests
  - 87% decrease
- Fewer mental health (MH) emergencies
  - 73% decrease



# Reaching Out: Three New Teams

## Responding to the Community

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### **Transition Team**

Short-term (60 day) case management to stabilize and connect individuals with ongoing services



### **Mobile Crisis Response Team**

Responds to mental health/substance use crises in the community seven days/week



### **Outreach & Engagement Team**

Supportive outreach to individuals not engaged in services and to their families/friends

# Impact of the Three New Teams

## Community Crisis Response Teams



- Majority of contacts initiated by Family/Friends and Law Enforcement
- Reduced use of acute and crisis services (hospital, PES, detoxification) and increased use of planned services (medication support, case management and FSP)

754

Individuals treated  
by the three teams

2,659

Services provided in  
FY2015-16 by the three  
teams

# Prevention and Early Intervention

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- Programs and Services designed to prevent mental illnesses from becoming severe and disabling
  - Early Intervention Programs provide treatment and other interventions to promote recovery and improve function for mental illness early in it's emergence
  - Prevention programs reduce risk factors for developing a serious mental illness and build protective factors for at risk populations
  - Outreach for increasing recognition for early signs of mental illness programs, teach responders to recognize and respond to early signs of mental illness
  - Access and Linkage connect individuals with SED or SMI with medically necessary care
  - Reduction in Stigma and Discrimination are aimed at reducing negative stereotypes or discrimination associated with mental illness
    - Suicide Prevention Programs

# Workforce Education and Training

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## Develop a diverse workforce

- Training for clients and families/caregivers to develop the skills to work collaboratively to deliver client and family-driven programs and services
- Provide outreach to unserved and underserved populations
- Provide services that are linguistically and culturally competent and relevant

## **5822.**

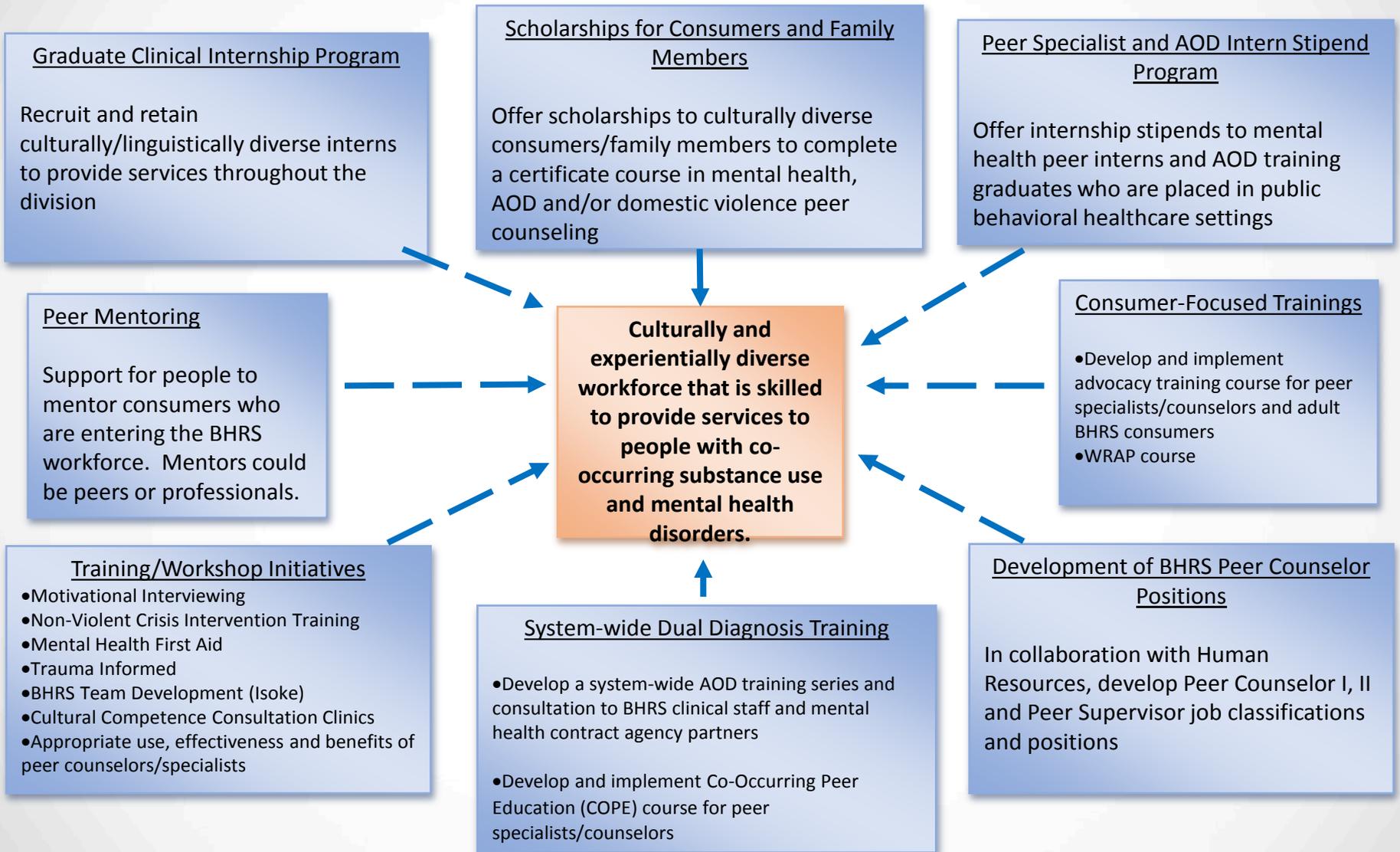
The Office of Statewide Health Planning and Development shall include in the five-year plan:

- Loan forgiveness, stipends and scholarship programs
- Staff training
- Employment and inclusion of mental health consumers and family members
- Promotion of meaningful inclusion of diverse racial and ethnic communities
- Cultural competence training programs

(a) E (Amended by Stats. 2012, Ch. 23, Sec. 57. Effective June 27, 2012. Note: This section was added on Nov. 2, 2004, by initiative Prop. 63.)

## APPENDIX - II

### Marin County BHRS Workforce Education and Training (WET) Program 2016-2017



# Capital Facilities and Technological Needs

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- Funds for the creation of facilities used for the delivery of MHSA services to clients and families or for administration
- The development of technological infrastructure to facilitate the highest quality and cost-effective services and supports for clients and their families

# Housing

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- Provided funds to acquire, rehabilitate, or construct permanent supportive housing for clients with serious mental illness and provide for operating subsidies.

California Code of Regulations, 3200.225

# Innovation

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- 5% of MHSA funding, is allocated towards Innovative Programs and Services in order to:
- Increase Access to Care
- Increase Access to Underserved Communities
- Improve Outcomes of Care
- Provide for Interagency Collaboration

# Community Planning Process

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- Identify the mental health and substance use services needs of the community
- Identify and reprioritize strategies to meet these mental health and substance use services needs
- Ensure client participation
- Ensure inclusion of the racial, ethnic, linguistic and sexual orientation of the community
- Link component parts into a continuum of care

# Marin County MHSA Community Planning Process

## Stakeholder Input

Community Meetings, Key Informant Interviews  
Focus Groups, Online Surveys



MHSA Advisory  
Committee



BHRS



30 day Public  
Comment



Public Hearing at Mental Health Board  
Mental Health Board Recommendations



Board of Supervisors for Approval



# APPENDIX II MHSA Funding Estimates

I. CSS	2017-18	2018-19	2019-20	TOTAL
Estimated - 3- Year Average Marin County MHSA Allocation	\$9,202,872	\$9,202,872	\$9,202,872	\$27,608,616
CSS Programs Currently Funded (FY 16/17)	\$7,725,675	\$7,725,675	\$7,725,675	\$23,177,025
WET Programs Currently Funded	\$333,333	\$333,333	\$333,334	\$1,000,000
Unallocated Funds	\$1,143,864	\$1,143,864	\$1,143,863	\$3,431,591
<b>Total CSS Funds Available</b>	<b>\$9,202,872</b>	<b>\$9,202,872</b>	<b>\$9,202,872</b>	<b>\$27,608,616</b>

II. PEI	2017-18	2018-19	2019-20	TOTAL
Estimated - 3- Year Average Marin County MHSA Allocation	\$1,996,433	\$1,996,433	\$1,996,433	\$5,989,299
PEI Programs Currently Funded (FY 16/17)	\$1,900,500	\$1,900,500	\$1,900,500	\$5,701,500
Unallocated Funds	\$95,933	\$95,933	\$95,933	\$287,799
<b>Total PEI Funds Available</b>	<b>\$1,996,433</b>	<b>\$1,996,433</b>	<b>\$1,996,433</b>	<b>\$5,989,299</b>

III. INN	2017-18	2018-19	2019-20	TOTAL
Estimated - 3- Year Average Marin County MHSA Allocation	\$517,765	\$517,765	\$517,765	\$1,553,295
INN Programs Currently Funded (FY 16/17) (Note: Existing INN funded programs will not be funded with INN funds in the next 3-year plan)	\$0	\$0	\$0	\$0
Unallocated Funds	\$517,765	\$517,765	\$517,765	\$1,553,295
<b>Total Estimated INN Revenues - County</b>	<b>\$517,765</b>	<b>\$517,765</b>	<b>\$517,765</b>	<b>\$1,553,295</b>

# Building an Integrated, Evidence-based System

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- Building multi-disciplinary teams to support seamless, scale-able and cost-effective delivery of integrated mental health and substance services.
- Launching first county-operated outpatient treatment program to address co-occurring substance use and mental health disorders
- Recruiting first Board-Certified Addiction Medicine Specialist

# Trauma

*“What happened to you? replaces “What’s wrong with you?”*

---

- 90% of people seeking treatment in public behavioral health settings have experienced trauma. A similarly significant number of traumatized individuals are seen in public sector primary care.
- Adverse Childhood Experiences (ACES): 59% of individuals in the US experience at least one adverse childhood experience in their life—9% experience five or more.
  - Psychological, physical, or sexual abuse
  - Community or school violence
  - Witnessing or experiencing domestic violence
  - National disasters or terrorism
  - Commercial sexual exploitation
  - Sudden or violent loss of a loved one
  - Refugee or war experiences
  - Military family-related stressors (e.g., deployment, parental loss or injury)
  - Physical or sexual assault
  - Neglect
  - Serious accidents or life-threatening illness
  - The national average of child abuse and neglect victims in 2013 was 679,000, or 9.1 victims per 1,000 children.

# Suicide

## A growing problem

---

- The suicide rate (age adjusted, per 100,000 population) in Marin was 12.8, higher than the CA rate of 9.8 (CHIS 2015).
- Increase in suicide rate for women, has led to a decrease in overall life expectancy for first time.
- (See also attached report regarding suicides and the GGB.)
- Facts About Mental Illness and Suicide:
  - The great majority of people who experience a mental illness do not die by suicide. However, of those who die from suicide, more than 90 percent have a diagnosable mental disorder.

# Depression

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- An estimated 2-15 % of persons who have been diagnosed with major depression die by suicide. Suicide risk is highest in depressed individuals who feel hopeless about the future, those who have just been discharged from the hospital, those who have a family history of suicide and those who have made a suicide attempt in the past.

# Bipolar Disorder

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- An estimated 3-20% of persons who have been diagnosed with bipolar disorder die by suicide. Hopelessness, recent hospital discharge, family history, and prior suicide attempts all raise the risk of suicide in these individuals.

# Schizophrenia

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- An estimated 6-15% of persons diagnosed with schizophrenia die by suicide. Suicide is the leading cause of premature death in those diagnosed with schizophrenia. Most of these occur early in the onset of the illness. Between 75 and 95% of these individuals are male.

# Multiple Disorders

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- Also at high risk are individuals who suffer from depression at the same time as another mental illness. Specifically, the presence of substance abuse, anxiety disorders, schizophrenia and bipolar disorder put those with depression at greater risk for suicide.

# Personality Disorders

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- People with personality disorders are approximately three times as likely to die by suicide, than those without. Between 25 and 50% of these individuals also have a substance abuse disorder or major depressive disorder.

*<http://mentalhealth.samhsa.gov/suicideprevention/suicidefacts.asp>*

# Substance Use

---

- 40% of clients who came into PES in the past three months tested positive for alcohol and/or non-prescribed substances.
- Between 2010 and 2013, 5,456 hospitalizations and 8,194 emergency room visits involving alcohol and drug use were reported in Marin County.

# Alcohol

**Marin youth drink too early, too often and too much.**

---

Youth in **non-traditional high schools** are impacted at higher rates.

- 40% of 9<sup>th</sup> graders had their first drink by age 14.
- Almost 19% of 11<sup>th</sup> graders have used alcohol three plus times in the last month, and 30% have binged at least once in last month. Almost **40% of youth attending a non-traditional high school** reported binge drinking during the same time period. (CHKS)
- **Improve access by geographic location:** services primarily centered in San Rafael. Limited services in Novato and Marin City, none in West Marin.
- **Improve ability to attract self-referrals.**
- FY 2014/15 < 3% of screenings and/or assessments (RCC) were from self-referrals. Most referrals from criminal justice and social services partners.
- Substance Use Strategic Plan Focus Group Finding: Policies and attitudes in some primary care and mental health settings reveal institutional stigma towards substance use disorders.

# Housing

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- According to the Substance Abuse and Mental Health Services Administration, 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness.
- People with substance and other mental disorders experience even greater barriers to accessible housing than their counterparts: income deficits, stigma and need for community wraparound services.<sup>i</sup>
- The ongoing stigma housing providers, funding sources, and neighborhood groups are reluctant to serve people with disabilities, despite such legislation as the Fair Housing Amendments Act.
- Key clinical barriers include lack of attention to issues of trauma, including childhood and adult physical and sexual abuse; failure to make the newer antipsychotic medications widely available; and lack of integrated treatment for co-occurring mental health and substance use disorders.

# Underserved Cultural Communities

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- Individuals, families, and communities that have experienced social and economic disadvantages are more likely to face greater obstacles to overall health. Characteristics such as race or ethnicity, religion, low socioeconomic status, gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to exclusion or discrimination are known to influence health status.
- Federal and state governments monitor Government funded programs and activities to ensure that access, use, and outcomes are equitable across racial and ethnic minority groups. *See Medi-Cal Approved Claims Data for Marin MHP LGBTQ: we do not collect these demographics so cannot track who we are serving and how.*
- Latino Medi-Cal beneficiaries: Adult system sees very few monolingual Spanish speakers – as opposed to the Children’s system that sees many. How to increase services to Adult primary Spanish Speakers? [See Attached Marin Approved Claims race/ethnicity edit for detail]

Thank you for your participation in  
the MHSA  
Community Planning Process

**APPENDIX - II**

**MHSA del Condado de Marin  
Proceso de Planificación  
Comunitaria de Tres Años  
AF2017-AF2020**



WELLNESS • RECOVERY • RESILIENCE

# Ley de Servicios de Salud Mental

## Antecedentes

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- Los sistemas locales operan con sobrecupo
- Los consumidores y sus familiares no reciben un cuidado adecuado
- Es necesario abordar la salud mental con la misma urgencia que el cuidado de la saludcare

# Proposición 63

## Ley de Servicios de Salud Mental

- Grupos de base buscaron firmas para el estado para una iniciativa en la votación de noviembre de 2004
- La propuesta de ley fue aprobada y se convierte en la Ley de Servicios de Salud Mental (MHSA, Ley de Servicios de Salud Mental)
- Impuesto del 1% de los ingresos por encima de \$1 millón de dólares
-

# Ley de Servicios de Salud Mental: Conceptos de transformación

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- Colaboración Comunitaria
- Competencia Cultural
- Intervenciones y programas impulsados por familias y clientes
- Atención específica para personas de las comunidades desatendidas
- Una experiencia de servicio integral para las personas y sus familias
- Recuperación del bienestar y resiliencia
- Diseño de programas con base en resultados

# APPENDIX - II

# Servicios y Programas Impulsados por los Clientes

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- Los servicios y programas impulsados por los clientes utilizan las opiniones de estos como el principal factor para la planificación, las políticas, los procedimientos, los servicios realizados, la evaluación y la definición y determinación de los resultados

# Ley de Servicios de Salud Mental:

## El Propósito

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- Definir una enfermedad de salud mental grave como un padecimiento que merece una atención prioritaria
- Reducir en las personas los efectos adversos a largo plazo resultantes de una enfermedad de salud mental no tratada
- Aumentar los servicios innovadores exitosos, incluidos los enfoques cultural y lingüísticamente competentes para las poblaciones desatendidas
- Ofrecer fondos para cumplir de manera adecuada con las necesidades de los niños/adultos/adultos mayores que pueden identificarse/inscribirse en los programas apoyados por esta medida
- Garantizar que los fondos se utilicen de la manera más eficaz en costos, y que los servicios se ofrezcan de acuerdo con las mejores prácticas recomendadas

# Ley de Servicios de Salud Mental

## Componentes

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- Servicios y Apoyos Comunitarios(CSS)
  - Alianzas de Servicios Completos (FSP)
  - Desarrollo de sistemas
  - Contactar y generar participación
  - Programa de Vivienda de MHSA
- Prevención e Intervención Temprana (PEI)
- Capacitación y Educación de la Fuerza Laboral (WET)
- Instalaciones Captales y Necesidades Tecnológicas (CFTN)
- Innovación (INN)

# Servicios y Apoyos Comunitarios

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- Poblaciones objetivo :
  - Niños y jóvenes con trastornos emocionales graves
  - Adultos y adultos mayores como un trastorno mental grave, tanto en grado como en persistencia y duración; por ejemplo: esquizofrenia, trastorno bipolar y un trastorno afectivo grave

Alianzas de Servicios Completos

# Hacer “lo que sea necesario”

## Alianzas de Servicios Completos

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- 282 consumidores atendidos en el AF2015/16
  - o Cinco Alianzas de Servicios Completos con todo el personal necesario
    - Hay dos puestos más aprobados para reclutamiento
    - Los nuevos puestos aumentarán la capacidad de la Alianza de Servicios Completos en 30 lugares para tratamiento
    - Se abrirá una nueva clínica en Novato para albergar a los equipos de Alianzas de Servicios Completos
  - o Treinta y siete (37) nuevos consumidores ingresaron a los servicios de las Alianzas de Servicios Completos desde febrero de 2016

282

**Consumidores atendidos  
AF2015-2016**

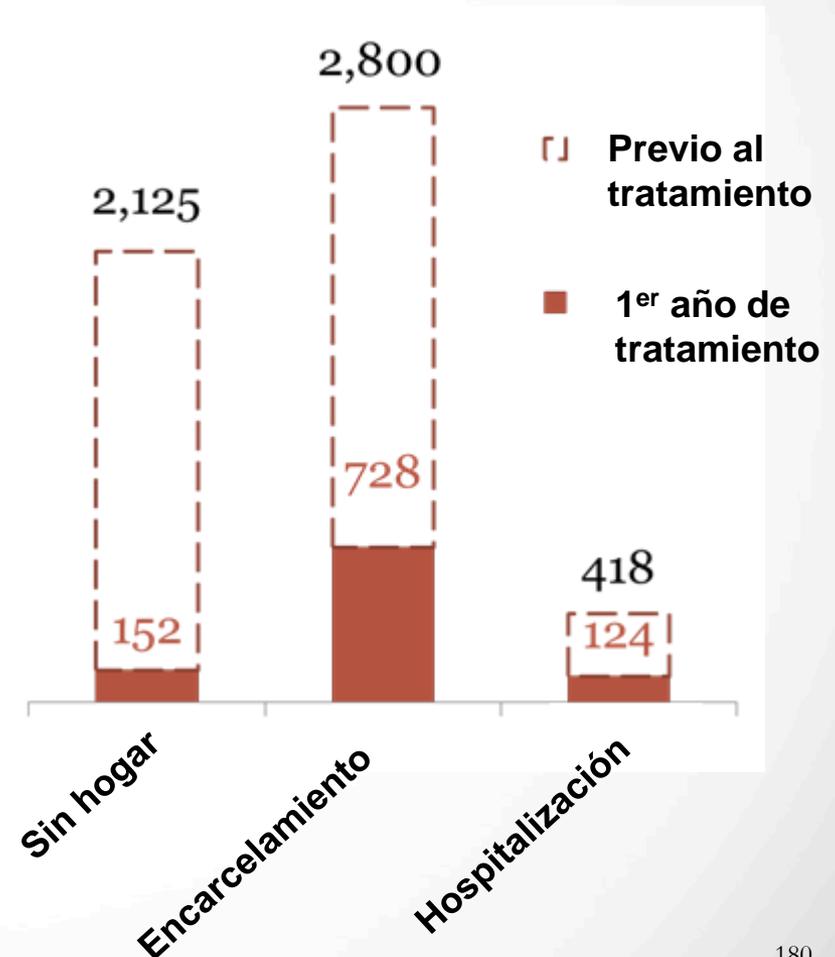
37

**Nuevos consumidores en  
alianza de servicios  
completos desde  
febrero de 2016**

## APPENDIX - II

# Resultados de apoyo y tratamiento después de la liberación (STAR) - Estado Residencial Alianzas de Servicios Completos

- N=54
- Aumento de vivienda
  - -1,973 días sin casa
- Aumento de la vida comunitaria
  - -2,072 días de encarcelamiento
- Aumento en el tratamiento para pacientes externos
  - -294 días de hospitalización



## APPENDIX - II

# Resultados de apoyo y tratamiento después de la liberación (STAR) – Eventos de emergencia Alianzas de Servicios Completos

- N=54
- Menos arrestos
  - Disminución en un 87%
- Menos emergencias de salud mental
  - Disminución en un 73%



# Difusión: Tres equipos nuevos

## Respuesta a la comunidad

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### Equipo de transición

Administración de caso a corto plazo (60 días) para estabilizar a las personas y ponerlas en contacto con servicios continuos



### Equipo móvil de respuesta a crisis

Responde a las crisis por consumo de sustancias/de salud mental en la comunidad, los siete días de la semana



### Difusión y generación de participación

Difusión de apoyo para personas que no participan en los servicios, así como para sus familiares/amigos

# Impacto de los tres equipos nuevos

## Equipos comunitarios de respuesta a crisis

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754

Personas tratadas  
por los tres equipos

- La mayoría de las veces, es un familiar/amigo o una agencia judicial quien hace el primer contacto
- Un menor uso de los servicios agudos y de crisis (hospital, PES, desintoxicación) y un mayor uso de los servicios planificados (apoyo con medicamentos, administración de caso y FSP)

2,659

Servicios prestados por los  
tres equipos en el AF2015-  
16

# Intervención Temprana y Prevención

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- Programas y Servicios diseñados para prevenir que las enfermedades de salud mental aumenten en gravedad y provoquen una discapacidad
  - Los Programas de Intervención Temprana ofrecen tratamiento y otros tipos de intervención para promover la recuperación y mejorar la funcionalidad de las enfermedades mentales en una etapa temprana de su aparición
  - Los programas de prevención reducen los factores de riesgo del desarrollo de una enfermedad mental grave y generan factores de protección para las poblaciones en riesgo
  - Contactar para aumentar los programas para el reconocimiento de las señales tempranas de una enfermedad mental, para enseñar al personal a reconocer y cómo responder a las señales tempranas de una enfermedad mental
  - Acceso y conexión para que las personas puedan entrar en contacto con SED y SMI, con el cuidado médicamente necesario
  - Se busca la reducción del Estigma y la Discriminación con el fin de disminuir los estereotipos negativos o la discriminación asociados con las enfermedades mentales
  - Programas de prevención del suicidio

# Capacitación y Formación de la Fuerza de Trabajo

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## Desarrollar una fuerza de trabajo diversa

- Capacitación para que los clientes y sus familiares/cuidadores desarrollen las habilidades necesarias para trabajar de forma colaborativa para ofrecer servicios y programas impulsados por el cliente y su familia
- Ofrecer difusión para las poblaciones menos atendidas y desatendidas
- Ofrecer servicios que sean cultural y lingüísticamente competentes y relevantes

## 5822.

La Oficina Estatal de Desarrollo y Planificación de Salud incluirá en el plan de cinco años:

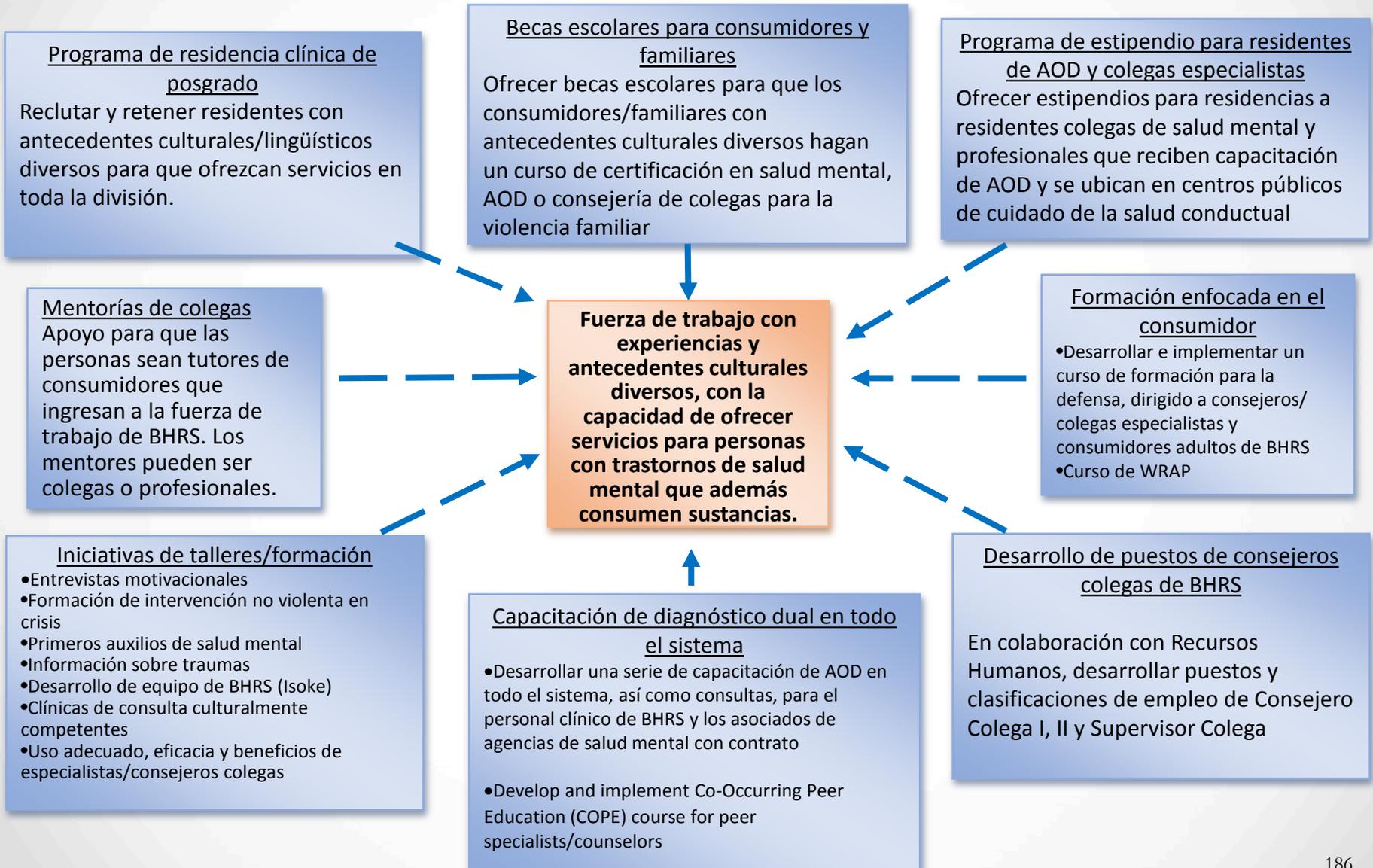
- Programas de becas, estipendios y condonación de préstamos
- Capacitación de personal
- Empleo e inclusión de consumidores de salud mental y de sus familiares
- Promoción de una inclusión significativa de las comunidades étnica y racialmente diversas
- Programas de capacitación de competencias culturales

(a) *(Enmendado por Stats. 2012, Ch. 23, Sec. 57. Vigente a partir del 27 de junio de 2012.*

- *Nota: Esta sección se añadió el 4 de noviembre de 2004, debido a la Prop. 63.)*

## APPENDIX - II

### Programa de capacitación y formación de fuerza de trabajo (WET) 2016-2017 de BHRS del Condado de Marin



# Instalaciones de capital y necesidades tecnológicas

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- Fondos para la creación de instalaciones utilizadas para dar servicios de MHSA a clientes y familias, o para la administración
- El desarrollo de infraestructura tecnológica para facilitar los apoyos y servicios más eficaces en costo y de mayor calidad para los clientes y sus familias

# Vivienda

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- Se proporcionaron fondos para adquirir, rehabilitar o construir viviendas permanentes de apoyo para clientes con una enfermedad mental grave y para los subsidios de operación.

Código de Regulaciones de California, 3200.225

# Proceso de Planificación Comunitaria

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- Identificar las necesidades de servicios contra el consumo de sustancias y de salud mental en la comunidad
- Identificar y volver a asignar prioridad a las estrategias para abordar estas necesidades de servicios contra el consumo de sustancias y de salud mental
- Asegurar la participación del cliente
- Garantizar la inclusión de razas, etnias, lenguas y orientaciones sexuales de la comunidad
- Vincular todas las fases en un proceso continuo de cuidado

# MHSA del Condado de Marin Proceso de Planificación Comunitaria

## Opiniones de las partes interesadas

Juntas comunitarias, entrevistas con los informantes clave, grupos de enfoque, encuestas en línea



Comité Consultivo  
de MHSA



BHRS



30 días de comentarios  
del público



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



Al Consejo de Supervisores para su aprobación



# APPENDIX II MHSA Funding Estimates

I. CSS	2017-18	2018-19	2019-20	TOTAL
Estimated - 3- Year Average Marin County MHSA Allocation	\$9,202,872	\$9,202,872	\$9,202,872	\$27,608,616
CSS Programs Currently Funded (FY 16/17)	\$7,725,675	\$7,725,675	\$7,725,675	\$23,177,025
WET Programs Currently Funded	\$333,333	\$333,333	\$333,334	\$1,000,000
Unallocated Funds	\$1,143,864	\$1,143,864	\$1,143,863	\$3,431,591
<b>Total CSS Funds Available</b>	<b>\$9,202,872</b>	<b>\$9,202,872</b>	<b>\$9,202,872</b>	<b>\$27,608,616</b>

II. PEI	2017-18	2018-19	2019-20	TOTAL
Estimated - 3- Year Average Marin County MHSA Allocation	\$1,996,433	\$1,996,433	\$1,996,433	\$5,989,299
PEI Programs Currently Funded (FY 16/17)	\$1,900,500	\$1,900,500	\$1,900,500	\$5,701,500
Unallocated Funds	\$95,933	\$95,933	\$95,933	\$287,799
<b>Total PEI Funds Available</b>	<b>\$1,996,433</b>	<b>\$1,996,433</b>	<b>\$1,996,433</b>	<b>\$5,989,299</b>

III. INN	2017-18	2018-19	2019-20	TOTAL
Estimated - 3- Year Average Marin County MHSA Allocation	\$517,765	\$517,765	\$517,765	\$1,553,295
INN Programs Currently Funded (FY 16/17) (Note: Existing INN funded programs will not be funded with INN funds in the next 3-year plan)	\$0	\$0	\$0	\$0
Unallocated Funds	\$517,765	\$517,765	\$517,765	\$1,553,295
<b>Total Estimated INN Revenues - County</b>	<b>\$517,765</b>	<b>\$517,765</b>	<b>\$517,765</b>	<b>\$1,553,295</b>

# Construir un sistema integral basado en evidencias

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- Juntar equipos multidisciplinarios para apoyar la oferta eficaz en costos, ampliable y continua de servicios integrales contra el consumo de sustancias y de salud mental.
- Lanzamiento del primer programa de tratamiento para pacientes externos operado en todo el país para el abordaje del consumo de drogas concomitante con uno o varios trastornos de salud mental
- Reclutamiento del primer especialista en medicina de adicciones certificado por el Consejo

# Trauma

*"¿Qué le pasó?" es preferible a "¿Cuál es su problema?"*

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- El 90% de las personas que buscan tratamiento en los centros públicos de salud conductual han sufrido de algún trauma. Se atiende un número igualmente significativo de personas con traumas en el cuidado primario del sector público.
- Experiencias Adversas de Infancia (Adverse Childhood Experiences-ACES): 59% de individuos en los Estados Unidos tienen una experiencia adversa de infancia en su vida-9% tienen cinco o más experiencias de
  - Maltrato psicológico, físico o abuso sexual
  - Violencia escolar o comunitaria
  - Violencia familiar, ya sea como testigo o víctima
  - Terrorismo o desastres nacionales
  - Explotación sexual comercial
  - Pérdida repentina o violenta de un ser amado
  - Refugiado o experiencias de guerra
  - Factores de estrés familiares de origen militar (por ejemplo, despliegue, pérdida o lesión de uno de los padres)
  - Ataque sexual o físico
  - Negligencia
  - Accidentes graves o enfermedades que ponen en riesgo la vida
- El promedio nacional de víctimas de negligencia y maltrato infantil en 2013 fue de 679,000, o 9.1 víctimas por cada 1,000 niños.

# Suicidio

## Un problema cada vez mayor

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- La tasa de suicidios (ajustada por edad, por cada 100,000 personas) en Marin fue de 12.8, mayor que la tasa de California de 9.8 (CHIS 2015).
- El aumento en la tasa de suicidios en mujeres ha provocado por primera vez una disminución en la expectativa general de vida.
- (Ver también el informe adjunto sobre suicidios y el GGB).
- Datos sobre la enfermedad mental y el suicidio:
  - La mayoría de las personas que sufren de una enfermedad mental no mueren a causa de un suicidio. Sin embargo, de aquellas personas que mueren debido al suicidio, más del 90% tienen un trastorno mental diagnosticable.

# Depresión

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- Aproximadamente entre el 2 y el 15% de las personas que reciben un diagnóstico de depresión grave mueren a causa de un suicidio.
- El riesgo de suicidio es mayor en personas deprimidas que sienten desesperanza con respecto al futuro, aquellas que fueron dados de alta del hospital, aquellas que tienen antecedentes familiares de suicidio y aquellas que han intentado suicidarse con anterioridad.

# Trastorno bipolar

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- Aproximadamente entre el 3 y el 20% de las personas que reciben un diagnóstico de trastorno bipolar mueren a causa de un suicidio.
- La desesperanza, un alta reciente del hospital, los antecedentes familiares y los intentos previos de suicidio son factores que aumentan el riesgo de suicidio en estas personas.

# Esquizofrenia

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- Aproximadamente entre el 6 y el 15% de las personas que reciben un diagnóstico de esquizofrenia mueren a causa de un suicidio. El suicidio es la principal causa de muerte prematura en las personas con un diagnóstico de esquizofrenia. La mayoría de estos ocurren en una etapa temprana de la aparición de la enfermedad. Entre el 75 y el 95% de estas personas son del sexo masculino.

# Varios trastornos

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- Las personas que sufren de depresión al mismo tiempo que otra enfermedad de salud mental también tienen un riesgo elevado.
- Específicamente, la presencia de consumo de sustancias, trastornos de ansiedad, esquizofrenia y trastorno bipolar ponen a las personas con depresión en un mayor riesgo de suicidio.

# Trastornos de la personalidad

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- Las personas con un trastorno de la personalidad tienen aproximadamente tres veces más probabilidades de morir a causa de un suicidio que aquellas personas que no lo sufren. Entre el 25 y el 50% de estas personas también tienen un trastorno de consumo de sustancias o un trastorno depresivo importante.

*<http://mentalhealth.samhsa.gov/suicideprevention/suicidefacts.asp>*

# Consumo de sustancias

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- El 40% de los clientes que llegaron a PES en los últimos tres meses arrojaron un resultado positivo de alcohol o sustancias no recetadas. Entre 2010 y 2013, se reportaron 5,456 hospitalizaciones y 8,194 visitas a salas de emergencias debido al consumo de alcohol o drogas en el Condado de Marin.

# Alcohol

Los jóvenes de Marin beben muy pronto, muy seguido y demasiado.

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Los jóvenes que **no están en preparatorias tradicionales** sufren en tasas más altas.

- El 40% de los jóvenes de 9° grado probaron su primera bebida alcohólica a los 14 años.
- Casi el 19% de los jóvenes de 11° grado han bebido alcohol tres o más veces en el último mes, y el 30% se ha emborrachado al menos una vez en el último mes. Casi el **40% de los jóvenes que asisten a una preparatoria no tradicional** reportó haberse emborrachado en el mismo periodo de tiempo. (CHKS)
- **Mejorar el acceso por ubicación geográfica:** servicios principalmente centrados en San Rafael.
- Los servicios en Novato y en Marin City son limitados, e inexistentes en West Marin.
- **Mejorar la capacidad para atraer a personas que llegan por iniciativa propia.**
- AF 2014/15 < 3% de evaluaciones o valoraciones (RCC) fueron de personas que llegaron por iniciativa propia. Más referencias de parte de los socios de servicios sociales y de justicia penal.
- Hallazgo del grupo de enfoque para el plan estratégico contra el consumo de sustancias:
- Las políticas y actitudes en algunos centros de salud mental y de cuidados primarios revelan que existe un estigma institucional hacia los trastornos de consumo de sustancias.

# Vivienda

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- Según la Administración de Servicios de Salud Mental y contra el Consumo de Sustancias, entre el 20 y el 25% de la población de personas sin hogar en los Estados Unidos sufre de alguna forma de enfermedad mental grave.
- Las personas con trastornos de consumo de sustancias o otros de salud mental sufren de barreras incluso más grandes que les impiden tener acceso a una vivienda: déficit de ingresos, estigma y necesidad de servicios comunitarios integrales.
- Los proveedores de vivienda, las fuentes de fondos y las agrupaciones de vecinos perciben un estigma y por lo tanto se sienten renuentes a atender a las personas con discapacidades, a pesar de que existe una legislación como la Ley de Enmiendas para la Vivienda Justa.
- Las barreras clínicas clave incluyen la falta de atención a problemas de trauma, incluido el maltrato físico y el abuso sexual, tanto en menores como en adultos; el no poner a disposición de las masas los medicamentos anti-psicóticos más novedosos; y la falta de un tratamiento integral para la concurrencia de un trastorno de salud mental con el consumo de sustancias.

# Comunidades culturales desatendidas

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- Las personas, familias y comunidades que han sufrido de desventajas económicas y sociales tienen una mayor probabilidad de enfrentarse a obstáculos más grandes para la salud en general. Se sabe que algunas características como la raza o etnia, la religión, un estatus socioeconómico bajo, el género, la edad, la salud mental, una discapacidad, la orientación sexual o identidad de género, la ubicación geográfica y otras características históricamente vinculadas con la exclusión o la discriminación, influyen en el estado de salud.
- Los gobiernos estatal y federal supervisan las actividades y los programas financiados por el Gobierno para garantizar que el acceso, el uso y los resultados sean equitativos para todos los grupos minoritarios étnicos y raciales. Ver los datos de reclamaciones aprobadas de Medi-Cal para LGBTQ de MHP de Marin: no recopilamos información sobre estas características demográficas, por lo tanto no podemos dar seguimiento a quién atendemos ni cómo.
- Beneficiarios latinos de Medi-Cal: El sistema para adultos atiende a muy pocos hispanohablantes monolingües - a diferencia del sistema para niños, que atiende a muchos. ¿Cómo aumentar los servicios para los adultos cuyo idioma principal es el español? [Ver las Reclamaciones Aprobadas por Marin adjuntas, editadas por raza/etnia, para conocer los detalles]

Gracias por su participación en el  
Proceso de Planificación  
Comunitaria de MHSA

## APPENDIX - II

# Đạo Luật về Dịch Vụ Y Tế Tâm Thần (MHSA) của Quận Marin Quy Trình Hoạch Định của Cộng Đồng Trong Ba Năm TK 2017-TK 2020



WELLNESS • RECOVERY • RESILIENCE

# Đạo Luật về Dịch Vụ Y Tế Tâm Thần

## Tổng Quan Lịch Sử

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- Các hệ thống dịch vụ địa phương đã vượt quá khả năng
- Những người tiêu dùng và thành viên gia đình không có sự chăm sóc đầy đủ
- Nhu cầu về y tế tâm thần phải được giải quyết khẩn cấp tương tự như chăm sóc y tế

## Dự Luật 63

# Đạo Luật về Dịch Vụ Y Tế Tâm Thần

- Cơ Sở Grassroots đã tiếp cận toàn tiểu bang để thu thập chữ ký cho một dự luật trong cuộc bầu cử tháng 11 năm 2004
- Dự luật đã được thông qua và trở thành Đạo luật về Dịch vụ Y tế Tâm thần (MHSA)
- 1% thuế cho những lợi tức trên 1 triệu đô la
-

# Đạo Luật về Dịch Vụ Y Tế Tâm Thần: Các Khái Niệm Chuyển Đổi

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- Sự Hợp tác của Cộng đồng
- Thông Thạo về Văn hóa
- Các chương trình và can thiệp do khách hàng và gia đình định hướng
- Đặc biệt quan tâm đến những cá nhân từ những cộng đồng không được phục vụ đúng mức
- Kinh nghiệm dịch vụ hợp nhất cho các cá nhân và gia đình
- Phục hồi sức khỏe và khả năng hồi phục
- Khắc phục dựa trên thiết kế chương trình
-

# Các Chương Trình và Dịch Vụ Do

APPENDIX - II

## Khách Hàng Định Hướng

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- Các chương trình và dịch vụ theo định hướng của khách hàng sử dụng ý kiến của khách hàng làm yếu tố chính cho việc lập kế hoạch, chính sách, thủ tục, cung cấp dịch vụ, đánh giá, định nghĩa và xác định kết quả

# Đạo Luật về Dịch Vụ Y Tế Tâm Thần:

## Mục Đích

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- Định nghĩa sự trầm trọng của bệnh tâm thần như một tình trạng xứng đáng được ưu tiên quan tâm đến
- Giảm tác động có hại lâu dài trên cho cá nhân do không được điều trị tâm thần
- Mở rộng các dịch vụ có tính cách sáng tạo thành công, bao gồm những cách tiếp cận thông thạo về văn hóa và ngôn ngữ cho các dân số không được phục vụ đúng mức
- Cung cấp tài chánh để đáp ứng đầy đủ những nhu cầu của trẻ em/người lớn/cao niên được nhận diện/ghi danh vào những chương trình của biện pháp này
- Đảm bảo kinh phí được chi tiêu một cách hiệu quả nhất và các dịch vụ được cung cấp phù hợp với những phương cách thực hành tốt nhất được khuyến nghị

# Các Thành Phần của Đạo Luật về Dịch Vụ Y Tế Tâm Thần

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- Dịch Vụ và Hỗ Trợ của Cộng Đồng (Community Services & Supports (CSS))
  - Hệ Đối Tác Dịch Vụ Cung Cấp Toàn Bộ (Full Service Partnerships (FSP))
  - Phát Triển Hệ Thống (Systems Development)
  - Tiếp Cận và Tham Gia (Outreach and Engagement)
  - Chương Trình Nhà Ở của MHSA (MHSA Housing Program)
- Phòng Ngừa và Can Thiệp Sớm (Prevention & Early Intervention (PEI))
- Giáo Dục và Đào Tạo Nhân Viên (Workforce Education & Training (WET))
- Cơ Sở Nhu Cầu Vốn và Công Nghệ (Capital Facilities & Technology Needs (CFTN))
- Sáng Tạo (Innovation (INN))

# Dịch Vụ và Hỗ Trợ của Cộng Đồng

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- Dân số Mục Tiêu:
  - Trẻ em và Thiếu niên bị Rối loạn Tâm thần Trầm trọng
  - Người Lớn và Cao niên bị rối loạn tâm thần trầm trọng với sự mức độ nghiêm trọng và dai dẳng kéo dài như: tâm thần phân liệt, rối loạn lưỡng tính và rối loạn ngoại hình trầm trọng

Hệ Đối Tác Dịch Vụ Cung Cấp Toàn Bộ

# Thực Hiện “Những gì phải làm” Hệ Đối Tác Dịch Vụ Cung Cấp Toàn Bộ

- 282 người tiêu dùng được phục vụ TK2015/16
  - o Hệ Đối Tác Dịch Vụ Cung Cấp Toàn Bộ hiện đã có đủ năm nhân viên
    - Đang tuyển dụng thêm hai vị trí nữa qua sự phê chuẩn của Hội Đồng Nghị Viên
    - Các vị trí mới sẽ tăng thêm 30 ca điều trị cho Hệ Đối Tác Dịch Vụ Cung Cấp Toàn Bộ
    - Phòng khám mới mở cửa ở Novato là cơ sở của các đội Hệ Đối Tác Dịch Vụ Cung Cấp Toàn Bộ
  - o Ba mươi bảy (37) người tiêu dùng mới được phục vụ từ tháng Hai 2016

282

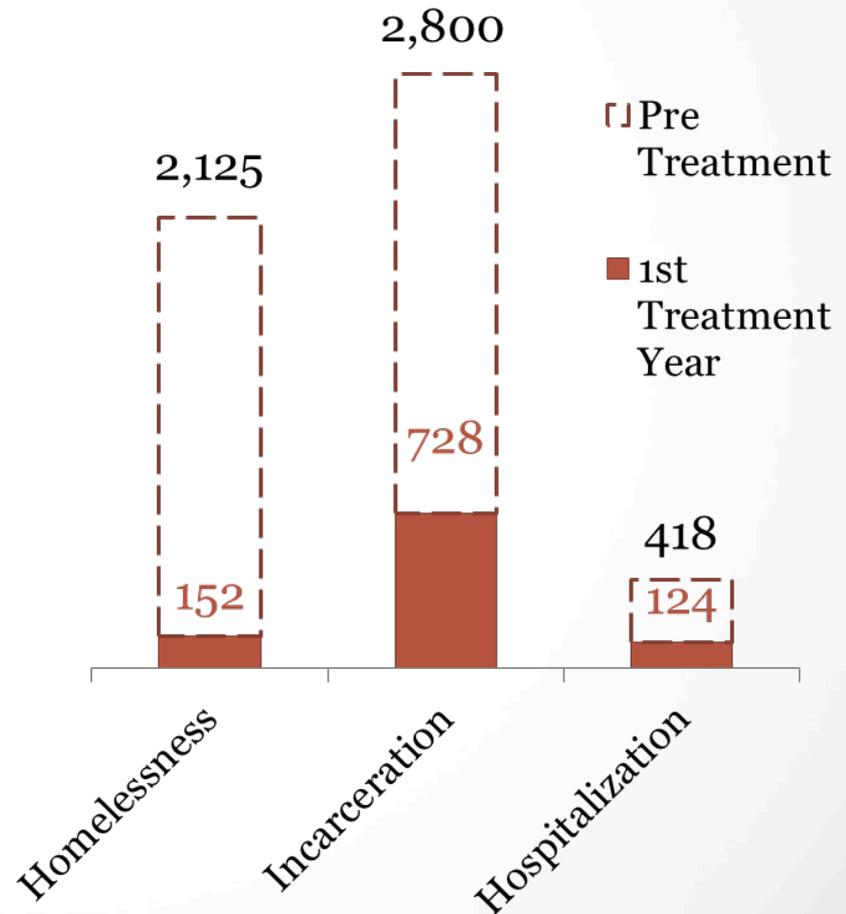
Consumers served  
FY2015-16

37

New Consumers  
entered Full Service  
Partnership services  
since Feb. 2016

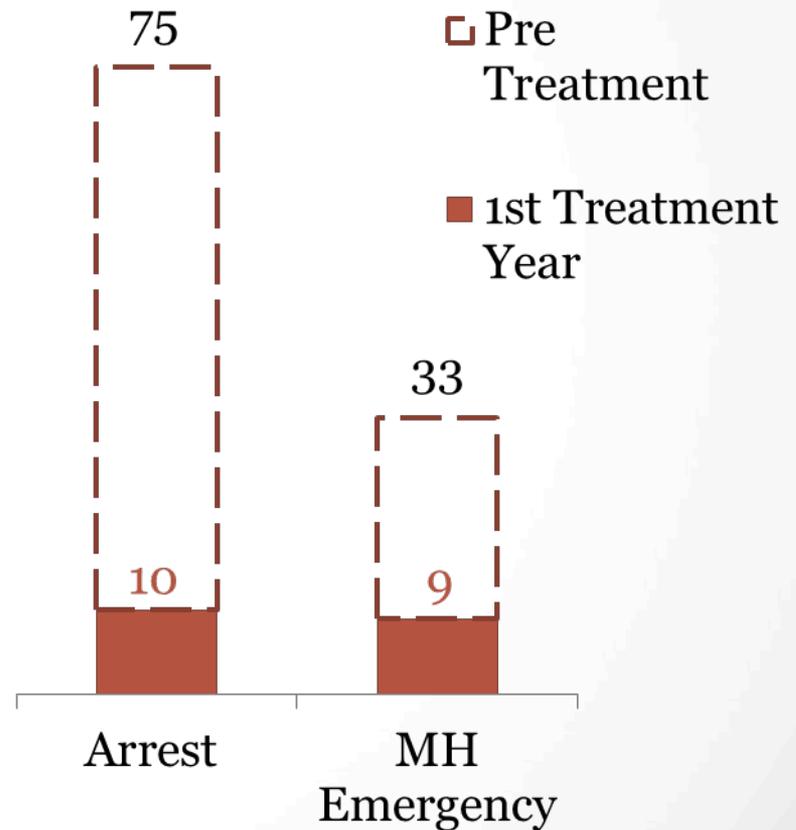
# Các Kết Quả của Hỗ Trợ và Chữa Trị Sau Khi Được Thả (STAR) – Tình Trạng Cư Trú Hệ Đối Tác Dịch Vụ Cung Cấp Toàn Bộ

- N=54
- Gia tăng về nhà ở
  - -1,973 ngày vô gia cư
- Gia tăng đời sống cộng đồng
  - -2,072 ngày bị giam
- Gia tăng chữa trị ngoại trú
  - -294 ngày nhập viện



# Các Kết quả của Hỗ trợ và Chữa trị sau khi được Thả (STAR) – Sự cố Cấp cứu Hệ Đối Tác Dịch Vụ Cung Cấp Toàn Bộ

- N=54
- Bắt giữ ít hơn
  - Giảm 87%
- Trường hợp cấp cứu tâm thần ít hơn
  - Giảm 73%



# Tiếp Cận: Ba Đội Mới

## Đáp Ứng Cho Cộng đồng

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### Transition Team

Short-term (60 day) case management to stabilize and connect individuals with ongoing services



### Mobile Crisis Response Team

Responds to mental health/substance use crises in the community seven days/week



### Outreach & Engagement Team

Supportive outreach to individuals not engaged in services and to their families/friends

# Tiếp Cận: Ba Đội Mới Đáp Ứng Cho Cộng đồng

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- **Đội Chuyển Tiếp:** Quản lý ngắn hạn (60) ngày để ổn định và kết nối các cá nhân với những dịch vụ đang có
- **Đội Ứng Phó Khủng Hoảng Di Động:** Ứng phó với các khủng hoảng về bệnh tâm thần/sử dụng chất gây nghiện trong cộng đồng bảy ngày một tuần
- **Đội Tiếp Cận và Tham Gia:** Tiếp cận hỗ trợ tới những cá nhân không tham gia dịch vụ và gia đình/bạn bè của họ

# Tác Động của Ba Đội Mới

## Đội Ứng Phó Khủng Hoảng Cộng Đồng



- Majority of contacts initiated by Family/Friends and Law Enforcement
- Reduced use of acute and crisis services (hospital, PES, detoxification) and increased use of planned services (medication support, case management and FSP)

754

Individuals treated  
by the three teams

2,659

Services provided in  
FY2015-16 by the three  
teams

# Tác Động của Ba Đội Mới

## Đội Ứng Phó Khủng Hoảng Cộng Đồng

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- Phần lớn những tiếp xúc khởi xướng bởi Gia đình/Bạn bè và Cơ quan Pháp luật
- Giảm các dịch vụ cấp tính, khủng hoảng (bệnh viện, dịch vụ khủng hoảng tâm thần-PES, giải độc) và tăng dịch vụ được kế hoạch (hỗ trợ thuốc, quản lý trường hợp và chương trình dịch vụ gia đình-FSP)
- 754 cá nhân được chữa trị bởi ba đội
- 2659 dịch vụ được cung cấp bởi ba đội

# Phòng Ngừa và Can Thiệp Sớm

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- Các Chương trình và Dịch vụ được thiết kế để phòng ngừa bệnh tâm thần trở nên trầm trọng và làm mất năng lực
  - Các Chương trình Can thiệp Sớm cung cấp chữa trị và những can thiệp khác để thúc đẩy phục hồi và cải thiện chức năng ngay khi bệnh tâm thần mới xuất hiện
  - Các chương trình phòng ngừa giảm các yếu tố nguy cơ phát triển bệnh tâm thần trầm trọng và xây dựng các yếu tố bảo vệ cho dân số có nguy cơ cao
  - Chương trình Tiếp Cận (Outreach) gia tăng sự nhận biết các dấu hiệu sớm của bệnh tâm thần, đào tạo các nhân viên ứng phó cách nhận biết và ứng phó với các dấu hiệu sớm của bệnh tâm thần
  - Access and Linkage kết nối các cá nhân với SED hoặc SMI để có được sự chăm sóc y tế cần thiết
  - Giảm kỳ thị và phân biệt đối xử nhằm mục đích giảm bớt định kiến tiêu cực hoặc phân biệt đối xử liên quan đến bệnh tâm thần
    - Các Chương trình Phòng ngừa Tự tử

# Lực Lượng Giáo Dục và Đào Tạo

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## Phát triển một đội ngũ nhân viên đa dạng

- Đào tạo cho khách hàng và gia đình/người chăm sóc để phát triển các kỹ năng cộng tác làm việc để cung cấp các chương trình và dịch vụ do khách hàng và gia đình định hướng
- Tiếp cận tới các dân số không được phục vụ và phục vụ không đúng mức
- Cung cấp các dịch vụ thông thạo về ngôn ngữ và văn hóa và thích đáng

## 5822.

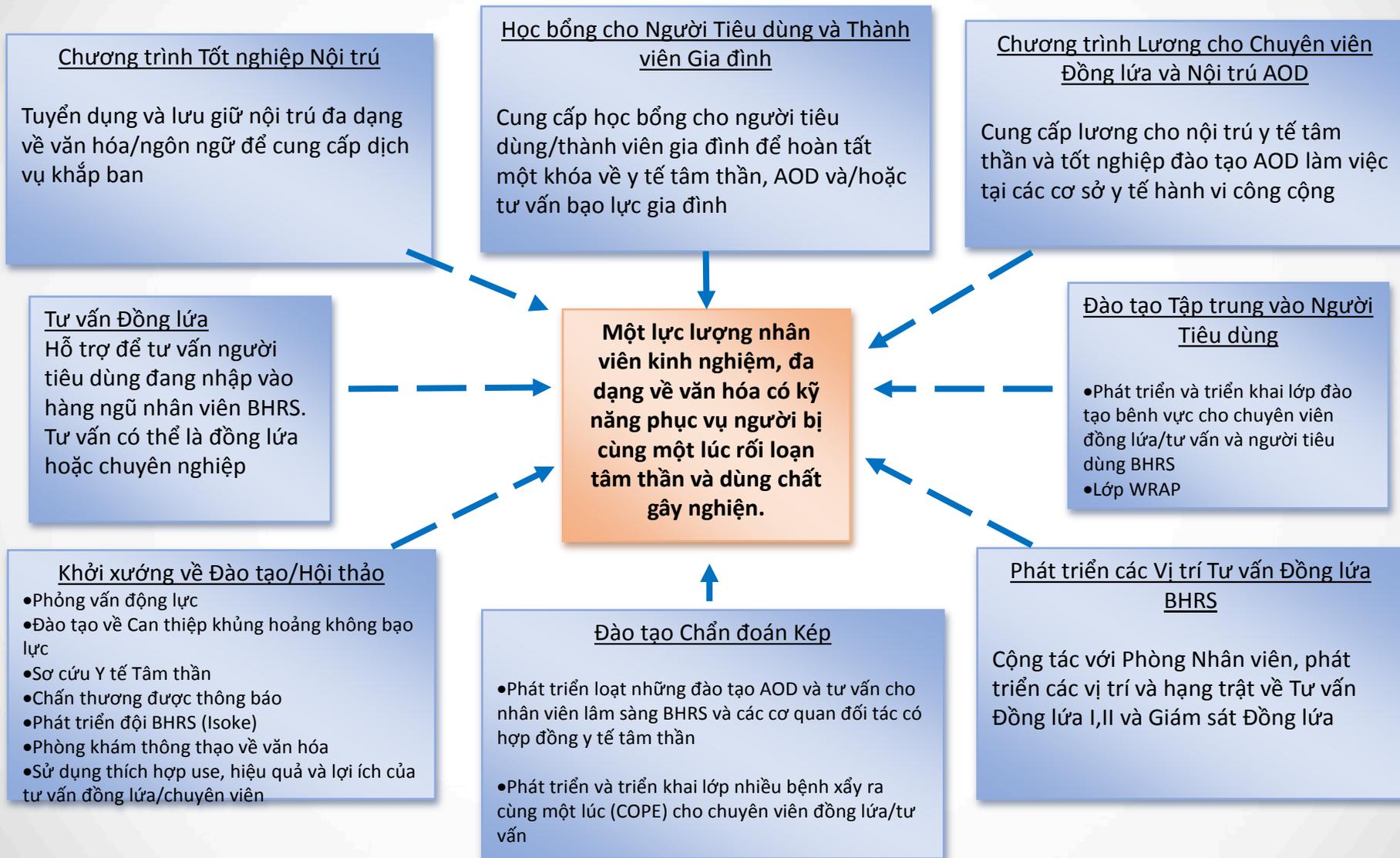
Văn Phòng Hoạch Định và Phát Triển Toàn Tiểu bang sẽ bao gồm vào kế hoạch năm năm:

- Các chương trình xóa nợ, cung cấp lương và học bổng
- Đào tạo Nhân viên
- Việc làm và sự hòa nhập người bệnh tâm thần và thành viên gia đình
- Thúc đẩy sự hòa nhập đáng kể của các cộng đồng khác chủng tộc và dân tộc
- Các chương trình đào tạo thông thạo về văn hóa

(a) E(Tu chính bởi *Thống kê. 2012, Ch. 23, Điều 57. Hiệu lực 27/6/2012. Ghi chú: Điều khoản này thêm vào ngày 2/11/2004 bởi Dự luật 63*).

## APPENDIX - II

### Chương Trình Lực Lượng Giáo Dục và Đào Tạo của Dịch Vụ Sức Khỏe Hành Vi và Phục Hồi của Quân Hạm Marin Năm 2016-2017



# Cơ Sở Nhu Cầu Vốn và Công Nghệ

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- Ngân quỹ để xây dựng các cơ sở dùng cho việc cung cấp các dịch vụ MHSA cho khách hàng và gia đình hoặc làm cơ sở hành chánh
- Phát triển cơ sở hạ tầng công nghệ để tạo điều kiện cho các dịch vụ chất lượng và hiệu quả cao nhất và hỗ trợ cho khách hàng và gia đình của họ

# Nhà Ở

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- Cung cấp ngân quỹ để mua, phục hồi, hoặc xây dựng nhà ở hỗ trợ lâu dài cho khách hàng bị bệnh tâm thần trầm trọng và cung cấp trợ cấp điều hành.

Đạo luật về Quy định của California, 3200.225

# Quy Trình Hoạch Định Cộng Đồng

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- Nhận diện các nhu cầu về dịch vụ sức khỏe tâm thần và cai nghiện của cộng đồng
- Nhận diện và lập lại ưu tiên các chiến lược để đáp ứng các nhu cầu về dịch vụ sức khỏe tâm thần và cai nghiện
- Đảm bảo sự tham gia của khách hàng
- Đảm bảo sự hòa nhập của các chủng tộc, dân tộc, ngôn ngữ và khuynh hướng dục tính trong cộng đồng
- Liên kết các bộ phận trở thành sự chăm sóc liên tục

# Quy Trình Hoạch Định MHSA của Quận Marin

## Ý kiến của các bên Liên Đới

Các buổi họp Cộng đồng, các cuộc Phỏng vấn chủ chốt, các Nhóm Tập trung, Thăm dò trực tuyến



Điều trần Công cộng tại Hội đồng Y Tế Tâm Thần  
Các Khuyến Nghị của Hội đồng Y Tế Tâm Thần

Hội Đồng Nghị Viên Phê Chuẩn



# APPENDIX II MHSA Funding Estimates

I. CSS	2017-18	2018-19	2019-20	TOTAL
Estimated - 3- Year Average Marin County MHSA Allocation	\$9,202,872	\$9,202,872	\$9,202,872	\$27,608,616
CSS Programs Currently Funded (FY 16/17)	\$7,725,675	\$7,725,675	\$7,725,675	\$23,177,025
WET Programs Currently Funded	\$333,333	\$333,333	\$333,334	\$1,000,000
Unallocated Funds	\$1,143,864	\$1,143,864	\$1,143,863	\$3,431,591
<b>Total CSS Funds Available</b>	<b>\$9,202,872</b>	<b>\$9,202,872</b>	<b>\$9,202,872</b>	<b>\$27,608,616</b>

II. PEI	2017-18	2018-19	2019-20	TOTAL
Estimated - 3- Year Average Marin County MHSA Allocation	\$1,996,433	\$1,996,433	\$1,996,433	\$5,989,299
PEI Programs Currently Funded (FY 16/17)	\$1,900,500	\$1,900,500	\$1,900,500	\$5,701,500
Unallocated Funds	\$95,933	\$95,933	\$95,933	\$287,799
<b>Total PEI Funds Available</b>	<b>\$1,996,433</b>	<b>\$1,996,433</b>	<b>\$1,996,433</b>	<b>\$5,989,299</b>

III. INN	2017-18	2018-19	2019-20	TOTAL
Estimated - 3- Year Average Marin County MHSA Allocation	\$517,765	\$517,765	\$517,765	\$1,553,295
INN Programs Currently Funded (FY 16/17) (Note: Existing INN funded programs will not be funded with INN funds in the next 3-year plan)	\$0	\$0	\$0	\$0
Unallocated Funds	\$517,765	\$517,765	\$517,765	\$1,553,295
<b>Total Estimated INN Revenues - County</b>	<b>\$517,765</b>	<b>\$517,765</b>	<b>\$517,765</b>	<b>\$1,553,295</b>

# Xây Dựng Hệ Thống Hợp Nhất, Dựa Trên Bằng Chứng

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- Xây dựng các đội ngũ đa ngành để hỗ trợ trọn tru, cung cấp các dịch vụ y tế tâm thần hợp nhất và cai nghiện một cách hiệu quả kinh tế nhất.
- Phát động chương trình điều trị ngoại trú đầu tiên do quận điều hành để giải quyết sự rối loạn tâm thần đi kèm với sử dụng chất gây nghiện.
- Tuyển dụng Chuyên Gia Cấp Chứng Y Học Khoa Nghiện Đầu Tiên

# Chấn Thương

*Câu “Điều gì đã xảy ra cho bạn?” thay thế câu  
“Bạn có vấn đề gì vậy?”*

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- 90% người đi tìm trị liệu tại các cơ sở sức khỏe hành vi đã trải nghiệm đau thương. Một số lượng đáng kể tương tự của các cá nhân bị tổn thương được thấy trong các văn phòng bác sĩ gia đình của khu vực công.
- Kinh nghiệm Bất lợi Tuổi Ấu thơ (Adverse Childhood Experiences(ACES)): 59% người Mỹ trải qua ít nhất một kinh nghiệm bất lợi thời trẻ thơ trong cuộc đời của họ. 9% trải nghiệm năm lần hoặc nhiều hơn.
  - Lạm dụng tâm lý, thể chất hoặc tình dục
  - Bạo lực trong cộng đồng hay trường học
  - Chứng kiến hay trải qua bạo lực gia đình
  - Thảm họa quốc gia hay khủng bố
  - Bóc lột tình dục
  - Sự mất đi đột ngột hay vì bạo lực của một người thân yêu
  - Các kinh nghiệm về ty nạn hoặc chiến tranh
  - Căng thẳng liên quan đến gia đình quân nhân(ví dụ: triển khai lực lượng, mất cha mẹ hoặc bị thương)
  - Bị tấn công thể chất hoặc tình dục
  - Bị bỏ bê
  - Tai nạn nghiêm trọng hoặc bị bệnh đe dọa tính mạng
  - Bình quân toàn quốc số nạn nhân trẻ em bị lạm dụng và bỏ bê năm 2013 là 679,000, hoặc 9.1 nạn nhân mỗi 1,000 trẻ em.

# Tự Tử

## Một Vấn Đề Lớn Dần

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- Tỷ lệ tự tử (tuổi đã điều chỉnh, trên 100,000 dân) trong Marin là 12.8, cao hơn tỷ lệ CA là 9.8 (CHIS 2015).
- Sự gia tăng trong tỷ lệ tự tử của phụ nữ đã lần đầu tiên dẫn đến sự suy giảm chung của tuổi thọ.
- (Xem báo cáo đính kèm về các vụ tự tử và GGB).
- Những sự kiện về Bệnh Tâm thần và Tự tử:
  - Phần lớn những người bị bệnh tâm thần không chết vì tự tử. Tuy nhiên, trong số những người chết vì tự tử, hơn 90 phần trăm có rối loạn tâm thần có thể chẩn đoán được.

# Trầm Cảm

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- Ước tính có khoảng từ 2-15% số người được chẩn đoán bị trầm cảm nặng đã chết vì tự tử. Nguy cơ tự tử cao nhất ở bệnh nhân trầm cảm khi họ thấy vô vọng về tương lai, ở những người vừa được xuất viện, những người có tiền sử gia đình tự tử và những người đã tìm cách tự tử trong quá khứ.

# Rối Loạn Lượng Tánh

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- Ước tính có khoảng từ 3-20% những người đã được chẩn đoán mắc chứng rối loạn lưỡng tính đã chết vì tự tử. Tuyệt vọng, mới xuất viện, tiền sử gia đình, những vụ tìm cách tự sát trước đây, tất cả làm tăng nguy cơ tự tử ở những người này.

# Tâm Thần Phân Liệt

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- Ước tính có khoảng từ 6-15% người được chẩn đoán mắc bệnh tâm thần phân liệt đã chết vì tự tử. Tự tử là nguyên nhân hàng đầu của tử vong sớm ở những người được chẩn đoán bị tâm thần phân liệt. Hầu hết những vụ này xảy ra khi bệnh mới bắt đầu. Từ 75-95% các người này là nam giới.

# Rối Loạn Cấp Tính

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- Cũng có nguy cơ cao là những người bị trầm cảm cùng một lúc với một bệnh tâm thần khác. Cụ thể, sự hiện diện của sự lạm dụng chất gây nghiện, rối loạn lo âu, tâm thần phân liệt và rối loạn lưỡng tính đặt những người bị trầm cảm vào nguy cơ tự tử lớn hơn.

# Rối Loạn Nhân Cách

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- Những người bị rối loạn nhân cách có khoảng gấp ba lần khả năng chết vì tự sát, hơn những người không bị. Từ 25 đến 50% các cá nhân này cũng bị rối loạn lạm dụng chất gây nghiện hoặc trầm cảm nặng.

*<http://mentalhealth.samhsa.gov/suicideprevention/suicidefacts.asp>*

# Lạm Dụng Chất Gây Nghiện

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- 40% khách hàng đến PES trong ba tháng qua có thử nghiệm dương tính với rượu và/hoặc các chất không kê đơn.
- Trong khoảng từ năm 2010 đến năm 2013, đã có 5,456 ca nhập viện và 8,194 lượt khám phòng cấp cứu liên quan đến rượu và ma túy được báo cáo ở Quận Marin.

# Rượu Cồn

Thiếu niên Marin uống quá sớm, quá thường xuyên và quá nhiều.

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Thiếu niên trong các **trường trung học phi truyền thống** đang bị ảnh hưởng ở mức cao hơn.

- 40% học sinh lớp 9 đã uống ly rượu đầu tiên ở tuổi 14.
- Gần 19% học sinh lớp 11 đã uống rượu hơn ba lần trong tháng qua, và 30% đã uống say ít nhất một lần trong tháng qua. Gần **40% thiếu niên trường trung học phi truyền thống** đã báo cáo có uống say trong cùng một khoảng thời gian. (CHKS)
- **Cải thiện tiếp cận bằng vị trí địa lý:** các dịch vụ tập trung chủ yếu ở San Rafael. Dịch vụ giới hạn ở Novato và Marin City, không có gì ở West Marin.
- **Cải thiện khả năng thu hút tự giới thiệu.**
- Trong TK 2014/15 ít hơn 3% những cuộc khám sàng lọc và/hoặc giám định (RCC) đến từ tự giới thiệu. Phần lớn các giới thiệu đến từ tòa án và các đối tác dịch vụ xã hội.
- Phát hiện của Nhóm Tập trung về Chiến lược đối với việc Sử dụng chất gây nghiện: Chính sách và thái độ ở một số phòng khám y khoa gia đình và y tế tâm thần cho thấy có sự kỳ thị đối với loại rối loạn sử dụng chất gây nghiện.

# Nhà Ở

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- Theo Sở Quản lý Dịch vụ Sức Khỏe Tâm Thần và Lạm Dụng Chất Gây Nghiện, 20-25% dân số người vô gia cư tại Hoa Kỳ bị một số dạng bệnh tâm thần nặng.
- Những người vừa nghiện vừa tâm thần phải trải qua những rào cản lớn hơn về nhà ở so với người thường: thu nhập thấp, bị kỳ thị và cần các dịch vụ trọn gói của cộng đồng.
- Sự kỳ thị liên tục của các chủ nhà, các nguồn tài trợ, và các nhóm khu phố đã ngăn ngại phục vụ người khuyết tật, bất chấp pháp luật như Đạo luật Tu Chính về Sự Công Bằng Trong Gia Cư.
- Những rào cản lâm sàng chính bao gồm thiếu sự chú ý đến các vấn đề về chấn thương, bao gồm cả lạm dụng thể chất và tình dục lúc ấu thơ và sau này; thất bại trong việc cung cấp rộng rãi các thuốc chống loạn thần mới; và thiếu điều trị hợp nhất cho bệnh nhân vừa tâm thần vừa nghiện.

# Các Cộng Đồng Không Được Phục Vụ Đúng Mức

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- Các cá nhân, gia đình và cộng đồng đã trải qua những bất lợi kinh tế xã hội có nhiều khả năng phải đối mặt với những trở ngại lớn đối với sức khỏe tổng quát. Những đặc điểm như chủng tộc hay sắc tộc, tôn giáo, tình trạng kinh tế xã hội thấp, giới tính, tuổi tác, sức khỏe tâm thần, khuyết tật, khuynh hướng tình dục và bản sắc giới tính, vị trí địa lý, hoặc các đặc tính khác trong lịch sử liên quan đến sự loại trừ hoặc phân biệt đối xử được biết là ảnh hưởng đến tình trạng sức khỏe.
- Các chính quyền liên bang và tiểu bang theo dõi các chương trình và sinh hoạt do Chính quyền tài trợ để đảm bảo rằng việc tiếp cận, sử dụng, và kết quả được công bằng giữa các nhóm chủng tộc và dân tộc thiểu số. Xem *Medi-Cal Approved Claims Data for Marin MHP LGBTQ*: chúng tôi không thu thập các con số nhân khẩu học nên không thể theo dõi những người chúng tôi đang phục vụ và cách phục vụ.
- Người thụ hưởng Medi-Cal gốc La tinh: Hệ thống cho Người lớn có ít người nói tiếng Tây ban nha – trái ngược với hệ thống của Trẻ em. Làm cách nào để tăng dịch vụ cho Người lớn chỉ nói tiếng Tây Ban Nha [Xem Tờ khai về chủng tộc/dân tộc đã được phê chuẩn của Marin để có chi tiết]

Xin cảm ơn quý vị đã tham gia vào  
Quy Trình Hoạch Định MHSA  
của Cộng Đồng



## APPENDIX - II

### Integrating Mental Health and Substance Abuse Services

1. What would integrated mental health and substance abuse services look like from the consumer perspective?
2. What are the barriers to integrated services in this community?

### Housing for Individuals with Mental Illness

1. Housing costs in Marin County are very high. What ideas do you have about strategies to develop affordable housing for the individuals whose lives are affected by serious mental illness?
2. NIMBYism is a barrier to the development of housing for members of this community who live with serious mental illness. What strategies can be employed to enlist community support for housing for individuals with serious mental illness?

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1. Are Crisis and Suicide Prevention Services readily available to Marin County Residents?
2. What services are not readily available?
3. How can we better address the crises/suicide in this community?
4. As a community, which is connected by the Golden Gate Bridge, which is a destination for individuals who are contemplating suicide, how can we respond to the challenges created by this phenomena?

### First Episode Psychosis

1. Research has shown that intervening early in the course of a developing psychotic disorder, can dramatically improve the long-term health of individuals who have experienced a first psychotic event. Do you support the development of a First Episode in Psychosis Program in Marin County?
2. How can we ensure that we reach these individuals and families early when they are first experiencing these symptoms?

*Help keep time by reminding them how much time they have left as you progress.*

*End time: 11:35 (Mary will announce if that is extended)*

*You will report out key points from the conversation during Report Out (1-2 minutes)*

**PROVIDER**  
**COMMUNITY MEMBER**

**CONSUMER/PERSON WITH LIVED EXPERIENCE**  
**FAMILY MEMBER OF CONSUMER (dot is YELLOW)**

# APPENDIX - II

Mental Health Services  
Access Line  
1 (888) 818-1115

Alcohol and Other Drug  
Access Line  
1 (888) 818-1115

Mental Health & AOD  
Co-occurring Programs  
Capacity

## PREVENTION SERVICES

## TREATMENT SERVICES

## RESIDENTIAL CARE & HOUSING

## FORENSICS

## CRISIS CONTINUUM

## RECOVERY

ADULT / FAMILIES MH PEI  
Community Action Marin  
Vietnamese Program  
3270 Kerner Blvd, Suite C San  
Rafael 415-457-4554

COUNTY MEDICATION &  
OUTPATIENT CLINICS  
250 Bon Air Rd. Unit B, Greenbrae  
3270 Kerner Blvd. Suite B, San Rafael  
10 N San Pedro Rd. Suite 1020  
San Rafael

AIR TEAM  
3270 Kerner Blvd. Suite B  
San Rafael, CA

RESIDENTIAL AOD TREATMENT  
Center Point  
415-456-6655  
Men; Women; Women with Children  
San Rafael, CA 94901

INDEPENDENT CONTRACTORS  
Criminal Justice Coordinator  
415-473-6409  
Jim Ricci  
Recovery Coach (AB 109/SB 678)  
Neil Miller  
Recovery Coach (AB 109/SB 678)  
VACANT  
Recovery Coach (ADC)  
Dena Martin  
Recovery Coach (Females)  
Teena Scovis, Ph.D.  
Assessment/Therapy (ADC)

PSYCHIATRIC  
EMERGENCY  
SERVICES  
250 Bon Air Road, Unit B  
Greenbrae  
415-473-6666

ANCILLARY SERVICES  
HIV/Hep C Testing – Marin Treatment  
Center  
1466 Lincoln Ave., San Rafael – 415-  
457-3755  
Sober Living (AB 109) – Marin  
Services for Men  
1005 A St., Suite 209 San Rafael –  
415-485-6736  
\*Thinking for a Change – San Rafael  
(AB 109) – BACR  
103 Shoreline Pkwy, San Rafael– 415-  
507-4137  
\*Thinking for a Change – Novato (AB  
109) - BACR  
1767 Grant Ave, Novato – 415-507-  
4137  
\*Thinking for a Change – Marin City  
(AB 109) PDEC  
850 Drake Ave., Marin City – 415-740-  
5590

ADULT / FAMILIES PEI  
Canal Alliance – MH PEI and  
Community Health Advocates  
91 Larkspur St., San Rafael  
415-454-2640

ADULT CASE  
MANAGEMENT SERVICES  
3270 Kerner Blvd. Suite B, San Rafael

CARE TEAM  
Outreach Engagement

CONTRACTED BOARD & CARE  
St. Michael's, St Anne's, All Saints, Golden  
Home, Providence Place, Creekwood Senior  
Home, Parfitt Rest Homes, Willow Glen Care  
Center, Davis Guest Home

IN-CUSTODY SERVICES – MARIN  
COUNTY JAIL  
Agency/Services: BACR (415-507-4137)  
Assessment, Seeking Safety Groups,  
Thinking for a Change Groups, Anger  
Management Groups  
Agency/Services: MTC (415-457-3755)  
Methadone Maintenance

ACUTE CARE  
HOSPITALS  
Marin General  
S.F. General  
St. Francis  
St. Helena  
Sutter Center  
John Muir  
Mills Peninsula  
Woodland Memorial

OLDER ADULT MH PEI  
Jewish Family and Children's Services  
(Countywide and In-Home: 600 5<sup>th</sup>  
Ave., San Rafael, 415-491-7960)

MARIN COMMUNITY CLINICS-MENTAL  
HEALTH INTEGRATED PHYSICAL  
HEALTH CARE CLINIC  
250 Bon Air Rd. Unit B, Greenbrae

ODYSSEY PROGRAM (FSP)  
250 Bon Air Rd. Unit B,  
Greenbrae

RESIDENTIAL SUPPORTSERVICES  
D Street House, Novato House, Avanti House,  
Draper House

JAIL MENTAL HEALTH SERVICES  
Services: Consultation, crisis  
intervention, psychiatric medications,  
discharge planning, court evaluations  
Location: 13 Peter Behr Drive, San Rafael

CRISIS  
RESIDENTIAL  
Casa Rene  
415-256-9995

COMMUNITY & PROVIDER PEI  
TRAINING  
Countywide  
(415) 473-2543

HOPE PROGRAM (FSP)  
10 N San Pedro Rd. Suite 1020 San  
Rafael  
Senior Peer Counseling  
Older Adult

SHORT-TERM HOUSING  
VOYAGER PROGRAM

ASSISTED INDEPENDENT LIVING  
CARMEL HOTEL PROGRAM  
MAIL PROGRAM  
SHELTER PLUS CARE PROGRAM

CIT LAW ENFORCEMENT OFFICERS  
JAIL MENTAL HEALTH  
Adult & Older Adult

CRISIS PLANNING  
Community Action Marin  
CM and Countywide:  
3270 Kerner Blvd. Suite C  
San Rafael  
415-457-4554

PRIMARY PREVENTION SERVICES  
Prevention Coordinator: 415-473-4230  
\*Novato Blue Ribbon Coalition for Youth  
– City of Novato  
Twin Cities Coalition – City of Larkspur  
Mill Valley Aware- City of Mill Valley  
W. Marin Coalition for Healthy Kids – San  
Geronimo Valley Community Center  
RXSafe Marin – rxsafemarin.org  
Media Advocacy – O'Rorke, Inc.  
Youth Coalition – Youth Leadership  
Institute  
Community Mobilizing for Change on  
Alcohol – Youth Leadership Institute

CONTRACT PROVIDER NETWORK  
(7) Organizational Providers  
(6) Individual Providers

ENGAGEMENT GROUPS  
Recovery Connections Center  
103 Shoreline Parkway, San Rafael

LONG-TERM CARE PROVIDERS  
(LOCKED)  
California State Hospitals, California  
Psychiatric Transitions, Creekside,  
Crestwood, Canyon Manor, Idylwood,  
American River, Country Villa Merced  
Behavioral Health Center

STAR PROGRAM & MH COURT (FSP)  
250 Bon Air Rd. Unit B, Greenbrae

MOBILE CRISIS RESPONSE  
TEAM  
415-473-6392

VETERANS COMMUNITY CONNECTION  
Marin County Veterans Service Office  
10 N. San Pedro, San Rafael  
(415) 473-6193

TRANSITION TEAM  
250 Bon Air Rd. Unit B,  
1-888-818-1115

ADULT/FAMILIES MH  
Marin Community Clinics  
415-448-1500  
Coastal Health Alliance  
415-868-0124  
Marin City Health & Wellness Center  
415-339-8813  
Ritter Center  
415-457-8182

INTENSIVE OUTPATIENT  
TREATMENT  
Center Point  
415-456-6655  
Marin Outpatient & Recovery Services  
415-485-6736  
Marin Treatment Center  
415-457-3755

OUTREACH AND  
ENGAGEMENT TEAM  
1-888-818-1115

MEDICATION ASSISTED TREATMENT  
Agency: Marin Treatment Center  
Location: 1466 Lincoln  
Avenue, San Rafael  
Telephone: 415-457-3755  
Services: Methadone Maintenance

SUICIDE PREVENTION  
HOTLINE  
FSA/Buckelew  
415-499-1100 (24/7)  
Countywide

Helen Vine Recovery Center  
301 Smith Ranch Road,  
San Rafael  
415-492-0818

# APPENDIX - II

**Mental Health Services  
Access Line**  
1-888-818-1115

**Alcohol and Other Drug Recovery  
Access Line**  
1-888-818-1115

**Mental Health & AOD  
Co-Occurring Programs  
Capacity**

## PREVENTION EARLY INTERVENTION

## SCHOOL BASED SERVICES Clinician on site 4-20 hr/wk

## TREATMENT SERVICES

## CRISIS CONTINUUM

Jewish Family and Children's Services  
*Triple P*  
(Countywide)

Jewish Family and Children's Services  
*Early Childhood Mental Health*  
(Countywide: 18 subsidized)

School Age PEI  
Bay Area Community Resources  
(WM: Shoreline School District)  
Marin City CSD  
(SM: Sausalito Marin City SD)  
Seneca  
(CM: San Rafael City Schools)

Huckleberry Youth Programs  
TAY (CM: 361 Third Ave., San Rafael,  
415.258.4944)

Novato Youth Programs  
TAY (NM: 680 Wilson Ave., Novato,  
415.892.1643)

Screening and Assessment  
Screening, Assessment and Referral  
Telephone 1-888-818-1115

### Primary Prevention Services

Prevention Coordinator: 415-473-4230  
\*Novato Blue Ribbon Coalition for Youth  
– City of Novato  
Twin Cities Coalition – City of Larkspur  
Mill Valley Aware- City of Mill Valley  
W. Marin Coalition for Healthy Kids –  
San Geronimo Valley Community Center  
RXSafe Marin – rxsafemarin.org  
Media Advocacy – O'Rorke, Inc.  
Youth Coalition – Youth Leadership  
Institute  
Community Mobilizing for Change on  
Alcohol – Youth Leadership Institute

Outpatient - Child & Family  
Bahia Vista Elementary  
Coleman Elementary  
Davidson Middle School  
Novato High School  
San Rafael High School  
Short Elementary  
Terra Linda High School  
Venetia Valley  
Elementary / Middle School

Youth & Family Services  
3230 Kerner Blvd., San Rafael  
415 -473-6724  
Outpatient  
Medication  
Wraparound  
Peer-Based Parent Support  
Parenting Classes  
Youth Mentoring

Youth Empowerment Services: (FSP)  
Juvenile Probation Services (thru 18)  
Outpatient  
Medication  
Wraparound

CalWORKS Services  
Assessment  
Brief intervention  
Referral  
Intensive Case Management  
Medication

West Marin Clinic  
Outpatient Services - Children, Youth &  
Adult  
Medication  
100 6<sup>th</sup> St., Pt. Reyes Station  
415-473-3800

Seneca Wraparound  
Collaboration with Social Services, MCOE,  
Juvenile Justice  
Services: Wraparound, in home, mentoring,  
"whatever it takes"

Intensive Outpatient Treatment  
Agency: Bay Area Community Resources  
Services: Individual, Group and Family  
Counseling; Case Management,  
Pro-Social Support  
Location: 103 Shoreline Parkway,  
San Rafael  
Telephone: 415-755-2319  
Populations Served: Juvenile Drug Court  
and Probation-referred adolescents (14-18  
years of age)

TAY Sunny Hills Services (FSP)  
615 B Street, suite 1A San Rafael  
415-457-3200  
FSP for 16-25 years old  
Case management  
Outpatient services  
Medication  
Job Coaching  
School support

General Outpatient Treatment  
Agency: Huckleberry Youth Programs  
Services: Individual, Group and Family  
Counseling; Pro-Social Support  
Location: 361 3<sup>rd</sup> Street, Suite G, San  
Rafael  
415-258-4944  
Populations Served: 12-25 years of age

Family Partnership Program - CAM  
Peer Support for Parents  
3230 Kerner Blvd., San Rafael

Second Step \*  
(D.V. transitional housing) Services  
Groups:  
Mothers  
Screening/Referrals

Contractor Provider Network  
(10) Organizational Providers  
(5) Individual Providers

PSYCHIATRIC EMERGENCY SERVICES  
250 Bon Air Rd, Greenbrae  
415-473-6666

ACUTE CARE HOSPITALS  
St. Mary  
St. Helena  
John Muir



Presented by the Marin City Community Services District and the County of Marin Health and Human Services Department, Mental Health and Substance Use Services Division



**JOIN US FOR A COMMUNITY MEETING!**

**Mental Health Services Act (Prop 63)  
Three Year Program and Expenditure Plan  
(FY2017-18 through FY2019-20)**

*Southern Marin residents, you are invited to provide your input and recommendations for mental health and substance use services in your community.*



- Discuss Southern Marin Mental Health and Substance Use Service needs and plan for FY2016-17.
- Provide Community Input on the Mental Health Services Act (MHSA) Three-Year Plan for FY2017-18 through FY2019-20.

<b>Monday June 20, 2016</b>	<b>Margarita C. Johnson Marin City Senior Center 640 Drake Avenue Marin City</b>	<b>5:00 – 7:00 pm</b>
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*Refreshments and Child Supervision will be provided.*

*If you have any questions, please contact Cesar Lagleva at:*  
[clagleva@marincounty.org](mailto:clagleva@marincounty.org) or 415.473.2662

*Please distribute this information widely.*



All County public meetings are conducted in accessible locations.  
If you require transportation to participate at these meetings, please contact us at least 72 hours in advance by calling: (415) 473-7465 (Voice) or (415) 473-3344 (TTY) or by email at: [kclarke@marincounty.org](mailto:kclarke@marincounty.org).  
Copies of documents used in this meeting are available in accessible formats upon written request.

VOICE YOUR OPINION!  
Mental Health Services Act (Prop 63)  
FY 2017-20 Three Year Plan Meeting

The County of Marin, Health and Human Services, Behavioral Health and Recovery Services would like you to voice your opinion on how to improve mental health and substance use services in Marin County. Express your feedback / recommendations on Marin's MHSA Three Year Plan! Now is the time to speak out about what your community needs and how you envision change.

Join us at one of our community meetings:

**Thursday**  
**November, 10**  
6:30 - 8:30 pm

Mill Valley  
Community  
Center

180 Camino Alto, Mill  
Valley

**Tuesday**  
**November, 15**  
6 - 8 pm

Novato Youth  
Center

680 Wilson Ave,  
Novato

**Monday**  
**December, 5**  
10 am- Noon

Albert J. Boro  
Community  
Center

50 Canal St,  
San Rafael

Transportation to participate at these meetings is available, please read below.

Refreshments and child supervision will be provided. If you have any questions, please contact:  
Gustavo Goncalves at: [ggoncalves@marincounty.org](mailto:ggoncalves@marincounty.org) or 415.473.2543. Please distribute this information widely.



¡VOZ SU OPINIÓN!  
Ley de Servicios de Salud Mental (MHSA/Prop. 63)  
Reunión del Plan Trienal FY 2017-20

El Condado de Marin, Division de Servicios de Salud y Servicios Humanos, departamento de Salud Mental y Servicios de Recuperación le gustaría que expresara su opinión sobre cómo mejorar los servicios de salud mental y uso de drogas en el Condado de Marin. ¡Expresé sus comentarios / recomendaciones sobre el plan de tres años de Marin MHSA! Ahora es el momento de hablar sobre lo que su comunidad necesita y cómo imagina el cambio.

Ven a una de nuestras reuniones comunitarias:

**Jueves**  
**November, 10**  
6:30 - 8:30 pm

Centro Comunitario  
de  
Mill Valley

180 Camino Alto, Mill  
Valley

**Martes**  
**November, 15**  
6 - 8 pm

Novato Youth  
Center

680 Wilson Ave,  
Novato

**Lunes**  
**December, 5**  
10 am- Noon

Centro Comunitario  
Albert J. Boro

50 Canal St,  
San Rafael

Hay transporte disponible para participar en estas reuniones, por favor lea a continuación abajo.

Se ofrecerá refrescos y servicios de cuidado de niños. Si tiene alguna pregunta, comuníquese con:  
Gustavo Goncalves [ggoncalves@marincounty.org](mailto:ggoncalves@marincounty.org) 415.473.2543.



Todas las reuniones públicas del condado se acontecen en lugares accesibles. Si necesita transporte para participar en estas reuniones, comuníquese con nosotros con 72 horas de anticipación llamando al (415) 473-2543 (voz) o (415) 473-3344 (TTY) o por correo electrónico a: [ggoncalves@marincounty.org](mailto:ggoncalves@marincounty.org). Las copias de los documentos utilizados en esta reunión están disponibles en formatos accesibles por solicitud. 247



## **APPENDIX - IV**

### **Integrating Mental Health and Substance Abuse Services**

1. What would integrated mental health and substance abuse services look like from the consumer perspective?
2. What are the barriers to integrated services in this community?

### **Housing for Individuals with Mental Illness**

1. Housing costs in Marin County are very high. What ideas do you have about strategies to develop affordable housing for the individuals whose lives are affected by serious mental illness?
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1. Research has shown that intervening early in the course of a developing psychotic disorder, can dramatically improve the long-term health of individuals who have experienced a first psychotic event. Do you support the development of a First Episode in Psychosis Program in Marin County?
2. How can we ensure that we reach these individuals and families early when they are first experiencing these symptoms?

*Help keep time by reminding them how much time they have left as you progress.*

*End time: 11:35 (Mary will announce if that is extended)*

*You will report out key points from the conversation during Report Out (1-2 minutes)*

**PROVIDER**  
**COMMUNITY MEMBER**

**CONSUMER/PERSON WITH LIVED EXPERIENCE**  
**FAMILY MEMBER OF CONSUMER (dot is YELLOW)**

**Marin County  
The Mental Health Services Act Community Planning Process  
(May 2016 through May 2017)**

In May 2016, Marin County Behavioral Health and Recovery Services (BHRS) initiated a planning process for the Mental Health Services Act (MHSA), Three-Year Program and Expenditure Plan for fiscal years 2017-2020. Under the direction of Suzanne Tavano, Ph.D., Behavioral Health Director, the planning process was led by Kasey Clarke, BHRS Administrative Services Manager, Kristen Gardner, Senior Program Coordinator MHSA Prevention and Early Intervention and MHSA Innovation, Cesar Lagleva, Ethnic Services Manager and Workforce Education and Training Manager, and Mary Roy, a consultant with MHSA planning expertise. This work was supported by Administrative Services Technician, Gustavo Goncalves.

A participatory framework was designed to maximize the involvement of consumers, family members, providers, and community members. Community Engagement activities included: A Policy Forum, Key Informant Interviews, Focus Groups and Community Forums. These planning efforts continued throughout 2016 through March 2017.

The official project launch began on June 20, 2016 with a Community Meeting in Marin City for Southern Marin residents. In September a Policy Forum was conducted. Those present included Behavioral Health Administration, managers, clinical staff and peer providers. The purpose of the Policy Forum was to increase understanding of the Mental Health Services Act, the Community Planning Process and to obtain input from service providers.

A Mental Health Services Act overview presentation was provided at the Policy Forum, Community Meetings and the Mental Health Services Act Advisory Committee Meeting. This included a PowerPoint Presentation, covering the Purpose of the Act; it's aims, target populations, key components, funding formulas and intended outcomes. An abbreviated overview was provided at each Focus Group Meeting and relevant data was reviewed to inform the discussions.

In each Community Forum, Focus Group and Key Informant Interview, areas of inquiry were explored. These included identifying key areas of need for health equity populations, the clinical advancement of service and housing. Specific questions included, identifying the strengths of the Behavioral Health System, the behavioral health needs of each community, barriers to access to care, systems capacity issues and gaps in the service delivery system. Participants were also asked to identify at risk populations, for whom early intervention may prevent mental illnesses from becoming severe and disabling. These are addressed in system development strategies.

**Marin County  
The Mental Health Services Act Community Planning Process  
(May 2016 through May 2017)**

Health Equity

The following populations were identified as underserved cultural groups defined by Medi-Cal services provided per population served by Marin Behavioral Health and Recovery Services. Latinos, (Hispanic, according to 2015 United States Census Bureau estimates) which comprise 18.2% of the population, Vietnamese, which are counted within the Asian Population of Marin (2015 US Census Bureau Estimates) and comprise 6.2% of the population of Marin. Consumers of Mental Health Services, who live with chronic and persistent mental illness, were chosen as a health equity population as a result of data, which confirms the poor health outcomes of this group.

Clinical advancement initiatives were identified as areas in which substantial clinical evidence indicates adoption of treatment methodologies proven to be effective in improving client care and health outcomes. These included Early Intervention in Psychosis, the integration of Mental Health and Substance Use Care, Trauma Informed Care and Suicide Prevention.

Throughout the planning process Marin Behavioral Health and Recovery Services redoubled their efforts to ensure that consumers of mental health services were included in each aspect of the process.

**COMMUNITY PLANNING FINDINGS**

**Strengths of the Marin Behavioral Health and Recovery Services**

Stakeholders identified many areas of strength during the Community Planning Process. These strengths included:

The Thursday family support meetings and the Bon Air trainings for parents were noted as important and appreciated components of care. Family members are often the most enduring means of support for those with Seriously Emotionally Disturbed(children and youth), adults with mental illness and co-occurring disorders. Providing supportive care for caregivers was recognized as critical and valued services.

The establishment of the Crisis Continuum has improved the ability of the department to meet the urgent behavioral health needs of the community. The Outreach & Engagement, Transition and Mobile Crisis Teams were noted as successful in providing community based care to individuals and families during times of critical need and vulnerability.

The addition of a Family Partner Staff Member to the Crisis Stabilization Unit, who supports individuals and families in crisis, was noted as another system

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strength. Family Partner Staff, many of who are bi-lingual and bi-cultural, support families throughout the System of Care.

Peer provided services were noted as a Behavioral Health System asset. The role of the Enterprise Resource Center (ERC) in supporting recovery was recognized as a system strength.

The establishment of the Access Team for screening and referral has resulted in more timely community connection to Behavioral Health care. Recent changes in the Access Team have further improved services with an increased number of Spanish speaking staff available to the Latino Community. Walk in assessment services have been added and were especially appreciated by consumers.

Ritter House, housing first services, was recognized as providing valuable support to formerly homeless individuals who live with mental illness or co-occurring disorders.

One informant wrote to express appreciation for the urgently needed care her family member received through the Crisis Continuum. These services were provided in home and at the Crisis Stabilization Unit. Ongoing care was arranged and services provided.

The value of Helen Vine detox program was highlighted by stakeholders who suggested establishing more programs modeled after these services.

The increasing efforts to attract a more racially/ethnically diverse workforce were recognized as being system strengths. The important role of the Cultural Competence Committee was recognized as furthering the aim of providing more culturally competent care throughout the system.

The work engaging the Latino community was recognized, including the Cuerpo Corazón Comunidad radio show, and the role of the Promotores in engaging and providing support for the Latino Community.

**Countywide Systems**

Marin County Behavioral Health and Recovery Services provides Behavioral Health Care to Marin County Residents, within the scope of public mental health. This is generally comprised of the Medi-Cal eligible population. The Mental Health Services Act expanded the scope of services, which can be provided by California's Public Behavioral Health Care System.

The Community Supports and Services (CSS) component of MHSA expanded the scope of treatment and support options to enable counties to provide more

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comprehensive community based care to children with Serious Emotional Disturbance and adults with Serious Mental Illness.

Prevention and Early Intervention, (PEI), broadened the provision of community based mental health by adding services effective in preventing mental illnesses from becoming severe and disabling. This included the goal of reducing the duration of untreated mental illness and assisting people in quickly regaining productive lives. This program emphasizes improving timely access to underserved populations.

**Community Services and Supports**

The majority of MHSA funds are directed to the Community Services and Supports Funding Category (CSS). These funds are allocated to serve children and youth; transition aged youth, adults and older adults. The target population served through CSS include, seriously mentally ill adults, and older adults. (W&I Code 5801) and seriously emotionally disturbed children and youth (SED), (W&I Code 5850).

**Full Service Partnership Programs**

Background

The cornerstone of MHSA, CSS services, are the Full Service Partnership Programs (FSP's) which provide individuals with mental illness or those dually diagnosed with mental illness and substance use issues, with a comprehensive approach to service delivery based on the evidence-based "Assertive Community Treatment" model. These services are defined as "the collaborative relationship between the County and the client, and when appropriate, the client's family, through which the county plans for and provides the full spectrum of community services so that the client can achieve the identified goals."

MHSA Statute requires the majority of CSS funds be allocated to Full Service Partnership Programs.

In Marin County, FSPs have been established to serve Seriously Emotionally Disturbed (SED) Youth, Transition Aged SED/SMI Youth, Support and Treatment After Release, (STAR), serving adults with involvement with the justice system, Helping Older People Excel (HOPE), and the Odyssey Program serving adults which are homeless or at risk of homelessness.

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Evaluative Findings

It was noted that not all adults in need of more intensive service, fit within the existing service target populations. Providing adults, who need a higher level of care, the option of (ACT) would fill this system gap.

**Priorities**

- It is recommended that consideration be given to establishing a general ACT program, which can serve adults with serious mental illness, in need a more intensive level of community based care.

**General Systems Development**

Background

The General Systems Development (GSD) component of CSS allows counties to fund a variety of supports and services.

Within Marin County a combination of grant funding and MHSA, GSD funds support the Crisis Continuum. The Crisis Continuum includes the Transition Team, the Mobile Crisis Response Team and the Outreach and Engagement Team.

The Transition Team provides short-term management to stabilize and link individuals to on-going services. The Mobile Crisis Response Team responds to mental health and substance use crises in the community seven days a week. The Outreach and Engagement Team provides supportive outreach to individuals in need of behavioral health care who are not currently engaged in service.

Currently the Outreach and Engagement Team and Transition Teams are funded by MHSA and the Mobile Crisis is funded through a SB 82 grant.

Informant Findings

Throughout the Community Planning Process, the Outreach Team, Mobile Crisis Response Team and the Crisis Stabilization Unit were identified as strengths of the BHRS. In Community Meetings, Policy Forum and Key Informant Interviews, recommendations included increasing the hours of operation to expand Mobile Crisis Response Services.

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Other recommendations included adding bi-lingual bi-cultural staff in key entry points, including the Outreach Team, Mobile Crisis Response and the Crisis Stabilization Unit. (See Latino Health Equity)

Informants described the challenge of accessing emergency services and the need for additional training for the police who responded to calls for help. The areas of concern were, understanding mental illness, de-escalation techniques and cultural sensitivity.

Evaluative Findings

It is possible that the grant funding for the Mobile Crisis Team will sunset in fiscal year 2019/20. Consideration for continuing these services through GSD is recommended.

There was community support for increasing the hours of operation of the Mobile Response Team to 24-hour community care.

The need to bolster the level of support for crisis planning was noted. Crisis planning increases client directed care during times of crisis. Wellness Recovery Action Planning is integral to this process. Consideration could be given for additional funding for crisis planning staff to support these efforts.

**Priorities**

- Increase the hours of Mobile Crisis Response Team to cover high demand hours and consider expansion to 24-hour operation if funding allows
- Strengthen the link between Crisis Intervention Training for Police and other Emergency Response Personnel with the Mobile Crisis Response Teams, including de-escalation techniques, and cultural considerations
- Continue to expand crisis planning efforts to maximize consumer input into crisis care
- Continue to support consumer Wellness Recovery Action Plan Development
- Create contingency funding for the Mobile Crisis and Transition Teams in FY 2019/20, to insure on-going operation

**Integrating Mental Health and Substance Use into Behavioral Health and Recovery Services**

Background

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It is recognized that many individuals who have mental illness have multiple disabilities, the most common of which is the co-occurrence of mental health and substance use issues. There has been a paradigm shift in viewing mental health problems as isolated from substance use problems. It has moved toward recognizing that individualized treatment within an integrated model is essential to developing best practices (Koala and Singer).

The National Comorbidity Study demonstrated that the lifetime rate of persons with severe mental illness with a substance abuse disorder was approximately 50%. A variety of negative treatment outcomes have been associated with individuals with co-occurring disorders, including relapse, hospitalization, violence, incarceration and homelessness.

Marin Behavioral Health and Recovery Services are committed to creating an integrated Behavioral Health and Recovery System of Care. BHRS utilizes a number of community-based providers, which offer Substance Use Services:

Center Point, (services include a primary care clinic, out-patient treatment, residential treatment, services for pregnant parenting women, intensive out-patient, and scattered site housing), Bay Area Community Resources, (BACR), (women's substance use treatment; (DUI programs. After school programs which focus on substance abuse prevention and mental health support are located at several elementary schools including, Bahia Vista, Davidson Middle, Laurel Dell Elementary, San Pedro Elementary, San Rafael High, Short Elementary and Venetia Valley Elementary), Buckelew Programs include, (Helen Vine Recovery Center a 26 bed residential detox center), Marin Outpatient and Recovery Services (outpatient substance abuse treatment) Marin Treatment Center (NTP, outpatient substance use treatment, outpatient opioid detox, primary medical service for agency clients, intensive outpatient program, dual diagnosis engagement groups, Mental Health provider for Beacon and Marin County Medi-Cal provider and access to additional medication assisted treatment), Ritter Center (outpatient substance use treatment), and Huckleberry Youth Programs (adolescent outpatient substance use intervention and treatment).

Providing truly integrated care for individuals who experience both serious mental illnesses and substance abuse issues is a challenging task. Often clients don't fit within one of the treatment components of service. Individuals in need of care may face the limitations of either mental health or substance use services, to effectively meet their treatment goals. This can result in relapse or a lack of engagement in recovery.

In 2016 BHRS established the Road to Recovery Program, which provides coordinated substance abuse treatment for adults with serious mental illness and substance abuse disorders. Currently, out-patient and intensive out-patient treatment are offered.

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Building on this framework, a comprehensive continuum of care for those with co-occurring mental health and substance use disorders can be established.

Informant Findings

Throughout the Community Planning Process recommendations for adoption of a harm reduction model for substance abuse and co-occurring treatment was made. Informants in the Policy Forum, the Southern Marin Community Meeting, the Mill Valley Community Meeting and Key Informant Interviews provided this recommendation.

Recommendations for increased stigma reduction, education, and public relations efforts were also made.

Evaluative Findings

Providing a comprehensive continuum of services within the Road to Recovery Program is in process. Further areas for development include the establishment of an engagement component. The proposed engagement efforts would provide group support for individuals with co-occurring disorders who are not yet ready to commit to recovery, but need support moving in this direction. Including mental health therapy as a treatment option and the integration of peer providers, would further develop, the Road to Recovery treatment continuum.

Training for both substance use and mental health providers to increase understanding of the etiology and treatment models for substance and mental health disorders is recommended.

Other needs identified included residential co-occurring treatment for youth, partial hospitalization and a medical detox.

Increasing the coordination of care for individuals throughout the system by integrating certified substance abuse counselors on treatment teams is recommended.

**Priorities**

- Cross training for both Mental Health and Substance Use Staff in evaluation and evidence based care for both Mental Health and Substance Abuse Services
- Integrating co-occurring trained staff at key entry points in the system, including the crisis continuum as funding permits

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- Integrating Substance Use Staff within treatment teams to provide more comprehensive care
- Establish engagement support groups for those who are not yet able to commit to recovery
- Providing mental health treatment to individuals with co-occurring disorders to support their recovery

**Trauma Informed Care**

Background

The effects of traumatic events place a heavy burden on individuals, families and communities. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have difficulties and experience traumatic stress reactions.

Research has shown that traumatic experiences are associated with both behavioral health and chronic physical health conditions. Substance abuse, mental health problems and risky behaviors have been linked with traumatic experiences.

Informant Findings

The importance of addressing trauma, within the context of Behavioral Health Treatment, was supported throughout the MHSA Community Planning Process. In each Community Forum, Population Specific Focus Group and Key Informant Interview, an inquiry into Trauma for each population was raised. In each of these venues the importance of providing Trauma Focused Care was supported. From Prevention and Early Intervention Programs through mental health and substance abuse treatment and recovery, addressing, clinically significant symptoms, trauma triggered relapse and providing clinically appropriate care was supported.

Evaluative Findings

There is a need to further embed ongoing Trauma Based Care within Behavioral Health and Recovery. This includes establishing standards for care and training for staff to support these efforts.

**Priorities**

- Support for the implementation of further evidence-based training and on-going case supervision, to ensure model fidelity, including the identification of an Evidence Based Practice expert who can support

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- implementation and provide case consultation throughout the system of care
- Increased use of validated measures to identify clinically significant trauma, depression and anxiety and utilize post-test measures to gauge the effectiveness of interventions

**Children and Transition Aged Youth**

Background

One half of all chronic mental illness begins by the age of 14, three-quarters by the age of 24. Despite effective treatment, there are often long delays between the appearance of first symptoms and the time young people receive the help they need. These delays in finding effective treatment impact the long-term outcomes for youth with major mental disorders.

Over 50% of students with a mental health condition age 14 and older are served by special education. This group has the highest school dropout rate of any disability group.

Marin County Office of Education reported serving 600 students a year in alternative education. These included; students which were truant, chronic social/behavioral difficulties, on Juvenile Probation, pregnant and parenting teens, homeless youth, foster care youth and youth who support themselves.

Informant Findings

Successful programs identified within the stakeholder process included Newcomer Groups, established by Huckleberry and Novato Youth Center in San Rafael, Terra Linda and Novato High Schools. These groups were established to support the integration of recent immigrants to the school culture. The value of services to this vulnerable population was noted and program expansion was recommended.

Children's Behavioral Health Staff Focus Group Members reported increased levels of illness in the youth they serve. A gap was identified between outpatient services and inpatient care where more intensive services are needed. They reported that some youth in need of hospitalization were not accepted into inpatient care due to their level of acuity.

Both staff and community informants supported the need for further development of an Early Intervention in Psychosis Program (See Recommendations under First Episode Psychosis below).

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Sunny Hills provides comprehensive support for Transition Aged Youth, including treatment, case management, educational and employment support. The need for these services, reportedly, outstretched availability.

Evaluative Findings

Strengthening the connection between Prevention and Early Intervention Services and the Children’s System of Care would enhance this treatment continuum.

An example of an area of focus within PEI Programs is trauma, which is identified as a target for intervention in many school based services. Establishing linkage and tracking mechanisms would help ensure that students in need of higher-level services are connected to the appropriate level of care. Children’s staff have been trained in evidence based Trauma Focused Cognitive Behavioral Therapy and would be a treatment resource for these students. The clinical oversight of PEI programs may serve to strengthen these linkages.

Children’s Lead Staff identified Davidson Middle School, as a high need school. 1200-1300 students attend Davidson and have recommended this school be a focus for PEI services.

The need for additional administrative support staff within Children’s Services was identified. The Clinical Supervisors are often tasked with administrative responsibilities and this diminishes available clinical and supervisory time.

**Priorities**

- Develop an Early Intervention in Psychosis or First Episode of Psychosis Program
- Expand comprehensive services for TAY
- Explore the expansion of Newcomer Groups to aid in the cultural transition for immigrant students, (currently BHRs, MCOE, the District Attorney and Probation are collaboratively supporting the Newcomer Efforts.)
- Increase staffing for the Children’s FSP Program

**OLDER ADULTS**

Background

The Marin County Older Adult population, (60 and over, as defined by MHSA statute), comprise 26% of the total population. It is anticipated that the older adult population will continue to grow and are projected to comprise 30 percent of

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the population by 2030. The income level of Marin County adults, is higher than the statewide average, with 6% falling at or below the poverty level, compared to the statewide average of 11%. However, because of the high cost of living in Marin many are considered economically insecure. Approximately 30% of Older Adults in Marin live alone.

Marin BHRS both serves Older Adults within the general system of care and within specific programming geared to meet their needs. These programs include the HOPE Older Adult Full Service Partnership Program (FSP). This program provides intensive and comprehensive services to 50 persons a year. As with other FSP's the targets for intervention include decreasing homelessness, hospitalization and decrease in psychiatric emergency visits. In FY 2014/15 this program decreased homeless days for enrollees by 68%, hospitalization by 14% and a decrease in mental health emergencies by 47%. By design FSP programs target those individuals with mental illness that is severe in degree and persistent in duration, who are not successfully engaged in treatment. Another component of this program is Outreach and Engagement. During FY 2014/15, 31 assessments of Older Adults were conducted. Senior Peer Counseling is also run by BHRS, which trains volunteers, who provide support to Older Adults, within their homes and the community.

Within Prevention and Early Intervention Older Adults were served through an expansion of Jewish Family and Children's Services (JFCS) existing Older Adult Program, Seniors at Home, to address depression, substance abuse and other Behavioral Health concerns. Each client in the Seniors at Home Program and other seniors who are referred to JFCS for Behavioral Health concerns is screened for depression and substance abuse as part of the standard clinical interview and assessment process. Tools used for screening include the PHQ-9 or the Geriatric Depression Scale and an agency adapted substance use screen. Individuals who score with an elevated risk are referred to the BOOST Program. In FY 2014/15 150 Older Adults received comprehensive assessments and 31 received on-going treatment from BOOST.

Within BOOST, JFCS provides Cognitive Behavioral Therapy, to address social isolation and depression. Clients, who are in the mild to moderate range, are offered 4-6 sessions. For moderately severe clients, treatment will focus on symptom management and strengthening protective factors. For the severely depressed client, a risk assessment is done, family support mobilized and referrals including hospitalization will be explored. Services may last from 6 to 10 months and may include medication management. Severe clients may be referred to higher-level treatment or hospitalization. Evaluations including the use of the PHQ-9 are repeated at 6-month intervals, to measure the effectiveness of treatment and either terminate or continue care.

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In 2014/15 the program launched Caring Connections Volunteers, providing training and supervision for 10 volunteers. Volunteers work with individuals who have completed the program to provide on-going support to stabilize the transition.

Community presentations are conducted to help community members recognize the signs of depression, how to use tools to manage it and when professional help is needed. Seniors from diverse economic and ethnic communities are targeted for these presentations. This past year with the help of translators, presentations were made to Vietnamese and Hispanic older adults, at congregate meal sites. Staff presented at Pt. Reyes Senior Program and has targeted outreach to Marin City.

BOOST accepts some Medi-Care, is a Beacon Provider and has received a small grant from Kaiser Community Benefit Program.

According to SAMHSA, “ Depression is one of the most common mental health disorders in older adults. One in ten older adults in primary care has symptoms of depression, and higher rates are found among older adults who are hospitalized and residing in a nursing home...Depression in older adults is associated with decreased levels of functioning, worse health status, reduced quality of life and increased disability and mortality. Depression is a leading risk factor for suicide in older adults...The incidence of major depression and suicide can be decreased by identifying older adults who are at risk for depression and providing them with effective prevention and early intervention programs.”

Informant Findings

The need for greater availability of psychiatry to provide evaluation and medication management for the older adult population was recognized. JFCS has a limited amount of psychiatry time and at times this has necessitated accessing services through JFCS in San Francisco.

The need to strengthen the connection between the BOOST Program and HOPE FSP was noted. Evaluation of the enrollment criteria for each program may be used to strengthen the continuum of care for Older Adults.

Elder depression, cognitive impairment, support groups and counseling for seniors were identified needs in Novato, Mill Valley, Al Boro Community Meetings and supported in the MHSA Advisory Committee “Community Meeting”. Potential targets for reaching older adults through community outreach and screening included senior centers and faith communities. Integrating Behavioral Health Services at health centers was also recommended.

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The connection between alcohol use/abuse and depression was noted and advocacy for more information being made available to the community to increase understanding of the treatment needs of older adults struggling with these issues.

Seniors who are shut-in or for whom transportation is a barrier to accessing needed care were also noted as a population needing support.

Community members also voiced concerns regarding the relatively low number of seniors served in Senior Peer Counseling and the cost of providing these services.

Focus group members, advocated for more community education to help older adults identify signs of depression and substance abuse and provide linkage to assessment and care. They advocated for the use of PEARLS evidence based model to treat moderate depression and dysthymia. Commission Members developed a curriculum entitled “Detect and Connect” for community education helping community members communicate effectively with older adults and identify signs of dementia and depression. They identified the need for additional staff training to increase awareness of older adult issues, and support for best practices to meet the needs of the older adult population. This included what they perceived as bias in attributing many symptoms of depression to memory loss. Loss and social isolation were also identified as common issues experienced by older adults.

Suicide rates in the older adult population were also noted as an area of focus and concern.

The complex issues medication management including the interactions of multiple medications and ensuring that the medications individuals are taking are currently prescribed and within their shelf life was identified as another area of concern.

Commission members recommended group therapy as an effective form of treatment delivery, which also decreases social isolation.

Another area of need identified was specific outreach to older adults which are homeless. Providing outreach and support within the community and through the shelter system was recommended.

Evaluative Findings

Increased dissemination and utilization of existing resources is recommended. These include, JFCS BOOST program for assessment and treatment of depression, Senior Peer Counseling, The Friendship Line ( San Francisco

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Institute on Aging,) for crisis intervention, emotional support, medication reminders and well-being check ins.

There is a need for greater integration of the senior service continuum. Linking the senior serving programs and increasing community awareness regarding existing services is needed. Prevention and Early Intervention targets include depression, social isolation, loss and substance abuse awareness. Outreach and education to Senior Centers and Faith Communities could increase community understanding and access.

CSS focus will continue to be on older adults whose mental illness is severe in degree and persistent in duration. Increasing the utilization and integration of existing services is a current focus of attention.

Consideration for program development for individuals in need of services who are shut-in or whom transportation should continue to be a focus of planning efforts.

There was considerable advocacy for services to individuals with cognitive impairments throughout the stakeholder process. However, this is not the primary focus of coverage for MHSA services.

Priorities

- Increase outreach and education efforts through PEI to enable the older adult community to recognize the signs that professional Behavioral Health intervention is needed and provide linkage to assessment and treatment.
- Increase utilization of existing services and strengthen the treatment continuum.
- Clarify enrollment criteria for HOPE FSP.
- The addition of a substance abuse counselor to the HOPE Team will increase integration of treatment for those Full Service Partners with co-occurring disorders.
- Explore utilization of screening tools within primary care to identify depression, anxiety and substance abuse.

**Prevention and Early Intervention**

Background

According to the National Substance Abuse and Mental Health Services Administration (SAMHSA) "Preventing mental and/or substance use disorders and related problems in children, adolescents and young adults is critical to Americans' behavioral and physical health. Behaviors and symptoms that signal

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the development of a behavioral disorder often manifest two to four years before a disorder is present.”

The majority of MHSA Prevention and Early Intervention funds are allocated to children and youth (0-25 years old). These programs are tasked with preventing mental illnesses from becoming severe and disabling. Recommendations for prevention and early intervention activities were sought in each stakeholder venue. Participants were asked to identify key populations, which might be reached earlier in the emergence of mental illness, which could prevent these disorders from becoming severe and disabling.

Informant Findings

Recommendations included:

The provision of Behavioral Health Support Services at schools within integrated health clinics

Increased mental health awareness education

Increasing awareness of PEI Programs, how to access them and who is eligible for these services

The development of an on-line resource guide was suggested, to facilitate referrals to support services

Creating support for individuals who are in housing, but at risk of losing housing without assistance

Evaluative Findings

Greater awareness among staff members may be accomplished through increased training for accessing existing resources.

Strengthening linkages between PEI providers and system of care providers was recommended. Where a target for intervention is indicated, e.g. trauma, linkages to trauma based care should be established and monitored. A process of warm hand off, including tracking cases to ensure needed services were accessed.

**Priorities**

- Support for the establishment of health navigators to strengthen the connection between PEI programs and system of care services

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- Support for individuals in maintaining housing through education and support
- Additional Stigma and Discrimination and Behavioral Health Awareness Training
- Consider adding additional staff and funding for the adoption of evidence based services
- Provide support and treatment the high risk youth at Marin Community Alternative Education sites and youth on independent study
- Target PEI school based services to high need schools

**Early Intervention in Psychosis**

Background

Evidence based Early Intervention in Psychosis models have been shown to dramatically improve the long-term health outcomes for youth who are developing a psychotic disorder. These comprehensive approaches have demonstrated positive effects on the long-term level of disability, interpersonal relationships, education, employment and motivation.

As part of clinical practice improvement, and adherence to the MHSA standard of providing care proven to be effective, an inquiry into the implementation of Early Intervention in Psychosis Program was made throughout the MHSA Planning Process.

Informant Findings

The development of an Early Intervention or First Episode in Psychosis Program was supported throughout the MHSA Planning Process. In each of the Community Meetings, Southern Marin, San Rafael, and Novato there was broad support for the development of a program targeting young people who have had a first psychotic episode or who are developing a psychotic disorder. The MHSA Advisory Committee, the Policy Forum and NAMI also strongly supported the importance of developing an evidence-based program, to respond to these critical needs.

NAMI provided some specific recommendations for the development of a first episode program. The recommendations included, using an evidence-based model, on-going supervision and case monitoring, to ensure model adherence and the measurement of clinical outcomes using validated instruments.

Evaluative Findings

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A Focus Group with key staff was held to identify next steps, map out current resources, and discuss implementation strategies. Identifying leadership, funding, and staffing required to fully support these efforts are necessary to move towards full implementation.

**Priorities**

- Develop an Evidence Based Early Intervention in Psychosis or First Episode Psychosis Program

**Suicide Prevention**

Background

Suicide rates in Marin County were higher than the average statewide rate for suicide. Recent statistics reported an increase in suicide rates for women and youth in Marin County. Suicide rates were highest in West Marin between 2006-2010.

The Golden Gate Bridge has long been a destination for those who are contemplating suicide. Recent statistics compiled by the Bridge Patrol Department of the Golden Gate Bridge, Highway and Transportation District have shown a five-fold increase in the number of people under 25 years of age who have arrived on the bridge contemplating suicide. In 2014, there were 28 completed suicides from the bridge. The bridge patrol successfully intervened, preserving the lives of 161 others who were on the bridge contemplating suicide. In 2016 The Golden Gate Bridge Transportation Department partnered with Crisis Text Line, which provides free 24-hour support for people via text, by texting GGB to 74141 or Bay in the Bay Area.

Severe mental disorders are associated with elevated suicide rates. For example, the mortality rate due to suicide is estimated to be over 12 times greater among people with schizophrenia compared to the general population. A history of suicide attempts, depression, not taking medications as prescribed, and drug and alcohol misuse are risk factors for suicide among patients with schizophrenia, bipolar disorder and other major mental illness.

Informant Findings

Throughout the Stakeholder Process, input was sought regarding suicide prevention in Marin County. Participants had varying degrees of awareness of suicide prevention supports such as the suicide prevention line within Marin County. Increasing information in a readily accessible format for clinical staff and community was recommended.

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Evaluative Findings

The need for training in assessing suicide risk and the adoption of a protocol for suicide prevention was recommended. AMSR, Assessing and Managing Suicide Risk could be provided to county and community based staff as a practice improvement initiative.

**Priorities**

- Additional training of staff in assessing and treating those at risk of suicide utilizing evidence based assessment and treatment
- Consider establishing a Suicide Prevention Committee comprised of individuals within Marin whose lives have been affected by suicide, in collaboration with concerned professionals, to examine the system of suicide prevention within Marin County. Together, they can evaluate current resources, identify the needs of individuals at risk of suicide within the community and propose recommendations with the goal of developing a comprehensive system of suicide prevention.
- Increased dissemination of resources for suicide prevention

**Veterans**

Background

It is estimated that 15,000 Veterans live in Marin County. Veterans may suffer from a variety of behavioral health conditions, according to the National Council on Behavioral Health:

“Since 2001, 2.4 million active duty and reserve military personnel were deployed to the wars in Iraq and Afghanistan. Of this group, 30% nearly 730,000 men and women will have a mental health condition requiring treatment. Studies have shown that 18.5% of all OEF/OIF veterans have post-traumatic stress disorder, Major Depression, or both PTSD and Major Depression. Other Mental Health Disorders are estimated at 11.6%.”

“Unfortunately, less than half of veterans needing mental health services receive any care and veterans being treated for PTSD and Major Depression are getting what is called “Usual Care,” the provision of a broad set of services, only a portion of which is Evidence-Based. Not surprisingly, research has proven that Evidence-Based care is more effective than Usual Care, but Usual Care is better than No Care.”

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Veterans comprise one in five homeless Americans. Over 58% of homeless veterans are minorities.

Informant Findings

The Marin County Veterans Service Office helps veterans, their spouses and children obtain all types of veteran's benefits. These include pensions for wartime veterans who are unable to work, free hospital care at VA medical facilities, home loans and veteran's preference for employment. Children of veterans who have a service-connected disability may be eligible to attend a state college or university without payment of tuition.

Veterans are eligible for mental health and drug and alcohol treatment programs within the VA System. However, of veterans who have been discharged, just more than half are using Veterans Administration Care.

The work of the Marin Veterans Service Office has been supported by the addition of Prevention and Early Intervention funds to hire additional staff, to aid in the outreach and assessment efforts. The goal of this program has been to link veterans, which are eligible for services and connect them to needed services. Veterans, who are not eligible for VA services, are connected to other resources. The primary targets for outreach include veterans involved in the criminal justice system and veterans' who are homeless and who have behavioral health needs.

Evaluative Findings

Staffing challenges have impacted the implementation of outreach and engagement efforts within this program. While additional outreach is needed within this community, the ability to fully implement this program has been hampered by personnel shortages.

**Priorities**

- Hiring temporary staff to fill these needs has been recommended
- Consider additional funding once current targets for outreach and engagement are met

**Workforce Education and Training**

Background

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The Workforce Education and Training component of the MHSA provides guidance on developing a workforce capable of meeting the needs of individuals and families with severe mental illness.

California's public mental health system has suffered from a shortage of public mental health workers. There has been a recognized lack racial ethnic and cultural diversity in the mental health workforce and under-representation of mental health professionals with consumer and family member experience.

The Mental Health Services Act includes the standard of providing services proven to be effective. In order for county and community based organizational staff to provide evidence based care, on going training and supervision are indicated. Stakeholders supported the need for the implementation of evidence-based practices. (See Trauma Informed Care, Integrating Substance Use and Mental Health, Latino, First Episode Psychosis and Suicide Prevention).

According to the Substance Abuse and Mental Health Services Administration, "Cultural competence is the ability to interact effectively with people of different cultures. In practice, both individuals and organizations can be culturally competent... Culture is a term that goes beyond just race and ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession.

Under the direction of the Ethnic Services Manager, Cesar Lagleva, both programs and strategies have been adopted to support the development of a workforce, which is clinically and culturally competent and culturally reflective of the communities, which are served by BHRS. These include the Graduate Intern Program, the scholarship program for Consumer and Family Members, the Peer Specialist and SUS Intern Stipend Program, The Peer Mentoring Program, consumer focused trainings, Dual Diagnosis Training, and leadership in the development of BHRS Peer Counselor Positions. Training which has been supported includes Motivational Interviewing, Mental Health First Aid, and Trauma Informed Care. Cultural Competence consultation is available throughout the system of care.

Informant Findings

Increasing the cultural and linguistic diversity of staff, which reflect the populations which they serve, including African American, Latino, Sexual and Gender Minorities, Vietnamese and older adults was a repeated stakeholder recommendation.

Throughout the Community Planning Process the importance of including Peer Providers on each team was emphasized. The inclusion of individuals who are actively in recovery was strongly supported.

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Support for further adoption of evidence based training and care was supported.

Evaluative Findings

Building on the foundational work done in the Workforce Education and Training component of MHSA continuing the advancement of clinical care through on-going training and support for evidence-based practices, for trauma, First Episode Psychosis, depression, and Integrated Behavioral Health Care would support the delivery of effective treatment services.

While some clinical staff expressed the invaluable contribution of Peer Providers on their teams, the need for continued culture change to fully integrate them was also expressed. Ideas for consideration include the development of a Speakers Bureau or support for NAMI's "In Our Own Voice Program". Exposure to individuals with who have experienced mental illness and are perceived as similar to their audience has been shown to be the most effective method to reducing the stigma associated with mental illness.

**Priorities:**

- Training and support for evidence based practices, including trauma based treatment, integrated Behavioral Health Care, Depression and First Episode Psychosis and suicide prevention
- Add more internship opportunities to recruit individuals from the communities which they serve including, Bachelors and Masters level students, Peer Providers and Family Partners
- Continue training and support for the expansion of Peer Provider Services

**Housing**

Perhaps the single most repeated theme throughout the Community Planning Process was the need for accessible, affordable housing as an essential element of the recovery process.

Background

According to the National Alliance for Mental Illness,

"For someone with a mental health condition, the basic necessity of a stable home can be hard to come by. The lack of safe and affordable housing is one of the most powerful barriers to recovery. When this basic need isn't met, people

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cycle in and out of homelessness, jails, shelters and hospitals. Having a safe, appropriate place to live can provide stability to allow you to achieve your goals. You may run into housing issues after being discharged from an inpatient care unit or jail and find that you have no home to return to. Even if you haven't been hospitalized, finding an affordable home can be difficult. Many people with a serious mental illness live on Supplemental Security Income (SSI), which averages just 18% of the median income and can make finding an affordable home near impossible. Finding stable, safe and affordable housing can help you on your journey to recovery and prevent hospitalizations, homelessness and involvement in the criminal justice system.”

The challenge of securing stable affordable housing is amplified in Marin, where housing costs are very high. The stigma and discrimination of individuals with mental illness and co-occurring disorders creates additional barriers to accessing affordable housing.

\$1.4 million dollars of one-time MHSA funds have been redirected from, California Housing Finance Agency, (CalHFA) to Marin County and are available to develop local housing.

**Informant Findings**

Addressing the phenomenon of “not in my back yard”, “NIMBYISM” was a concern expressed by stakeholders who recommended tackling this issue as part of the solution to meeting the challenge of housing. Recommendations included finding a champion within the community who could garner community support from the residents of Marin. This could involve community education and use of local media to highlight the plight of individuals who live with mental illness.

Other recommendations were supported both in Community Forums and during Consumer Focus Groups. Implementing a harm reduction model within available housing, the development of supported housing and the provision of group treatment and support services at housing sites were included. Consumer participants recommended, support for individuals in subsidized housing through training on managing the physical environment and relationship skill building with landlords.

Recommendations for increased after hours access to existing resources including Casa Rene, shelter beds and Helen Vine Recovery.

One focus group member reported living in his car for several months making it his full time job to find housing. This highlighted the difficulty of the task and the skills and fortitude necessary to secure housing. It was recommended that a Housing Systems Navigator be established to assist individuals who are working to secure housing.

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Several types of housing needs were identified, including increased family and youth shelters, supported housing, tiny homes villages, lily pad houses, housing for the medically fragile, increased co-occurring housing, hotel vouchers. Short-term interim housing and support for individuals who are exiting short-term housing to maintain their stability and secure longer-term housing were included. Other ideas included trailer park renovation and providing year round shelter care.

It was suggested that identifying a champion or partner with the ability to join with the county such as George Lucas or The Marin Agricultural Trust could further efforts to meet this area of critical need. It was also suggested that each city could contribute to securing space or funds for housing.

**Priorities**

- Direct \$1.4 million CalHFA funds to establish permanent supportive housing
- Seek a community partner to join in this effort
- Consider hiring a housing scout to locate housing opportunities
- Develop a support system for consumers on maintaining housing
- Consider creating a Housing Navigator to support individuals in their housing search

On-going funding for this component is accomplished through the MHSA 3-Year Community Planning Process and should be included in the recommendations for on-going funding.

**Health Equity**

**Latinos**

Background

There are a variety of significant efforts within Marin County to reach the Latino Members of this community. The role of Dr. Muñoz-Kiehne was identified as critical in reaching this concentration population. Dr. Muñoz-Kiehne offers consultation and training to the PEI mental health Promotores, who work throughout Marin County providing outreach, education and support to the Latino Community. She also leads six weekly psycho-education and behavioral activation groups in Spanish on a year-round basis, which can be accessed on an ongoing or drop-in basis. Examples of these are a parenting class and a Latina women's group. Dr. Muñoz-Kiehne also supervises bilingual bicultural doctoral level psychology interns, which provide outpatient treatment, and are

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key to service provision throughout the county. Since 2014 Doctora Marisol has been funded to broadcast a live, weekly, interactive educational Spanish radio show on health and wellness, which is also aired online: “Cuerpo Corazón Comunidad” (Body, Heart and Community), where topics covered include, mental health, parenting, coping with stress and where to find needed resources. This award-winning show reaches many individuals who would otherwise be isolated. She also does weekly segments on mental health and wellness which air on a Univision TV morning show.

Other significant system efforts have supported outreach to this population, such as the inclusion of bi-lingual and bi-cultural staff throughout the system. In the Children’s System of Care, 65% of the clinical staff is bi-lingual, bi-cultural. These services are provided in 6 schools, located throughout the county, which have large Latino populations. They have conducted parenting groups at the Kerner Campus in San Rafael and weekly at the Center for Domestic Peace transitional housing.

The “Portrait of Marin”, which was produced in 2012, documented the poverty of these working class individuals who are an “invisible minority” and live in the shadows of the affluent residents of Marin. In addition to those established in San Rafael, concentrations of Marin Latinos live in Novato and Marin City. The majority of more recent immigrants come from Guatemala.

The children of migrants attend school primarily in San Rafael City Schools, Novato Unified School District and West Marin Schools. A large number of Latino students are served in alternative education schools.

The Canal Alliance provides a broad base of support services to the Latino Community in Central Marin/ San Rafael. Services offered include, educational support, advocacy and a food pantry. Promotores provide health promotion, and support. One clinical staff member provides short-term Behavioral Health treatment services. Additional mental health treatment staffing is needed to provide for bi-lingual behavioral health needs of this community.

Family Partners provide invaluable support throughout BHRS. Some of these services include the NAMI Latino Support groups, which meet semi-monthly at the Health and Wellness Campus.

Informant Findings

The Behavioral Health needs of this community were reported to include; violence related trauma, intergenerational child abuse, both physical and sexual, intimate partner violence, gang related violence, chronic stress and substance use issues.

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Currently there are daily AA groups offered in Spanish in San Rafael and Novato. The smaller communities of Marin do not list Spanish AA groups on their website. More alternatives for substance abuse treatment and support were identified as areas of need.

Another complexity in meeting the needs of Latinos, is that a reported 10% of migrants do not speak Spanish as their first language, and providing Behavioral Health Services with this language barrier even for Spanish Speaking staff was challenging.

Recent restructuring at Access Line has increased the availability of Spanish Speaking staff to respond the Latino Community. Key Informants, Latino Providers Focus Group and Community Forums all supported the addition of Spanish Speaking staff. Key points of entry were identified as a specific priority to ensure that Latino Individuals receive the support they need at critical junctures. These included the Crisis Stabilization Unit, Casa Rene, the Crisis Continuum, the jail and in Community Based Organizations.

There are pockets of Latino residents living throughout Marin County. Concentrations of Latinos may be found in the canal area of San Rafael, in Novato and in Western Marin. Within Focus Groups with Latino Community Members, identified stressors, which they experience, include alcohol abuse, fears regarding immigration officials and deportation, (which limits their mobility) and the high cost of housing. Concerns raised included: too many people living in one apartment, poor housing conditions, lack of agency to advocate with landlords, lack of rent control, bullying of their children in schools, community prejudice, and domestic violence.

While most participants in the focus groups didn't know anyone with mental illness, those who did described cultural stigma as a barrier to families from seeking services. One focus group participant described her own experience with overcoming major depression with the support of the treatment staff of BHRS. Another participant described supporting a friend whose child was mentally ill. Obtaining services was reportedly challenging and requests for support were slow to be responded to.

Evaluative Findings

A gap was identified between Prevention and Early Intervention Services and services for those with mental illness or emerging mental illness. Finding a way to bridge this gap will be important in creating a continuum of care to meet the Behavioral Health needs of the Latino Community.

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Additionally, services for those with mild to moderate behavioral health needs are contracted to Beacon Health. However, many challenges were reported in accessing care through this system, including the lack of responsiveness of Beacon Staff to callers, availability of bi-lingual therapists who are accepting referrals and the difficulty for bi-lingual individuals in navigating the Beacon treatment system.

**Priorities**

Priorities for development included:

- Additional community based clinical treatment staff to meet the Behavioral Health needs of the Latinos
- Health Navigator to provide needed linkages between the Promotores, community based providers and the continuum of care
- Bi-lingual staff at Crisis Stabilization Unit, Mobile Crisis Team and Outreach and Engagement team
- More Peer Providers with lived experience to work with Latinos
- More Behavioral Health education and support for the Promotores
- More education for the Latino Community to reduce stigma and increase understanding regarding mental illness
- Offering services in non-stigmatizing settings, such as the WIC offices and providing field based assessment and linkage services
- Expansion of Mental health services in high need schools
- Increase the use of universal validated measures to identify clinically significant trauma, depression and anxiety and the utilization of post test measures to gauge the effectiveness of treatment
- Consider adding additional staff and funding to reach the high-risk youth served by Marin Community Alternative Education.
- Ensure that directions for taking medications are provided in Spanish to monolingual patients.

**Consumers**

Background

Consumers of Mental Health Services were identified as a health equity population because of their poor health outcomes and decreased lifespan. According to the World Health Organization:

*“People with severe mental disorders are also more likely to receive lower quality health and social care than the general population. One of the central issues around healthcare access for people with a severe mental disorder is the stigma and discrimination associated with mental illness.*

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*Strategies to improve health and life expectancy must focus not only on modifying individual risk factors but also on improving access to quality health care and eliminating the stigma associated with severe mental disorders.”*

Factors contributing to premature death

*“People with severe mental disorders have a higher prevalence of many chronic diseases and are at higher risk for premature death associated with these diseases than the general population. The excess mortality among this group is largely related to cardiovascular, respiratory and metabolic diseases. Metabolic Disease is a collective term referring to diabetes, hypertension and weight gain.*

*The prevalence of diabetes in people with schizophrenia is 2-3 times higher than the general population. This is in part due to lifestyle and health risk factors, but it is also partly due to unmonitored antipsychotic treatment, which can lead to weight gain. Significant weight gain is one of the main reasons patients do not want to take prescription medication. Patients with schizophrenia are more likely to smoke. The prevalence of smoking among them is about three times more than the general population. Patients with schizophrenia have been found to be at higher risk for tuberculosis than the general population due to factors such as a history of substance abuse, poor nutrition, homelessness, or previous time spent in an institution or prison.*

*“There is some evidence that people with a severe mental disorder do not receive the same levels of care and treatment for their physical health as the general population. In the majority of cases, people with mental disorders are often at a disadvantage as compared with the general population due to unemployment, living in institutions, isolation and exclusion, as well as socioeconomic status – all risk factors that can prevent recovery as well as lead to poor health and premature mortality. “*

Informant Findings

The Consumer Movement in Marin has strong roots and was established early in the 1980's. Longstanding consumer champions in Marin have made significant contributions to this community including the establishment of the Enterprise Resource Center, the establishment of Marin Advocates for Mental Health, and a housing project among others. Over time, leadership changes and lack of funding for necessary infrastructure have hampered the development of a more robust consumer network.

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Recently core recovery tools have been reintegrated into programs including Wellness Recovery Action Plans (Evidence Based Practice) and Crisis Plans, models that are taught and supported through the Enterprise Resource Center (ERC). Courses in Peer Counseling are offered at ERC, which include: Introduction to Peer Counseling, (including understanding diagnoses, how to become an effective listener, and making referrals to resources), Case Management, (working with clients to support self identified recovery goals), Understanding Medi-Cal, Cultural Competence, Abnormal Psychology and Medication and Treatment Planning. Classes are taught by a Marriage and Family Therapist, with lived experience, and are conducted over the course of 12 weeks.

The Peer Companion Program trains volunteers to accompany isolated individuals in the community to engage in a social activity on a weekly basis.

Advocacy for a pay ladder increase for Peer Providers has resulted in better wages and opportunities for advancement for Peer Providers. Many of the staff of ERC has advanced from program participants, to volunteers, to staff members. However, other Peer Providers reported pay and healthcare inequities.

The Enterprise Resource Center also supports other important projects including the art gallery and the community garden.

ERC staff is being trained in Motivational Interviewing techniques and also have access to Relias on-line learning classes.

With the support of Community Action Marin (CAM, the Community Based Organization which has sponsored the ERC), ERC is transitioning to a fully peer-operated program.

**Evaluative Findings**

Many of the individuals who utilize the recovery support services provided through Enterprise Resource Center are of a similar age and ethnic group. Providing specific programming geared to meet the needs of different ages, and cultural and linguistic groups may enable the ERC to expand support to a more diverse consumer population.

**Priorities**

- Locate space in other areas of the county. Establish satellite programs to support consumers within their communities
- Create age and culturally specific programming and hours to attract younger, and more culturally diverse clients to ERC, e.g. Friday night

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- youth programming, day(s) dedicated to the support of Latino consumers, sexual and gender minority support group
- Increase access to psychiatry services
  - One time short term funding for transition staff, to support the Enterprise Resource Center moving to a fully consumer operated center
  - Create lunch and learn opportunities for administration, clinical staff and peer providers, to discuss recovery
  - Support the Development of a Speakers Bureau. This approach has proven to be the most effective strategy for reducing stigma and discrimination towards those who live with mental illness and co-occurring disorders.
  - Review the career advancement opportunities available to Peer Providers, as well as pay scale and health benefits available to them, ensuring COLA's are and benefits are passed on to Peer Providers through contract language

**Vietnamese**

Background

Many of the Vietnamese in Marin arrived through the refugee resettlement program between the 1970's through the 1990's. Most of the Vietnamese immigrants are ethnic Chinese. Vietnamese residents live in the canal area with other areas of concentration in Novato and Marin City. Historically support for this community focused on preparation for obtaining citizenship and employment.

Informant Findings

Five years ago, as part of the MHSA Stakeholder process, Prevention and Early Intervention funds were provided for outreach in this community to individuals with behavioral health needs. Bi-lingual, bi-cultural, county case management staff was later hired to provide support to Vietnamese individuals, who experience mental illness. The hiring of these staff has resulted in improved access to care. Bilingual bicultural staff conducts a weekly support group, which serves individuals in the system of care. Dr. Tran, who stakeholders described as friendly and gentle, also provides support to the members of this community at the support group. Services to this community have dramatically improved as a result of increasing the availability of Vietnamese Staff.

Behavioral Health issues identified within this community through Key Informant Interviews and Community Provider Focus Groups are alcohol abuse, gambling, trauma and domestic violence. The level of acculturation within this group varies widely with some older adults experiencing ongoing depression and loss. Younger immigrants and youth born in the United States have generally

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assimilated more successfully into American Culture. The varying degree of integration places additional stress on older adults, whose children may move away, and whose values may have changed as a result of this influence. Prejudice towards members of this community still exists and isolated incidents of racism and abuse were noted.

Focus Group participants noted several barriers for Vietnamese speaking clients. These included the need for additional bi-lingual staff and the need for written resources and prescriptions in Vietnamese. The need for Vietnamese speaking step down care from case management and step up from PEI could bridge an existing gap. It was noted that Whistlestop and Canal Alliance no longer have Vietnamese-speaking staff members to serve this community. Aging and Older Adult Services could better serve this community with the addition of Vietnamese speaking staff.

Access to health care was also raised as an issue among some stakeholders. They described difficulty making appointments, cancelling appointments and obtaining medications, with reception staff members who speak English as a second language as a particular challenge.

Focus group members stressed a strong preference for competent in-person interpreters for monolingual residents.

Language barriers were also noted in arranging public transportation. There is no Vietnamese-speaking bus ambassador to provide transportation training.

One area of need, which the PEI Provider could support, was the need for basic technology training, including using the phone and introduction to computer technology.

Evaluative Findings

One barrier in access to care is the strong stigma towards individuals who have mental illness within this culture. More than one focus group member, described individuals with mental health concerns, using pejorative terms. The high degree of stigma and discrimination, coupled with the small insular community and concerns about confidentiality, continue to result in barriers in access to care.

While some community members have gained a greater understanding of the biological nature of mental illness, there is a need to provide continued stigma reduction and education efforts to this community. Similarly PEI Provider staff would benefit from ongoing support in this area. Further inquiry into the search for materials developed in Santa Clara and other counties, which target the cultural stigma and discrimination in the Vietnamese community, could support this effort.

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As in other places, establishing a stronger connection between the Prevention and Early Intervention efforts and services to the continuum of care should be explored. Adding Vietnamese Speaking staff at the Enterprise Resource Center could increase accessibility of recovery support services.

Consider creating a health navigator to assist Vietnamese individuals and families with accessing behavioral health services and support integration of care and needed culture change.

**Priorities**

- Increase Stigma and Discrimination Reduction training
- Recruit Vietnamese Speaking Staff/ Peers at the Enterprise Resource Center
- Ensure that recommendations for taking medications are available in Vietnamese
- Consider establishing a Vietnamese health navigator

**LGBTQ/Gender and Sexual Minorities**

Efforts to gather information regarding the Gender and Sexual Minority Community included Key Informant Interviews with both adults and youth and a Youth Focus Group.

Background

In October 2016 the U.S. Department of Health and Human Services formally designated sexual and gender minorities (SGMs) as a health disparity population for National Institute of Health Research. Information released by NIH suggests that SGM populations have less access to health care, and higher rates of certain diseases such as depression, cancer and HIV/Aids. Research shows that Sexual and Gender Minorities, who live in communities with high levels of anti-SGM prejudice, die sooner. This reduced lifespan is 12 years on average, when compared to those living in more accepting communities.

The Center for Disease Control (CDC), nationally surveyed youth grades 9-12 on a variety of health risk behaviors. The 2015 report stated that:

*“The majority of sexual minority students cope with the transition from childhood through adolescence to adulthood successfully and become healthy and productive adults. However, this report documents that sexual minority students have a higher prevalence of many health-risk behaviors compared with nonsexual minority students.”*

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Of particular concern was the experience of not feeling safe to the point of missing school.

*“The prevalence of not having gone to school because of safety concerns was higher among gay, lesbian, and bisexual students (12.5%) and not sure students (10.8%) than heterosexual students (4.6%).” Electronic bullying is particularly prevalent: Nationwide, 15.5% of all students; 28.0% of gay, lesbian, and bisexual students; and 22.5% of not sure students had been electronically bullied, compared to 14.2% of heterosexual students.*

*Forced to Have Sexual Intercourse*

*The prevalence of having ever been forced to have sexual intercourse was higher among gay, lesbian, and bisexual students (17.8%) than heterosexual students (5.4%).*

Dating Violence

Among the students nationwide who dated or went out with someone during the 12 months before the survey, 9.6% of all those students; 8.3% of the heterosexual students; 17.5% of the gay, lesbian, and bisexual students; and 24.5% of the not sure students had been physically hurt on purpose (counting being hit, slammed into something, or injured with an object or weapon) by someone they were dating or going out with one or more times during the 12 months before the survey (i.e., physical dating violence). The prevalence of physical dating violence was higher among gay, lesbian, and bisexual students (17.5%) and not sure students (24.5%), was higher than heterosexual students (8.3%).

Sadness, Hopelessness

During the 12 months before the survey, 60.4% of gay, lesbian, and bisexual students and 46.5% of not sure students nationwide had felt so sad or helpless almost every day for 2 or more weeks in a row that they stopped doing some usual activities. The prevalence of having felt sad or hopeless was higher among gay, lesbian, and bisexual students (60.4%) than heterosexual students (26.4%).

Contemplated Suicide

Nationwide, 17.7% of all students; 14.8% of heterosexual students; 42.8% of gay, lesbian, or bisexual students; and 31.9% of not sure students had seriously considered attempting suicide during the 12 months before the survey.

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During the 12 months before the survey, 14.6% of all students; 11.9% of heterosexual students; 38.2% of gay, lesbian, and bisexual students; and 27.9% of not sure students had made a plan about how they would attempt suicide. The prevalence of having made a suicide plan was higher among gay, lesbian, and bisexual students (38.2%) than heterosexual students (11.9%).

**Attempted Suicide**

Nationwide, 8.6% of all students; 6.4% of heterosexual students; 29.4% of gay, lesbian, and bisexual students; and 13.7% of not sure students had attempted suicide one or more times during the 12 months before the survey. The prevalence of having attempted suicide was higher among gay, lesbian, and bisexual students (29.4%) than heterosexual students (6.4%).

**Family Acceptance**

Research has established a predictive link between specific, negative family reactions towards their child's sexual orientation and serious health problems. "LGB young adults who reported higher levels of family rejection during adolescence were 8.4 times more likely to report having attempted suicide, 5.9 times more likely to report high levels of depression, 3.4 times more likely to report having engaged in unprotected sexual intercourse compared with peers from families that reported no or low levels of family rejection." Latino males reported the highest number of negative family reactions to their sexual orientation in adolescence.

**Informant Findings**

Stakeholders raised particular concern for youth who may be targeted for bullying. Nationally other forms of abuse are more common in this population.

The agency, identified as providing LGBTQ support in Marin County, was the Spahr Center. The Spahr Center, historically, an advocacy organization, merged two years ago with Spectrum an HIV and AIDS organization. They are in the process of expanding the focus of the Spahr center to provide more direct services. Currently they focus their efforts primarily on youth and older adults.

**Youth**

Services directed to youth include a monthly support group for parents of youth who are questioning, gender fluid and transitioning, two support groups for youth one focused on youth of color, is co-led by a bi-lingual bi-cultural Children's Mental Health Clinician. Other services offered include assessment, referral and some individual counseling. They also provide 4 hours of counseling weekly at

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the school-based Wellness Centers located at Sir Francis Drake and Mount Tamalpais High Schools and are expanding to Redwood High School. They also provide support to Alternative Education. Spahr Center staff are authorized Beacon Providers.

One area of concern raised by Key Informants was the lack of support for LGBTQ Youth who may be the target of bullying in schools.

High School aged Focus Group Members, unanimously endorsed the experience of being the target of discrimination. They identified anxiety, depression, eating disorders and trauma as common mental health conditions in their peer community. Two of the 8 Focus Group Members had sought counseling services at the Spahr Center. They described the importance they placed on therapist providers understanding the experience of being “LGBT+”, through their own lived experience.

Services are not provided at middle schools and parents have reached out to Spahr Center asking for support for youth but the agency does not have the financial capacity at this time to expand services.

Information obtained indicated that some parents in this community are supportive of their LGBTQ children while other families are rejecting of them.

One area of concern voiced by key informants, and echoed in the Community Forums, was the lack of data collection efforts within the BHRS system of care on gender and sexual minority individuals. Without data on the number of gender and sexual minority individuals served, it is not possible to determine whether BHRS has proportionally served this population.

To fully understand the needs of this community, it was recommended that a needs assessment, which was beyond the scope of this inquiry, be conducted to better understand the Behavioral Health needs of the gender and sexual minority members of the Community in Marin.

Older Adults

Older adults were also identified as a group in a transition period of life as a vulnerable population. Informants sited depression, fear, isolation and loss as common experiences in the older adult LGBTQ Community. This community may not have family support and may have experienced more stigma and discrimination. Many GSM Older Adults who are transitioning to assisted living and other care facilities, face another critical challenge when attempting to integrate into a new community.

Evaluative Findings

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School based services to LGBTQ/GSM youth provide a natural point of service delivery. School can provide a safe haven for youth, through school based health centers, Gay Straight Alliance Support Groups, (GSA's), and may be the only support for youth in rejecting families. Currently there is some support for youth in school-based Wellness Centers. Expanding and solidifying this support would be a natural focus for intervention including providing service to youth in middle schools.

Support to families of LGBTQ/GSM youth is critical to their health outcomes. This is another potential target for intervention.

Older GSM Adults are another population in need of specific support to decrease their isolation, depression and support them during critical life transitions. When possible group support would be indicated.

Marin Behavioral Health and Recovery Service (BHRS) has recently established a data collection protocol for collection of sexual and gender minority clients.

Consider staff training for individuals who are collecting this information.

As part of the MHSA funded Innovation Project, inquiry is being made into the needs of Transitional Aged Youth (TAY). As part of this project a TAY advisory council has been formed and more information and recommendations on the needs and supports for TAY will be forthcoming as a result of the work of this group.

**Priorities**

- Assessment, counseling and referral through school based Gay Straight Alliances
- Expand education and support to families of GSM youth
- Conduct a needs assessment to better understand the behavioral health needs of gender and sexual minority residents of Marin including the needs of older adults

**Physical Location of Services**

Throughout the Community Planning Process stakeholders recommended service sites be developed in other areas of the county.

Transportation to central services was reported as creating a barrier to accessing care. Stakeholders' recommended locating services near transportation hubs.

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Consumer stakeholders described the hours it may take to access needed care and the barrier this presented.

Recommendations included expanding services to Novato, Southern Marin and West Marin. Additional space may be a key component of reaching individuals within these communities. (Please see specific recommendations for each area of Marin County.

**Priorities**

- Prioritize establishing a mobile van to provide integrated health/behavioral health care within rural areas of the county especially Western Marin
- Consider expanding the number of sites closer to high need areas, Novato, (Novato expansion in progress) Southern Marin

**Central Marin**

Background

Central Marin serves as the center of Behavioral Health Services for Marin County. These include: The Wellness Center, Marin General In-Patient Psychiatric Care. The Transition Team, Mobile Crisis, Outreach and Engagement Team, Adult Case Management, STAR FSP, HOPE FSP, Odyssey, The Crisis Stabilization Unit, The Access Line and Behavioral Health Administration. While these services are located in San Rafael, which is the most populous area of the county they serve all of Marin County.

Informant Findings

Strengths

Consumer participants in the Central Marin Community Meeting identified the strengths of BHRS as peer programs, increased diversity of staff, Full Service Partnership Programs, the Mobile Crisis Continuum and Access walk-in intake hours.

Family members and community members identified dedicated staff, Family Partners and the Thursday night Family Support Group as strengths.

Providers identified collaboration, flexibility, expertise, diversity and dedication and longevity of staff as strengths.

Prevention Activities

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The following ideas were proposed for consideration for prevention and early intervention activities.

Consumer participants identified education regarding recovery, trauma informed care and emergency crisis shelter, for all age groups, modeled after “9 Grove Lane”.

Community members identified peer led senior services, services in the community such as churches and community centers, an integrated team approach for service delivery and outreach to youth regarding mental illness.

Family Members identified stigma reduction and early education in schools and through media regarding seeking support regarding mental health issues.

Community Needs (Central Marin continued)

Consumer participants identified dual diagnosis treatment, recovery oriented support groups, services near transportation hubs, mobile van services, Transitional Aged Youth programs and housing support for maximizing community integration in housing, employment support, consumer operated programs and a Clubhouse Model Program as areas of need.

Those that identified as family members advocated for increased outreach, Laura’s law implementation, family support, greater flexibility in hours which services are offered, employment opportunities, peer support and treatment incentives.

Those that identified as community members identified school based mental health services, assessment for depression in seniors, Assertive Out Patient Treatment for homeless and transitional housing. They advocated for the evaluation of outcomes for existing programs to be public and accessible.

Providers who participated identified the need for additional psychiatry staff time, inpatient beds, stigma reduction and public awareness efforts, housing, services for the aging population and services for the undocumented.

A recommendation for the expansion of 24-hour crisis response was supported in this community meeting.

The development of a First Episode in Psychosis Program was strongly supported in the Central Marin Community Meeting.

Evaluative Findings

**Marin County  
The Mental Health Services Act Community Planning Process  
(May 2016 through May 2017)**

Many of the priorities identified in this community meeting were consistent throughout the stakeholder process and are specifically addressed above. These include the expansion of crisis response to 24-hour operation, the need for housing, housing supports and the development of a First Episode Psychosis Program. The recognition of the importance of providing accessible co-occurring care and integrating trauma based care into the treatment continuum was consistent throughout.

A consistent group of family members attended each community meeting advocating for the adoption of Assisted Out Patient Treatment, AB 1421.

**Southern Marin**

Background

Southern Marin is an area of the county with a complex mix of populations, encompassing Marin City, Mill Valley and Sausalito. Marin City has the largest concentration of African American residents in the county. The enrollment in the school lunch program serves as a measure of poverty. In the Sausalito Marin City School District 63% of the students are enrolled in the school lunch program.

In FY 15-16 the adult and child patient population comprised 11% of the population served by Marin Behavioral Health and Recovery Services.

Informant Findings

Key informants explained that individuals in Southern Marin, who live with serious mental illness, have many challenges accessing services. These include transportation to the hub of Behavioral Health treatment in Central Marin, the availability of culturally relevant care and the lack of local recovery support services.

Key Informants cited the need for community education to raise the understanding of the biological basis for mental illness. It was recommended that individuals within the community, be identified who can share their recovery stories and break down social stigma. Further recommendations included a developing a co-occurring support group.

While community members may seek support through churches. ‘They may be trying to pray these illness away’ instead of seeking appropriate treatment. Education for the faith communities in this area was recommended. Individuals in the community may seek services at the Wellness Center in Marin City but they do not offer behavioral health treatment services for those with serious mental illness.

**Marin County  
The Mental Health Services Act Community Planning Process  
(May 2016 through May 2017)**

Key informants advocated for the development of a Clubhouse Model Program to provide recovery and employment support.

**Stakeholder feedback obtained through the MHSA Community Meeting**

Strengths of Behavioral Health and Recovery Services

Consumer participants identified consumer run services, dual diagnosis groups, Enterprise Resource Center, WRAP planning, and the growing respect for individuals with lived experience as system strengths.

Family members in attendance recognized Ritter House, the Enterprise Resource Center, Thursday Family Meeting and the Outreach Team as system strengths.

Community Members recognized Peer Providers, cultural competence and an ethnically diverse workforce as system strengths.

Providers in attendance recognized the importance of the workforce education and certification programs supporting the development of a more culturally, linguistically and experientially diverse workforce. They also acknowledged the role the Department of Rehabilitation in assisting individuals to enter the workforce.

Community Needs

Consumer participants identified the need for more services for women, increased availability of in-patient treatment, detox programs for co-occurring disorders, and more Spanish Speaking providers. Housing needs included another Casa Rene, transitional housing programs like Hotel Carmel, year-round homeless housing and increasing housing options. The location of service sites near transportation hubs was also recommended.

Family members, who participated, identified a need for recovery support services similar to ERC in Southern Marin. The need to provide culturally competent care and an ethnically diverse workforce were also emphasized.

Providers sited the need for both recovery services and supported employment in this area of the county.

Evaluative Findings

The needs of Southern Marin identified within the Community Planning Process, echoed many of the general recommendations covered above. (See Workforce

**Marin County  
The Mental Health Services Act Community Planning Process  
(May 2016 through May 2017)**

Education and Training, Peer Providers, Physical Location of Services and stigma reduction).

Community advocates have explored the Clubhouse Model for psychosocial rehabilitation and have advocated for a clubhouse model program in Marin. The Clubhouse model is a comprehensive program of support, for people with severe and persistent mental illnesses. Clubhouse Programs focus on the development of employment skills, supported employment and job placement. In contrast to traditional day-treatment and other day program models, Clubhouse participants are called members and activities focus on their strengths and abilities.

Clubhouses are places where people can belong as contributing adults. The Clubhouse Model seeks to demonstrate that people with mental illness can successfully live productive lives and work in the community, regardless of the nature or severity of their mental illness.

The development of a Clubhouse Model Program would provide a hub of recovery support in Southern Marin. It would also provide opportunities for developing the skills necessary to support individual employment goals.

**Priorities**

- The establishment of a program in collaboration with the Department of Rehabilitation to meet the recovery needs of this diverse community, formed on the evidence based Clubhouse Model
- Ongoing support, education and linkage to services for local Faith Communities
- Increased Stigma and Discrimination Reduction Effort

**West Marin**

Background

Within West Marin there are distinct communities with varying needs. This area of the county is more sparsely populated and covers a large geographic area. According to a 2006-2010-health indicator study, 20 to 30% of the west Marin population is at, or below, 200% of the Federal Poverty Level.

The Mental Health Clinic in West Marin operates from 9-5 in Point Reyes Station. While this seems to be an area of high need, the available mental health services have historically been under-utilized.

Informant Findings

**Marin County  
The Mental Health Services Act Community Planning Process  
(May 2016 through May 2017)**

One Key Informant who works in this community offered that traditional clinical services might not be the most effective approach. A health navigator who is in the community, rather than within clinic walls may be a better way to reach those in need of support. Often working class individuals, including the Latinos who work on dairy farms and ranches in more isolated regions of the county may not be able to access services within the available clinic hours.

During both Key Informant Interviews and a West Marin Focus Group, additional services for both substance abuse and domestic violence treatment were identified. The need for additional bi-lingual bi-cultural staff in this area was also identified.

Another issue, which was raised, was the community concern regarding, the confidentiality of service in this small community and the stigma associated with accessing mental health services.

**Priorities**

- Consider expanding community outreach services to this area
- Recruit additional bi-lingual, bi-cultural staff
- Provide Stigma and Discrimination Reduction training
- Consider establishing mobile integrated health/behavioral health mobile treatment capacity to reach the more remote areas of West Marin

**Northern Marin-Novato**

Background

Novato covers 28 square miles and according to 2010 census data comprises 5.2% of the population of Marin. Census data indicate that the majority of the residents of Novato are white, (79.9%) 3% of the population African American, 14.9% Latino and 6.6% Asian American. 32% of the total population in 2010 were children under 18. The majority of the residents lived in families, 66.5%.

Informant Findings

Strengths of BHRS

Consumer participants identified the increased accessibility and availability of services as strengths. Additionally they recognized the increased diversity of staff and the increasing recognition of the value of lived experience and the TAY Council.

**Marin County  
The Mental Health Services Act Community Planning Process  
(May 2016 through May 2017)**

Family Member participants recognized the family workshops and education, DBT, Seeking Safety, family partner program and inclusion of families in the treatment planning process as strengths. Staff, were recognized as approachable and The Enterprise Resource Center as an asset.

Community member participants acknowledged the Outreach and Engagement efforts, peer counseling, Promotoras, and recovery oriented services behavioral health services as strengths.

Community Needs

Consumer participants identified the need for peer-operated services, services that are non-stigmatizing and the need for detox for co-occurring disorders. They recommended the expansion of Mobile Crisis Team hours, and bi-lingual outreach to underserved populations.

Family member participants continued to advocate for AOT, increased capacity for crisis services and the need for additional medical staff.

Evaluative Findings

In Novato, Northern Marin, as in each area of the county, the need for increased housing was seen as a top priority.

Support for the development of a First Episode Psychosis Program was strongly endorsed.

The value of peer providers recognized and supported for inclusion throughout the system of care.

The value of outreach and the need to provide additional bi-lingual bi-cultural staff throughout the system of care supported.

The need for system navigation to increase accessibility and integration of PEI with the system of care services was identified.

**Priorities**

- Bi-lingual bi-cultural staff
- Inclusion of Peer Providers and Family Partners throughout the system of care
- Systems navigators to connect PEI efforts to system of care
- Service sites located near transportation hubs
- Increased emphasis on evidence based care

**Marin County  
The Mental Health Services Act Community Planning Process  
(May 2016 through May 2017)**

- Increased stigma reduction efforts
- Development of a First Episode Psychosis Program

**Other Systems Considerations**

Physical Location of Services

Throughout the Community Planning Process requests to have increased availability of services throughout the county to better serve the Behavioral Health population were made.

Transportation was reported as creating a barrier to accessing care. Stakeholders' recommended service sites, which are located near transportation hubs. Consumer stakeholders described the hours it may take to access needed care and the barrier this presented.

Recommendations included expanding services to Novato, Southern Marin and West Marin. Additional space may be a key component of reaching individuals within these communities. (Please see specific recommendations for each area of Marin County.)

Recommendations

- The establishment of mobile services to provide integrated health/behavioral health care within rural areas of the county, Western Marin (See specific regional recommendations)
- Consider expanding the number of sites closer to high need areas, Novato, Southern Marin

**Administrative Staff**

During the Medical Staff Focus Group, Key Informant Interviews and Policy Forum the need for additional administrative support was noted. Additional administrative staff would maximize the utilization of clinical time and provide necessary support at the clinic level. It was also recommended that increasing the proximity to Quality Management Staff to clinic staff would improve the communication and integration of these services.

**Priorities**

- Fund additional administrative staff to support expanded clinical services

**Capitol Facilities and Technology**

**Marin County  
The Mental Health Services Act Community Planning Process  
(May 2016 through May 2017)**

The Capital Facilities and Technology component of MHSa provided one-time Funding for the creation of facilities and for the creation of the technological infrastructure. These facility funds were allocated to build facilities in which to provide MHSa Services. The goal of technological infrastructure is to facilitate the delivery of the highest quality and most cost effective services and supports to clients and their families.

Electronic Health Record System

Throughout the planning process staff were queried about the adequacy of the current Electronic Health Record (EHR) System. General consensus was that the current EHR system is inflexible and outdated. A tension exists between the expense of replacing the current system, anticipated regulatory changes for claiming and the frustration of staff that report spending an inordinate amount of time working around an inflexible system. The requirements for documentation of clinical services are time consuming and streamlining the amount of staff time dedicated to this may increase clinical availability.

**Priorities**

- Consideration should be given to funding an Electronic Medical Record System, which reduces medical and other clinical staff time.

## APPENDIX - VI



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BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION  
MHSA Advisory Committee Meeting  
*March 29, 2017*  
*1:30 to 3:00 p.m.*

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### AGENDA

- Welcome, Introductions and Announcements
- MHSA Background
- Older Adult Update
- MHSA Three Year Planning Timeline
- MHSA Budget for Three Year Plan FY17-18 through FY19-20
- Review Priorities
- Next Steps
- Adjourn

**Next Meeting Date: April 26<sup>th</sup>, 2017 1:30 – 3:00**  
**20 N. San Pedro, Pt. Reyes Conf. Room**

## APPENDIX - VI

MHSA Advisory Committee  
 3/29/2017 – 20 N. San Pedro Rd., Conf. Room Pt. Reyes  
 1:30 – 3:00 pm

**In Attendance:** Suzanne Tavano, Mary Roy, Kasey Clarke, Kristen Gardner, Celia Allen, Denise Zvanovec, Gustavo Goncalves, Robbie Powelson, Kerry Peirson, Carol Kerr, Sandra Ponek, Nick Avila, Maya Gladstern, Barbara Coley, Suzanne Sadowsky, Kay Browne, Brian Slattery, Karin Jinbo, Gail Theller.

**Next Meeting:** April 26<sup>th</sup>, 2017. 1:30 – 3:00  
 20 N. San Pedro Road, Pt. Reyes Conf. Room

Agenda Item	Discussion
<p><b>Welcome Introductions and Announcements</b></p>	
<p><b>MHSA Background</b></p>	<p>Answering to the request made in the previous MHSA Advisory Committee Meeting, Older Adult services has been added to the MHSA 3 yr. Plan.</p> <p><b>Review of MHSA Planning Process</b>                      What are we doing? What is MHSA? Who are we doing this for? Covered in the handout 'MHSA Handbook'. MHSA is guided by the W&amp;I Code 5801 and 5850</p> <ul style="list-style-type: none"> <li>• The MHSA Handbook (attached) defines the purpose, intent, and stakeholders in the MHSA planning process.</li> </ul> <p>MHSA Stakeholder recommendations are outlined in the <i>MHSA Community Planning Process</i>, (MHSACPP - Attached) reviews the input provided by community stakeholders. This information was used to produce the <i>MHSA Stakeholder Recommendations</i> (handout) that summarizes whether, through stakeholder input or other input, if programs will receive ongoing or 1 time funding for programs under the five MHSA components: CSS, PEI, WET, CFTN, INN. There is no particular order in which the recommendations are currently listed. There is no current dollar amount; however, during the next meeting a revised version will be provided that incorporates tentative prioritization and dollar amounts.</p> <p>In the event that a program is under performing and/or failing to serve the target population in the middle of an active MHSA 3 yr. plan, that program may be closed and that programs' funding may be realigned to other programs. (Examples: Buckelew's TAY program was closed and Sunny Hills took over the TAY services after a RFP process)</p>

## APPENDIX - VI

<b>Older Adults</b>	<p><b>Older Adults</b>            In response to concerns raised, an Older Adult section has been incorporated in to the MHSA 3yr. Plan recommendations, including older adult services expansion: home visits, community education, outreach to senior centers, etc. (Older Adult PEI – current recommendation is to continue with changes)            These changes may or may not be able to be incorporated based on the budget.</p>
<b>MHSA Update</b>	<p><b>ERC</b>            ERC is to be maintained and a Club House Model program (RFP - Consumer Operated Wellness and Recovery Program) would also be created and incorporated into our continuum of care. The two program models work well with one another due to their differences and similarities.</p> <p>(Discussed: Concern was raised over the lack of discussion on Substance Use Disorder system capacity. Response: The current list is tentative and this may be discussed in the future.)</p> <p><b>Program Support</b>            Program Support for FSP’s have been included, this will increase staff support and improve data gathering and other non-clinical efforts.</p> <p><b>Allocation Adjustment</b>            5% Allocation Adjustment for existing CSS Services will be provided. Intended to offset increases in overhead/operating costs and increase staff salaries.</p> <p>(Discussed: Allow for the use of community defined practices in addition to evidence based practices)</p> <p>Marin County has submitted a ‘Whole Person Care’ grant application, if we are awarded the grant we will be integrating these funds into this MHSA 3yr. plan” We will find out in the first week of July.</p> <p><b>Suicide Prevention</b>            PEI currently funds Buckelew (formerly Family Services Agency) to conduct the suicide prevention hotline. The new Executive Director has been looking at expanding the suicide prevention hotline to include other services. The county has also been looking at other suicide prevention efforts due to the high incidence rate of suicidality in Marin county.</p> <p><b>Electronic Health Record (EHR)</b>            Replacement of EHR (Electronic Health Record) – to remove inefficiency form the current EHR, it would be preferable to find a replacement EHR. With new upcoming rules, data, and other needs a new HER is central to improving the quality of services</p>

## APPENDIX - VI

<p><b>MHSA Three Year Planning Timeline</b></p>	<p><i>MHSA 3 yr. Planning Timeline for FY 17-18 through FY 19-20 (Attached) has been provided.</i></p> <p>March 29<sup>th</sup>, 2017 – MHSA Advisory Committee Meeting – Budget and Recommendation review/prioritization</p> <p>April 26<sup>th</sup>, 2017 – MHSA Advisory Committee Meeting – Review updated budgets</p> <p>May, 2017 – Post MHSA Three Year Program and Expenditure Plan for FY 17-18 through FY 19-20 for Public Comment</p> <p>June, 2017 – Close of Public Comment Period – Hold Public Hearing at Mental Health Board</p> <p>July, 2017 – Board of Supervisor’s review/approve MHSA Three Year Plan for FY 17-18 through FY 19-20.</p>
<p><b>MHSA Budget for Three Year Plan FY 17-18 Through FY 19-20</b></p>	<p><b>MHSA Review:</b>          Note: ERC Expansion should be considered as ERC. Since the ERC existed prior to the MHSA, Prop. 63, the ERC was expanded upon at that time, rather than created.</p> <p><b>Co-Occurring</b>          Currently the Alliance in Recovery (AIR), Tobacco Cessation, Co-Location Consultation, Road to Recovery</p> <p><b>Crisis Continuum</b>          Casa Rene is partially/ primarily a Medi-Cal funded program. It was originally funded through INN and when that project ended it was moved to CSS funding.</p> <p><b>PEI</b>          Key feedback and response has been outlined in the <i>MHSA PEI Three Year Plan – Recommendations Regarding Existing Programs (Attached)</i>. This document pertains to existing programs.</p> <p>(Discussed: hope for continued and more contracting so that more individuals may be served. Due to the lower cost of CBO’s compared to county.)</p> <p>(Discussed: When contracts are left that we look first and foremost at Marin county organizations before looking outside of Marin.)</p>

## APPENDIX - VI

<b>Review Priorities</b>	<p><b><i>MHSA Planning Estimates Summary – Draft (Attached)</i></b> The following are ideas that have surfaced throughout the community planning process of the MHSA 3 year plan. Additional information such as staffing, number served, location, have not been provided to the county. This information is needed to create a budget that outlines dollar amounts and prioritization.</p> <p>Note: Mental Health services are about 35-40 million dollars annually. The MHSA 3 yr. Plan services are roughly 13 million, or 30%. For every dollar of MHSA money spent, \$2 federal dollars are provided. The previous MHSA 3 yr. plan required little to no competition between contractors for these dollars and we are hopeful that this will be the case for this MHSA 3 yr. plan.</p>
<b>Next Steps</b>	During the next meeting we will review these documents with dollar amounts and prioritizations. After reviewing with the MHSAAC the MHSA 3 yr. Plan will be open for a 30 day public comment period.
<b>Adjourn</b>	<b>Next Meeting: April 26, 2017 1:30 – 3:00pm</b> <b>20 N. San Pedro, Pt. Reyes Conf. Room</b>

## APPENDIX - VI



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BEHAVIORAL HEALTH AND RECOVERY SERVICES DIVISION  
**MHSA Three Year Planning Timeline for FY17-18 through FY19-20**  
*As of March 29, 2017*

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### Timeline

March 29, 2017	MHSA Advisory Committee Meeting Budget and Recommendation review/prioritization
April 26, 2017	MHSA Advisory Committee Meeting Review updated Budgets
May, 2017	Post MHSA Three Year Program and Expenditure Plan for FY17-18 through FY19-20 for Public Comment  Give Overview of Three Year Plan to the Mental Health Board
June, 2017	Close of Public Comment period Hold Public Hearing at Mental Health Board
July, 2017	Board of Supervisor's review/approve MHSA Three Year Plan for FY17-18 through FY19-20

**APPENDIX VI**  
**MHSA Statewide Recommendations**  
**FY2017/18 through FY2019/20**

	A	B	C	D	E
1	Recommendation / Description	On Going Funding	1 Time Funding	MHSA Component	BHRS Program
2	<b>Community Services and Supports (CSS)</b>				
3	Expand Capacity of the Mobile Crisis and Transition Teams (including bi-cultural/bi-lingual capacity)	X		CSS	Systemwide
4	Evidence Based Practice Lead Staff	X		CSS	Systemwide
5	Substance Use Disorder system capacity	X		CSS	Systemwide
6	Expansion of Transition Age Youth (TAY) FSP to add 4 additional slots	X		CSS	TAY FSP
7	First Episode Psychosis (FEP) Program	X		CSS	Systemwide
8	ACT Expansion for SMI Adults	X		CSS	New Program
9	YES Program Expansion	X		CSS	YES FSP
10	Increase Providers with Lived Experience	X		CSS	Systemwide
11	Increase Vocational and Independent Living Skills to FSP/ACT Participants	X		CSS	FSP's/ACT
12	Program Support for FSP's	X		CSS	All FSP's/ACT
13	5% Allocation Adjustment for existing CSS services	X		CSS	CSS Systemwide
14	<b>Prevention and Early Intervention (PEI)</b>				
15	Older Adult expansion: home visits, community education, outreach to senior centers	X		PEI	Older Adult
16	Evidence Based Practice Lead Staff	X		PEI	Systemwide
17	Health Navigator for PEI	X		PEI	Systemwide
18	LGBTQ Youth Support at School Based Gay/Straight Alliances	X		PEI	Systemwide
19	Suicide Prevention Training, AMSR and Planning	X		PEI	Systemwide
20	First Episode Psychosis (FEP) Program	X		PEI	Systemwide
21	<b>Workforce Education and Training (WET)</b>				
22	Suicide Prevention Training, AMSR and Planning	X		WET	Systemwide
23	Consumer Focused Training Initiative	X		WET	Systemwide
24	Peer Specialist and AOD Intern Stipend Initiative	X		WET	Systemwide
25	<b>Capital Facilities and Technological Needs (CFTN)</b>				
26	Electronic Health Record replacement		X	CFTN	Systemwide

**APPENDIX - VI**  
**MHSA PEI THREE YEAR PLAN**

**RECOMMENDATIONS REGARDING EXISTING PROGRAMS**

<b>PROGRAM</b>	<b>FEEDBACK</b>	<b>RESPONSE/RECOMMENDATIONS</b>	<b>Current</b>
<b>Youth</b>			
<b>PEI 1 Early Childhood MH</b>	<ul style="list-style-type: none"> <li>• Increase validated measures</li> </ul>	<ul style="list-style-type: none"> <li>• Eliminate sensory integration consultation</li> <li>• Require use of CANS assessment, esp trauma</li> </ul>	<p>\$230,000</p> <p>Continue with changes</p>
<b>PEI 2 Triple P</b>	<ul style="list-style-type: none"> <li>• L2-3 provides prevention, not early intervention (can expand L4-5)</li> <li>• BHRS staff use L3-4 and can continue independently</li> </ul>	<ul style="list-style-type: none"> <li>• Limited evidence of demand for L4-5 services at this time</li> <li>• Current providers not supportive of using L4-5 with fidelity</li> </ul>	<p>\$62,000</p> <p>Eliminate</p>
<b>PEI 18 School Age</b>	<ul style="list-style-type: none"> <li>• SRCS has prevention initiative, but needs higher level services</li> <li>• Reach youth in Alternative Ed sites, independent study, other high-risk circumstances</li> <li>• Under-identification of youth eligible for BHRS services</li> </ul>	<ul style="list-style-type: none"> <li>• Increase Shoreline staff hours</li> <li>• Continue Sausalito Marin City</li> <li>• Eliminate current San Rafael City Schools program</li> <li>• Develop new project to reach high risk students</li> <li>• Require use of CANS assessment, esp trauma</li> </ul>	<p>\$310,000</p> <p><i>SMC \$110</i> <i>Shrln \$80</i> <i>SRCS \$120</i></p> <p>Continue with changes</p>
<b>PEI 4 TAY</b>	<ul style="list-style-type: none"> <li>• Increase validated measures</li> <li>• Increase Newcomers services</li> <li>• Increase LGBTQ services</li> </ul>	<ul style="list-style-type: none"> <li>• Require use of CANS assessment, esp trauma</li> <li>• Increase Newcomers and LGBTQ support</li> <li>• Limited changes now, see INN Plan</li> </ul>	<p>\$160,000</p> <p>Continue with changes</p>

## APPENDIX - VI

PROGRAM	FEEDBACK	RESPONSE/RECOMMENDATIONS	Current
<b>PEI 5 Latino Community</b>			
Radio show	•	• Co-funded with PH Maternal Child Health	\$14,000
Latino Community Connection	<ul style="list-style-type: none"> <li>• Additional clinical staff</li> <li>• Increase promotores training</li> <li>• Services in WIC, etc</li> <li>• Validated outcome measures</li> </ul>	<ul style="list-style-type: none"> <li>• Add 1 FTE Spanish speaking clinician (cover W Marin and inland)</li> <li>• Require promotores to take Mental Health First Aid</li> <li>• Increase outreach at WIC, etc</li> <li>• Increase Newcomer services</li> <li>• Use validated trauma screen/assessment</li> </ul>	\$190,000  Continue with changes
<b>Other Adult</b>			
PEI 6 IBH	•	•	\$180,000  Eliminate
PEI 7 Older Adult	<ul style="list-style-type: none"> <li>• Serve LGBTQ OA experiencing depression/anxiety</li> <li>• Peer services</li> </ul>	<ul style="list-style-type: none"> <li>• Expand depression/anxiety services, esp LGBTQ</li> <li>• Develop peer led support groups, services</li> <li>• Indicate target population by income level</li> </ul>	\$100,000  Continue with changes
PEI 11 Vietnamese Community Connection	•	<ul style="list-style-type: none"> <li>• Outreach to other Asian populations</li> <li>• Require training for staff and community health advocates, including stigma/ Mental Health First Aid</li> </ul>	\$52,000  Continue with changes
PEI 19 Veterans	•	• Wait to consider expansion until program re-stabilizes	\$60,000  Continue
<b>Other</b>			
PEI 12 Training	<ul style="list-style-type: none"> <li>• Training for community providers and school staff in trauma, behavioral health ID and referral</li> <li>• Increase stigma reduction education (ie speakers bureaus)</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain Mental Health First Aid</li> <li>• Training plan for community providers &amp; school staff</li> <li>• Funding for SDR (ie speakers bureaus)</li> </ul>	\$85,000  Continue with changes
PEI 20 Suicide Prevention	<ul style="list-style-type: none"> <li>• Develop comprehensive SP plan</li> <li>• Increase SP training for County/community staff</li> <li>• Increase outreach about SP resources</li> </ul>	<ul style="list-style-type: none"> <li>• Maintain SP Hotline FY17-18</li> <li>• Develop SP Strategic Plan in FY17-18, then reconsider funding</li> </ul>	\$100,000  Continue with changes
Statewide	• CalMHSA contribution	• 4% minimum requested	\$75,000 Contribute 4%

A

**APPENDIX - VI**

C

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3  
4 **MARIN COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES**  
5 **MHSA PLANNING ESTIMATES SUMMARY- DRAFT**  
6 **FY 17/18, 18/19 and 19/20**

7 Updated: 3.29.17

8	I. CSS	2017-18	2018-19	2019-20	TOTAL	3 - Year Average
9	Estimated - Marin County MHSA Allocation	\$7,998,221	\$7,805,198	\$7,805,198	\$23,608,617	
10	Current 3-Year Average CSS Funding	\$7,725,675	\$7,725,675	\$7,725,675	\$23,177,025	
11	Add: Estimated Funding Growth	\$272,546	\$79,523	\$79,523	\$431,592	
12	Estimated - Marin County MHSA Allocation	\$7,998,221	\$7,805,198	\$7,805,198	\$23,608,617	
13	Add: Estimated Prior Year Unspent Funds	\$2,100,000	\$2,100,000	\$2,100,000	\$6,300,000	
14	<b>Total Estimated CSS Funds Available</b>	<b>\$10,098,221</b>	<b>\$9,905,198</b>	<b>\$9,905,198</b>	<b>\$29,908,617</b>	<b>\$9,969,539</b>
18						
19	II. PEI	2017-18	2018-19	2019-20	TOTAL	3 - Year Average
20	Estimated - 3- Year Average Marin County MHSA Allocation	\$1,996,433	\$1,996,433	\$1,996,433	\$5,989,299	
22	PEI Programs Currently Funded (FY 16/17)	\$1,900,500	\$1,900,500	\$1,900,500	\$5,701,500	
23	Add: Estimated Funding Growth	\$95,933	\$95,933	\$95,933	\$287,799	
24	<b>Total PEI Funds Available</b>	<b>\$1,996,433</b>	<b>\$1,996,433</b>	<b>\$1,996,433</b>	<b>\$5,989,299</b>	
25	Add: Estimated Prior Year Unspent Funds	\$300,000	\$300,000	\$300,000	\$900,000	
26	<b>Total Estimated PEI Revenues - County</b>	<b>\$2,296,433</b>	<b>\$2,296,433</b>	<b>\$2,296,433</b>	<b>\$6,889,299</b>	<b>2,296,433</b>
27						
28	III. INN	2017-18	2018-19	2019-20	TOTAL	3 - Year Average
29	Estimated - 3- Year Average Marin County MHSA Allocation	\$517,000	\$517,000	\$517,000	\$1,551,000	517,000
31						
32						
33	IV. INTEREST	2017-18	2018-19	2019-20	TOTAL	1 - Time
34	Interest Revenue				\$500,000	\$500,000

# APPENDIX - VI

A	B	C	D	E	F	G	H	I	J	K
MHSA 3 YEAR PLAN PROPOSALS (FY 17-18 to FY 19-20)										
<b>CSS COMMUNITY SERVICES AND SUPPORT</b>										
FSP	Program	PROGRAM	PROGRAM DESCRIPTION	Current Avg annual funded CSS Programs (FY 16/17)	Estimated Cost (year1)	Estimated Cost (year2)	Estimated Cost (year3)	Total		
<b>CSS Funds Available</b>					\$9,969,000	\$9,969,000	\$9,969,000	\$29,907,000		
<b>Less: BHRS Administration &amp; Indirect</b>					(\$1,495,350)	(\$1,495,350)	(\$1,495,350)	(\$4,486,050)		
<b>Net Funds Available</b>					\$8,473,650	\$8,473,650	\$8,473,650	\$25,420,950		
<b>1) Existing Programs Currently Funded</b>										
CSS	YES	Youth Empowerment Services	Full service partnership program serving 40+ seriously high risk youth through age 18 who are involved with Probation and/or attend County Community School, an alternative high school.	\$649,227				\$0		
CSS	TAY	Transition Age Youth	Transition Age Youth (TAY) Partnership, provided by Sunny Hills serving 20 TAY plus 50 partial/drop in youth, is a full service partnership providing young people (16-25) with independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services.	\$446,773				\$0		
CSS	STAR	Support and Treatment after Release	Full service partnership providing culturally competent intensive, integrated services for up to 60 mentally ill offenders at a given time. The program's target population is adults, transition age young adults and older adults with serious mental illness, ages 18 and older, who have involvement with the criminal justice system and are at risk of re-offending and re-incarceration.	\$519,644				\$0		
CSS	HOPE	Helping Older People Excel	Full service partnership that provides culturally competent intensive, integrated services with capacity to serve 60 clients at a given time. The program serves at-risk older adults, ages 60 and older, with serious mental illness, who are unserved by the mental health system, have experienced or are experiencing a reduction in their personal or community functioning, and, as a result, are at risk of hospitalization, institutionalization or homelessness.	\$848,517				\$0		
CSS	Odyssey	Odyssey Programs	Full service partnership that provides culturally competent intensive, integrated services to 100 clients at a given time. Target clients are adults, transition age young adults and older adults with serious mental illness, ages 18 and older, who are homeless or at-risk of homelessness.	\$1,283,035				\$0		
CSS	ERC	Enterprise Resource Center Expansion	Serving 400+ people and known for its low-barrier access and welcoming environment, the ERC plays a key role in Marin's efforts to outreach to and engage with adults with serious mental illness in the county who are disenfranchised and reluctant to seek help and services. Managed and staffed entirely by mental health consumers, the center promotes a strengths-based, harm-reduction approach and offers clients a one-stop central location to access and receive services such as socialization activities, peer counseling, mentoring, psycho-educational activities, and support groups. CARE Team	\$347,387				\$0		
CSS	ERC	Step-Up Program	Club House RFP being prepared for release April 2017	\$254,943				\$0		
CSS	ASOC	Adult System of Care	This General System Development/Outreach and Engagement expansion project was designed to expand and enhance supports and services available in Marin's system of care for priority population adults and their families by 1) increasing peer specialist services on the Adult Intensive Case Management team, 2) providing outreach and engagement services to Hispanics/Latinos, 3) increasing Vietnamese outreach and engagement services, 4) adding family outreach, engagement and support services to the ASOC at large, and 5) providing short-term housing assistance. The project's target population is transition-age young adults, adults and older adults, age 18 and older, who have serious mental illness, and their families, and who are at risk of hospitalization, institutionalization, incarceration, homelessness, frequent emergency medical care or other long-term adverse impacts of mental illness.	\$801,460				\$0		
CSS		Co-Occurring Capacity	Co-Occurring Capacity (includes outreach and engagement services for individuals with co-occurring mental health & substance use disorders, co-location of substance use and mental health services and co-occurring capabilities of the behavioral health workforce.	\$347,409				\$0		
CSS		Crisis Continuum	Crisis Continuum of Care - Casa Rene Crisis Residential; Crisis Planning	\$600,000				\$0		
CSS		MHSA Coordination	MHSA Coordinator and Ethnic Services Manager	\$228,986				\$0		

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	A	B	C	D	F	G	H	I	J	K
	FSP	Program	PROGRAM	PROGRAM DESCRIPTION	Current Avg annual funded CSS Programs (FY 16/17)		Estimated Cost (year1)	Estimated Cost (year2)	Estimated Cost (year3)	Total
4										
21	CSS	WET	Workforce Education and Training	Transfer of CSS Funds to Workforce, Education and Training; Includes APA Interns	\$333,333					\$0
22	<b>TOTAL - EXISTING PROGRAMS</b>				<b>\$6,660,714</b>		<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
23										
24	<b>2) Discontinued Programs in new Plan</b>									
25	CSS	SMSS	Southern Marin Site Services	The Southern Marin Services Site Program (SMSS), was discontinued during FY16-17	\$277,729					
26	<b>TOTAL - Discontinued Programs</b>				<b>\$277,729</b>					
27										
28	<b>3) NEW/Enhancement Proposed Programs</b>									
29	CSS									
30	CSS									
31	CSS									
32	CSS									
33										
34	<b>Subtotal - NEW Proposed Programs</b>						<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
35										
36	<b>Net Funds Available</b>						<b>\$8,473,650</b>	<b>\$8,473,650</b>	<b>\$8,473,650</b>	<b>\$25,420,950</b>
37	<b>Total Estimated Ongoing Costs</b>						<b>\$6,660,714</b>	<b>\$6,660,714</b>	<b>\$6,660,714</b>	<b>\$19,982,142</b>
38	<b>Total Estimated Available for Planning</b>						<b>\$1,812,936</b>	<b>\$1,812,936</b>	<b>\$1,812,936</b>	<b>\$5,438,808</b>

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A	B	C	D	F	G	H	I	J	K	
1 MHSA 3 YEAR PLAN PROPOSALS (FY 17-18 to FY 19-20)										
2										
3 PEI - PREVENTION AND EARLY INTERVENTION PROGRAMS										
4	PEI	Program	PROGRAM	PROGRAM DESCRIPTION	Current Avg annual funded PEI Programs (FY 16/17)	Estimated Cost (year1)	Estimated Cost (year2)	Estimated Cost (year3)	Total	
5	PEI Funds Available					\$2,296,000	\$2,296,000	\$2,296,000	\$6,888,000	
6	Less: BHRS Administration & Indirect					(\$344,400)	(\$344,400)	(\$344,400)	(\$1,033,200)	
7	Net PEI Funds Available					\$1,951,600	\$1,951,600	\$1,951,600	\$5,854,800	
8										
9	I) Existing Programs Currently Funded									
10	PEI	ECMH	Early Childhood Mental Health	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 in subsidized preschools and other settings.	230,000				0	
11	PEI		School Age Program	Provide services for high risk youth, such as ones identified through the School Attendance Review Boards, coordinate with continuum of school and community services. School Districts: Shoreline, Sausalito, Marin City and San Rafael City Schools.	275,000				0	
12	PEI	TAY	Transition Age Youth Program (in existing TAY services)	Transitional Aged Youth (TAY) PEI program aims to increase wellness by increasing access for transition age youth (16-25) to behavioral health support in trusted settings. Huckleberry Youth Program (HYP) and Novato Youth Center (NYC) have implemented screening, brief intervention, newcomers services and linkages to other services.	153,333				0	
13	PEI	CANAL	Latino Community Based	Latino Community Connection program aims to increase wellness by increasing access to mental health prevention and intervention services for Latino un/underserved residents at the earliest signs of mental health problems. Canal Alliance (CA) has implemented this program since July 2009.	202,333				0	
14	PEI	VIET	(PEI) Vietnamese Community Connection	This program provides outreach to and behavioral health education for the Vietnamese community; assistance for Vietnamese residents in accessing mental health services by providing services such as accompanying them to appointments and translation. Community Action Marin/Marin Asian Advocacy Program began this program in July 2012.	53,000				0	
15	PEI		Veterans Community Connection	Provide a part time Veteran Advocate to assist with : linking veterans to federal, state and local programs; outreach, especially to jail and homeless populations; brief intervention services and collaboration among veterans service providers.	48,333				0	
16	PEI	OA	Older Adult PEI	Older adults are a growing portion of the population of Marin. Due to changes brought on by aging, they are at-risk for isolation, depression, chronic health problems, substance abuse, or other issues. Older Adult PEI program aims to increase wellness by providing services to un/underserved older adults who are at risk for mental health concerns, such as experiencing life transitions, poverty, or isolation.	100,000				0	
17	PEI		Statewide Prevention and Early Intervention	Suicide Prevention Hotlines; CalMHSA Statewide Campaigns	163,845				0	

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A	B	C	D	F	G	H	I	J	K
PEI	Program	PROGRAM	PROGRAM DESCRIPTION	Current Avg annual funded PEI Programs (FY 16/17)		Estimated Cost (year1)	Estimated Cost (year2)	Estimated Cost (year3)	Total
4									
18	PEI	Community and Provider Training	Provides training and education to support: (1) increasing recognition of mental illness, (2) reduce stigma and discrimination, and (3) implement effective practices. A central component is the Mental Health First Aid (MHFA) training. 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, and sending providers, consumers, families and others to conferences related to PEI efforts.	75,000					0
19	PEI	Program Evaluation	PEI Program Data and Evaluation services	40,000					
20	PEI	Program Coordination	PEI Coordination services	67,933					0
21	<b>TOTAL - EXISTING PROGRAMS - PEI</b>			<b>\$1,408,777</b>		<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
22									
23	<b>2) Discontinued Programs in the new Plan</b>								
24	PEI	Triple P (Positive Parenting Program)	Triple P Marin is an evidence-based model for coaching and empowering parents to improve their parenting skills. Triple P Marin coordinates training and technical assistance for providers who work with families to implement Triple P with fidelity. The program also provides parent workshops and individual consultations. Marin has focussed on Levels 2 and 3, with some Levels 4 and 5 services.	59,667					0
25	PEI	Integrated Behavioral Health in Primary Care	The target population for this integrated program is un- and under-insured individuals accessing primary care at community clinics. This program provides screening, brief intervention and linkages to other services.	180,000					0
26	<b>TOTAL - Discontinued Programs</b>			<b>\$239,667</b>					
27									
28	<b>3) NEW/Enhanced Proposed Programs</b>								
29	PEI								
30	PEI								
31	PEI								
32	PEI								
33	<b>Subtotal New Proposed Programs</b>					<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
34									
35	<b>Net Funds Available</b>					<b>\$1,951,600</b>	<b>\$1,951,600</b>	<b>\$1,951,600</b>	<b>\$5,854,800</b>
36	<b>Total Estimated Ongoing Costs</b>					<b>\$1,408,777</b>	<b>\$1,408,777</b>	<b>\$1,408,777</b>	<b>\$4,226,331</b>
37	<b>Total Estimated Available for Planning</b>					<b>\$542,823</b>	<b>\$542,823</b>	<b>\$542,823</b>	<b>\$1,628,469</b>

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1	A	B	C	D	E	F	G	H	I	J	K
	<b>MHSA 3 YEAR PLAN PROPOSALS (FY 17-18 to FY 19-20)</b>										
2	<b>WET WORKFORCE EDUCATION AND TRAINING</b>										
3	<b>WET</b>	<b>Program</b>	<b>PROGRAM</b>	<b>PROGRAM DESCRIPTION</b>	<b>Current Avg annual funded WET Programs (FY 16/17)</b>	<b>Estimated Cost (year1)</b>	<b>Estimated Cost (year2)</b>	<b>Estimated Cost (year3)</b>	<b>Total</b>		
4	<b>WET Funds Available</b>					\$333,333	\$333,333	\$333,334	\$1,000,000		
5											
6	<b>Net WET Funds Available</b>					\$333,333	\$333,333	\$333,334	\$1,000,000		
7											
8	<b>1) Existing Programs Currently Funded</b>										
9	WET		System-wide Dual Diagnosis Training	This action item is to provide a series of Integrated Dual Disorder Treatment (IDDT) trainings.	28,812						
10	WET		Scholarships for Underserved Consumers & 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.	51,435						
11	WET		Training Initiatives	The proposal is to continue to train the staff and community members in Evidenced Based Practices as well as to coordinate this effort county-wide	36,126						
12	WET		Peer Mentoring	Support scholarship recipients to complete their course work and enter the workforce.	37,072						
13	WET		BHRS Intern Stipends	To fund the stipends for the APA accredited Internship Program throughout the County system of care, as well as the stipends for the SW graduates Total: \$203,200 on going.	152,000						
14	<b>Total WET</b>					<b>\$305,445</b>					
15											
16	<b>2) Discontinued Programs in the new Plan</b>										
17	WET		Family Member Focus Training	Supports consumers to qualify for employment within the mental health system, and participate in planning and policy within the system. Increases the capacity of providers to include families in treatment and planning processes.	1,300						
18	WET		CBO Intern Stipends	Trains providers and ensures that all trainings are available to our community based partners serving individuals with mental health and substance use issues.	16,667						
19	WET		WET Coordination	Contracted Coordinator - was discontinued in FY15-16	10,000						
20	WET		California Institute for Mental Health-Training	CIMH MH Directors Leadership Institute Training	5,283						
21	<b>TOTAL - Discontinued Programs</b>					<b>\$33,250</b>					

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	A	B	C	D	F	G	H	I	J	K	
	WET	Program	PROGRAM	PROGRAM DESCRIPTION	Current Avg annual funded WET Programs (FY 16/17)		Estimated Cost (year1)	Estimated Cost (year2)	Estimated Cost (year3)	Total	
3											
22											
23	<b>3) NEW/Enhanced Proposed Programs</b>										
24	WET										
25	WET										
26	WET										
27	WET										
28	<b>Subtotal - NEW Proposed Programs</b>							\$0	\$0	\$0	\$0
29											
30	<b>Net Funds Available</b>						\$333,333	\$333,333	\$333,334	\$1,000,000	
31	<b>Total Estimated Ongoing Costs</b>						\$305,445	\$305,445	\$305,445	\$916,335	
32	<b>Total Estimated Available for Planning</b>						\$27,888	\$27,888	\$27,889	\$83,665	

# **Marin Behavioral Health and Recovery Services**

## **MHSA HANDBOOK**

**March 2017**



WELLNESS • RECOVERY • RESILIENCE

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## MHSA HANDBOOK

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## MENTAL HEALTH SERVICES ACT As of September 2016

### SECTION 1. Title

This Act shall be known and may be cited as the "Mental Health Services Act." SECTION 2.

### Findings and Declarations

The people of the State of California hereby find and declare all of the following:

1. (a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.
2. (b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.
3. (c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.
4. (d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.
5. (e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.
6. (f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job

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saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.

7. (g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars (\$1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars (\$1,000,000). They have an average pre-tax income of nearly five million dollars (\$5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million dollar homes in other states.

### SECTION 3. Purpose and Intent.

The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows:

1. (a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.
2. (b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.
3. (c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.
4. (d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.
5. (e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

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SECTION 4. Part 3.6 (commencing with Section 5840) is added to Division 5 of the Welfare and Institutions Code, to read:

### PART 3.6

#### PREVENTION AND EARLY INTERVENTION PROGRAMS

5840. (a) The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

2. (b) The program shall include the following components:
  1. (1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
  2. (2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.
  3. (3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.
  4. (4) Reduction in discrimination against people with mental illness.
3. (c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.
4. (d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:
  1. (1) Suicide.
  2. (2) Incarcerations.
  3. (3) School failure or dropout.
  4. (4) Unemployment.
  5. (5) Prolonged suffering.
  6. (6) Homelessness.
  7. (7) Removal of children from their homes.
5. (e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.
6. (f) In consultation with mental health stakeholders, and consistent with regulations from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

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### \*Welfare and Institutions Code Section 5600.3

To the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority:

(a)(1) Seriously emotionally disturbed children or adolescents.

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

(b)(1) Adults and older adults who have a serious mental disorder.

(2) For the purposes of this part, "serious mental disorder" means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

(B)(i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:

(A) Homeless persons who are mentally ill.

(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.

(C) Persons arrested or convicted of crimes.

(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

(5) California veterans in need of mental health services and who meet the existing eligibility requirements of this section, shall be provided services to the extent services are available to other adults pursuant to this section. Veterans who may be eligible for mental health services through the United States Department of Veterans Affairs should be advised of these services by the county and assisted in linking to those services.

(A) No eligible veteran shall be denied county mental health services based solely on his or her status as a veteran.

(B) Counties shall refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or other federal health care provider.

(C) Counties should consider contracting with community-based veterans' services agencies, where possible, to provide high-quality, veteran specific mental health services.

(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.

(d) Persons who need brief treatment as a result of a natural disaster or severe local emergency.

7. See more at: <http://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-5600-3.html#sthash.sb0JxSLS.dpuf>

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SECTION 5. Article 11 (commencing with Section 5878.1) is added to Chapter 1 of Part 4 of Division 5 of the Welfare and Institutions Code, to read: Article 11.

### **Services for Children with Severe Mental Illness.**

5878.1 (a)

It is the intent of this article to establish programs that ensure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and his or her family.

(b) Nothing in this act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

5878.2 For purposes of this article, severely mentally ill children means minors under the age of 18 who meet the criteria set forth in subdivision (a) of Section 5600.3. \* *See Section 5600*

5878.3 (a) Subject to the availability of funds as determined pursuant to Part 4.5 (commencing with Section 5890), county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

2. (b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.
3. (c) The State Department of Health Care Services shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

SECTION 6. Section 18257 is added to the Welfare and Institutions Code, to read:

18257. The State Department of Social Services shall seek applicable federal approval to make the maximum number of children being served through such programs eligible for federal financial participation and amend any applicable state regulations to the extent necessary to eliminate any limitations on the numbers of children who can participate in these programs.

SECTION 7. Section 5813.5 is added to Part 3 of Division 5 of the Welfare and Institutions Code, to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county

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mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, seniors means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

1. (a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.
2. (b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health programs plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. \*

4. (d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:
  1. (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
  2. (2) To promote consumer-operated services as a way to support recovery.
  3. (3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.
  4. (4) To plan for each consumer's individual needs.
5. (e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.
6. (f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1).
7. (g) The department shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section the term grants referred to in Sections 5814 and 5814.5 shall refer to such contracts.

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SECTION 8. Part 3.1 (commencing with Section 5820) is hereby added to Division 5 of the Welfare and Institutions Code, to read:

### PART 3.1 HUMAN RESOURCES, EDUCATION, AND TRAINING PROGRAM

5820. (a) (b)

It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide

(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5822. The Office of Statewide Health Planning and Development shall include in the five- year plan:

1. (a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.
2. (b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, masters degrees, or doctoral degrees.
3. (c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.
4. (d) Establishment of regional partnerships between the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.
5. (e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.
6. (f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with 5840), and Part 4 (commencing with 5850) of this division.

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7. (g) Promotion of the employment of mental health consumers and family members in the mental health system.
8. (h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).
9. (i) Promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.
10. (j) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

SECTION 9. Part 3.2 (commencing with Section 5830) is added to Division 5 of the Welfare and Institutions Code, to read:

### Part 3.2 INNOVATIVE PROGRAMS

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

The innovative programs shall have the following purposes:

- (1) To increase access to underserved groups.
- (2) To increase the quality of services, including better outcomes.
- (3) To promote interagency collaboration.
- (4) To increase access to services.

All projects included in the innovative program portion of the county plan shall meet the following requirements:

1. (1) Address one of the following purposes as its primary purpose:
  1. (A) Increase access to underserved groups.
  2. (B) Increase the quality of services, including measurable outcomes.
  3. (C) Promote interagency and community collaboration.
  4. (D) Increase access to services.
2. (2) Support innovative approaches by doing one of the following:
  1. (A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention.
  2. (B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community.
  3. (C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in nonmental health contexts or settings.

An innovative project 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, including, but not limited to, any of the following:

1. (1) Administrative, governance, and organizational practices, processes, or procedures.
2. (2) Advocacy.
3. (3) Education and training for service providers, including nontraditional mental health practitioners.
4. (4) Outreach, capacity building, and community development.
5. (5) System development.

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6. (6) Public education efforts.
7. (7) Research.
8. (8) Services and interventions, including prevention, early intervention, and treatment.

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.

County mental health programs shall expend funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

### Expenditure Plans

SECTION 10. Part 3.7 (commencing with Section 5845) is added to Division 5 of the Welfare and Institutions Code, to read:

5. (e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.
6. (f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (d) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.
2. (b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.
3. (c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the California Mental Health Directors Association.
4. (d) Mental health services provided pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be included in the review of program performance by the California Mental Health

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Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

SECTION 11. Section 5771.1 is added to the Welfare and Institutions Code, to read:

### 5891. (a) **Funding**

The funding established pursuant to this act shall be utilized to expand mental health services. Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

(4) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

2. (b) Nothing in the establishment of this fund, nor any other provisions of the act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.
3. (c) Nothing in this act shall be construed to modify or reduce the existing authority or responsibility of the State Department of Health Care Services.
4. (d) The State Department of Health Care Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.
5. (e) Share of costs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

(b) Notwithstanding subdivision (a), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the

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Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

5892. (a)

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850).

(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).

In order to promote efficient implementation of this act the county shall use funds distributed from the Mental Health Services Fund as follows:

1. (1) In 2005-06, 2006-07, and in 2007-08 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.
  2. (2) In 2005-06, 2006-07 and in 2007-08 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.
  3. (3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.
  4. (4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.
  5. (5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850), for the children's system of care and Part 3 (commencing with Section 5800), for the adult and older adult system of care.
  6. (6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.
- 
2. (b) In any year after 2007-08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

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3. (c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The

Planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

4. (d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

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## Definitions

### 9 CCR

#### § 3200.030. **Children and Youth**

“Children and Youth” means individuals from birth through 17 years of age.

- (1) Individuals age 18 and older who meet the conditions specified in Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code are considered children and youth and are eligible to receive services.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5878.2, Welfare and Institutions Code.

#### § 3200.040. **Client**

“Client” means an individual of any age who is receiving or has received mental health services. As used in these regulations, the term “client” includes those who refer to themselves as clients, consumers, survivors, patients or ex-patients.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5801(b)(6) and (7), Welfare and Institutions Code.

#### § 3200.050. **Client Driven**

“Client Driven” means that the client has the primary decision-making role in identifying his/her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(d)(2) and (3), 5830(a)(2) and 5866, Welfare and Institutions Code; and Section 2(e), MHSA.

#### § 3200.060. **Community Collaboration**

“Community Collaboration” means a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5830(a)(3) and 5866, Welfare and Institutions Code.

#### § 3200.070. **Community Program Planning Process**

“Community Program Planning” means the process to be used by the County to develop Three-Year Program and Expenditure Plans, and updates in partnership with stakeholders to:

- (1) Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act.

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- (2) Analyze the mental health needs in the community.
- (3) Identify and re-evaluate priorities and strategies to meet those mental health needs.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(d) and 5892(c), Welfare and Institutions Code.

### § 3200.100. Cultural Competence

“Cultural Competence” means incorporating and working to achieve each of the goals listed below into all aspects of policy-making, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals.

- (1) Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural, and linguistic populations or communities.
- (2) Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.
- (3) Disparities in services are identified and measured, strategies and programs are developed and implemented, and adjustments are made to existing programs to eliminate these disparities.
- (4) An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.
- (5) An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.
- (6) An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.
- (7) Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.
- (8) Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community that they serve.
- (9) Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5813.5(d)(3), 5868(b), 5878.1(a), Welfare and Institutions Code; and Sections 2(e) and 3(c), MHSA.

### § 3200.120. Family Driven

“Family Driven” means that families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

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Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5822(h), 5840(b)(1), 5868(b)(2) and 5878.1, Welfare and Institutions Code.

### § 3200.125. **Financial Incentive Programs Funding Category**

“Financial Incentive Programs Funding Category” means the funding category of the Workforce Education and Training component of the Three-Year Program and Expenditure Plan that funds stipends, scholarships and the Mental Health Loan Assumption Program for the purpose of recruiting and retaining Public Mental Health System employees.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5822, Welfare and Institutions Code.

### § 3200.130. **Full Service Partnership**

“Full Service Partnership” means the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5801, 5802, 5850 and 5866, Welfare and Institutions Code.

### § 3200.140. **Full Service Partnership Service Category**

“Full Service Partnership Service Category” means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans, under which the County, in collaboration with the client, and when appropriate the client's family, plans for and provides the full spectrum of community services so that children and youth, transition age youth, adults and older adults can achieve the identified goals.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5847(a) and 5892(a)(5), Welfare and Institutions Code.

### § 3200.150. **Full Spectrum of Community Services**

“Full Spectrum of Community Services” means the mental health and non-mental health services and supports necessary to address the needs of the client, and when appropriate the client's family, in order to advance the client's goals and achieve outcomes that support the client's recovery, wellness and resilience.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5801(b), 5813.5(d), 5851 and 5868(b)(2), Welfare and Institutions Code.

### § 3200.160. **Fully Served**

“Fully Served” means clients, and their family members who obtain mental health services, receive the full spectrum of community services and supports needed to advance the client's recovery, wellness and resilience.

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Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5801(b), 5806, 5852 and 5813.5(d), Welfare and Institutions Code.

### § 3200.170. **General System Development Service Category**

“General System Development Service Category” means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans under which the County uses Mental Health Services Act funds to improve the County's mental health service delivery system for all clients and/or to pay for specified mental health services and supports for clients, and/or when appropriate their families.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5892(a)(5) and 5847(a)(2) and (3), Welfare and Institutions Code.

### § 3200.180. **Individual Services and Supports Plan**

“Individual Services and Supports Plan” means the plan developed by the client and, when appropriate the client's family, with the Personal Service Coordinator/Case Manager to identify the client's goals and describe the array of services and supports necessary to advance these goals based on the client's needs and preferences and, when appropriate, the needs and preferences of the client's family.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5699.4, 5806(b) through (d), 5813.5(d)(4) and 5868, Welfare and Institutions Code.

### § 3200.210. **Linguistic Competence**

“Linguistic Competence” means organizations and individuals working within the system are able to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including individuals with Limited English Proficiency; individuals who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that structures, policies, procedures and dedicated resources are in place that enable organizations and individuals to effectively respond to the literacy needs of the populations being served.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5806(a)(2) and 5868(b)(3) and 5868(b)(4), Welfare and Institutions Code, Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d et seq., Sections 2(e) and 3(c), MHSA.

### § 3200.230. **Older Adult**

“Older Adult” means an individual 60 years of age and older.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5689.2, Welfare and Institutions Code.

### § 3200.240. **Outreach and Engagement Service Category**

“Outreach and Engagement Service Category” means the service category of the Community

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Services and Supports component of the Three-Year Program and Expenditure Plan under which the County may fund activities to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5600.2, 5802(a)(1), 5806(a)(2) and 5814(b), Welfare and Institutions Code.

### § 3200.253. Public Mental Health System

“Public Mental Health System” means publicly-funded mental health programs/services and entities that are administered, in whole or in part, by the Department or County. It does not include programs and/or services administered, in whole or in part, by federal, state, county or private correctional entities or programs or services provided in correctional facilities.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5820, Welfare and Institutions Code.

### § 3200.254. Public Mental Health System Workforce

“Public Mental Health System Workforce” means current and prospective Department and/or County personnel, County contractors, volunteers, and staff in community-based organizations, who work or will work in the Public Mental Health System.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5820, Welfare and Institutions Code.

### § 3200.270. Stakeholders

“Stakeholders” means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814.5(b)(1) and 5848(a), Welfare and Institutions Code.

### § 3200.275. Supported Employment Services

“Supported Employment Services” means vocational rehabilitation activities provided to a client and/or a family member of a client for the purpose of obtaining, sustaining and enhancing their employment.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5822, Welfare and Institutions Code.

### § 3200.276. Training and Technical Assistance Funding Category

“Training and Technical Assistance Funding Category” means the funding category of the

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Workforce Education and Training component of the Three-Year Program and Expenditure Plan that funds consultation and/or education to assist those providing services and supports to individuals, clients and/or family members of clients who are working in and/or receiving services from the Public Mental Health System.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5822, Welfare and Institutions Code.

### § 3200.280. **Transition Age Youth**

“Transition Age Youth” means youth 16 years to 25 years of age.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5847(c), Welfare and Institutions Code.

### § 3200.300. **Underserved**

“Underserved” means clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client's recovery, wellness and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas, Native American rancherias and/or reservations who are not receiving sufficient services.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814(a)(1), 5814(d), 5814.5, 5830, 5840 and 5848, Welfare and Institutions Code.

### § 3200.310. **Unservd**

“Unservd” means those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814(a)(1), 5814.5, 5830, and 5840 Welfare and Institutions Code.

### § 3200.320. **Workforce Education and Training**

“Workforce Education and Training” means the component of the Three-Year Program and Expenditure Plan that includes education and training programs and activities for prospective and current Public Mental Health System employees, contractors and volunteers.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Section 5820, Welfare and Institutions Code.

## **APPENDIX - VI**

### **§ 3200.325. Workforce Staffing Support Funding Category**

“Workforce Staffing Support Funding Category” means the funding category of the Workforce Education and Training component of the Three-Year Program and Expenditure Plan that funds staff needed to plan, administer, coordinate and/or evaluate Workforce Education and Training programs and activities.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5820, 5821 and 5822, Welfare and Institutions Code.

# MENTAL HEALTH SERVICES ACT (MHSA)

## Three Year Integrated Planning

Fiscal Years

**2017-18, 2018-19, 2019-20**



WELLNESS • RECOVERY • RESILIENCE

# AGENDA

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- Welcome and Introductions
- Statement of Purpose and review of relevant MHSA guidelines
- Recommendations by MHSA Component
- Discussion
- Next Steps
- Adjourn

# Today's Goal

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MHSA Advisory Committee will Review and provide their Input on the Community and Stakeholder Recommendations for the Mental Health Services Act (MHSA) Three Year Integrated Plan for July 2017 through June 2020

# MHSA Committee Purpose

The goal of Marin County Mental Health Services Act (MHSA) Advisory Committee (MHSAAC) is to provide input and recommendations to the Behavioral Health and Recovery Services (BHRS) Division when determining what MHSA funded programs are developed and prioritized, including prevention and early intervention, crisis intervention services, treatment services, and recovery services.

**WIC § 5848** *Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.*

## Committee Member Roles and Responsibilities

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Represent the views of their constituency group as a whole rather than their individual or agency agenda(s). The MHSAAC is not a place to advocate for funding for an individual entity or organization, nor does it mean that attendance will guarantee funding. The MHSAAC is intended to be a safe place for members to voice their concerns and share input in order to increase access and reduce barriers to services for their unserved/underserved constituents.

## Client Driven Programs and Services

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Client driven programs and services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and definition and determination of outcomes

# Community Services and Supports (CSS)

*See Handout*

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## **Existing Programs:**

### *Full Service Partnerships (FSPs):*

YES FSP, TAY FSP, STAR FSP, HOPE FSP, ODYSSEY FSP

### *System Development/Outreach and Engagement (SDOE):*

Enterprise Resource Center

Adult System of Care

Co-Occurring Capacity

Crisis Continuum

## **Discontinued Programs:**

Southern Marin Services Site

# Community Services and Supports (CSS)

*See Handout*

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## **New / Enhancement Proposed Programs:**

Expand Capacity of Mobile / Transition Teams

Evidence Based Practice Lead Staff

Expansion of Transition Age Youth (TAY) FSP

First Episode Psychosis Program

Assertive Community Treatment (ACT) Program

Youth Empowerment Services (YES) FSP Expansion

Program support for FSPs

3% Allocation Adjustment for Existing Programs

# Community Services and Supports (CSS)

*See Handout*

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## **New / Enhancement Proposed Programs (con't):**

Substance Use Disorder System Capacity for SMI

- *Related to Co-Occurring Capacity initiative, funded under existing CSS program*

Increase Providers with Lived-Experience

- *Embedded in new CSS program budget proposals*

Increase Vocational and Independent Living Skills to FSP participants

- *Will be funded with non-MHSA funding*

# Prevention and Early Intervention (PEI)

*See Handout*

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## **Existing Prevention and Early Intervention Programs:**

- Early Childhood Mental Health (ECMH)
- School Age Program
- Transition Age Youth (TAY) Prevention and Early Intervention
- Latino Community Connection
- Vietnamese Community Connection
- Veteran's Community Connection
- Older Adult Prevention and Early Intervention
- Statewide Prevention and Early Intervention
- Community and Provider Training

## **Discontinued Programs:**

- Triple P (Positive Parent Program)
- Integrated Behavioral Health in Primary Care

# Prevention and Early Intervention (PEI)

*See Handout*

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## **New / Enhancement Proposed Programs:**

Older Adult Prevention and Early Intervention Expansion

Evidence Based Practice Lead Staff

Health Navigator

Transition Age Youth (TAY) Expansion (LGTBQ school support)

Statewide Prevention and Early Intervention Planning Expansion

# Prevention and Early Intervention (PEI)

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## **New / Enhancement Proposed Programs** *(con't)*:

School Age Program Expansion (Shoreline School)

School Age Program New Program for outreach/support/linkage for high risk (e.g. homeless) students

Latino Community Connection Expansion

Statewide Prevention and Early Intervention CalMHSA contribution

Community and Provider Training Speakers Bureau Expansion

Data Collection to meet new State PEI data requirements

# Workforce, Education and Training (WET)

*See Handout*

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## **Existing Workforce Education and Training Programs:**

- Scholarships for Underserved Consumer and Family Members
- Consumer / Family Member Training Initiatives
- Peer Mentoring
- BHRS APA Intern Stipends

## **Discontinued Programs:**

- Family Member Focus Training
- CBO Intern Stipends
- WET Coordination
- System-wide Dual Diagnosis Training
- California Institute for Mental Health Training

# Workforce, Education and Training (WET)

*See Handout*

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## **New Proposed Program:**

Peer Specialist and AOD Intern Stipend Program

# Capital Facilities and Technological Needed (CFTN)

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## Existing CFTN Programs:

Electronic Health Record Upgrade

## Discontinued Programs:

Scanning

E-Prescribing

Consumer Family Empowerment

Behavioral Health Information Crosswalk

## New/Enhanced Proposed Program:

Practice Management System

*New electronic health record (EHR) and Billing system to replace existing system*

## Innovation (INN)

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### **Current Innovation Project:**

*Growing Roots: The Young Adult Services Project*

MHSOAC Approved: April 28, 2016

Project Completion Date: June 30, 2019

Project Budget: \$1,616,900

### **New Innovation Project:**

Begin Stakeholder Process in FY2017-18

Project Budget: \$517,000 per year for 3 years (\$1,551,000)

# COMMITTEE MEMBER INPUT PROCESS

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- ❑ Charts are on the walls with the CSS and PEI Recommendations
- ❑ Each Member has 3 Green CSS stickers and 3 Yellow PEI stickers with their names on them
- ❑ Only 1 sticker per Recommendation
- ❑ Count off 1-2-1-2 and the 1's go to the PEI Charts and the 2's go to the CSS Charts
- ❑ Once you've put up all your CSS stickers, go to the PEI Charts to do the same

## Next Steps

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- ❑ BHRIS Director finalized recommendations
- ❑ BHRIS Writes MHSA Three-Year Program and Expenditure Plan for FY17-18 through FY19-20
- ❑ Plan posted and open for 30-day Public Comment Period
- ❑ Public Hearing at the Mental Health Board
- ❑ Finalize MHSA Three Year Plan
- ❑ Bring before the Board of Supervisors for their support/approval
- ❑ Submit approved plan to the State and begin new plan as of July 1, 2017.

# Q & A

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# Thank you!

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## On the Road to Mental Health

### Highlights from Evaluations of California's Statewide Mental Health Prevention and Early Intervention Initiatives

The California Mental Health Services Authority (CalMHSA)—a coalition of nearly all of California's counties—has implemented an ambitious, first-of-its-kind set of statewide prevention and early intervention (PEI) initiatives with the broad goals of reducing mental illness stigma and discrimination, preventing suicide, and improving student mental health. The initiatives took a public health, population-based approach to developing and implementing many PEI resources and programs, beginning in 2011. This implementation was guided by a comprehensive strategic plan informed by evidence regarding the effectiveness of PEI approaches and carefully developed through a process that involved diverse stakeholders. The CalMHSA PEI initiatives were funded by Proposition 63, the Mental Health Services Act.

CalMHSA selected the RAND Corporation to conduct an independent evaluation of the PEI initiatives. This brief reviews RAND's key evaluation findings. Overall, results show that many program components were successfully implemented and achieved their intended impacts in the short term. Continued dissemination and support of effective programs will be required to sustain short-term gains and to observe longer-term impacts on the mental health, quality of life, and productivity of Californians.

#### Social Marketing Campaigns Were Associated with Reduced Mental Illness Stigma and Increased Confidence to Intervene

CalMHSA implemented two campaigns: "Each Mind Matters" is a stigma-reduction social marketing campaign that includes branded promotional items (ribbons, bracelets, etc.) that aim to get Californians talking about mental illness; documentary screenings; the EachMindMatters.org website, which provides stigma-reduction resources; the ReachOut.com online forum, which provides support for teens and young adults; and theatrical productions for youth. "Know the Signs" is a mass media suicide-prevention effort that uses billboards and advertisements to encourage people to visit the campaign website ([www.suicideispreventable.org](http://www.suicideispreventable.org)) to learn about suicide warning signs and resources.

#### Key findings:

- California has implemented an ambitious set of statewide prevention and early intervention initiatives focused on reducing mental illness stigma and discrimination, preventing suicide, and improving student mental health.
- Programs were successfully implemented and had positive short-term outcomes.
- Continued dissemination and support of programs will be required to sustain short-term gains and to observe longer-term impacts on Californians' mental health and quality of life.

- "Each Mind Matters" and other stigma-reduction campaign activities targeted at adults reached 45 percent of California adults in 2013 or 2014, and reach is growing. Over the two years evaluated, more Californians said that they were willing to socialize with, live next door to, or work closely with people experiencing mental illness, and those experiencing mental illness symptoms were more likely to receive treatment.
- "Know the Signs" reached 56 percent of adults in California. Those who were exposed to the campaign reported being more confident in intervening with those at risk of suicide. An expert panel found that the campaign is aligned with best practices and holds it in high regard.

#### Trainings Increased Knowledge and Improved Attitudes Toward Mental Illness

Training efforts targeted many different kinds of audiences, such as community members; K–12 and higher-education students, parents, and educational staff; health care providers; and other "gatekeepers" who interact with those with mental illness. Goals included providing social contact with people with mental illness to reduce stigma and providing knowledge, such as skills needed to intervene with those

## APPENDIX - VIII

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with mental health needs. For instance, one program trained individuals to deliver Applied Suicide Intervention Skills Training (ASIST), who in turn trained gatekeepers—those whose jobs may put them in a position to interact with people at risk for suicide—in how to recognize and help those at risk. RAND observed some ASIST training sessions and found that new trainers demonstrated high fidelity to the prescribed training. Tens of thousands of trainings were conducted, with positive results, including the following:

- Participants in educational training programs conducted by the National Alliance on Mental Illness reported immediate improvements in knowledge about mental health and attitudes toward people with mental health challenges, including greater willingness to socialize with, live next door to, and work closely with individuals with mental illness.
- Other training programs aimed at reducing stigma and discrimination, such as those carried out by Mental Health America of California and Disability Rights California, similarly influenced a variety of stigma-related attitudes, beliefs, and intentions among attendees.
- Attendees at educational trainings for faculty, students, and staff at the K–12 and higher-education levels reported improvements in their confidence to refer and intervene with students who appeared to be emotionally distressed.

### **Hotlines Provided Support to Those at Risk for Suicide**

CalMHSA invested in 12 suicide-prevention hotlines to support improvements in their reach and capacity. For example:

- One suicide-prevention hotline was created; one was rebranded to accept calls from a larger geographic region; three “warmlines” services for noncrisis calls were created or expanded; and chat or text crisis support was created or expanded by three crisis centers.
- Live monitoring of 241 calls made to ten suicide-prevention hotlines showed that those answering the calls exhibited predominantly positive behaviors with callers and that 43 percent of callers experienced reductions in distress, as measured by an objective rater, over the course of the calls (the remainder did not experience any change or were not in distress at the beginning of the call).

### **PEI Programs Had a Positive Return on Investment**

The evidence suggests that some PEI programming not only pays for itself but also yields money back to the state, when future economic benefits are projected.

- The training of ASIST trainers was projected to prevent suicide attempts and deaths and return money to the state through averted Medi-Cal health care costs and increased state income tax revenue.

- Distressed individuals who were exposed to the “Each Mind Matters” campaign were more likely to seek treatment, which should produce a positive return on investment for the state in terms of higher productivity and employment.
- PEI programs in California’s public universities and colleges are projected to increase engagement in mental health treatment and thus increase graduation rates, in turn leading to higher lifetime earnings and a high return on investment to the state.

### **Evaluation Findings Enhanced Understanding of California’s Mental Health PEI Needs and Priorities for Ongoing Intervention**

Although CalMHSA’s programs have made a great deal of progress thus far, there is an ongoing need for mental health PEI efforts in California. RAND’s evaluation identified areas in which continued, targeted efforts are needed:

- Mental illness stigma and discrimination remain widespread. Among those who have recently experienced symptoms of mental illness, more than two-thirds would definitely or probably hide a mental health problem from coworkers or classmates, and more than one-third would hide it from family or friends. Nine out of ten of those who reported a mental health problem in the past year reported experiencing discrimination as a result.
- Asian American adults reported relatively high levels of stigmatizing attitudes toward individuals with mental illness and low rates of mental health treatment.
- Latinos were also in relatively high need of efforts to reduce mental illness stigma. In particular, Latinos with mental illness who primarily speak Spanish need encouragement to get into treatment.
- Young adults hold some of the least-stigmatizing attitudes toward mental illness and are more likely to know someone with mental illness, but they are less likely to feel that they know how to help, suggesting the importance of programming that educates this group about how to be supportive and how to connect people to the resources that they need.
- The highest suicide rates are in California’s rural counties in the northern region, but the burden, measured by the number of lives lost to suicide, is highest in the more-populous southern counties, suggesting that suicide prevention approaches need to focus on the entire state.
- One out of five higher-education students reported probable serious psychological distress, and high numbers of students reported impairment in academic performance associated with anxiety or depression. However, four out of ten higher-education faculty and staff did not know how to help connect distressed students to the services that they needed.

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- On campuses that are perceived to be supportive of mental health issues, rather than stigmatizing, students were over 20 percent more likely to receive treatment.

### **Summary and Considerations for the Future**

RAND's evaluation of CalMHSA's statewide PEI initiatives to date shows that extensive programmatic capacities and resources were successfully developed and rolled out. Implementation included dissemination of two major social marketing campaigns, numerous trainings throughout the state, distribution of extensive online and print materials, and regionally tailored improvements in hotline capacity.

The evaluation examined short-term impacts of key program activities and generally found that individuals reached by programs showed changes in attitudes, knowledge, or behavior consistent with the intent of the program. Furthermore, the reach to target audiences was impressive, given the relatively short period over which the programs were developed and implemented. For some program activities, RAND used evaluation findings and prior literature to project future societal benefits and costs; these simulations suggest a positive return on California's investment in the PEI programs, even under conservative assumptions.

Statewide PEI programs provide an important opportunity for California to move toward a comprehensive population-based public health approach to mental health, as recommended by the Centers for Disease Control and

Prevention and the President's New Freedom Commission on Mental Health. To inform planning and improve PEI programs over time, ongoing population surveillance and performance monitoring are essential. Public health literature and experience suggest that coordinated and sustained PEI efforts over several decades are often required to substantially effect changes in public knowledge, attitudes, and behavior and create shifts in social norms and institutions that improve health (e.g., regarding HIV/AIDS, cigarette smoking, and mental illness stigma).

The CalMHSA statewide PEI initiatives represent a first step toward a strategic and effective public health approach to mental health in California. RAND's evaluations of these initiatives so far has found that many programs show promise toward achieving the initiatives' broader goals, and the evaluations have highlighted several important targets for outreach and education in California's diverse communities. However, RAND evaluators suggest that California's progress toward broader goals—including reducing suicide, improving early receipt of needed services, reducing discrimination, and avoiding some of the negative social and economic consequences associated with mental illness—will require a long-term commitment to a coordinated PEI strategy that is continuously informed by population needs, evidence regarding promising and best practices, and indicators of program performance and quality.

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## RAND Health

This research was conducted in RAND Health, a division of the RAND Corporation. A profile of RAND Health, abstracts of its publications, and ordering information can be found at [www.rand.org/health](http://www.rand.org/health).

## CalMHSA

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and early intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

## About RAND

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This brief describes work done in RAND Health. To view this brief online, visit [www.rand.org/l/RB9917](http://www.rand.org/l/RB9917). This research brief highlights findings from a number of previously published RAND reports. We list here the documents' publication numbers and years of publication: RB-9737-CMHSA (2014), RB-9904-CMHSA (2016), RR-438/1-CMHSA (2014), RR-438/4-CMHSA (2014), RR-684-CMHSA (2014), RR-685-CMHSA (2014), RR-686-CMHSA (2014), RR-755-CMHSA (2014), RR-818-CMHSA (2014), RR-819-CMHSA (2014), RR-953-CMHSA (2015), RR-954-CMHSA (2015), RR-1073-CMHSA (2015), RR-1074-CMHSA (2015), RR-1115-CMHSA (2015), RR-1134-CMHSA (2015), RR-1139-CMHSA (2015), RR-1240-CMHSA (2015), RR-1247/1-CMHSA (2015), RR-1370-CMHSA (2015), RR-1441-CMHSA (2016), and RR-1491-CMHSA (2016). Complete citation information is available at <http://www.rand.org/health/projects/calmhosa/publications.html>. In addition, this brief references a forthcoming publication: Rajeev Ramchand, Lisa H. Jaycox, Patricia Ebener, Mary Lou Gilbert, Dionne Barnes-Proby, and Prodyumna Goutam, "Characteristics and Proximal Outcomes of Calls Made to Suicide Crisis Hotlines in California: Variability Across Centers," *Crisis: The Journal of Crisis Intervention and Suicide Prevention* (in press).

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## APPENDIX VIII – CULTURAL COMPETENCY ADVISORY BOARD (CCAB) MEMBERS

Behavioral Health and Recovery Services Staff		
Name	Position/Representation	Ethnicity
Darby Jaragosky	HHS Senior Program Coordinator	Caucasian
Marisol Munoz-Kiehne	Promotores Coordinator (Adult Team)	Latina
Brian Robinson	Unit Supervisor (Child Team)	Caucasian, LGBTQ
Cesar Lagleva	Ethnic Services Manager Mental Health Practitioner	Asian / Pacific Islander
Kristen Gardner	MHSA/PEI Coordinator	Caucasian
Jessica Diaz	Mental Health Practitioner, Adult Case Management, (Adult Team)	Mixed Heritage
Cecilia Guillermo	Bilingual Mental Health Practitioner Adult Case Management (Adult Team)	Latina
Robert Harris	Mental Health Practitioner Case Management (Adult Team)	African American
Maria Abaci	Mental Health Practitioner Case Management (Adult Team)	African American
Ngoc Loi	Mental Health Practitioner (Adult Team)	Asian / Pacific Islander
Kristine Kwok	Unit Supervisor (Adult Team)	Asian / Pacific Islander
Cammie Duvall	Mental Health Practitioner	Caucasian, LGBTQ
Sadegh Nobari	Licensed Mental Health Practitioner	Middle Eastern
Marta Flores	Licensed Mental Health Practitioner	Latina
Ellie Boldrick	Licensed Mental Health Practitioner	Caucasian
Angel Cassidy	Licensed Mental Health Practitioner	Caucasian
Gustavo Goncalves	Behavioral Health Administration	Latino, Transition Age Youth

Agency Partners		
Name	Position/Representation	Ethnicity
Leticia McCoy	Family Partner Community Action Marin	African American, Former Consumer
Vinh Luu	Asian Advocacy Project Marin Link	Asian / Pacific Islander
Douglas Mundo	Executive Director Canal Welcome Center	Latino
Julie Madjoubi-Lehman	Spahr Center	Palestinian, Former Consumer, LGBTQ
Sandy Ponek	Program Director, Canal Alliance	Caucasian

<b>Community Volunteers</b>		
<b>Name</b>	<b>Position/Representation</b>	<b>Ethnicity</b>
Daron Austin	Marin City	African American
Maya Gladstern	West Marin	Caucasian
Cat Wilson	San Rafael	Jewish, Consumer
Cheryl August	San Rafael	Jewish, Former Consumer
Kerry Peirson	Mill Valley	African American, Family Member, Older Adult
Maria Benet	San Rafael	Caucasian
Alexis Wise	Marin City	African American
Oscar Curry	Mill Valley	African American

## APPENDIX X – WORKFORCE EDUCATION AND TRAINING (WET) STEERING COMMITTEE MEMBERS

Name	Position/Representation	Ethnicity
Stephen Marks	Mental Health Association of San Francisco	Caucasian
Afriye Quamina	Volunteer	African American
Nick Avila	Licensed Mental Health Practitioner	Latino
Barbara Coley	Community Action Marin	Caucasian
Homer Hall	Volunteer	African American
Leah Fagundes	Volunteer	Caucasian
Leticia McCoy	Community Action Marin	African American
Marisa Smith	Community Action Marin	Caucasian
Mark Parker	Community Action Marin	Caucasian
Maya Gladstern	Volunteer	Caucasian
Terry Fierer	Integrated Community Services	Caucasian
Cesar Lagleva	Ethnic Services and Training Manager	Asian/Pacific Islander
Gustavo Goncalves	Behavioral Health Administrative Staff	Latino
Cornelia Learson	Behavioral Health Staff	African American