

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

MENTAL HEALTH SERVICES ACT

FY2017-2018 ANNUAL UPDATE REPORTING FY2015-2016 SERVICES AND OUTCOMES



*Year 2 of the
MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN
for FY2014-15 through FY2016-17*

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DIRECTOR'S INTRODUCTION

Dear Community Members,

As always, thank you for your continued support for all the services and programs provided to the Marin community as made possible by the Mental Health Services Act (MHSA). California is unique in passage of Proposition 63 (MHSA), which specifically funds counties to transform the traditional Medi-Cal community mental health system into one that supports prevention and early Intervention, development and training of the workforce, investment in technology and housing, and creation of Full Service Partnerships (FSPs) that address the complex issues faced by adults with the diagnosis of a Serious Mental Illness (SMI) and youth identified with a Serious Emotional Disorder (SED). Further, the MHSA emphasizes the importance of client and family perspectives, the value of lived experience and the essential inclusion of cultural humility and linguistic capacity.

In the second year of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, Prevention and Early Intervention (PEI) services were provided to over 7,900 individuals. The diverse array of services included training in Mental Health First Aid (MHFA), services to Latino and Vietnamese communities, parent training, early childhood mental health consultation, suicide prevention, school based services, support of older adults, and state-wide efforts to reduce stigma and discrimination of person living with mental illness. Full Service Partnerships served 43 children/youth, 80 Transitional Age Youth, and over 200 Adults. The MHSA funded Enterprise Resource Center (ERC), operated by peers with lived experience, continued to serve as a welcoming and supportive environment for persons with mental illness and provided opportunities for treatment, outreach and engagement. The Crisis Residential program, Casa René, provided diversion from hospitalization and crisis stabilization services to 160 individuals. MHSA supported numerous trainings to staff and the community and provided funding for an APA accredited doctoral-post doctoral internship program. This is a representative, but not exhaustive, list of activities supported by the MHSA.

The work of the Mental Health Services Act Advisory Committee, Mental Health Advisory Board, Alcohol and Other Drug Advisory Board, Board of Supervisors, Behavioral Health and Recovery Services (BHRS) Cultural Competence Advisory Board, community service providers, and the many Marin residents who participated in the planning of the current MHSA Plan has been most appreciated.

With warm regard,



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

FY2017-2018 MHSA ANNUAL UPDATE STAKEHOLDER REVIEW

We welcome feedback on the FY2017-2018 MHSA Annual Update. The required thirty (30) day public comment period for the MHSA Annual Update begins on **Thursday, June 8th, 2017** and ends on **Sunday, July 9th, 2017**.

For a copy of the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 or a copy of the FY2017-2018 MHSA Annual Update, please call: 415.473.7465 or you can find it on our website at: <https://www.marinhhs.org/mhsa>.

A Public Hearing for the FY2017-2018 MHSA Annual Update will take place at the Mental Health Board Meeting on **Tuesday, July 11th, 2017 at 6:00 pm** at 20 N. San Pedro Road, San Rafael, CA 94903 in the Point Reyes Conference Room. The public is welcome.

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

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MHSA ANNUAL UPDATE FY2017-18 EXECUTIVE SUMMARY

The FY2017-18 MHSA Annual Update provides an opportunity to report on outcomes and activities from FY2015-16, an update on the programs for FY2016-17. FY2015-16 is the second year of implementation of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17.

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

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

COMMUNITY SERVICES AND SUPPORTS (CSS)

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

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

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

PREVENTION AND EARLY INTERVENTION (PEI)

Prevention and Early Intervention (PEI) continues to expand its efforts to reach un/underserved communities. The current MHSA Three-Year Program and Expenditure Plan established Promotores in West Marin and programs in diverse school districts. Services are continuously adjusted to best serve the clients, identifying and responding to their varied needs.

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

INNOVATION (INN)

The current Innovation Plan – *Growing Roots: The Young Adult Services Project* focuses on reducing disparities by working closely with the Transition Age Youth (TAY), 16-25 year olds, from un/underserved populations who are at risk for or experiencing a mental illness and informal providers who successfully engage them. The Innovation Plan was approved by the Mental Health Services Oversight and Accountability Commission on April 28, 2016. Since then a TAY Advisory Council has been meeting regularly and has completed phase one; a Needs Assessment, which will be reported on June 28th, 2017 at the Marin County Office of Education. (See Appendix I – 6.28.17 TAY Event Flyer)

WORKFORCE EDUCATION AND TRAINING (WET)

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

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

In Marin County, our goal focused on technological improvements that support the development of an Electronic Health Record (EHR) enabling advancement towards a paperless record, support of meaningful use, and other MHSA compliance related enhancements. Our current EHR, Clinician’s Gateway (documentation) and ShareCare (billing), has been challenged by the needs of the Marin County system of care; we will be researching an alternative EHR in FY2017-18.

MENTAL HEALTH SERVICES ACT (MHSA) 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 (MHSA) COMPONENTS

The MHSA has five (5) components:

A. Community Services and Supports (CSS)

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

B. Prevention & Early Intervention (PEI)

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

C. Innovation (INN)

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

D. Workforce Education & Training (WET)

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

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

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

MENTAL HEALTH SERVICES ACT (MHSA) BACKGROUND

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

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

MENTAL HEALTH SERVICES ACT (MHSA) REPORTING REQUIREMENTS

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

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

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

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

CULTURAL 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. See Appendix VI – Cultural Competence Advisory Board Members. The charge of the Board is to examine, analyze and make recommendations about promising and current mental health services and practices that are culturally sensitive, appropriate and responsive to our diverse consumer community. Additionally, the Board shall identify barriers and challenges within BHRS’ system that prevent consumers from adequately accessing needed behavioral health and recovery services. Barriers may include, but are not limited to, stigma and discrimination, language and/or lack of cultural awareness.

OUTCOMES FY2015-16

1. POLICY

Use of Interpreters

- Reviewed and updated the Use of Interpreters Policy to exclude the use of children as interpreters. Ethnic Services and Training Manager (ESM) reviewed the existing Interpreter Policy statement and discovered that the term, use of children, was still included in the statement. Ethnic Services and Training Manager revised Interpreter Policy to remove the use of children as interpreters in its revised policy.
- Interpretation via telecommunications

May Is Mental Health Month Resolution

- CCAB submitted a resolution to the Board of Supervisors in regards to May Is Mental Health Month to affirm its commitment to improve access and quality of care for its Marin residents.

Increase Diversity and Consumer/Family Involvement in BHRS

- Developed a policy recommendation to the BHRS director to increase diversity and consumer/family member involvement on existing BHRS committees, boards and/or commissions and to continue to offer incentives for participation to volunteers who are economically disadvantaged.

AB1421-Laura’s Law

- The CCAB advocated to the Board of Supervisors against the implementation of AB1421, Laura’s Law. The reasons for which were many and included lack of funding, housing

requirement, and likely increase in disparity, where minorities are more likely to be forced to engage in court-mandated intensive outpatient treatment. The Board of Supervisors ruled to postpone a decision in February 2017 whether to approve or reject the implementation of AB1421.

Diversity in Job Interview Panels

- BHRS worked closely with HHS' Human Resources staff to pilot a one-year plan to include ethnic and cultural diversity in interview panels by using the diverse staff of BHRS. Human Resources implemented the plan which resulted in increased participation of culturally diverse staff in job interview processes.

2. ACCESS

Accessibility on website

- Contributed to content and design. Advocated and consulted with the media team to engage the public online in a culturally competent way.
- Continued to work to improve access to behavioral health and recovery services by Latino and African American inmates at the county jail. Additionally, advocate for a continuity of care system from jail to community upon discharge of inmates from county jail.
- Advocated in hiring qualified bilingual/bicultural (Latino/a, African American) service providers in the STAR program
- Advocated for an increase in prevention and early intervention programs/services within the African American communities to reduce the African American's overrepresentation in the adult system of care.
- Continued to improve outreach and engagement activities in West Marin's Latino community.
- Explored the feasibility of piloting peer-to-peer counseling programs in two targeted high schools in Marin. Additionally, explore the feasibility of developing vocational/internship opportunities to identified school(s) as a means for students to consider careers in behavioral health.
- Advocated for an increase/improvement in behavioral health and recovery services for the LGBTQ community.

3. TRAINING

Cultural Competence Training Series

- 15 Cultural Competence trainings were offered during FY 2015-16. The trainings included: Cultural Competence: Bridging Cultural Divide Among Staff, Colleagues & Consumers

Through Effective Communication & Culturally Responsive Intervention Strategies, Introduction to CLAS standards, From Combat to Community, Cultural Consideration in Working with Vietnamese Consumers, Unpacking our Assumptions-Challenging our Beliefs: A cultural competence training based on community-defined best practices, Understanding the Treatment Needs and Challenges of Newly Arrived Indigenous Immigrants in the United States, Team Building Workshop, The Role and Importance of Faith and Spirituality in the Recovery of People with Mental Illness and Substance Use Challenges, Working with Criminal Justice-Involved Teens and Transitional Age Youth.

- Offered to provide county-wide trainings/consultation to agency partners and stakeholders around cultural competence.
- ESM attended a national Policy Conference on Equity hosted by PolicyLink.

4. OUTREACH AND ENGAGEMENT

Spanish and English Educational TV Shows

- CCAB piloted 6 original TV Mental Health and Substance Use episodes. Two series were created, Meaningful Mental Health and Latinos en La Casa, English and Spanish, respectively. The TV series discussed topics such as, Suicide Prevention, Crisis Intervention, Transitional Age Youth and more with an emphasis on cultural competence and community resources. Available online at: <https://www.marinhhs.org/latinos-en-la-casa> and <https://www.marinhhs.org/meaningful-mental-health-tv-series>.

Faith Initiative

- 35 clergy and lay leaders throughout Marin participated in this all-day Mental Health First Aid training and that it was unanimously well received as evidenced by the positive responses in the training evaluations.
- Several faith leaders from various faith traditions conducted a half-day training on the value, importance and effectiveness of faith in the treatment and recovery of mental health and substance use consumers/family members.

May Mental Health Day Event

- On May 18th, 2016 the CCAB hosted an estimated 200 individuals in the first CCAB led May Is Mental Health Day: Each Mind Matters event. The event was a collaborative effort amongst community members, consumers, family members, and BHRS staff. Each Mind Matters was an all-day event that included: Opening Remarks, Classical Music, Stigma Stew Live!, Agency Information Tables, Berkeley Folk Dancers, Zumba, Music Medicine, Promotores Role Playing, Meaningful Mental Health and Latinos en la Casa TV series, Hearing Voices, Speakers Bureau, Youth Poetry Slam. (See Appendix II – May Is Mental Health Month Materials)

5. SERVICE DELIVERY

Mental Health Loan Assumption Program (MHLAP)

- BHRS amended its hard to fill/retain eligibility criteria for the state MHLAP to include providers with lived experience as a mental health consumer/family member or representing one or more ethnically and culturally diverse communities that Marin County's BHRS serves. There were 8 BHRS staff members awarded. 5 were bilingual Spanish speakers. 2 Caucasian, 1 African American, 5 Latinos/Hispanics.

PREVENTION AND EARLY INTERVENTION OVERVIEW

MHSA Prevention and Early Intervention (PEI) funds are intended to help prevent mental illnesses from becoming severe and disabling. This includes:

- 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
- Outreach: Increase recognition of and response to early signs of mental illness
- Access and Linkage to Treatment for those with Serious Mental Illness
- Reduce Stigma and Discrimination related to mental illness
- Suicide Prevention

A focus of PEI is to reach un- and underserved populations. Some of the strategies employed are:

- Improve Timely Access: Increase the accessibility of mental health services for underserved populations by being culturally appropriate, logistically accessible, and financially accessible
- Non-stigmatizing: Promote, design and implement services in a way that reduces the stigma of accessing services, such as locating them within other trusted services
- Effective Methods: Use evidence-based, promising and community defined practices that show results

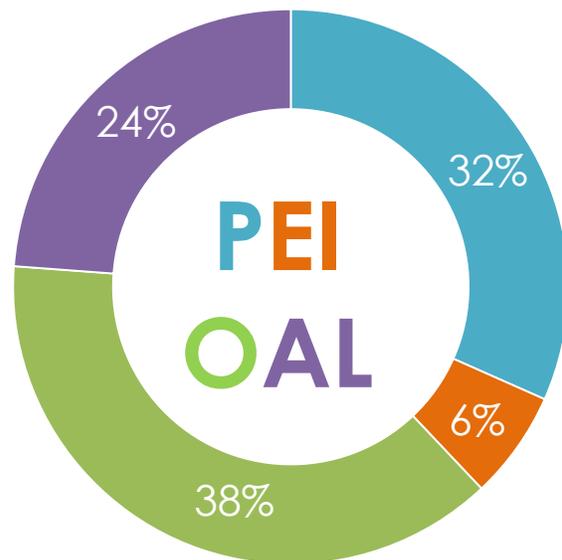
A minimum of 51% of PEI funds are required to be dedicated to youth and transition age youth (0-25 years old).

PEI

SUMMARY FY2015-16

Clients Served: FY2015-16

7,901 Individuals
785 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

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

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

PEI Committee Outcomes	2009	2016
Participation on the PEI Committee helps my organization to develop expertise in MH prevention and programs.	2.85	3.25
The PEI Committee fosters a "culture of prevention" for mental health.	3.00	3.33
The PEI Committee works collaboratively with other efforts in the community to address issues.	3.00	3.38
Participation on the PEI Committee helps my organization to collaborate effectively with other organizations.	2.89	3.38
The PEI Committee contributes to the development of a mental health system of care.	3.12	3.54

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

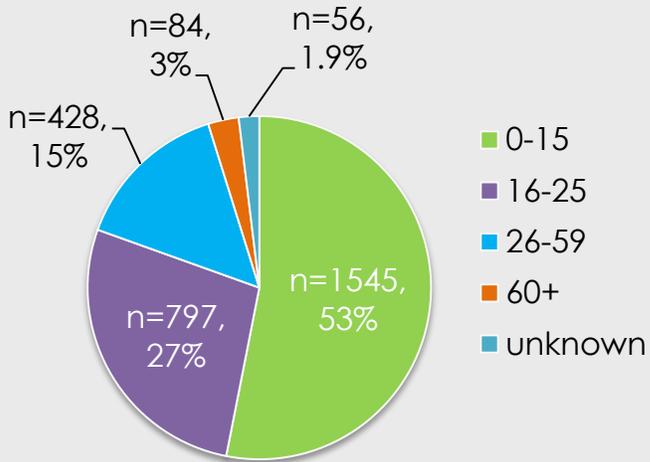
The rating about working collaboratively with other efforts in the community increased significantly this year, likely due to conducting a series of Resource Roundtables to provide information and connections to PEI providers to increase their ability to refer clients to needed services.

CLIENTS SERVED

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

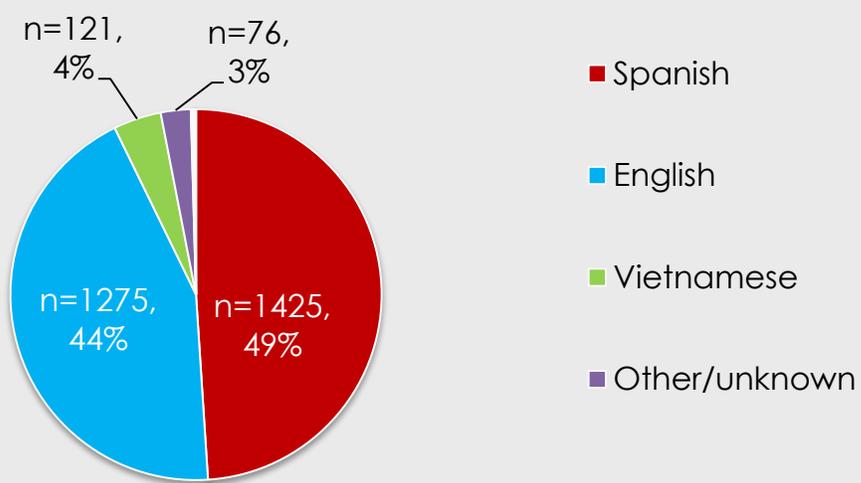
The program narratives in this report include program descriptions, populations served, outcomes, and client stories. An overview of the populations served by PEI is provided below. Demographics are collected for Prevention and Early Intervention programs that include services such as support groups, counseling, skill building, and service navigation and advocacy. Demographics are not reported for Outreach and Access programs that include services such as outreach events, screening for risk factors, or other “light touch” activities.

**PEI FY2015-16:
AGE GROUP (N=2910)**

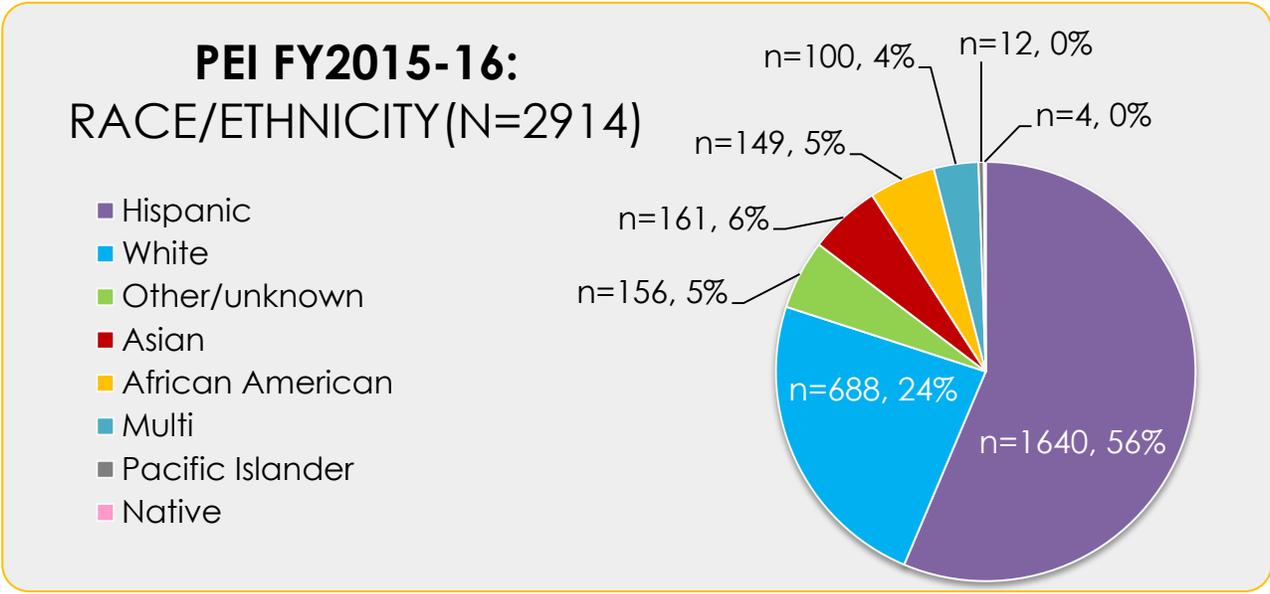


During the 2015-2016 Fiscal Year, the County of Marin’s Prevention and Early Intervention programs provided risk reduction and symptom reduction services for 2,910 Individuals, of which, 1,545 (53%) individuals were between the age of 0 – 15, 797 (27%) were youth ages 16 – 25, and 429 (15%) were adults ages 26-59. Older adults comprise 3% of PEI clients, as they are provided a more intensive level of services.

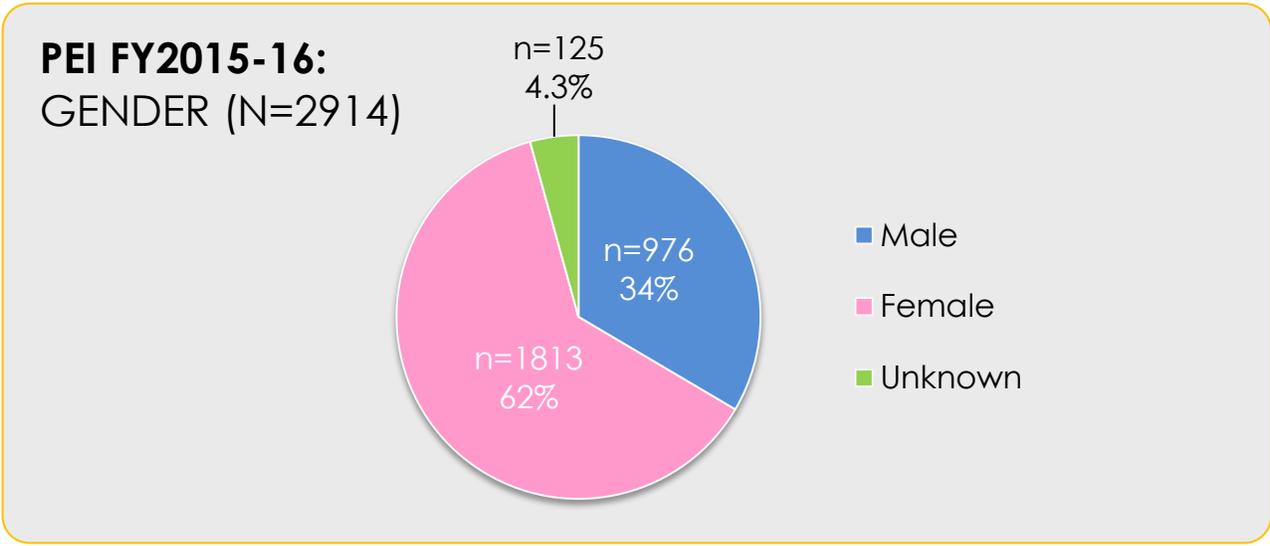
**PEI FY2015-16:
PRIMARY LANGUAGE (N=2910)**



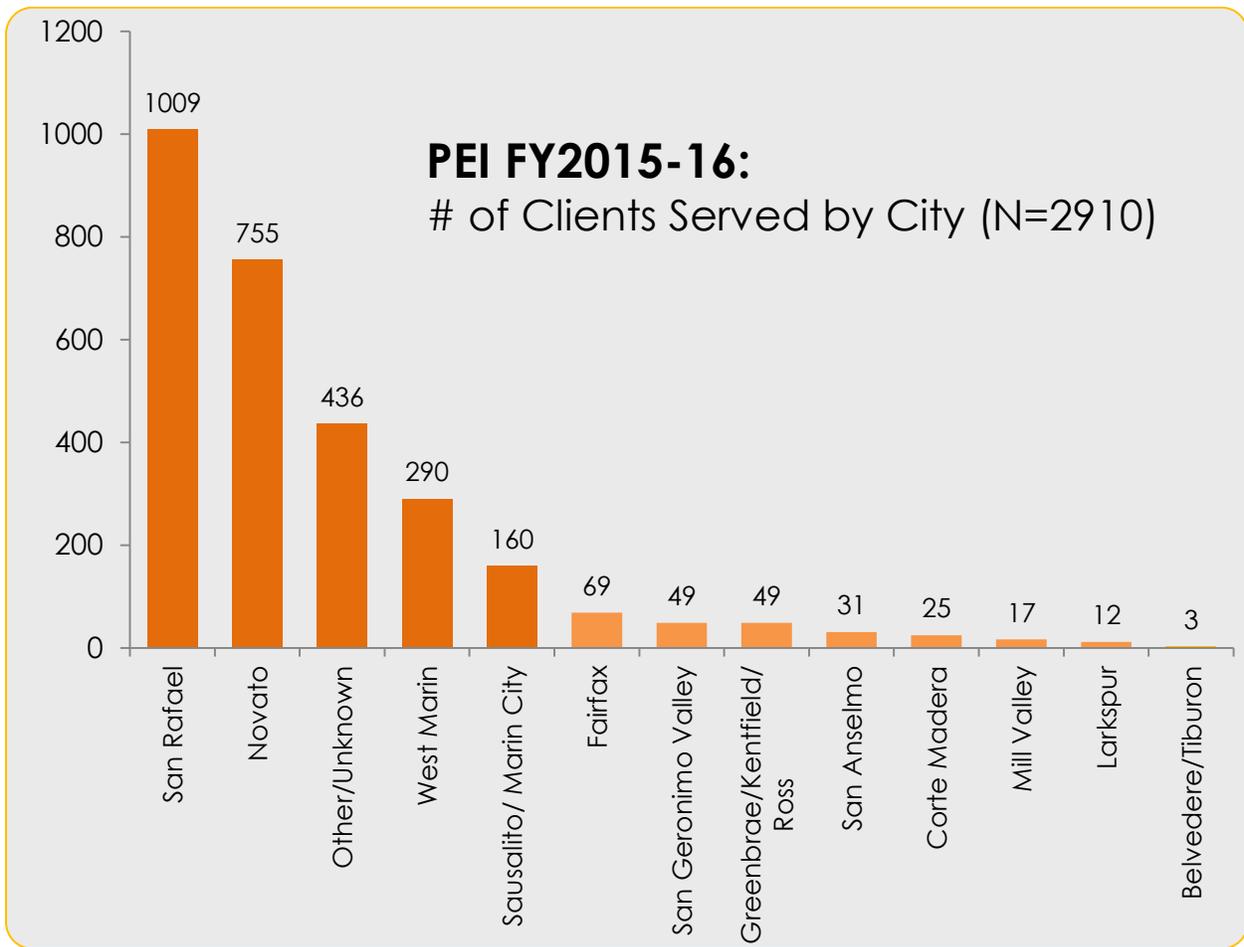
During the 2015-2016 Fiscal Year, the County of Marin’s Prevention and Early Intervention programs provided risk reduction and symptom reduction services for 2,910 Individuals, of which 1425 (49%) spoke Spanish and 1275 (44%) spoke English as their primary language.



During the 2015-2016 Fiscal Year, the County of Marin’s Prevention and Early Intervention programs provided risk reduction and symptom reduction services for 2,910 Individuals, of which, 1640 (56%) identified as Hispanic, 688 (24%) identified as White, 196 (7%) identified as Other/Unknown, 161 (6%) identified as Asian, and 109 (4%) identified as African American.



During the 2015-2016 Fiscal Year, the County of Marin’s Prevention and Early Intervention programs provided risk reduction and symptom reduction services for 2,910 Individuals, of which, 1813 (62%) identified as Female, 976 (34%) identified as Male. Expanded gender data will be collected in the future.



During the 2015-2016 Fiscal Year, the County of Marin’s Prevention and Early Intervention programs provided risk reduction and symptom reduction services for 2,910 Individuals, of which, 1009 lived in San Rafael, 755 lived in Novato, 436 represented Other/Unknown, 290 lived in West Marin, and 160 lived in Sausalito/Marin City.

Program	FTE*	P	EI	O	SDR	A&L	SP
Early Childhood Mental Health Consultation	2.6	100%					
Triple P (Positive Parenting Program)	0.5	100%					
Transition Age Youth PEI	1.7	30%	60%			10%	
Latino Community Connection	2.5	65%		35%			
Integrated Behavioral Health in Primary Care	2.4		85%			15%	
Older Adult PEI	0.9		80%	20%			
Vietnamese Community Connection	0.8	60%		40%			
PEI Community and Provider Training	NA			50%	50%		
School Age PEI	3.8	90%		10%			
Veterans Community Connection	0.6					100%	
Statewide	NA			40%		10%	50%

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

PEI PROGRAMS

Prevention: Reduce risk factors and increase protective factors.

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

Early Intervention: Promote recovery and functional outcomes.

Examples: clinical services.

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

Examples: Mental Health First Aid, provider training.

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

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

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

Examples: screening, assessment, referral, help lines.

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

Examples: campaigns, hotlines, training, screening.

EARLY CHILDHOOD MENTAL HEALTH (ECMH) CONSULTATION

PROGRAM OVERVIEW

Early Childhood Mental Health Consultation (ECMH) is promoting the mental health of children 0-5 by helping teachers and parents to observe, understand, and respond to children's emotional and developmental needs. A team of Jewish Family and Children's Services (JFCS) mental health consultants provide training, coaching and interventions at subsidized preschools and other early childhood education sites to:

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

TARGET POPULATION

The target population is pre-school students (0-5), and their families, who attend subsidized pre-schools. These students are 69% Latino, 3% Asian, 6% African American, 3% multi-racial, and 72% speak Spanish at home. 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 staffs at the subsidized pre-schools are the target population for the training in recognizing and responding to risk factors and signs of emotional disorders.

ECMH

SUMMARY FY2015-16

Clients Served: **FY2015-16**

640 Individuals
279 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

PROGRAM DESCRIPTION

➤ Prevention: Reducing Risks Related to Emotional Disturbance

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

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

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

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

EXPECTED OUTCOMES

Early Childhood Mental Health Consultation is intended to:

- Reduce Prolonged Suffering for those at significantly higher risk or mental illness by increasing protective factors and reducing risk factors.
- JFCS' "Consultation Questionnaire" is completed by pre-school staff to track changes in relevant knowledge and skills. The "Parents' Questionnaire" is completed by families at the conclusion of receiving intervention services to track changes in parenting skills and strategies. A DECA-C pre and post-test is completed by teacher to track changes in the child's behavior in the preschool setting.

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

The program is expected to achieve the intended results due to implementing evidence-based practices and best practices that have been shown to achieve positive impacts for the target population:

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

ACTUAL OUTCOMES

In FY2015-16 ECMH provided consultation for 14 Marin County subsidized preschools and one community playgroup. The ECMH program is successful at providing prevention and capacity building that reaches far beyond a direct services model. By training and coaching childcare

providers, many children and families will benefit for years to come, including increasing their access to services due to early identification and effective linkages. In addition, JFCS has increased their work with childcare directors to improve organizational practices, such as increasing child-caregiver bonds by reducing the times teachers are moved between classrooms. Intervening early in a child's life can reduce poor outcomes that would require more extensive services later in life.

ECMH continues to collaborate with the County Office of Education to implement the California Teaching Pyramid (evidence based) to provide mental health promotion and early intervention services for students in pre-school through 3rd grade.

Outcomes for FY2015-16	Goal	Actual
Children and Families Receiving Services		
Children that received prevention services.	670	640
Percent of these children that come from un/underserved cultural populations (Latino, Asian, African American, West Marin).	70%	81% N=640
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	83
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%	100% N=640
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%	100% N=21
Families receiving ECMH Consultation services that report satisfaction with the services (would use again, would recommend, were helpful). <i>PEI survey</i>	75%	100% N=17
Early Childhood Education Sites Receiving Services		
Childcare staff that received additional consultation and/or training	130	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%	91% N=83
Staff receiving ECMH Consultation services that report satisfaction with the services (would use again, would recommend, were helpful). <i>PEI survey</i>	75%	88% N=83

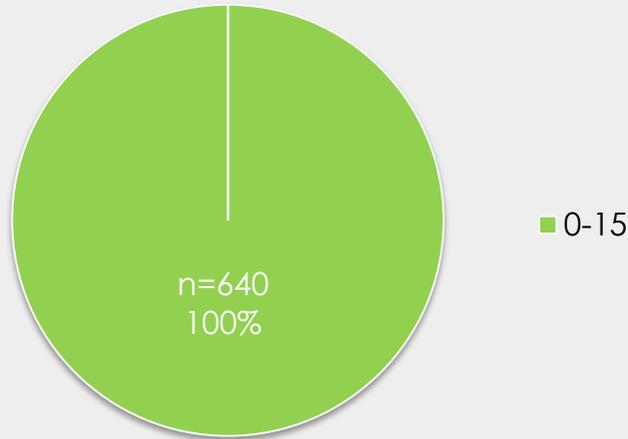
N = the total number in the sample (i.e. total number who received services or completed a survey)

PEI funding has increased the capacity of the program to provide bilingual services. All materials are available in Spanish, with an effort made to provide materials and resources in other languages as needed. Many of these families do not have other opportunities to obtain identification and intervention services for their children's behavioral issues.

PROGRAM CHALLENGES

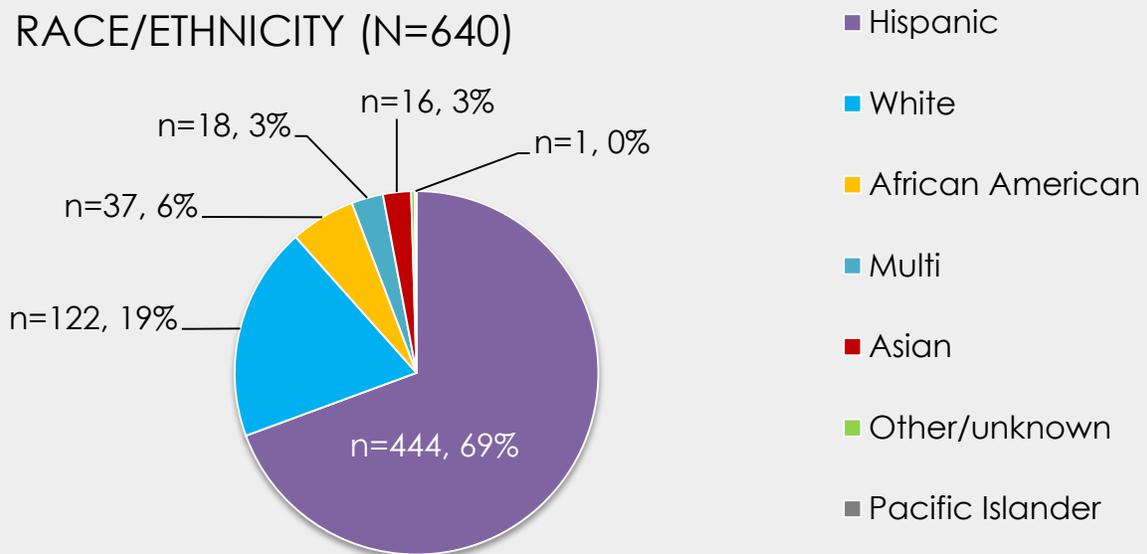
There are not enough providers in Marin County who are trained in evidence-based services, such as Infant-Parent and Child-Parent Psychotherapy and trauma informed services to immigrant families with children 0-5 years old. Through ECMH's participation in the Marin County Early Intervention Team, spearheaded by the Marin Office of California Children's Services, they continue to facilitate access to services for children whose behavior is indicative of developmental delays but who are not delayed enough to qualify for Golden Gate Regional or school district services.

**PEI ECMH FY2015-16:
 AGE GROUP (N=640)**



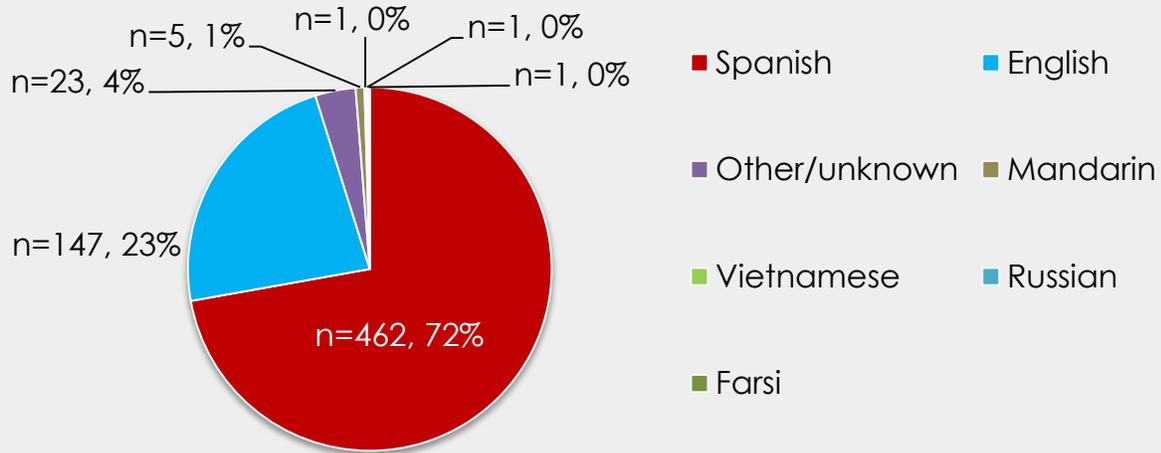
During the 2015-2016 Fiscal Year, the County of Marin's Early Childhood Mental Health Consultation Program worked with child care sites serving 640 children 0-5 years old.

**PEI ECMH FY2015-16:
 RACE/ETHNICITY (N=640)**



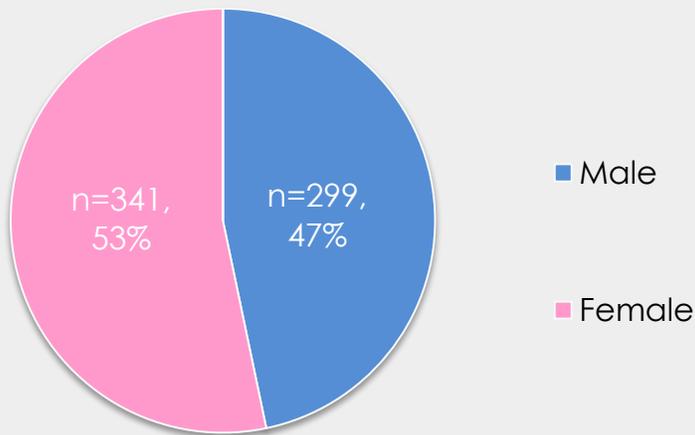
During the 2015-2016 Fiscal Year, the County of Marin's ECMH Program reached 640 children who are Hispanic/Latino (69%), White (19%), African American (6%), Multi-racial (3%), and Asian (3%).

**PEI ECMH FY2015-16:
 PRIMARY LANGUAGE (N=640)**

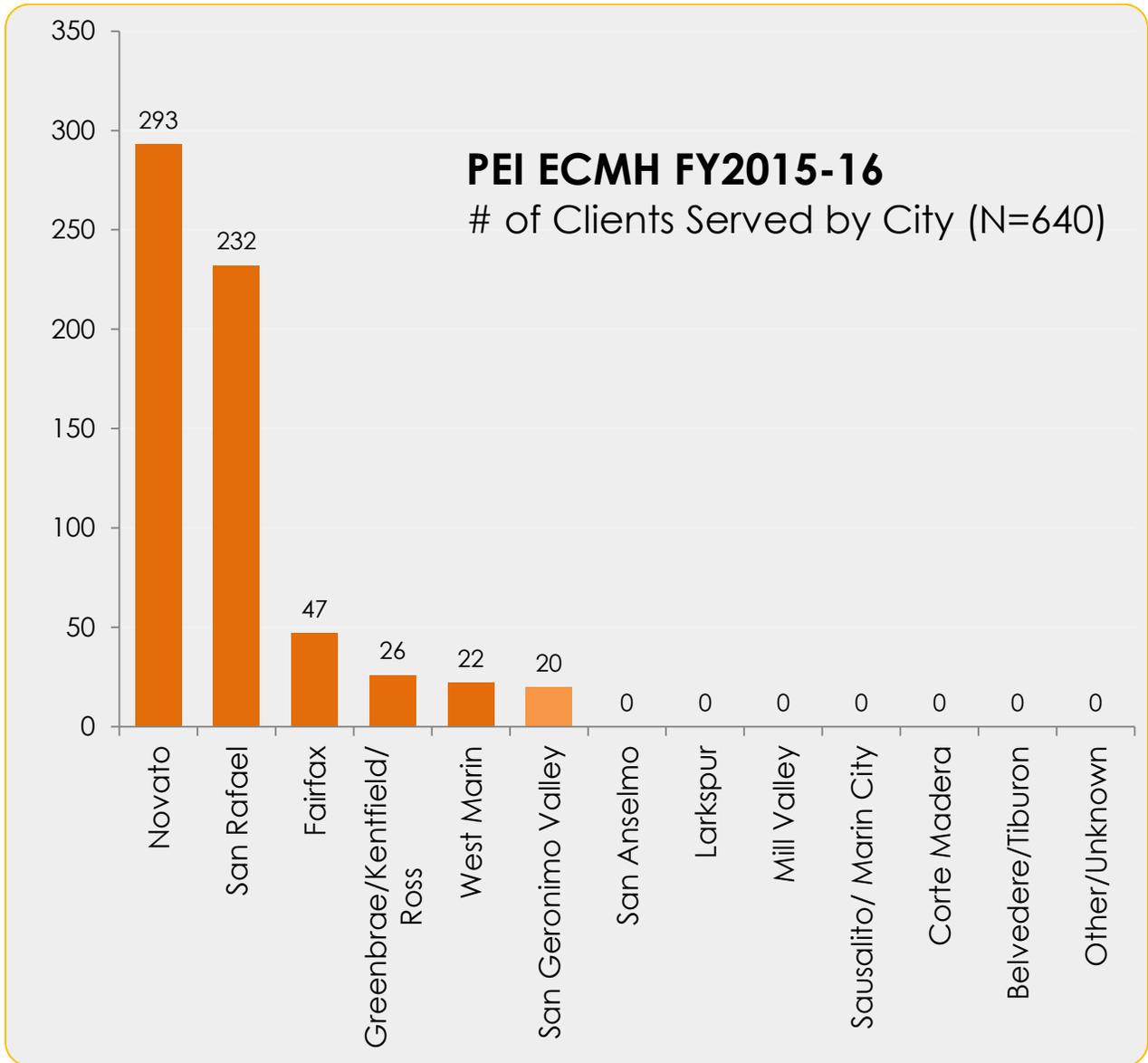


During the 2015-2016 Fiscal Year, the County of Marin’s ECMH Program reached 640 children whose primary language is Spanish (72%), English (23%), and other or unknown (5%).

**PEI ECMH FY2015-16:
 GENDER (N=640)**



During the 2015-2016 Fiscal Year, the County of Marin’s ECMH Programs reached 640 children who are Female (53%) and Male (47%).



During the 2015-2016 Fiscal Year, the County of Marin’s ECMH Program reached 640 children in Novato (293), San Rafael (232), and other areas of Marin.

CLIENT STORY – EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

Harlan was born with a positive toxicology screen to a drug-addicted mother. At 15 months, Harlan was living full time with his paternal grandmother. The main issues presented were attachment, parental stress, teacher stress, and special needs including dysregulation, coordination, and balance. After one year of meeting with the consultant and implementing some of the recommendations, the grandmother had decreased her stress, increased her ability to protect Harlan by setting clear boundaries with adults in her and Harlan's life, and requested a referral for therapy for herself. She also was a staunch advocate for her grandson in pursuing services and an appropriate preschool setting for him when he turned 3 years old. She said, *"Imagine how wonderful it is to have someone truly listen, remembering what you've said months later, guiding you to think things through for yourself, testing your conclusions, supporting your decisions. She helped me make a major decision in my life and supported me through the difficulty of implementing it. She's a gem."*

Harlan's teacher, Karen, had difficulty expressing how she felt put off by him because he would not let her comfort him as other children did and by his almost constant heightened dysregulated state. As the consultant validated Karen's feelings and helped her understand how Harlan's own attachment issues affected relationships and bonding with others, she was able to find what she did like about Harlan and move into a comforting mutual attachment with him. Over time, he was able to provide the structure that Harlan needed in her classroom. Harlan became more regulated in the classroom, used his outstanding verbal skills in service of his attachment to Karen, and increasingly let himself be comforted.

TRIPLE P (POSITIVE PARENTING PROGRAM) MARIN

PROGRAM OVERVIEW

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

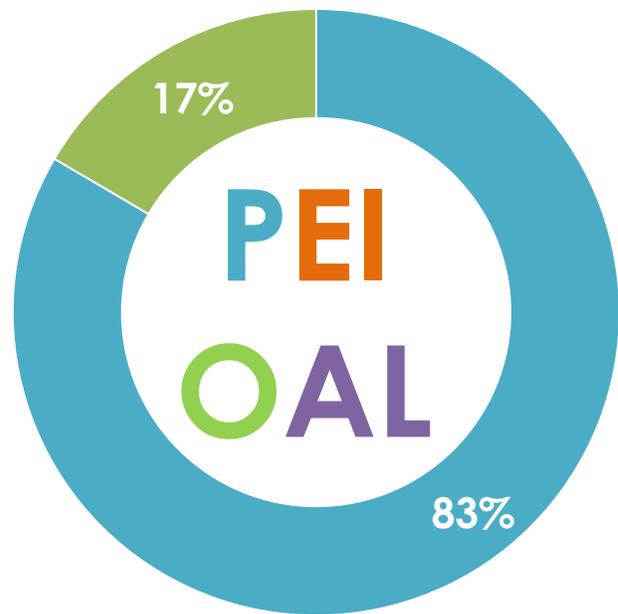
TRIPLE P LEVELS	
1	Media/Information Campaign to normalize need for parenting help and inform families and providers about services.
2	Group presentations about general child development and parenting issues.
3	Individual or group, brief parent “coaching” about a specific concern the parent(s) has. Provided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

Triple P

SUMMARY FY2015-16

Clients Served: FY2015-16

465 Individuals
219 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

TARGET POPULATION

The target population for this program is:

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

PROGRAM DESCRIPTION

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

Triple P Marin reduces children’s risk for emotional disturbance, such as likelihood of adverse childhood experiences, by increasing their connection to supportive and skilled caregivers. Triple P provides training and technical assistance for providers working with families. Technical assistance includes ensuring that they implement the program with fidelity, collect outcome data, identify at-risk families appropriate for Triple P services, and identify and effectively refer families needing services outside of their scope. Triple P trains providers to respond to families with an evidence-based coaching method to improve parenting skills, thereby reducing risk for negative outcomes.

This program also provides direct services for families including Triple P Level 2 and 3 group and individual services. Providers trained in Triple P also offer other levels of services that are aimed at reducing risk related to mental illness, but these services are not funded by PEI.

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

Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is provided through assessment and referral by mental health providers trained in Triple P. They make 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. 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

Triple P Marin is intended to:

- Assist existing providers to recognize and respond to at-risk families:
The number and type of providers participating in the technical assistance will be tracked. This data will be analyzed to ensure that participating providers are adequate to serve the target populations based on number, settings, language and other factors.
- Reduce Prolonged Suffering for those at significantly higher risk of mental illness by increasing protective factors and reducing risk factors:
The number and demographics of the families participating in group services will be tracked, as well as outcome data. This data will be analyzed to ensure the target populations are being reached.

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

The program is expected to achieve the intended results due to implementing Triple P, an evidence-based practice (SAMHSA, NREPP) that has been validated for the target populations. Triple P Marin ensures fidelity by providing certification courses, as well as ongoing trainings and technical assistance to support implementation with fidelity. In addition, the Triple P Marin Program Coordinator participates in regional meetings regarding implementation of Triple P.

ACTUAL OUTCOMES

In FY2015-16, Jewish Family and Children's Services (JFCS) focused on strategically expanding the pool of trained providers and providing brief intervention services for individual families based on a program assessment conducted in FY2014-15.

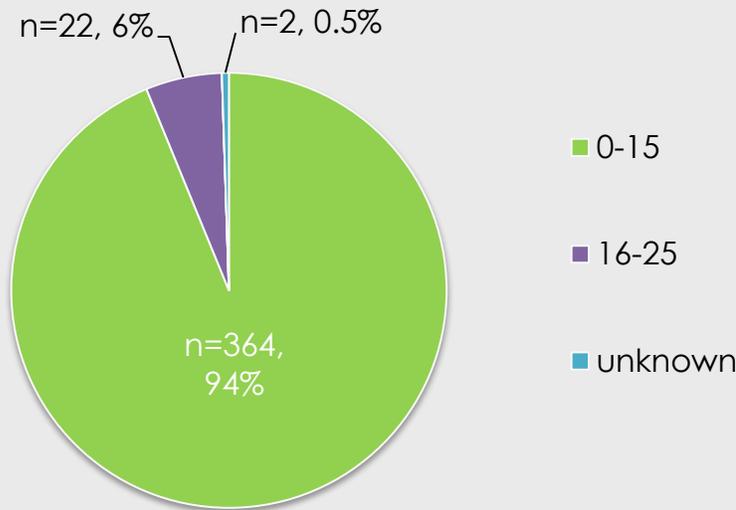
Outcomes for FY2015-16	Goal	Actual
Children and Families Receiving Services		
Parents attending Triple P seminars and discussion groups (Level 2-3) (unduplicated)	200	219
Parents receiving group services in Spanish.	33%	50%
Parents receiving group services that are referred to individual services.	10%	11%
Families receiving individual Triple P services (Level 3) (unduplicated)	20	18
Parents receiving individual services in Spanish.	33%	67%
Parents reporting satisfaction with services (would use again, would refer others). <i>PEI survey</i> <i>Some parents attended more than one session so N is higher than total served.</i>	75%	94% N=236
Providers Receiving Services		
Providers that received training and technical assistance	10-12	20
Participating providers reporting increased confidence in providing services with fidelity. <i>Provider survey</i>	75%	100% N=12
Participating providers reporting satisfaction with the training and technical assistance. <i>PEI survey</i>	75%	100% N=12

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

Type of Participants in Outreach Events	Number Served
Providers	
County Mental Health and Substance Use Services	5
Community-based Mental Health and/or Substance Use Provider	69
Education	2
Primary Health Care	1

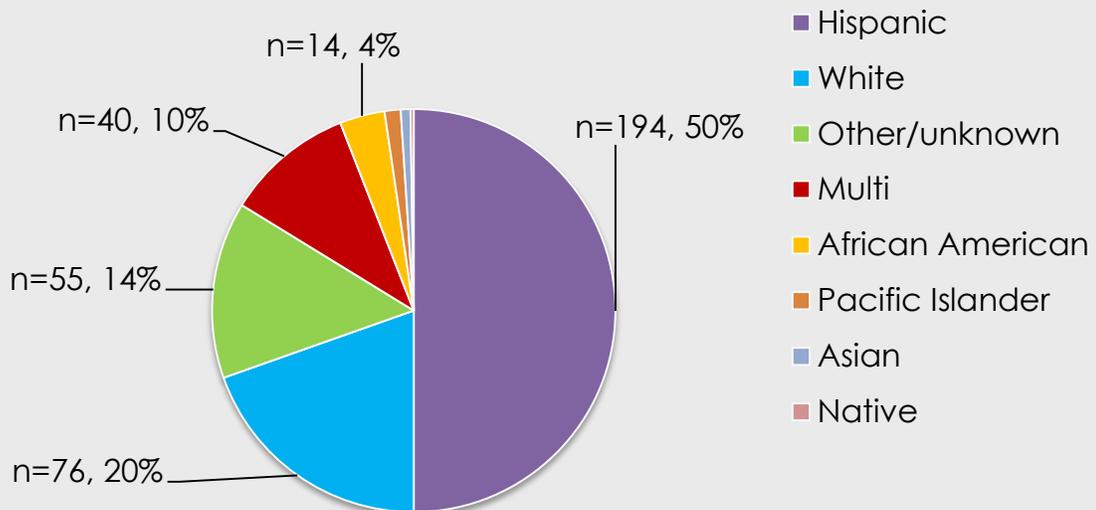
The target population of Triple P Marin is children 0-15 years old, so the demographics reflect the children of parents participating in Triple P Marin sponsored group or individual services. While 219 parents participated, there was a total attendance of 324, showing that many parents found it valuable enough to access multiple services. In addition, the goal for Spanish speaking attendance was exceeded. This year, Triple P Marin sought out agencies serving higher risk populations, including a teen mother support group, families in transitional housing, and Marin Head Start.

**PEI TRIPLE P FY2015-16:
 AGE GROUP (N=388)**



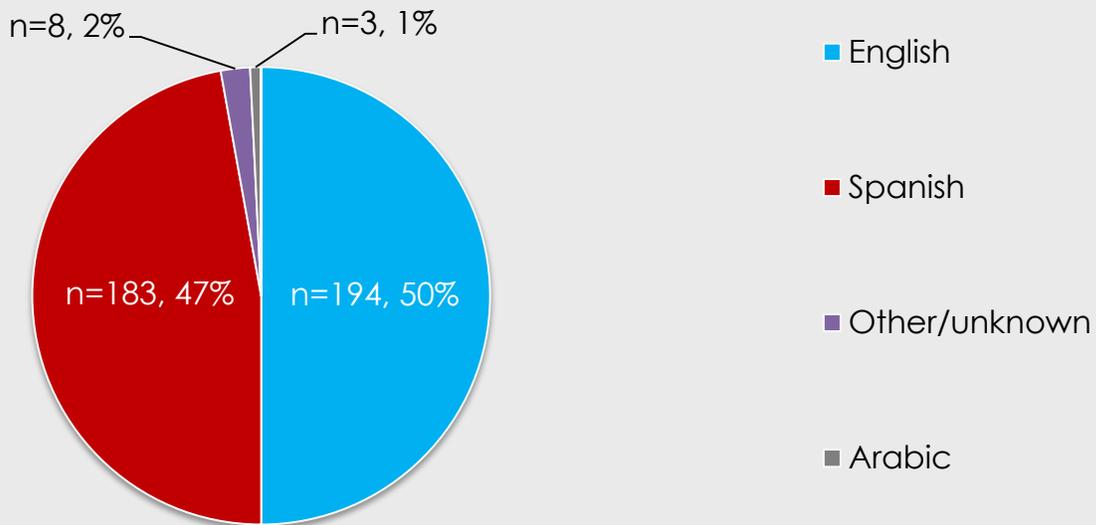
During the 2015-2016 Fiscal Year, the County of Marin's Triple P Program reached 388 children ages 0-15 (94%) and 16-25 (6%).

**PEI TRIPLE P FY2015-16:
 RACE/ETHNICITY (N=388)**



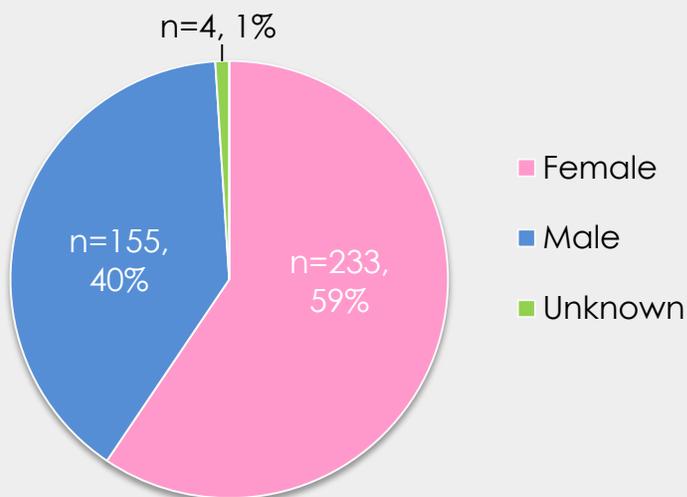
During the 2015-2016 Fiscal Year, the County of Marin's Triple P Program reached 388 children who are Hispanic/Latino (50%), White (20%), African American (4%), Multi-racial (10%), and other or unknown (14%).

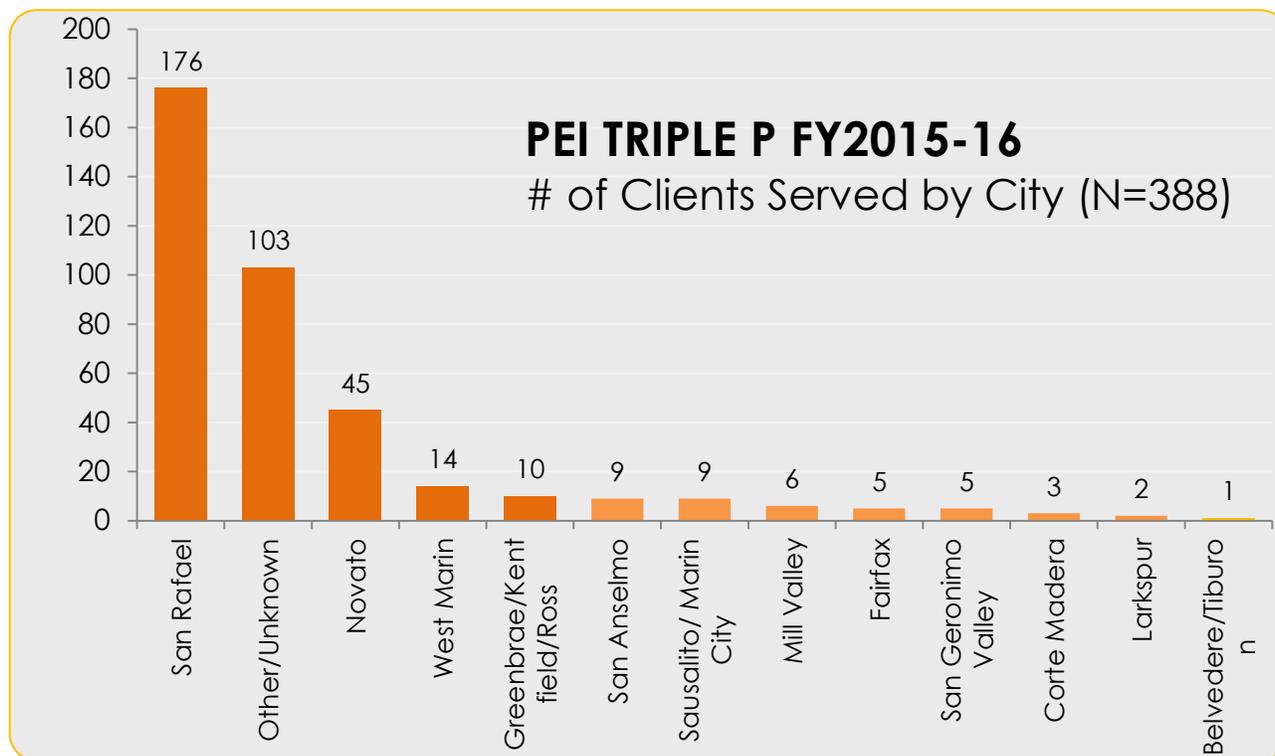
PEI TRIPLE P FY2015-16: PRIMARY LANGUAGE (N=388)



During the 2015-2016 Fiscal Year, the County of Marin's Triple P Program reached 388 children whose primary language is Spanish (50%), English (47%), Arabic (1%), and other or unknown (2%).

PEI TRIPLE P FY2015-16: GENDER (N=388)





During the 2015-2016 Fiscal Year, the County of Marin’s Triple P Program reached 388 children in San Rafael (176), Novato (45), and other areas of Marin.

PROGRAM CHALLENGES

When Triple P Marin began there were many providers trained in Levels 2-5. Some providers liked the model and continued using it. Many did not continue, often due to changing jobs or not liking the model. In FY14-15, the Triple P allocation was reduced to focus on determining how to implement Triple P given the need and capacity in Marin. Levels 2-3 have been well received by parents, especially Spanish speaking, and by a group of providers who like the model. Levels 4-5 continue to be implemented by Marin County BHRS staff. At this point, in order to more fully implement Triple P with fidelity, it would need to be significantly expanded to include Level 1 and ensure funding for all levels of services for a broader range of clients.

This program will not continue in FY2017-18. Implementation of Triple P will continue to be supported within BHRS Youth and Family Services.

CLIENT STORY - TRIPLE P (POSITIVE PARENTING PROGRAM)

Anna is the African-American mother of David (almost 2 years old). She is currently separated from her husband after leaving an emotionally abusive situation. Anna felt overwhelmed as she settled in to her new transitional housing situation. She was anxious to establish consistency for her toddler in a new group living situation. She reported concerns around her son's temper tantrums and needing a new bedtime routine given their change in residence. The parent educator discussed positive parenting techniques and Anna's interactions with her son. Discussions focused on the importance of routines, how to set limits with her toddler, ways to navigate the household, and bedtime routines. The consultant discussed ways to support David using Triple P tip sheets during temper tantrums. Together, Anna and the consultant created a routine that Anna implemented. She reported that incorporating the Triple P strategies resulted in a more settled, relaxed mood for both her son and herself. Anna reported, *"I feel supported and affirmed. Our conversations helped me to navigate the changes in my life in a more positive way, and I feel much less overwhelmed. We discussed many good ideas, and you were helpful in supporting me to tweak them according to my own ideas and needs in my situation."*

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

PEI TAY

SUMMARY FY2015-16

PROGRAM OVERVIEW

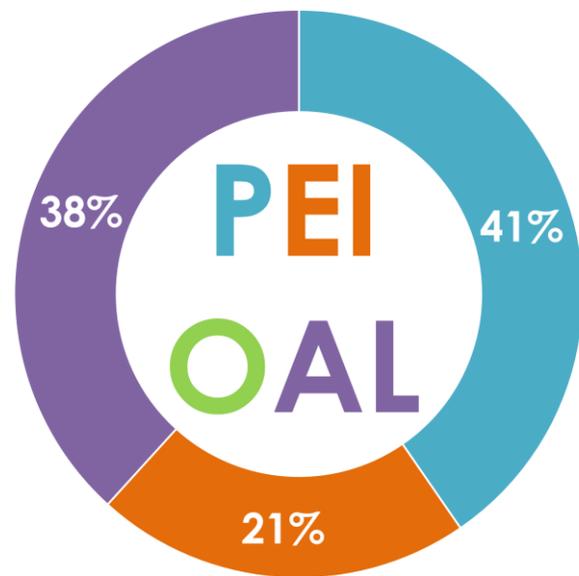
In 2009, MHSA PEI funds began the Transition Age Youth (TAY) Prevention and Early Intervention (PEI) program, provided by Huckleberry Youth Programs (HYP) and Novato Youth Center (NYC). TAY PEI provides screening and brief intervention for behavioral health concerns in teen clinics and group and individual services in middle and high schools for at-risk students.

Clients Served: FY2015-16

1223 Individuals
71 Families

TARGET POPULATION

The target population is 16-25 year olds, and some younger teens, from underserved populations. Many of the TAY are unlikely to receive services through other routes due to lack of insurance, lack of parental connection, unfamiliarity with navigating the service systems, concern about cost of services, or lack of linguistically accessible services.



PROGRAM DESCRIPTION

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

- Prevention
- Early Intervention
- Outreach
- Access and Linkage

The TAY PEI program aims to reduce prolonged suffering due to unaddressed mental illness by increasing identification of at-risk TAY, increasing protective

factors for those with significantly higher risk, and providing access to services for those with early onset of signs of emotional disturbance.

Prevention:

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

Early Intervention:

- Brief Intervention: Youth screening positive for signs of emotional disturbance in the teen health clinics, identified through the school groups, or referred from school personnel or 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 youth are included in brief intervention services as appropriate.

Access and Linkage to Treatment:

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

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

Individuals at risk or showing signs of developing emotional disturbance are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by licensed mental health providers at the clinic or school sites. They make the referrals to County 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. PEI staff maintains relationships with referral sites and participates in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

EXPECTED OUTCOMES

Transition Age Youth (TAY) PEI is intended to:

- Screen clients for an array of mental health and substance use issues at Teen Clinics for early identification of mental health issues and linkage to appropriate services.

Number of clients screened at Teen Clinics will be tracked.

- Reduce Prolonged Suffering for those at significantly higher risk of emotional disturbance or mental illness by increasing protective factors and reducing risk factors.

Participants of school groups complete an evidence-based tool, the Outcome Rating Scale (ORS), at each session which asks the client to rate how they are doing individually, interpersonally, socially and their overall sense of well-being. The change in these scores will be evaluated for clients that participate in three or more sessions.

- Reduce Prolonged Suffering for those experiencing early onset of symptoms of emotional disturbance or mental illness by reducing symptoms and improving related functioning.

Clients receiving early intervention services complete an evidence based tool, the Outcome Rating Scale (ORS), at each session which asks the client to rate how they are doing individually, interpersonally, socially and their overall sense of well-being. The change in these scores will be evaluated for clients that participate in three or more sessions.

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

The program achieves the intended results due to implementing practices that have been shown to achieve positive impacts with the target population:

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

ACTUAL OUTCOMES

The TAY PEI program has been successful in reaching the intended population and the intended outcomes. Huckleberry Youth Programs (HYP) and the Novato Youth Center (NYC) have consistently adjusted the program to ensure it is providing effective and needed services. By integrating behavioral health screening into confidential reproductive health services, many youth have both identified issues and received help they would have not otherwise.

Outcomes for FY2015-16	Goal	Actual
TAY screened for behavioral health concerns.	450	468
TAY participating in at least 5 sessions of school-based skill building groups.	80	102
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> <i>Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change.</i>	65%	77% N=26
TAY participating in individual counseling.	180	261
Family members participating in TAY counseling in support of the client.	30	70
TAY participating in at least 3 sessions of counseling.	NA	103
TAY participating in at least 3 sessions of counseling showing statistically significant improvement in client well-being. <i>PCOMS: Outcome Rating Scale</i> <i>Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change.</i>	65%	82% N=44
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%	90% N=99
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%	85% N=83

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

All TAY PEI services have a focus on un/underserved populations. As can be seen above, the services are successfully reaching underserved populations. Many of the staff hired with MHSA funding are bilingual and bicultural with both personal experience and understanding of the challenges that youth in our community face.

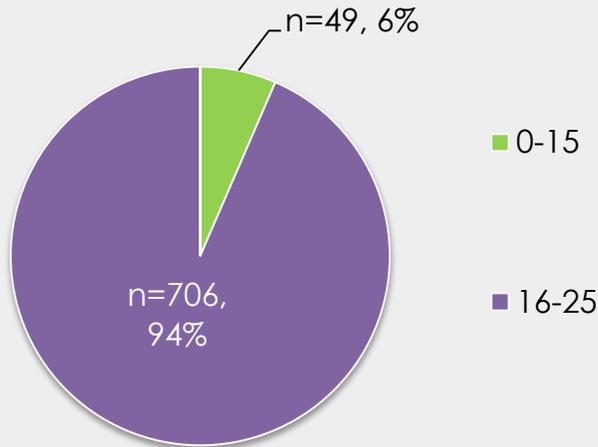
TAY PEI respond to client need by adjusting services, such as increasing skill building groups for newcomers when there was an influx of immigrants. In addition, the use of PCOMS: Session Rating Scale allows for immediate adjustment to counseling services based on client feedback at each session.

HYP and NYC have long-term, successful partnerships with middle and high schools, including providing group and individual services on school sites. Having bilingual staff with relationships with the students has enabled HYP and NYC to be instrumental at times of crisis (see Client Story).

PROGRAM CHALLENGES

While TAY PEI provides mental health services for many TAY who could not access it elsewhere, there are many TAY who have insurance with behavioral health services. In order to make best use of the resources, a case manager has been hired to assist TAY in accessing covered services.

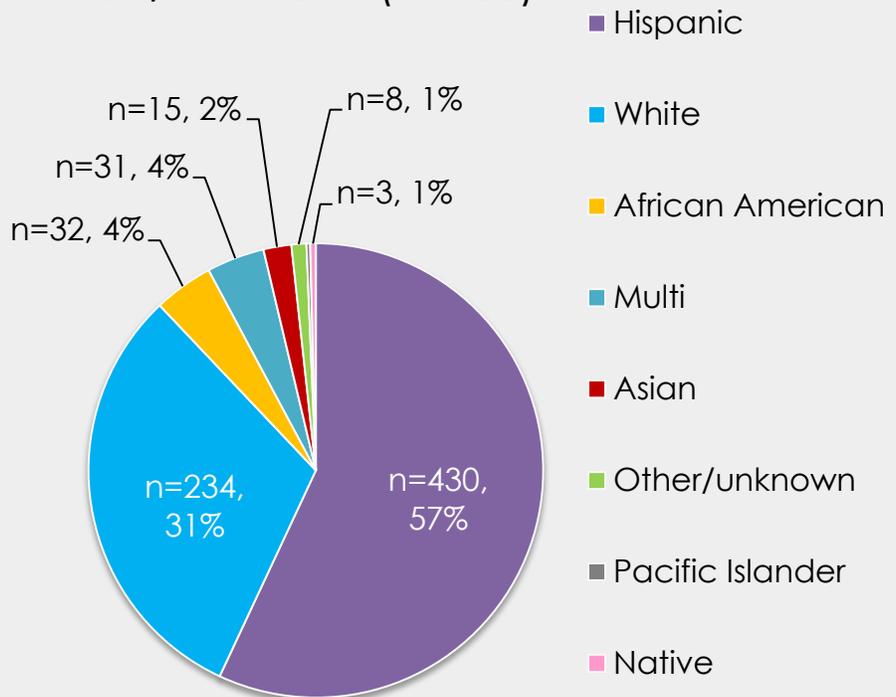
**PEI TAY FY2015-16:
 AGE GROUP (N=755)**



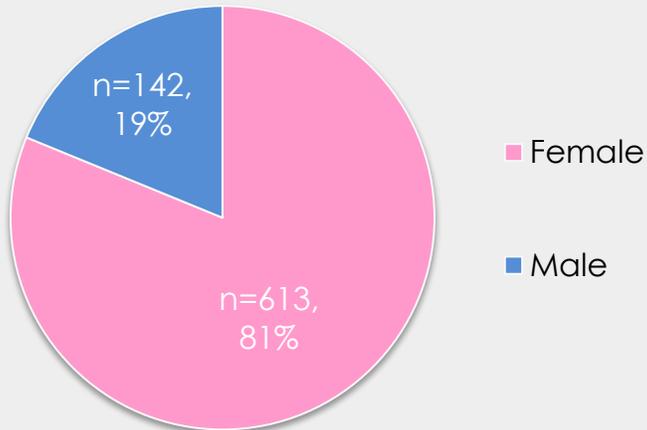
During the 2015-2016 Fiscal Year, the County of Marin's Transition Age Youth (TAY) PEI program provided risk and symptom reduction services to 755 youth, primarily 16-25 year olds.

During the 2015-2016 Fiscal Year, the County of Marin's TAY PEI program successfully reached underserved populations.

**PEI TAY FY2015-16:
 RACE/ETHNICITY (N=755)**

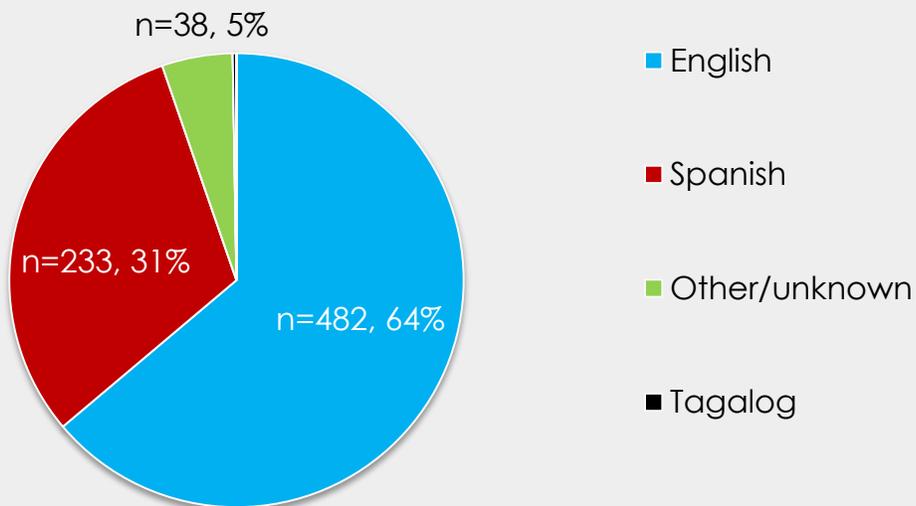


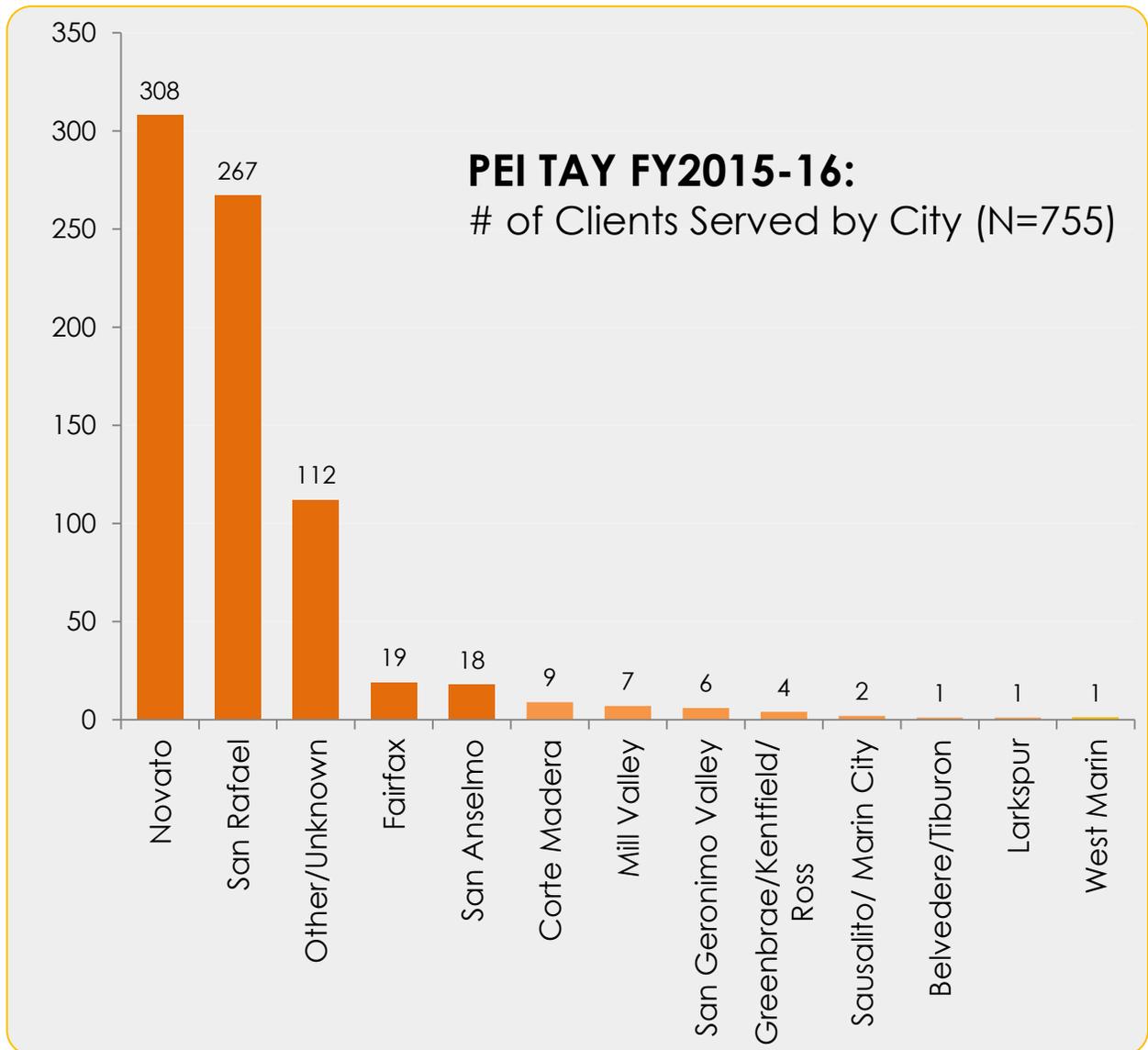
PEI TAY FY2015-16: GENDER (N=755)



During the 2015-2016 Fiscal Year, the County of Marin's TAY PEI program served more females. The MHS Innovation Plan has identified TAY males as underserved in PEI and will explore solutions.

PEI TAY FY2015-16: PRIMARY LANGUAGE (N=755)





During the 2015-2016 Fiscal Year, the County of Marin’s TAY PEI program served mainly San Rafael and Novato residents, as those are the towns the teen clinics are located in.

CLIENT STORY - TRANSITIONAL AGE YOUTH PEI

When a group of students who were affected by a violent tragedy in Novato were brought into the school library, a few ran to Berta, one of their former Newcomer Group facilitators, and hugged her. The students were offered the support of a bilingual therapist, but their body language clearly reflected they were uncomfortable with the idea. Berta reassured them that they didn't have to, that they could just hang out in the library, but she also encouraged them to meet with the therapist, saying she and the therapist were good friends—almost like cousins. Berta introduced the students to the therapist and told the students that the clinician was very sweet and easy to talk to. Berta further explained that therapists go through special training to learn how to support youth in difficult situations and that although she was happy to talk and hang out with them, the therapist would be able to help them with special skills that Berta didn't have. The students stayed in the library for a while, chatting with the clinicians and Berta. After a half hour, the students took off to a private room with the therapist and were there for at least an hour. Once other Latino students who did not know Berta saw what happened, they started reaching out to her and to the clinicians. It was clear that the trust built with the Newcomers Group in the Fall was extremely helpful in connecting students to the emotional support they needed during this tragedy.

LATINO COMMUNITY CONNECTION

PROGRAM OVERVIEW

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

TARGET POPULATION

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

PROGRAM DESCRIPTION

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

Latino CC

SUMMARY FY2015-16

Clients Served: **FY2015-16**

1 404 Individuals

8 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

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

Outreach for Increasing Recognition:

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

Prevention:

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

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

Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by the program’s behavioral health provider. Promotores, family advocates and others are trained to identify signs and symptoms and refer clients to the behavioral health provider as needed. The behavioral health provider makes referrals to County 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 the “Access and Assessment line,” enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

EXPECTED OUTCOMES

Latino Community Connection is intended to:

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

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

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

- The Promotores program is a practice-based model with a long history. It has been described and studied in many articles, including “The Promotor Model: A Model for Building Healthy Communities” (The California Endowment) and “Promotores: Vital PRC Partners Promote Nutrition and Physical Activity” (Center for Disease Control).
- Promotores and other providers in this program receive training in Motivational Interviewing and trauma informed care as a basis for all of their work.
- The Posttraumatic Stress Disorder Checklist (PCL-C) is a validated tool for assessing symptoms of trauma.

ACTUAL OUTCOMES

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

The partnership between Novato Youth Center, Canal Alliance, West Marin Services, and Dr. Marisol Muñoz-Kiehne has been key to the success of the Latino Community Connection, allowing it to reach a large portion of the population. Participation in the “Cuerpo Corazon Comunidad” (www.cuerpocorazoncomunidad.org) radio show has been an important vehicle for Promotores to reach those who are isolated. Promotores and staff regularly participate in the radio show to discuss the Promotores Program, substance use, managing stress, domestic violence, trauma and other related topics.

Outcomes for FY2015-16	Goal	Actual
Individuals receiving health information and support from Promotores or Family Resource Advocates.	640	1211
Individuals participating in support groups or individual/family sessions.	100	161
Family members participating in support of the client.	20	30
Support group participants attending for at least 3 months.	65%	70% N=28
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%	90% N=20
Individuals participating in support groups or individual/family sessions reporting an increased ability to address their problems. <i>PEI Survey</i>	80%	85% N=161
Individuals participating in support groups or individual/family sessions reporting satisfaction with the services (would use again, would recommend). <i>PEI Survey</i>	80%	85% N=167

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

Type of Participants in Outreach Events	Number Served
Community Members (Latino/Spanish Speaking)	1131
Providers	
County Behavioral Health and Recovery Services	4
Education (including High School Students)	2
Primary Health Care	1
Social Services (County and Community)	2
Faith-based	1
Other – List: DV, BOS, Parks Svcs, PH	6

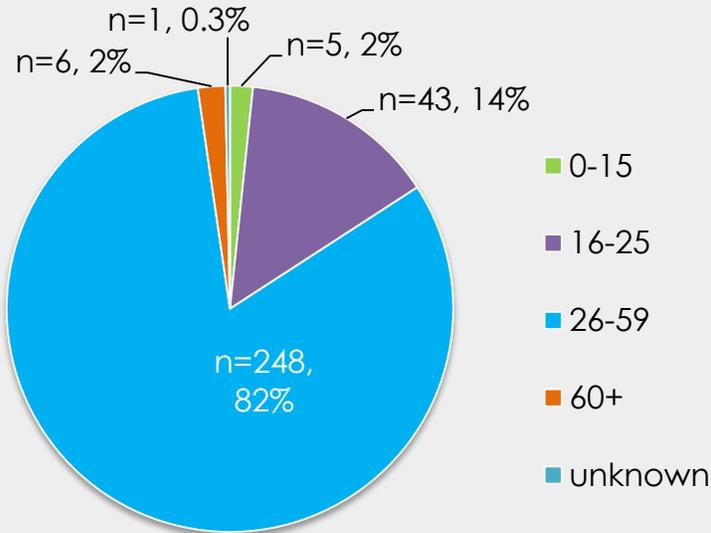
Canal Alliance (CA) is located in the Canal neighborhood of San Rafael, comprised mostly of new immigrants from Mexico and Central America. CA has provided a wide array of services to this community for 30 years, building a high level of respect and trust. They have partnered with Novato Youth Center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

The demographics represent individuals who received individual, group, or family services from Promotores, Family Resource Advocates, or Behavioral Health Coordinators.

PROGRAM CHALLENGES

Finding affordable accessible therapy in Spanish for mild to moderate clients continues to be a challenge, particularly for those who are uninsured. Because there is only one clinician to serve such a large population, the clinician is booked three weeks out.

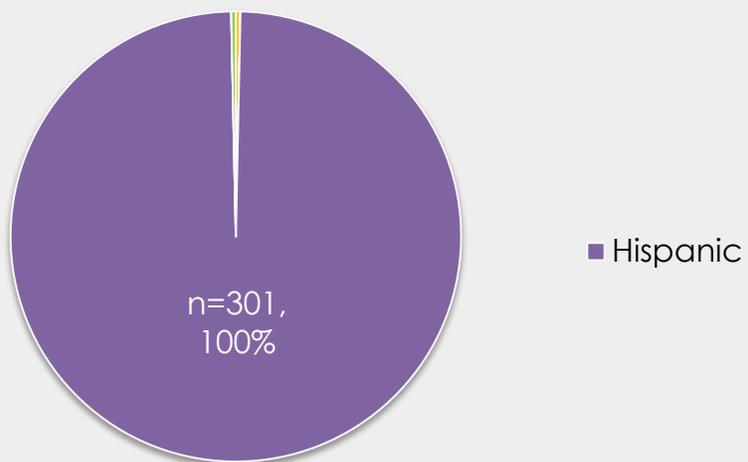
**PEI LCC FY2015-16:
 AGE GROUP (N=301)**



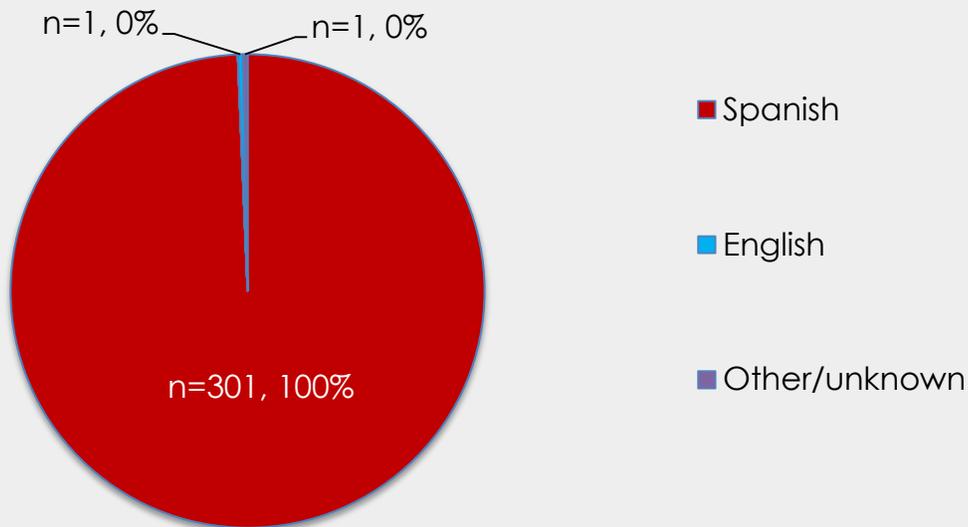
During the 2015-2016 Fiscal Year, the County of Marin's Latino Community Connection Program served 303 individuals ages 0-15 (2%), 16-25 (14%), 26-59 (82%), and 60+ (2%).

During the 2015-2016 Fiscal Year, the County of Marin's Latino Community Connection Program served 303 individuals, of which 301 were Hispanic/Latino.

**PEI LCC FY2015-16:
 RACE/ETHNICITY (N=301)**

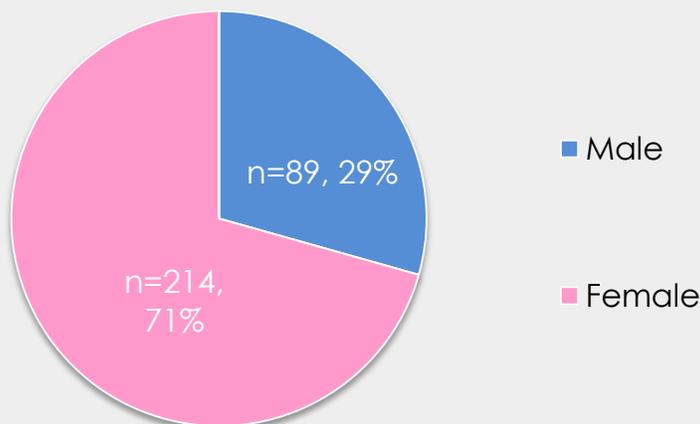


PEI LCC FY2015-16: PRIMARY LANGUAGE (N=301)

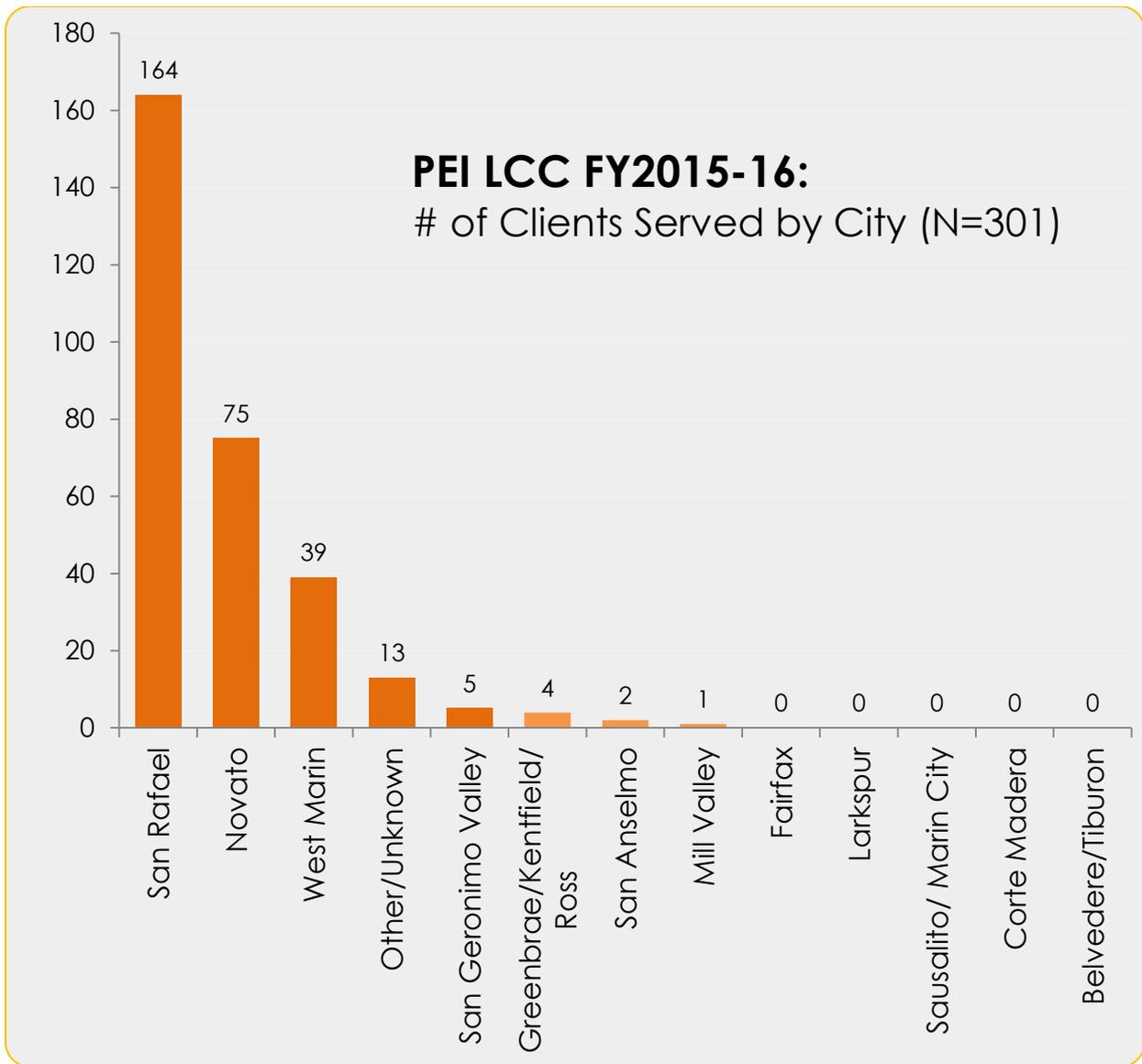


During the 2015-2016 Fiscal Year, the County of Marin's Latino Community Connection Program served 303 individuals, 301 of whom primarily spoke Spanish.

PEI LCC FY2015-16: GENDER (N=301)



During the 2015-2016 Fiscal Year, the County of Marin's Latino Community Connection Program served 303 individuals, who are Female (71%) and Male (29%).



During the 2015-2016 Fiscal Year, the County of Marin’s Latino Community Connection Program is primarily located in San Rafael, Novato and West Marin, as reflected in the client demographics.

CLIENT STORIES - LATINO COMMUNITY CONNECTION

A promotora worked with a family who lives in Marshall. This family is very private and keeps to themselves. The son began having hallucinations and talking to voices in his head. He started destroying objects in the home claiming they had evil spirits. The family was scared and didn't know what to do. They would sleep in the family car to get away from him. This had been going on for months. It wasn't until they spoke casually with a promotora on the street that they began to feel there may be a solution. The promotora shared resources and encouraged them to get help. The son met the seriously mentally ill criteria and is receiving services from the West Marin Service Center.

.....

Angela was referred to Canal Alliance through the local community clinic after experiencing panic attacks. She reported feeling as if she was going to die, trembling, urge to run, feeling dizzy, sweating, racing thoughts, and inability to sleep. Angela would consistently end up in the emergency room thinking she was suffering from a heart attack. She was then referred to her local community clinic where she was prescribed medication to treat anxiety, which she was taking at least four times a week. She came to Canal Alliance and the Behavioral Health Therapist worked with her to learn breathing and stress reduction techniques. Through their work together, Angela is no longer taking medication and, she is experiencing one panic attack a month. She is now able to manage it without medication, is able to implement techniques for herself, and is now teaching them to her children.

.....

A promotora was providing support for a single mother who was suffering emotional abuse by her boyfriend. She wanted to leave the relationship but was afraid. The promotora helped the woman explore the benefits and disadvantages of staying in the relationship. She helped the family connect with the Center for Domestic Peace. The woman eventually left the relationship and went to a shelter. The promotora continued supporting her and helped her find an apartment after the shelter. The client is now much happier and living in a less stressful environment.

INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

PROGRAM OVERVIEW

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

TARGET POPULATION

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

PROGRAM DESCRIPTION

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

The ACA provides screening and intervention services for mild to moderate mental health and substance use concerns in primary care settings. PEI provides support to primary care settings to ensure un- and underinsured

Coastal Health Alliance

SUMMARY FY2015-16

Clients Served: **FY2015-16**

1,238 Individuals
15 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

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

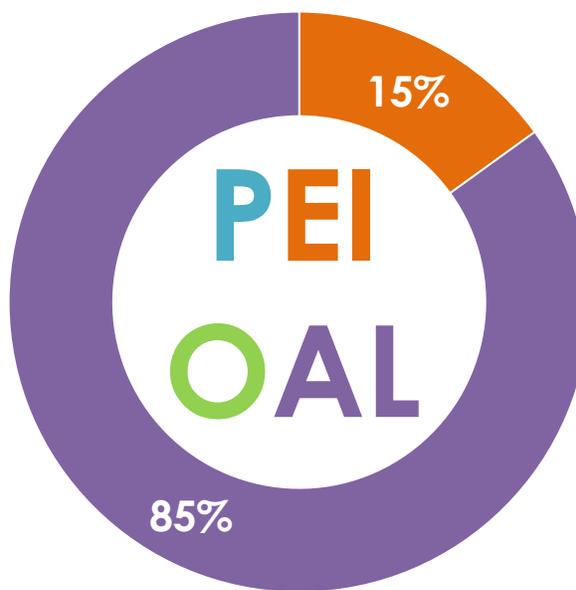
Individuals/families at risk or showing signs of developing mental illness or emotional disturbance are provided risk reduction and early intervention services, or linked other resources as needed. Access and linkage to treatment for

Ritter Center

SUMMARY FY2015-16

Clients Served: FY2015-16

377 Individuals
0 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

individuals experiencing symptoms of serious mental illness or emotional disturbance is provided through assessment and referral by licensed mental health providers in the primary care setting. They make the referrals to County 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 the “Access and Assessment line,” enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

EXPECTED OUTCOMES

Integrated Behavioral Health in Primary Care is intended to:

- Screen clients for an array of mental health and substance use issues at primary care clinics for early identification of mental health issues and linkages to appropriate services.

Number of clients screened will be tracked.

- Reduce Prolonged Suffering by reducing symptoms and improving mental, emotional and related functioning.

Primary care clients are screened for behavioral health concerns. Numbers screened are tracked. Those screening positive are further assessed. If they participate in early intervention the assessment is repeated periodically throughout services. Change in status is measured for each client, then reported in aggregate. Providers track the number and demographics of the clients/families served.

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

The program is expected to achieve the intended results by implementing a variety of evidence-based models and tools shown to have positive impact for the target population. Initially the program followed two evidence-based models: IMPACT (SAMHSA NREPP) and SBIRT (SAMHSA NREPP). Some adjustments have been made in consultation with best practices and emerging practices in IBH. Interventions incorporate a number of evidence-based practices, including Problem Solving Treatment with Behavioral Activation (Day A., Baker F., Gath DH, Mynors-Wallis LM. Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *BMJ*. 2000 Jan 1;320(7226):26-30) (Mynors-Wallis L. Problem-Solving treatment: evidence for effectiveness and feasibility in primary care. *Int J Psychiatry Med*. 1996;26(3):249-62), Motivational Interviewing (<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.461.8794&rep=rep1&type=pdf>), Seeking Safety (SAMHSA NREPP), Cognitive Behavioral Therapy (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3584580/>) and Eye Movement Desensitization and Reprocessing (SAMHSA NREPP). Screening, assessment and evaluation tools are validated, including PHQ2, PHQ9, GAD7, AUDIT, DAST. Staff are trained in these models and tools and receive regular follow-up education to ensure fidelity.

ACTUAL OUTCOMES

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

Outcomes for FY2015-16	CHA		Ritter	
	Goal	Actual	Goal	Actual
Staff in contact with clients participating in suicide prevention training.	50%	67% N=42	3	4
Screen un/underinsured clients for depression. <i>PHQ2</i>	800	1047	300	322
Screen un/underinsured clients for substance use concerns. <i>SBIRT form, includes suicide</i>	300	404		
Un/underinsured clients participating in behavioral health services.	NA	126		
Un/underinsured clients completing at least 3 behavioral health sessions.	25	45		
Clients completing at least 3 behavioral health sessions decreasing depression symptoms by 50% or achieving a score less than 10 (none/mild). <i>PHQ9</i>	50%	38% N=16		
Un/underinsured clients receiving behavioral health brief intervention.			20	20
Un/underinsured clients receiving psychiatric med management (MM) services.			60	39
Un/underinsured clients receiving MM services that attended at least 2 sessions.			40%	62% N=39
Un/underinsured clients attending at least 2 MM sessions decreasing depression symptoms by 50% or achieving a score less than 10 (none/mild). <i>PHQ9</i>			40%	46% N=24
Clients attending behavioral health sessions reporting satisfaction with services (use again, refer others).	75%	100% N=28	75%	95% N=32

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

Coastal Health Alliance has continuously worked to increase access to their behavioral health services, including warm hand-offs, more flexible scheduling, not charging a copay, and outreaching to the Latino community through community partners. Having a consistent bilingual behavioral health provider has contributed to developing knowledge and trust of the services, but the rate of usage continues to be lower for the Latino community than the overall population.

Ritter Center has continuously worked to increase access to their behavioral health services, including better welcoming and serving needs of individuals from the LGBTQ community, providing drop-in services, providing services at New Beginnings, and implementing trauma informed care particularly to better serve clients with PTSD.

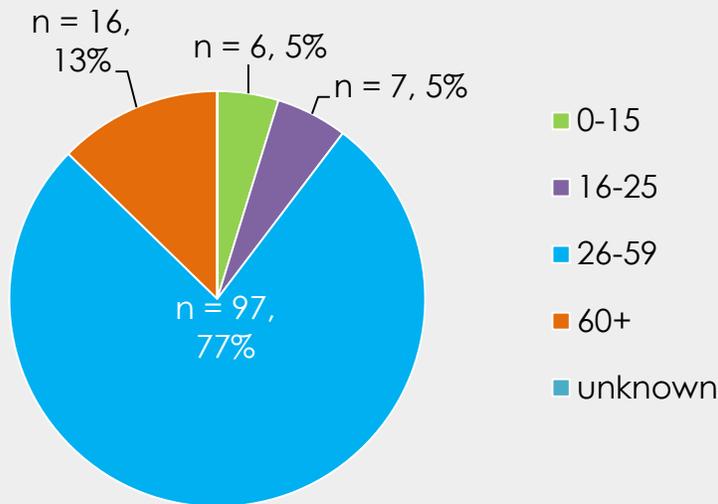
PROGRAM CHALLENGES

There is a high need for moderate to moderate/severe services among the populations served by these clinics. This has been balanced with the goal of intervening early with limited services, rather than solely providing ongoing therapy, as well as a client base that may not be able to attend services regularly.

This program will not continue in FY2017-18. BHRS will continue to collaborate with Federally Qualified Health Centers to support client access to mental health services.

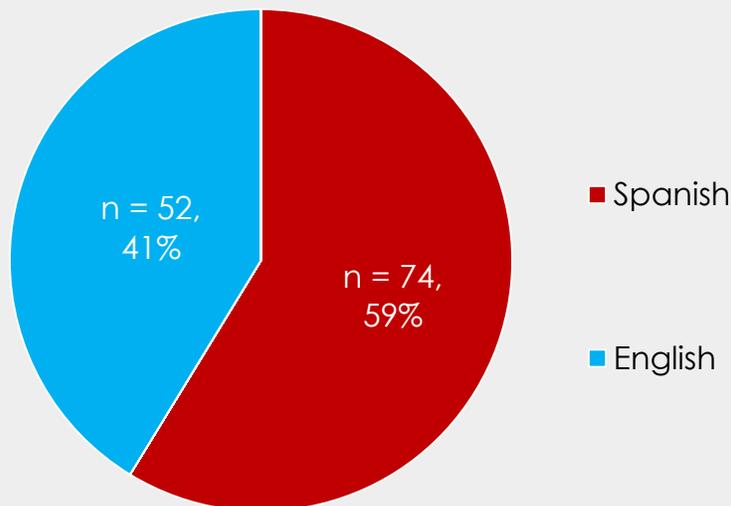
Coastal Health Alliance

PEI CHA FY2015-16: AGE GROUP (N=126)



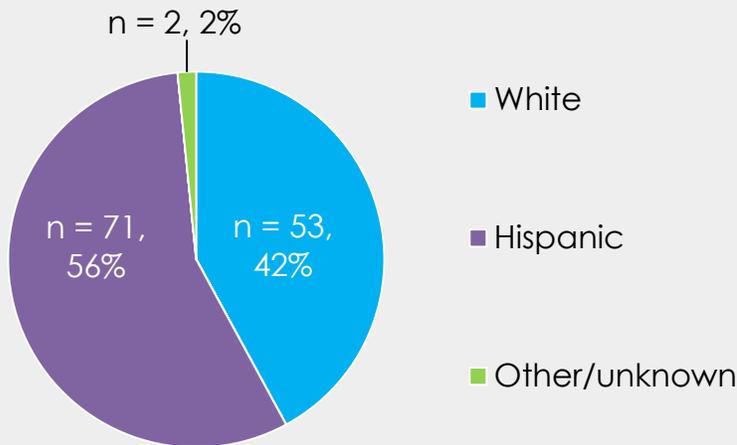
During the 2015-2016 Fiscal Year, the Coastal Health Alliance provided early intervention services for 126 individuals through Marin County's Integrated Behavioral Health Program.

PEI CHA FY2015-16: PRIMARY LANGUAGE (N=126)



During the 2015-2016 Fiscal Year, those receiving early intervention services spoke Spanish (59%) and English (41%).

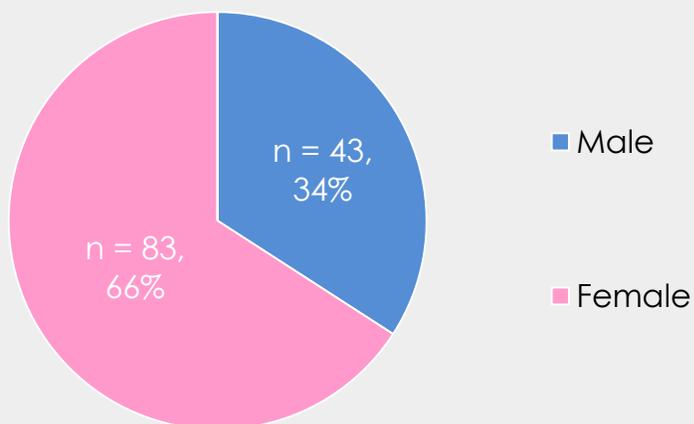
PEI CHA FY2015-16: RACE/ETHNICITY (N=126)

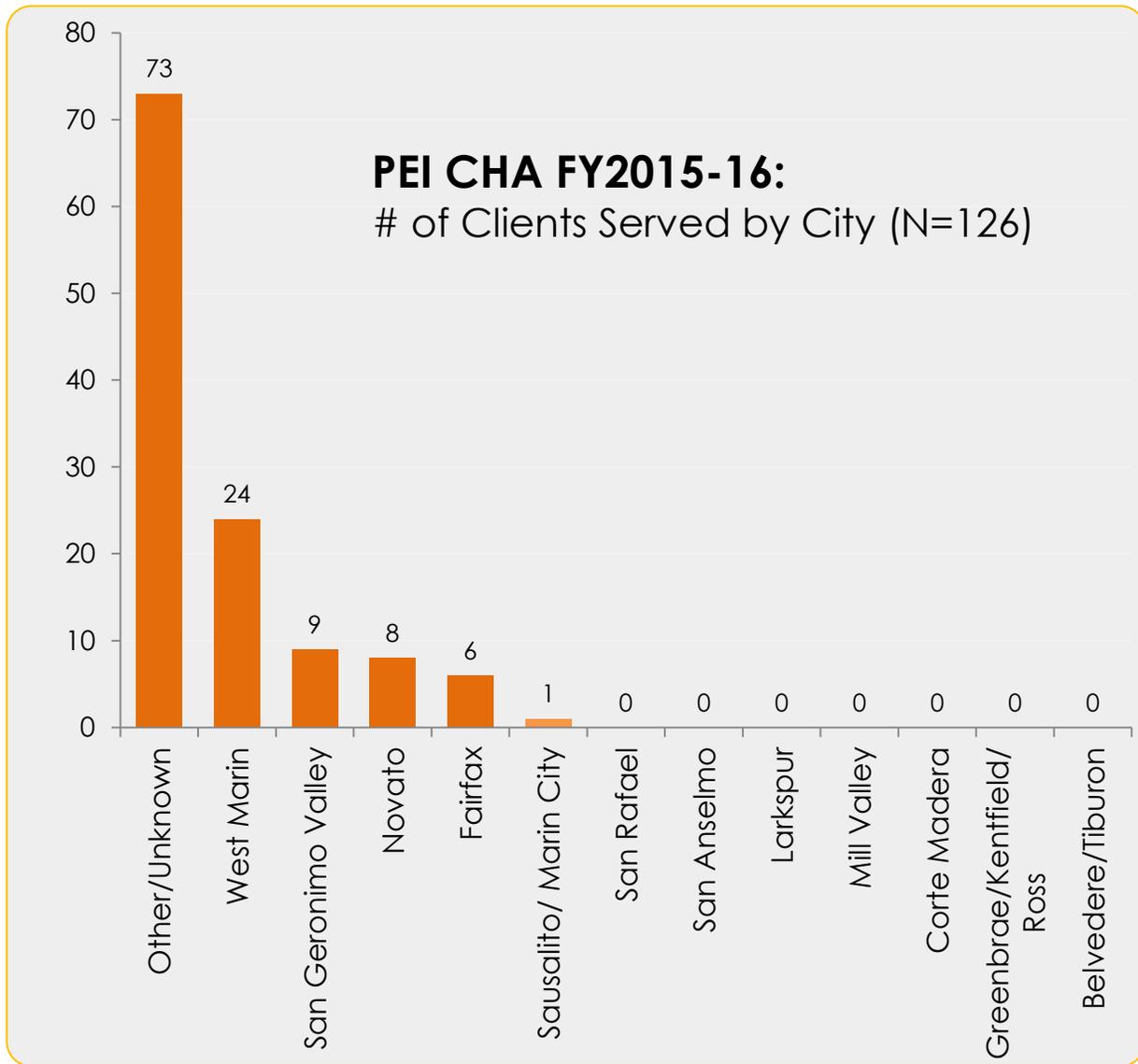


During the 2015-2016 Fiscal Year, Coastal Health Alliance reached the Latino population in coastal Marin.

During the 2015-2016 Fiscal Year, Coastal Health Alliance's early intervention services were accessed by 83 women and 43 men.

PEI CHA FY2015-16: GENDER (N=126)

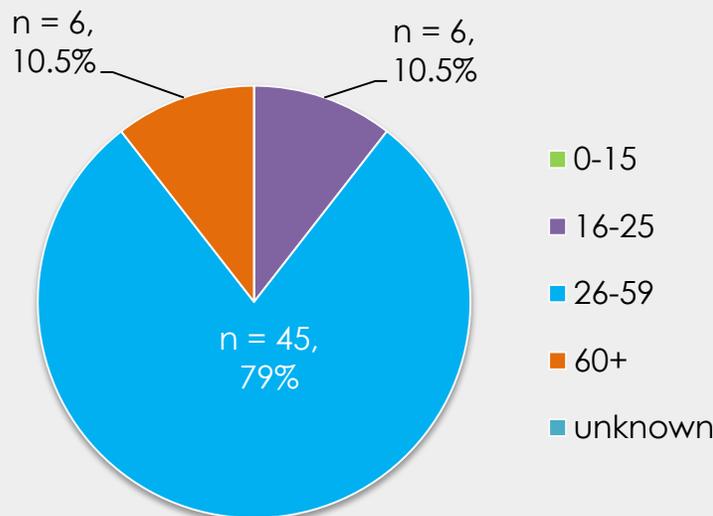




During the 2015-2016 Fiscal Year, the Coastal Health Alliance served primarily West Marin residents.

Ritter Center

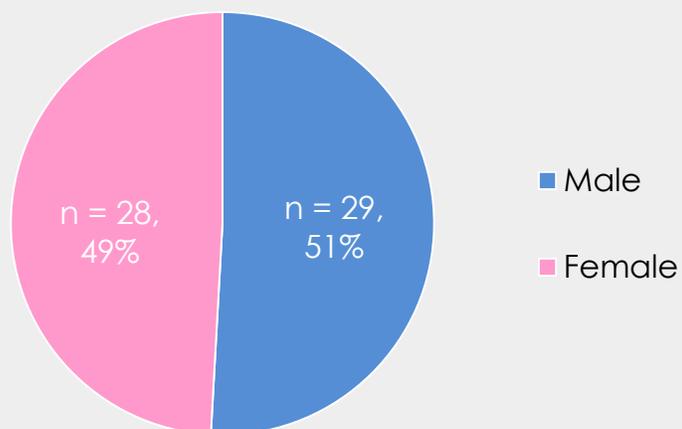
PEI RITTER FY2015-16: AGE GROUP (N=57)



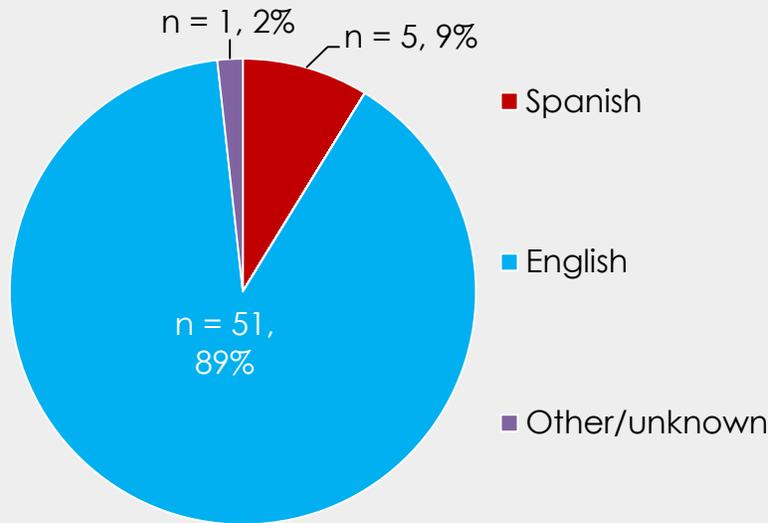
During the 2015-2016 Fiscal Year, Ritter Center provided intervention services for 59 individuals through Marin County's Integrated Behavioral Health program.

During the 2015-2016 Fiscal Year, Ritter Center's intervention services were accessed by 28 women and 29 men.

PEI RITTER FY2015-16: GENDER (N=57)

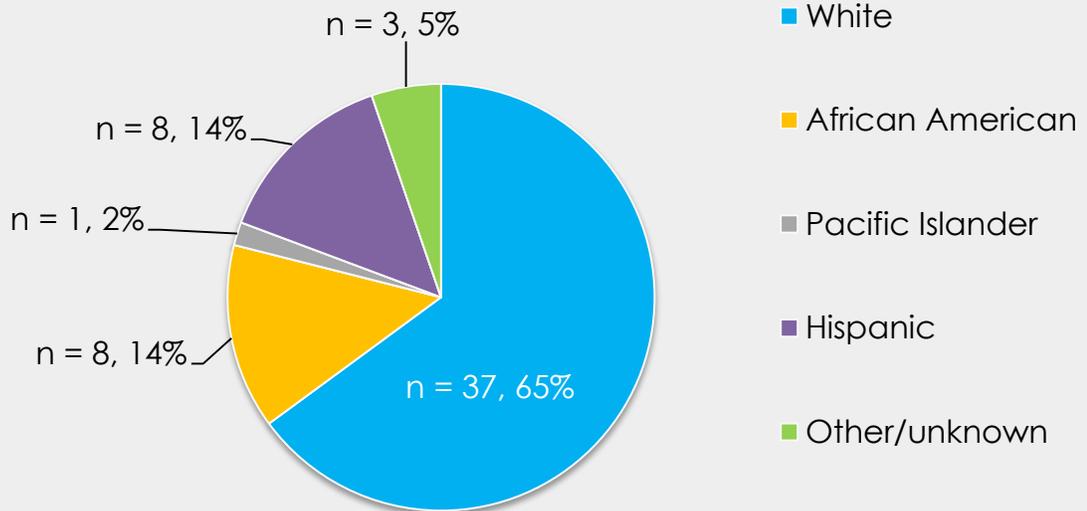


PEI RITTER FY2015-16: PRIMARY LANGUAGE (N=57)

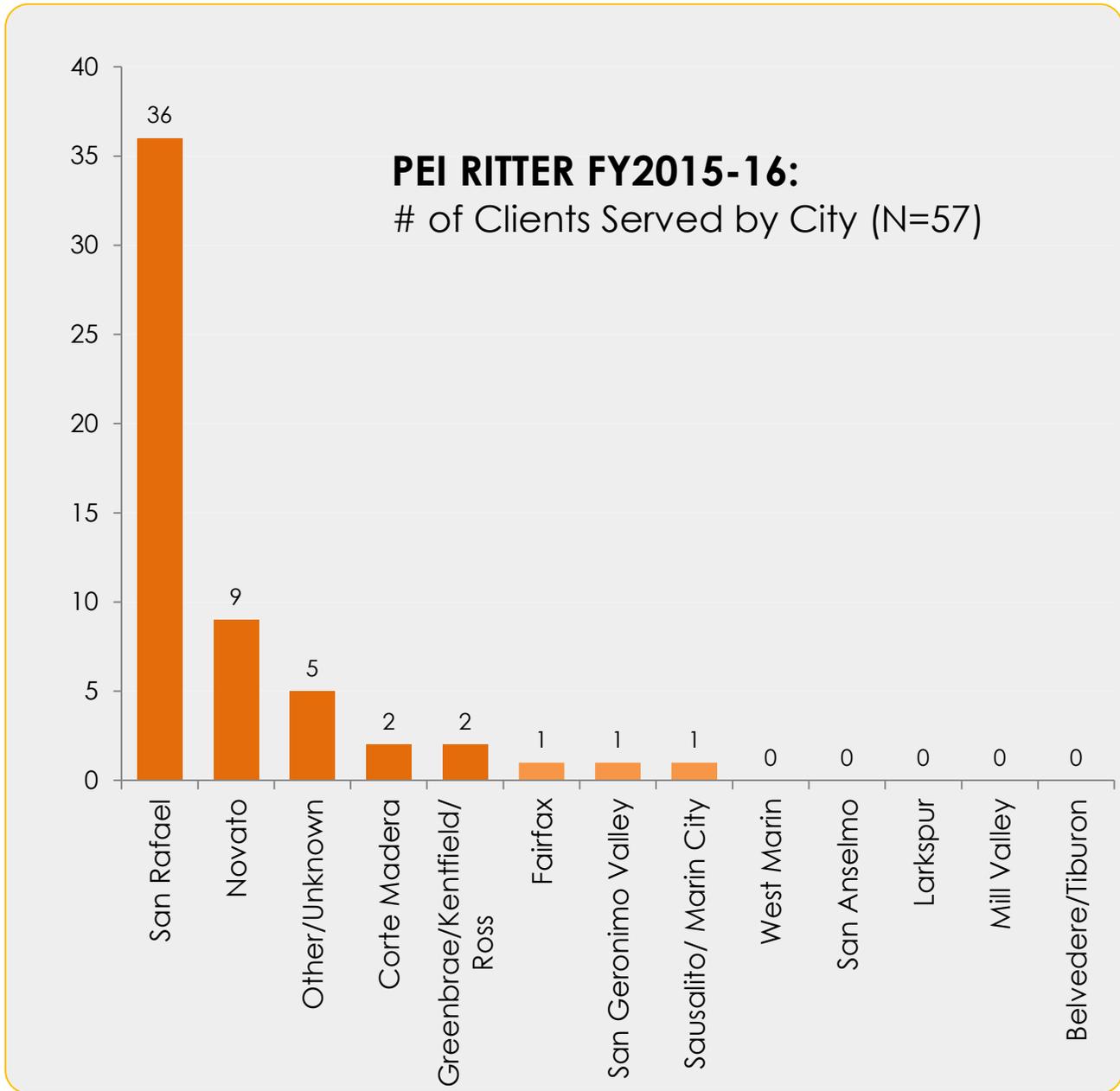


During the 2015-2016 Fiscal Year, the Ritter Center served homeless and very low income residents.

PEI RITTER FY2015-16: RACE/ETHNICITY (N=57)



During the 2015-2016 Fiscal Year, the Ritter Center served homeless and very low income residents.



During the 2015-2016 Fiscal Year, Ritter Center served primarily San Rafael residents.

CLIENT STORY - INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

Richard suffered very extreme abuse and neglect as a child. His parents were often not present and he was cared for minimally by relatives. He experienced chronic depression and had been diagnosed with Seasonal Affective Disorder and Major Depressive Disorder two years ago. He sought outpatient psychotherapy at Ritter Center and was connected with our psychologist. Services at Ritter were provided on a weekly basis to help Richard avoid inpatient hospitalization and make a more successful adjustment to his chronic depression. Outpatient therapy was provided using cognitive behavioral techniques, including imaginal exposure to feared situations. However, Richard had been depressed for so long and had become very isolated. The therapist encouraged him to acquire a pet as a companion to assist with better socialization and get him out into the community. Fortunately, Richard had his own housing, and could incorporate a dog into his life at this time. Within a week of obtaining a companion pet, Richard's depressive symptoms began to remit - he became much more active, appeared cheerful and affectively more present. Richard is making plans for the future and recognizes that active follow through and on-going therapy will help him sustain improvement. When asked about his recovery, Richard laughed and said, "This dog has been a lifesaver for me!"

OLDER ADULT PREVENTION AND EARLY INTERVENTION

PROGRAM OVERVIEW

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

TARGET POPULATION

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

PROGRAM DESCRIPTION

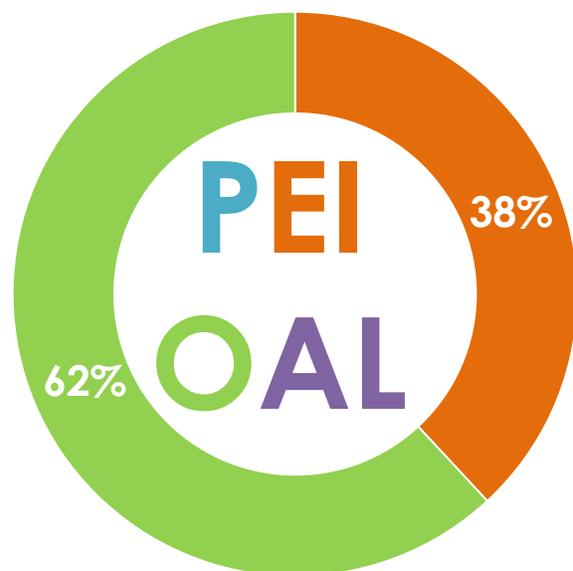
- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Intervene Early in the Onset of Mental Illness

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

Older Adult

SUMMARY FY2015-16

105 Individuals
24 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

Outreach for Increasing Recognition:

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

Early Intervention:

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

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

Individuals at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness is achieved through assessment and referral by JFCS licensed mental health providers. They make the referrals to County 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 the “Access and Assessment line,” enabling the County to track referrals, timeliness of services, and services received. PEI staff will maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

EXPECTED OUTCOMES

Older Adult PEI is intended to:

- Educate providers, older adults, and gatekeepers to recognize and respond to early signs of mental illness through providing training and written materials to organizations and networks.
The number and types of individuals trained will be tracked. Participant surveys are conducted to show changes in knowledge and skill for those receiving training.
- Reduce Prolonged Suffering for those experiencing early onset of depression and/or anxiety by reducing symptoms and improving related functioning.

For clients completing treatment, including CBT or the Healthy IDEAS intervention, pre- and post-PHQ9s 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.

The program achieves the intended results due to implementing a combination of clinical approaches and program practices that have been shown to achieve positive impacts in older adults. Healthy IDEAS (Identifying Depression, Empowering Activities for Senior) (<https://www.ncoa.org/resources/program-summary-healthy-ideas/>) is evidence based and a core program model. Cognitive Behavioral Therapy is also an evidence-based treatment practice (<http://www.currentpsychiatry.com/home/article/how-to-adapt-cognitive-behavioral-therapy-for-older-adults/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.

ACTUAL OUTCOMES

With PEI funding, Jewish Family and Children’s Services expanded their existing older adult intervention services to address depression, substance use and other behavioral health concerns, including an evidence-based approach to depression, Healthy IDEAS. The Older Adult PEI program has been very successful at adapting to meet the needs of the clients.

Outcomes for FY2015-16	Goal	Actual
Individuals receiving education regarding behavioral health signs and symptoms in older adults.	100	120
Individuals receiving education that are from an underserved population or primarily serving underserved populations (race, ethnicity, language, LGBTQ).	20%	53% N=120
Seniors at Home clients screened for behavioral health concerns. <i>PHQ9, substance use</i>	150	155
Low income clients receiving brief intervention services.	35	40
Low income clients receiving brief intervention services that are from underserved populations.	20%	20% N=40
Clients with family members participating in brief intervention services in support of the client.	30%	60% N=40
Clients completing a short-term treatment protocol for depression or anxiety.	70%	82% N=40
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%	64% N=33
Clients receiving brief intervention reporting satisfaction with services (would use again, recommend).	75%	100% N=17

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

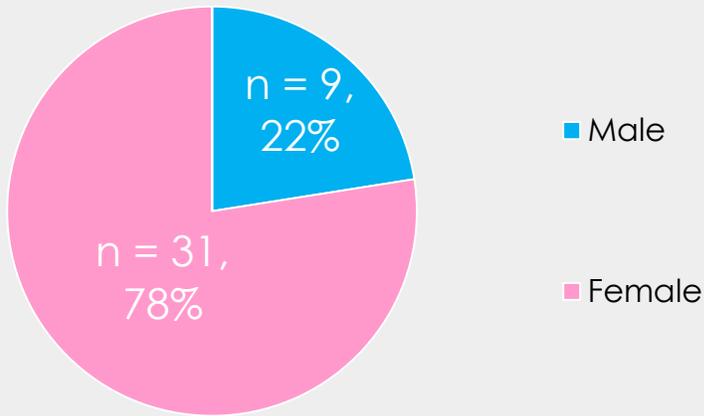
Type of Participants in Outreach Events	Number Served
Community Members (Older adults and their family members)	65

Older Adult PEI continues to expand its outreach to underserved populations, including providing presentations with translation into Spanish and Vietnamese and working with Marin City Senior Center on strategies for reaching Southern Marin. The program remains flexible in order to accommodate the clients' numerous medical challenges. JFCS also began a volunteer peer program to provide ongoing support to clients once they have completed the OA PEI services.

PROGRAM CHALLENGES

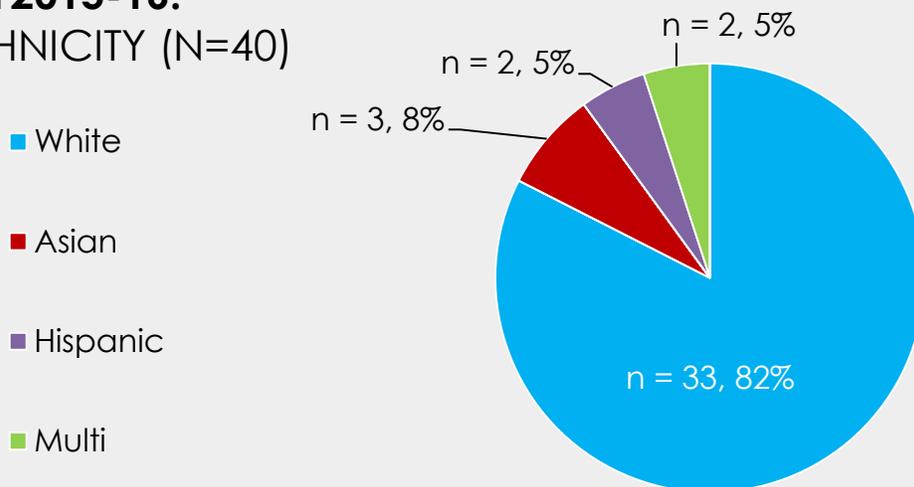
There is a lack of services for individuals needing psychiatric evaluation and those experiencing memory issues, chronic unmanageable pain, and dependency on pain medications. There are limited ongoing supports for older adults who have completed the OA PEI services, increasing the chances of relapse. In addition, over half of client services are provided in the client's home due to mobility limitations, reducing the number of clients that can be seen.

PEI OA FY2015-16: GENDER (N=40)



During the 2015-2016 Fiscal Year, the County of Marin's Older Adult PEI Program provided early intervention for 40 clients, of whom 78% are Female and 22% Male.

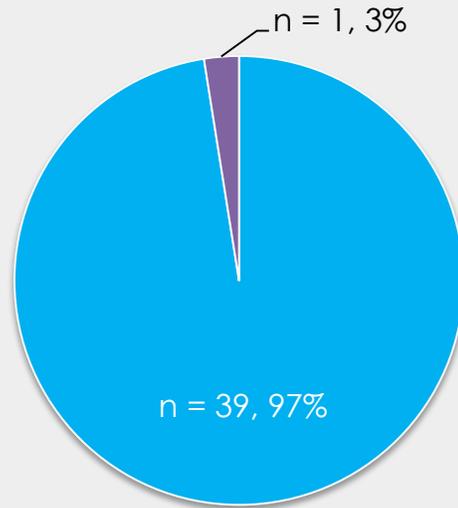
PEI OA FY2015-16: RACE/ETHNICITY (N=40)



During the 2015-2016 Fiscal Year, the County of Marin's Older Adult PEI Program conducted outreach to underserved communities to increase their access to services.

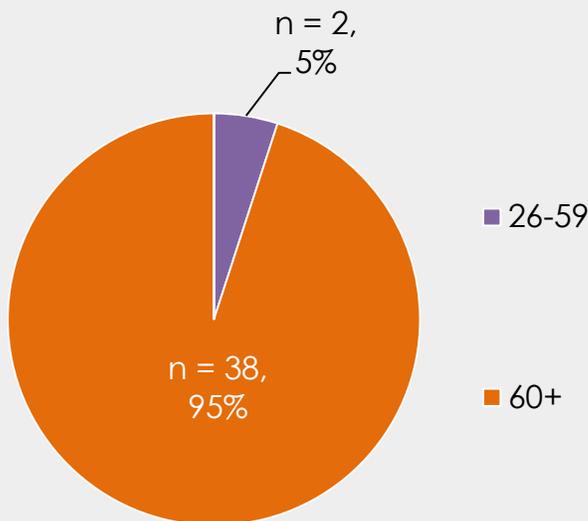
PEI OA FY2015-16: PRIMARY LANGUAGE (N=40)

- English
- Other/unknown

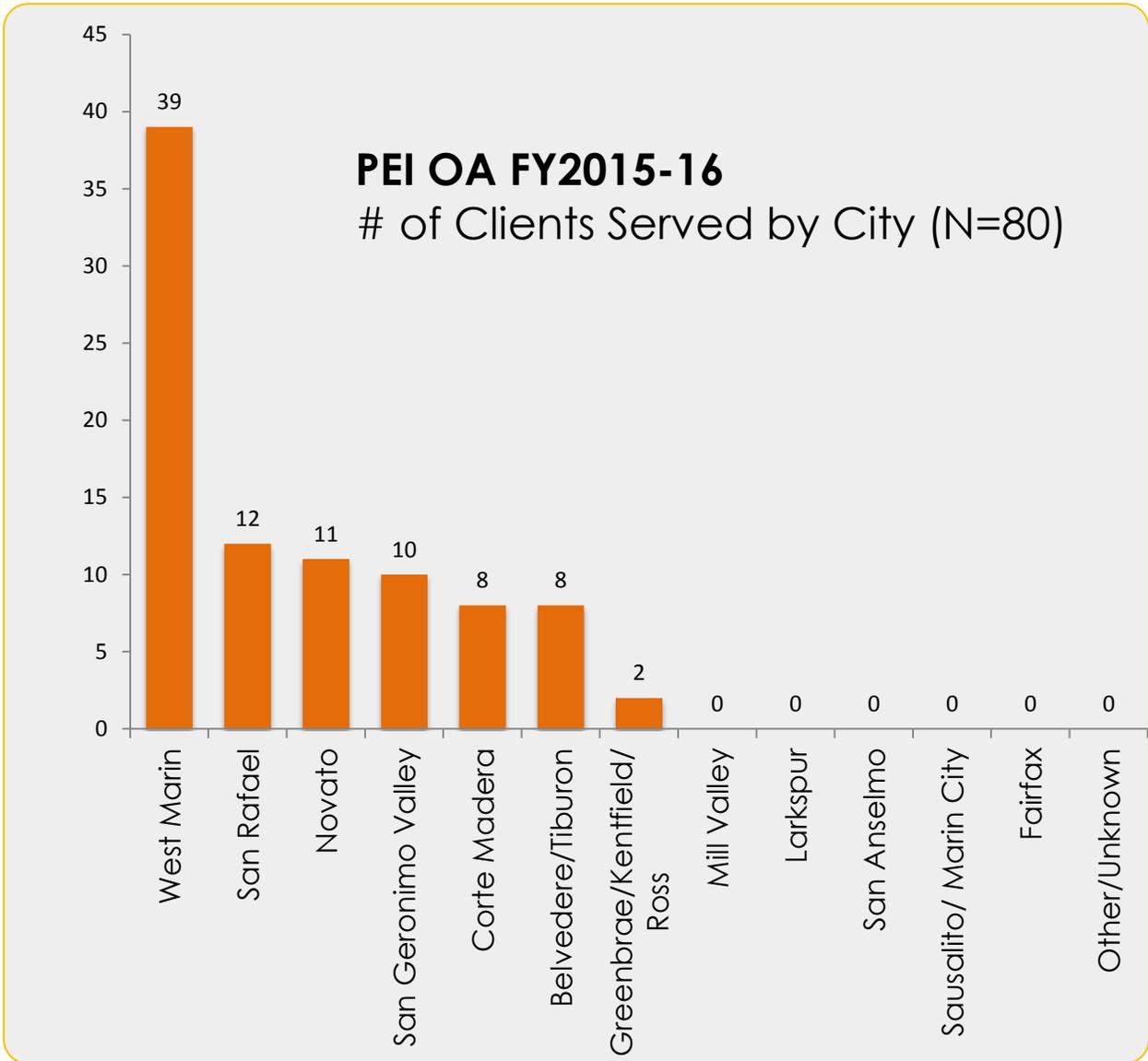


During the 2015-2016 Fiscal Year, the County of Marin's Older Adult PEI Program provided early intervention for 40 clients, most of whom are primarily English speaking. Older Adults who are primarily Spanish speaking are served by the Peer Counseling Program associated with the HOPE FSP.

PEI OA FY2015-16: AGE GROUP (N=40)



During the 2015-2016 Fiscal Year, the County of Marin's Older Adult PEI Program provided early intervention for 40 clients, 95% of whom were 60+ years old. Thirty eight percent (38%) of clients are between 85 and 98.



During the 2015-2016 Fiscal Year, the County of Marin's Older Adult PEI Program served clients throughout the County. Many of the clients have limited mobility, requiring home visits.

CLIENT STORY - OLDER ADULT PEI

Betty is a very frail 88 year old widow living with many medical challenges. Betty is pleasant, gracious, and not into “self-pity,” as she states. She is now wheelchair bound and is losing both her vision and hearing. Her many losses, of family, friends, health, mobility, sight, and hearing, have left her depressed and anxious. Betty’s symptoms include difficulty sleeping, increased social isolation, pervasive worry, and deep distress about nearing end of life. The one long-time involvement Betty had with a meaningful social organization abruptly ended when she was asked to resign to make room for “new blood,” leaving her more isolated and distressed. Betty shared that she is not ready to die yet, as there are so many things she still wants to do in this world. Due to her disabilities, she wondered how to continue living. Our work with Betty focused on how to re-engage in the activities that gave her life meaning. Through cognitive behavioral interventions and behavioral activation, Betty learned to manage the negative thoughts which were immobilizing her, and identified new ways she could participate in activities that were meaningful to her. Recently, Betty came up with the phrase “little bits of chocolates” to describe how these small comforts - people, memories, happy moments - can help when life feels overwhelming. With therapist support and intervention, Betty has learned new ways to get around or get over the “speed bumps” of life. The road is still a challenging one for Betty, but now she can find the joy and strength that were temporarily missing to make the rest of her journey worth taking.

VIETNAMESE COMMUNITY CONNECTION

PROGRAM OVERVIEW

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

TARGET POPULATION

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

PROGRAM DESCRIPTION

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

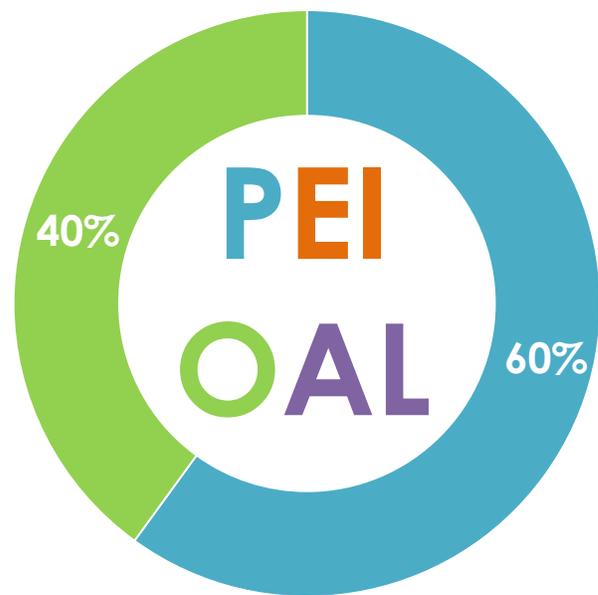
The Vietnamese Community Connection program aims to reduce prolonged suffering due to unaddressed mental illness by increasing identification of individuals with mental health difficulties and increasing protective factors for those with significantly higher risk for mental illness.

Vietnamese CC

SUMMARY FY2015-16

Clients Served: **FY2015-16**

200 Individuals
13 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

Outreach for Increasing Recognition:

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

Reducing Risk:

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

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

Individuals/families at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is achieved through assessment and referral by the program's behavioral health provider. CHAs and others front-line workers are trained to identify signs and symptoms and refer clients to the behavioral health provider as needed. The behavioral health provider makes referrals to County 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. PEI staff maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

EXPECTED OUTCOMES

Vietnamese Community Connection is intended to:

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

A survey will be completed by participants at the end of services regarding the impact of the services.

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

The program achieves the intended results due to implementing program practices that have been shown to achieve positive impacts. CHA's attended Mental Health First Aid (SAMHSA NREPP) and received training based on Marin's promotores program model.

ACTUAL OUTCOMES

In FY2015-16, the program coordinated the CHAs, conducted community outreach, provided problem solving services for individuals and families, and linked community members to needed services.

Outcomes for FY2015-16	Goal	Actual
Community Health Advocates (CHAs) will receive training in: <ul style="list-style-type: none"> ○ CHA Basics: role, confidentiality, outreach and engagement, making referrals, etc. ○ Mental Health First Aid 	5	3 1
CHAs will receive at least 6 hours each of group or individual supervision.	100%	100%
Individuals receiving information about mental health and access to services via tabling and other outreach strategies.	75	80
Individuals participating in group activities.	120	120
Individuals participating in individual/family sessions.	NA	67

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

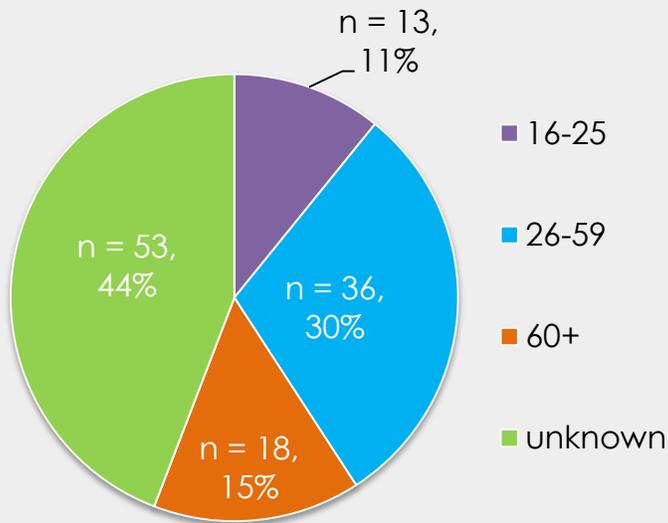
Participant feedback about the field trips: for 99% their mental state changed for the better, 100% would recommend to their friends or family members, 99% wish to have more trips like this in a year. N=120

Type of Participants in Outreach Events	Number Served
Community Members (Vietnamese)	49
Providers	
County Behavioral Health and Recovery Services	1
Education (including High School Students)	2
Primary Health Care	5
Social Services (County and Community)	3
Other – List: Family Law Office	2

PROGRAM CHALLENGES

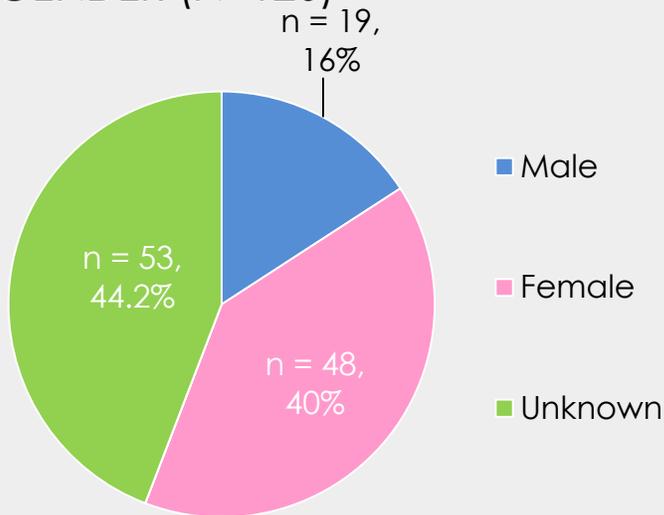
Marin Asian Advocacy Project (MAAP) is enthusiastic about the CHA model, but has had challenges with implementation including recruitment and training/supervision. BHRS is providing increased technical assistance in developing the CHA model.

**PEI VCC FY2015-16:
 AGE GROUP (N=120)**



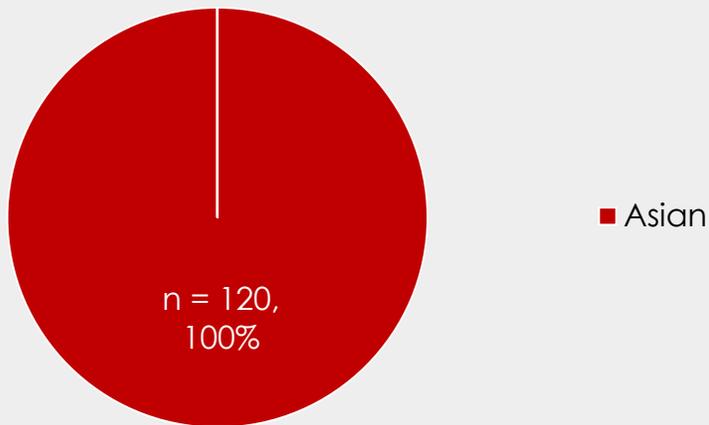
During the 2015-2016 Fiscal Year, the County of Marin's Vietnamese Community Connection Program reached all ages of the Vietnamese community.

**PEI VCC FY2015-16:
 GENDER (N=120)**



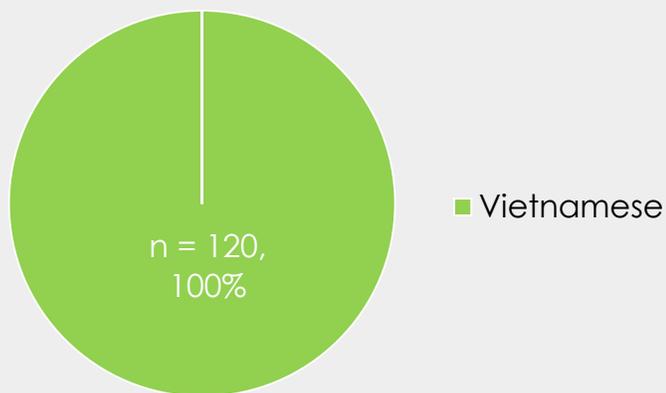
During the 2015-2016 Fiscal Year, the County of Marin's Vietnamese Community Connection Program reached 120 individuals of which 48 were females and 19 were males.

**PEI VCC FY2015-16:
RACE/ETHNICITY (N=120)**

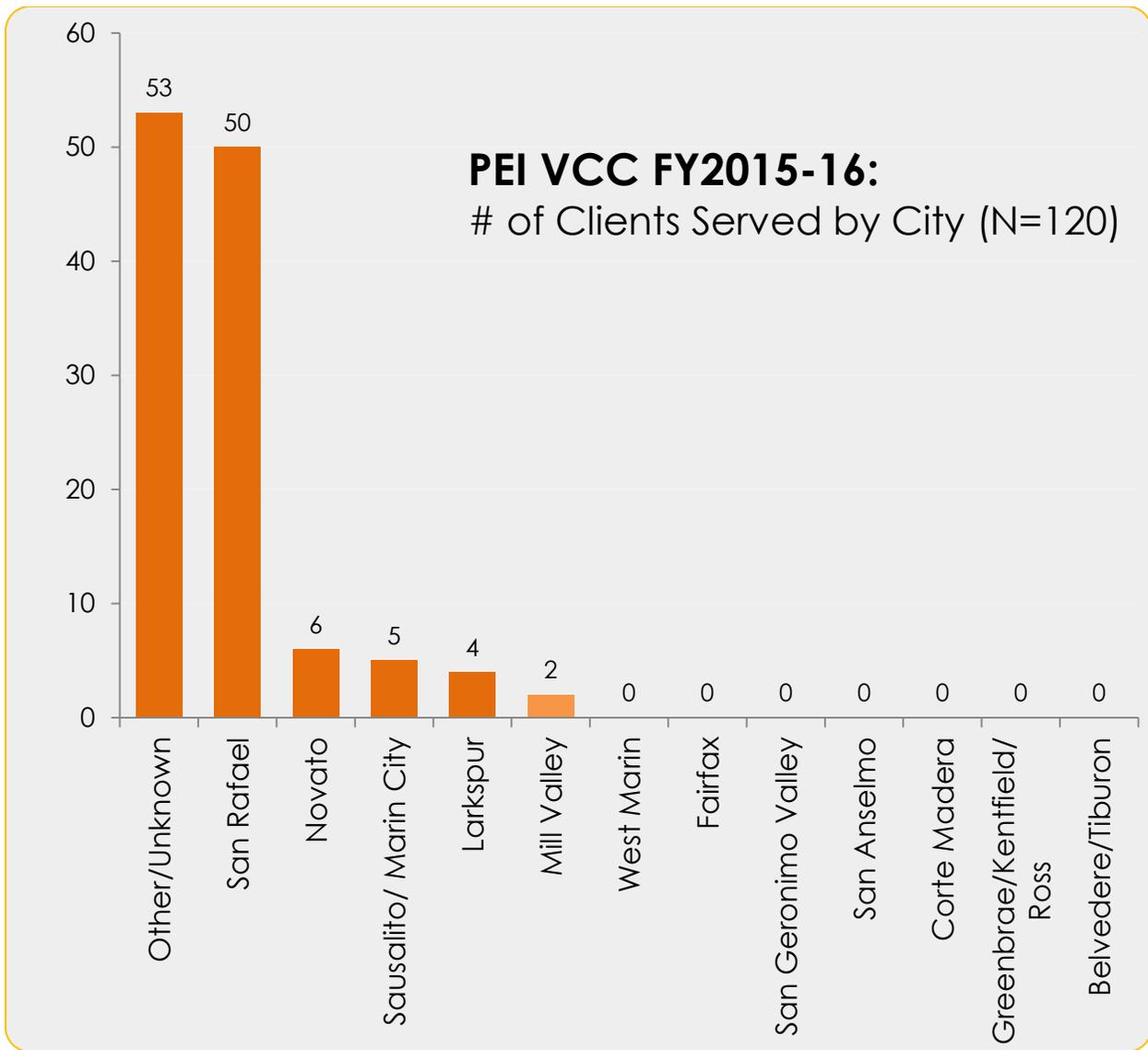


During the 2015-2016 Fiscal Year, the County of Marin's Vietnamese Community Connection program reached their target population and provided services almost exclusively in Vietnamese.

**PEI VCC FY2015-16:
PRIMARY LANGUAGE (N=120)**



During the 2015-2016 Fiscal Year, the County of Marin's Vietnamese Community Connection program reached their target population and provided services almost exclusively in Vietnamese.



During the 2015-2016 Fiscal Year, the County of Marin's Vietnamese Community Connection program provided most of their services in San Rafael, but some outreach and individual services are provided elsewhere in the county.

CLIENT STORY - VIETNAMESE COMMUNITY CONNECTION

Loan is a lady in her 40s, who has moved to San Rafael from Oakland about a year ago. She has been living in the US less than 5 years with her teenage daughter and working as a nail tech in Marin County. One day she passed out at her work and was sent to ER. They told her to continue seeing her primary doctor for her problems. Many times she went to her appointments with the primary doctor but always ended up on pain killer medication. But her problem was not solved by pain killer medicine. She got very frustrated. She came to our office and requested someone to accompany her to her next appointment.

We went to her appointment. First the doctor asked for interpreter services through the phone, as is their policy. The client did not understand what the interpreter said because of her different dialect due to different regions in Vietnam. Last but not least, the interpreter cut her off and did not let her complete explanations of her problems. She grew more frustrated and broke down crying.

The PEI provider explained to the doctor what was the problem, as she is a medical interpreter. I observed that the interpreter on the phone was omitting some doctor's information as well as cutting off the patient's explanations. Finally, the doctor was able to help her to treat her problems correctly.

The client reported after a week: "I am so happy that you were with me that day and explained clearly what were my problems to the doctor. I got right treatment. I feel much better now!"

COMMUNITY AND PROVIDER PREVENTION AND EARLY INTERVENTION TRAINING

PROGRAM OVERVIEW

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

TARGET POPULATION

The target population for this program is:

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

PROGRAM DESCRIPTION

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

Mental Health First Aid (MHFA) is an 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.

MHFA trainings are offered throughout the community. In the past, three to five trainings have been offered per year. Trainings include standard, youth, and Spanish. The type of trainings, locations, and frequency depend on the demand for the trainings.

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

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

EXPECTED OUTCOMES

Community and Provider Trainings are intended to:

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

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

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

ACTUAL OUTCOMES

Mental Health First Aid Outcomes for FY15-16	Actual
Number of Marin County community members that participated in MHFA. Of these, 69 attended the course in Spanish and 26 attended Youth MHFA.	263
Participants reporting increased knowledge about mental illness signs/symptoms. (0-5 scale)	<i>N=210</i>
“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.”	4.5
Participants reporting feeling able to offer a distressed person basic “first aid” information and reassurance about mental health. (0-5 scale)	4.5
Participants reporting ability to assisting somebody experiencing a mental health problem or crisis to seek appropriate professional help. (0-5 scale)	4.5

Type of Participants in MHFA	Number Served
Community Members	50
Family Member of Person with Serious Mental Illness	1
Providers	
County Behavioral Health and Recovery Services	8
Community-based Mental Health and/or Substance Use Provider	12
Education (including High School Students)	24
Law Enforcement	2
Primary Health Care	7
Senior Centers/Services	14
Social Services (County and Community)	20
Veterans	1
Faith-based	45
Shelters/Homeless Services/Public Housing	5
Libraries	3
Public Transit	
Employment	6
Other – List: DV, BOS, Parks Svcs, PH	14
Security, Emergency Svcs	4
Unknown	47

OTHER OUTRACH AND TRAINING ACTIVIES IN FY2015-16

Marketed the 30-minute video segments produced by Community Media Center in partnership with the Cultural Competence Advisory Board in 2014-15: three “Meaningful Mental Health” and three “Latinos en la Casa.” Aired on the Community Channel and available on YouTube and the BHRS website at: www.marinhhs.org/bhrs.

- Community outreach and education events including “May is Mental Health Month” (See Appendix II – May Is Mental Health Month Materials)and “Day of the Dead”
- Conference Registrations for staff and interns supporting PEI programs
- Triple P Trainings
- BHRS Calendar featuring client artwork and information about mental health

SCHOOL AGE PREVENTION AND EARLY INTERVENTION

PROGRAM OVERVIEW

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

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

TARGET POPULATION

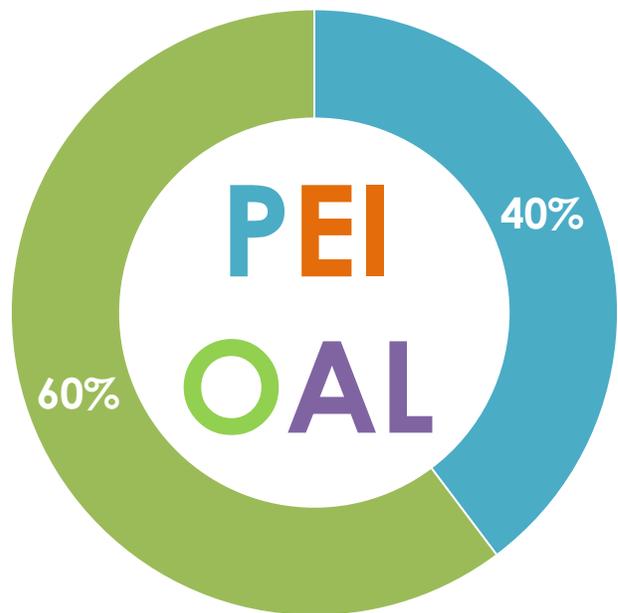
The target population is kindergarten through eighth grade students (ages 5-14) who may be experiencing emotional disturbance or are at significantly higher risk due to adverse childhood experiences, severe trauma, poverty, family conflict or domestic violence, racism and social inequality or other factors. Classrooms and students may be referred for services through school staff, Success/Study Teams (SST), or Student Attendance Review Teams (SART) and Boards (SARB). They will then be assessed to determine whether they are appropriate for PEI services or are linked to other services. The program is targeting three areas of Marin County at this point:

Bay Area Community Resources

SUMMARY FY2015-16

Clients Served: **FY2015-16**

677 Individuals
77 Families



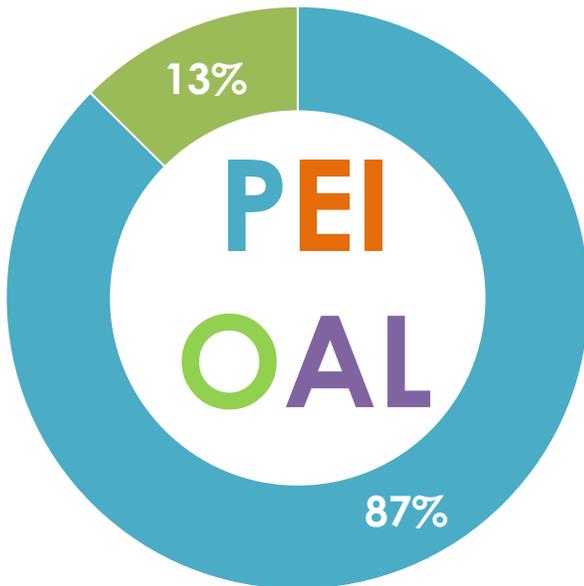
- Prevention
- Early Intervention
- Outreach
- Access and Linkage

Marin City Community Services District

SUMMARY FY2015-16

Clients Served: **FY2015-16**

159 Individuals
0 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

Seneca Family of Agencies

SUMMARY FY2015-16

Clients Served: **FY2015-16**

1223 Individuals
79 Families



- Prevention
- Early Intervention
- Outreach
- Access and Linkage

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

* Percentages are approximate.

PROGRAM DESCRIPTION

- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Prevention: Reducing Risks Related to Mental Illness

The primary objective of this program is to reduce risks related to emotional disturbance and prevent further impairment in functioning. In addition, programs provide training for parents, school staff and community providers to identify and respond to signs for mental illness.

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

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

Individuals/families at risk or showing signs of developing serious emotional disturbance or mental illness will be linked to services as needed. These services may be provided by the PEI program, the school, community based organizations, or other available providers. Individuals eligible for services through health coverage, including Medi-Cal, Early Periodic Diagnosis Screening and Treatment (EPDST), or private coverage will be referred to those resources. Individuals experiencing symptoms of serious mental illness or emotional disturbance will be referred to Marin County 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. PEI staff maintains relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

San Rafael City Schools

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

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

Sausalito Marin City School District

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

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

Shoreline School District

Bay Area Community Resources (BACR) provides an array of services: Stigma reduction is addressed through education for school staff, students and families about mental health and available resources. Evidence based social emotional 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.

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) and Strong Start/Strong Kids (evidence based practice, 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.

EXPECTED OUTCOMES

School Age PEI is intended to:

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

The numbers and types of individuals trained will be tracked.

- Reduce prolonged suffering for those at significantly higher risk of mental illness by increasing protective factors and reducing risk factors.

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

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

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

ACTUAL OUTCOMES

The School Age PEI program began in FY2014-15 with three different models of service in three different school districts, depending on the local needs. There has been an effort to have all programs use the same core methods for assessing outcomes: the Strengths and Difficulties Questionnaire (SDQ) (validated) and school attendance and performance records. The school districts have different procedures regarding releasing that data, and therefore might not be a viable measure for some programs.

San Rafael City Schools/Seneca Outcomes for FY2015-16	Goal	Actual
Behavioral health trainings for school staff.	2	2
Participation of school staff in trainings.	75%	GL 85% VV 100%
Participants reporting increase in skills/knowledge. <i>Participant survey</i>	80	100% N=64
Students participating in Social Emotional Skills groups.	60	55
SES group participants showing statistically significant improvement on SDQ	80%	73% N=44
Students (or parents of) participating in SES groups reporting satisfaction with services (would recommend, participate again, etc). <i>PEI Survey</i>	75%	87-100% N=34

Sausalito Marin City School District/MCCSD Outcomes for FY2015-16	Goal	Actual
Southern Marin providers and community members receiving behavioral health education, information about Community Connector (CC) services.	40	40
Students/families receiving outreach, engagement, referral services from CCs	20	32
Students/families receiving support, advocacy and coordination services from CCs	20	14
Youth/families receiving support services from CCs achieving at least 40% of the goals in their action plan. <i>Case records</i>	60%	45% N=14
Students participating in at least 20 Girl Power Groups.	50	53
Students participating in CC support services or Girl Power Groups showing improved risk factors, increase in school attendance and/or improved school performance. <i>SDQ, school records</i>	60%	85% N=53

The current data for Marin City CSD does not fully describe the range of work or impact. For example, the Community Connectors were instrumental in implementing a Walking School Bus as well as a weekly parents group at the school. The school reports the following outcomes:

- *An average of 27 students participate in the Walking School Bus each day*
- *The average number of absences per day reduced from 13 to 6*
- *The average number of tardies per day reduced from 17 to 7*

Shoreline School District/BACR Outcomes for FY2015-16	Goal	Actual
Behavioral health training for school staff	8 hrs	4 hrs
Training participants reporting awareness of risks, signs, and symptoms of children experiencing emotional disturbances and/or risk of abuse. (Post-survey)	80%	91% N=43
Students, parents, community members participating in psycho-education, anti-stigma and resource events (i.e. anti-bullying workshops, outreach at parent gatherings, etc).	NA	350
Students participating in self-regulation curriculum. (162 participated in at least 8 sessions)	350	253
Students with mild to moderate mental health concerns receiving at least 3 sessions of individual or group counseling.	40	68
Students (or parents of) receiving at least 3 sessions reporting improvement on the SDQ (emotional problems, conduct problems, hyperactivity problems, peer problems and/or socialization).	65%	97% N=31
Students completing at least 3 sessions showing improved attendance or improved school performance.	65%	88% N=63
Parents completing at least 3 sessions family counseling.	20	37
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	65%	78% N=7
Parents receiving 3 or more counseling services reporting satisfaction with the PEI services (would recommend, use again, etc).	75%	86+% N=21

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

PROGRAM CHALLENGES

While all programs have implemented the Strengths and Difficulties Questionnaire (SDQ) for evaluation, only one of the three districts has provided attendance and performance data. The other two are in conversation with the school districts about it. In general, ensuring the school administration is supportive of the programs needs further attention.

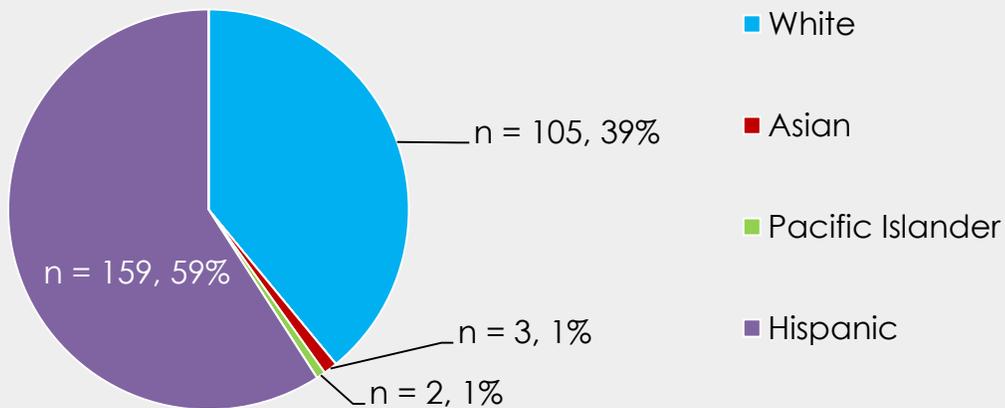
Bay Area Community Resources (BACR) Data

PEI BACR FY2015-16: AGE GROUP (N=269)



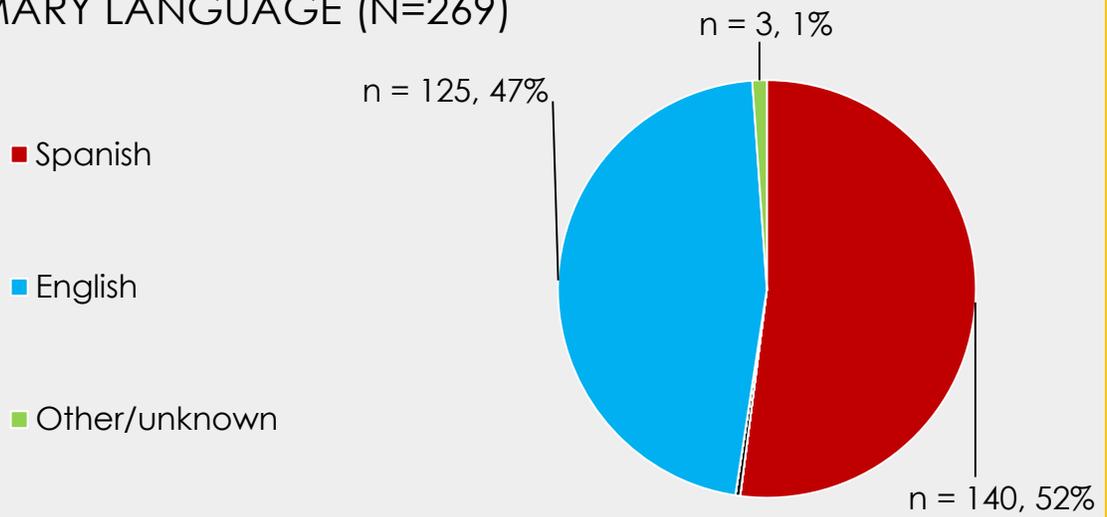
During the 2015-2016 Fiscal Year, BACR provided risk reduction services for 269 K-8 students through Marin County's School Age PEI Program.

PEI BACR FY2015-16: RACE/ETHNICITY (N=269)



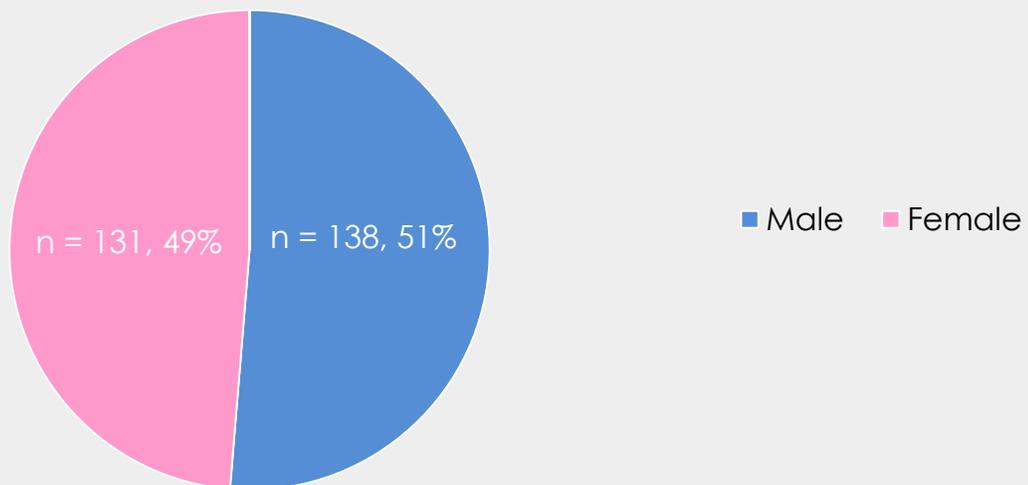
During the 2015-2016 Fiscal Year, BACR served the Shoreline School District which has primarily White and Latino students.

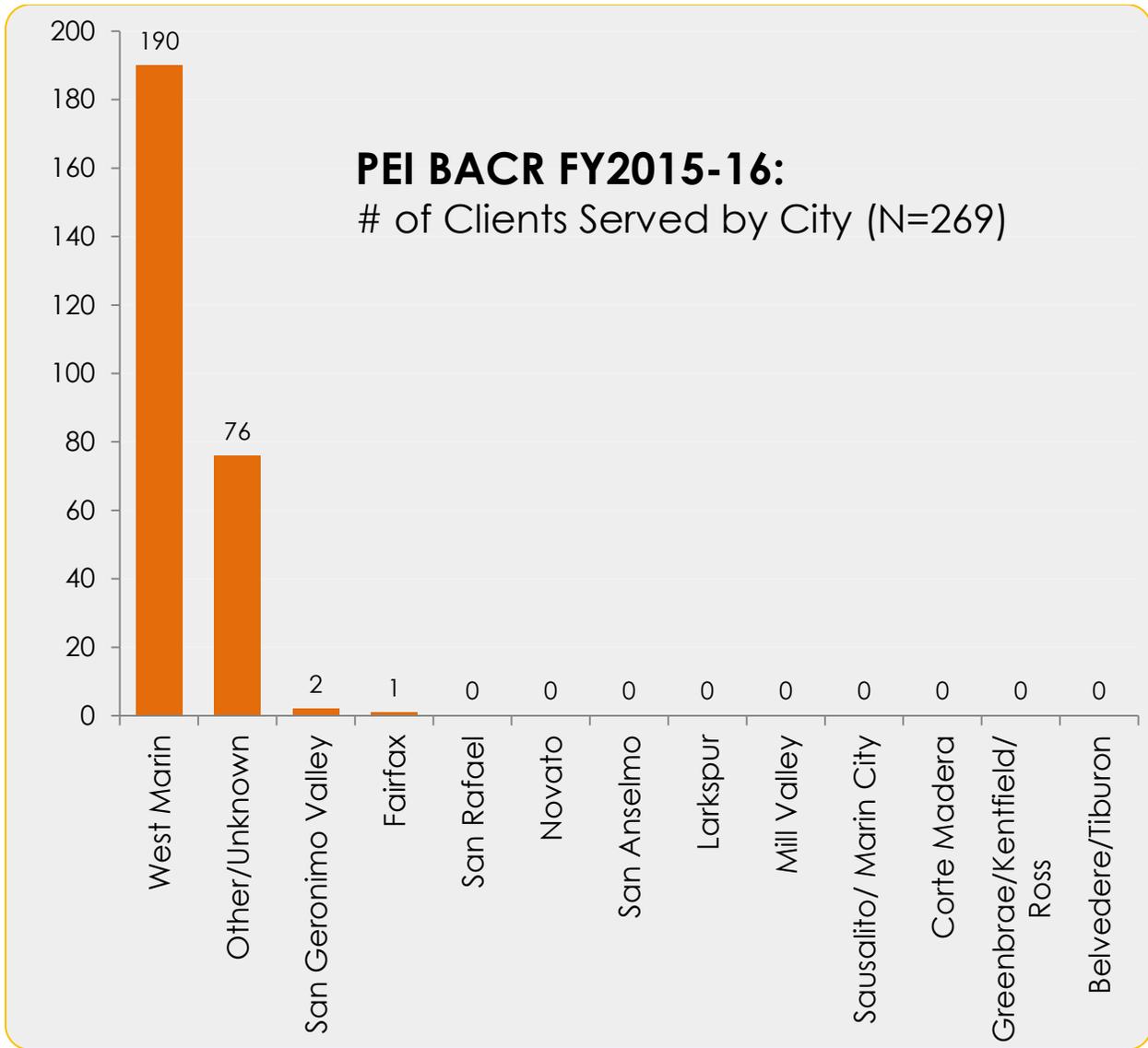
PEI BACR FY2015-16: PRIMARY LANGUAGE (N=269)



During the 2015-2016 Fiscal Year, BACR reached 140 primarily Spanish speaking students, most of whom are also fluent in English, 51 percent were male and 49 percent were female.

PEI BACR FY2015-16: GENDER (N=269)

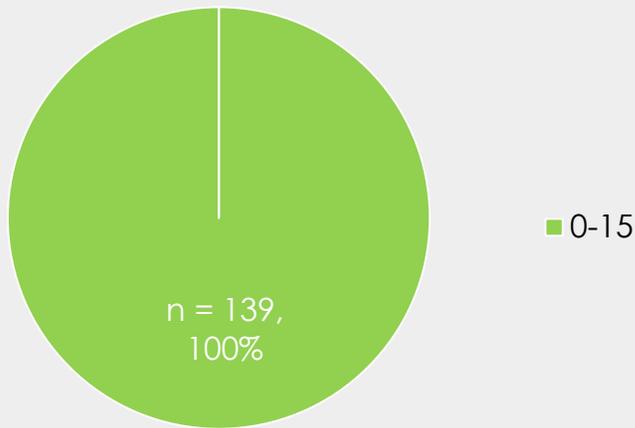




During the 2015-2016 Fiscal Year, BACR served the Shoreline School District which is located in West Marin, a geographically isolated community with limited services.

Marin City Community Services District (MCCSD) Data

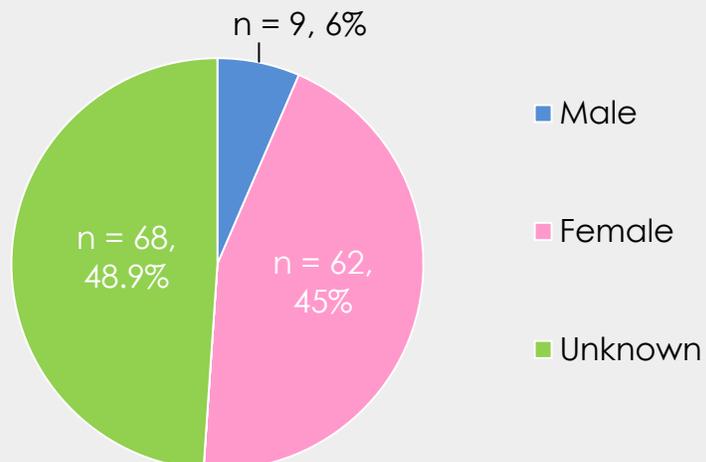
PEI MCCSD FY2015-16: AGE GROUP (N=139)



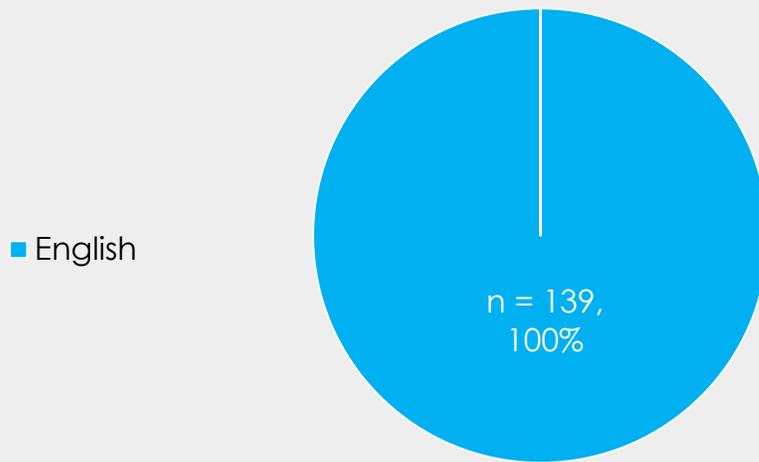
During the 2015-2016 Fiscal Year, the Marin City CSD School Age PEI Program provided risk reduction services to 139 K-8 students through Marin County's PEI program.

During the 2015-2016 Fiscal Year, the Marin City CSD School Age PEI Program provided risk reduction services to 139 K-8 students through Marin County's PEI program. Of these 139 students, 9 were male, 62 were female and 68 did not provide a response.

PEI MCCSD FY2015-16: GENDER (N=139)

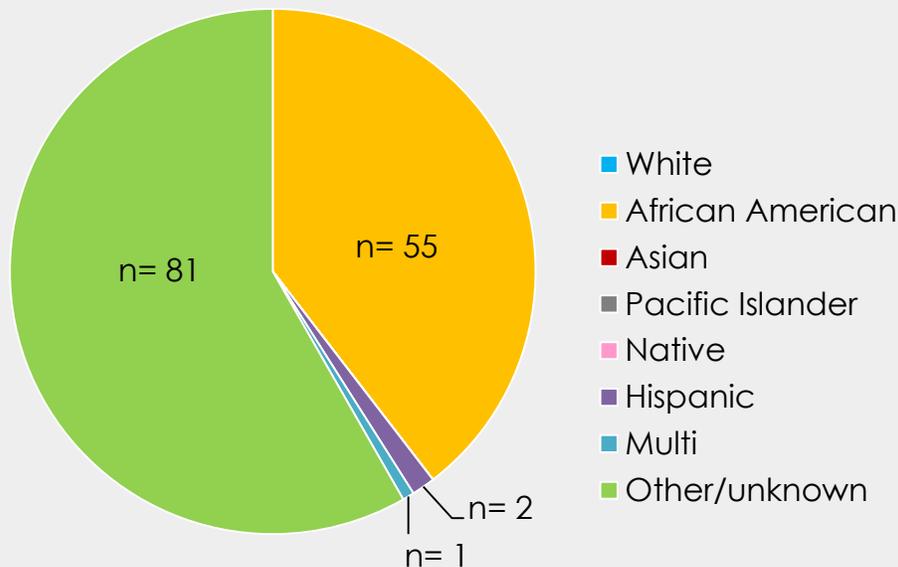


PEI MCCSD FY2015-16: PRIMARY LANGUAGE (N=139)

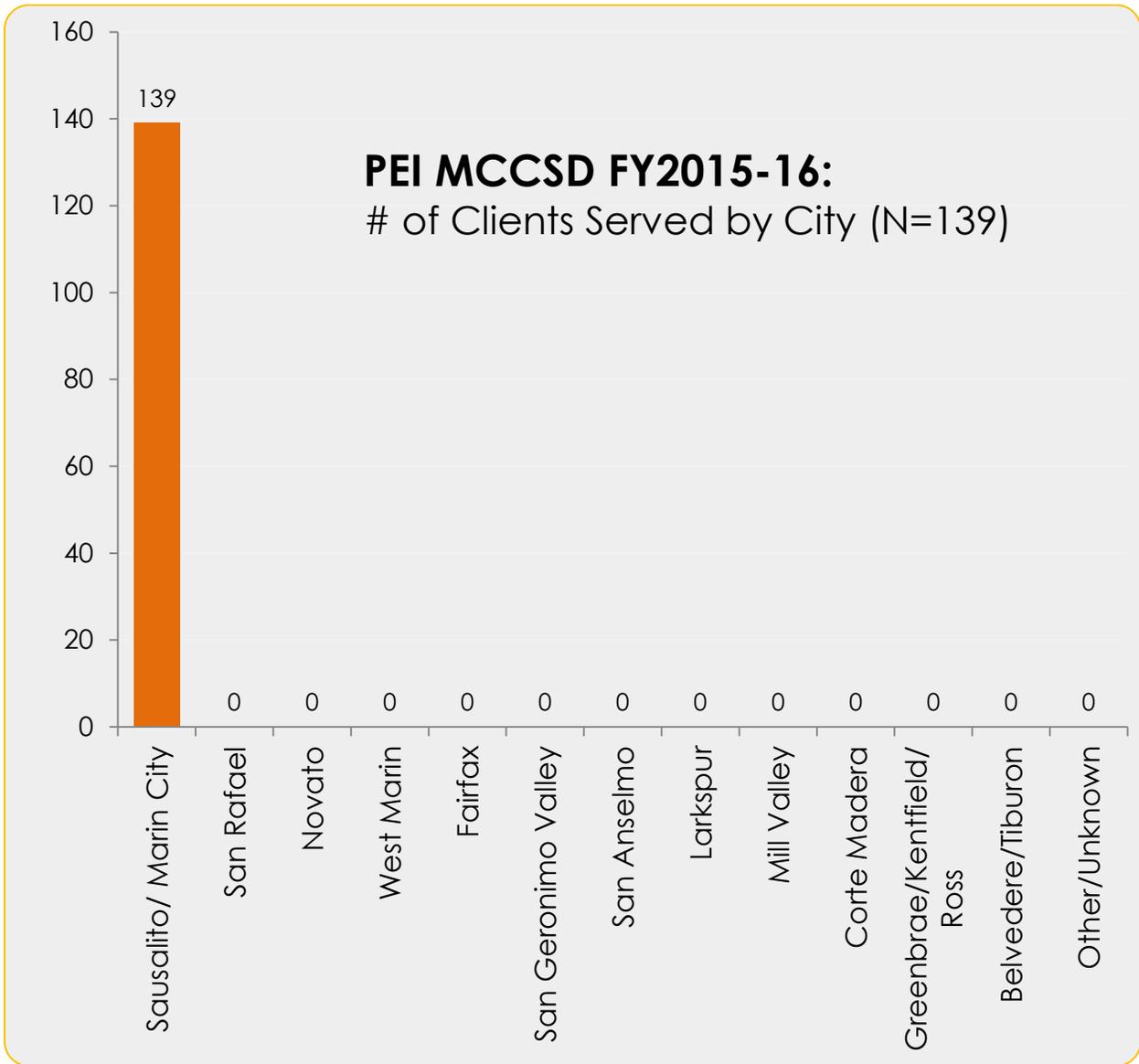


During the 2015-2016 Fiscal Year, MCCSD served students and families in Marin City, a diverse, low-income community.

PEI MCCSD FY2015-16: RACE/ETHNICITY (N=139)



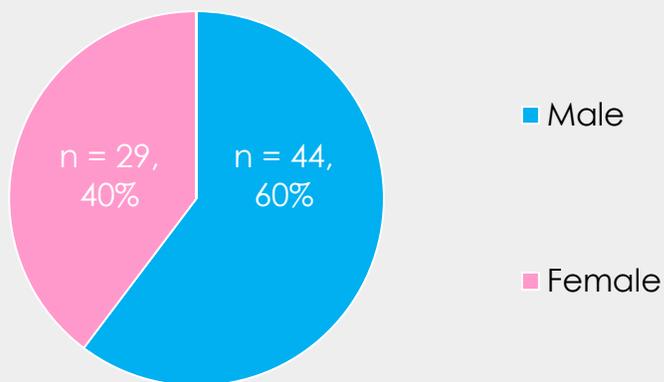
During the 2015-2016 Fiscal Year, MCCSD served students and families in Marin City, a diverse, low-income community.



During the 2015-2016 Fiscal Year, MCCSD provided services within the Sausalito Marin City School District.

Seneca Data

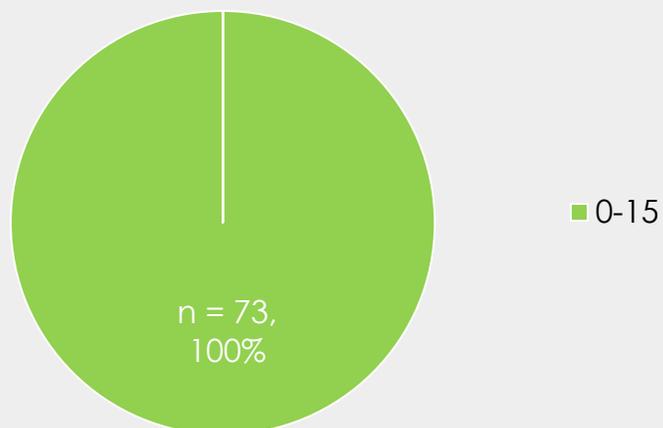
PEI SENECA FY2015-16: GENDER (N=73)



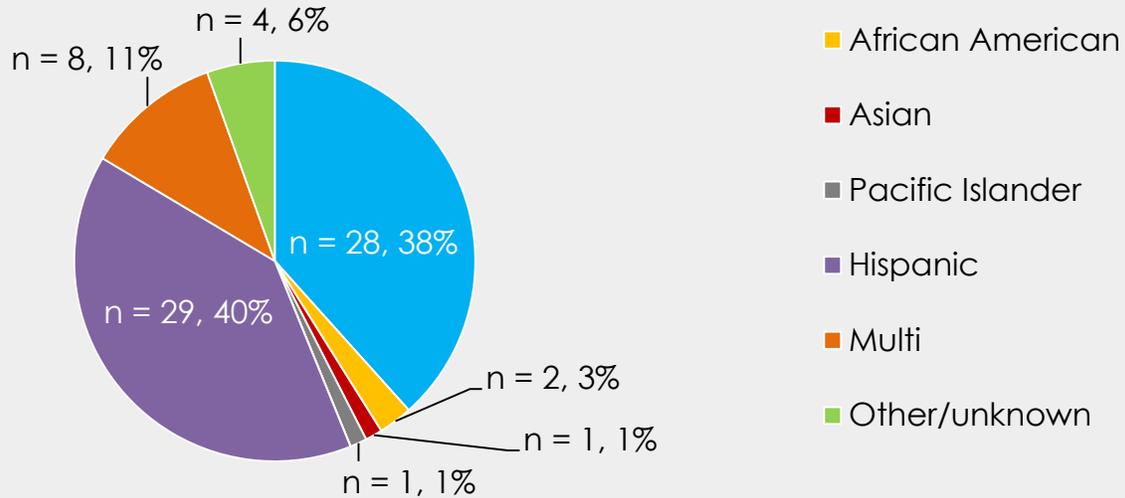
During the 2015-2016 Fiscal Year, Seneca's School Age Program provided risk reduction services for 73 K-8 students through Marin County's PEI program. 60% were male and 40% were female.

During the 2015-2016 Fiscal Year, Seneca's School Age Program provided risk reduction services for 73 K-8 students through Marin County's PEI program.

PEI SENECA FY2015-16: AGE GROUP (N=73)

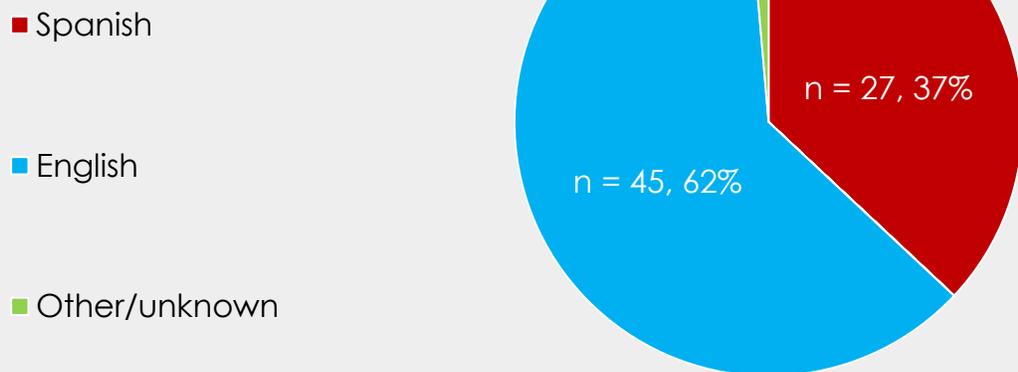


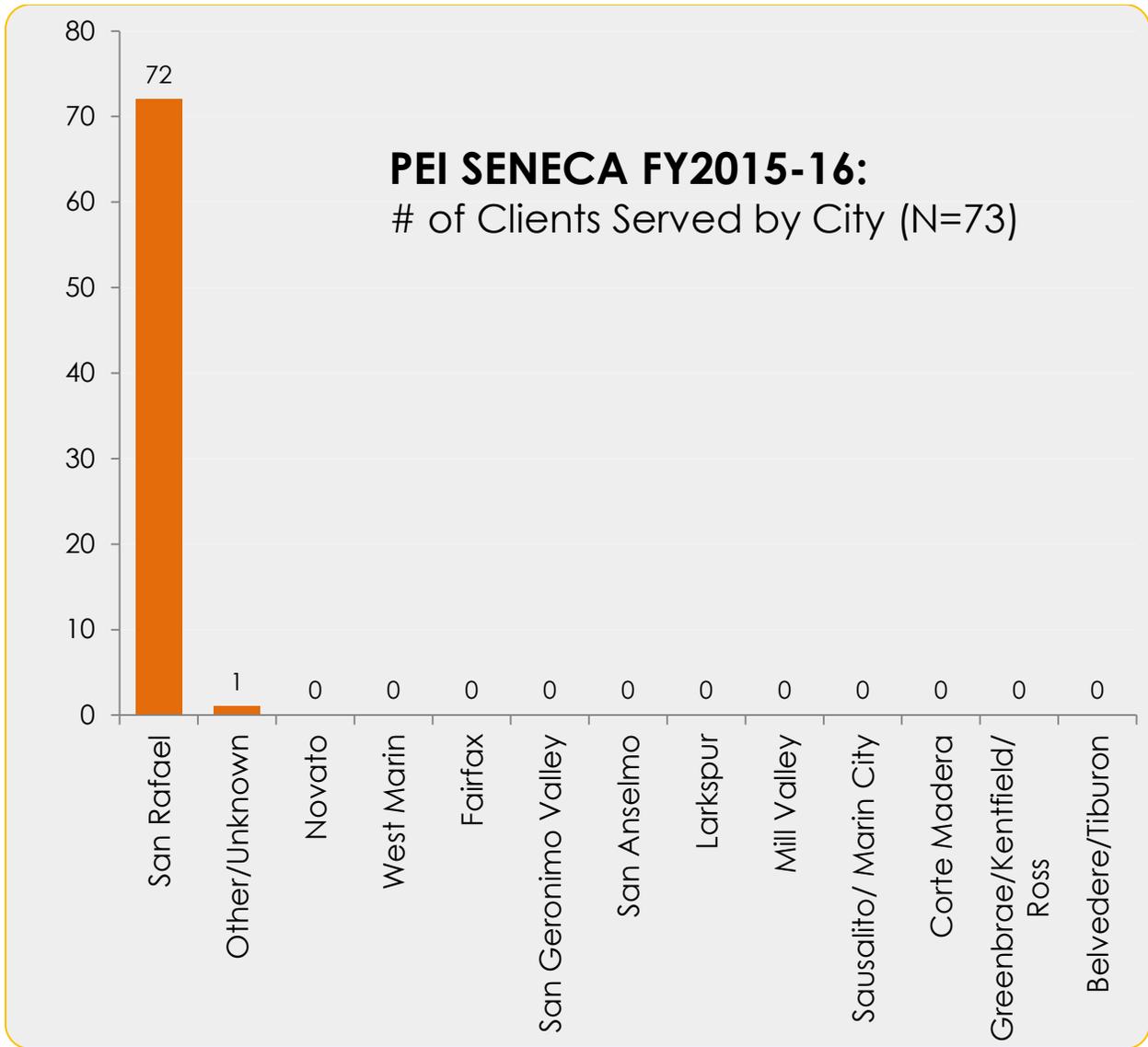
**PEI SENECA FY2015-16:
 RACE/ETHNICITY (N=73)**



During the 2015-2016 Fiscal Year, Seneca provided PEI services in the San Rafael City Schools, a diverse community composed of multi-lingual individuals of various ethnicities.

**PEI SENECA FY2015-16:
 PRIMARY LANGUAGE (N=73)**





During the 2015-2016 Fiscal Year, Seneca provided services in the San Rafael City Schools, the largest population center in Marin County.

CLIENT STORY - SCHOOL AGE PEI

An eighth grade student, Anna, was referred to the PEI specialist. Anna had recently moved in with her grandmother, mother and sibling and was enrolled in a Shoreline school. Previously, she had two psychiatric hospitalizations and was on a home school program due to her psychiatric conditions. She was diagnosed with social anxiety disorder and panic disorder and would become overwhelmed before leaving for school although she would get prepared and anticipate attending. She was receiving treatment from Kaiser so was not able to access County BHRS. Anna wanted to attend school. She wanted to improve her grades and prepare for high school, make her family proud, but her anxiety overwhelmed her and prevented her from walking out the door for school. Anna, her family members, treatment providers and the PEI specialist worked together during home visits to understand her anxiety, create goals and routines, increase her support system and return to school. Anna was able to return to school, connect with teachers and peers, and bring her grades up. She continued to see the PEI specialist at school where a number of issues were addressed and she was able to graduate middle school with her class. Anna will be attending her first year of high school in Fall 2016.

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 with a mental illness.

TARGET POPULATION

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

PROGRAM DESCRIPTION

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

This program does active outreach and support for Veterans, particularly those who are homeless or involved in the criminal justice system, to link them to medically necessary mental health services. Many of the Veterans are provided the support they need, such as transportation and entry into housing and Veterans Administration (VA) benefits, to access needed mental health services. Some are already connected to the VA and have a mental health treatment plan. The VA usually covers clinical treatment costs associated with the plan, but there are many barriers to a veteran completing their treatment. When they do not complete their treatment, they are at high risk for escalating mental health needs, as well as recidivism.

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

- Outreach and engagement.
- Case management, linking clients to housing, behavioral health services, and more.
- Assistance with logistical barriers to completing a treatment plan.
- Ongoing contact to increase likelihood of engaging with services.
- Services for significant support people, such as family.
- Assistance with obtaining other forms of support available to the veterans and their families, such as financial benefits or community resources.

The program will improve timely access to services for underserved populations by providing the support services needed to access treatment that is available, and required. These support services

are provided by a veteran who can meet the client where they are literally and figuratively, and can help to de-stigmatize the situation. Access and linkage to treatment will be provided by the case manager or the VA.

EXPECTED OUTCOMES

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

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

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

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

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

ACTUAL OUTCOMES

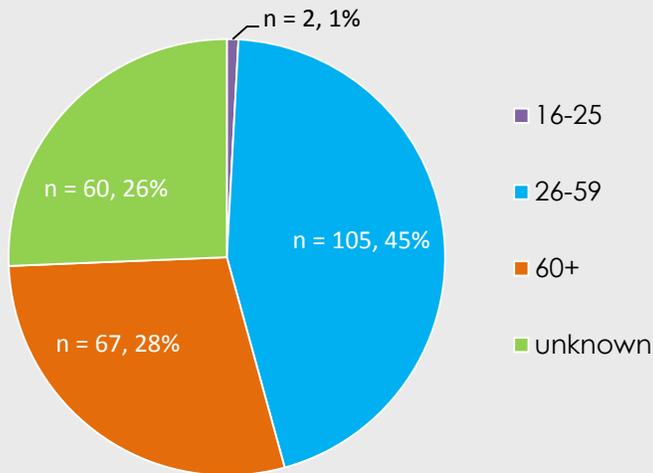
The program staff person has been out on extended medical leave, and therefore only partial FY2015-16 program data is available at this time. Since starting in February 2015, the program has worked with many veterans with mental illness ensuring they completed mental health treatment plans and linking them to other support services to reduce prolonged suffering. In particular, clients were successfully linked to housing, employment assistance, and substance use services.

PROGRAM CHALLENGES

For much of FY2016-17 the PEI staff person has been on leave. Recently approval was granted for hiring a temporary worker to fill that position.

Outcomes FY2015-16	Goal	Actual FY2015-16
Prevention		
Number of veterans that received support services to increase likelihood of completing the veteran's mental health treatment plan. (Average number of services: 8)	120	234
Number of family members that received services to increase their capacity to support the client.	20	NA
Percent of veterans receiving support that complied with their mental health treatment plan.	80%	NA
Satisfaction		
Clients receiving support services reporting satisfaction with the services: <ul style="list-style-type: none"> • would use the services again in the future • would be very or somewhat likely to recommend the services • agree or strongly agree staff were culturally sensitive • report services were very or somewhat helpful in addressing their problems 	75%	NA

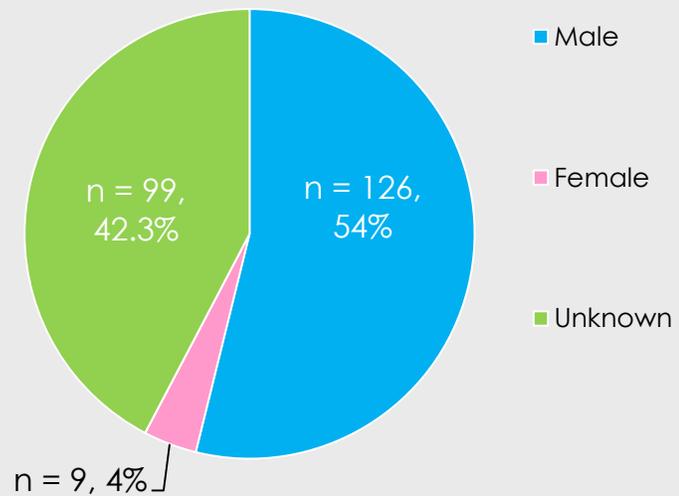
PEI VETERAN'S FY2015-16: AGE GROUP (N=234)



During the 2015-2016 Fiscal Year, the County of Marin's Veteran's Community Connection served 234 Veterans the majority of which were 26-59 years old.

During the 2015-2016 Fiscal Year, the County of Marin's Veteran's Community Connection served 126 males, 99 unknown, and 9 females.

PEI VETERAN'S FY2015-16: GENDER (N=234)



CLIENT STORIES – VETERAN'S COMMUNITY CONNECTION

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

He had a bi-polar diagnosis and it was decided to release him to the Veterans Community Connection case manager on Tuesday. The case manager met the veteran at the hospital and the he agreed to be medication compliant. The case manager immediately secured him temporary housing through the use of the REST Program, a rotating emergency shelter program, administered by St. Vincent De Paul (at almost 5PM), ensured he had food, took him to pick up his medication at a pharmacy and introduced him to REST staff.

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

.....

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

STATEWIDE PREVENTION AND EARLY INTERVENTION

PROGRAM OVERVIEW

In FY2015-16, Marin County contributed PEI funds to support the California Mental Health Services Authority (CalMHSA) to conduct statewide efforts to reduce suicide and reduce stigma and discrimination. 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

In addition, Marin provides funding to the regional North Bay Suicide Prevention Program run by Buckelew Programs. Three other counties participate in this regional project. The 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

CalMHSA targets all California residents.

The Suicide Prevention Hotline 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%).

ACTUAL 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

The full report, “On the road to Mental Health: Highlights from Evaluations of California’s Statewide Mental Health Prevention and Early Intervention Initiatives,” is available at www.rand.org/pubs/research_briefs/RB9917.html. Also see Appendix III – Statewide PEI for an overview of the impact of Statewide efforts on Marin County.

The Suicide Prevention Hotline collects data for each participating county.

Suicide Prevention Hotline/Buckelew Outcomes for FY2015-16	Goal	Actual
Calls to hotline originating in Marin County	6-8000	8327
Callers who express a reduction in level of suicidal intent by 1 level of maintain Low (Low, Medium, High)	-	92% N=5378
Agencies receiving campaign materials from FSA	20	20

CLIENT STORY - SUICIDE PREVENTION HOTLINE

A 16 year old female called the hotline late one night crying and reported that she wanted to kill herself. She stated that her step-father didn't support her or understand her and that she just had an argument with her mother. She felt alone, unheard, misunderstood, and uncared for and claimed that if her mother didn't listen to her, she would kill herself. The phone counselor listened empathically, gathered information about the situation, and assessed the caller's lethality. The caller reported that she had a plan for how she would attempt suicide and she had access to means in the house, but she refused to disclose her plan or the means. She also reported that she had been hospitalized in the past year for suicidality, all of which placed her at an elevated suicide risk. The counselor worked with the caller to help calm her down and tried to engage her in creating a safety plan. The caller was resistant and expressed fear of being hospitalized again. The counselor explained that she wanted to find ways to keep her safe so that she wouldn't need to go to the hospital. She then stressed the importance of letting her mother know how she was feeling and asked if she could speak with the caller's mother. The caller agreed and put her mother on the phone. The counselor shared her concerns for the caller's safety and gathered more information from the mother about the caller's history and the current stressors at home. The mother expressed concern and the counselor offered her support. The counselor advised the mother of options for keeping the caller safe, including resources to use in case of emergency. She then facilitated a conversation between the caller and her mother, asking the caller to share with her mother what she needed in order to keep herself safe. The caller asked her mother to stay with her that night and to call her therapist in the morning. The mother agreed. The counselor re-assessed the caller's lethality and the caller reported that she was feeling a little better and wasn't thinking of suicide any longer. They discussed additional coping skills to use if the caller feels herself getting upset again and the counselor reminded both the caller and the mother that the hotline is available 24/7 and encouraged them to call again if either one of them needed support. Both the mother and the caller expressed appreciation and agreed to call back if needed.

PREVENTION AND EARLY INTERVENTION (PEI) NUMBERS TO BE SERVED IN FY2016-17

Program	Type of Service	Individuals					Family Members	Providers	FY2016-17 Cost per Person Projected
		0-15	16-25	26-59	60+	Total			
Early Childhood Mental Health	Outreach							130	
	Prevention	640				640	83		\$360
Triple P	Prevention						219	20	\$300
Transition Age Youth	Prevention		102			102			\$450
	Early Intervention		261			261	70		\$400
	Access & Linkage	76	392			468			\$40
Latino Community Connection	Outreach					1,211		14	\$60
	Prevention		28	129	4	161	30		\$800
Integrated Behavioral Health	Early Intervention	6	15	142	22	185			\$800
	Access & Linkage					1,369			\$20
Older Adult PEI	Outreach					62	3	55	\$100
	Early Intervention				40	40	24		\$1,800
Vietnamese Community Connection	Outreach					67		17	\$150
	Prevention		36	100	51	187			\$350
PEI Training	Outreach					50	1	212	\$56
School Age PEI	Outreach						32	147	\$100
	Prevention	409				409	156		\$500
Veterans Community Connection	Prevention					NA			\$600
PEI Statewide	Suicide Prevention Hotline						8,327		\$12

**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
Subtotal Direct Services	\$1,806,060	\$1,806,060	\$1,806,060	\$5,418,180
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
Total	\$2,296,000	\$2,296,000	\$2,296,000	\$6,888,000

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

COMMUNITY SERVICES AND SUPPORTS (CSS)

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

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

Full Service Partnerships (FSPs)

Designed to provide all necessary services and supports – a “whatever it takes” approach - for designated populations. 51% of funding is required to be devoted to FSPs.

System Development (SD)

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

Outreach and Engagement (OE)

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

MHSA Community Supports and Services Program Outcomes

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

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

The County recognizes the need to better engage and serve diverse populations, especially those identified as un/underserved. In addition to PEI-funded efforts that increase engagement of underserved populations, CSS continues efforts to hire bilingual and bicultural staff and other strategies to better serve diverse populations.

The key outcome data for each program is included in each program section of this FY2017-18 Annual Update.

YOUTH EMPOWERMENT SERVICES (YES) FULL SERVICE PARTNERSHIP

PROGRAM OVERVIEW

Marin County's Youth Empowerment Services (YES), formerly known as the Children's System of Care (CSOC), is a Full Service Partnership program serving 40+ youth through age 21 who are at risk emotionally and behaviorally due to significant mental health issues.

This program was originally implemented as a Children's System of Care grant in the late nineties. In FY2005-06 the Mental Health Services Act began supporting a major portion of the program, enabling the program to expand beyond the juvenile justice focus of the original grant.

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, intensive based model with the goal of meeting youth and families in their homes and in the community to provide culturally appropriate mental health services with a 'whatever it takes' model.

TARGET POPULATION

YES serves youth through age 21 who present with significant mental health issues that negatively affect education, family relationships, psychiatric stability and substance use. For FY2015-16 most clients in this program were under 18 (N=38, 88% < 18 years old) 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).

PROGRAM DESCRIPTION

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

YES staffing consists of three (3) bilingual clinicians, one of whom is a Latino male working with students at Marin Community School. For FY2015-16, only 2 of the positions in this program were filled so capacity was reduced.

The YES program also utilizes family partners, parents who have had a child in the mental health or juvenile justice system, who are able to engage and support the parent in a unique manner because

of their life experience. Family partners provide support and guidance to parents in navigating the various systems and with parenting youth engaged in high-risk behaviors.

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

EXPECTED OUTCOMES

YES program objectives include serving 40+ youth per fiscal year to develop better coping skills to manage daily stresses and increase pro-social activities in the community (i.e., employment, sports, etc.) and to decrease substance use. Additional outcomes include increasing school attendance and performance and decreasing school suspensions, and decreasing days spent in a psychiatric hospital or in juvenile hall.

In the MHSA Three-Year MHSA Program and Expenditure Plan, there were three outcomes identified. During FY2014-15 it became clear that there is not sufficient school related data, and therefore the outcomes were revised. In FY2015-16 the YES Program began using the Child Adolescent Needs and Strength (CANS) instrument administered on admission and then every six (6) months.

ACTUAL OUTCOMES

In FY2015-16, the YES program served 43 clients with only 2 of 3 staff positions filled. 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 Marin City homes.

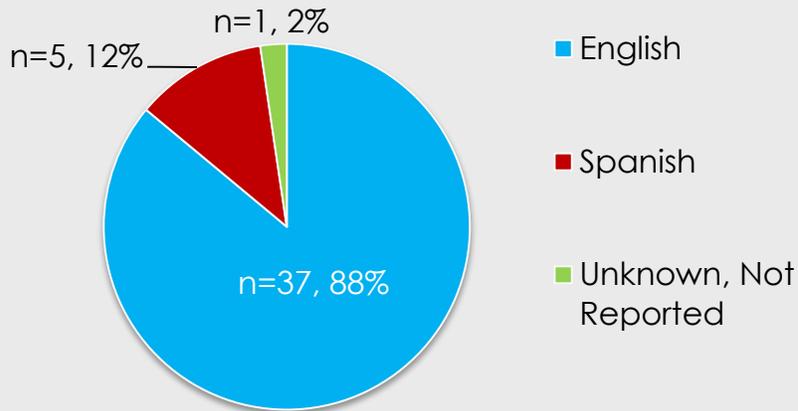
The YES program also supports our outreach efforts to reach unserved and underserved communities. 82% of YES clients identify as Hispanic, with 12% (N=5) reported as primarily Spanish speaking. In many cases, YES clients are bilingual, but family based services to parents often require a bilingual clinician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

CSS · YOUTH EMPOWERMENT SERVICES (YES)
PROGRAM ALLOCATION FY2015-16 · \$649,227

Three areas of focus during FY2015-16 included addressing client symptoms of early psychosis, addressing suicidal ideation and safety planning for clients at ongoing risk, and addressing substance use issues. Issues of trauma, including exposure to domestic violence, immigration trauma, and sexual abuse were salient issues in the YES client population. For FY2016-17, CANS ratings for these three (3) factors at six (6) month intervals will be reviewed to determine program outcomes.

Many of the clients with the most intensive needs were also provided wraparound services by our community partner Seneca. Referrals to Seneca wraparound are primarily made by juvenile probation and child welfare. Wraparound services include regular team meetings, case management and support counseling in addition to the therapy services provided to clients and their families.

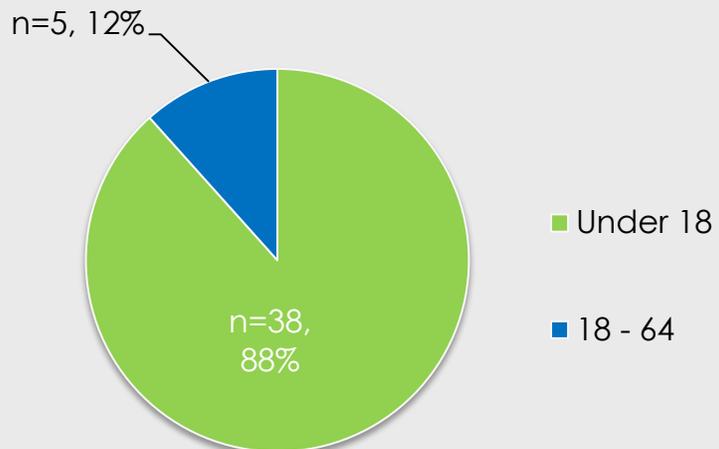
CSS YES FY2015-16: PREFERRED LANGUAGE (N=43)



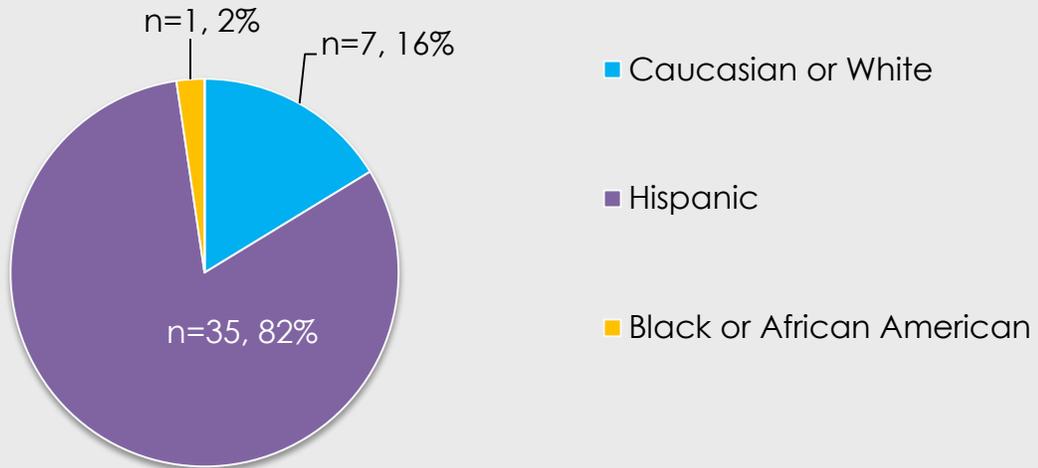
During the 2015-2016 Fiscal Year, of those enrolled in the YES FSP 37 spoke English and 5 spoke Spanish.

During the 2015-2016 Fiscal Year, YES FSP served 43 individuals, 88% were under 18 years old.

CSS YES FY2015-16: AGE GROUP (N=43)

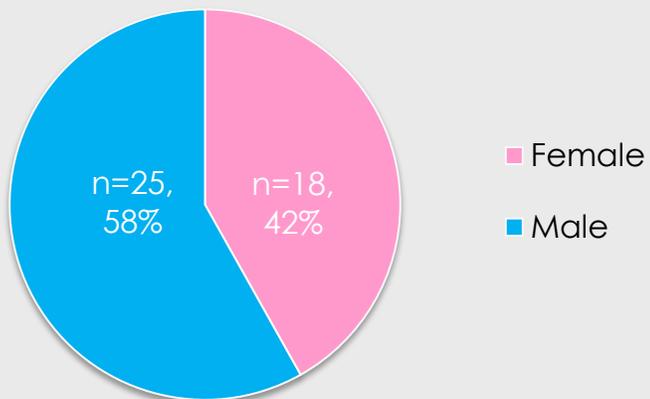


CSS YES FY2015-16: RACE/ETHNICITY (N=43)



During the 2015-2016 Fiscal Year, the YES FSP served 43 participants, the majority of which self-identified as Hispanic.

CSS YES FY2015-16: GENDER (N=43)



During the 2015-2016 Fiscal Year, Marin County's YES FSP served 43 individuals, 58% were male and 42% were female.

PROGRAM CHALLENGES

In FY2015-16, The YES program remained understaffed for much of this year, with only 2 positions filled.

In FY2016-17, with a full complement of staff the YES program will serve at least 40 unduplicated clients and track most frequent actionable items on the CANS to align training needs of staff with the clinical needs of the client. It is anticipated that trauma could be an actionable item identified with many YES clients.

CLIENT STORY - YOUTH EMPOWERMENT SERVICES

Maria is a 14 year old Latina female who resides with her mother and sibling in one room in a shared apartment. Maria was referred for mental health services by her parent due to angry and assaultive behavior. She was subsequently placed on probation after assaulting her mother.

Maria was raised by her grandmother in Mexico and then came to live with her mother and sister at age 9. She was exposed to considerable trauma, including community violence, sexual assault, and possible exploitation. Maria developed emotional and behavioral difficulties that affected her ability to attend and function at school, disrupted family relationships, presented safety issues in the home and resulted in school failure and formal probation status.

Through YES services, Maria and her mother were able to improve their relationship and avoid struggles that had previously resulted in significant conflict. Maria attended individual therapy consistently to work on her coping abilities to regulate her mood and behavior more effectively. She remains at risk currently, but YES services are supporting the client and her parent to advocate with school and probation further and to improve communication and decrease conflict at home.

TRANSITION AGE YOUTH (TAY) FULL SERVICE PARTNERSHIP (FSP)

PROGRAM OVERVIEW

Marin County's Transition Age Youth (TAY) Program is a Full Service Partnership (FSP) providing young people (16-25 years old) with serious emotional disturbance or emerging mental illness with independent living skills, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance use services. These services are strengths based, evidence based and client centered. A multi-disciplinary team provides assessment, individualized treatment plans and linkages to needed supports and services, as well as coordinated individual and group therapy and psychiatric services for TAY participants. There is also a well-attended partial program for youth who can take advantage of the group activities and ongoing social support. This program is run by an agency partner, Sunny Hills Services. The TAY Program leadership work closely with Behavioral Health and Recovery Services Youth and Family Services leadership in the initial referral process and in on going collaboration.

TARGET POPULATION

The priority population is transitional age youth, 16-25 years of age, with serious emotional disturbances/serious mental illness. The average age in FY2015-16 was 22.9 years which included two youth, each with a small child. These youth may be aging out of the children's system, child welfare and/or juvenile justice system or may be experiencing new mental health challenges that are seriously impacting their ability to function appropriately in their home and community as young adults. Priority is also given to TAY who are experiencing first-episode psychosis and need access to developmentally appropriate mental health services.

In the past years, Latino youth, 18 years of age and over, were underrepresented in the TAY Program, but in FY2014-15, 29%, (N=8) self-identified as Hispanic and in FY2015-16, 46% self-identified as Hispanic (N=13) and there were two youth whose preferred language was Spanish. The TAY Program has several bilingual Spanish speaking staff, so they have the needed capacity to work with Latino families. Parent support groups are offered in Spanish and English at the TAY offices.

PROGRAM DESCRIPTION

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

This program provides ‘whatever it takes’ with the goal of providing treatment, skills and the level of self-sufficiency necessary to TAY to manage their illness and accomplish their goals, avoiding deep end services, incarceration and homelessness. In addition, partial services, such as drop-in hours and activities, at the TAY office and drop in center in central San Rafael, are available to all TAY FSP clients as well as any youth who choose to drop in. Often this welcoming approach is effective in engaging youth experiencing serious mental health challenges that are open to dropping by and engaging in social activities before committing to joining the program.

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

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

EXPECTED OUTCOMES

The broad goals of the TAY Program, including decreasing hospitalization and homelessness and increasing attendance at school or work, have not changed and are evident in the chart on the previous page. Additionally, specific goals targeting vocational support and independent living skills that support such outcomes were monitored and the results are in the outcomes table below.

ACTUAL OUTCOMES

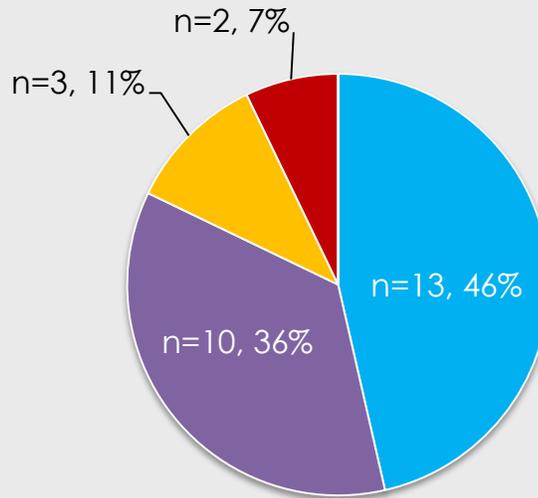
In FY2015-16, there were 28 unduplicated FSP clients in the TAY Program. Currently 14 of the 20 FSP’s receive psychiatric medication support directly through the TAY Program and 25% receive individual therapy. Approximately 70% attended independent living skills activities.

Outcomes FY2015-16	Goal	Actual FY2015-16
Number of clients served: • FSP • Partial/drop-in	20 60	28 52
FSP clients engaged in work, vocational training or school.	50%	55%
FSP clients engaged in activities designed to improve independent living skills.	50%	70%
FSP clients screened for substance use.	100%	100%
Clients identified as having substance use issues that receive substance use services.	50%	66%

Only three clients were identified as having substantial risk for alcohol and drugs. It is believed that many denied use and/or under reported, specifically the use of marijuana/medical marijuana which was explored frequently in drop in activities and groups utilizing Motivational Interviewing (MI) techniques. One client worked with an AA sponsor outside of TAY and another collaboratively developed a plan with their individual case manager. 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.

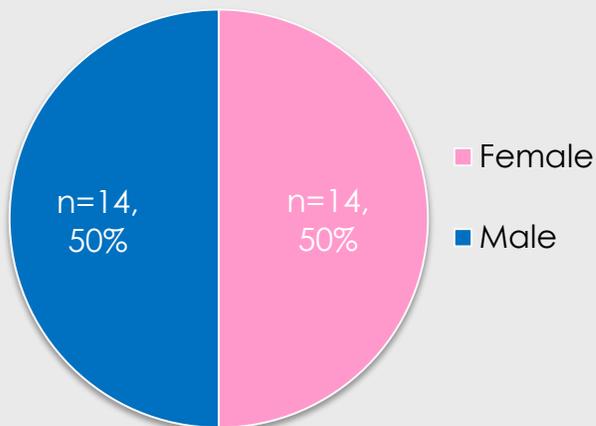
CSS TAY FY2015-16: RACE/ETHNICITY (N=28)

- Caucasian or White
- Hispanic
- Black or African American
- Vietnamese
- Other
- Unknown / Not Reported



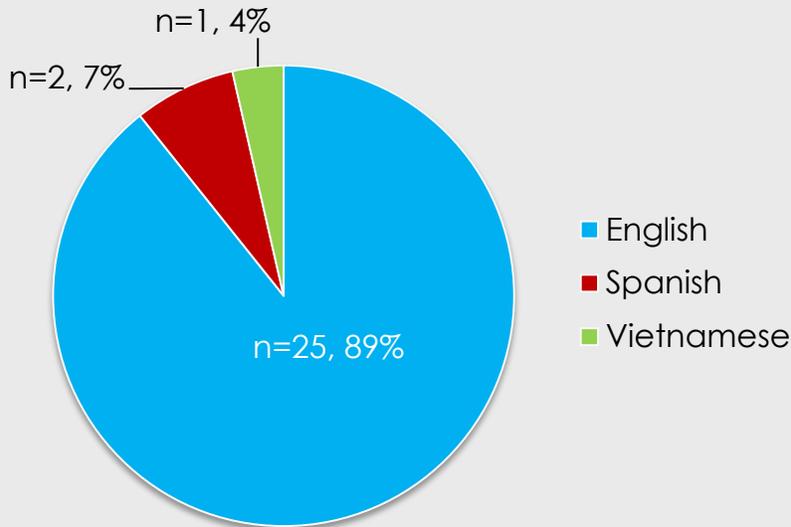
During the 2015-2016 Fiscal Year, the TAY program served 28 individuals, the majority of which were White and Hispanic.

CSS TAY FY2015-16: GENDER (N=28)



During the 2015-2016 Fiscal Year, the TAY FSP served 14 men and 14 women.

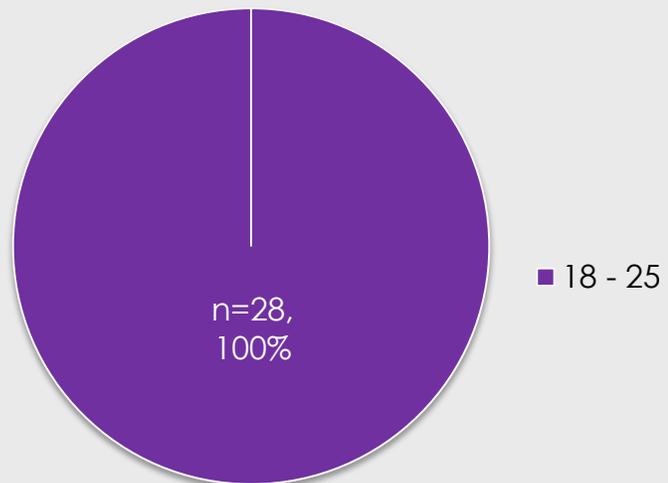
CSS TAY FY2015-16: PRIMARY LANGUAGE (N=28)

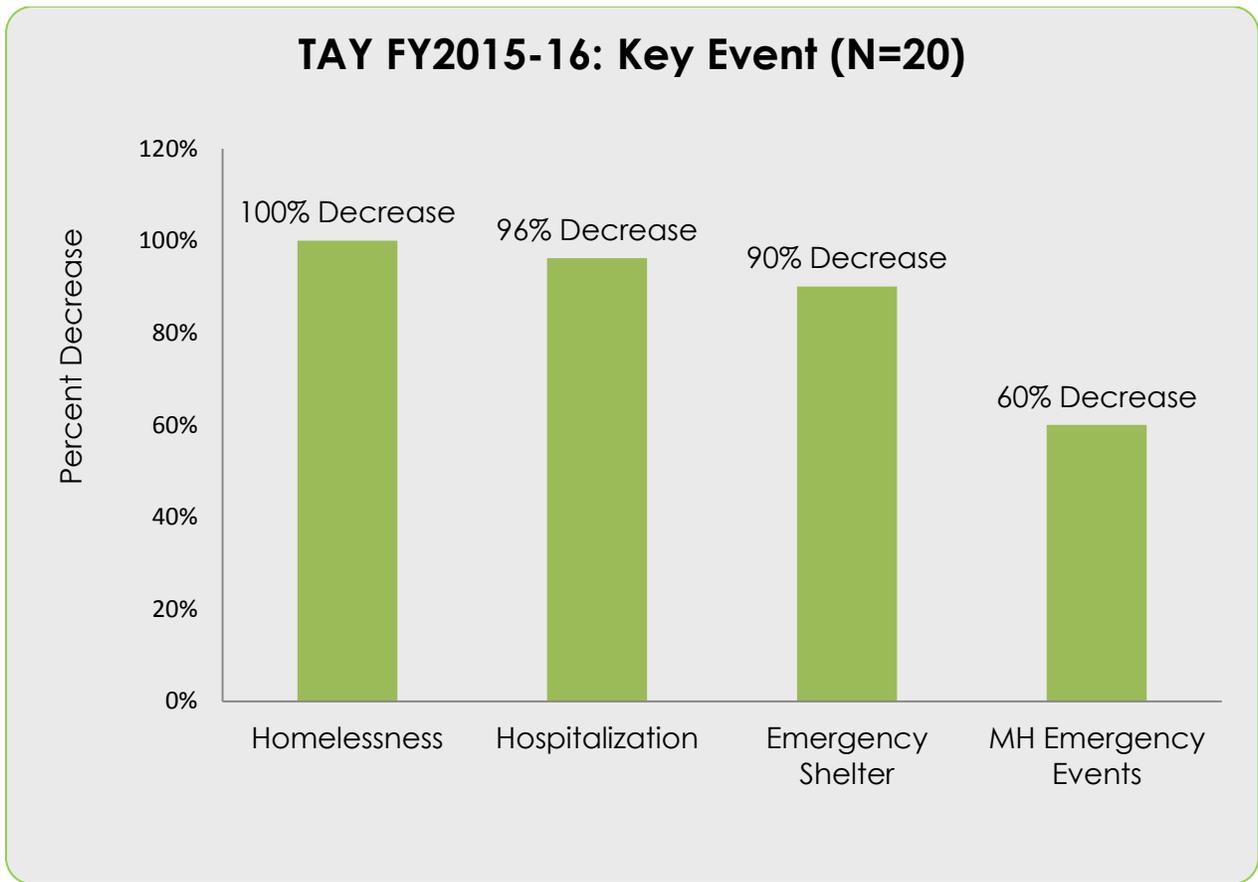


During the 2015-2016 Fiscal Year, the TAY FSP primarily served English speaking individuals.

During the 2015-2016 Fiscal Year, all participant in the TAY FSP were 18-25 years old.

CSS TAY FY2015-16: AGE GROUP (N=28)





During the 2015-2016 Fiscal Year, the TAY FSP experienced a decrease in homelessness, hospitalizations, emergency shelter placement, and mental health emergency events.

PROGRAM CHALLENGES

In FY2015-16, 100% of clients were screened by the substance abuse counselor and appropriate interventions such as groups for youth and families were provided to engage the youth while acknowledging their individual readiness for change. Motivation in this age group remains a challenge and overall, youth were reluctant to identify drug and alcohol use, in particular medical marijuana use, which has been given a patina of acceptability through changing society standards and legalization. Thus medical marijuana is considered an acceptable solution for handling a variety of symptoms, even in the face of the proven negative impact on brain development. Youth with co-occurring disorders need ongoing support in recognizing the impact of substance abuse on their mental health as well as comprehensive services that promote recovery and self-sufficiency. This continues to be a challenge in the TAY Program.

In FY2016-17 a post doc intern began providing groups and individual therapy with some of the FSPs who were identified as experiencing a first episode of psychosis (FEP). Many of the clients seen in the TAY Program suffer with serious mental illness which impacts their ability to function in their daily lives. A proposal was developed to establish a small coordinated team to work with these clients across the youth and adult behavioral health county system with the needed support and consultation in place to support the staff in this endeavor. Additionally, increasing the available FSP slots for FEP in the TAY Program is under consideration in the county MHSA Planning Process taking place in the spring of 2017.

CLIENT STORY – TRANSITION AGE YOUTH

Cathy was removed from her mother's home by CPS due to physical abuse when she was a young teenager and spent the rest of her teenage years in group homes and foster care. Cathy was later psychiatrically hospitalized and struggled with symptoms of bipolar disorder.

When she was 20 years old, she was referred to the TAY program and for the past two years, she has attended the program and been able to build a trusting relationship with her TAY clinical case manager, and begin to figure out what she wanted to do with her life. She had ups and downs while at TAY-- she dropped out of college several times and lost jobs due to emotional and behavioral challenges. She ended up in a homeless shelter but knew she had to work hard to build a different life for herself. There were days where she would cry in bed all day, but she got up the next day and tried to work toward her goals.

Catherine finally became steadily employed, despite how difficult it was to deal with work stressors alongside her mental health symptoms. Because of stable employment, she was then able to move from the homeless shelter into transitional housing and then applied for a Section 8 housing voucher, a place just for herself where she could be safe. Cathy finally succeeded in finding a small apartment in walking distance to many services and business. The road has not be easy for her and she has met with many challenges, but Cathy has shown that with steady support from TAY as well as other community partners, she could achieve her goals despite so many challenges.

SUPPORT AND TREATMENT AFTER RELEASE (STAR) FULL SERVICE PARTNERSHIP

PROGRAM OVERVIEW

The Marin County Support and Treatment After Release (STAR) Program has been an MHSA-funded Full Service Partnership (FSP) serving adults with serious mental illness who are at risk of incarceration or re-incarceration since 2006. The STAR Program was originally implemented in 2002 through a competitive Mentally Ill Offender Crime Reduction Grant (MIOCRG) awarded by the California Board of Corrections. Upon the conclusion of that grant, the STAR Program was approved as a new Full Service Partnership, providing culturally competent, intensive, integrated services to 40 mentally ill offenders. Operating in conjunction with Marin’s mental health court – the STAR Court – the program was designed to provide comprehensive assessment, individualized client-centered service planning, and provision of or linkages to all needed services and supports. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce incarceration, and reduce hospitalization.

TARGET POPULATION

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

PROGRAM DESCRIPTION

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

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

Integral to the team, the nurse practitioner provides medical case management, health screening/promotion and disease prevention services, coordinates linkage to community-based physical health care services, and is able to furnish psychiatric medications under the supervision of the team psychiatrist. The employment specialist provides situational assessments, job development and job placement services, and coordinates services with other vocational rehabilitation providers in the county. Where appropriate, participants are assisted to enroll in the Department of Rehabilitation to leverage funding for additional vocational services, including job coaching. The independent living skills counselor is available to support participants with development of skills needed to obtain and maintain independence in the community. The substance abuse counselor provides appropriate group and individual counseling to participants as needed.

CSS one-time expansion funds were approved beginning in FY2011-12 through FY2013-14 to provide Crisis Intervention Training, a 32-hour training program for police officers to enable them to more effectively and safely identify and respond to crisis situations and mental health emergencies. Because earlier trainings were successful and popular, the program has been extended through FY2016-17, and we anticipate continuing in the next MHSA 3 year plan. Funds are used for stipends to local law enforcement jurisdictions to enable them to send officers to the training, support their ongoing participation in the monthly meetings of the county-wide problem-solving Forensic Multi-Disciplinary Team (FMDT), and help pay for the cost of the training. This training is provided to 25-30 sworn officers annually.

EXPECTED OUTCOMES

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

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

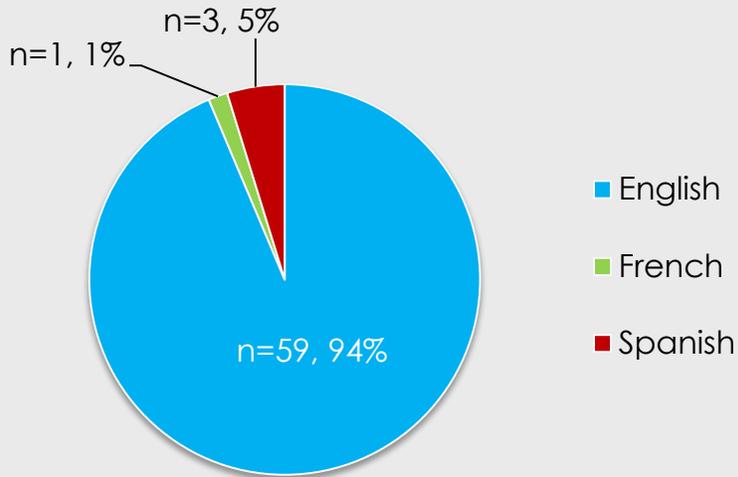
ACTUAL OUTCOMES

In FY2015-16, the STAR Program engaged 42 individuals who had serious mental illness and significant criminal justice involvement, not reaching the program’s target enrollment of 60. Of those served, homeless days were reduced by 83%, arrests decreased 85%, and hospitalizations by 69%, all far exceeding program goals. Participant incarceration decreased by 71% and the program saw a 67% reduction in mental health emergencies.

Of the 20 program participants referred for employment services, 13 (65%) were successfully engaged in job development. Twelve (60%) were placed in jobs, and 10 (50%) engaged in volunteer

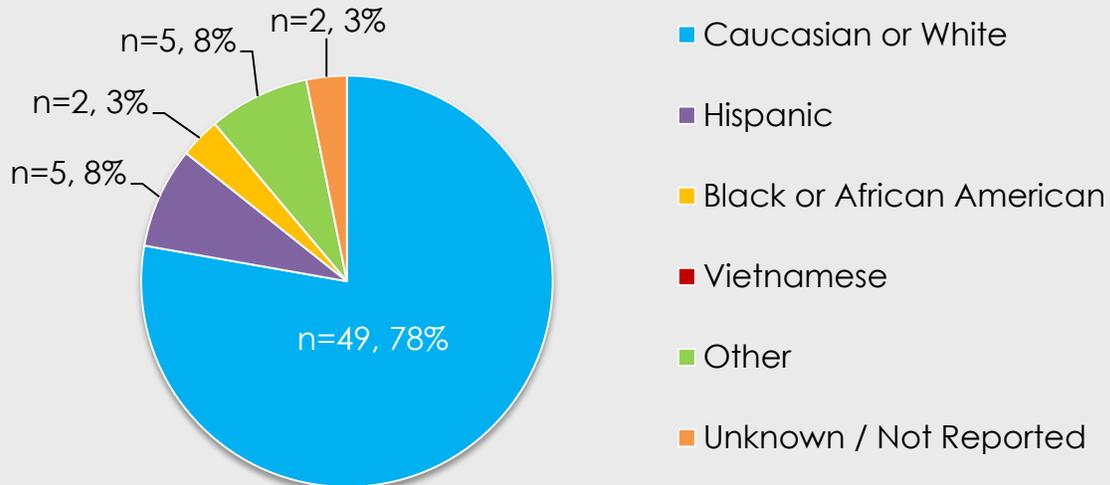
work. Independent Living Skills (ILS) Services were provided to 7 participants, exceeding the annual goal of 4-5, and 5 (71%) achieved at least one skill toward independent living. Substance use services were provided to 18 program participants through fifty groups specifically focused on support for those affected by both mental illness and substance use.

CSS STAR FY2015-16: PREFERRED LANGUAGE (N=63)



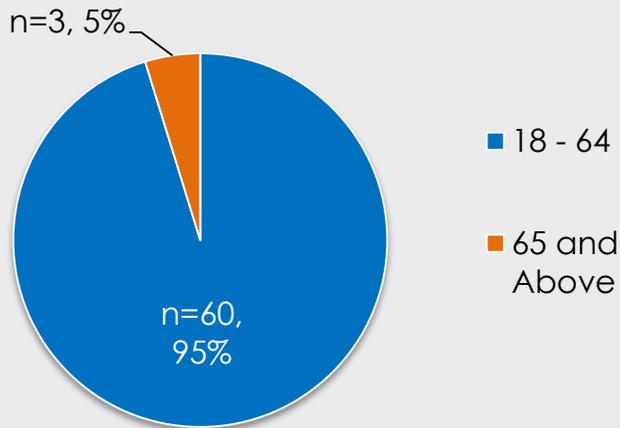
During the 2015-2016 Fiscal Year, the STAR FSP served primarily English speaking individuals.

CSS STAR FY2015-16: RACE/ETHNICITY (N=63)



During the 2015-2016 Fiscal Year, the majority of participants in the STAR FSP identified as White.

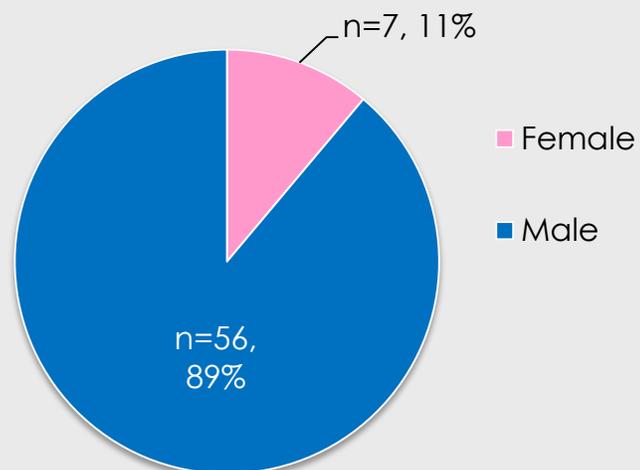
CSS STAR FY2015-16: AGE GROUP (N=63)

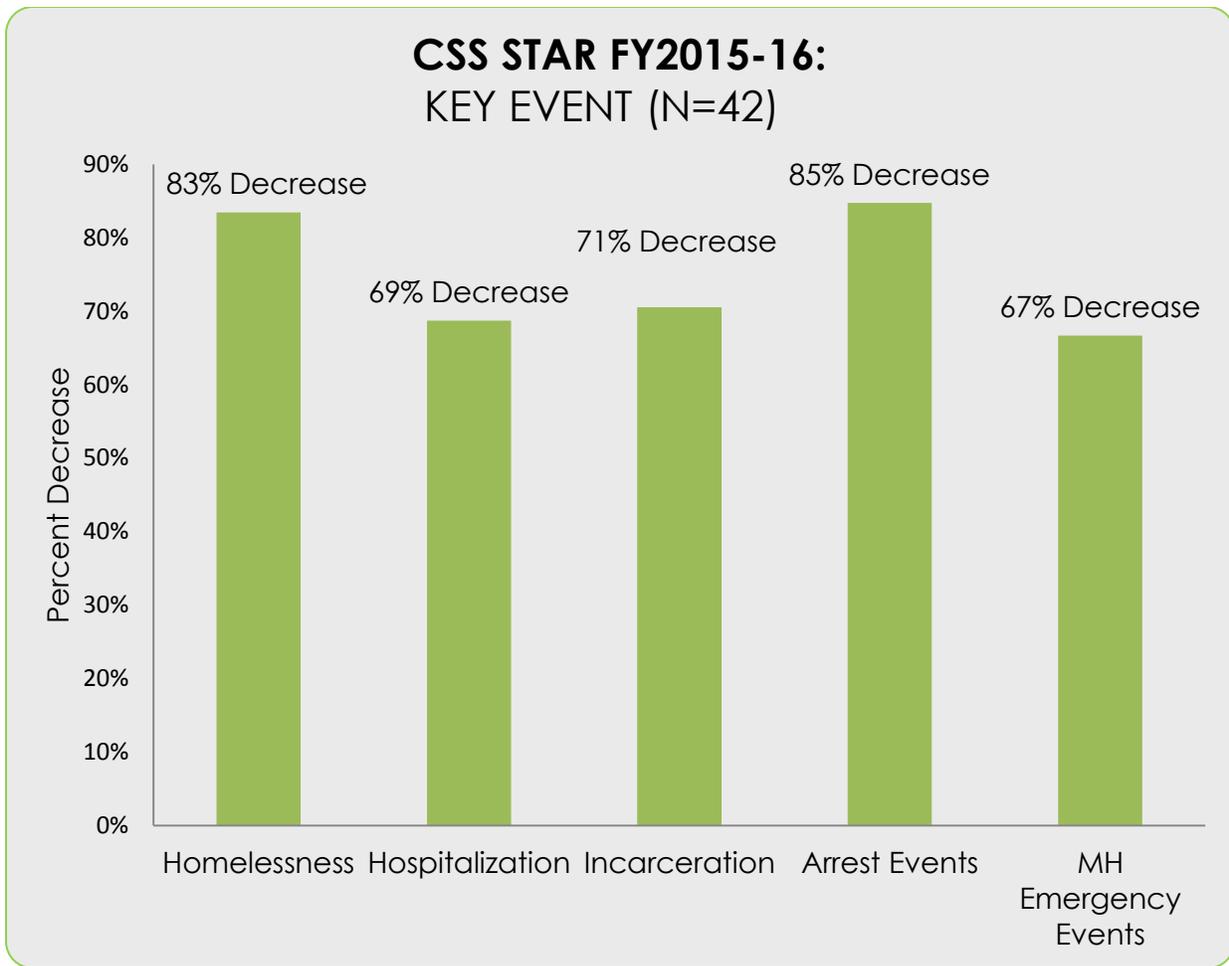


During the 2015-2016 Fiscal Year, the majority of the STAR FSP participant were between the ages of 18 and 64.

During the 2015-2016 Fiscal Year, of the 63 individuals in the STAR FSP, 56 were male and 7 were female.

CSS STAR FY2015-16: GENDER (N=63)





During the 2015-2016 Fiscal Year, the STAR FSP experienced a decrease in homelessness, hospitalizations, incarceration, arrest events, and mental health emergency events.

PROGRAM CHALLENGES

In FY2015-16, multiple factors negatively affected program enrollment. Changes in staffing caused significant stress for this well-developed program. The team's long-time Nurse Practitioner retired, both the Psychiatrist and Unit Supervisor positions have been vacant, and challenges filling the newly added bilingual clinical position all delayed the anticipated increase in enrollment from 40 to 60 participants. These positions have now been filled, and enrollment is expected to increase to target in FY2016-17. These same factors contributed to the program not meeting target for decreasing incarcerations, and the program is expected to meet this target in the coming year. The position added has allowed the program to enroll participants without the requirement of participation in STAR Court. Enrollment guidelines have been defined for this expanded service, and as the program reaches target enrollment it will also be able to enroll and engage a more diverse participant population.

In FY2016-17, we anticipate having all of the current positions filled, and the services up to the anticipated levels. Once the program has re-stabilized we will begin to explore enhanced services for families of program participants, understanding that natural supports are an integral part of the recovery process. We will also explore strategies for enhancing collaboration between STAR, the Jail Mental Health Team, and our law enforcement partners.

CLIENT STORY - STAR FULL SERVICE PARTNERSHIP

Joseph has been diagnosed with schizoaffective disorder, panic disorder and poly substance use disorder. Joseph has a long history of legal entanglements, psychiatric hospitalizations, and chronic substance use. Joseph is a participant in STAR court for the second time. During his first attempt he was derailed in his efforts to succeed by relapse and new drug charges. In this attempt to complete STAR court he has really been engaged with the treatment and services that the STAR team provides and has been extraordinarily successful at meeting his own goals and fulfilling the mandates of the court.

Using the therapeutic tools and psycho-education he works to master with STAR providers, Joseph has a better understanding of his diagnosis and how to overcome the barriers it can create, and has had huge success in reducing the frequency and severity of his symptoms. Joseph is deeply engaged in his recovery, and has maintained sobriety for over 9 months! Joseph has worked with STAR providers to secure permanent affordable housing and to enroll in classes at College of Marin, where he just scored a 96% (highest in the class) on his most recent intermediate algebra exam. Joseph attributes his success in taking on and managing these new challenges in his treatment, housing, sobriety, and education in part to the support and skills he gets from the STAR, and says that STAR has helped him understand that he is deserving of the success he is working hard for.

HELPING OLDER PEOPLE EXCEL (HOPE) PROGRAM

PROGRAM OVERVIEW

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

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

In 2006, Marin's HOPE Program was approved as a new MHSa-funded full service partnership providing culturally competent, intensive, integrated services to 40 priority population at-risk older adults. In 2016 program capacity was expanded to accommodate 50 participants with the addition of another clinician. The Program is designed to provide community-based outreach, comprehensive gero-psychiatric assessment, individualized client-centered service planning, and provision of or linkages to all needed services and supports by a multi-disciplinary, multi-agency team.

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

TARGET POPULATION

The target population of the HOPE Program is older adults with serious mental illness, ages 60 and older, who are currently unserved or underserved 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, psycho-education, assistance with money management, and provision of or linkages to all needed services and supports. Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided on a case-by-case basis. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained.

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

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

EXPECTED OUTCOMES

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

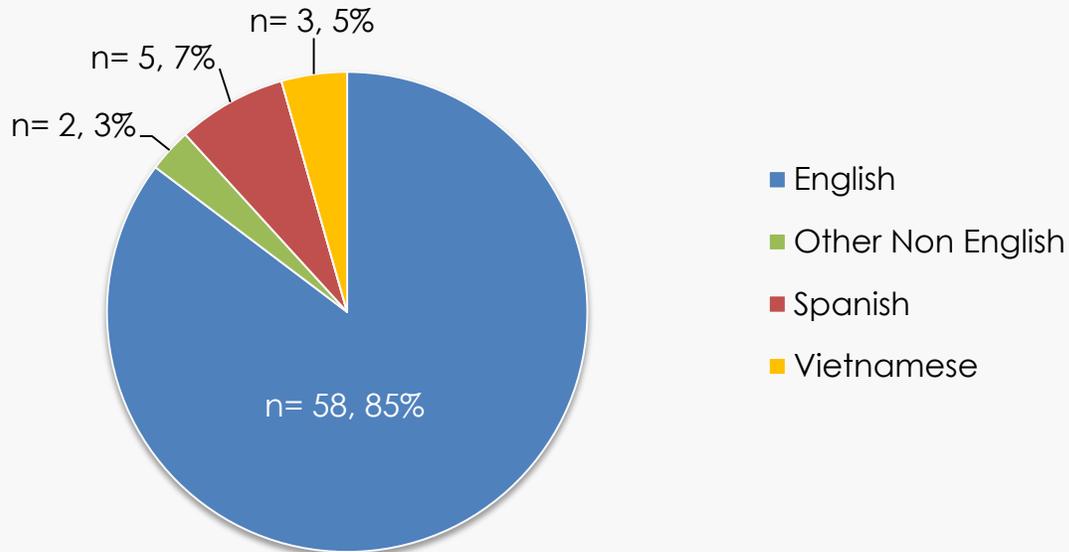
Outcome	GOAL
Decrease in homelessness	75%
Decrease in hospitalization	50%

ACTUAL OUTCOMES

In FY2015-16 the HOPE Program engaged 58 individual older adults, of which 31 have participated for at least 2 years. For those 31 individuals served for at least 2 years: homeless days were decreased by 83%, exceeding the goal of 75%, hospitalizations increased by 26%, mental health emergencies requiring crisis stabilization decreased by 31%.

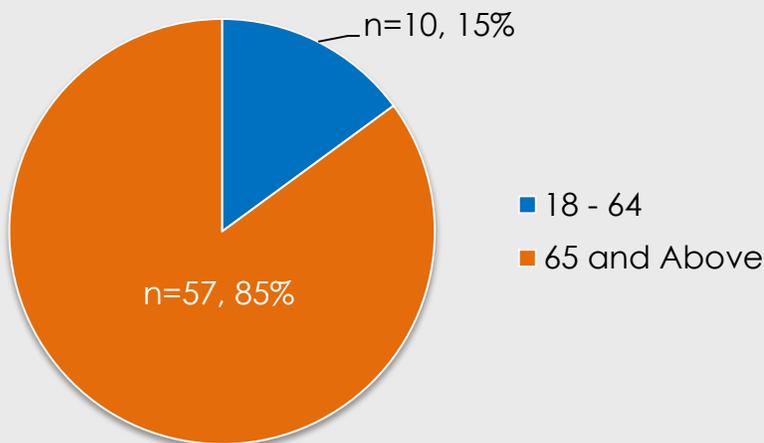
Outreach and engagement services by the Senior Peer Counseling program staff conducted 1,075 client visits and 44 services that either resulted in the client receiving a Senior Peer Counselor, declining services or referring out.

CSS HOPE FY2015-16: PREFERRED LANGUAGE (N=67)



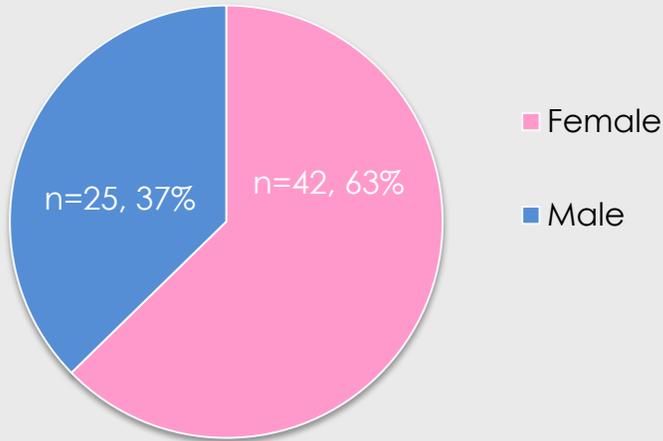
During the 2015-2016 Fiscal Year, the HOPE FSP program served 67 individuals of which 58 were English speaking.

CSS HOPE FY2015-16: AGE GROUP (N=67)



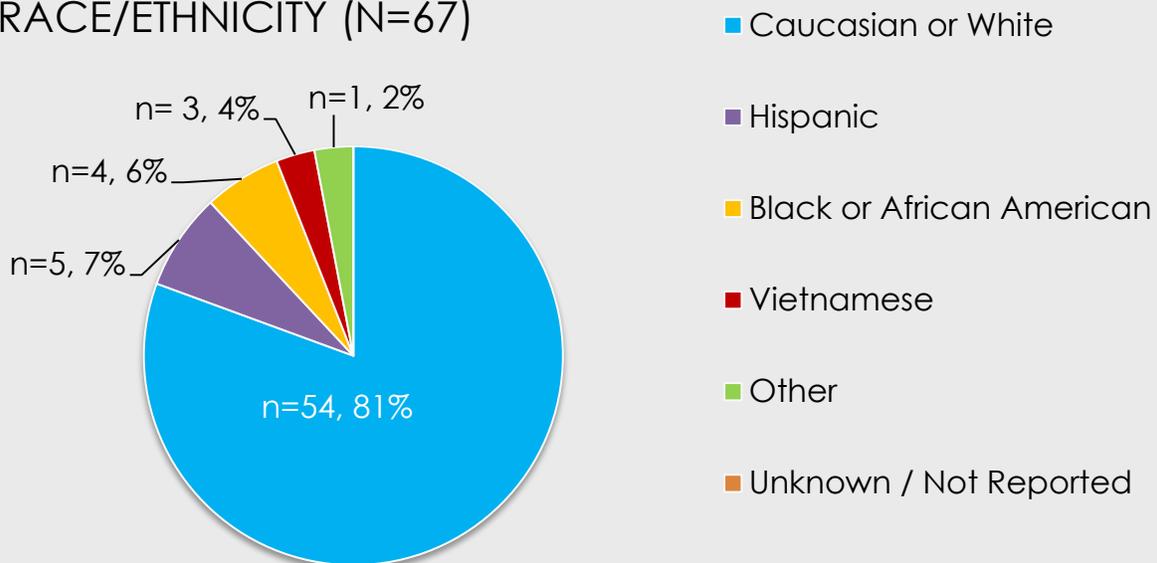
During the 2015-2016 Fiscal Year, the HOPE FSP program served 67 individuals of which 85% were 65 years old or older.

CSS HOPE FY2015-16: GENDER (N=67)

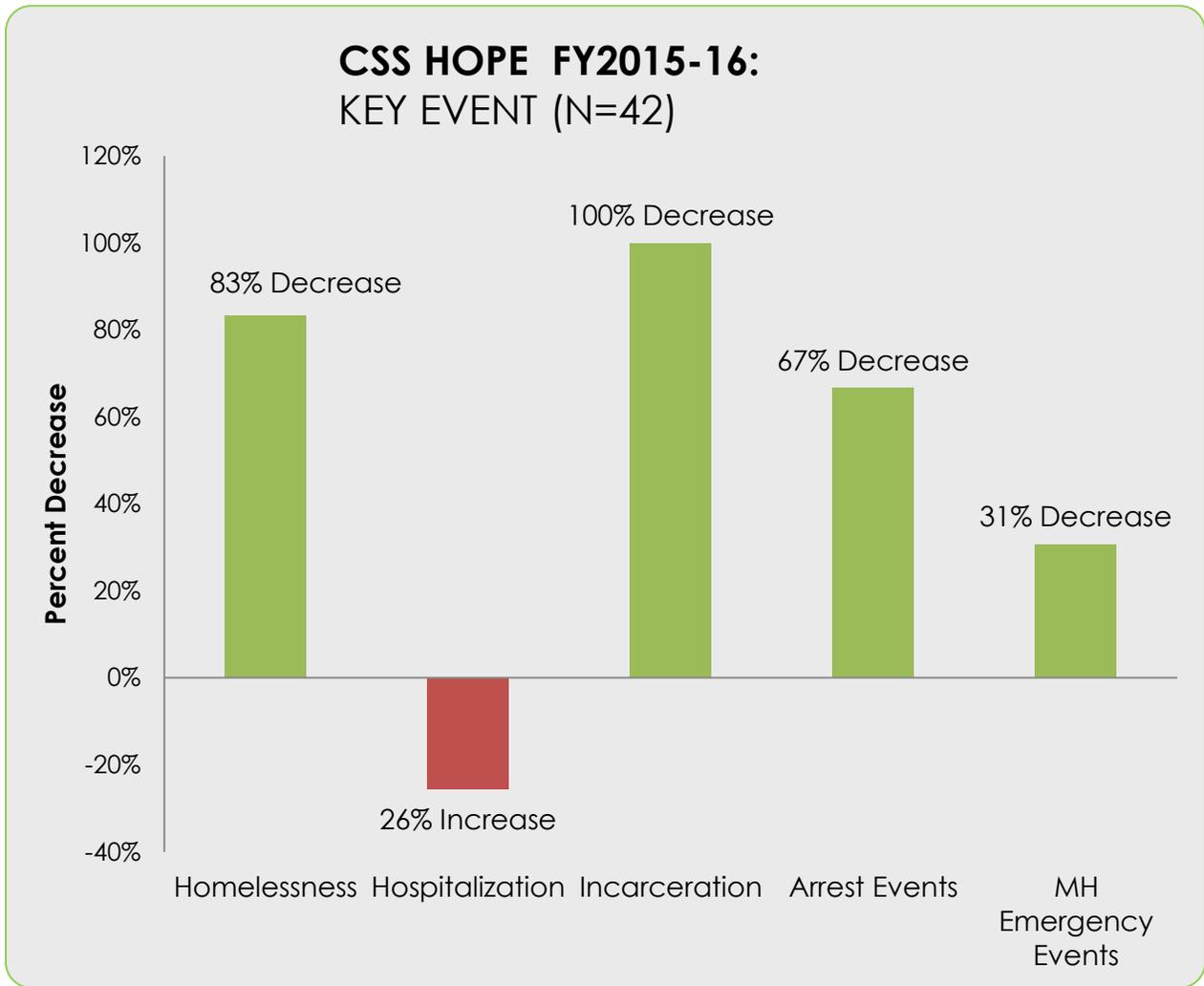


During the 2015-2016 Fiscal Year, the HOPE FSP served 42 females and 25 males.

CSS HOPE FY2015-16: RACE/ETHNICITY (N=67)



During the 2015-2016 Fiscal Year, the HOPE FSP served 67 individuals, the majority of which identified as White.



During the 2015-2016 Fiscal Year, the HOPE FSP experienced a decrease in homelessness, incarceration, arrest events, and mental health emergency events. The HOPE FSP also experienced an increase in hospitalization.

PROGRAM CHALLENGES

In FY2015-16, a continuing challenge was the lack of available housing and placement options for older adults who suffer from chronic and persistent mental illness. As the population of Marin ages, so does the population of older adults who have mental illness, medical comorbidities and neurocognitive deficits. This profile makes psychiatric hospitalizations and medical hospitalizations very challenging. The larger health care system is in the process of becoming more integrated, but when psychiatric illness intertwines with complex medical issues, longer term care options are limited. Lack of alternative placements that can accommodate complex needs has resulted in longer acute hospital stays. While the program has expanded by one mental health clinician, the anticipated increase in capacity was not fulfilled. This is due in large part by the difficulties of filling and retaining the new position.

In FY2016-17, the HOPE Program and Senior Peer Counseling will participate in a CiBHS Coordinated Care Learning Collaborative, with a focus on better integration of mental health and primary care services. Addressing the interplay of the older adult's comorbidities may support a decrease in hospitalization days for program participants. The program will continue to explore alternative housing options in the community as well.

ODYSSEY PROGRAM (HOMELESS) FULL SERVICE PARTNERSHIP

PROGRAM OVERVIEW

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

TARGET POPULATION

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

PROGRAM DESCRIPTION

A multi-disciplinary, multi-agency assertive community treatment team comprised of mental health practitioners and peer specialists provides comprehensive assessment, individualized client-centered service planning, crisis management, and other supportive services as indicated, including support to obtain/maintain housing, crisis planning, peer counseling and support, employment services, money management, support for development of independent living skills, psycho-education, access to medication services and management support, substance abuse services as indicated, and medical case management when needed. The program has a pool of flexible funding to purchase needed goods and services that cannot be otherwise obtained, including time-limited emergency housing, medications and transportation. A limited amount of supportive housing is provided through partnerships with the Marin Housing Authority's Shelter Plus Care Program, and other community partners. Recognizing the critical role natural support systems play in participant's recovery, friends and family members have access to an array of support services to assist them to develop alternative strategies and skills for coping with and addressing the effects of serious mental illness on themselves and their family member. Program participants and their families are provided education regarding the management of health and mental health issues, with a focus on reducing stigma, restoring hope and promoting recovery of health and functioning.

The team consists of three (3) mental health practitioners, one of whom is bilingual/bicultural Spanish speaking, four (5) peer specialists, a support service worker, a mental health nurse practitioner and a psychiatrist, an independent living skills specialist, an employment specialist and a substance use specialist. Outreach and engagement services are provided by a team of two (2) peer specialists. Support is available to participants and their families 7 days a week, 24 hours a day.

Integral to the team, the nurse practitioner provides medical case management, health screening/promotion and disease prevention services, coordinates linkage to community-based

physical health care services, and is able to furnish medications under the supervision of the psychiatrist. The employment specialist provides situational assessments, job development and job placement services, and coordinates services with other vocational rehabilitation providers in the county. Where appropriate, participants are assisted to enroll in the Department of Rehabilitation to leverage funding for additional vocational services, including job coaching. The independent living skills counselor is available to support participants with development of skills needed to maintain independence in the community. The substance abuse counselor provides group and individual counseling to participants as needed.

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

EXPECTED OUTCOMES

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

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

ACTUAL OUTCOMES

The Odyssey Program targets individuals who, by virtue of being unserved or underserved, are either homeless or at-risk of homelessness. In FY2015-16, the program engaged 87 individuals of which 71 have participated for at least 2 years. Of those 71 individual participants who participated for at least 2 years, homeless days were decreased 68%, falling short of the goal of 80%. This will be discussed further in the Challenges section of this report. Days spent incarcerated decreased by 57%, falling short of the 60% goal. Frequency of arrests was decreased by 32% vs. the goal of 50%. Hospitalization rates were minimally affected this year, with only a 3% decrease. This may be attributable to a notable increase in the acuity of clients, but also may be a factor of some significant staffing changes. Crises requiring evaluation by the Crises Stabilization Unit decreased by 61%, an improvement from last year’s 54%.

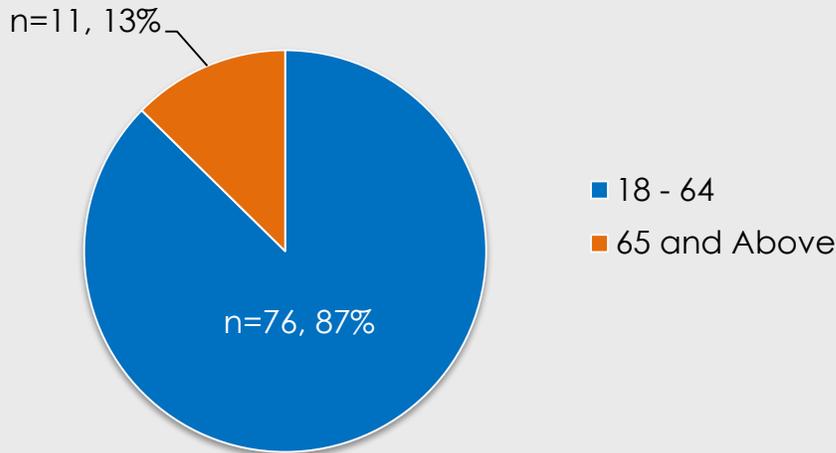
Outreach and engagement services to homeless individuals are provided by the CARE Team and supported by the Enterprise Resource Center, a peer operated drop-in center. The CARE Team

works closely with Odyssey and is the primary source of referrals for the program. In FY2015-16 the CARE Team provided 685 service contacts to 67 individuals in the field, short of their annual goal of 1000 visits and 175 individuals.

Independent Living Skills services were provided to 16 participants, exceeding the goal of 4-5. Of those 16, 75% remained engaged or completed ILS Goals during the year. Vocational Rehabilitation Services were offered to 18 Participants: 9 (50%) engaged in job development, 9 (50%) were placed in employment and 3 (2%) were placed in volunteer positions.

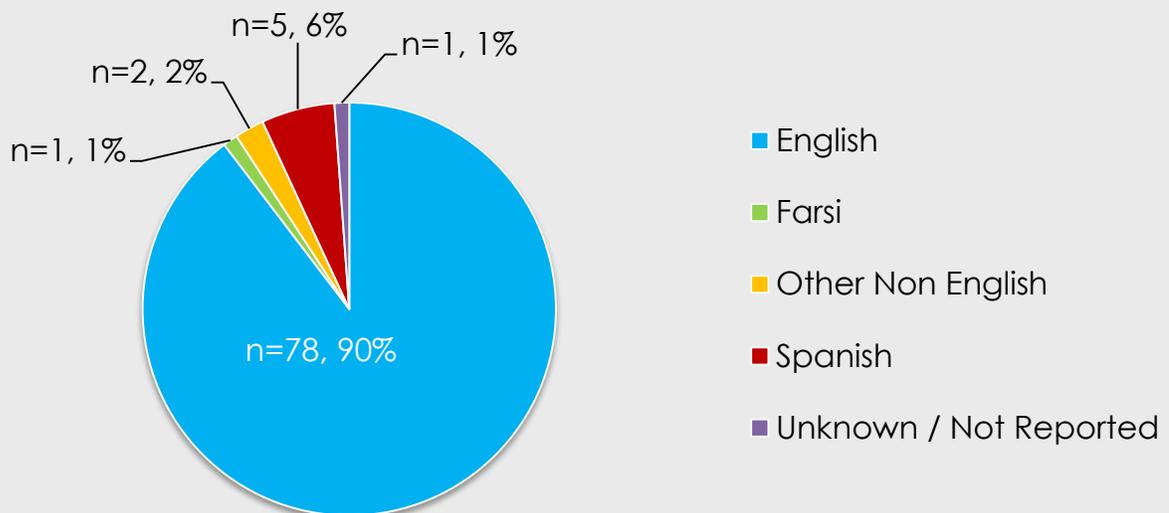
On average, 58% of Odyssey program participants present with a co-occurring substance use disorder, putting them at even greater risk. Odyssey's low-barrier harm-reduction based substance group provided services to 10 individuals. A total of 50 groups were provided throughout the year. The program will continue to explore strategies for engaging participants in this aspect of their recovery.

CSS ODYSSEY FY2015-16: AGE GROUP (N=87)



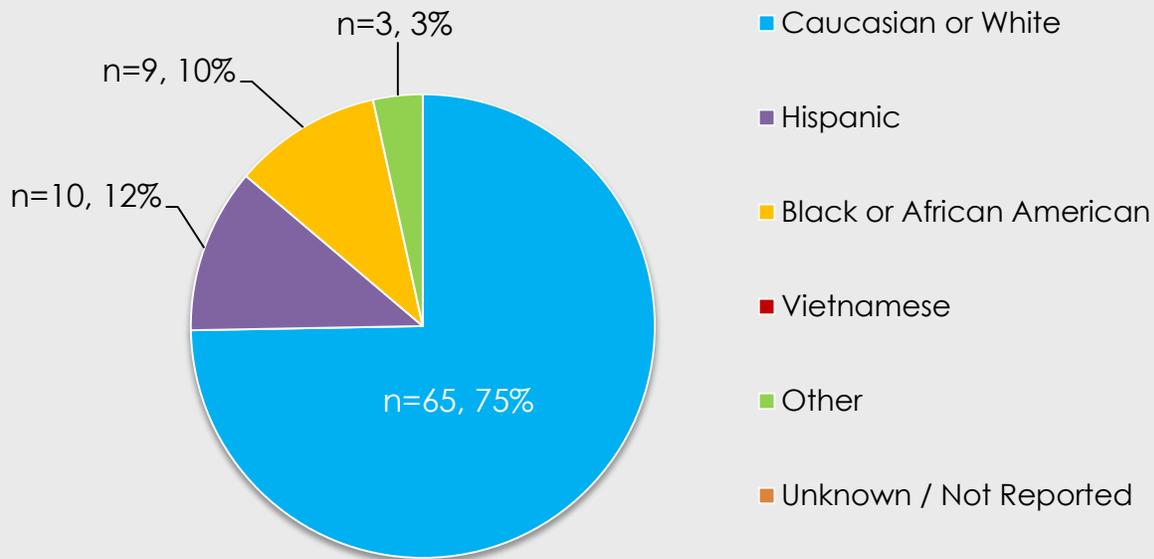
During the 2015-2016 Fiscal Year, the Odyssey FSP served 87 individuals of which 76 were 18-64 years old and 11 were 65 years old or older.

CSS ODYSSEY FY2015-16: PREFERRED LANGUAGE (N=87)



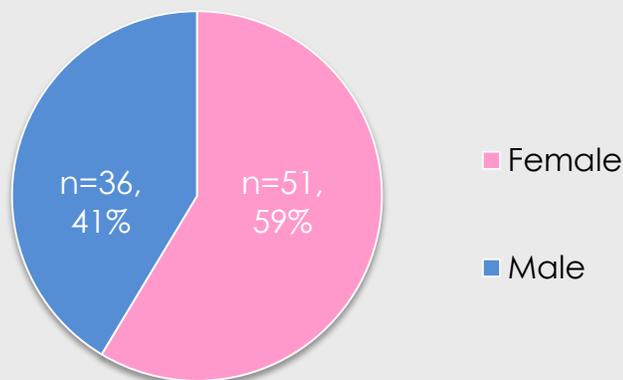
During the 2015-2016 Fiscal Year, the majority of the Odyssey FSP participants were English speakers.

CSS ODYSSEY FY2015-16: RACE/ETHNICITY (N=87)

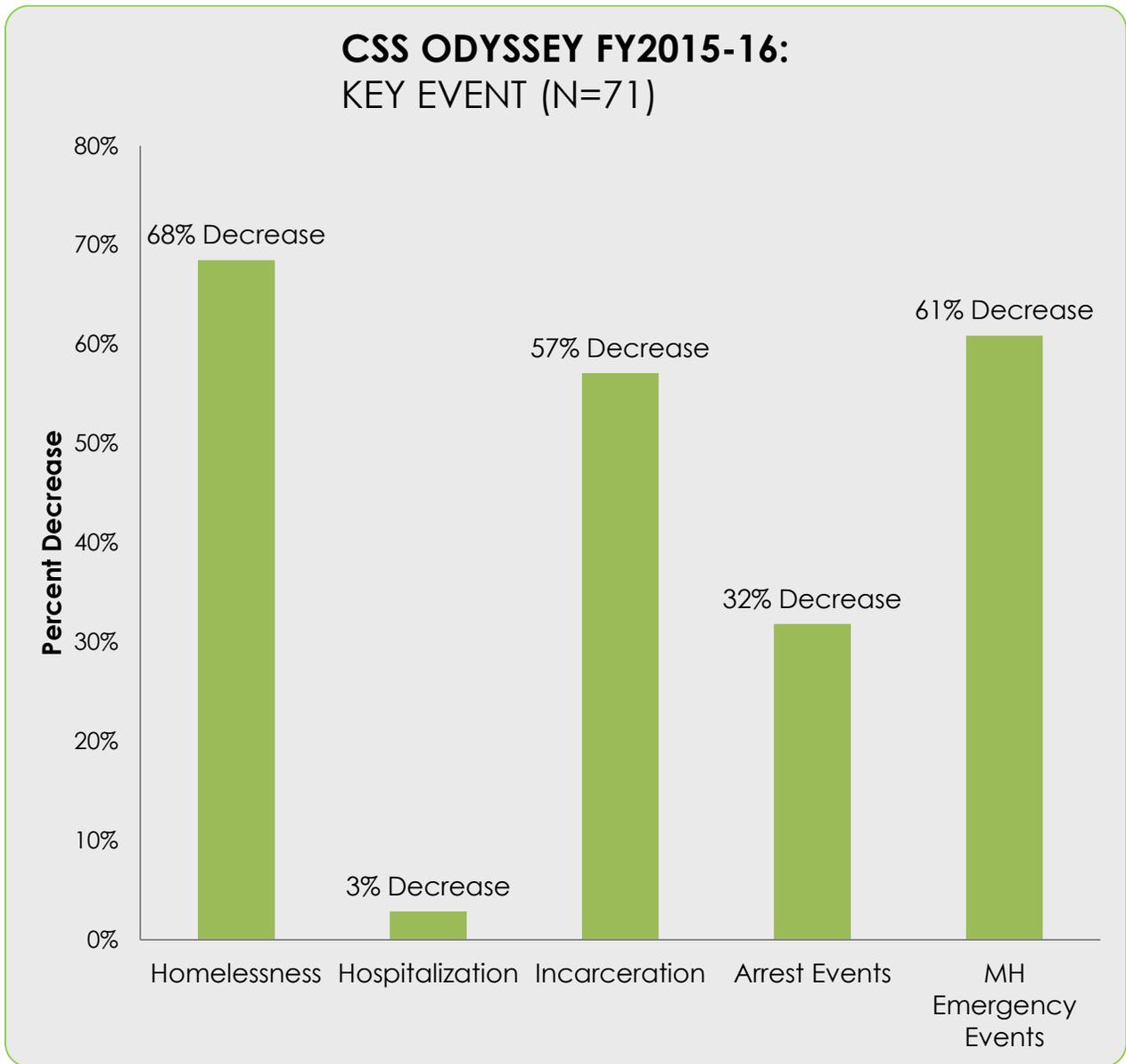


During the 2015-2016 Fiscal Year, the Odyssey FSP program served 87 individuals, of which 75% identified as White.

CSS ODYSSEY FY2015-16: GENDER (N=87)



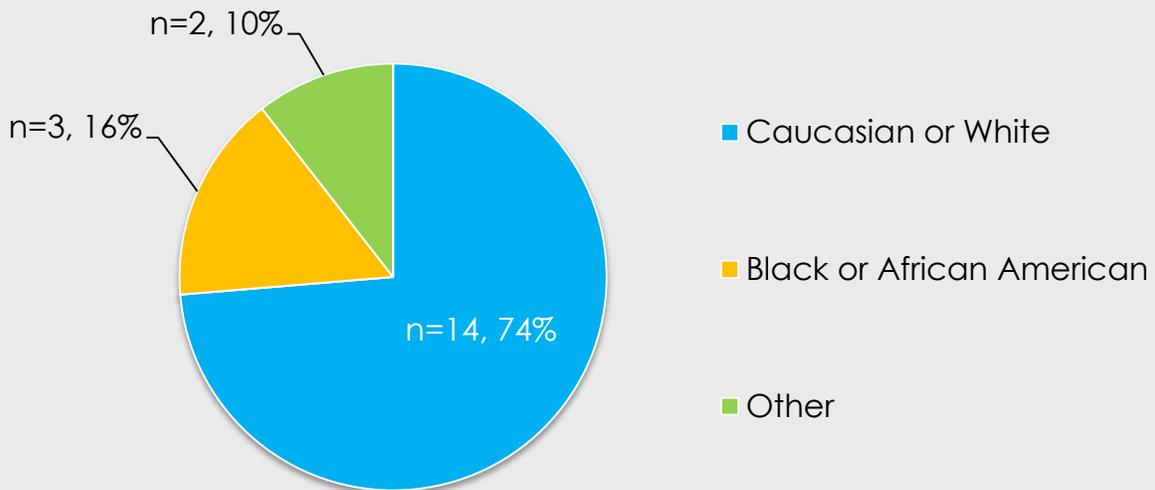
During the 2015-2016 Fiscal Year, the Odyssey FSP served 51 females and 36 males.



During the 2015-2016 Fiscal Year, the Odyssey FSP experienced a decrease in homelessness, hospitalization, incarceration, arrest events, and mental health emergency events.

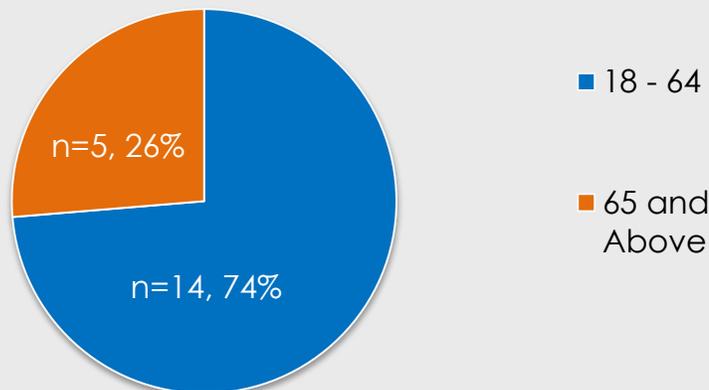
ODYSSEY STEP DOWN DATA

**CSS ODYSSEY STEP DOWN FY2015-16:
RACE/ETHNICITY (N=19)**



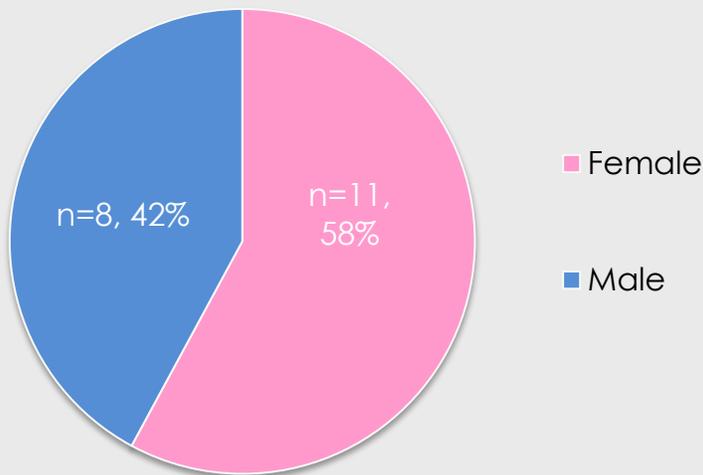
During the 2015-2016 Fiscal Year, the majority of participants in the Odyssey Step Down program identified as White.

**CSS ODYSSEY STEP DOWN FY 2015-16:
AGE GROUP (N=19)**



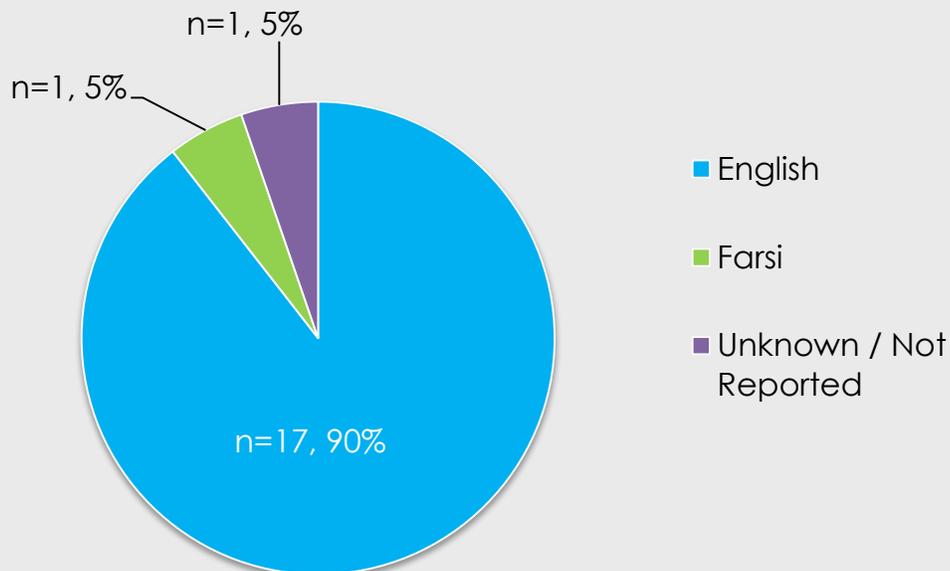
During the 2015-2016 Fiscal Year, 74% of participants in the Odyssey Step Down program were 18-64 years old and 26% were 65 years old or older.

CSS ODYSSEY STEP DOWN FY2015-16: GENDER (N=19)



During the 2015-2016 Fiscal Year, the Odyssey Step Down program provided services for 19 individuals, 8 were male and 11 were female. 17 individuals preferred English and 1 individual preferred Farsi.

CSS ODYSSEY STEP DOWN FY2015-16: PREFERRED LANGUAGE (N=19)



PROGRAM CHALLENGES

In FY2015-16, the Odyssey Program was implemented as described in the MHSa Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17, which included the addition of a Step-Down component. This component is staffed by a support service worker with lived experience and a peer specialist, to provide services to 40 participants who continue to struggle with independent community living but no longer require the support of the assertive community treatment component of the program. The objectives of this component were to increase the capacity for assertive community treatment services, in addition to supporting smooth transitions from intensive services to independence. Since implementation in 2015, this component has struggled to define criteria for participants appropriate to the component, as well as clear delineation of roles between the para-professional with lived experience and the peer specialist.

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

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

As we approach the next MHSa Three-Year Program and Expenditure Plan, the Odyssey Program will define strategies for attaining outcome goals, including evaluation for adherence to the Full Service Partnership model. It is likely that the Step-Down component will be absorbed into the FSP, in an effort to provide enhanced Peer Specialist Services to a greater number of people.

CLIENT STORY - ODYSSEY FULL SERVICE PARTNERSHIP

One of our consumers suffered from command auditory hallucinations, panic attacks and flashbacks related to an intense fear of becoming homeless again.

Due to the intensity of his symptoms, he had become unable to leave his apartment alone, other than to walk along extremely restricted routes to perform very specific tasks.

He also had become unable to use public transportation, and would often spend hours lying on his back in his apartment, paralyzed by fear.

With a team-based approach which included intensive and consistent ongoing contact with his personal care coordinator, adjustments to his medication regimen, individual therapy, and referral for vocational rehabilitation, he is now able to use public transportation, attends social events, playing his music at an open mic event bi weekly. He will also begin working in the Growing Excellence in Marin (GEM) program, through Integrated Community Services, in the next month with the hope of transitioning into a part time employment within his community.

ENTERPRISE RESOURCE CENTER (ERC) EXPANSION

PROGRAM OVERVIEW

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

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

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

TARGET POPULATION

The target population of the ERC Expansion Program is transition-age youth (18+), adults and older adults who have serious mental illness and their families, many of whom are currently disenfranchised or reluctant to become involved in the mental health system. These individuals may or may not have a co-occurring substance use 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 support. In addition to optimizing outreach and engagement possibilities, an expanded client-operated Enterprise Resource Center co-located with other services that promote and support recovery builds trust, maximizes opportunities for collaboration and increasingly engages clients in their own recovery process. Managed and staffed entirely by mental health consumers, the center promotes a strengths-based, harm-reduction approach and offers clients a one-stop central location to access and receive services such as socialization activities, peer counseling, mentoring, psycho-educational activities, and support groups. Consumers working to assist other consumers serve as role models and a message of hope that further promotes wellness and recovery.

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

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

EXPECTED OUTCOMES

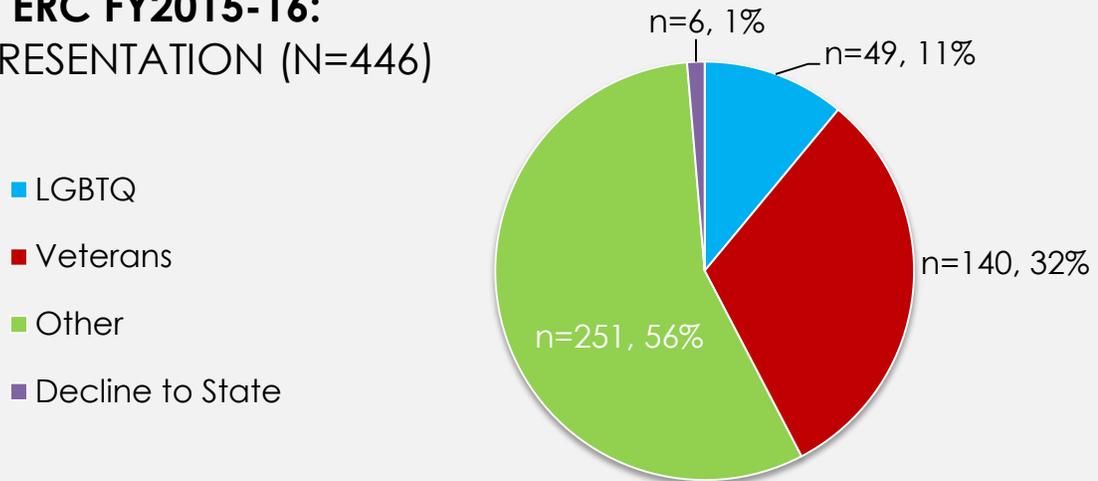
Listed in the table below, the expected outcomes for the ERC Expansion Program are based on the goals of the program and currently remain unchanged. There may be a need to adjust some of the program goals in response to the more accurate data being collected and reported. The data for these measures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

	Goal	FY2015-16
# ERC first time visitors	200	292
Average daily attendance	35	50
# Warm Line contacts	6,500	6,249
Average monthly contacts - CARE	100	57

ACTUAL OUTCOMES

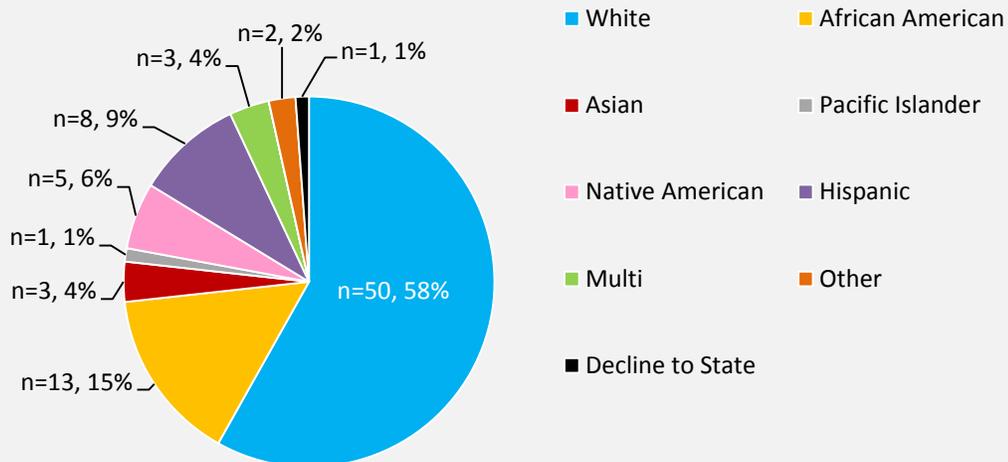
As in previous years, the ERC continues to exceed the goals of the program. In FY2015-16, there were a total of 14,241 consumer visits, with an average daily attendance of 50 people, representing a 6% increase from last year. Of those attending, 13% (1,904) self-identified as homeless. There were 292 were first-time visitors, significantly exceeding the goal of 200. Seventy-five of those chose to enroll in the ERC Membership Program, for a current total of 371 members accessing additional resources such as computers. The Linda Reed Activities Club continues to be popular and had a cumulative attendance of 1,105 throughout the year. The Warmline was able to assist callers with 6,249 contacts, short of the goal of 6,500. The 1108 Gallery, an Art Gallery showcasing consumer Artwork, celebrated its second year. Six Peer Specialist courses were held, expanding total enrollment to 59. Forty-four (75%) successfully completed the course. Challenges related to the CARE team not meeting goals for monthly contacts will be discussed in challenges section below.

**CSS ERC FY2015-16:
 REPRESENTATION (N=446)**



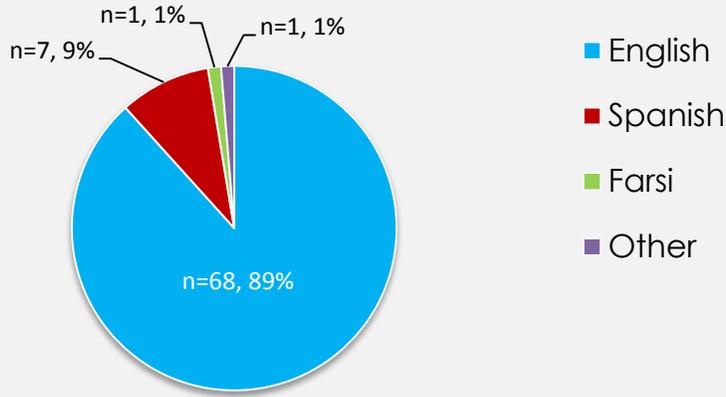
During the 2015-2016 Fiscal Year, the Enterprise Resource Center had contact with members of the Veteran's, LGBTQ, and other communities.

**CSS ERC FY2015-16:
 RACE/ETHNICITY (N=86)**



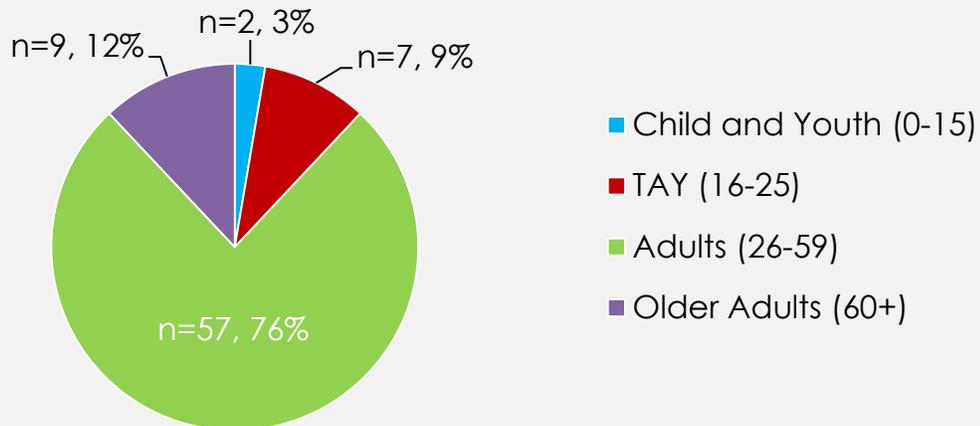
During the 2015-2016 Fiscal Year, the Enterprise Resource Center provided services to 86 participants, 58% identified as White, 15% identified as African American, and 9% identified as Hispanic.

CSS ERC FY2015-16: PRIMARY LANGUAGE (N=77)



During the 2015-2016 Fiscal Year, the Enterprise Resource Center primarily served English speaking individuals.

CSS ERC FY2015-16: AGE GROUP (N=75)



During the 2015-2016 Fiscal Year, the Enterprise Resource Center predominantly served Adults age 26-59 years old.

PROGRAM CHALLENGES

In FY2015-16, ERC has continued to re-stabilize following the retirement of staff from key management and administrative positions. They have continued internal development activities, particularly as new leadership shapes the future of the program. The Step-Up Recovery Program was not implemented as originally planned. Among other issues, it has become difficult to secure additional space due to rising real estate values. Alternately an RFP process will occur in FY-2015-16 for a Clubhouse model program. Challenges have been faced with consistently staffing the CARE team, partially due to challenges with cost of living in Marin and relatively low pay of Peer Counselors. This will be evaluated as part of the next three year planning stakeholder process.

In FY2016-17 the program will continue to explore opportunities for organizational development. A particular area for development will be a feasibility assessment of the potential for the ERC to detach from the umbrella organization of Community Action Marin, and become a fully Peer owned and operated program. This restructuring will be proposed for funding in the next round of MHSA three year community planning process.

CLIENT STORY – ENTERPRISE RESOURCE CENTER

The ERC has given me a very strong sense of community and connection with others that have experienced mental health issues. I have made many lasting, quality acquaintances and friendships over time. I have served as an administrative assistant, one on one peer counselor, peer case manager, and now, for the last five years, a volunteer peer counselor. The ERC has given me many opportunities to grow both personally and professionally. I have been through many ups and downs and the staff and volunteers were always there to support me in times of need. CAM Mental Health and the ERC have made a huge impact on my life for the better. I know that this is true for many of the volunteers, employees and clients who frequent the ERC as well. I feel very blessed and grateful to be a part of this rich, family-like community.

.....

The ERC is a supportive place. My friend Beth encouraged me to come to the ERC in 1998. The first group I went to was the art class. Beth told me about a Process Group with a Peer named Jesse in 1999. 2001 was a rough year for me. My mom died and I had a rough time in a group home in Fairfax. Coming to the ERC and Tam Day in San Anselmo and calling the Warmline were very helpful. I still attend the ERC Process groups almost daily. I also facilitate a Drama Therapy Group at the ERC every Thursday.

.....

My name is Angela and I am a great fan of the ERC. I first came to the ERC in 2013 to use the computers and have coffee. At the time I was going through a great loss, grieving for my son who was born prematurely and died just two weeks after being born. I was very depressed and ended up losing everything after I lost him. I fell into such a great depression that soon I didn't know how to survive and became homeless. I was mentally ill and out in the streets of San Rafael. I would often stop at the ERC to go to a group or use the computer, but I wasn't well at all. This year things started changing (after much wreckage) in part to the support I received from the ERC, Mill Street Shelter, and my higher power. I am now staying at New Beginnings and even though I am not 100%, I have been able to attend and graduate both the "WRAP" and "Intro to Peer Counseling" classes. I was able to focus enough to learn and grow and get experience to maybe be a Peer Counselor. I am very excited to have accomplished these goals through the ERC. I also participated in the play "Stigma Stew," put on by the Peer Players for Mental Health Month. I continue to have fun at the Saturday Art Group and I still really love coming to the ERC.

SOUTHERN MARIN SERVICES SITE (SMSS) PROGRAM

PROGRAM OVERVIEW

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

TARGET POPULATION

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

PROGRAM DESCRIPTION

The Southern Marin Services Site Program (SMSS), initially implemented by Family Service Agency, which is now part of Buckelew Programs, has an outreach and engagement component that targets unserved and underserved children with serious emotional disturbance and adults with serious mental illness living in the Southern Marin area. The program provides an array of culturally competent, recovery-oriented mental health services, with special attention paid to providing services to ethnic minorities in that area of the County. In-house services include individual psychotherapy for adults and children, Parent Child Interaction Therapy (PCIT), couple's therapy, family therapy, medication evaluation, substance use services, and case-management services. In addition, home visits are conducted by a parent aide/family advocate trained in Triple P (Positive Parenting Program). Clinical staff members stationed at Willow Creek school provide facilitated groups, classroom guidance, and individual counseling. In late 2011, SMSS stationed a clinician at the Phoenix Project, which focuses on young men in Marin City. They provide psycho-education, clinical counseling and case management services, parenting support, assistance with re-entry, and goal setting.

EXPECTED OUTCOMES

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

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

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

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

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

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

ACTUAL OUTCOMES

In FY2015-16, SMSS provided services for a total of 229 residents, as follows:

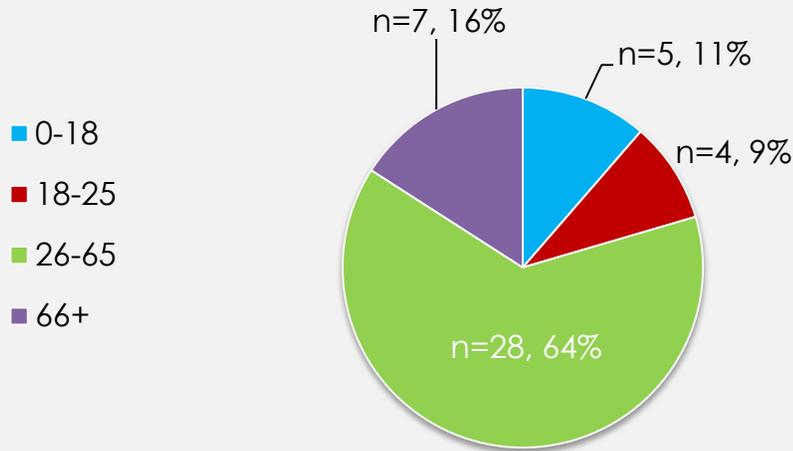
- Outpatient services for SED/SMI children/adults 44 individuals
- Home visiting by Family Advocate/Parent Aide 12 families (17 parents, 23 children)
- School-based services at Willow Creek by BACR 49 students
- Community Services Project referrals 96 individuals

Outpatient Services Clients	Actual FY2015-16
Clients that received outpatient behavioral health services	44
Clients from un-served and under-served populations	100%
Percent of clients on MediCal eligible	76%
Percent of clients experiencing serious emotional disturbance/mental illness	100%
Percent of clients that are residents of Southern Marin	100%

Outpatient Services Outcomes	Goal	Actual FY2015-16
Percent of children experiencing improvement or stabilized in one or more dimension on the Child Outcome Survey.	70%	NA
Percent of adults experiencing improvement or stabilized in one or more dimension on the Adult Outcome Survey.	70%	82% N=44
Percent of families receiving home visiting services for at least 6 months experiencing improvement or stabilized in one or more parenting/caregiving dimension on the Adult Outcome Survey.	70%	88% N=8

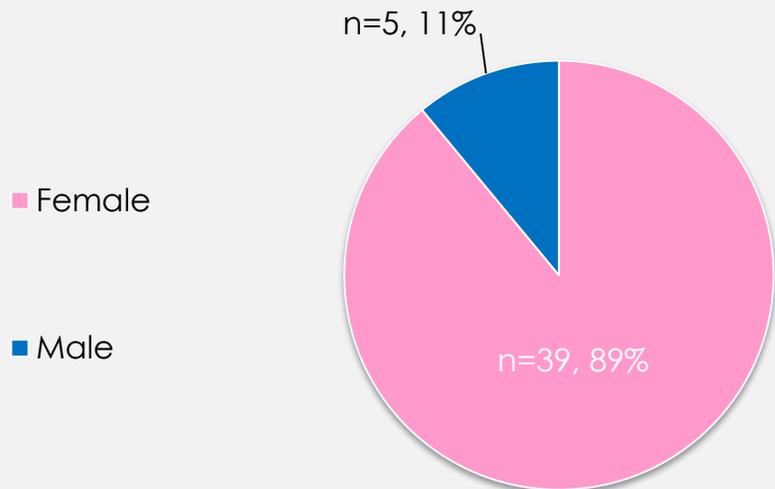
* Southern Marin Services provided community education in these areas: Suicide Prevention, Teen Resilience and Teen Screen. There is no measured outcome for TeenScreen at this time, other than the number of students referred for further treatment.

CSS SMSS FY2015-16: AGE GROUP (N=44)

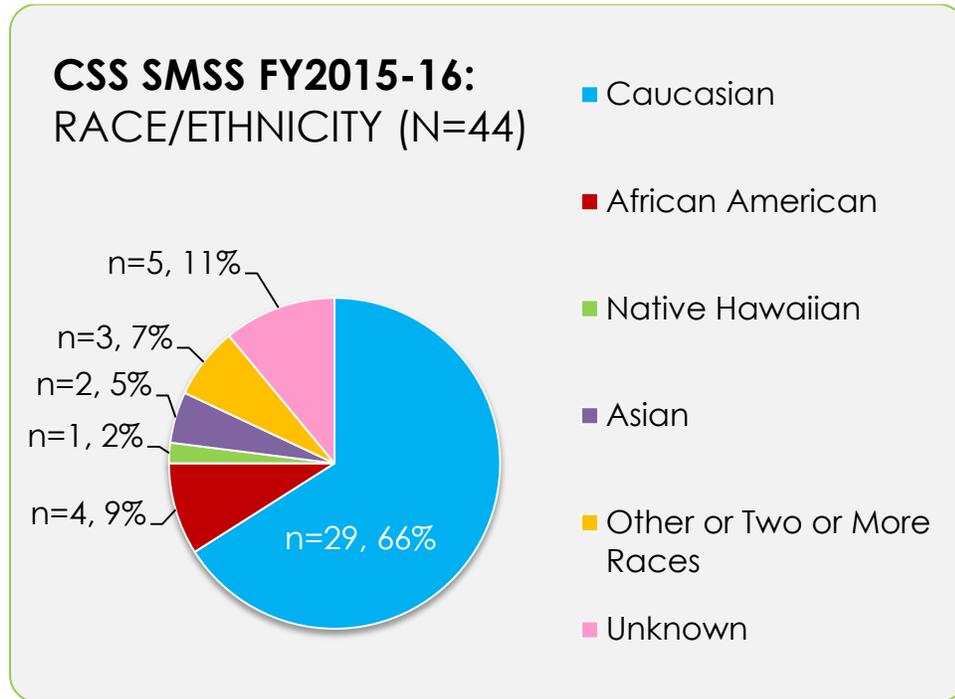


During the 2015-2016 Fiscal Year, the Southern Marin Services Site (SMSS) provided services to 44 individuals, the majority of which were 26-65 years old.

CSS SMSS FY2015-16: GENDER (N=44)



During the 2015-2016 Fiscal Year, the majority of individuals who received services at the Southern Marin Services Site (SMSS) were female.



During the 2015-2016 Fiscal Year, the Southern Marin Services Site (SMSS) provided services to 44 individuals, of which 29 identified as Caucasian, 4 as African Americans, 4 as Asian, and 5 were unknown.

School Based Service	Actual FY2015-16	
Clients that received school based counseling	49	
Average number of in person services clients received	14	
Change on a five point scale	Pre	Pre
- Has stable emotional functioning	3.4	3.6
- Has positive family/adult/peer relationship	3.4	3.7
- Is able to cope and navigate	3.4	3.6
- Avoids high risk behavior	3.9	4.1
- Stage of change	3.5	3.7

PROGRAM CHALLENGES

In FY2015-16, Marin City leaders and residents requested to receive more culturally appropriate, responsive and appropriate services. SMSS and BHRS met to discuss a more effective outreach and engagement strategy that would improve the penetration rate of, and access to services by, community residents. Some changes were made to the existing program. In February 2016, BHRS decided to close the existing program at the end of FY2015-16. New services will be included in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20.

ADULT SYSTEM OF CARE (ASOC) EXPANSION

PROGRAM OVERVIEW

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

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

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

TARGET POPULATION

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

PROGRAM DESCRIPTION

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

Increased Peer Specialist Services

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

Provide Outreach to and Engagement with Hispanic/Latino Individuals

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

Increased Outreach and Engagement to Vietnamese-Speaking Individuals

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

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

Family Outreach, Engagement and Support Services

This program component expanded the operations of the existing Children's System of Care Family Partnership Program into the ASOC through the addition of a part-time Family Partner with personal experience as a family member of an adult with mental illness. The ASOC Family Partner provides outreach and engagement services to families of adults with serious mental illness, as well as family-to-family case management services, including provision of support and advocacy,

assistance with service plan development and implementation, information and referral to NAMI-Marin and other local community resources, and co-facilitation of family support group

EXPECTED OUTCOMES

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

Outcomes	Goal	FY2015-16
# Served	325	245
% Hispanic	50%	13%
# Primary language-Spanish	100	22
# Asian	15	39
# Primary language-Vietnamese	10	29
# Served – Outreach & Engagement team	20	155

ACTUAL OUTCOMES

In FY2015-16 ASOC has seen a significant increase in the number of people needing an intensive level of services. It is likely that this is attributable to increased outreach efforts and development of a cohesive Crisis Continuum of Care, which is appropriately identifying and engaging new consumers into planned (non-crisis based) services. Due to demand for intensive services, ASOC was not able to serve the number of people traditionally served by the same staffing levels: 245 unique individuals, compared to the goal of 325. In response, we will be expanding all of our services to accommodate this increased demand. We will also continue to evaluate effectiveness of getting the right consumers into the right programs based on each person’s individual needs.

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

Outreach and Engagement with Hispanic/Latino and Vietnamese Individuals continues to develop and build a strong component of the ASOC. Services are provided in part by the Community Health Advocate (CHA) Liaison, a part-time clinician who works with the Promotores, Vietnamese CHA’s and other key partners, utilizing a variety of strategies intended to improve community awareness of mental health issues and resources, improve access and increase mental health related services and resources for Hispanic/Latino and Vietnamese community member, including:

- Training and support for Latina mental health CHA’s through meetings 2 times a month

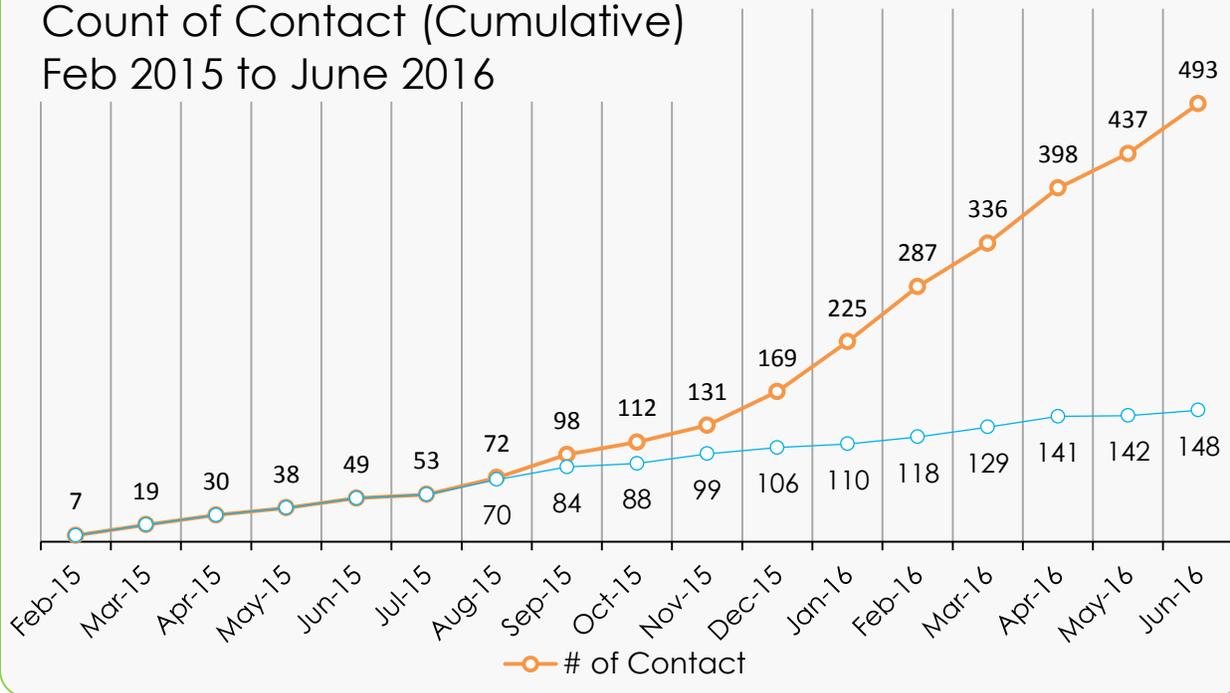
- Training and supervision of bilingual and bicultural interns who support the Latino and Vietnamese Family Health programs by providing culturally appropriate mental health services such as community educational/recreational events and stress management groups.

The interns serve more than 150 individuals throughout the year.

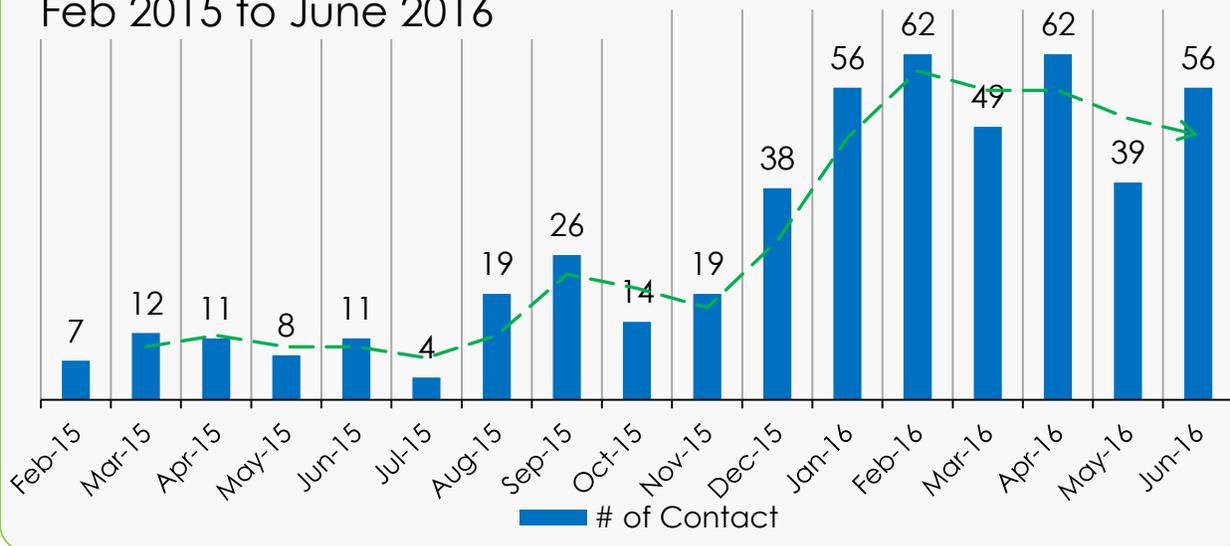
- Provision of information, referral, brief interventions and linkage to services for more than 200 Latino adults
- Provision of no-cost classes in Spanish, including parenting classes, psychoeducational groups for women, and behavioral activation groups
- Provision of multiple presentations to the community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

ASOC Outreach and Engagement Team newly launched in FY2014-15, the Outreach and Engagement Team (O&E) 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 serious mental illness with symptoms that result in significant functional impairments in activities of daily living, social relations, and/or ability to sustain housing, but who are not in crisis, are not current clients of the public mental health system, and are unwilling or unable to engage in treatment. These individuals may or may not have a co-occurring substance use disorders and/or other serious health conditions. The team responds to calls for assistance and provides outreach services in-home and in the community county-wide, with a goal of engaging individuals in the ASOC. In FY2015-16, the team provided 550 services to 155 individuals. The initial design for this program provided more intensive services to a smaller number of individuals. The initial goal was to serve approximately 20 individuals per year. Due to the high level of demand for these services, the program has greatly expanded the number of individuals served, with a result of providing less intensive services. It is likely that this program will be re-evaluated during the approaching MHSA three year planning process to determine suitability of expansion.

Outreach & Engagement: Count of Contact (Cumulative) Feb 2015 to June 2016



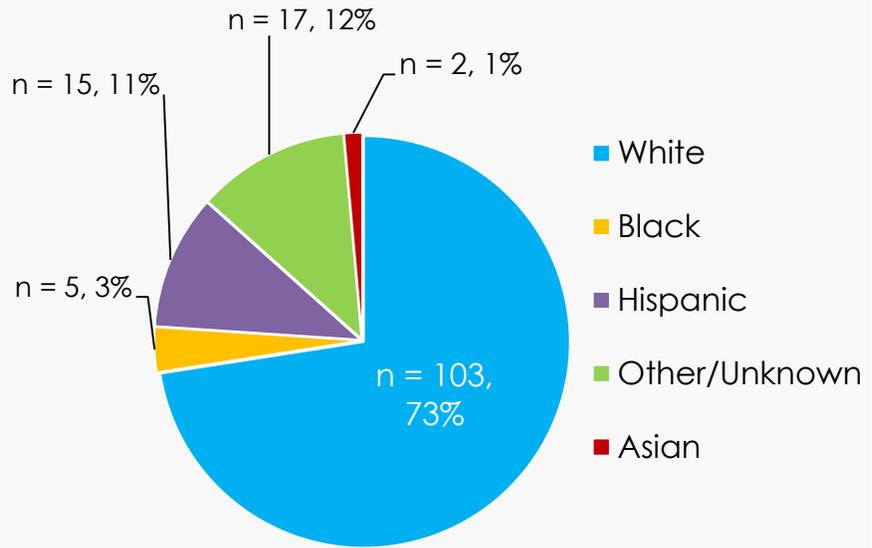
Count of Contact per Month: Feb 2015 to June 2016



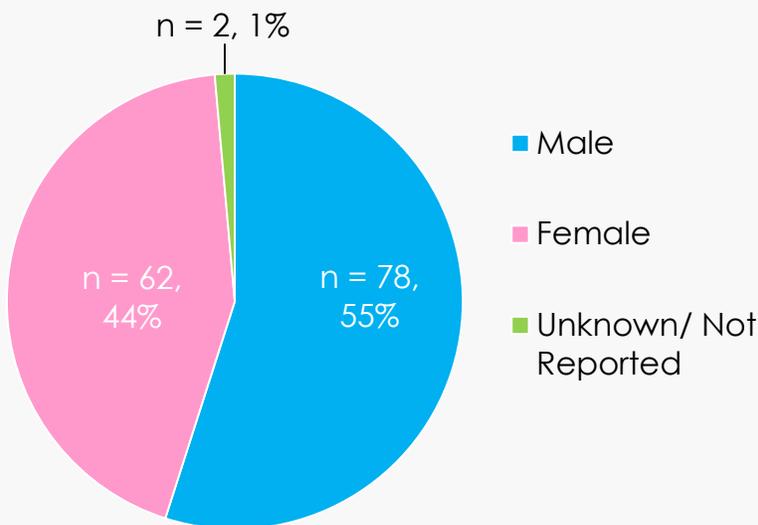
Between February 2015 and June 2016, the Outreach and Engagement team had a peak of 62 contacts in the months of February and April 2016.

During the 2015-2016 Fiscal Year, the Outreach and Engagement team provided services to 142 individuals, of which 73% identified as White.

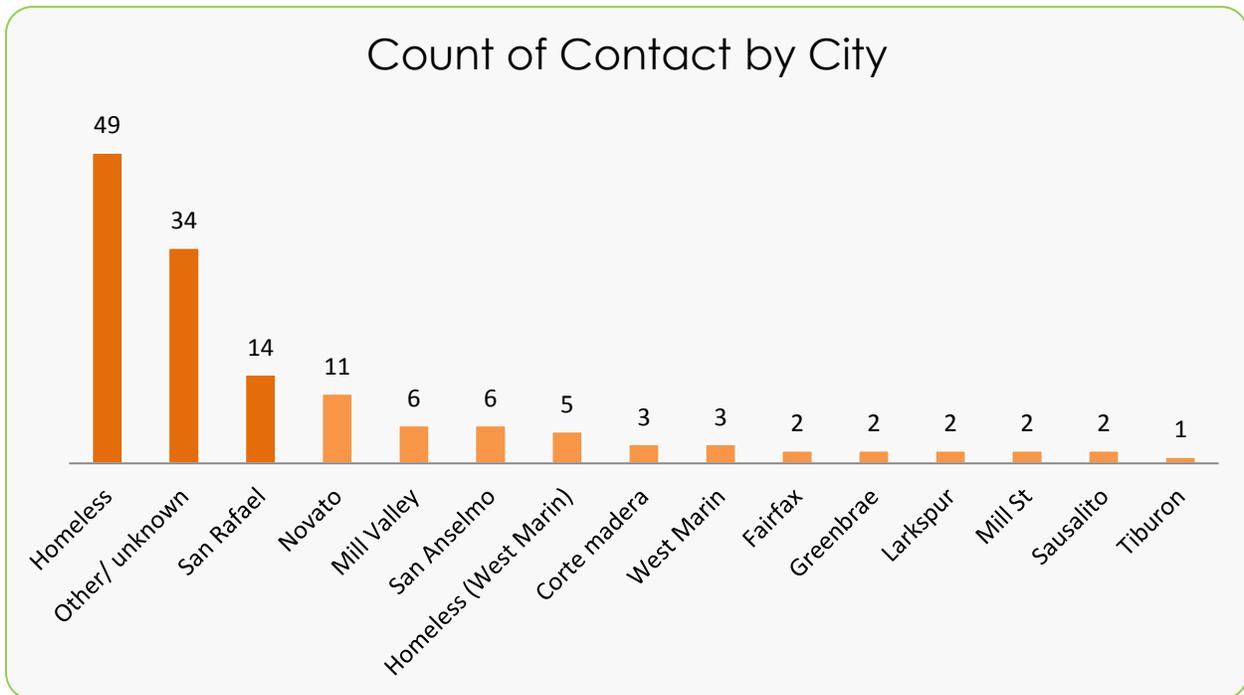
**O&E FY2015-16:
 RACE/ETHNICITY (N=142)**



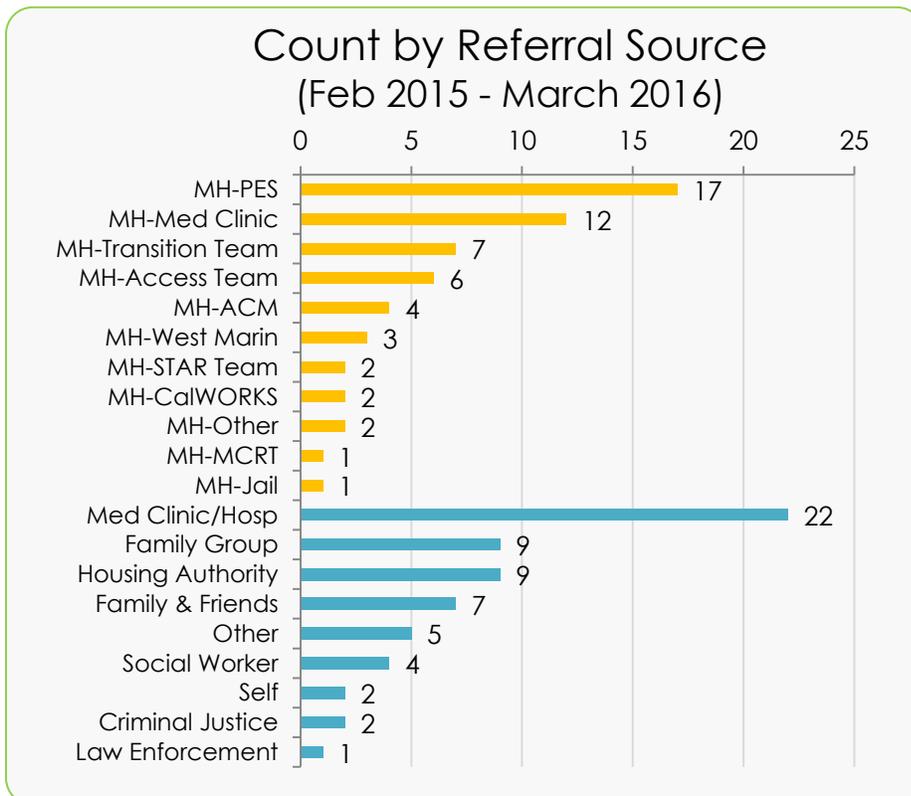
**O&E FY2015-16:
 GENDER (N=142)**



During the 2015-2016 Fiscal Year, the Outreach and Engagement Team provided services to 78 males, 62 females, and 2 Unknown/Not Reported individuals.



During the 2015-2016 Fiscal Year, the Outreach and Engagement Team were in contact with 49 homeless individuals and 34 individuals who identified their residence as 'Other/Unknown'.



Between February 2015 and March 2016, the Outreach and Engagement Team received the majority of their referrals from the Med Clinic/Hospital or the Psychiatric Emergency Services (PES) now named Crisis Stabilization Unit (CSU) – labeled MH-PES on the adjacent graph.

PROGRAM CHALLENGES

In FY2016-17, the ASOC programs will be challenged once again by retirements and reassignments of key leadership staff. The primary focus of the year will be the integration of the system's two largest teams, what has been known as Adult Case Management and Medication Clinic, into one large interdisciplinary team. The newly formed team will be divided between two locations, to continue to allow consumer choice in where services are accessed. In addition to providing more coordinated care, this will also allow for a higher level of support for a larger number of people.

In FY2017-18, we will be exploring options for development of a new Assertive Community Treatment Program. The goals of this program would be to serve clients needing a high level of intensity of services, but who do not fit the established eligibility criteria for a Full Service Partnership. We will also be exploring options for locating a clinic in Novato, where due to affordable housing locations, an expanding number of consumers reside.

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. In the last few years, some of the CSS programs have increased their capacity to address co-occurring disorders, and significant progress has been made in increasing coordination and integration of mental health and substance use services and administration. The Three-Year plan presents the opportunity to expand and institutionalize these efforts in order to effectively and seamlessly serve clients with co-occurring mental health and substance use disorders, including tobacco dependence.

TARGET POPULATION

Alliance in Recovery (AIR) Program

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

Co-Location of Substance Use Specialist – Recovery Connections Center

The target populations of the services provided by the licensed consulting substance use specialist are both County and County-contracted mental health staff/providers, and youth, adult and older adult clients and families in the County mental health system of care.

Peer to Peer Tobacco Cessation Services

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

PROGRAM DESCRIPTION

Alliance in Recovery (AIR) Program

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

Co-Location of Substance Use Specialist – Recovery Connections Center

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

Peer to Peer Tobacco Cessation Services

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

EXPECTED OUTCOMES

Alliance in Recovery (AIR) Program

The goals initially established for the AIR Program are to reduce hospital days, Crisis Stabilization Unit (CSU), formerly known as Psychiatric Emergency Services (PES) admissions, homelessness and criminal justice involvement. Specific goals are listed in the FY2015-16 Outcomes section. Although this is not a Full Service Partnership, it is intended that the data for these measures are obtained from the Full Service Partnership dataset mandated by the State Department of Health Care Services and collected/reported by the AIR Program staff on a daily basis. Program staff will continue to explore methods for measuring engagement.

Co-Location of Substance Use Specialist – Recovery Connections Center

As this project focuses on staff capacity building and providing an ancillary or short-term service for clients in the mental health system of care, the expected outcomes associated with this project are largely process-oriented, such as number of clients served and change in provider skills. A follow-up survey also collects data on change in substance use for clients. Data is being collected and reported through a combination of Marin WITS—the substance use electronic health record—and service logs.

Peer to Peer Tobacco Cessation Services

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

ACTUAL OUTCOMES

Alliance in Recovery

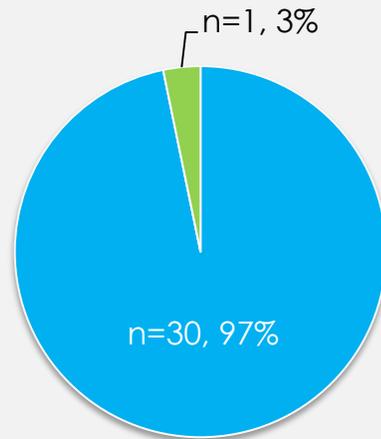
In addition to engaging 31 individuals in case management, and individual and group counseling services, AIR provided outreach, information and engagement group sessions at community agencies, including Homeward Bound Voyager, Buckelew Programs Supported Housing, Casa Rene Crisis Residential, and Helen Vine Recovery Center.

There is no FY15-16 data to report for reduced hospital days, homeless days, Crisis Stabilization Unit admissions and criminal justice involvement as the data was not entered into Clinician’s Gateway due to the impact it has on the FSP dataset. The AIR team is exploring whether the measures identified during the three-year planning process sufficiently capture the intended outcomes of the program.

	GOAL	Actual FY2015-16
Number of clients with mental health and substance use disorders	40	31
Reduced hospital days	30%	
Reduced Crisis Stabilization Unit admissions	30%	
Reduced homeless days	30%	
Reduced criminal justice involvement	30%	

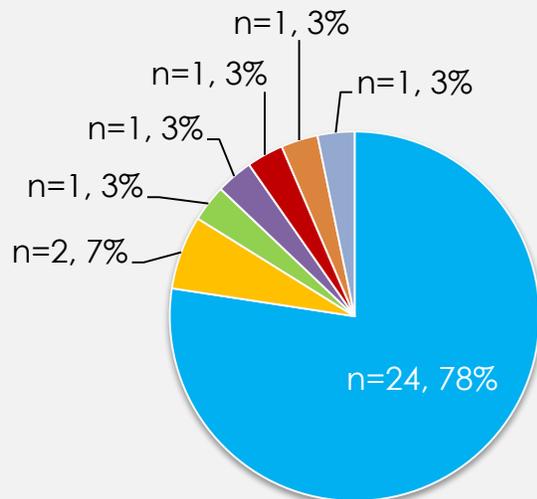
**CSS AIR FY2015-16:
 PRIMARY LANGUAGE (N=31)**

- English
- Vietnamese



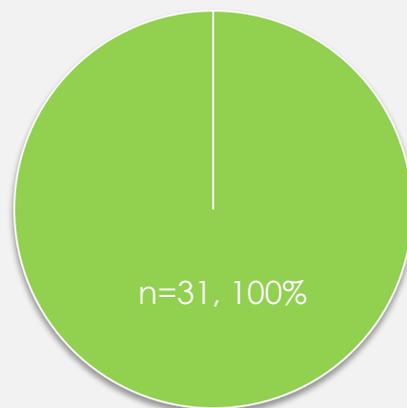
**CSS AIR FY2015-16:
 RACE/ETHNICITY (N=31)**

- White
- African American
- Vietnamese
- Filipino
- Native
- Hispanic
- Other



**CSS AIR FY2015-16:
 AGE GROUP (N=31)**

- 26-59



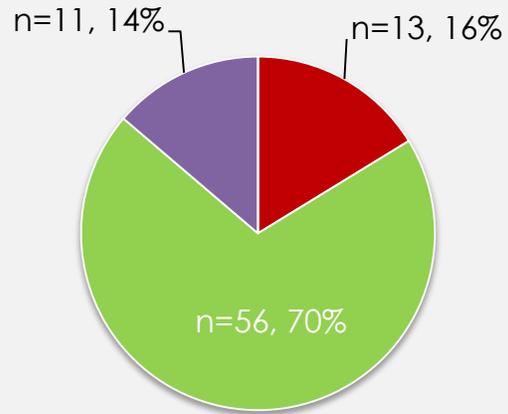
Co-Location of Substance Use Specialist – Recovery Connections Center

The consulting addiction specialist continued to provide staff consultation and direct client care at mental health sites and programs throughout the County. Through this work, the following outcomes were achieved during the FY2015-16 project period:

Outcome	Goal	Actual FY2015-16
Number of mental health County and contractor staff/providers (Crisis Stabilization Unit, BHRS medical providers, HHS Division of Children and Family Services, Casa Rene Crisis Residential program and others) receiving case consultation and staff training/presentations	50	>100
Number of mental health clients receiving substance use assessment, care management and other support services	75	80
Staff receiving consultation report increase in ability to address substance use issues	80%	98%
Clients served will take recommended action in relationship to reducing substance use and/or related problems. Upon follow-up clients reported:	50%	49%

**CSS RCC FY2015-16:
 AGE GROUP (N=80)**

- 16-25
- 26-59
- 60+



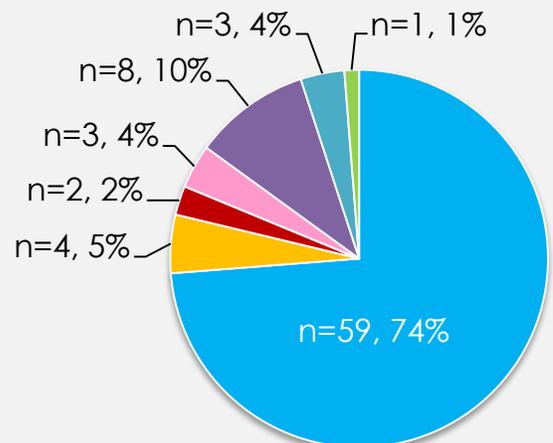
**CSS RCC FY2015-16:
 PRIMARY LANGUAGE (N=80)**

- English



**CSS RCC FY2015-16:
 RACE/ETHNICITY (N=80)**

- White
- African American
- Asian
- Native
- Hispanic
- Multi
- Not Reported



Peer to Peer Tobacco Cessation Services

Most program objectives were met during the FY2015-16 project period, including 75% of clients participating in peer-led cessation services reporting attempting to stop smoking. The number of clients participating in smoking cessation services exceeded the annual goal by 61%. On February 14, 2016 in the Marin Independent Journal, a story about this peer-led program was published; see Appendix V – Co-Occurring Marin IJ Article for details.

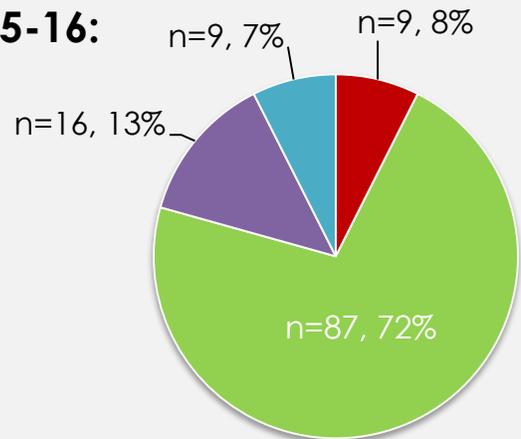
Below is a summary of outcomes that were achieved during the FY2015-16 project period:

	GOAL	Actual FY2015-16
Number of peers receiving training and supervision to provide peer to peer smoking cessation services	8	9
Number of mental health clients participating in smoking cessation services	75	121
Percentage of clients participating in peer-led cessation services who report reducing their tobacco use	60%	44%
Percentage of clients participating in peer-led cessation services who report attempting to quit smoking	75%	75%
Percentage of clients participating in peer-led cessation services who maintained their quit status at 3-month follow-up	30%	3%
Number of County and contractor agencies that integrate tobacco cessation support into their programs	5	4

Demographics

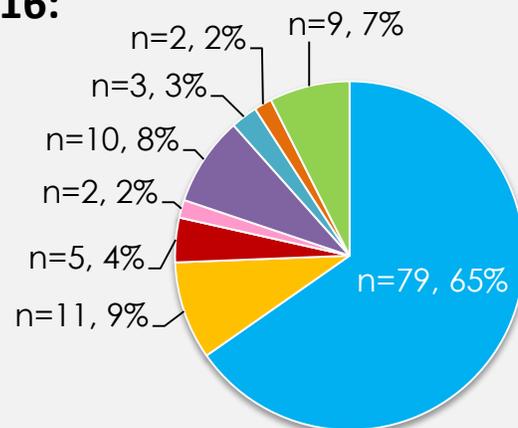
**CSS TOBACCO CESSATION FY2015-16:
 AGE GROUP (N=80)**

- 0-15
- 16-25
- 26-59
- 60+
- unknown



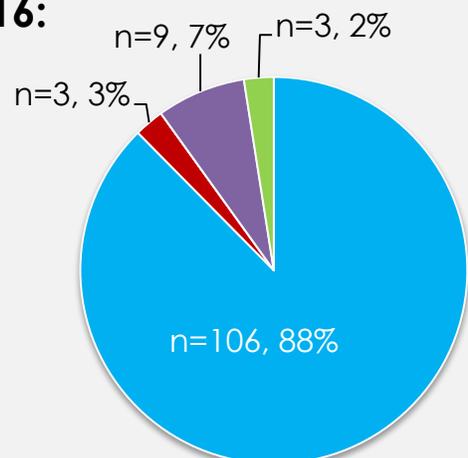
**CSS TOBACCO CESSATION FY2015-16:
 RACE/ETHNICITY (N=80)**

- White
- African American
- Asian
- Native
- Hispanic
- Multi
- Other
- Not Reported



**CSS TOBACCO CESSATION FY2015-16:
 PRIMARY LANGUAGE (N=80)**

- English
- Spanish
- Not Reported
- Unknown



PROGRAM CHALLENGES

In FY2016-17, the Alliance in Recovery program experienced significant staffing and programmatic changes, resulting in services being paused in the Fall of 2016. Although clients were successfully transitioned to other programs and services—including the new County-operated *Road to Recovery* substance use treatment program—there continues to be a need for engagement services for individuals with co-occurring Serious Mental Illness and substance use disorders. In the upcoming Three-Year Plan, it is recommended to integrate AIR services into existing programs.

Similar to FY2015-16, co-location of a consulting addiction specialist has been invaluable in terms of staff consultation services and direct client care. However, the staff time needed to successfully address the complex needs of the client population does not afford the additional time necessary of many mental health staff and programs to also take on the capacity building aspect of the project as originally envisioned. Despite the County continuing to allocate substance use services funding to make the consulting addiction specialist a full-time position, staff capacity building remained fairly limited. In the upcoming Three-Year Plan, it is recommended to implement other strategies that effectively increase the co-occurring capacity of the behavioral health workforce, while ensuring continuity in care for existing clients served through the consulting addiction specialist.

CRISIS CONTINUUM OF CARE

PROGRAM OVERVIEW

The Crisis Continuum of Care significantly expanded during FY2015-16. With the addition of funding from the Investment in Mental Health and Wellness Act of 2013, The Continuum was extended to include a Mobile Crisis Response Team (MCRT) and a Transitions Team. The Continuum now includes Crisis Planning, MCRT, Transitions, Outreach and Engagement, Crisis Stabilization Unit, crisis-focused family support and the Crisis Residential Unit. The additional services have been well received by consumers, families, and the larger community. Due to the success of these programs, expansion is now needed. Stakeholders have provided feedback that the capacity of these services is inadequate to meet the needs, and plans are in place to include expansion of these programs during the next MHSA three year planning process. To support this effort the entirety of the Continuum will be outlined here, with funding streams noted under each program.

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 less choice on the consumer's part about services. Current approaches to care clearly demonstrate that if crises can be detected early on and the individual can be linked to appropriate services, such as crisis planning, crisis residential or other support services, crises can often be resolved through voluntary services, and the need for involuntary services such as hospitalization can be avoided or drastically reduced. Additionally, individuals are empowered to make choices for themselves before a crisis hits, when judgement and decision making is most impaired, forcing others to make decisions about their care such as law enforcement, hospital staff, or jail personnel.

TARGET POPULATION

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

Crisis Planning

PROGRAM DESCRIPTION

The Crisis Planning program consists of specially trained Peer Specialists who assist individuals at risk of psychiatric crises to create a plan for treatment should they experience future crises (a "crisis plan"). This team collaborates closely with the Crisis Stabilization Unit (CSU), Crisis Residential Unit, treatment providers and others to engage individuals. They meet with people in the community to create a realistic plan for care that the client can utilize if they find themselves experiencing signs of a crisis. The plan is placed in the client's Behavioral Health electronic record, with client permission, so that it can be used as a guide if the client presents to CSU in crisis. The

crisis planning staff are integral members of the Crisis Continuum, participating in weekly Crisis Residential meetings.

Crisis Planning aims to (1) increase clients' knowledge, skills and network of support to avoid crises or resolve them quickly when they do happen; (2) to inform CSU staff of client's wishes, particularly around treatment choices and family involvement when faced with a crisis; and (3) to engage and support clients participating in the Crisis Residential Unit in the completion of a crisis plan. Developing and using crisis plans allows for a more recovery-oriented focus, supporting individuals in choosing how they want to engage in their recovery.

The target population focuses upon those individuals at-risk of experiencing a psychiatric crisis, including individuals with a recent visit to CSU, clients in the Full Service Partnership programs, and those who are currently in the Crisis Residential Program. The planning services are available in both English and Spanish.

EXPECTED OUTCOMES

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

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

ACTUAL OUTCOMES

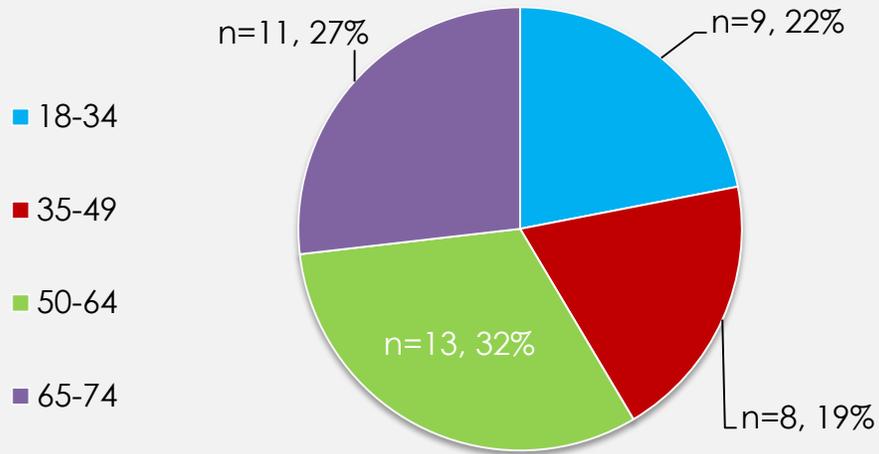
In FY2015-16, 50 individuals were supported to develop crisis plans. While we continue to strive to have crisis plans available to all staff who may interact with an individual, during times of crisis or during the course of outpatient treatment, an effective system has been implemented in CSU to store and have accessible crisis plans available if individuals present in crisis. At this time over 135 crisis plans are available to CSU staff when needed. All those with plans in effect are given the

CSS · CRISIS CONTINUUM OF CARE
PROGRAM ALLOCATION FY2015-16 \$600,000

opportunity to update them each year, and an ongoing follow-up group is available once per week for support and follow-up. Ongoing outreach to service providers is available in the form of brochures and availability to attend team meetings for education and support.

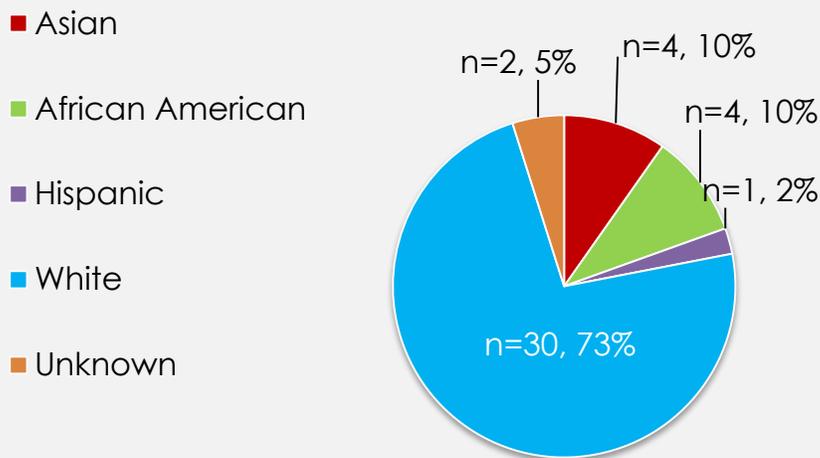
Over the course of the year, Crisis Planning Counselors conducted outreach and discussed crisis planning services with 120 individuals, far exceeding their goal of 80. Crisis Planning and follow up services were provided to 41 individuals and family members. At the time of this report, over 135 Crisis Plans have been added to client mental health records. Program plans for the future include expanding program capacity by integrating existing peer providers embedded in county programs to create crisis plans with their clients who have received services at CSU or the Crisis Residential Unit.

**CRISIS PLANNING FY2015-16:
 AGE GROUP (N=41)**



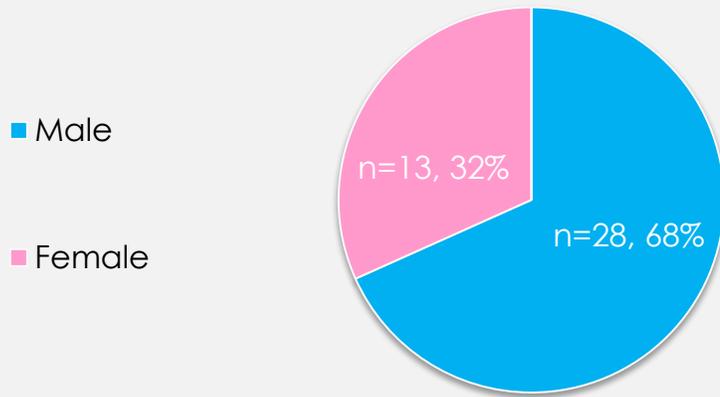
During the 2015-2016 Fiscal Year, the Crisis Planning Program provided services to 41 individuals, of which, 32% were 50-64 years old, 27% were 65-74 years old, 22% were 18-34 years old, and 19% were 35-49 years old.

**CRISIS PLANNING FY2015-16:
 RACE/ETHNICITY (N=41)**



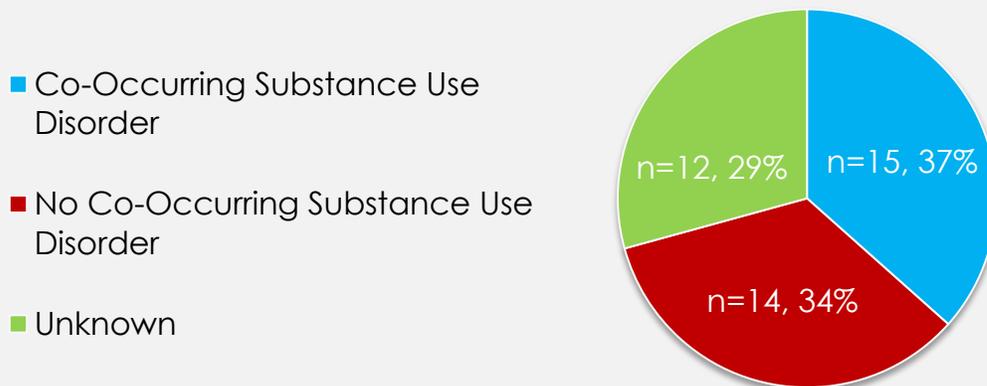
During the 2015-2016 Fiscal Year, the Crisis Planning Program primarily served individuals who identified as White.

CRISIS PLANNING FY2015-16: GENDER (N=41)



During the 2015-2016 Fiscal Year, the Crisis Planning Program served 28 males and 13 females.

CRISIS PLANNING FY2015-16: SUBSTANCE USE (N=41)



During the 2015-2016 Fiscal Year, the Crisis Planning Program provided services to 15 individuals with a co-occurring substance use disorder.

Mobile Crisis Response Team (MCRT)

PROGRAM DESCRIPTION

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. Since MCRT's launch in July 2015, the teams have provided 1,470 services to 700 individuals. In FY2015-16 MCRT served 426 individuals.

In addition to providing individual crisis support, MCRT provides crisis response and support for events affecting the larger community. For example, the team responded to an event involving an episode of fatal self-harm that occurred at a local medical clinic. MCRT was able to provide support to staff and other patients who witnessed this event. MCRT was also able to provide on-site support to a local high school community after the violent death of two of its students. Of particular salience to Marin Behavioral Health and Recovery Services (BHRS), one of our own staff died due to gun violence this year; MCRT was able to mobilize quickly to support internal behavioral health staff as we struggled to make sense of this tragedy and to grieve one of our own. Due to the high value this service brings to the Marin community, MCRT is in the process of being incorporated into our departmental Disaster Response Plan.

The community has expressed a desire for increased and expanded services through this program, and proposals will likely be presented as part of the MHSA three year stakeholder planning process. The intent is to expand the capacity and reach of this program, and to provide additional recovery-oriented services with expanded hours and increased geographical availability.

ACTUAL OUTCOMES

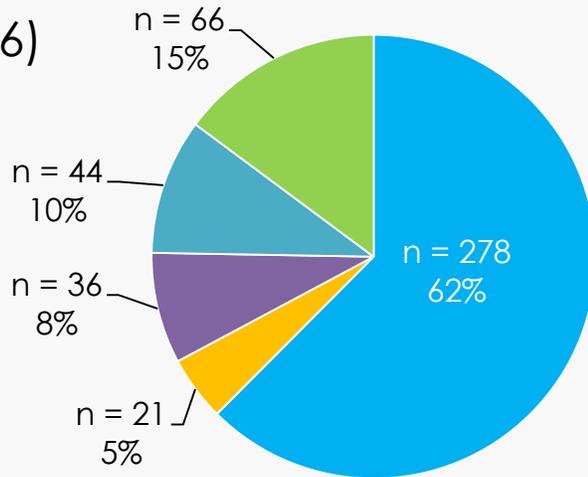
The Mobile Crisis Response Team began in July of 2015. Since, the program has provided services to 700 individuals and provided 1,470 services. In FY2015-16 MCRT served 426 individuals.

PROGRAM CHALLENGES

In FY2015-16, the Mobile Crisis Response Team was challenged by staffing changes and turnover.

CSS MCRT FY2015-16: RACE/ETHNICITY (N=426)

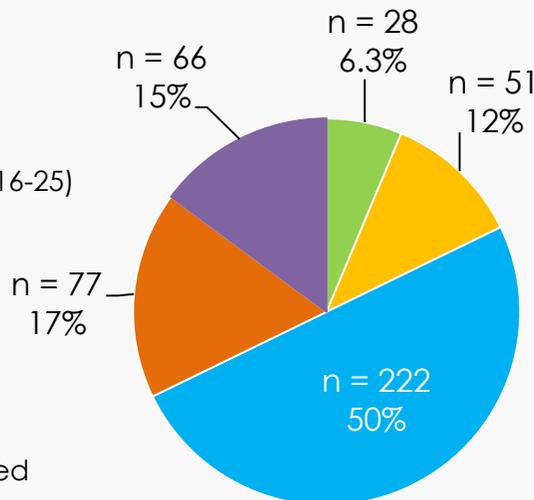
- White
- Black
- Hispanic
- Other
- Unknown



During the 2015-2016 Fiscal Year, the Mobile Crisis Response Team (MCRT) provided services with 426 individuals, the majority of which identified as White.

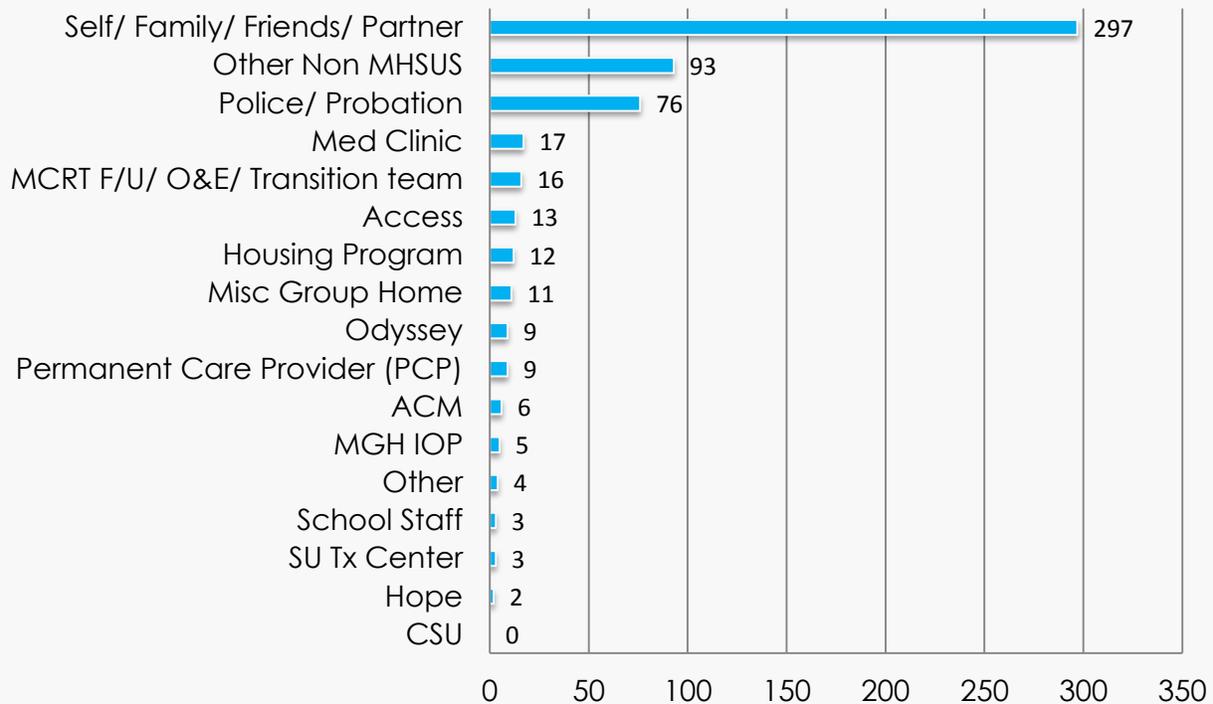
CSS MCRT FY2015-16: AGE GROUP (N=426)

- Children (0-15)
- Transition Age Youth (16-25)
- Adult (26-59)
- Older Adult (60+)
- Unknown/ Not Reported



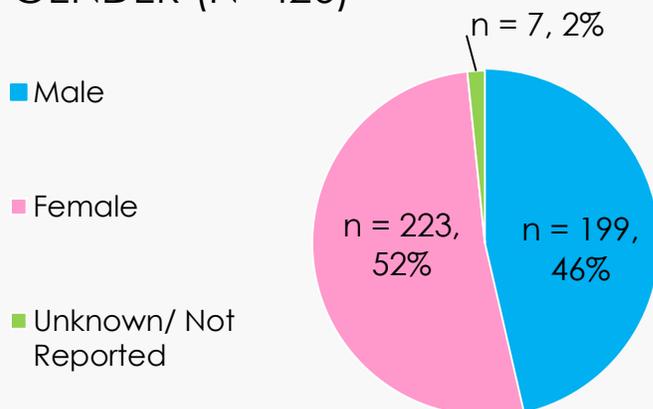
During the 2015-2016 Fiscal Year, the Mobile Crisis Response Team (MCRT) primarily served Adults 26-59 years old.

Mobile Crisis Response Team: Referral Source FY2015-16

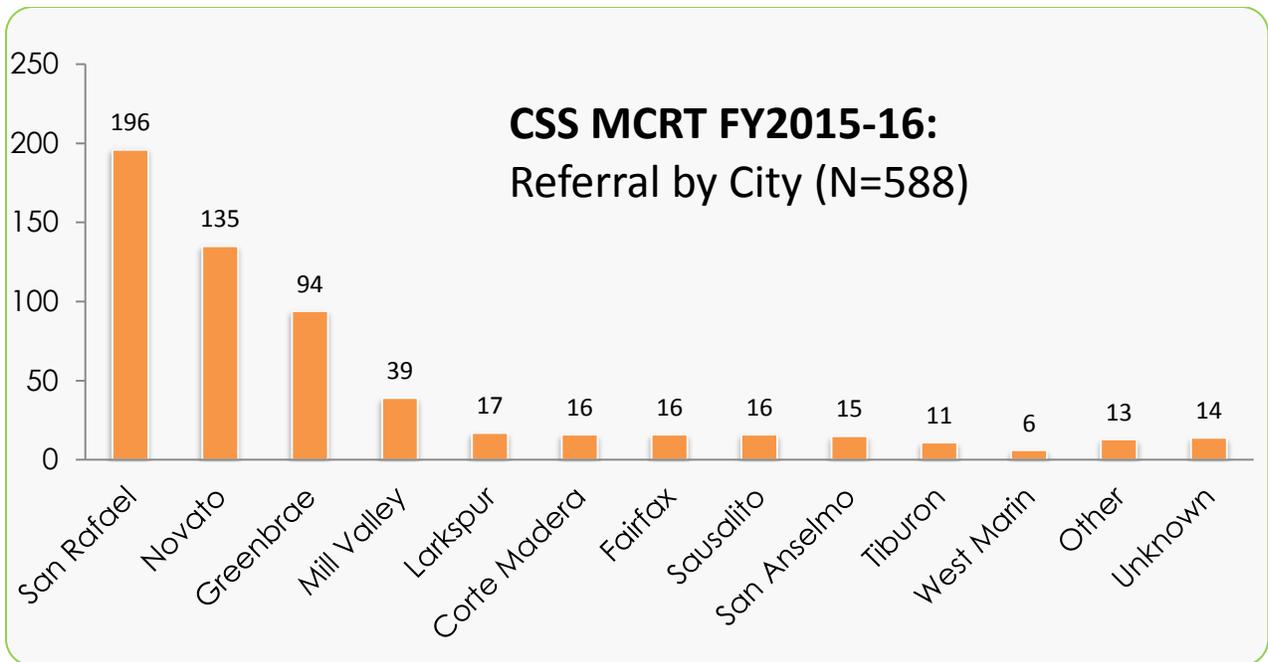


During the 2015-2016 Fiscal Year, the Mobile Crisis Response Team (MCRT) received the majority of their referrals from 'self', family, friend, or partner.

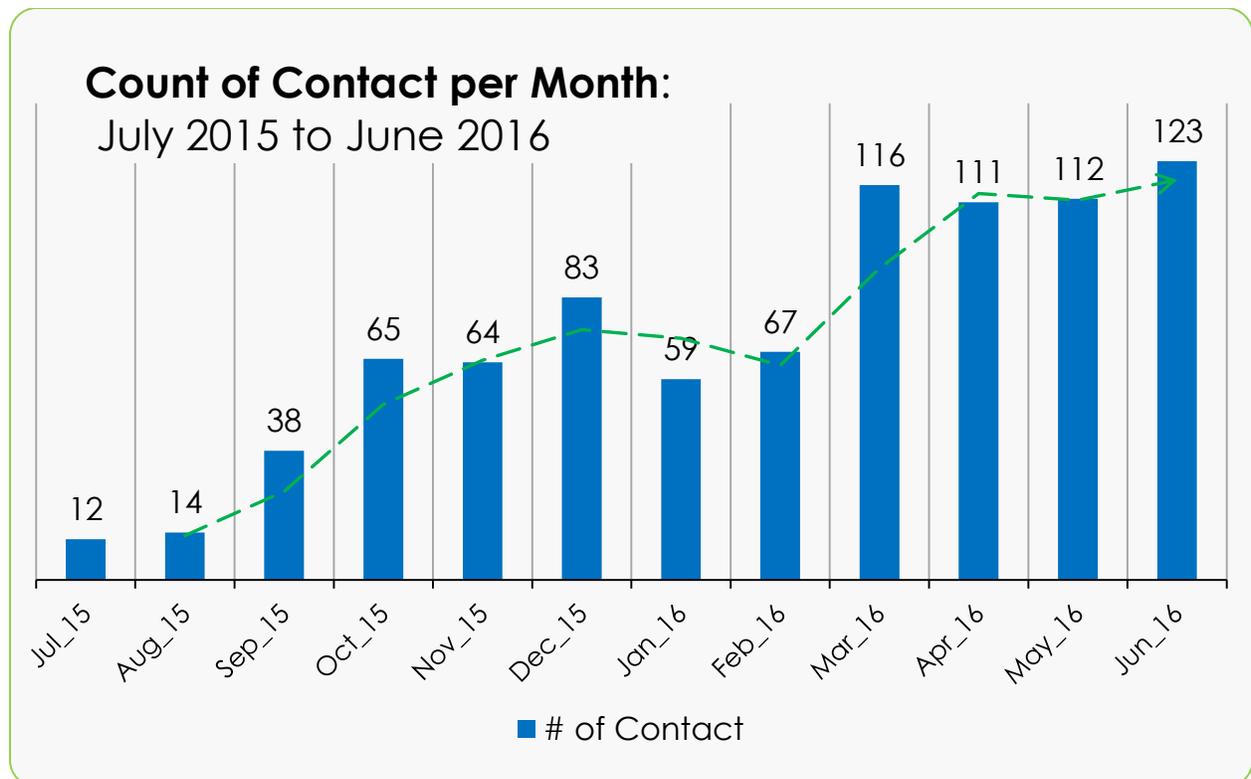
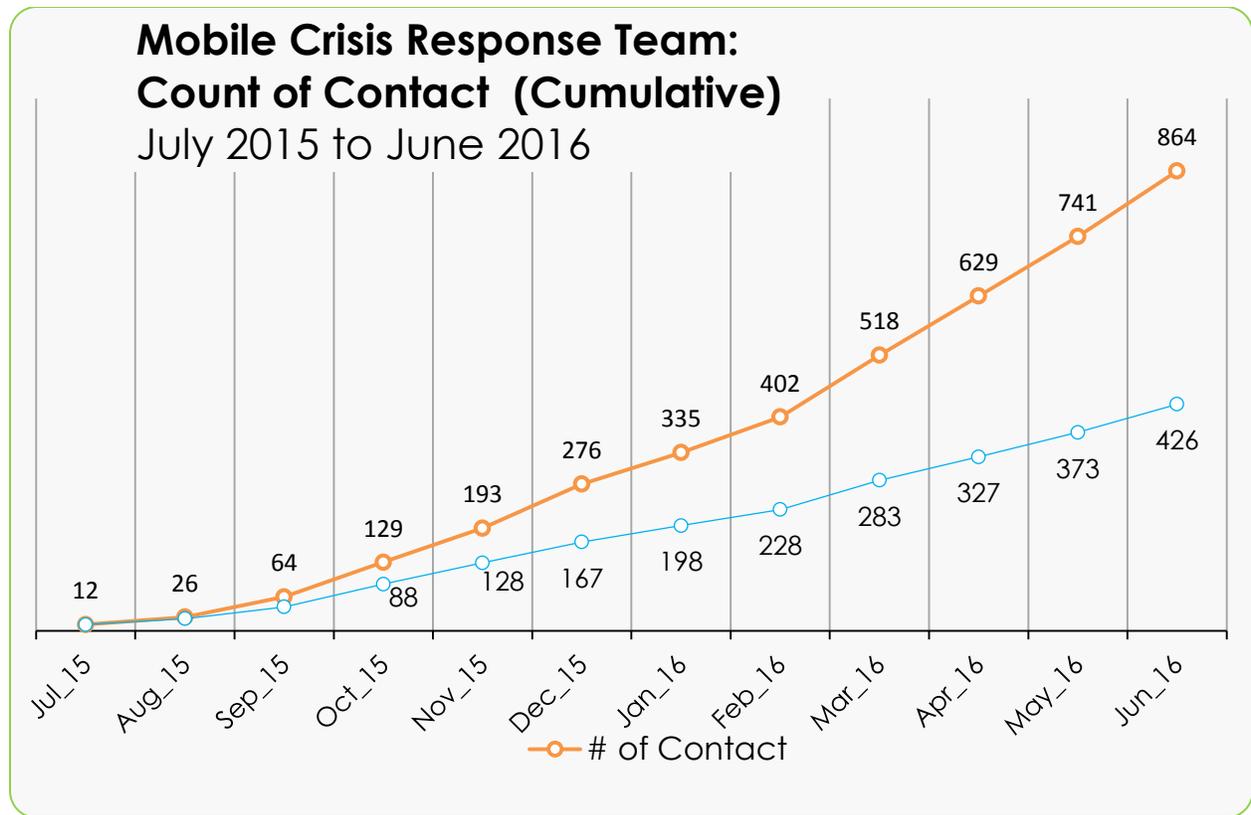
CSS MCRT FY2015-16: GENDER (N=426)



During the 2015-2016 Fiscal Year, the Mobile Crisis Response Team (MCRT) served 426 individuals, of which, 199 identified as male, 223 identified as female, and 7 identified as unknown or did not report.



During the 2015-2016 Fiscal Year, the Mobile Crisis Response Team received 588 referrals, of those, 196 were from San Rafael, 135 were from Novato, and 94 were from Greenbrae.



Transitions Team

PROGRAM DESCRIPTION

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 team is comprised of four staff: two clinicians, a peer specialist and a family partner. Services are provided Monday through Friday from 11am to 7pm. 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. Since the Transition Team launch in March 2015 they have provided 2,171 services to 312 individuals. In FY2015-16 the Transition Team served 224 individuals.

As with the Mobile Crisis Response Team, the Transitions Team has been well received by the community, and the need is greater than the resource as it is currently designed. It is also likely that expansion of this team will be proposed as part of the MHSA three year planning process, with a specific focus on expediting a return to stabilization following acute crises, such as hospitalization.

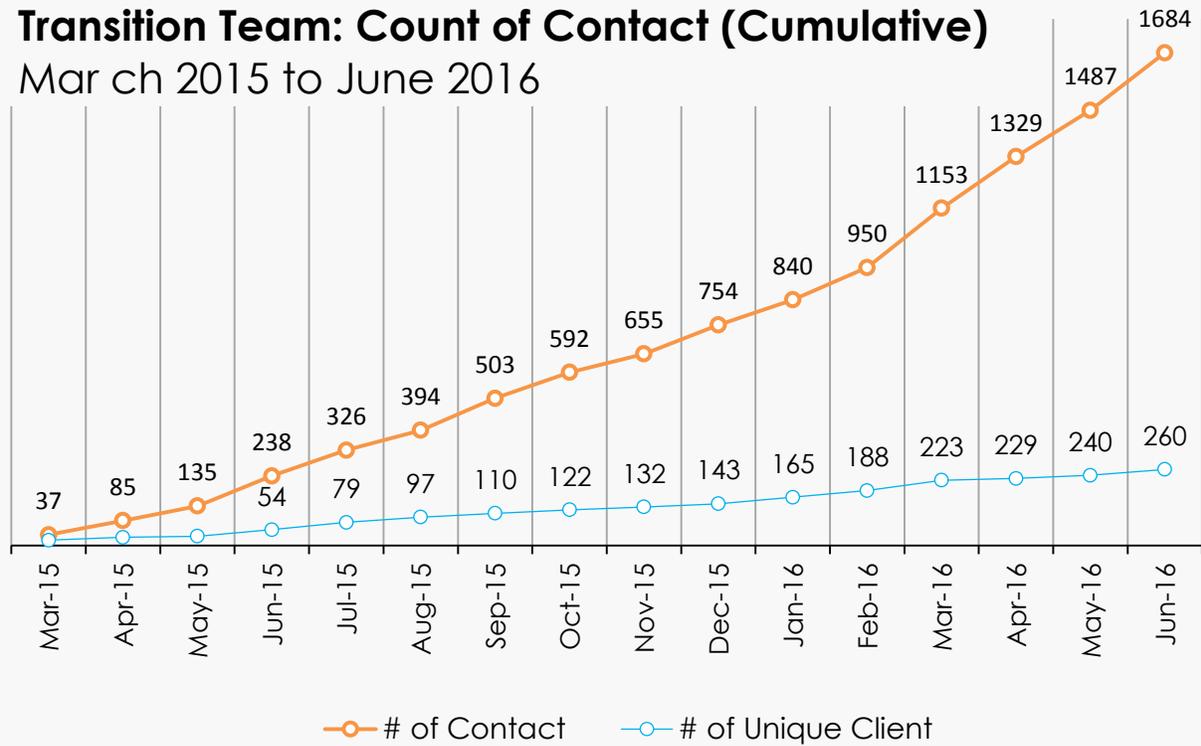
ACTUAL OUTCOMES

The Transition Team launched in March of 2015 and have since served 312 individual and provided 2,171 unique services to community members. In FY2015-16 the Transition Team served 224 individuals.

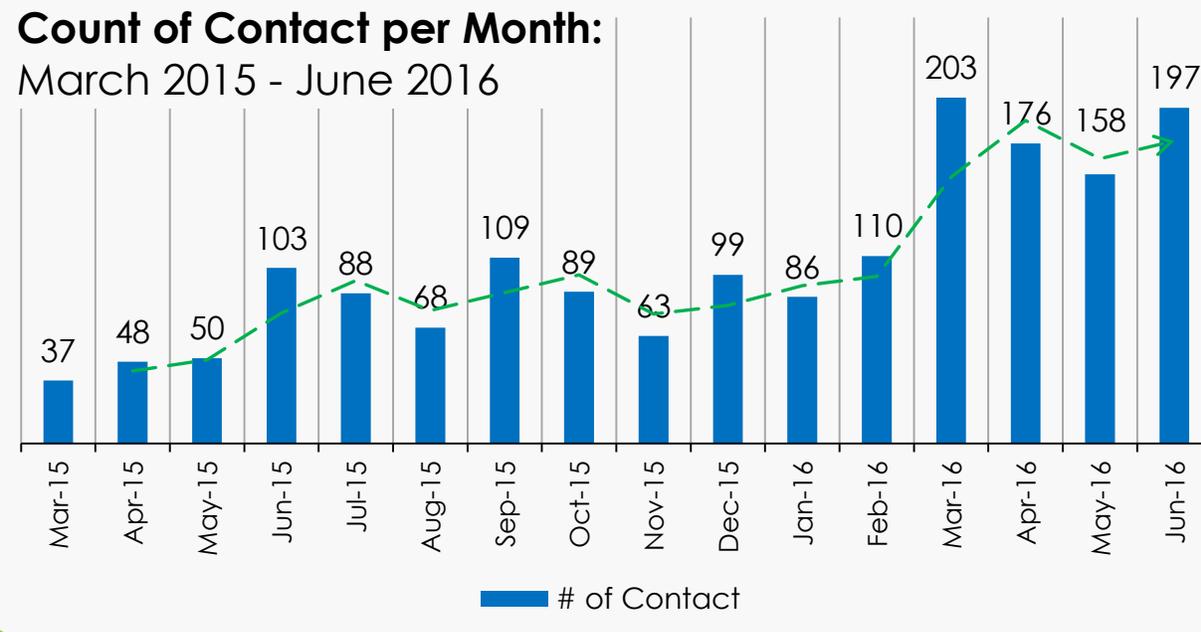
PROGRAM CHALLENGES

In FY2015-16 the Transition Team was challenged by staffing the program and maintaining positions filled.

Transition Team: Count of Contact (Cumulative) March 2015 to June 2016



Count of Contact per Month: March 2015 - June 2016

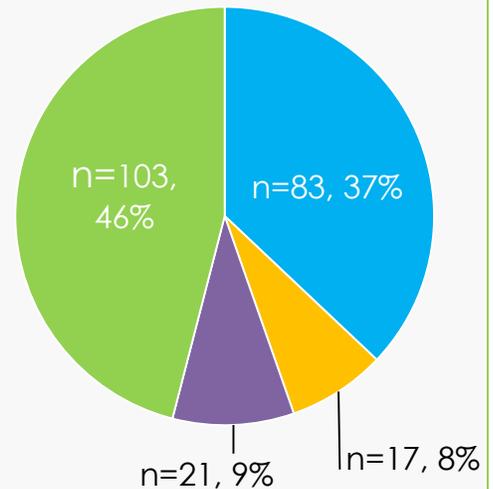


Between March 2015 and June 2016, the Transition Team had a peak of 203 contacts in March of 2016.

During the 2015-2016 Fiscal Year, the Transition Team provided services to 224 individuals, 46% identified as Other/Unknown and 37% identified as White.

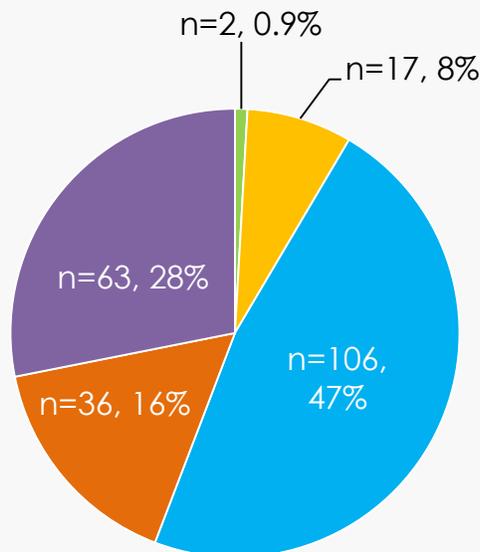
TRANSITION TEAM FY2015-16: Race/Ethnicity (N=224)

- White
- Black
- Hispanic
- Other/Unknown



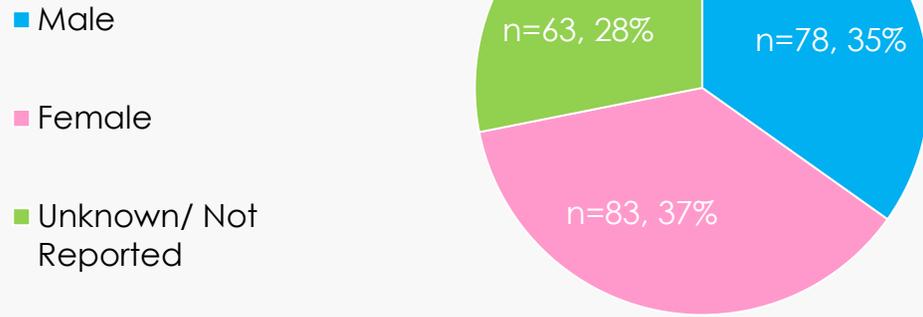
TRANSITION TEAM FY2015-16: Age Group (N=224)

- Children (0-15)
- Transition Age Youth (16-25)
- Adult (26-59)
- Older Adult (60+)
- Unknown/ Not Reported



During the 2015-2016 Fiscal Year, the Transition Team primarily provided services to Adults 26-59 years old.

TRANSITION TEAM FY2015-16: Gender (N=224)



During the 2015-2016 Fiscal Year, the Transition Team served 224 individuals, of which, 83 identified as female, 78 identified as male, and 63 identified as Unknown/Not Reported.

CSU Family Partner

PROGRAM DESCRIPTION

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

ACTUAL OUTCOMES

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

Crisis Residential – Casa René

PROGRAM DESCRIPTION

Casa René is a 10-bed Crisis Residential facility currently administered by Buckelew Programs. The program aims to reduce unnecessary acute psychiatric hospitalizations by providing a home-like setting where individuals can resolve crises in the community and re-stabilize for up to thirty (30) days. The program integrates peer and professional staffing as well as client centered programming focused on principles of wellness and recovery. Crisis residential staff works with each individual's circle of support: family, friends, treatment professionals, substance abuse counselors, health care providers, naturally occurring resources including faith-based organizations, 12-step programs and any other resources that support the individual's recovery. Individuals are also be offered individual, group and family therapy.

Currently all referrals to Casa Rene are directly from Marin County Crisis Stabilization Unit (CSU), but recently the program has been piloting referrals from other sources such as acute psychiatric hospitals as part of discharge planning, in an effort to continue supporting restabilization following an acute episode. The program is a collaborative effort between many community partners, especially between Buckelew Programs, Community Action Marin and County Behavioral Health and Recovery Services. Buckelew Programs provide the facility and staffing; BHRS provides nurse practitioner care for residents while at Casa René; and Community Action Marin provides crisis planning services.

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

EXPECTED OUTCOMES

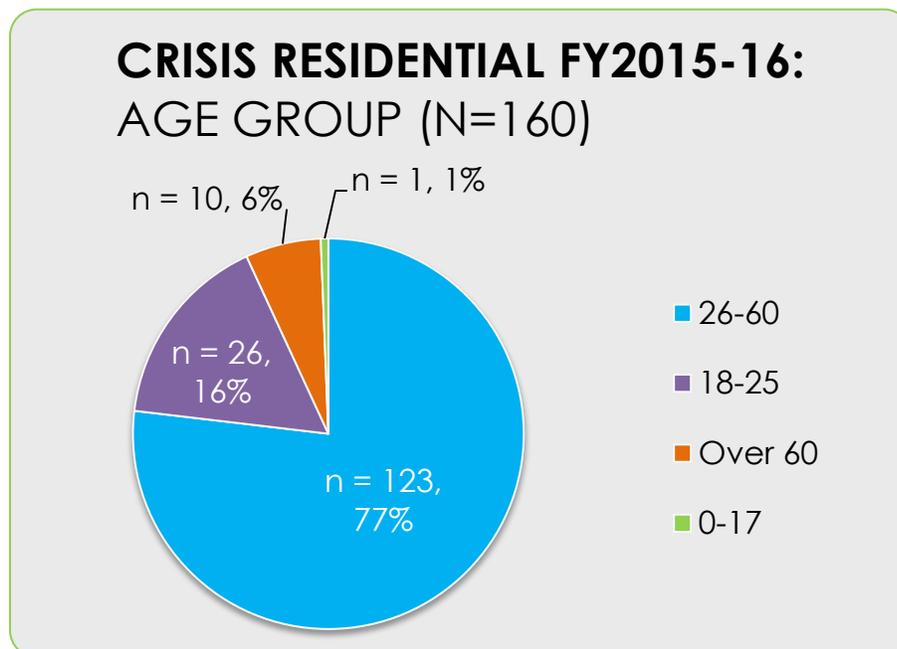
Casa René will maintain an occupancy rate of at least 75% the first year and 90% thereafter. Seventy-five percent of clients discharged from the program will have engaged in crisis planning; 90% of the clients will be linked to outpatient services at discharge; and 90% of clients will be discharged to a lower level of care.

ACTUAL OUTCOMES

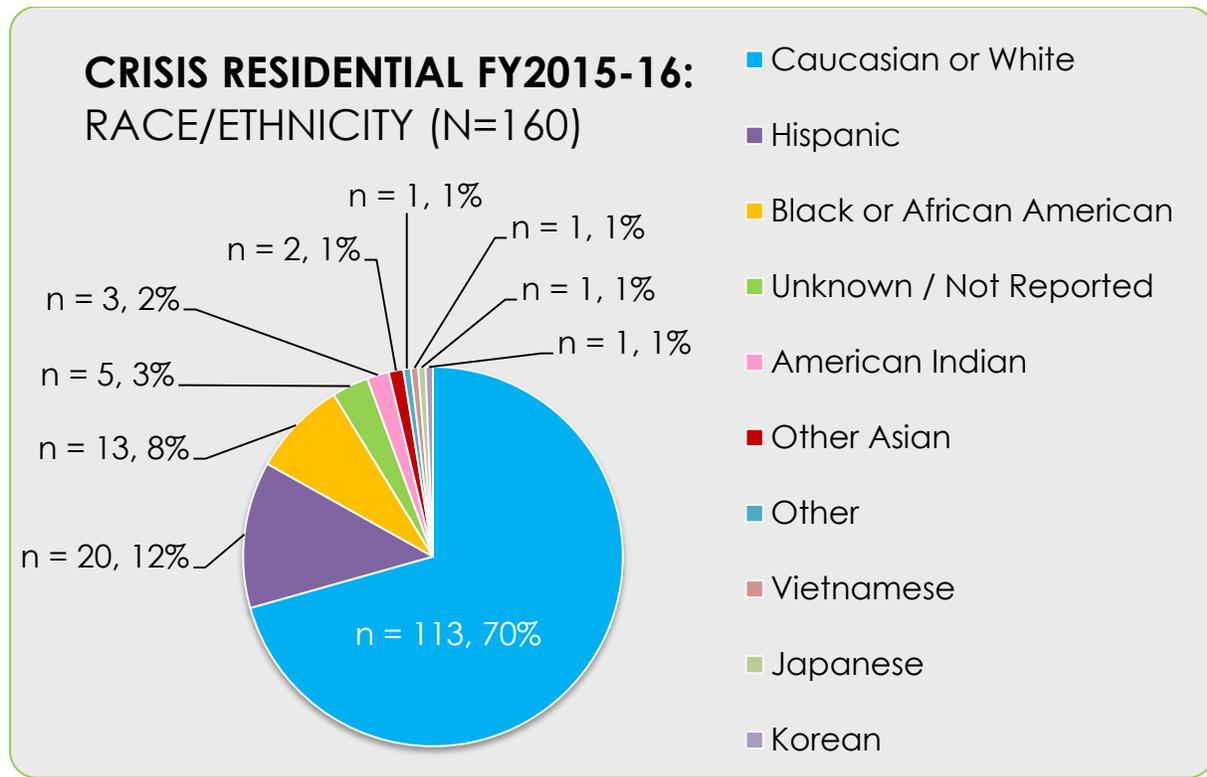
Casa René provided services to 160 individuals, with 193 distinct admissions. The occupancy rate averaged 63%, well below the expected 90%. All individuals accessing Casa René were linked with Crisis Planning services. Almost all (99%) of individuals were referred to outpatient services at discharge. Likewise, almost all individuals (99%) were discharged to a lower level of formal support.

PROGRAM CHALLENGES

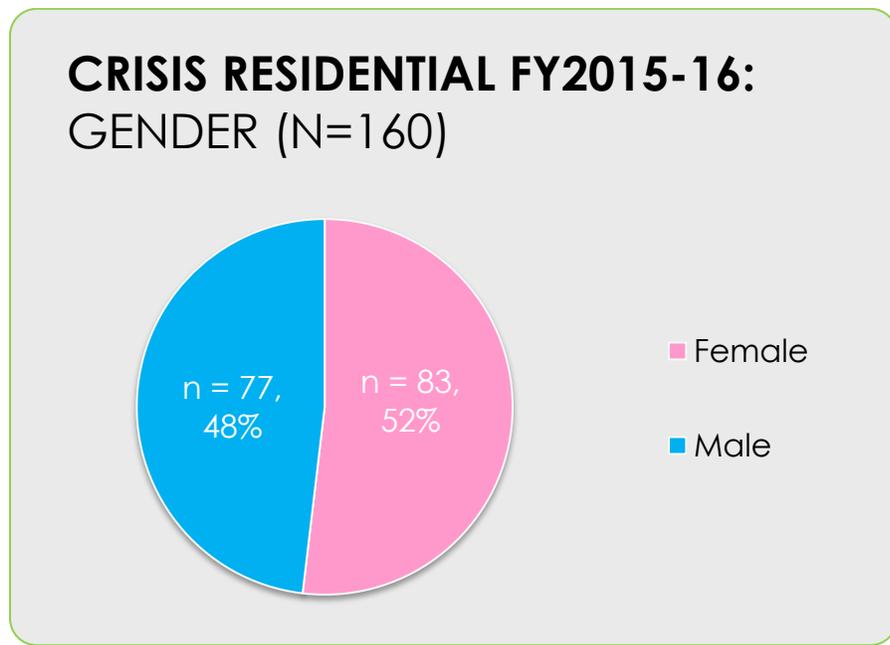
In FY2015-16 program staffing and turnover rates have posed a challenge to the Crisis Residential program.



During the 2015-2016 Fiscal Year, the Crisis Residential program predominantly served 26 to 60 year olds.



During the 2015-2016 Fiscal Year, the Crisis Residential program served 160 individuals, 70% of which identified as White.



During the 2015-2016 Fiscal Year, the Crisis Residential program served 77 males and 83 females.

CRISIS RESIDENTIAL SURVEY QUESTIONS	
Question 1	Casa Rene staff treats me with care dignity and respect
Question 2	Casa Rene staff help me take charge of my recovery
Question 3	I felt fully informed and welcomed by Casa Rene Staff even before admission or even while at CSU
Question 4	I am better able to manage my life challenges because of my participation at Casa Rene
Question 5	Staff at Casa Rene assisted me in accessing other community services such as crisis planning, housing, medical services, and therapy.
Question 6	Casa Rene Staff are sensitive to my cultural background and needs (race, ethnicity, religion, language, sexual orientation, gender identity.)
Question 7	I feel comfortable talking with Casa Rene staff about my challenges, needs and hopes.
Question 8	At Casa Rene, my beliefs and opinions are valued by staff.
Question 9	I am more hopeful about my future as a result of participating at Casa Rene
Question 10	My life skills have improved as a result of my stay at Casa Rene

CRISIS RESIDENTIAL SURVEY OUTCOME FY2015-16										
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Strongly Agree	58 (78%)	47 (64%)	44 (59%)	38 (51%)	42 (57%)	44 (59%)	51 (69%)	45 (61%)	48 (65%)	41 (55%)
Agree	14 (19%)	22 (30%)	16 (22%)	25 (34%)	13 (18%)	19 (26%)	17 (23%)	19 (26%)	17 (23%)	20 (27%)
Neutral	2 (3%)	4 (5%)	9 (12%)	10 (14%)	10 (14%)	5 (7%)	6 (8%)	9 (12%)	9 (12%)	12 (16%)
Disagree	0	1 (1%)	2 (3%)	1 (1%)	5 (7%)	3 (4%)	0	0	0	0
Strongly Disagree	0	0	0	0	1 (1%)	0	0	0	0	1 (1%)
N/A	0	0	3 (4%)	0	2 (3%)	3 (4%)	0	1 (1%)	0	0

AGE RANGE	
Unknown	19
18-20	3
21-34	18
35-49	17
50-69	15
70+	0

GENDER	
Male	23
Female	36

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.

COMMUNITY SERVICES AND SUPPORTS (CSS) NUMBERS OT BE SERVED IN FY2017-18

Program			FY2015-16 Actual	FY2016-17 Projected	FY2016-17 Cost Per person
FSP-01	Youth Empowerment Services (YES)	FSP	43	40	\$16,231
FSP-02	Transition Age Youth (TAY)	FSP	28	25	\$17,871
		Partial	52	60	
FSP-03	Support and Treatment After Release (STAR)		63	55	\$9,448
FSP-04	Helping Older People Excel (HOPE)		67	60	\$14,142
FSP-05	Odyssey (Homeless)		87	90	\$14,256
SDOE-1	Enterprise Resource Center (ERC)		292	200	
SDOE-4	Southern Marin Services Site (SMSS)		229	0**	
SDOE-7	Adult System of Care (ASOC)		245	325	
SDOE-8	Co-Occurring Capacity		191	190*	
SDOE-9	Crisis Continuum of Care			350	
	Housing		5	5	

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

**Southern Marin Services Site (SMSS) ended June 30, 2016.

MHPA COMMUNITY SERVICES AND SUPPORTS (CSS) MHPA 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
Subtotal	\$7,675,040	\$7,675,040	\$7,675,040	\$23,025,120
MHPA 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
Total	\$9,635,667	\$9,635,667	\$9,635,667	\$28,907,000

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

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

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 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.

ACTUAL OUTCOMES

To date, the TAY Advisory Council has been meeting regularly for over a year. With the assistance of the program evaluators and facilitators, they have completed a needs assessment. The complete needs assessment report will be available on the BHRS INN webpage in late July 2017. The needs assessment is being used to develop an Action Plan and Requests for Proposals to implement the actions identified in FY2017-18.

WORKFORCE EDUCATION AND TRAINING PROGRAM

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, CBOs, peer providers, and 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 members guide and direct and create trainings for their respective populations and fully participate in the process.

PROGRAM DESCRIPTIONS AND OUTCOMES

One of the many successful examples of WET's accomplishment during FY2015-16 is its ongoing progress to integrate mental health and substance use programs and services into a more

coordinated system of care. This trend has continued during this reporting period as evidenced by the high number of peer/family member WET scholarship recipients who opted to receive formal trainings in substance use certification programs and the development of a Peer certification course program, Co-Occurring Peer Education (COPE).

After FY2014-15 the WET component program strategies were realigned to better reflect BHRS' identified workforce education and training needs and goals. The 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 strategies has been implemented which includes:

BHRS INTERN STIPENDS (GRADUATE CLINICAL TRAINING 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.

In FY2015-16, the Graduate Clinical Training Program included six (6) psychology doctoral interns, five (5) Social Work interns, three (3) psychology practicum trainees, and one (1) MFT intern. The MHSA funding continued to support the stipends that are key to drawing bilingual/bicultural applicants, given the number of competing training opportunities available in the Bay Area.

Of the fifteen (15) interns, eight (8) brought bilingual/bicultural skills that enhanced service delivery: six (6) were fluent in Spanish, one (1) in Vietnamese, one (1) in Tagalog. Other cultural identity factors that contributed to improved cultural match and workforce diversity included: one (1) was African-American, three (3) were family members of consumers, six (6) were first or second generation immigrants, three (3) identified as LGBT.

- The intern cohort provided the following mental health services as part of their supervised training program:

Individual outpatient psychotherapy, group psychotherapy, psychodiagnostic assessment, case management, brokerage and rehab services, psychoeducational groups, and community outreach and engagement, including bilingual broadcast and print media.

- They provided additional mental health services in the following programs:

Latino Family Health, Supported Treatment After Release (STAR), Odyssey Homeless Outreach, Helping Older Adults Excel (HOPE), Transitional Age Youth (TAY), Vietnamese Family Health Adult Case Management, Adult Case Management, and Children's Mental Health. They also contributed to Prevention and Early Intervention outreach and engagement efforts (e.g., Cuerpo, Corazan and Comunidad Radio Program that is presented weekly by a county bilingual psychologist, a truly unique experience for those interns who are interested).

In the FY2015-16 intern cohort, those completing graduate training went on to local employment with Marin County two (2), Family Service Agency of Marin one (1), San Francisco County one (1), Kaiser SSF Chemical Dependency, and the SFVA Community-Based Outpatient Clinic one (1). Trainees still completing graduate school went on to settings such as the Clinical de la Raza in San Francisco and Contra Costa integrated behavioral primary care.

ACCOMPLISHMENTS AND CHALLENGES

The Graduate Clinical Training Program continues to meet the primary goal of improving the range and diversity of outpatient services to County residents with serious mental illness and families affected by severe emotional disturbances in childhood. Annually, interns provide individual and group psychotherapy services to more than 400 BHRS clients that might not otherwise have access to mental health services in the community. They also specifically increase the scope of outpatient therapy and rehab services that meet cultural and linguistic needs. As in preceding years, we were able to hire some interns into open County staff positions and others went on positions meeting the needs of underserved populations in the Bay Area.

A major challenge in FY2015-16 was being unable to fill our full-time Latino Family Health internship positions in the initial APPIC National Match for FY2016-17, despite having a strong field of applicants. This was the first time these positions were unfilled since the origin of the program. The key factor identified was the comparatively low stipend relative to other clinical training sites in the Bay Area, particularly for competitive bilingual placements. After completing an analysis of local stipend trends, we proposed a substantive increase be made for the next funding cycle, which was in place for the FY2017-18 recruitment season. We were eventually able to fill the open Latino Family Health positions for FY2016-17 and the increased FY2017-18 stipend did result in a greater number of applicants, quality of candidates, and a successful Match with all positions filled.

GOALS FOR FY2016-17

Three goals were identified for FY2016-17:

1. Expand and develop group psychotherapy services to provide steady availability of intern-led groups at both major clinic sites that were evidence-based, and trauma-informed
2. Clarify the client needs identified by the Full-Service Partnerships and Case Management teams and increase the staff's knowledge about when, how, and where to motivate and connect clients to therapy, psychological testing, and group services
3. Support the development of a team with internship placement opportunities to better identify and meet the needs of clients experiencing a first episode of psychosis

SCHOLARSHIPS FOR UNDERSERVED CONSUMERS AND FAMILY MEMBERS

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.

This scholarship program for consumers and family members produced positive outcomes. This program, which is also the County of Marin and Health and Human Services Department's 5-year Equity Initiative Business Plan, awarded scholarship funds and/or mentor support to forty one (41) Marin residents with lived experience. Twenty (20) scholarship recipients have already graduated at a

drug/alcohol certification program; one (1) obtained a domestic violence peer counseling certificate; one (1) obtained a mental health peer counseling certificate; and the rest of the nineteen (19) are still in the process of completing their coursework. 6 out of 22 graduates have either found or maintained gainful employment as drug/alcohol counselors in the county. The remaining 16 graduates are either placed in a public behavioral healthcare setting as volunteers and/or interns. Of the 41 scholarship recipients, twenty (20) males and twenty one (21) females; Eighteen (18)-Caucasian, sixteen (16)-African American, three (3)-Latinos, four (4)-other/multiple; five (5)-TAY, thirty(30)-Adults, six (6)-Older Adults. A public graduation ceremony was held at the Board of Supervisors Chambers where one of the Board of Supervisors, Steve Kinsey, was the keynote speaker who addressed the graduates and their families. Public newspaper media also covered the event to honor the graduates and their families.

PEER MENTORING

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.

This program recruited and retained five (5) peer mentors to provide support to consumers/family members who received scholarship awards. All mentors represent un/underserved populations four (4) African Americans and one (1) Latina) with lived experience. Two (2) out of five (5) mentors are recent graduates and scholarship recipients of the Scholarship program

SYSTEM-WIDE DUAL DIAGNOSIS TRAINING

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.

Based on FY2014-15 feedback and evaluations received from BHRS clinical staff, supervisors and managers to offer substance use trainings, the WET coordinator worked closely with the division's Substance Use Services managers to offer two (2) ASAM trainings in FY2015-16. Plans are underway to provide a comprehensive training series on substance use in FY2016-17. Also, WET funded an innovative Peer Counseling Program that was taught by two instructors with lived experience. Named Co-Occurring Peer Education (COPE), this two-part nine month course was offered in Marin City, the highest concentration of African American residents in the county. The first of the two-part program enrolled 12 students and graduated nine (9) students and became certified Peer Counselors. Of the nine (9) graduates, three (3) are males and six (6) are females; six (6)-African Americans, two (2)-Spanish speaking Latinas, one (1)-Caucasian. It is expected that all nine graduates will advance to the second and more advanced course work in FY2016-17. . It is expected that COPE will continue for at least another year to fully determine the effectiveness of the program.

COMMUNITY BASED ORGANIZATION INTERN STIPENDS

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.

This program was not utilized in FY2015-16 as all scholarship recipients were still enrolled in their coursework. Funds are expected to be fully utilized in FY2016-17 as most, if not all, scholarship recipients would have successfully completed their coursework and will be ready to advance in volunteer and/or internship placement experience

TRAINING INITIATIVES

Consumer Focused Trainings - identify, develop, and implement training opportunities for consumers to become certified instructors, educators and/or students related to mental health/substance use-related services, interventions and/or advocacy

At the recommendation of the WET Steering Committee to offer consumer advocacy trainings for adult consumers in the county due to the lack of behavioral healthcare consumer advocacy in the county, WET coordinator identified an instructor with lived experience to develop and teach an advocacy training course to a culturally diverse group of adult Peer Specialist and consumers. The instructor is an African American family member with lived experience. Advocacy course instructions is hoped to begin in FY2016-17. See Appendix VII – Workforce Education and Training (WET) Steering Committee Members.

Training/Workshop Initiatives-Provide a series of trainings that have been identified by the division's Training Committee and WET Steering Committee for its staff and CBO partners.

BHRS offered eight (8) introductory cultural competency trainings in FY2015-16 on culture-specific topics. Although results of written evaluations that were submitted by participants after each training revealed that they were overall satisfied with the training content and delivery, it is unclear how these trainings have improved BHRS' service delivery and treatment interventions in a culturally competent or appropriate manner that would reduce disparities and how participants have become more culturally competent as a direct result of the trainings offered. At best, the introductory trainings may just have provided a greater level of awareness about cultural norms which is only a small aspect in the spectrum of becoming culturally competent.

Other trainings offered in FY2015-16 were:

- Motivational Interviewing
- Clinical Supervision and Trauma Informed Care
- Law and Ethics
- Crisis Intervention
- CPR/First Aid
- WRAP
- Harm Reduction training for administrators, managers, clinical supervisors and staff

Development of BHRS Peer Counselor Positions-In collaboration with the Health and Human Services Department's Human Resources Office, this initiative will explore the feasibility of developing a Peer Employment job classification within BHRS that will provide employment opportunities to consumers/family members to qualifying applicants.

BHRS' ESM participated in the development of a training curriculum for employers to support consumers and family members in the workplace. Once developed, the ESM used the curriculum to help guide the draft development of classified Peer Counselor positions within the County of Marin. The curriculum will be widely disseminated in FY2016-17 throughout the county by the ESM in a training and/or informational presentation format.

CALIFORNIA INSTITUTE FOR BEHAVIORAL HEALTH (CIBHS)

CIBHS Leadership Institute is a leadership development program designed to help good leaders become effective system leaders and innovators in public behavioral health and related health systems. Transformational leadership is essential to improve the quality and experience of care that result in better outcomes and lower costs.

In FY2015-16 the BHRS Division Director for Quality Management/Quality Improvement applied and was accepted to attend a six (6) day intensive training in Sacramento. CIBHS partners with the University of Southern California Sol Price School of Public Policy. The curriculum includes but is not limited to: personal leadership assessment, leadership effectiveness, quality improvement for systems change, public policy analysis, history and current issues in behavioral health policy and funding, health care reform and care integration, health equity and cultural humility, cross-system leadership, understanding organizational networks, and negotiating and leading through influence.

PROGRAM CHALLENGES

One of the major challenges experienced during this fiscal year was the lack of an adequate tracking system of staff who has taken trainings. Also, due to the various organizational changes and transitions in the division's policies and procedures, and changes in staffing, mandated/required trainings were difficult to enforce and/or monitor.

Another major challenge that was experienced was the division's renewal of its CE provider status. Since the Board of Behavioral Sciences ceased to be an accrediting institution that approves organizations to become a CE provider, the WET coordinator was challenged to seek and apply with an organization, whom this division has not worked with in the past, to become a CE provider.

GOALS FOR FY2016-17

- Improve training implementation and tracking system for the purpose of getting accurate and readily available information as requested.
- Make necessary changes on CE administrators, CAMFT, recommendations to ensure compliance as a CE provider.
- Establish first ever classified Peer Counselor position in BHRS

WET · WORKFORCE EDUCATION AND TRAINING (WET)
PROGRAM ALLOCATION FY2015-16 \$428,162

- Increase the number of bilingual/bicultural Spanish speaking scholarship recipients to become mental health peer, domestic violence and/or substance use counselors
- Provide ongoing coaching and consultation system on major training initiatives (i.e. Motivational Interviewing, Cultural Competency, etc.)
- Increase substance use-related trainings for clinical staff of BHRS and its contract agency partners.
- Improve data collection of staffing demographics within BHRS and among contract agency partners

**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
Total	\$383,200	\$363,200	\$333,600	\$1,080,000

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

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS

ELECTRONIC HEALTH RECORDED (EHR)

In FY2015-16 Marin continues to make progress toward systems enhancement and upgrades to our electronic health record, Clinicians Gateway. Additional Meaningful Use and Physicians Quality Reporting System (PQRS) documentation, data collection capability, forms, and reporting upgrades were made to the system. This includes the following:

- Clinical Decision Support modules for Meaningful Use certification requirements were added by enhancing the Metabolic Monitoring form to include smoking status, adding the PHQ-9 and SBQ-R form for completion electronically.
- Electronic signature pad functionality and software upgrades were made to the confirmation section in Clinicians Gateway in order to electronically capture client signatures. Signature pads were installed on service provider computers and lap tops. Tablets with signature capability were purchased for Case Management teams treating clients in the field.
- Small desk top printers were purchased and installed for medical providers. With Patient-Specific Education Resources capacity being added to our EHR, for Meaningful Use certification requirements; the ability to print out education resources and medication specific patient handouts for discussion during the visit enhances the quality of care for Marin clients.
- Marin continues the Health Information Exchange (HIE) project to improve the coordination, quality and cost-effectiveness of care delivered to the citizens of Marin. The goal of this project is to implement a data sharing and integration service with HHS, Community Clinics and other external partners securely through our electronic health record, Clinicians Gateway.
- Additional software and services were purchased to meet Meaningful Use certification requirements and allow for adequate system support.

PRACTICE MANAGEMENT UPGRADES

Marin has continued to upgrade ShareCare to further meet State and Federal reporting requirements, as well as enhance billing and claiming functionality.

As required by HIPAA, ICD-10 implementation requires a major system upgrade to be fully implemented by the Department of Health Care Services. In September of 2014 Marin established an implementation steering committee lead by Quality Management to plan for coding analysis and crosswalk, impact analysis, implementation and training for both county and contracted operated services.

E-PRESCRIBING

Marin is currently utilizing RxNT to provide e-prescribing support at the Integrated Clinics at Bon Air and Health and Wellness Campus.

SCANNING PROJECT

This component involves the implementation of IMAVISER, a scanning application fully integrated with Clinician's Gateway. Adding scanning capabilities to the EHR to incorporate the paper documentation will allow authorized clinical staff at any workstation to access key documents necessary for their work electronically. In FY2015-16 Marin continues to face challenges with the EHR supporting the scanning project which has further delayed the scanning project.

BEHAVIORAL HEALTH CROSSWALK

In FY2012-13, MHSA one-time funds were approved for the development of a behavioral crosswalk between Alcohol and Drug and Mental Health EHR systems to create a secure data-sharing process to reduce duplication and improve care coordination. Marin continues to consider this functionality to be vital for integration and quality of care efforts. Unfortunately this project has continues to be delayed due to other system needs.

EMERGENCY BACKUP

Expanding hardware configuration to provide for emergency backup continues to be delayed due to limited County IT resources being directed to higher priority components of this project, including practice management, and EHR enhancements.

FACILITY MAINTENANCE AND IMPROVEMENTS

During FY2016-17 facilities in need of maintenance or improvements will be identified and reviewed to ensure that general upkeep, security needs, technological needs, safety, and longevity are meeting their respective operational needs/standards for the facilities and programs operated by the County of Marin.

**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
Total	\$566,667	\$566,667	\$566,666	\$1,700,000	

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

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)
Total MHSA Funds Allocated	\$13,398,534	\$13,378,534	\$13,348,933	\$40,126,000	

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

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

STAKEHOLDER PROCESS IN MARIN COUNTY

BACKGROUND

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

The funding for the five (5) components of the Mental Health Services Act was released at different times after the Act was approved by voters. For each MHSA component, additional community stakeholder processes were conducted to develop the specific component plans. These are posted on the MHSA website at www.marinhhs.org/mhsa.

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

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

This MHSA Annual Update for FY2017-18 reports on the second year (FY2015-16) of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. The following encompasses the MHSA Stakeholder Process for the FY2017-18 MHSA Annual Update

ONGOING STAKEHOLDER INPUT

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

Behavioral Health and Recovery Services (BHRS) representatives regularly discuss MHSA programs with individuals, the Mental Health Board, the Quality Improvement Committee, and in other forums. Input received in these settings is brought to BHRS Senior Management, the MHSA Coordinator and Component coordinators and other settings as appropriate for consideration.

MHSA COMPONENT MEETINGS

- The PEI Committee meets quarterly to discuss PEI Program implementation, including reviewing annual program evaluation reports. It is comprised of PEI providers, community advocates, consumers, Marin Health and Human Services representatives, Mental Health Board members, school representatives, and other community organizations. PEI Committee Meeting Notes can be found at 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 Transitional Aged Youth Advisory Committee. See the Innovation Component section of this report for more details.

Innovation Project “*Growing Roots: The Young Adult Services Project*” Stakeholder Process

A Community Stakeholder process was initiated on October 28, 2014 with over 40 community members and providers attending a presentation by the Mental Health Services Oversight and Accountability Commission (MHSOAC) on MHSA Innovation Promise and Potential, Primary Purposes and MHSA General Standards, as well as understanding the Reducing Disparities theme and how to submit ideas and recommendations. On January 9, 2015, a second Innovation Planning stakeholder meeting was held and was attended by 48 community stakeholders. Innovation idea submissions were received from community stakeholders and in an effort to keep their ideas confidential, but still give the community a sense of what was submitted we posted a summary of target population or geographical area and what the “hard to solve problem” was. We also opened an online survey to get stakeholder feedback from those that couldn’t participate in an in-person community meeting.

Taking all the stakeholder input and recommendations into consideration, a draft Innovation Plan was created to focus on reducing disparities for the un/underserved Transitional Aged Youth population in Marin County. The new Innovation Project was named, “*Growing Roots: The Young Adult Services*” Project. The draft Innovation Plan was posted for a thirty (30) day public comment period beginning on Wednesday, October 28, 2015 and ended on Sunday, November 29, 2015.

The Innovation Plan was reviewed with the Mental Health Board and Alcohol and Other Drug Advisory Board joint meeting on Monday, November 2, 2015 to provide them an overview of the Plan. A Public Hearing was held on Tuesday, December 8, 2015 at 6pm at 20 N. San Pedro Road in San Rafael in the Pt. Reyes Conference Room.

While the Innovation Plan was supported and built on Stakeholder input, there were internal meetings with staff and with the MHSA Advisory Committee to finalize the draft Plan language before going before the Marin Board of Supervisors for their review and approval which was given at their Tuesday, March 1, 2016 meeting.

Marin then was granted approval to present our Board Approved MHSA Innovation Plan to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on Thursday, March 24, 2016 in Sacramento, California at their monthly Board meeting. Unfortunately, due to an MHSOAC clerical error Marin was not able to have their Plan reviewed at the March meeting as expected.

On Thursday, April 28, 2016 the MHSOAC hosted their monthly Board meeting in Calaveras County and Marin was able to present and receive the support and approval from the MHSOAC for the Innovation Plan: *Growing Roots: The Young Adult Services Project*.

MHSA ADVISORY COMMITTEE

During FY2015-16 reporting period, the new MHSA Advisory Committee met monthly and below is an overview of the meeting dates:

- September 2, 2015
- September 23, 2015
- October 28, 2015
- December 2, 2015
- January 27, 2016
- February 24, 2016
- March 23, 2016
- April 27, 2016
- May 25, 2016
- June 22, 2016

The committee continues to meet on the 4th Wednesday of each month for 1.5 hours. All MHSA Advisory Committee meeting agenda and minutes can be found on the web at: <https://www.marinhhs.org/mhsa>. See Appendix IV – MHSA Advisory Committee Members.

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

Stakeholder Involved	Policy	Program Planning and Implementation	Monitoring	Quality Improvement	Evaluation	Budget Allocations
Mental Health Board	X	X	X			
MHSA 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

FY2017-18 ANNUAL UPDATE PROCESS

This Annual Update is reporting on the second year of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. This Annual Update was developed by BHRS staff, the MHSA Advisory Committee and agencies contracted to provide MHSA services. The Annual Update approval process included:

The MHSA Annual Update for FY2017-18 was posted for a thirty (30) day public comment period from **Thursday, June 8th, 2017** through **Sunday, July 9th, 2017**. It has been widely distributed:

- The MHSA Annual Update was posted for thirty (30) day public comment on Marin County’s website at, www.marinhhs.org/mhsa and on the BHRS website banner at, 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.
- Copies of the MHSA Annual Update for FY 2017-18 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 Annual Update for FY2017-18 were available and 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 announcement about the posting was placed in the local newspaper, the Marin Independent Journal, including information about getting a copy of the update, how to comment, and the date of the Public Hearing.
- An email with a link to the website posting was sent to all 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 Annual Update for FY2017-18 is expected to go before the Board of Supervisors in September of 2017.

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

Substantive Comments and Responses:

(Substantive comments and responses will be added after the thirty (30) day public comment period and the Public Hearing)

No substantive comments were received during the thirty (30) day comment period or during the MHSA Public Hearing at the Mental Health Board meeting on July 11th, 2017.

Marin County Characteristics

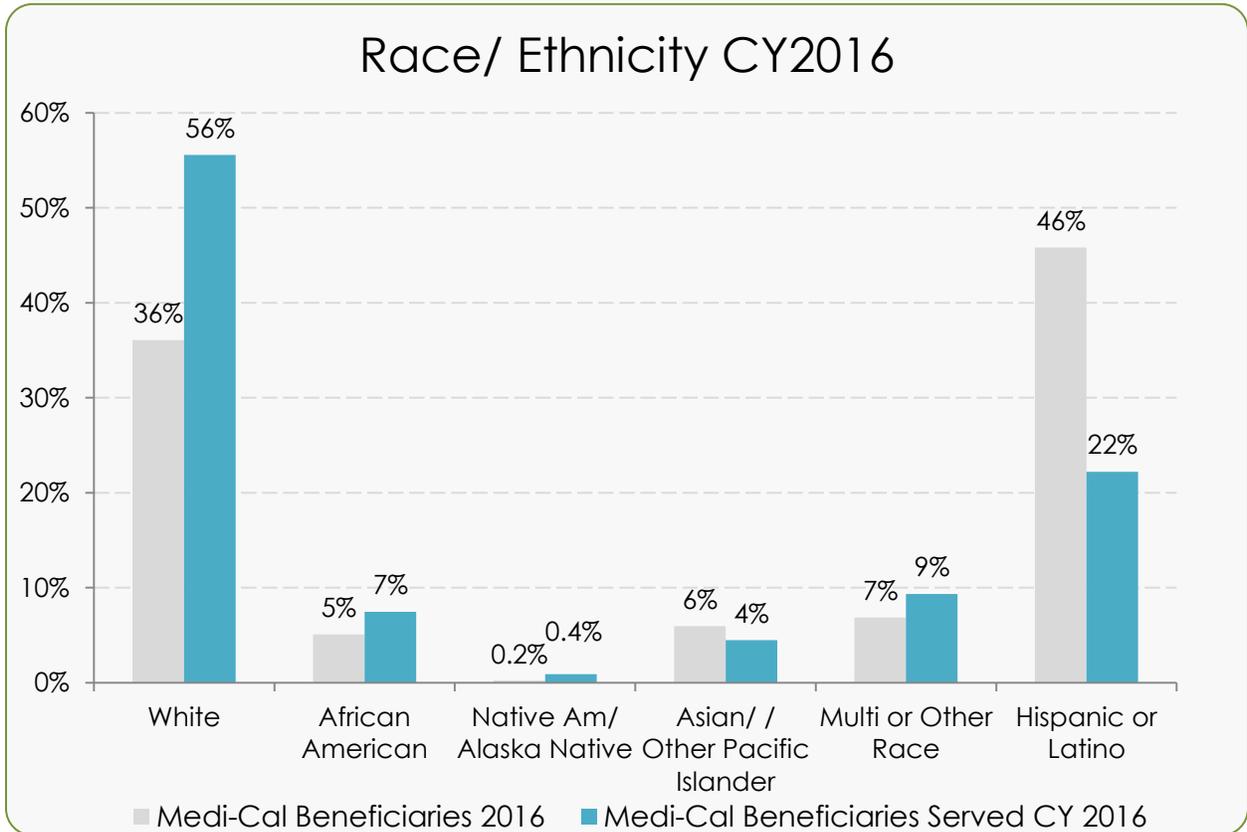
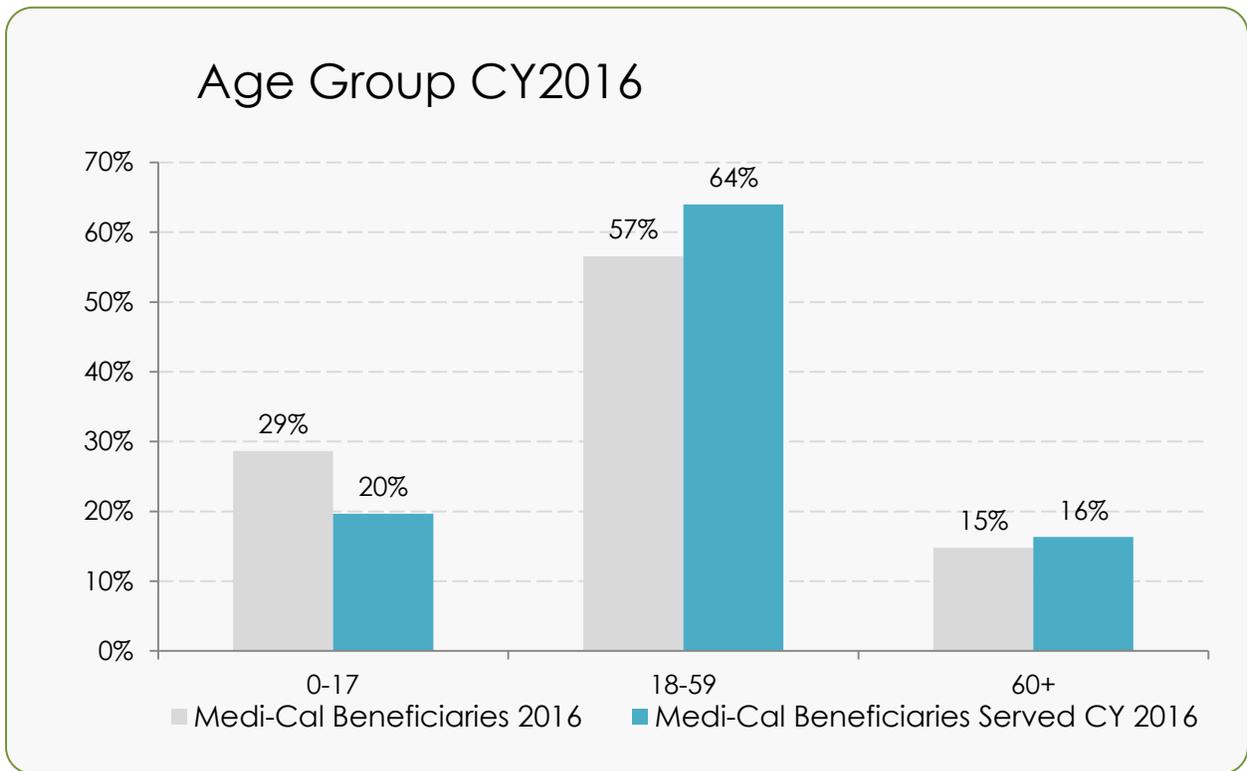
Marin County is a mid-sized county with a population of approximately 260,750 and spanning 520 square miles of land. The population is 51% female. The majority of residents live in the eastern region of the county, along the Highway 101 corridor. Ranching and dairying are major features of the rural 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.



Growing Roots:

The Young Adult Services Project



Come hear what Transition Age Youth have to say about the mental health and substance use services they need.

Join us for a presentation by the Transition Age Youth (TAY) Advisory Council on the results of a countywide needs assessment they conducted. Following the presentation, attendees will receive information about the next phase of the project, including funding that will be available to meet needs identified by TAY.



Wednesday, June 28, 2017
4:00 - 6:00pm
Marin County Office of Education
1111 Las Gallinas Ave., San Rafael



This project is funded by the Marin County Behavioral Health & Recovery Services - Mental Health Services Act (MHSA/Prop 63) Innovation funds. For more information, contact Kristen Gardner: 415-205-9111 or kgardner@marincounty.org



All public meetings and events sponsored or conducted by the County of Marin are held in accessible sites. Requests for accommodations may be made by calling (415)473-4381 (Voice), (415)473-3232 (TTY), or by emailing disabilityaccess@marincounty.org at least **four work days** in advance of the event. Copies of documents are available in alternative formats, upon written request.

May Mental Health Day: Each Mind Matters

“For hope, recovery,
and resilience”



Where: Wellness Campus
3240 Kerner Blvd.,
San Rafael CA.

When: Wednesday, May 18th, 2016
9:00 am - 5:00 pm

What: A FREE day-long event to raise awareness for mental health and substance use. Join us for music, exhibits, food, and much more.



All public meetings and events sponsored or conducted by the County of Marin are held in accessible sites. Requests for accommodations may be made by calling (415) 473 - 4381 (Voice) / (415) 473 - 3232 (TTY) or by emailing at disability-access@marincounty.org at least four work days in advance of the event. Copies of documents are available in alternative formats, upon written request.



Día de Salud Mental en Mayo: SanaMente

“Para la esperanza,
la recuperación, y
la fortaleza”



Cuándo: Miércoles 18 de mayo de 2016
9:00 AM - 5:00 PM

Dónde: Marin Health and Wellness Campus
3240 Kerner Blvd
San Rafael, CA 94901

Qué: Un día GRATIS de eventos para crear conciencia sobre la salud mental y el uso de sustancias. Únase a nosotros. Habrá música, exposiciones, comida, y mucho más.



Todas las reuniones públicas y eventos patrocinados o realizados por el Condado de Marin se llevan a cabo en lugares accesibles . Las solicitudes de alojamiento pueden hacerse llamando al (415) 473 - 4381 (Voice) / (415) 473- 3232 (TTY) o por correo electrónico a disability-access@marincounty.org al menos cuatro días hábiles de anticipación del evento . Las copias de los documentos están disponibles en formatos alternativos, previa solicitud por escrito.



APPENDIX II

Ngày Tháng Năm là Ngày sức khỏe tâm thần: Mọi suy nghĩ đều được ghi nhận

“Cho sự hy vọng, sự hồi phục và không bỏ cuộc”



Vào ngày thứ 4, 18 Tháng Năm, 2016
9:00 am - 5:00 pm

Tại Trung tâm bảo vệ sức khỏe, 3240 Kerner Blvd., San Rafael CA

Vô cửa miễn phí. Mục đích của chương trình là để cao cảnh giác về sức khỏe tâm thần và nghiện ngập. Có thức ăn, triển lãm, và nhạc sống.



All public meetings and events sponsored or conducted by the County of Marin are held in accessible sites. Requests for accommodations may be made by calling (415) 473 - 4381 (Voice) / (415) 473 - 3232 (TTY) or by emailing at disability-access@marincounty.org at least four work days in advance of the event. Copies of documents are available in alternative formats, upon written request.



APPENDIX II

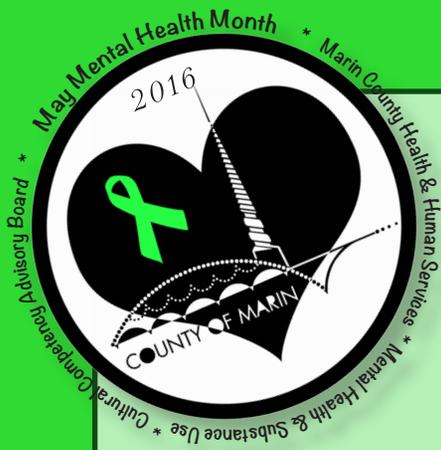
May Mental Health Month

“For hope, resilience, and recovery”



Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	1		1	10		1
2	1	3	1	6	7	8
9	1	11	1	13	14	15
16	1, 9, 8	7, 12	5, 1	19	11, 21	22
23	1, 8	12	1	26	27	28, 29
30	1, 8	31	1			

APPENDIX II



- 1** **Name:** “Work Independent Network (WIN)”Orientation
Date: Tuesdays at 12:00 pm: 555 Northgate Drive
Date: Thursdays at 1:00 pm: Goodwill Industries:
809 Lincoln Blvd
Contact: Tamahtra McClure (415) 456-9350 ext.148

- 2** **Name:** Marin Communications Forum
Date: May 23rd, 10:00 -11:30 am
Location: 1010 Northgate Dr, San Rafael, CA 94903
(4 Points by Sheraton)
Contact: Marisol Munoz – marisolmunozk@gmail.com
Description:
Discussion about local mental health services for families with children.

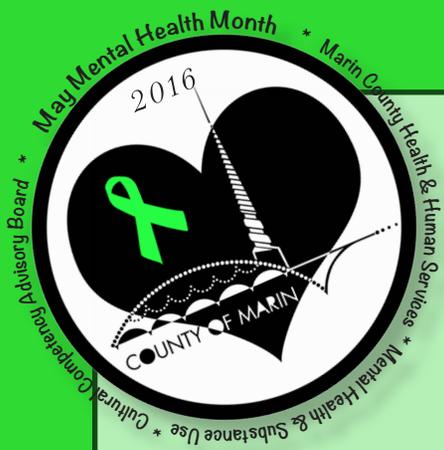
- 3** **Name:** Interfaith Breakfast
Contact: Carol Havis - chovis@marinifc.org
Date: May 4th, 8:00 -10:00 am
Location: Congregation Kol Shofar.

Name: May Mental Health Day
Date: May 18th, 9:00 am - 5:00 pm
Location: 3240 Kerner Blvd. San Rafael, CA.
Wellness Campus.

Description:
A FREE day long event to raise awareness for mental health and substance use. Join us for music, food, exhibits, food, and much more.

- 5** **Name:** REAL: Conversations about Mental Health and Mental Illness
Date: May 19th, 7:00 - 9:00pm
Location: Congregation Rodef Sholom
170 N. San Pedro Rd.
Contact: please RSVP to MHI@rodefsholom.org or 415.479.3441. joanne@rodefsholom.org
Description:
Rodef Sholom is hosting a free lecture evening with local author Mary Widdifield and her sister Elin Widdifield, authors of ‘Behind the Wall’; the true story of mental illness as told by parents. They will be speaking about the value of community for mental health recovery. Free and open to the public.

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- 6** **Name:** Town Hall Meeting
Contact: Barbara Coley - bcoley@camarin.org
Date: May 6th from 3:00 - 5:00 pm
Location: Rm 109 and 110 at the Wellness Campus.
3240 Kerner Blvd. San Rafael.
Description:
Town Hall Meeting - The goal is to get feedback and to move forward to create an Advisory Committee consisting of peers and family members for CAM's Mental Health Programs. Sponsored by Community Action Marin's Steering Committee.
- 7** **Name:** Music with Ron Corral
Date: May 18th, 1:00 - 2:00
Location: The Enterprise Resource Center
Description:
The Enterprise Resource Center will open its doors with some healthy snacks and will present the original music of guitarist, Ron Coral.

- 8** **Name:** Suicide Prevention and Community Counseling Course
Date: Tuesday evenings 7:00 -10:00 pm, May 17-June 21
One required class, Saturday,
June 11, 10:00 am - 5:00 pm.
Location: Family Service Agency of Marin.
Contact: For more information or to register:
415-499-1193x3003 or email fsa@fsamarin.org
Description:
Suicide Prevention & Community Counseling is looking for volunteers for our 24/7 hotline. Hotline volunteers counsel people in a personal crisis, those concerned about friends and family, and community members grieving a loved one. To become a volunteer, individuals must successfully complete our Hotline Training Class. Training is comprehensive & supportive, includes training in active listening skills, crisis intervention & how to assess suicide risk. Fee \$25.
Registration required.
- 9** **Name:** Board of Supervisors Resolution
Date: May 17th
Location: Civic Center, Marin BOS Chamber
3501 Civic Center Dr, San Rafael.
Description:
Resolution commemorating May Mental Health Month.

APPENDIX II



- 10** **Name:** Mental Health Shabbat
Date: April 29 th, 6:15 - 7:15 pm
(pre-oneg starts at 5:45 pm)
Location: Congregation Rodef Sholom;
170 N. San Pedro Road
Contact: joanne@rodefsholom.org
Description:
Join us on April 29th for a Mental Health Shabbat where we will celebrate the amazing accomplishments of Congregation Rodef Sholom's Mental Health Initiative. At the service, we will launch our stigma-reducing program for Mental Health Awareness month. The service will feature a sermon by Rabbi Stacy Friedman, the unveiling of our interactive community art installation, personal stories from congregants and a special thank you and blessing for members of our Mental Health Initiative team. Everyone is welcome.

- 11** **Name:** Mental Health First Aid Training
Date: May 21st 8:30 am - 5:30 pm
Location: First Congregational Church of San Rafael
8 North San Pedro Road, San Rafael, CA. 94903
Contact: Edtiana Rockwell -
(ERockwell@marincounty.org)
Description:
A First Aid course for first responders, students, teacher, leaders of faith communities, service providers, and caring citizens on how to help others experiencing mental illness or crisis . Registration is required. Contact Edtiana Rockwell (ERockwell@marincounty.org)

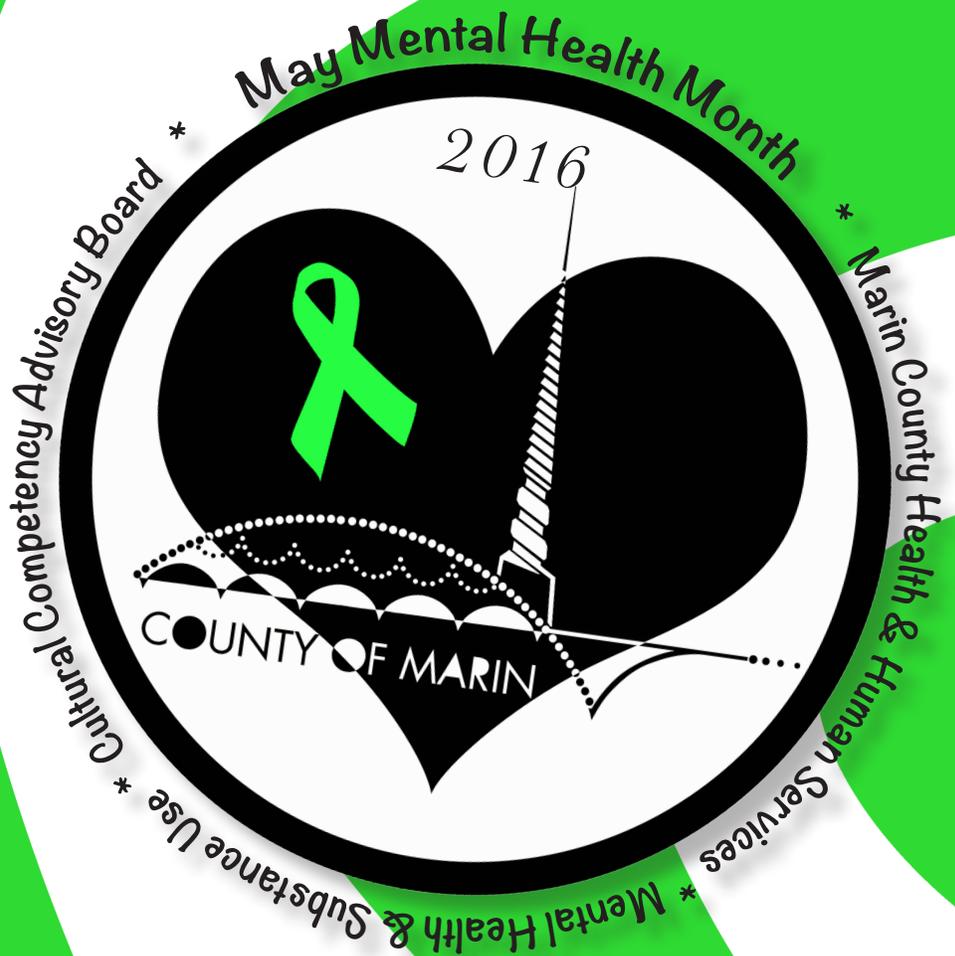
- 12** **Name:** A Silent Auction
Contact: Barbara Coley - bcoley@camarin.org
Date: May 25th, 5:00 - 8:00pm
Location: Falkirk Mansion
Description:
"A Silent Auction" to raise funds for the 1108 Gallery. Sponsored by Community Action Marin's Mental Health Programs. The goal is to raise funds (\$20,000) to staff the 1108 Gallery that supports artist's that are mental health clients.

May Mental Health Day: Each Mind Matters

“For hope, recovery,
and resilience”

Wednesday,
May 18th, 2016
9:00 am - 5:00 pm

Wellness Campus,
3240 Kerner Blvd.,
San Rafael CA.



Mental Health Day Schedule

Doors Open 9:00 am

Opening Remarks 9:30 - 9:40 am [Room 109/110]

Dr. Grant Colfax, Director of Health and Human Services, and Dr. Suzanne Tavano, Director of Mental Health and Substance Use Services

Classical Music to Start the Day 9:40 - 10:00 am [Room 109/110]

Beethoven was the first of the romantic period composers who dominated classical music during the 19th century. He was a passionate man who carried his feelings on his sleeve. Beethoven had episodes of depression accompanied by suicidal thoughts, and also episodes of elation with flights of ideas. This moodiness is reflected in his music. Artists, Krisanthy Desby (Cello) and Elizabeth Prior (Viola) will perform Ludwig von Beethoven eyeglass duet in e flat major, composed in 1796.

Stigma Stew Live! 10:00 - 11:00 am [Room 109/110]

A live theatrical piece produced by, Cheryl August. Stigma Stew is a stigmatized chef from overseas who is confronted by local chefs, kitchen staff and even vegetables who plot and protest against him. This inspirational tale shows us how obstacles and interpersonal conflicts are met with spirit, experience, and hope. The most amazing things come from the most unexpected places.



The cast and crew of Stigma Stew!

Agency Information Tables 11:00 - 2:00 pm [Lobby]

Community Agencies offer information about their services and experiences as mental health and substance use providers in Marin County. Come and learn about resources in our community.

Berkeley Folk Dancers 11:00 - 11:45 am [Room 109/110]

Join the Berkeley Folk Dancers as they lead participants in a series of informal folk dances from around the world (Bolivia, Scotland, among others). All are welcome to participate.



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Zumba 12:00 - 1:00 pm [Outside]

Get fit with a musical experience of Latin flavors that will surely brighten up your day!

Music Medicine 11:00 - 2:00 pm [Lobby]

Enjoy original music by Michael Reiss and Mark Lerner to motivate and celebrate your spirit. Songs like 'Perfect Imperfection' reminds us of the little imperfections that make each of us, uniquely, us.

Promotores Role Play 1:00 - 1:45 pm [Room107]

Join us with 'Los Promotores' as they perform 3 skits on the common myths about accessing mental health services. Offered in Spanish!

Meaningful Mental Health & Latinos en la Casa 1:00 - 2:30 pm [Room 105]

An original television series produced by the Cultural Competence Advisory Board (CCAB) in collaboration with Community Media Center of Marin (CMCM). Learn about youth mental health, crisis intervention, suicide prevention and the unique stories of community members as they work with local agencies towards recovery.

Hearing Voices 1:00 - 2:30 pm & 2:30 - 4:00 pm [Room 109/110]

Sign up spots are limited! Participants must sign up on the day of the event, registration is on a first come first serve basis. For an opportunity to experience first-hand what it is like to hear voices. Facilitators Jessica Diaz, ASW Mental Health Practitioner, and Erin Gray, LMFT Mental Health Practitioner from the Adult Case Management Team, lead us through up to 40 minutes of simulated voices, resembling that of someone with a psychotic mental health diagnosis. Participants will engage in everyday tasks and interact with the public. At the end of the exercise, facilitators will lead a discussion on the experience.

Speakers Bureau 3:00 - 4:00 pm [Room 110]

The Marin National Alliance on Mental Illness members share their personal and inspiring stories about their journey through mental health diagnosis to recovery.

Youth Poetry Slam 4:00 - 5:00 pm [Room 110]

Marin City Teen Council invites you to showcase your artistic talent! Bring and share your poem, rap, songs and artistic story in an effort to encourage, inspire and educate the audience about the meaning of mental health and substance use in the lives of young people. This session is designed to encourage the honest narratives of young people who often struggle silently in the shadows of stigma. Step up to the mic and express yourself!

Tabling Organizations

Bay Area Community Resources (BACR)
Buckelew Programs
Canal Alliance
Center for Domestic Peace
Community Action Marin (CAM)
Enterprise Resource Center (ERC)
Homeward Bound
Marin Interfaith Council
Marin Outpatient & Recovery
Services (MORS)
Mental Health & Substance Use -
Services Division

National Alliance on -
Mental Illness (NAMI)
Promotores del Bienestar -
Emocional
Project Avary
Rodef Sholom
Spahr Center
Sunny Hills -TAY
Voter Registration
and many others



COUNTY OF MARIN

All public meetings and events sponsored or conducted by the County of Marin are held in accessible sites. Requests for accomodations may be made by calling (415) 473 - 4381 (Voice) / (415) 473 - 3232 (TTY) or by emailing at disabilityaccess@marincounty.org at least four work days in advance of the event. Copies of documents are available in alternative formats, upon written request.



Día de Salud Mental en Mayo: SanaMente

“Para la esperanza,
la recuperación, y
la fortaleza”

Miércoles
18 de mayo, 2016
9:00 am - 5:00 pm

Wellness Campus
3240 Kerner Blvd.,
San Rafael CA.



Horario del Día de la Salud Mental

Puertas se abren 9:00

Comentarios Iniciales 9:30 - 10:00 [Sala 109/110]

Dr. Grant Colfax, Director del departamento de Salud y Servicios Humanos y Dra. Suzanne Tavano, Directora de Servicios de Salud Mental y de Uso de Substancias, hablarán de la importancia de los servicios en el condado de Marin.

Música Clásica 9:30 - 10:00 [Sala 109/110]

Beethoven fué el primero de los compositores románticos a dominar la música clásica en el siglo XIX. Beethoven era un hombre apasionado que se expresó libremente. Tenía episodios de depresión acompañados de ideas suicidas, y también tenía episodios de euforia. Estos cambios en el estado de ánimo se reflejan en su música. Dos artistas presentarán el dúo de las gafas en viola y violonchelo en e bemol mayor, compuesto en 1796.

¡Obra de Teatro en Vivo Stigma Stew! 10:00 - 11:00 [Sala 109/110]

Stigma Stew es una obra de teatro en vivo sobre un chef extranjero que es estigmatizado por los chefs locales, trabajadores de la cocina e incluso las verduras que protestan contra él. El Stigma Stew es un cuento inspirado de cómo los obstáculos y conflictos interpersonales se conquistan con espíritu, experiencia, y esperanza. Las cosas más sorprendentes pueden venir de los lugares más inesperados.

Mesas de Información de Agencias 11:00 - 2:00 [Vestíbulo]

Las agencias de la comunidad ofrecerán información sobre sus servicios y experiencias como proveedores de salud mental y uso de sustancias en el condado de Marin. Venga y aprenda sobre los recursos disponibles en nuestra comunidad.

Danzantes Berkeley Folk Dancers

11:00 - 11:45 [Sala 109/110]

La actividad física puede reducir el estrés, la ansiedad, y promueve la salud. Berkeley Folk Dancers guiarán 2-3 bailes populares (Bolivia, Escocia, entre otros). Ellos demostrarán y enseñarán cómo bailar su música. Todos están invitados a participar.



APPENDIX II

Zumba 12:00 - 1:00 [Afuera]

Póngase en forma con una experiencia musical segura de animar su día!

Medicina Musical 12:00 - 12:45 [Sala 109/110]

Disfrute de música original de Michael Reiss y Mark Lerner para motivar y celebrar su espíritu. Canciones como 'Perfecta Imperfección' nos recuerdan las pequeñas imperfecciones que hacen que cada uno de nosotros, de forma única, seamos nosotros.

Teatro de Promotores 1:00 - 1:45 [Sala 107]

Únase a nosotros con 'Promotores del Bienestar Emocional' que realizan 3 parodias sobre los mitos comunes sobre el acceso a los servicios de salud mental. ¡Ofrecido en español!

Programas de TV 1:00 - 2:30 [Sala 105]

Una serie de televisión original, Latinos en la Casa y Meaningful Mental Health son programas de televisión originales producidos por el Consejo Asesor de la competencia cultural (CCAB) en colaboración con el Centro Comunitario de Medios de Marin (CMCM). Obtenga información acerca de los servicios para la prevención, el tratamiento y la recuperación de las enfermedades mentales.

Oyendo Voces 1:00 - 2:30 & 2:30 - 4:00 [Sala 109/110]

¡Inscríbase, pues los asientos son limitados! La participación será por orden de llegada. Tenga la experiencia de lo que se siente al oír voces. Las facilitadoras, Jessica Díaz, MSW profesional de la salud mental, Erin Gray, LMFT, nos llevarán a través de 40 minutos de voces simuladas, parecida a la de una persona con un diagnóstico de psicosis. Los participantes realizarán tareas de la vida diaria y tendrán interacciones. Al final del ejercicio, las facilitadoras dirigirán una discusión sobre la experiencia.

Oradores 3:00 - 4:00 [Room 110]

Miembros de La Alianza Nacional de Enfermedades Mental comparten sus historias personales e inspiradoras acerca de su viaje a través del diagnóstico de salud mental hasta la recuperación.

Youth Poetry Slam 4:00 - 5:00 [Room 110]

¡El Concilio de Jóvenes de Marin City le invita a mostrar su talento artístico! Traiga y comparta su poema poema, rap, canciones ó cuento artísticos, en un esfuerzo para alentar, inspirar y educar al público sobre el impacto de la salud mental y consumo de sustancias en la vida de los jóvenes. Esta sesión está diseñada para alentar las narrativas honestas de los jóvenes que a menudo luchan en silencio en las sombras del estigma. Acerquese al microfono y exprese sus emociones!

Agencias Representadas

Bay Area Community Resources (BACR)
Buckelew Programs
Canal Alliance
Center for Domestic Peace
Community Action Marin (CAM)
Enterprise Resource Center (ERC)
Homeward Bound
Marin Interfaith Council
Marin Outpatient & Recovery
Services (MORS)
Mental Health & Substance Use -
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and many others



COUNTY OF MARIN

Todas las reuniones públicas y eventos patrocinados o realizados por el Condado de Marin se llevan a cabo en lugares accesibles. Las solicitudes de alojamiento pueden hacerse llamando al (415) 473 - 4381 (Voice) / (415) 473- 3232 (TTY) o por correo electrónico a disabilityaccess@marincounty.org al menos cuatro días hábiles de anticipación del evento. Las copias de los documentos están disponibles en formatos alternativos, previa solicitud por escrito.





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) 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

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.

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. 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 IV

MHSA ADVISORY COMMITTEE MEMBERS

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

San Rafael art exhibit puts focus on tobacco use and mental illness



Mark Parker takes a look at one of the art pieces hanging at the 1108 Gallery in San Rafael on Thursday. The cigarette butt-themed work is part of art exhibit aimed to discourage smoking. (Alan Dep/Marin Independent Journal)

By **Adrian Rodriguez**, *Marin Independent Journal*

POSTED: 02/14/16, 12:26 PM PST | UPDATED: 4 WEEKS AGO
3 COMMENTS “Mixed Feelings” by Barbara Coley is part of the smoking cessation art exhibit at the 1108 Gallery in San Rafael. Coley is a San Anselmo resident. (Alan Dep/Marin Independent Journal)

More Information

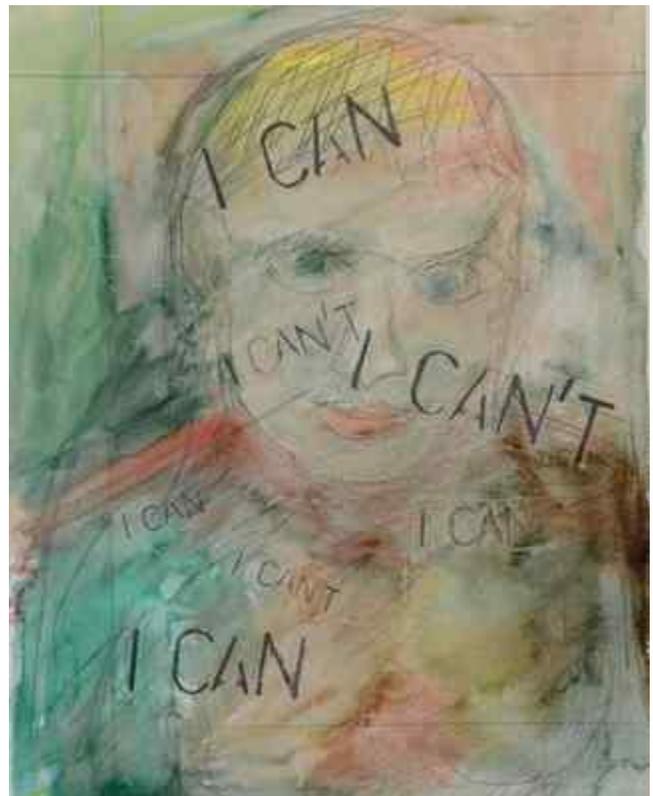
The 1108 Gallery, the site of the smoking cessation exhibit, is at 1108 Tamalpais Ave. in San Rafael.

The gallery is open from 6 to 9 p.m. Thursdays and 5 to 8 p.m. Fridays. It holds monthly receptions as part of the Second Fridays Art Walk.

More information on Community Action Marin is at bit.ly/1Qft5Ev. The gallery accepts donations at gofundme.com/1108Gallery.

Mark Parker is trying to kick a bad habit.

Parker, a 28-year-old San Rafael resident, has smoked for nine years, but the past two months he has done his best to quit. Recently, he created a motivational art piece



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made of cut up cigarette cartons that he pasted to a sheet of paper, forming the phrase, “You can do it.”

The piece is featured in the tobacco cessation art exhibit that opened last week at the 1108 Gallery at 1108 Tamalpais Ave. in San Rafael. Parker is a peer director at the Enterprise Resource Center, whose members produced the work for the exhibit.

“I’m trying constantly,” he said. “It’s off and on with smoking. I wanted to do something that would really inspire people and push them to (quit) and to inspire me.”

The center is a branch of the nonprofit Community Action Marin’s mental health program, which offers peer-directed group sessions to support people making the transition back into the workforce. The center offers drop-in art classes on Saturdays.

In collaboration with the adult tobacco cessation program, governed by the nonprofit Bay Area Community Resources, the artists took on a theme that challenged themselves and others to quit smoking.

“The life expectancy for people with mental health issues is about 25 years less than the general population who use tobacco,” said Beth Lillard, the tobacco cessation program director. “This is about education and achieving a goal of living tobacco free.”

Lillard, 66, of San Anselmo, smoked for 35 years herself. Just a year before she took her job 14 years ago, she quit, and has been on a mission to help others do the same.

In working with Community Action Marin, she has been able to focus some of the effort to help the mental health community.

In California, the adult smoking rate has reached a historic low of 12 percent, according to the state department of public health. Marin’s rate is 7.3 percent, according to a 2010 survey by the state’s Tobacco Control Program.

“Unfortunately, people with mental illness smoke 30 percent of all tobacco today,” said Bob Curry, the head of the county tobacco-related disease program.

“Beth has been our cessation expert and has touched the lives (of) many of our most vulnerable with her passion and dedication,” he said. “This art exhibit is just one example of her desire to help the population that continues to have a high percentage of tobacco use.”

The program is funded through Proposition 63, which uses county money to finance mental health programs. The funding gives them the boost to offer stipends and to produce outlets and venues such as the 1108 Gallery.

“What we are trying to do is create a really positive environment without shaming or scaring,” said Marisa Smith, who like Parker is a peer director and featured artist.

Smith, 36, of San Rafael, has been smoking for 16 years. She created a word collage of magazine clippings with phrases like, “Your health,” “What a thrill,” “Best days happen here,” and other words of inspiration.

APPENDIX V

And that's why it's important for the program to have peer directors with lived experience, said Barbara Coley, the mental health program director.

“(They) understand the difficulty of recovery and the stigma around mental health issues,” she said.

Coley, 65, of San Anselmo, has been working in the peer programs for 15 years and she has seen people in every stage of recovery.

“It's really made a difference in people's lives,” she said.

Parker, as a peer director, is an example.

“It's really a nice program here,” he said. “It's teaching us to be healthy through art — and with life.”

CULTURAL COMPETENCE 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 (Child Team)	Asian / Pacific Islander
Alana Rahab	Program Manager	African American
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, Adult Case Management (Adult Team)	African American
Maria Abaci	Mental Health Practitioner, Adult 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

Agency Partners		
Name	Position/Representation	Ethnicity
Leticia McCoy	Family Partner, Community Action Marin	African American, Former Consumer
Vinh Luu	Asian Advocacy Project, Community Action Marin	Asian / Pacific Islander
Douglas Mundo	Executive Director, Canal Welcome Center	Latino
Julie Madjoubi-Lehman	Spahr Center	Palestinian, Former Consumer, LGBTQ
Sandy Ponck	Program Dir., Canal Alliance	Caucasian
David Escobar	District 5 – Aide to Supervisor Steve Kinsey	Central American Indian

APPENDIX VI – CULTURAL COMPETENCE ADVISORY BOARD (CCAB)

Community Volunteers		
Name	Position/Representation	Ethnicity
Gustavo Goncalves	San Rafael	Latino, Community Volunteer, Transition Age Youth
Leah Fagundes	San Rafael	Caucasian, Former Consumer, Consumer Advocate
Cat Wilson	San Rafael	Jewish, Consumer
Cheryl August	San Rafael	Jewish, Former Consumer
Kerry Peirson	Mill Valley	African American, Family Member, Older Adult
Amanda Araki	San Rafael	Asian / Pacific Islander Transition Age Youth

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	Staff	Latino