County of Marin

MENTAL HEALTH SERVICES ACT
FY2018-19 ANNUAL UPDATE & SPENDING PLAN

REPORTING ON FY2016-17 SERVICES AND OUTCOMES
June 19, 2018

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

SUBJECT: Department of Health and Human Services, Division of Behavioral Health and Recovery Services: Approve the Mental Health Services Act (MHSA) FY 2018-19 Annual Update and Spending Plan.

Dear Supervisors:

RECOMMENDATIONS:
1. Authorize the President to approve the Mental Health Services Act (MHSA) FY 2018-19 Annual Update reporting on FY 2016-17 outcomes.
2. Authorize the President to approve the included AB114 Spending Plan for reverted and reallocated MHSA funding.

SUMMARY: The Mental Health Services Act (MHSA) FY 2018-19 Annual Update provides information on the MHSA funded programs and service outcomes for the FY 2016-17 reporting period, the final year of Marin’s MHSA Three-Year Program and Expenditure Plan for FY 2014-17. Each program narrative in the Annual Update includes the annual program budget allocation and describes the program, the target population served, and the actual outcomes achieved.

In response to Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017), there is a Spending Plan included in the Annual Update. Assembly Bill (AB) 114 amended certain Welfare and Institutions Code (WIC) Sections related to the reversion of MHSA funds. Funds that could be subject to reversion as of July 1, 2017 were distributed to counties from Fiscal Year (FY) 2005-06 through FY 2014-15. These funds were deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1 (a)).

On May 15, 2018, Marin received an updated final determination from the State that $2,914,240 in MHSA funds are subject to reversion and must be spent by the County of Marin by July 1, 2020. Any unspent funds at the end of this time must be returned to the State.

During the next two fiscal years, the reverted and reallocated MHSA funds are proposed for a range of already approved and new programs, including:

- Innovation (INN): $616,235 to fund a new innovative project specifically targeted to address the needs of the growing population of older adults (this
proposal will be brought to your Board for approval at a later date); $23,500 to be reserved for Innovation Planning costs to ensure we have the widest possible stakeholder engagement; and $829,832 already allocated to the Growing Roots: Young Adult Services Project;

- Capital Facilities and Technological Needs (CFTN) programs including $685,000 to support the expansion of the Crisis Stabilization Unit; as well as $504,008 in previously approved funding for Electronic Health Record System Enhancements; and $255,665 for the Whole Person Care Case Management system that was approved by your Board on June 5, 2018.

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

This MHSA Annual Update and Spending Plan was developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft MHSA Annual Update and AB114 Spending Plan was posted for any interested party for thirty (30) days on the Marin County Mental Health Services Act webpage for public comment and feedback beginning on Saturday, May 12, 2018 and ending on Monday, June 11, 2018. A legal notice ran in the Marin Independent Journal (IJ) seeking public comment and feedback as well. On Tuesday, June 12, 2018, the Mental Health Board hosted a Public Hearing for the MHSA Annual Update for FY2018-19 including the AB114 Spending Plan.

COMMUNITY BENEFIT: MHSA, formerly Prop 63, was approved by voters in November 2004 and was designed to expand and transform California’s county mental health services system to provide better coordinated and more comprehensive care to those with serious mental illness, particularly in underserved populations. The additional resources and community process associated with the Act have brought measurable improvements to the lives of many Marin County residents.

FISCAL IMPACT: There will be no increase to the General Fund Net County cost as a result of your Board’s approval. The AB114 Spending Plan lays out the spending priorities for $2,914,240 in MHSA funds that were reverted and reallocated back to the County to be spent by June 30, 2020, as described above.

These amounts include existing previously approved funds, and expansion/growth funds. The Department will work with the CAO to make the necessary budget adjustments to reconcile the annual funding allocation with the funds already budgeted in the MHSA CFTN and INN program baseline budgets.
Respectfully submitted,

Grant Nash Collax, MD
Director
# MHSA COUNTY COMPLIANCE CERTIFICATION

**County:** Marin County

<table>
<thead>
<tr>
<th>Local Mental Health Director</th>
<th>Program Lead</th>
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<tbody>
<tr>
<td><strong>Name:</strong> Jei Africa</td>
<td><strong>Name:</strong> Galen Main</td>
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<tr>
<td><strong>Telephone Number:</strong> 415.473.7595</td>
<td><strong>Telephone Number:</strong> 415.473.6238</td>
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<tr>
<td><strong>E-mail:</strong> <a href="mailto:JAfrica@MarinCounty.org">JAfrica@MarinCounty.org</a></td>
<td><strong>E-mail:</strong> <a href="mailto:GMain@MarinCounty.org">GMain@MarinCounty.org</a></td>
</tr>
</tbody>
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**County Mental Health Mailing Address:**

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

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

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 19, 2018.

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

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

Jei Africa, PsyD, MSCP, CATC-V  
Local Mental Health Director/Designee (PRINT)

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<thead>
<tr>
<th>Signature</th>
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**County:** Marin County

**Date:** 6/29/2018
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Director’s Introduction

Dear Community Members:

I welcome you to review and provide feedback on Marin County’s FY2018-19 MHSA Annual Update and Spending Plan. This report reflects the Department’s commitment to health, well-being, safety, and self-sufficiency through an array of outreach and engagement, prevention, early intervention, crisis services and a continuum of care to people of all ages.

While there is still more that can be accomplished, we can reflect on the outcomes from FY2016-17 and be grateful for the dedication and hard work of our clients and their families, our community based organizations, our peer and family partners, our Behavioral Health staff, our advisory committees, and all those who have been working toward wellness and recovery throughout our county.

Through the Mental Health Services Act, 9,961 individuals in Marin received Prevention and Early Intervention (PEI) services ranging from early childhood mental health consultation to reducing isolation among the older adult Vietnamese population. 323 Marin Residents received care through one of the five Full Service Partnerships which provide 24/7 wraparound services to seriously mentally ill individuals across the lifespan. And hundreds more have been involved in helping to develop and test innovative strategies to address the mental health needs of Marin County residents.

Thank you for your continued support and participation in the County’s MHSA planning process. Your voice and participation are critical to our collective success.

Sincerely,

Jei Africa, PsyD, MSCP, CATC-V
DIRECTOR
County of Marin
Behavioral Health and Recovery Services
FY2018-19 MHSA ANNUAL UPDATE STAKEHOLDER REVIEW

We welcome feedback on the FY2018-19 MHSA Annual Update. The required thirty (30) day public comment period for the MHSA Annual Update begins on Saturday, May 12, 2018 and ends on Monday, June 11th, 2018.

For a copy of the FY2018-19 MHSA Annual Update, please call: 415.473.6238 or you can find it on our website at: https://www.marinhhs.org/mhsa.

A Public Hearing for the FY2018-19 MHSA Annual Update will take place at the Mental Health Board Meeting on Tuesday, June 12, 2018 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:

Galen Main, MSW  
Mental Health Services Act Coordinator  
Department of Health and Human Services  
Behavioral Health and Recovery Services  
10 N. San Pedro Road, Suite 2021  
San Rafael, CA 94903  
415-473-6238 phone  
gmain@marincounty.org email
MHSA Annual Update FY2018-19 Executive Summary

The FY2018-19 MHSA Annual Update provides an opportunity to report on outcomes and activities from FY2016-17, an update on the programs for FY2017-18, and changes expected in FY2018-19. FY2016-17 is the final year of implementation of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. All MHSA related Annual Updates and the MHSA Three-Year Plan Amendment can be found at: www.marinhhs.org/mhsa.

This annual update also includes the Spending Plan in response to AB114 and updated budgets for each affected component to reflect the changes discussed in the Spending Plan.

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

COMMUNITY SERVICES AND SUPPORTS (CSS)

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

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

PREVENTION AND EARLY INTERVENTION (PEI)

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

**INNOVATION (INN)**

This section will report out on the current *Growing Roots: The Young Adult Services Project*. The Plan will focus on reducing disparities by working closely with the Transition Age Youth (TAY), 16-25 years of age, 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. Currently stakeholder engagement is underway for Marin’s next Innovation Plan which will be targeted toward innovative approached to meeting the mental health the needs of Older Adults in our aging county.

**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 mental health 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 enhancement of an Electronic Health Record (EHR) enabling advancement towards a paperless record. The existing system was a hybrid of electronic and paper documentation and provided many elements of an EHR. Prescribers were handwriting prescriptions, and the legacy billing system (INSYST) needed upgrading and modernization. In addition, as described in the spending plan there are new Capital Facilities projects.
Mental Health Services Act Principles

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

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

Mental Health Services Act Components

The MHSA has five (5) components:

A. Community Services and Supports (CSS)

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

B. Prevention & Early Intervention (PEI)

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

C. Innovation (INN)

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

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

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

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

Mental Health Services Act (MHSA) Background

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

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

Mental Health Services Act Reporting Requirements

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

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

The MHSA Three-Year Program and Expenditure Plan is different than an MHSA Annual Update. CCR § 3310 states that a county shall update the MHSA Three-Year Plan annually. An MHSA Annual Update includes an update to the MHSA Three-Year Plan addressing the elements that have changed, the service outcomes for the reporting year and the coming year’s expenditure plan.
AB114 SPENDING PLAN

INTRODUCTION AND OVERVIEW

On December 28, 2017, Marin County BHRS received Information Notice (IN) 17-059 from California Department of Health Care Services (DHCS) Mental Health & Substance Use Disorders Services (MHSUDS).

The purpose of Information Notice (IN) 17-059 was to inform counties of the following:

- The process the Department of Health Care Services (DHCS) will use to determine the amount of unspent Mental Health Services Act (MHSA) funds subject to reversion as of July 1, 2017;
- The appeal process available to a county regarding that determination; and
- The requirement that by July 1, 2018, counties have a plan to expend the reverted funds by July 1, 2020.

BACKGROUND AND LOCAL IMPACT FOR IN 17-059:

Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017) became effective July 10, 2017. The bill amended certain Welfare and Institutions Code (WIC) Sections related to the reversion of MHSA funds. Funds subject to reversion as of July 1, 2017, were deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1 (a)). Funds that could be subject to reversion as of July 1, 2017, were distributed to counties from Fiscal Year (FY) 2005-06 through FY 2014-15.

By July 1, 2018, DHCS is required to prepare a report to the Legislature identifying the amounts of funds subject to reversion by county. Prior to releasing the report, DHCS is required to provide each county with the amount of funds they have determined are subject to reversion and a process for counties to appeal that determination (WIC Section 5892.1 (b)).

On March 28, 2018, Marin received a determination from the State on funds subject to revision that must be spent by the County of Marin by July 1, 2020. This amount was then updated on May 15, 2018, when the State realized there was an error in their calculation and there was no WET funding at risk of reversion. Therefore many of the items that went out for public comment in the WET portion of this spending plan can now be found in the WET section of the Annual Update. The final amounts for each affected component is:

- Innovation (INN): $1,469,567
- Capital Facilities and Technological Needs (CFTN): $1,444,673
By July 1, 2018, counties are required to have a plan to spend those funds by July 1, 2020 (WIC Section 5892.1 (c)). This document constitutes the required Plan to Spend for Marin. Pursuant to WIC Section 5892.1, subdivision (e), 1 DHCS provided counties with IN 17-059 to implement those requirements. Additionally, IN 17-059 supersedes all other reversion policies contained in past Information Notices developed by the former Department of Mental Health and DHCS.

Information Notice 17-059 specified the following instructions for counties to plan to spend the funds:

- Every county must develop a plan to spend its reallocated funds and post it to the county’s website; (This document constitutes the required Plan to Spend for Marin)

- The county must submit a link to the plan to DHCS via email at MHSA@dhcs.ca.gov by July 1, 2018;

- Each county’s Board of Supervisors (BOS) must adopt a final plan within 90 days of the county posting the plan to the county’s website;

- Each county must submit its final Plan to Spend to DHCS and the MHSOAC within 30 days of adoption by the county’s BOS;

- A county may not spend funds that are deemed reverted and reallocated to the county until the county’s BOS has adopted a plan to spend those funds;

- The expenditure plan must account for the total amount of reverted and reallocated funds for all impacted FYs, as indicated in the applicable notice of unspent funds subject to reversion or in the final determination on an appeal;

- The county must include the Plan to Spend in the County’s Three-Year Program and Expenditure Plan or Annual Update, or as a separate plan update to the County’s Three-Year Program and Expenditure Plan, and comply with WIC Section 5847(a);

- Reallocated funds must be expended on the component for which they were originally allocated to the county.

**PLAN TO SPEND**

This spending plan is a product of community planning process and ongoing input is welcome.

**Innovation (INN): $1,469,567**

- $829,832 of this reallocated money will fund the final stage of the Transition Age Youth “Growing Roots” Innovation Project. This project was approved by the OAC on April 28, 2016, with a total budget of $1,616,900, of which $829,832 is
The remaining $616,235 of this allocation will go toward a new Innovation project with an additional $23,500 reserved for Innovation Planning costs to ensure we have the widest possible stakeholder engagement in the development of our innovation plans and to support staffing costs through the planning and approval process. Our stakeholder engagement process so far has highlighted an interest in finding innovative strategies toward meeting the needs of older adults in our community, as Marin is the oldest county in the Bay Area and has a rapidly growing aging population. We have been conducting multiple community engagement sessions, key informant interviews, focus groups, and meetings with providers, social services, and other programs serving older adults in our community to understand the needs and discuss innovative approaches. Using technology to better engage isolated seniors has been a highlighted need. BHRS staff are currently working with the OAC for technical assistance on developing the proposal and are coordinating with the cross-county Technology Suite to see if that will be able to meet our County’s needs.

<table>
<thead>
<tr>
<th>INN Project/Program</th>
<th>Timeline</th>
<th>Amount</th>
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<tbody>
<tr>
<td>“Growing Roots” TAY Innovation project</td>
<td>FY18-19 and 19-20</td>
<td>$829,832</td>
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<tr>
<td>New Older Adult Focused Innovation Project</td>
<td>FY18-19 and 19-20</td>
<td>$616,235</td>
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<tr>
<td>Innovation Planning Costs</td>
<td>FY18-19 and 19-20</td>
<td>$23,500</td>
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<tr>
<td><strong>Total:</strong></td>
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<td><strong>$1,469,567</strong></td>
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**Capital Facilities and Technological Needs (CFTN): $1,444,673**

This funding will be utilized for one Capital Facilities Project and two Technological Needs projects.

- **$685,000** of the reverted and reallocated money will go toward a Capital Facility project expanding the Crisis Stabilization Unit from 5 beds to 10. The Crisis Stabilization Unit is a significant part of our Crisis Continuum and this expansion will reduce overcrowding and allow for the unit to better meet the needs of the community.

- **$504,008** will be used for Electronic Health Record System Enhancements as described and approved in the FY2017-18 through FY2019-20 Three-Year Plan. This
includes improvements to the Electronic Health Record System, including system enhancements that capture our clinical crisis services electronically as well as updates to make the Clinician’s Gateway system ready to participate in Health Information Exchange. Additionally, this work will complete the remaining electronic forms/documents in Clinicians Gateway and provide for expanded hardware to provide emergency back up in the event of a system failure.

- **$255,665** of this funding will go toward the development of the electronic Case Management System that will be implemented by Whole Person Care (WPC). WPC, with the help of this technology project, will allow the county and community providers to improve coordination to better serve Medi-Cal beneficiaries with complex medical and psychosocial conditions, including mental health and substance use disorders as well as those who are homeless and precariously housed. WPC utilizes a team-based service model that integrates physical health, behavioral health, social services, and housing providers.

The County expects to integrate the case management system with its Health Information Exchange (HIE), the Marin Health Gateway, as well as have it bi-directionally share with County and partner data systems that are not connected or planned for connection to the HIE. These include current and future BHRS systems.

The County has recruited a broad range of stakeholders who have committed to data sharing through a case management tool. These partners include many Marin County departments, including:

- Behavioral Health and Recovery Services
- Epidemiology
- Social Services
- Adult Protective Services
- Emergency Services (EMS)
- Criminal Justice

MHSA dollars used to support system development and implementation may be used as leverage for the county to draw down an equal amount in Federal funds.
## CFTN Project/Program Timeline Amount

<table>
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<tr>
<th>CFTN Project/Program</th>
<th>Timeline</th>
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<tr>
<td>Crisis Stabilization Unit expansion</td>
<td>Approval through FY18-19</td>
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<tr>
<td>Electronic Health Record System Enhancements</td>
<td>FY18-19 through 19-20</td>
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<tr>
<td>Coordinated Case Management System</td>
<td>Approval through FY19-20</td>
<td>$255,665</td>
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<td><strong>Total:</strong></td>
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### Local Review Process:

This spending plan is the result of stakeholder feedback during the planning process for the MHSA 3-year plan and incorporates feedback from follow-up sessions and other community engagement events. The County of Marin’s MHSA Draft Plan to Spend Reverted/Reallocated Funds was presented to the Representative Stakeholder MHSA Advisory Committee on April 25, 2018, where it received recommendations, clarification, and input.

The MHSA Plan to spend was available for 30-day public review and comment from May 12, 2018 – June 11, 2018, with the ability to give feedback using the following website: [www.marinhhs.org/mhsa](http://www.marinhhs.org/mhsa). To see other options for giving input please refer to the Stakeholder Review section of this Annual Update. The public hearing was held at the Mental Health Board Meeting at 6pm on June 12th in the Point Reyes Room of 20 North San Pedro Avenue in San Rafael.
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 FY2016-17

1. POLICY

Mandatory Cultural Competence Trainings

- Reviewed and updated BHRS’ policy on required participation of BHRS staff in cultural competence trainings to explicitly state that all staff **MUST attend a minimum of four (4) hours annually.**
- All BHRS staff completed a 30-minute online training/refresher on the use of language line interpreters. Completion of the training/refresher counted toward the mandatory 4-hour cultural competence training policy requirement.

Cultural Competence Advisory Board Attendance Policy

- CCAB revised its membership policy to explicitly state that all board members **MUST attend a minimum of four (4) meetings per calendar year in order to remain serving on the board.**

Diversity in Job Interview Panels

- Successfully advocated for a policy that would require all BHRS interview panels to include at least one (1) member of underserved communities.
2. ACCESS

Improve Access By Having Diverse Workforce

- Successfully advocated for an increase in bilingual/bicultural staff as evidenced in an increase of Latina/o hired by BHRS from five (5) in FY15/16 to sixteen (16) in FY16/17; and Asians hired by BHRS from four (4) in FY15/16 to seven (7) in FY16/17
- Successfully advocated for continued commitment to offer and provide scholarship opportunities to culturally/ethnically diverse consumers/family members to enroll in and become peer, substance use or domestic violence counselors (see WET Annual Update)
- Advocated for a Vietnamese-speaking clinician to be a part staff of the Access Unit due to reported persistent communication barriers due to language.
- Successfully advocated for increased presence and services in a historically underserved community, Marin City, home to the highest concentration of African American residents who reside in Marin County which resulted in the first-ever consumer-operated Wellness and Recovery program; a dedication of an African American post-graduate clinical intern who is stationed to provide behavioral health services referrals and treatment services to community residents; and the development of a peer counseling internship program.

3. TRAINING

Cultural Competence Trainings

- Co-sponsored and hosted two (2) cultural competence trainings on LGBTQ and Military Veteran related topics
- Continued to offer and provide monthly cultural competence clinical consultation clinics for BHRS clinical staff and service agency partners.
- Provided two (2) community educational presentations on the role, value and effectiveness of peer counselors/specialists in public behavioral healthcare system to BHRS staff and agency partners. Each presentation was geared specifically for direct service providers while the other was geared for supervisors, managers and directors.
- Supported and funded several CCAB members to attend a state-wide Cultural Competence Summit
4. OUTREACH AND ENGAGEMENT

Outreach and Engagement to underserved grassroots organizations

- CCAB recommended and advocated for the inclusion of underserved grassroots organizations in the county’s Mental Health Plan (MHP) as legitimate and culturally appropriate service providers, particularly with the TAY population. Advocacy resulted in a competitive RFP process in which ten (10) grassroots organizations that serve under-served/hard-to-reach TAY were awarded INNOVATION grants. Technical assistance and program evaluators were included in the grants process to ensure that the funded organizations have the means to accurately measure and evaluate the effectiveness of their service delivery and practice.
- Successfully advocated for the increase in Promotoras from seven (7) to eleven (11) to better reach, engage, and serve the Latino community.

5. SERVICE DELIVERY

Cultural Appropriateness and Responsive Service Delivery

- CCAB began to analyze existing data on the penetration rates of underserved racial/ethnic populations. In addition to diversifying the workforce to better reflect the cultural/ethnic populations that BHRS and its contract agency partners serve by increasing the hiring of bicultural/bilingual staff and providing cultural competence trainings and consultation, the board has and will continue to study and analyze other factors and possible barriers that prevent underserved cultural/ethnic populations from not only accessing services, but the length/duration of their engagement to successfully complete or achieve their treatment goals.
- Supported PEI-funded Vietnamese Community Health Advocates to better understand the behavioral healthcare system of care in order to improve navigation of the system, thus, improving access to services.
- Promoted the hiring and retention of underserved cultural/ethnic consumers/family members who have graduated from peer, substance use and/or domestic violence counseling programs as a means to improve access to care and provide culturally appropriate support to underserved cultural/ethnic consumers.
- Successfully advocated for the development of the first-ever county classified Peer Counselor positions by getting the approval of the county Board of Supervisors.
COMPLIANCE WITH REVISED PEI REGULATIONS

BACKGROUND

New PEI Regulations were adopted effective October 6, 2015. Various amendments to those regulations are underway. In the meantime, Marin County has been assessing and improving its compliance with these regulations.

COMPLIANCE PLAN

There are many areas of the regulations that Marin was already in compliance with before they were adopted. These include:

- The purpose of PEI
- Implementing the types of programs (Prevention, Early Intervention, Outreach, Stigma and Discrimination Reduction, Access and Linkage to Treatment, Suicide Prevention - optional)
- Implementing the required strategies (Access and Linkage to Treatment, Improve Timely Access for Underserved Populations, Non-stigmatizing, Effective Methods)
- Collecting and reporting on the majority of required data (number served, number of family members served, previously required demographics, outcomes, etc.)

The following areas are under development:

Demographics

There are a number of new aspects to the demographics including a separation of race and ethnicity, types of disability, sexual orientation, gender assigned at birth, and current gender identity. As of July 1, 2017, all Early Intervention programs are collecting this data. This was a good way to introduce the new demographics because early intervention programs have more extensive interactions with clients than most other programs. As of July 1, 2018, all PEI funded programs will be required to gather the expanded demographics when appropriate. For example, it may be appropriate to collect the data at the end of a long workshop or series of workshops, but not at a short presentation or outreach activity. The PEI Coordinator will work with the programs to determine which activities are appropriate for gathering demographic data.

Outreach – Settings and Types of Responders

In the new regulations, programs that teach people to recognize and respond to early signs of potentially severe mental illness are expected to report on the settings where the trainees
might use those skills (i.e. where they work) as well as the type of responder they are (i.e. what their job is). Currently the programs collect information on the setting, but not on the type of responder. We expect to begin collecting that data July 1, 2018. As with the demographics, some activities will lend themselves to this and some will not. For Mental Health First Aid we can either collect that information at the time of registration, which is done online, or at the course as part of the demographic data form. But for contracted providers conducting shorter workshops and more informal education, that data may be harder to collect.

Access and Linkage to Treatment

July 1, 2016, PEI providers began collecting information on referrals to County of Marin Access Line. Names, date of referral, and other data was submitted to the County. The County then looked at whether those referred contacted the Access Line and what action was taken. Future PEI provider data collection will be improved to include demographics, only include referrals for those thought to be experiencing SMI/SED, and provide more of the required information. The assessment is done once they are referred to County Access Line, so whether or not an individual referred to Access Line is actually experiencing SMI/SED can only be determined if they contact Access and complete an assessment.

Improve Timely Access

PEI providers will begin collecting data on referrals to other PEI programs as of July 1, 2018. We are working out the details of how the follow-up will be conducted in compliance with HIPAA. Based on conversations with PEI providers, they rarely provide a written referral to another PEI program, and therefore may have limited data to report in this area. The strategies used for encouraging timely access to services are described in the narrative part of the Annual Update.
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

**Clients Served: FY2016-17**

9,961 Individuals
552 Families

### SUMMARY FY2016-17

- **PEI**
  - Outreach: 43%
  - Prevention: 20%
  - Early Intervention: 17%
  - Access and Linkage: 16%
  - Suicide Prevention: 4%

Clients Served: FY2016-17

9,961 Individuals
552 Families
A minimum of 51% of PEI funds are required to be dedicated to youth and transition age youth (0-25 years old).

Recognizing that increased funding and services are not 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 to collaborate toward a stronger system of care.

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

<table>
<thead>
<tr>
<th>PEI Committee Outcomes</th>
<th>2009</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation on the PEI Committee helps my organization to develop expertise in MH prevention and programs.</td>
<td>2.85</td>
<td>3.25</td>
</tr>
<tr>
<td>The PEI Committee fosters a &quot;culture of prevention&quot; for mental health.</td>
<td>3.00</td>
<td>3.33</td>
</tr>
<tr>
<td>The PEI Committee works collaboratively with other efforts in the community to address issues.</td>
<td>3.00</td>
<td>3.38</td>
</tr>
<tr>
<td>Participation on the PEI Committee helps my organization to collaborate effectively with other organizations.</td>
<td>2.89</td>
<td>3.38</td>
</tr>
<tr>
<td>The PEI Committee contributes to the development of a mental health system of care.</td>
<td>3.12</td>
<td>3.54</td>
</tr>
</tbody>
</table>

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

**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.
PREVENTION AND EARLY INTERVENTION OVERVIEW

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 FY2016-17:
AGE GROUP (N=2749)

PEI FY2016-17:
RACE/ETHNICITY (N=2749)
PEI FY2016-17:
PRIMARY LANGUAGE (N=2749)

- Spanish: 52%
- Vietnamese: 3%
- English: 41%
- Other/unknown: 4%

PEI FY2016-17:
GENDER (N=2749)

- Male: 42%
- Female: 57%
- Transgender/Other: 1%
- Unknown: 3%
PEI FY2016-17:
# of Clients Served by City (N=2749)
PEI Funding Use by Program in FY2016-17

<table>
<thead>
<tr>
<th>Program</th>
<th>FTE*</th>
<th>P</th>
<th>EI</th>
<th>O</th>
<th>SDR</th>
<th>A&amp;L</th>
<th>SP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Childhood Mental Health Consultation</td>
<td>2.6</td>
<td>52%</td>
<td>48%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triple P (Positive Parenting Program)</td>
<td>0.5</td>
<td>81%</td>
<td>19%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transition Age Youth PEI</td>
<td>1.7</td>
<td>75%</td>
<td></td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino Community Connection</td>
<td>2.5</td>
<td>74%</td>
<td></td>
<td>26%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated Behavioral Health in Primary Care</td>
<td>2.4</td>
<td>78%</td>
<td></td>
<td>22%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Older Adult PEI</td>
<td>0.9</td>
<td>80%</td>
<td></td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vietnamese Community Connection</td>
<td>0.8</td>
<td>66%</td>
<td></td>
<td>34%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEI Community and Provider Training</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td>59%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>School Age PEI</td>
<td>3.8</td>
<td>81%</td>
<td></td>
<td>19%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans Community Connection</td>
<td>0.6</td>
<td></td>
<td></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statewide</td>
<td>NA</td>
<td></td>
<td>26%</td>
<td></td>
<td></td>
<td>18%</td>
<td>56%</td>
</tr>
</tbody>
</table>

* FTE = Full Time Equivalent indicates the number of staff hours (1 FTE = 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 serious 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) who attend subsidized pre-schools, and their families. These students are 69% Latino, 21% White, 5% African American, 2% Asian, and 2% multi-racial. Sixty-eight percent of the students speak Spanish at home. Eighty-six percent of families served have subsidized childcare. 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 FY2016-17

Clients Served: FY2016-17

620 Individuals
80 Family Members

PEI & OAL

100%

- Outreach
- Prevention
- Early Intervention
- 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 receive 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.” Gaining skills in these areas increases the providers’ abilities 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 using 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; identifying the child’s areas of resilience and creating a support plan to build on these strengths; supporting staff and parents with self-initiated strategies (both child-directed and programmatic) to meet the needs of the child’s identified behavior; encouraging the development of strong bonds between teacher and child, and between teacher and parents; facilitating meeting(s) between parents and staff; helping parents identify areas of personal/familial stress as a bridge to referrals; and providing 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.
EXPECTED OUTCOMES

Early Childhood Mental Health Consultation is intended to:

- Reduce Prolonged Suffering for those at significantly higher risk for 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 by implementing evidence-based practices and best practices that have been shown to achieve positive impacts for the target population:

- Early Childhood Mental Health Consultation (ECMHC) is a practice-based method that is emerging as an effective strategy for supporting young children’s social and emotional development and addressing challenging behaviors in early care and education settings (Gilliam & Shahar, 2006). ECMHC aims to strengthen the capacity of staff, families, programs, and systems to promote positive social and emotional development as well as prevent, identify, and reduce the impact of mental health problems among children from birth to age 6 (Kaufman et. al., 2012). As a result, more and more states and communities are investing in ECMHC programs. Georgetown University Center for Child and Human Development (GUCCHD) faculty are nationally-recognized leaders in the field of early childhood mental health consultation, and have drawn on their expertise to help states and programs across the country build their capacity for delivering and evaluating ECMHC services for young children and their caregivers.


- The 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 FY2016-17, ECMH provided consultation for 17 Marin County subsidized preschools, 3 Early Head Start home visitors, and a play group. The ECMH program is successful at providing prevention and capacity building that reaches far beyond a direct services model. By training and coaching childcare providers, many children and families will benefit for years to come, including increasing their access to services due to early identification and effective linkages. Intervening early in a child’s life can reduce poor outcomes that would require more extensive services later in life.

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. In addition, ECMH provides training and consultation for Head Start and Early Head Start providers and parents.

Due to efforts to reach geographically isolated communities, the total number of children served has reduced. This is because those sites tend to have less children per site and require increased travel time.

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. In addition, services to geographically isolated West Marin have increased. Many of the families served do not have other opportunities to obtain identification and intervention services for their children’s behavioral issues.

<table>
<thead>
<tr>
<th>Outcomes for FY2016-17</th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children and Families Receiving Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children that received prevention services.</td>
<td>670</td>
<td>620</td>
</tr>
<tr>
<td>Percent of these children that come from un/underserved cultural populations (Latino, Asian, African American, West Marin).</td>
<td>70%</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>N=620</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>75</td>
<td>80</td>
</tr>
<tr>
<td>Children in childcare settings served by ECMH Consultants retained in their current program, or transitioned to a more appropriate setting. <em>Case notes</em></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>N=620</td>
<td></td>
</tr>
</tbody>
</table>
Parents/primary caregivers of families receiving intensive services who report increased understanding of their child’s development and improved parenting strategies. *JFCS multi-county parent questionnaire*

<table>
<thead>
<tr>
<th>Percentage</th>
<th>N=15</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Families receiving ECMH Consultation services who report satisfaction with the services (would use again, would recommend, were helpful). *PEI survey*

<table>
<thead>
<tr>
<th>Percentage</th>
<th>N=19</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

**Early Childhood Education Sites Receiving Services**

<table>
<thead>
<tr>
<th>Staff Receiving Services</th>
<th>130</th>
<th>110</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childcare staff that received additional consultation and/or training</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage</th>
<th>N=89</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

Childcare staff receiving ECMH Consultation who report increased ability to identify, intervene with, and support children in their care with emotional/behavioral issues. *JFCS multi-county provider questionnaire*

<table>
<thead>
<tr>
<th>Percentage</th>
<th>N=89</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

Staff receiving ECMH Consultation services who report satisfaction with the services (would use again, would recommend, were helpful). *PEI survey*

<table>
<thead>
<tr>
<th>Percentage</th>
<th>N=89</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td></td>
</tr>
<tr>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

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

---

**ECMH FY2016-17:**

**AGE GROUP (N=620)**

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

n=620, 100%
ECMH FY2016-17:
RACE/ETHNICITY (N=620)

- White: n=430, 69%
- African American: n=128, 21%
- Asian: n=28, 5%
- Pacific Islander: n=14, 2%
- Hispanic: n=15, 2%
- Multi: n=4, 1%
- Other/unknown: n=1, 0%

ECMH FY2016-17:
GENDER (N=620)

- Male: n=320, 52%
- Female: n=300, 48%
ECMH FY2016/17:
PRIMARY LANGUAGE (N= 620)

- Spanish: 423 (68%)
- English: 182 (30%)
- Other/unknown: 8 (1%)
- Mandarin: 3 (1%)
- Tagalog: 2 (0%)
- Vietnamese: 1 (0%)
- Cantonese: 1 (0%)
Challenges and Upcoming Changes

In **FY2017-18**, the ECMHC program was implemented as expected.

In **FY2018-19**, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20. In the upcoming fiscal year, this program will continue to be categorized as a Prevention Program.
CLINT STORY – EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

Carlos was 4 years old when he was brought to the attention of the Early Childhood Mental Health (ECMH) Consultant. The teachers reported that he was restless and “goofed” around a lot. The consultant met with Carlos’ parents and heard that the teachers “complain” to them that he interrupts, has trouble concentrating, cannot stay seated and cannot stay calm. Elena reported her concerns to the consultant that it would typically take him a full hour to fall asleep and that he bites his nails. Elena also revealed that Carlos was born at 33 weeks and spent “several weeks” in the hospital. In response to the standard question about his hearing, the parents reported that he received one hearing test that he did not pass because of fluid in his ears. He was also unable to pass the follow-up hearing test.

After classroom observations and meeting with Carlos’ teachers and parents, the consultant began to put together a set of goals for Carlos, which included having the lead teacher complete a DECA-C pretest (Devereux Early Childhood Assessment-Clinical). The parents accepted the consultant’s recommendation to try “chewelry” for Carlos – discreet chewable jewelry for kids or adults who need to chew – to keep him from biting his nails. When Carlos brought the chewelry to class, the lead teacher found it babyish and hard to accept. After a few meetings with the consultant and the ECMH pediatric Occupational Therapist, as well as observing the chewelry’s effectiveness in helping Carlos calm down and refrain from biting his nails, the teacher accepted it as a good intervention.

At a subsequent meeting, Carlos’s parents talked about his fear of going to appointments that dated back to a traumatic dental visit. According to his parents, the dental team held Carlos down and pried open his mouth to perform a minor surgery. Since this incident, Carlos expresses fear any time he needs to go to any kind of appointment. The consultant addressed the invasiveness of the NICU, the discomfort that led to the need for dental surgery, and the surgery visit as traumatic experiences in Carlos’s life, and for his parents as well. The consultant helped the parents realize that they could request a different dentist, which they did, and the session with the new dentist went well.

The consultant recommended therapy for Carlos and his parents accepted the recommendation. They navigated through Beacon’s referral process with the consultant’s help. The consultant also spoke with several potential therapists to determine a good fit given the trauma history and current behavior.

The DECA-C pre-test results indicated scores of “average to low” for all protective factors, “average to high” on three behavioral concerns, and “high concern” on attention problems. A support plan was created based on this assessment. Teachers and parents were guided in ways to reinforce positive behaviors as they increased their efforts to connect with Carlos in a focused way. Using Positive Descriptive Acknowledgement, as described in the California Teaching Pyramid, was emphasized rather than continually trying to teach Carlos what not to do. In addition, the adults were guided by the assessment to increase Carlos’ focused attention by scaffolding his ability to participate in pretend play and his interest in trying new activities. With input from the Occupational Therapist on our team, the teachers and parents were introduced to fidgets for restlessness, chewelry
for oral sensory seeking, and the suggestion to join Carlos in a song when he starts humming – one way in which Carlos self-soothes – and recognizing the behavior as a means of self-control on his part. Post-DECA-C results showed all protective factors elevated to “high typical bordering on strength” and the behavioral area of most concern, attention problems, reduced to the “lowest level of concern bordering on typical”. Also, with the consultant’s guidance, the parents are working with their doctor on Carlos’ substandard hearing.

In mid-July, the consultant saw Carlos at the childcare site and let him know that she missed him that morning. Carlos replied, with a big smile on his face, “I was at the dentist!”
TRIPLE P (POSITIVE PARENTING PROGRAM) MARIN

PROGRAM OVERVIEW

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

![Triple P Clients Served: FY2016-17]

- **513** Individuals
- **262** Families

**PEI**
- Outreach (no demographics)
- Prevention
- Early Intervention
- Access and Linkage

**OAL**
- 4%
- 96%
TRIPLE P LEVELS

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

TARGET POPULATION

The target population for this program is:

- Providers working with families from underserved populations. Providers include mental health clinicians, family partners/advocates, school staff, front-line workers, and others who work with families on a regular basis.
- Families from underserved populations, including Latino, Asian, African American, Spanish-speaking, and residents of West Marin, with children ages 0-15. The parents and children may be at risk for mental illness due to adverse childhood 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 stress, 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 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 by 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 FY2016-17, Jewish Family and Children’s Services (JFCS) focused on providing services for parents and increasing the capacity of providers to implement the program with fidelity. There was a significant increase in numbers served, especially in the Latino population. JFCS provided presentations through Women, Infants and Children (WIC), school sites, transitional housing, and primary care clinics.

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. There were a total of 513 children whose parents participated. While 262 parents participated, there was a total attendance of 414, showing that many parents found it valuable enough to attend multiple services. In addition, the goal for Spanish speaking attendance was exceeded.
<table>
<thead>
<tr>
<th>Outcomes for FY2016-17</th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children and Families Receiving Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents attending Triple P seminars and discussion groups</td>
<td>200</td>
<td>262</td>
</tr>
<tr>
<td>(Level 2-3) (unduplicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portion of seminars/discussion groups conducted in Spanish.</td>
<td>33%</td>
<td>69%</td>
</tr>
<tr>
<td>Parents receiving group services that are referred to individual services.</td>
<td>10%</td>
<td>11%</td>
</tr>
<tr>
<td>Families receiving individual Triple P services (Level 3)</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>(unduplicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents receiving individual services in Spanish.</td>
<td>33%</td>
<td>82%</td>
</tr>
<tr>
<td>Parents reporting satisfaction with services (would use again, would refer others). <em>PEI survey</em></td>
<td>75%</td>
<td>95%</td>
</tr>
<tr>
<td>Some parents attended more than one session so N is higher than total served.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=320</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Providers Receiving Services**

<table>
<thead>
<tr>
<th>Providers Receiving Services</th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers that received training and technical assistance</td>
<td>12-15</td>
<td>22</td>
</tr>
<tr>
<td>Participating providers reporting increased confidence in providing services with fidelity. <em>Provider survey</em></td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>N=11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating providers reporting satisfaction with the training and technical assistance. <em>PEI survey</em></td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>N=11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Type of Participants in Outreach Events</th>
<th>Number Served</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Providers</strong></td>
<td></td>
</tr>
<tr>
<td>County Behavioral Health providers</td>
<td>2</td>
</tr>
<tr>
<td>Community-based Mental Health and/or Substance Use providers</td>
<td>6</td>
</tr>
<tr>
<td>Education</td>
<td>2</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>1</td>
</tr>
</tbody>
</table>

*PEI · TRIPLE P (POSITIVE PARENTING PROGRAM)  ·  PEI-02*
**TripleP FY2016-17:**
**AGE GROUP (N=491)**

- 0-15: \(n=457, 93\%\)
- 16-25: \(n=23, 5\%\)
- 26-59: \(n=10, 2\%\)
- 60+: \(n=1, 0\%\)
- Unknown: \(n=340, 69\%\)

**TripleP FY2016-17:**
**RACE/ETHNICITY (N=491)**

- White: \(n=109, 22\%\)
- African American: \(n=19, 4\%\)
- Asian: \(n=15, 3\%\)
- Native: \(n=4, 1\%\)
- Hispanic: \(n=3, 1\%\)
- Multi: \(n=10, 2\%\)
- Other/unknown: \(n=1, 0\%\)
**TripleP FY2016-17:**

**GENDER (N=491)**

- Male: 256 (52%)
- Female: 204 (42%)
- Transgender/Other: 30 (6%)
- Unknown: 1 (0%)

**TripleP FY2016/17:**

**PRIMARY LANGUAGE (N=491)**

- Spanish: 327 (67%)
- English: 154 (31%)
- Other/unknown: 10 (2%)
Triple P FY2016/17
# of Clients Served by City

San Rafael: 293
Novato: 82
San Anselmo: 27
Other/Unknown: 19
San Geronimo: 18
Fairfax: 16
Mill Valley: 12
West Marin: 11
Greenbrae/Kentfield/Ross: 6
Sausalito: 5
Corte Madera: 1
Larkspur: 1
Belvedere/Tiburon: 1
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 under PEI in FY2017-18. Implementation of Triple P will continue to be supported within BHRS Youth and Family Services. JFCS has been able to secure other funding sources to continue Triple P for the wider community.
CLIENT STORY - TRIPLE P (POSITIVE PARENTING PROGRAM)

Sheri, a mother of three children, was housed at Gilead House. Gilead House provides transitional housing for women and their children who have left domestic abuse situations or otherwise unsafe living situations, and are finding their way to creating a new life.

Sheri attended Triple P Seminar and Group sessions offered on-site at Gilead House over the last two years. She then met with the Consultant for two individual sessions. She has 10-year-old twins and a 6 year old. She struggled with gaining cooperation, sibling fighting, and concerns about her upcoming transition into her own apartment.

The more typical parenting issues she experienced with her children were addressed in the group sessions. Sheri utilized the homework to help her with sibling conflict issues and gaining her children’s cooperation. In individual meetings, we worked more specifically on the issues that kept her from following through with the strategies she had been taught, as well as how to better manage her stress as she was in a challenging time of transition and these stressors were adversely affecting her ability to parent.

We then created some plans from the Planned Routines template which helped her create an organized approach to supporting herself and the children during the recently added visits with their father, which were proving difficult for them all. We used the template to help them know what to do when saying hello and good-bye to both Dad and Mom and for her to better respond to behavioral difficulties if they arose. Sheri also had the idea to practice with the children what to do if the children were having difficulties during these emotionally challenging transitions. There were things the children expressed to her about seeing Dad that she was able to help them address and the children were willing for her to share the plan with Dad. Sheri was skeptical about doing so but with the consultant’s assistance she figured out an effective way to present it to Dad and he was receptive. Sherri was pleased to have this successful parenting collaboration. In addition, Sheri also came to see that the children would benefit from some counseling, and that she would continue her own, which the Parent Educator strongly encouraged.
TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION

PROGRAM OVERVIEW

In 2009, MHSA PEI funds began the Transition Age Youth (TAY) Prevention and Early Intervention (PEI) program, provided by Huckleberry Youth Programs (HYP) and North Marin Community Services (NMCS), formerly 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.

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

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 those at risk for dropping out of traditional school settings. Skill building groups are offered at schools and in classrooms that specifically target these groups of students, therefore involvement in the groups 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 school skill building groups for high risk students, 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. If identified as experiencing serious mental illness, clients are linked to medically necessary services. 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 receive 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 North Marin Community Services (NMCS) 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 FY2016-17

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAY screened for behavioral health concerns.</td>
<td></td>
<td>350</td>
</tr>
<tr>
<td>TAY participating in at least 5 sessions of school-based skill building groups.</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>TAY participating in at least 5 sessions of school-based skill building groups showing statistically significant improvement in client well-being. <em>PCOMS: Outcome Rating Scale</em></td>
<td>65%</td>
<td>81%</td>
</tr>
<tr>
<td>Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change.</td>
<td>N=72</td>
<td></td>
</tr>
<tr>
<td>TAY participating in individual counseling.</td>
<td>180</td>
<td>242</td>
</tr>
<tr>
<td>Family members participating in TAY counseling in support of the client.</td>
<td>30</td>
<td>79</td>
</tr>
<tr>
<td>TAY participating in at least 3 sessions of counseling.</td>
<td>NA</td>
<td>134</td>
</tr>
<tr>
<td>TAY participating in at least 3 sessions of counseling showing statistically significant improvement in client well-being. <em>PCOMS: Outcome Rating Scale</em></td>
<td>65%</td>
<td>74%</td>
</tr>
<tr>
<td>Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change.</td>
<td>N=91</td>
<td></td>
</tr>
<tr>
<td>TAY participating in at least 3 sessions of counseling showing a validated positive therapeutic alliance, a significant predictor of clinical outcomes. <em>PCOMS: Session Rating Scale</em></td>
<td>75%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>N=123</td>
<td></td>
</tr>
</tbody>
</table>

_N = the total number in the sample (i.e. total number who received services or completed a survey)_
PREVENTION TAY FY2016/17: AGE GROUP (N=453)

- 0-15: n=37, 8%
- 16-25: n=416, 92%
- 26-59: n=258, 61%
- 60+: n=139, 33%
- Unknown: n=8, 2%

PREVENTION TAY FY2016/17: RACE/ETHNICITY (N=453)

- Hispanic: n=258, 61%
- White: n=139, 33%
- Multi: n=19, 4%
- Other/unknown: n=8, 2%
PREVENTION TAY FY2016/17:
GENDER (N=453)

- Male
- Female
- Transgender/Other

PREVENTION TAY FY2016/17:
PRIMARY LANGUAGE (N=453)

- English
- Spanish
- Other/unknown
- Tagalog
- Farsi
PREVENTION TAY FY2016/17
# of Clients Served by City

San Rafael: 160
Novato: 153
Greenbrae/Kentfield/Ross: 96
Mill Valley: 11
Corte Madera: 10
Fairfax: 7
San Anselmo: 5
Belvedere/Tiburon: 5
San Geronimo: 3
Sausalito: 2
Larkspur: 1
West Marin: 1
EI TAY FY2016/17: AGE GROUP (N=252)

- 0-15: n=91, 36%
- 16-25: n=129, 51%
- 26-59: n=14, 6%
- 60+: n=9, 4%
- Unknown: n=6, 2%

EI TAY FY2016/17: RACE/ETHNICITY (N=251)

- Hispanic: n=91, 36%
- White: n=129, 51%
- African American: n=1, 1%
- Multi: n=1, 0%
- Asian: n=6, 2%
- Pacific Islander: n=9, 4%
- Native: n=14, 6%
EI TAY FY2016/17:
GENDER (N=252)

- Male (n=141, 56%)
- Female (n=111, 44%)

EI TAY FY2016/17:
PRIMARY LANGUAGE (N=252)

- English (n=180, 71%)
- Spanish (n=57, 23%)
- Other/unknown (n=15, 6%)
Challenges and Upcoming Changes

In **FY2017-18**, due to the loss of its bilingual Case Manager mid-year, NMCS was unable to provide the intended range of case management services for the latter part of the fiscal year. Other TAY program components were implemented as expected.

In **FY2018-19**, the TAY PEI program is expected to be fully staffed and implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20. In the upcoming fiscal year, this program will be categorized as an Early Intervention Program.
CLIENT STORY - TRANSITIONAL AGE YOUTH PEI

A 15-year-old who was new to the area dropped-in to the Novato Teen Clinic. She was having trouble accessing mental health support because she needed a high level of care and was temporarily not covered by Medi-Cal due to a transfer in benefits. The Case Manager helped her explore different mental health options and was able to arrange an appointment with a doctor at Marin Community Clinics who could then connect her to their psychiatrist. Because we work in an integrated model with Marin Community Clinics, the Case Manager and youth were able to schedule the appointment right then without going through the typical additional step of requiring the parent to call in and schedule the appointment. This teen had already reached out to a few agencies for help and was weary from the barriers she was encountering. The Case Manager also secured permission from the teen to contact her mother to offer additional support. Both the teen and her mother expressed that the Teen Clinic was the most helpful organization they had reached out to so far.

Rodolfo first came to Huckleberry when he was 18-years-old and was referred to family counseling by his academic school counselor. His counselor reported that he had “familial turmoil” that was greatly impacting his school work, school participation and performance. Rodolfo is an immigrant from Central America who arrived to be reunited with his parents 2½ years prior and was having a difficult time with the transition with reunited family. Shortly after arriving to the US Rodolfo had turned to illicit substances to manage his emotions and deep feelings of sadness and loss that the immigration and the reunification triggered. Rodolfo reported that with feelings of isolation, angst and uncertainty of his role in the family and in the community, he was having feelings of hopelessness and at times contemplated suicide. He described feelings of confusion, disconnection, sadness, mistrust, anger and a longing to be connected to his family to feel loved and understood, all the necessary things he felt he had missed out on during the many years of separation from his parents. Rodolfo’s counseling focused on communication with his parents and discussing emotions in a way that would allow them to engage and connect with him. While family counseling focused on family dynamics and trust, individual counseling included goal setting and development of personal vision and areas of passion. In early June, Rodolfo graduated from high school surrounded by his family and close friends. Today, he plans on attending community college to follow his passion to be a mechanic and has shifted to now see himself as an important person within his family and his community.
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

Latino CC
SUMMARY FY2016-17

Clients Served: FY2016-17

1,490 Individuals
10 Families

17% Outreach
83% Prevention
Early Intervention
Access and Linkage
- Outreach for Increasing Recognition of Early Signs of Mental Illness
- Prevention: Reduce Risk Related to Mental Illness

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

Outreach for Increasing Recognition:

- Radio Show: A licensed mental health provider will host a weekly live one-hour radio show in Spanish on the health of Latino individuals, families and communities, in particular mental health topics. It will be a 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.

<table>
<thead>
<tr>
<th>Outcomes for FY2016-17</th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals receiving health information and support from Promotores or Family Resource Advocates.</td>
<td>640</td>
<td>1490</td>
</tr>
<tr>
<td>Individuals participating in support groups or individual/family sessions.</td>
<td>100</td>
<td>113</td>
</tr>
<tr>
<td>Family members participating in support of the client.</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Support group participants attending for at least 3 months.</td>
<td>65%</td>
<td>90% N=18</td>
</tr>
</tbody>
</table>
**PEI · LATINO COMMUNITY CONNECTION (LCC)**

**PROGRAM ALLOCATION FY2016-17 $204,000**

<table>
<thead>
<tr>
<th>Individuals participating in a support group for at least 3 months reporting statistically significant improvement in PTSD symptoms. <strong>PCL-C 5 pt change</strong></th>
<th>80%</th>
<th>95%</th>
<th>N=16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals participating in support groups or individual/family sessions reporting an increased ability to address their problems. <strong>PEI Survey</strong></td>
<td>80%</td>
<td>98%</td>
<td>N=95</td>
</tr>
<tr>
<td>Individuals participating in support groups or individual/family sessions reporting satisfaction with the services (would use again, would recommend). <strong>PEI Survey</strong></td>
<td>80%</td>
<td>100%</td>
<td>N=105</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th><strong>Type of Participants in Outreach Events</strong></th>
<th><strong>Number Served</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Members (Latino/Spanish Speaking)</td>
<td>658</td>
</tr>
</tbody>
</table>

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 Providers.
Latino CC FY2016-17:
AGE GROUP (N=254)

- 0-15: n=5, 2%
- 16-25: n=29, 11%
- 26-59: n=209, 82%
- 60+: n=9, 4%
- Unknown: n=2, 1%

Latino CC FY2016-17:
RACE/ETHNICITY (N=254)

- White: n=5, 2%
- Hispanic: n=249, 98%
**Latino CC FY2016-17:**
**GENDER (N=254)**
- Female: 62, 24%
- Male: 192, 76%

**Latino CC FY2016-17:**
**PRIMARY LANGUAGE (N=254)**
- Spanish: 249, 98%
- Other/unknown: 5, 2%
CHALLENGES AND UPCOMING CHANGES

In **FY2017-18**, due to the unexpected loss of its bilingual Behavioral Health Coordinator mid-year, Canal Alliance was unable to provide the intended range of prevention services for the latter part of the fiscal year. Other LCC program components were implemented as expected.

In **FY2018-19**, this program is expected to be fully staffed and implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20. In the upcoming fiscal year, this program will be categorized as a Prevention Program.
CLIENT STORIES - LATINO COMMUNITY CONNECTION

Emiliano sought services after experiencing symptoms of post-traumatic stress disorder. He had fled his native country because his life was being threatened. He reported being held hostage for a month by coyotes before being detained by immigration at the border. Emiliano reported nightmares, flashbacks, sweating, anxiety attacks, hyper-vigilance, body aches, headaches, night terrors, and physical pain. He engaged in the weekly support group sessions and reported a decrease in symptoms. He also expressed the benefit of meeting other men who shared his experience. Emiliano was able to begin employment, as well as taking medication and attending his doctor’s appointments consistently.

A Promotor worked with Matias. They were friends and had come from the same town in Mexico. Matias had previously been a member of Alcoholic Anonymous, but had stopped attending. The Promotor used motivational interview techniques to help him explore his ambivalence around making healthy changes in his life. As a result, Matias is currently sober and attending AA sessions.
**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.
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 clients, who often have increased barriers, are able to access those services. The most common concerns presenting in the primary care setting include depression, anxiety, substance use, and PTSD. If a client screens positive, they are further assessed during the primary care visit, or are referred to on-site behavioral health providers, depending on the clinic. Assessments may include PHQ9, GAD7, or other validated tools. Clients are offered on-site services as appropriate. If an individual is identified as experiencing serious mental illness, they are linked to medically necessary services. On-site providers are trained in evidence-based practices, such as Problem Solving Treatment. The program improves timely access to services for underserved populations because the target population already accesses the community clinics for primary care. The screening and interventions offered are culturally and linguistically appropriate, utilizing Spanish speaking staff and interpretation for other languages as needed. Due to Federal guidelines regarding client copays, the cost of the services can be a barrier for the target population, therefore PEI funds assist in reducing the costs to the client. In addition, PEI supports the Latino Community Connection program, which provides similar services for free in a community-based setting. These two programs work together to assist clients in receiving the most appropriate
services available. Services are non-stigmatizing by being offered through sites clients are already accessing and by focusing on issues like stress and wellness rather than “mental health.

Individuals/families at risk or showing signs of developing mental illness or emotional disturbance are provided risk reduction and early intervention services, or linked other resources as needed. Access and linkage to treatment for individuals experiencing symptoms of serious mental illness or emotional disturbance is provided through assessment and referral by licensed mental health providers in the primary care setting. They make the referrals to County 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 or 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. Randomized controlled trial

**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, off-site services, combining physical and behavioral health services in a single visit, and reduced copays.
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.
Ritter Center has continuously worked to increase access to their behavioral health services, including providing drop-in services and providing services at housing/shelter sites. While they have been able to hire more behavioral health providers, they have not been able to recruit a Spanish speaking provider. Ritter continues to work with Canal Alliance to provide appropriate services for Spanish speaking clients.

*This program will not continue under PEI in FY2017-18.* BHRS will continue to collaborate with Federally Qualified Health Centers to support client access to mental health services.
CHA FY 2016-17: AGE GROUP (N=99)

- 0-15: n=61, 62%
- 16-25: n=36, 36%
- 26-59: n=1, 1%
- 60+: n=1, 1%
- Unknown: n=14, 14%
- CHA FY 2016-17: 73, 74%

CHA FY 2016-17: RACE/ETHNICITY (N=99)

- Hispanic: n=61, 62%
- White: n=36, 36%
- Asian: n=1, 1%
- Other/unknown: n=4, 4%
- CHA FY 2016-17: 8, 8%
CHA FY 2016-17: GENDER (N=99)

- Male: 40, 40%
- Female: 59, 60%

CHA FY 2016/17: PRIMARY LANGUAGE (N=99)

- Spanish: 4, 4%
- English: 54, 55%
- Other/unknown: 1, 1%
CHARITY FY 2016-17
# of Clients Served by City

- Other/Unknown: 49
- West Marin: 20
- San Geronimo: 9
- Fairfax: 8
- San Rafael: 5
- Novato: 4
- Mill Valley: 2
- San Anselmo: 1
- Sausalito: 1
- Belvedere/Tiburon: 1
- Corte Madera: 1
- Greenbrae/Kenfield/Ross: 1
- Larkspur: 0
Ritter FY 2016-17:
AGE GROUP (N=56)

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

Ritter FY 2016-17:
RACE/ETHNICITY (N=56)

- White
- Other/unknown
- African American
- Hispanic
- Multi
- Pacific Islander
- Asian
- Native

- n=6, 11%
- n=4, 7%
- n=5, 9%
- n=7, 12%
- n=46, 82%
- n=31, 55%
- n=2, 4%
- n=1, 2%
Ritter FY 2016-17: GENDER (N=56)

- Male: n=30, 54%
- Female: n=26, 46%

Ritter FY 2016/17: PRIMARY LANGUAGE (N=56)

- Spanish: n=5, 9%
- English: n=51, 91%
Ritter FY 2016/17

# of Clients Served by City
CLIENT STORY - INTEGRATED BEHAVIORAL HEALTH IN PRIMARY CARE

When he came to the clinic, Teo wasn’t expecting more bad news. He had been struggling with terrible insomnia and panic attacks since surviving a violent assault in the work-place a few weeks earlier. While his health care provider recognized his need for guidance and emotional support, Teo also learned as the result of routine lab work that he was pre-diabetic. Years of poor diet, inconsistent access to medical care due to financial barriers, and lack of education had added up. This new diagnosis intensified Teo’s sense of helplessness, putting him at greater risk of developing long-term anxiety and depression. For a time, it was difficult for Teo to even leave his house.

Fortunately, Teo recognized he needed help, and in addition to taking the medication his doctor started him on, he began weekly behavioral health counseling at CHA. He was also able to attend a weekly support group for diabetics, which was co-facilitated by his behavioral health provider. Over time through Cognitive Behavioral Therapy, Teo learned about his body’s somatic response to stress, as well as positive coping skills to manage his feelings of anxiety. His sleep improved greatly, and, feeling more reassured and in control of his health, his panic attacks dissipated quickly. As he integrated tips learned from his support group, Teo made changes in his diet and lifestyle, lost weight, and felt more energetic.

At the end of three months, Teo was riding his bike daily and his insomnia was well-controlled. He expressed confidence in his ability to manage his stress and anxiety independently with the tools he’d developed in treatment. In addition, he’d become a role model for others in his support group and in his community, where he said he liked to remind people “to get help when you need it and not to be afraid to ask for it.”

Rhonda is a 51 year old woman who struggles with symptoms of bi-polar disorder and went nearly her whole life without treatment. She had a very traumatic childhood growing up in New York City and was surrounded by violence inside and outside of her home. In addition to her bi-polarity, she had been drinking heavily for most of her adult life as a means to cope. When she first came to Ritter Center she had very little stability in her life. Fortunately, she held down a part-time job and had a place to live. She was, however, at risk of losing her housing due to increasing rent.

The first thing she did when she got to Ritter was to connect with one of our medical providers. She had numerous health problems that needed treatment due to being uninsured for a prolonged period of time. One of our nurses suggested therapy after she became tearful during a medical appointment.
She began weekly therapy and was able to get perspective on her life and better understanding of her moods and her heavy drinking. After much consideration and discussion, Rhonda connected with our psychiatric NP and got medications to stabilize her mood. With her new found stability she was able to introspect and fully engage in therapy. She took a leap and connected with AA for the first time and has blossomed.

Rhonda continues to grow and develop strong relationships, something that was greatly affected by her untreated bipolar and drinking. She no longer feels alone and has been able to connect in the community and volunteer. Lastly, Ritter Center case management helped her to get SSI and she is now able to afford her apartment. Life for her is finally where she wants it to be because of her hard work and willingness to get the help she needed.
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:

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/99ca53c09cedec628b20672d7cc4e5b.html). In addition, commonly used tools are validated, including PHQ9 and GAD7. Providers are trained in the practices and receive follow-up training as needed.

ACTUAL OUTCOMES

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

In addition to ongoing outreach to underserved communities, JFCS has increased its collaboration with health partners. Home health agencies have identified the client’s depression as a factor in their failure to recover after hospitalization. BOOST’s collaboration with physicians and other health care provides is critical for success, in part
because when referrals come from a health care providers, the clients are often more receptive to mental health services. When the medical provider and the mental health provider work collaboratively, the client outcomes improve.
<table>
<thead>
<tr>
<th>Outcomes for FY2016-17</th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals receiving education regarding behavioral health signs and symptoms in older adults.</td>
<td>50</td>
<td>85</td>
</tr>
<tr>
<td>Individuals receiving education who are from an underserved population or primarily serving underserved populations (race, ethnicity, language, LGBTQ).</td>
<td>20%</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td>N=85</td>
<td></td>
</tr>
<tr>
<td>Seniors at Home clients screened for behavioral health concerns. <em>PHQ9, substance use</em></td>
<td>150</td>
<td>153</td>
</tr>
<tr>
<td>Low income clients receiving brief intervention services.</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Low income clients receiving brief intervention services who are from underserved populations.</td>
<td>20%</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>N=35</td>
<td></td>
</tr>
<tr>
<td>Clients with family members participating in brief intervention services in support of the client.</td>
<td>30%</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td>N=35</td>
<td></td>
</tr>
<tr>
<td>Clients completing a short-term treatment protocol for depression or anxiety.</td>
<td>70%</td>
<td>71%</td>
</tr>
<tr>
<td></td>
<td>N=35</td>
<td></td>
</tr>
<tr>
<td>Clients completing a short-term treatment protocol for depression or anxiety experiencing a decrease of at least one category of severity (i.e.: moderate to mild). <em>PHQ9, GDS, GAD7</em></td>
<td>60%</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td>N=35</td>
<td></td>
</tr>
<tr>
<td>Clients receiving brief intervention reporting satisfaction with services (would use again, recommend).</td>
<td>75%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>N=20</td>
<td></td>
</tr>
</tbody>
</table>

*N = the total number in the sample (i.e. total number who received services or completed a survey).*
<table>
<thead>
<tr>
<th>Type of Participants in Outreach Events</th>
<th>Number Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Members (Older adults and their family members)</td>
<td>59</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td></td>
</tr>
<tr>
<td>County Mental Health and Substance Use Services</td>
<td>8</td>
</tr>
<tr>
<td>Community-based Mental Health and/or Substance Use Provider</td>
<td>6</td>
</tr>
<tr>
<td>Senior Centers/Services</td>
<td>5</td>
</tr>
<tr>
<td>Social Services</td>
<td>7</td>
</tr>
</tbody>
</table>
PEI · OLDER ADULT

PROGRAM ALLOCATION FY2016-17 · $100,000

OA FY2016/17:
AGE GROUP (N=35)

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

n=35, 100%

OA FY2016/17:
RACE/ETHNICITY (N=35)

- White
- African American
- Asian
- Hispanic
- Native
- Multi
- Pacific Islander
- Other/unknown

n=27, 77%

n=2, 6%

n=1, 3%

n=2, 6%

n=2, 6%

n=1, 3%

n=5, 14%
OA FY2016/17:
PRIMARY LANGUAGE (N=35)

- English: n=34, 97%
- Other/unknown: n=1, 3%

OA FY2016/17:
GENDER (N=35)

- Male: n=8, 23%
- Female: n=27, 77%
CHALLENGES AND UPCOMING CHANGES

In **FY2017-18**, the Older Adult PEI program was implemented as expected.

In **FY2018-19**, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20. In the upcoming fiscal year, this program will be categorized as an Early Intervention Program.
CLIENT STORY - OLDER ADULT PEI

Mrs. T is a 78 year old divorced woman who has lived alone in a mobile home for the past 40 years. She suffers from a range of medical problems, commencing from her early 20’s. Mrs. T.’s only son lived overseas, and had only been able to see her once or twice yearly. She has no other living relatives as her only sister died five years ago, the same year her son committed suicide after returning home from abroad.

Even with all the unimaginable losses Mrs. T. suffered, she lived independently and with good humor with her loyal companion, ‘The Cat’ until 4 years ago, when she checked herself into ER with shortness of breath. A cascade of troubling medical diagnoses followed, including a colostomy and a back injury that never healed. Mrs. T. had to give up driving and became despondent about the future. She was referred for counseling by her home health social worker as Mrs. T. found it hard to cope after losing her independence. Through home visits, we started to work on short term and long term goals. First, we focused on the grief and acceptance for her loss of independence and the future that she imagined. Then, we worked on tools in managing the depressed mood and the anxiety about being more dependent. At the same time, we used behavioral activation to help nurture her interest in leaving home again. During the sessions, we explored ways she could rebuild a new future even with her limitations and an unclear prognosis. We provided transportation service to help Mrs. T. to our office for weekly appointments. When she had to get ready to leave home, she started to pay more attention to dressing up again – something she likes to do. She was a different person in the office environment; her wit and humor wins over many staff. With her success coming to the office, Mrs. T. was motivated to go out more, and began to re-engage in social interactions.

After ten months, we successfully reached the goals we identified and her case was closed. We learned that Mrs. T. recently took a fall, and is now in a rehabilitation facility; her social worker recently shared that even with this latest fall, Mrs. T. is using the tools she learned to access the resiliency she is noted for, and is already talking about leaving rehab and returning home to her cat. She states: “I am so blessed to be working with Dr. Chu, and her talent, knowledge, and compassion were so supportive.”
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

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**Vietnamese CC**

SUMMARY FY2016-17

Clients Served: FY2016-17

362 Individuals
15 Families

- Outreach: 83%
- Prevention: 17%
- Early Intervention: 0%
- Access and Linkage: 0%
identification of individuals with mental health difficulties and increasing protective factors for those with significantly higher risk for mental illness.

Outreach for Increasing Recognition:

- Community Health Advocates Training and Support: For hard to reach populations, trusted community members provide an effective cultural and linguistic bridge to information and services. This project provides training, supervision and stipends for CHAs to provide mental health and substance use education, identification of risk and signs, and linkages to services. The program coordinator also provides individual and family consultations to assist with problem solving and linkages to other needed 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 members 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 FY2016-17, 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 FY2016-17

<table>
<thead>
<tr>
<th></th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Advocates (CHAs) will receive training in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o CHA Basics: role, confidentiality, outreach and engagement, making referrals, etc.</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>o Mental Health First Aid</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CHAs will receive at least 6 hours each of group or individual supervision.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Individuals receiving information about mental health and access to services via tabling and other outreach strategies.</td>
<td>75</td>
<td>120</td>
</tr>
<tr>
<td>Individuals participating in group activities.</td>
<td>120</td>
<td>260</td>
</tr>
<tr>
<td>Individuals participating in individual/family sessions.</td>
<td>NA</td>
<td>62</td>
</tr>
<tr>
<td>Individuals participating in individual/family sessions reporting satisfaction with these services.</td>
<td>80%</td>
<td>100% N=62</td>
</tr>
</tbody>
</table>

*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 90% 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=60

<table>
<thead>
<tr>
<th>Type of Participants in Outreach Events</th>
<th>Number Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Members (Vietnamese)</td>
<td>260</td>
</tr>
</tbody>
</table>
Vietnamese CC FY2016-17: RACE/ETHNICITY (N= 62)

- Asian: n=62, 100%

Vietnamese CC FY2016-17: AGE GROUP (N= 62)

- 0-15: n=25, 40%
- 16-25: n=37, 60%
- 26-59
- 60+
- Unknown
Vietnamese CC FY2016-17: GENDER (N= 62)

- Male: 15, 24%
- Female: 47, 76%

Vietnamese CC FY2016-17: PRIMARY LANGUAGE (N= 62)

- Vietnamese: 62, 100%
CHALLENGES AND UPCOMING CHANGES

In FY2017-18, the Vietnamese Community Connection continued to focus its efforts on broadening its outreach and engagement with the Asian community and on developing collaborative partnerships with community leaders and organizations serving the Asian population in Marin.

In FY2018-19, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20. In the upcoming fiscal year, this program will be categorized as an Outreach Program.
CLIENT STORY - VIETNAMESE COMMUNITY CONNECTION

Linh is a disabled woman in her 30s who cannot speak English or walk well. Everywhere she goes, she needs her father to accompany her. Her father does not speak much English either. They have a very hard time at doctor appointments. They came to VCC and asked for assistance at doctor appointments. In particular they wanted face-to-face interpretation, because they could not understand the interpreter through phone services.

The program coordinator went with them to a doctor appointment and explained to the medical office the need for in-person interpretation. Finally, one of the specialist medical offices agreed to provide a face-to-face interpreter for each of their appointments.

The father stated: “We appreciated that you went with us and explained our need for interpretation in order to understand my daughter’s diagnosis and medications. We wish you good health so you can continue to help out those people like us, and be our voices.”
COMMUNITY AND PROVIDER PREVENTION AND EARLY INTERVENTION TRAINING

PROGRAM OVERVIEW

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

TARGET POPULATION

The target population for this program is:

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

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

- PEI providers.

PROGRAM DESCRIPTION

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

Mental Health First Aid (MHFA) is an 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 and Assessment 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**

<table>
<thead>
<tr>
<th>Mental Health First Aid Outcomes for FY16-17</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Marin County community members that participated in MHFA.</td>
<td>139</td>
</tr>
<tr>
<td>Participants reporting increased knowledge about mental illness signs/symptoms. (0-5 scale)</td>
<td>N=45</td>
</tr>
<tr>
<td>“As a result of this training, I feel more confident I can recognize the signs that someone may be dealing with a mental health problem or crisis.”</td>
<td>4.4</td>
</tr>
<tr>
<td>Participants reporting feeling able to offer a distressed person basic “first aid” information and reassurance about mental health. (0-5 scale)</td>
<td>4.5</td>
</tr>
<tr>
<td>Participants reporting ability to assisting somebody experiencing a mental health problem or crisis to seek appropriate professional help. (0-5 scale)</td>
<td>4.6</td>
</tr>
</tbody>
</table>

Data was collected for all 139 participants, but due to the upgrade of the MHFA website, data for some courses was lost.
### Settings where participants might use MHFA

<table>
<thead>
<tr>
<th>Settings</th>
<th>Number Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Members</td>
<td>47</td>
</tr>
<tr>
<td>Family Member of Person with Serious Mental Illness</td>
<td>2</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td></td>
</tr>
<tr>
<td>County Behavioral Health and Recovery Services</td>
<td>6</td>
</tr>
<tr>
<td>Community-based Mental Health and/or Substance Use Provider</td>
<td>12</td>
</tr>
<tr>
<td>Education (including High School Students)</td>
<td>6</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>0</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>5</td>
</tr>
<tr>
<td>Senior Centers/Services</td>
<td>12</td>
</tr>
<tr>
<td>Social Services (County and Community)</td>
<td>10</td>
</tr>
<tr>
<td>Veterans</td>
<td>0</td>
</tr>
<tr>
<td>Faith-based</td>
<td>8</td>
</tr>
<tr>
<td>Shelters/Homeless Services/Public Housing</td>
<td>9</td>
</tr>
<tr>
<td>Libraries</td>
<td>1</td>
</tr>
<tr>
<td>Public Transit</td>
<td>0</td>
</tr>
<tr>
<td>Employment</td>
<td>8</td>
</tr>
<tr>
<td>Other – List: DV, BOS, Parks Svcs, PH</td>
<td>7</td>
</tr>
<tr>
<td>Security, Emergency Svcs</td>
<td>6</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
</tr>
</tbody>
</table>
Design and produce signs for the new SMART train route to reduce suicide attempts and raise awareness about mental health assistance.

- Participation in community outreach and education events including “Day of the Dead” in the Latino community and the “IMAN Summit” in the Black community.
- Conference Registrations for staff and interns supporting PEI programs
- “Triple P” Trainings
- “Positive Behavioral Intervention and Support” (PBIS) training for school staff
- Cultural competency trainings, including for PEI providers in gathering data regarding sexual orientation and gender identity
- BHRS Calendar featuring client artwork and information about mental health
CHALLENGES AND UPCOMING CHANGES

In FY2017-18, nine (7) MHFA trainings were offered, including 2 youth, 1 in Spanish and 1 in Vietnamese. Most trainings met or exceeded expected enrollment.

In FY2018-19, we expect this program will continue to be implemented as described. This program will be categorized as an Outreach Program.
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
Seneca Family of Agencies

Clients Served: FY2016-17

77 Individuals
69 Families

Marin City Community Services District

Clients Served: FY2016-17

83 Individuals
0 Families

PEI
OAL

100%

Outreach
Prevention
Early Intervention
Access and Linkage
staff, Success/Study Teams (SST), or Student Attendance Review Teams (SART) and Boards (SARB). They will then be assessed to determine whether they are appropriate for PEI services or are linked to other services. The program is targeting three areas of Marin County at this point:

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

*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 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.

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.

<table>
<thead>
<tr>
<th>San Rafael City Schools/Seneca Outcomes for FY2016-17</th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral health trainings for school staff.</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Participation of school staff in trainings.</td>
<td>75%</td>
<td>76%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N=46</td>
</tr>
<tr>
<td>Participants reporting increase in skills/knowledge.</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td><em>Participant survey</em></td>
<td></td>
<td>N=35</td>
</tr>
<tr>
<td>Hours of TA provided weekly to school staff.</td>
<td>10-16</td>
<td>16</td>
</tr>
<tr>
<td>Students participating in Social Emotional Skills groups.</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>SES group participants attending at least 50% of sessions.</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N=60</td>
</tr>
<tr>
<td>Students receiving individual services.</td>
<td>NA</td>
<td>17</td>
</tr>
</tbody>
</table>
### Sausalito Marin City School District/MCCSD

**Outcomes for FY2016-17**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Marin providers and community members receiving behavioral health education, information about Community Connector (CC) services.</td>
<td>30</td>
</tr>
<tr>
<td>Students/families receiving outreach, engagement, referral services from CCs</td>
<td>40</td>
</tr>
<tr>
<td>Students/families receiving support, advocacy and coordination services from CCs</td>
<td>25</td>
</tr>
<tr>
<td>Youth/families receiving support services from CCs achieving at least 40% of the goals in their action plan. <em>Case records</em></td>
<td>60%</td>
</tr>
<tr>
<td>Students participating in at least 20 Girl Power Groups.</td>
<td>50</td>
</tr>
<tr>
<td>Students participating in CC support services or Girl Power Groups showing improved risk factors, increase in school attendance and/or improved school performance. <em>SDQ, school records</em></td>
<td>60%</td>
</tr>
<tr>
<td>Shoreline School District/BACR</td>
<td>Goal</td>
</tr>
<tr>
<td>-------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Outcomes for FY2016-17</td>
<td></td>
</tr>
<tr>
<td>Behavioral health training for school staff</td>
<td>8 hrs</td>
</tr>
<tr>
<td>School staff participating in trainings reporting awareness of risks, signs, and symptoms of children experiencing emotional disturbances and/or risk of abuse. (Post-survey)</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>N=18</td>
</tr>
<tr>
<td>Students, parents, community members participating in psycho-education, anti-stigma and resource events (i.e. anti-bullying workshops, outreach at parent gatherings, etc).</td>
<td>NA</td>
</tr>
<tr>
<td>Students participating in self-regulation curriculum.</td>
<td>250</td>
</tr>
<tr>
<td>Students with mild to moderate mental health concerns receiving at least 3 sessions of individual or group counseling.</td>
<td>40</td>
</tr>
<tr>
<td>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).</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>N=32</td>
</tr>
<tr>
<td>Students completing at least 3 sessions showing improved attendance or improved school performance.</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>N=39</td>
</tr>
<tr>
<td>Parents completing at least 3 sessions family counseling.</td>
<td>20</td>
</tr>
<tr>
<td>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</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>N=8</td>
</tr>
<tr>
<td>Parents receiving 3 or more counseling services reporting satisfaction with the PEI services (would recommend, use again, etc).</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>N=8</td>
</tr>
</tbody>
</table>

*N = the total number in the sample (i.e. total number who received services or completed a survey)*
BACR FY2016/17:
AGE GROUP (N=267)

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

n=267, 100%

BACR FY2016/17:
RACE/ETHNICITY (N=267)

- Hispanic
- White
- Asian
- Pacific Islander

n=106, 40%
n=158, 59%
n=1, 0%
n=2, 1%
BACR FY2016/17:
GENDER (N=267)

- Male: n=141, 53%
- Female: n=126, 47%

BACR FY2016/17:
PRIMARY LANGUAGE (N=267)

- Spanish: n=125, 47%
- English: n=141, 53%
- Other/unknown: n=1, 0%
PROGRAM ALLOCATION FY2016-17 · $95,000

BACR FY2016/17
# of Clients Served by City

- West Marin: 127
- San Geronimo: 81
- Fairfax: 58
- Belvedere/Liburn: 1

Other/Unknown, Corte Madera, Greenbrae/Kentfield/Ross, Larkspur, Mill Valley, Novato, San Anselmo, San Rafael, Sausalito
MCCSD FY2016/17:
AGE GROUP (N=83)

- **0-15**: n=71, 86%
- **16-25**: n=12, 14%
- **26-59**: n=6, 7%
- **60+**: n=5, 6%
- **Unknown**: n=1, 1%

MCCSD FY2016/17:
RACE/ETHNICITY (N=83)

- **African American**: n=11, 13%
- **Hispanic**: n=6, 7%
- **White**: n=12, 15%
- **Multi**: n=1, 1%
- **Other/unknown**: n=5, 6%
- **Asian**: n=48, 58%
MCCSD FY2016/17:
GENDER (N=83)

- Male: 16 (19%)
- Female: 67 (81%)

MCCSD FY2016/17:
PRIMARY LANGUAGE (N=83)

- English: 68 (82%)
- Spanish: 3 (4%)
- Other/unknown: 2 (2%)
- Arabic: 1 (1%)
- Russian: 1 (1%)

Program Allocation FY2016-17: $95,000
MCCSD FY2016/17:
# of Clients Served by City

- Sausalito: 58
- Belvedere/Tiburon: 25
- Other/Unknown: 0
- Corte Madera: 0
- Fairfax: 0
- Greenbrae/Kenfield/Ross: 0
- Larkspur: 0
- Mill Valley: 0
- Novato: 0
- San Anselmo: 0
- San Geronimo: 0
- San Rafael: 0
- West Marin: 0
**Seneca FY2016/17:**
**GENDER (N=77)**

- Male: n=30, 39%
- Female: n=47, 61%

**Seneca FY2016/17:**
**AGE GROUP (N=77)**

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

n=77, 100%
Seneca FY2016/17:
PRIMARY LANGUAGE (N=77)

- Spanish: 32, 42%
- English: 44, 57%
- Other/unknown: 1, 1%

Seneca FY2016/17:
RACE/ETHNICITY (N=77)

- Hispanic: 1, 1%
- White: 6, 8%
- Multi: 3, 4%
- African American: 4, 5%
- Other/unknown: 2, 3%
- Asian: 36, 47%

n=77
CHALLENGES AND UPCOMING CHANGES

In **FY2017-18**, services in San Rafael City schools were discontinued. BRHS announced two Requests for Proposals to expand school-based services in Marin County. One RFP focuses on serving high risk students, especially those who have experienced trauma and/or homelessness in the San Rafael area and the other RFP focuses on continuing to provide services in Shoreline School District.

In **FY2018-19**, existing school-based PEI Programs are expected to continue as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20, with expanded school-based services to be implemented in accordance with the requirements in the RFP. In addition, a PEI School Age sub-committee will be established with new and existing school-based providers to allow for providers to share insights, especially regarding best practices for working with schools and implementation of evaluation tools. In the upcoming fiscal year, this program will be categorized as a Prevention Program.
CLIENT STORY - SCHOOL AGE PEI

An eighth grade student was referred to therapy for conflict in peer relationships, declining grades and a family history of domestic violence. The student was hesitant to begin therapy because she was worried what her peers would think in such a small community. The PEI specialist would often see her before school or during recess while she was interacting with younger relatives and began to develop a relationship. She eventually agreed to attend therapy and was open and honest. She attended weekly and would have a hard time ending the session on time. She discussed conflicts she had with peers and various ways of resolving them. She discussed her mother’s domestic violence relationships, her father’s imprisonment from drug use and dealing and her desire to avoid the same paths. In therapy, she worked on setting goals and avoiding obstacles, learning about healthy relationships and prevention of illegal substance use that she may be exposed to in high school. She greatly benefited from counseling and would often encourage her classmates to seek therapy if they were struggling.
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 who are homeless or 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.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td></td>
</tr>
<tr>
<td>Number of veterans that received support services to increase likelihood of completing the veteran’s mental health treatment plan. (Average number of services: 8)</td>
<td>120</td>
</tr>
<tr>
<td>Number of family members that received services to increase their capacity to support the client.</td>
<td>20</td>
</tr>
<tr>
<td>Percent of veterans receiving support that complied with their mental health treatment plan.</td>
<td>80%</td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
</tr>
<tr>
<td>Clients receiving support services reporting satisfaction with the services:</td>
<td>75%</td>
</tr>
</tbody>
</table>
PROGRAM ALLOCATION FY2016-17 · $60,000

- 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

ACTUAL OUTCOMES

The program staff person has been out on extended medical leave, and therefore no FY2016-17 program data is available at this time. Outreach and linkage efforts were maintained at a lower rate by other Veterans Services staff. 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.

CHALLENGES AND UPCOMING CHANGES

In FY2017-18, the Veteran’s program was implemented as expected. A staff person was hired in September 2017 to fill the vacant PEI position.

In FY2018-19, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 and slightly expanded with a $10,000 allocation increase for each of FY2018-19 and FY2019-20 from the PEI operational reserve. In the upcoming fiscal year, this program will continue to be categorized as an Access and Linkage to Treatment Program.
STATEWIDE PREVENTION AND EARLY INTERVENTION

PROGRAM OVERVIEW

In FY2016-17, 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. 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. The demographics for FY2016-17 unduplicated callers from Marin are included below.

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. In addition, see appendices for reports from CalMHSA on statewide and county specific impact for FY2016/17.

The Suicide Prevention Hotline collects data for each participating county. The methods for analyzing and reporting the data has been updated, affecting the number of calls attributed to Marin.

<table>
<thead>
<tr>
<th>Suicide Prevention Hotline/Buckelew Outcomes for FY2016-17</th>
<th>Goal</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls to hotline originating in Marin County</td>
<td>6-8000</td>
<td>5224</td>
</tr>
<tr>
<td>Callers who express a reduction in level of suicidal intent by 1 level of maintain Low (Low, Medium, High)</td>
<td>-</td>
<td>84%</td>
</tr>
<tr>
<td>Agencies receiving campaign materials from FSA</td>
<td>20</td>
<td>17</td>
</tr>
</tbody>
</table>
**Suicide Prevention FY2016-17:**

**AGE GROUP (N=4304)**

- 0-15: n=212, 5%
- 16-25: n=646, 15%
- 26-59: n=1596, 37%
- 60+: n=1357, 32%
- Unknown: n=493, 11%
- Unknown: n=3, 0%

**Suicide Prevention FY2016-17:**

**RACE/ETHNICITY (N=4304)**

- Other/unknown: n=42, 1%
- White: n=75, 2%
- Hispanic: n=445, 10%
- African American: n=101, 2%
- Asian: n=3, 0%
- Pacific Islander: n=3, 0%
- Multi: n=3635, 85%
Suicide Prevention FY2016-17:
GENDER (N=4304)

- Female
- Male
- Unknown
- Transgender/Other

Suicide Prevention FY2016-17:
PRIMARY LANGUAGE (N=4304)

- Spanish
- English
Challenges and Upcoming Changes

In FY2017-18, this PEI program was implemented as expected.

In FY2018-19, this program is expected to be implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20.

Client Story - Suicide Prevention Hotline

Jane is a high school freshman in Marin struggling to adapt to a new school amid her parents’ divorce. Overwhelmed and feeling isolated, she called the hotline with suicidal thoughts. The counselor established a warm connection with Jane, and after listening and assessing for lethality, the counselor acknowledged Jane’s struggles and discussed ways to keep her safe. They talked about who and where she could turn to for support and the counselor asked if he could speak with Jane’s mother. Jane put her mom on the call via speakerphone. The counselor acted as facilitator and apprised the mother of Jane’s struggles, then offered the Marin County Access Line as a resource. Jane’s mother was grateful to learn of the gravity of her daughter’s situation and agreed to work with her daughter to seek counseling.
### PREVENTION AND EARLY INTERVENTION (PEI)

#### NUMBERS TO BE SERVED IN FY2017-18

<table>
<thead>
<tr>
<th>Program</th>
<th>Type of Service</th>
<th>Individuals 0-15</th>
<th>Individuals 16-25</th>
<th>Individuals 26-59</th>
<th>Individuals 60+</th>
<th>Total Individuals</th>
<th>Providers</th>
<th>FY2017-18 Cost per Person Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Childhood Mental Health</td>
<td>Outreach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention</td>
<td>500</td>
<td></td>
<td></td>
<td></td>
<td>500</td>
<td>80</td>
<td>$460</td>
</tr>
<tr>
<td>Transition Age Youth</td>
<td>Prevention</td>
<td>20</td>
<td>80</td>
<td></td>
<td></td>
<td>100</td>
<td></td>
<td>$475</td>
</tr>
<tr>
<td></td>
<td>Early Intervention</td>
<td>50</td>
<td>200</td>
<td></td>
<td></td>
<td>250</td>
<td>70</td>
<td>$500</td>
</tr>
<tr>
<td></td>
<td>Access &amp; Linkage</td>
<td>50</td>
<td>300</td>
<td></td>
<td></td>
<td>350</td>
<td></td>
<td>$59</td>
</tr>
<tr>
<td>Latino Community Connection</td>
<td>Outreach/Radio</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,000</td>
<td></td>
<td>$17</td>
</tr>
<tr>
<td></td>
<td>Outreach</td>
<td>200</td>
<td>700</td>
<td>100</td>
<td></td>
<td>1,000</td>
<td>15</td>
<td>$75</td>
</tr>
<tr>
<td></td>
<td>Early Intervention</td>
<td>40</td>
<td>150</td>
<td>10</td>
<td></td>
<td>200</td>
<td>20</td>
<td>$1,105</td>
</tr>
<tr>
<td>Older Adult PEI</td>
<td>Outreach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>50</td>
<td>20</td>
<td>$100</td>
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<tr>
<td></td>
<td>Early Intervention</td>
<td>50</td>
<td>50</td>
<td>20</td>
<td></td>
<td>50</td>
<td>20</td>
<td>$2,920</td>
</tr>
<tr>
<td>Vietnamese Community Connection</td>
<td>Outreach</td>
<td>30</td>
<td>75</td>
<td>45</td>
<td></td>
<td>150</td>
<td>5</td>
<td>$150</td>
</tr>
<tr>
<td></td>
<td>Prevention</td>
<td>15</td>
<td>50</td>
<td>35</td>
<td></td>
<td>100</td>
<td>10</td>
<td>$328</td>
</tr>
<tr>
<td>PEI Training</td>
<td>Outreach</td>
<td>150</td>
<td></td>
<td>150</td>
<td></td>
<td>150</td>
<td>100</td>
<td>$150</td>
</tr>
<tr>
<td>School Age PEI</td>
<td>Outreach</td>
<td>170</td>
<td></td>
<td>170</td>
<td></td>
<td>170</td>
<td>50</td>
<td>$1,788</td>
</tr>
<tr>
<td>Veterans Community Connection</td>
<td>Access and Linkage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>120</td>
<td>20</td>
<td>$525</td>
</tr>
<tr>
<td>PEI Statewide</td>
<td>CalMHSA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Suicide Prevention Hotline</td>
<td>Suicide Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$20</td>
</tr>
<tr>
<td>Health Navigator</td>
<td></td>
<td>15</td>
<td>25</td>
<td>10</td>
<td></td>
<td>50</td>
<td>15</td>
<td>$2,761</td>
</tr>
</tbody>
</table>
## UPDATED MHSA PREVENTION AND EARLY INTERVENTION (PEI) COMPONENT BUDGET

<table>
<thead>
<tr>
<th>Program</th>
<th>FY2017-18</th>
<th>FY2018-19</th>
<th>FY2019-20</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEI-01 Early Childhood Mental Health Consultation - ECMH</td>
<td>$230,000</td>
<td>$230,000</td>
<td>$230,000</td>
<td>$690,000</td>
</tr>
<tr>
<td>PEI-04 Transition Age Youth (TAY) PEI</td>
<td>$193,000</td>
<td>$193,000</td>
<td>$193,000</td>
<td>$579,000</td>
</tr>
<tr>
<td>PEI-05 Latino Community Connection</td>
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REVISED INNOVATION REGULATIONS

BACKGROUND
New Innovation (INN) Regulations were adopted effective October 1, 2015. Various amendments to those regulations are underway. In the meantime, Marin County has been developing processes to ensure compliance with the new regulations.

COMPLIANCE PLAN
The current Innovation Plan is in compliance with the revised INN regulations. This report includes a narrative report on the implementation of the Plan, including changes to the expected implementation. There is no evaluation data, including client demographics, available at this time due to the stage of the project we are in.

Marin will provide an annual report next year as part of the MHSA Annual Update that includes an implementation update and any available data. Within six months of the completion of the Innovation Plan a final report will be submitted that includes all required data. At this time we are training participating providers to gather the required demographics and outcome data. In addition, records are being maintained for all activities related to the project in order to report on what was learned, what was effective and what was not.
GROWING ROOTS:
THE YOUNG ADULT SERVICES PROJECT

PROGRAM OVERVIEW

The MHSA Oversight and Accountability Commission (MHSOAC) 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

The Innovation Plan has been implemented as expected in the INN Plan, although with a slight delay mainly due to ensuring that the TAY Advisory Council was meaningfully engaged in the needs assessment process.

- June 2016: The TAY Advisory Council began meeting monthly.
- July 2016: TAY AC helped identify facilitators (Kawahara and Associates) and evaluators (Resource Development Associates).
- October 2016: TAY AC helped identify organizations to assist in conducting the needs assessment.
- Late 2016-Early 2017: TAY AC, facilitators and evaluators developed and implemented a needs assessment. Selected providers assisted with ensuring TAY from underserved populations participated in the focus groups.
- Summer 2017: The TAY Advisory Council presented their work and findings to formal and informal TAY providers and other stakeholders. The complete needs assessment report was released. It can be found at the following URL:
UPCOMING CHANGES

In **FY2017-18** Phase 2 implementation began, starting with developing an Action Plan and Evaluation Plan that incorporate the Needs Assessment findings. Providers to implement recommendations from the Needs Assessment were identified and began their services. Training and technical assistance has been provided to them.

The impact of the delayed timeline is that we will have 20 months, instead of 24 months, for providers to implement the recommendations in the Needs Assessment, as well as engage in capacity and skill building opportunities. In order to make best use of those 20 months, we will extend the timeline of the project by 3 months (July-Sept 2019) to allow for the final report to be completed after the services contracts are completed. This change will not increase the cost of the program, it will just allow a final report to include all evaluation data through June 2019.

GROWING ROOTS INNOVATION PROJECT REVISED BUDGET

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<th></th>
<th>FY15-16</th>
<th>FY16-17</th>
<th>FY17-18</th>
<th>FY18-19</th>
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FUTURE PROJECTS

Please see the AB114 Spending Plan and the following budget for more information about future Innovation projects and funding.
MHSA INNOVATION (INN)

MHSA THREE YEAR PLAN (FY2017-18 THROUGH FY2019-20)

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<th>Program</th>
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One-Time Funding Sources:

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<td>Innovation funds from other Fiscal Years</td>
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a) Note this is the projected budget for the first two years of the Older Adult Innovation project from AB114 funds. The Innovation Proposal will have a more detailed and updated budget projection for the duration of the project.
COMMUNITY SERVICES AND SUPPORTS (CSS)  
COMPONENT OVERVIEW

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

CSS funds are intended to expand and transform services provided for children, youth, adults, and older adults living with serious mental illness toward 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 FY2016-17 it was 22.6%. 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 FY2018-19 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 enabled 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. Additionally, the YES program serves youth who do not have Medi-Cal coverage or lack the resources to access services elsewhere. 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. In FY2016-17, out of 65 total clients, most clients were under 18 (N=61, 94% < 18 years old) and equally split between males and females (F=33, M=32). Latino youth in particular made up the majority of the YES clients (N=53, 82%) followed by Caucasian/white (N=8, 12%). English was the preferred language for 85% of clients (N=55), although many clients have parents who primarily speak Spanish.

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, Seneca, 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 to provide both linguistic and cultural capability to address the diverse needs of the client population who face many challenges including trauma and environmental stressors. For FY2016-17, 2 of the 3 staff were present all year and the third position was filled mid-year which expanded the program’s capacity to serve more youth (increase from 43 clients in FY2015-16 to 65 clients in FY2016-17).

The YES program works collaboratively with school staff, probation officers, Seneca wraparound clinicians and family partners to support clients and their families. Family partners provide support and guidance to parents in navigating the various systems and with parenting youth engaged in high-risk behaviors. Many YES clients also receive wraparound services through Seneca Family of Agencies, which consists of monthly team meetings to help families identify and meet their goals as well as provide in home behavioral support to clients. YES clinicians also work closely with child psychiatrists in care coordination and safety planning when clients are in crisis.

To support our larger objective of decreasing barriers to service, most of the YES services are provided in schools and in clients’ homes or community. Services are 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 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.

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 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 FY2016-17, the YES program provided assessment, case management and individual/family therapy, as well as family partner support and medication services to 65 youth. Providers in the YES program utilize a variety of interventions including trauma focused CBT, DBT, attachment and relational therapies and substance use interventions related to harm reduction and motivational interviewing.

For clients who received YES services for at least one year (N=28), YES services helped decrease emergency events from a total of 10 events to 6 events during the first year of
service. 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.

YES services also helped decrease overall number of arrests for this subset of 28 clients, from a total of 14 arrests prior to entering the program down to 5 during first year of service. YES staff often works closely with probation officers and school staff to coordinate support effectively and to pursue mental health intervention instead of detention when possible.

The YES program has also continued to serve youth at high risk of suicide and ongoing hospitalization. Of the 28 clients served for one year, 3 clients experienced hospitalizations totaling 29 days, which was an increase from the baseline of 18 days. This speaks to the nature of YES clients, many of whom have ongoing suicidal thinking, depression or other mood symptoms. Safety planning remains a priority for many YES providers, as well as building in additional supports through schools, parents, wraparound services and medication.

**PROGRAM CHALLENGES**

In FY2016-17, Despite the sizable increase in client numbers from 43 clients in FY2015-16 to 65 clients in FY2016-17, staff changes continue to have a negative impact on the YES program. One of the 3 clinicians retired at the end of FY2016-17 so recruitment began for his replacement. There was also KIDnet software implementation difficulties which has led to an inability to reliably report on the CANS data due to the detachment of CANS records from individual client records. The data issues are being worked on and will be resolved in the next fiscal year.
CSS YES FY2016-17: Preferred Language (N=65)

- English: n=54, 83%
- Spanish: n=11, 17%

CSS YES FY2016-17: Age Group (N=65)

- <18 (Child): n=4, 6%
- 18-64 (Adult): n=61, 94%
- 65 and Over (Older Adult):
CSS YES FY2016-17:
Race/Ethnicity (N=65)

- Caucasian or White: n=53, 81%
- Hispanic: n=3, 5%
- Black or African American: n=8, 12%
- Other: n=1, 2%

CSS YES FY2016-17:
Gender (N=65)

- F - Female: n=33, 51%
- M - Male: n=32, 49%
CSS YES FY2016-17: City of Residence (N=65)

CSS YES FY2016-17: KEY EVENTS (N=65)

- MH Emergency: 40% Decrease
- Arrests: 64% Decrease
CLIENT STORY - YOUTH EMPOWERMENT SERVICES

“Jose” is a 17 year old Latino male who resides in foster care after arriving on his own to California. Jose was referred for mental health services to better understand his needs, support him in foster care and address trauma related difficulties including agitation, nightmares, angry outbursts, avoidance and hyperarousal, isolation and inability to trust others.

Jose’s history was positive for neglect, physical and sexual abuse and abandonment. He is reported to have been “sold” at age 7 or 8 to a man for child labor. Jose reportedly escaped and returned to live with his parent and then came to the United States with a sibling years later. Both were detained by ICE at the border and his sibling was returned to their country of origin, while Jose came to live with a family friend in Marin County. After this person moved, Jose was placed in foster care with a family.

Jose was placed in a local school in English speaking classes and he managed to attend and maintain a 2.5 GPA despite primarily speaking Spanish. He remained isolated, unable to pay attention at school and struggled in foster placement, repeatedly stating he didn’t belong there and was not welcome. He was at risk of leaving and becoming homeless during this time.

Through YES services, Jose was able to engage in support services that helped stabilize his foster care placement. He was able to utilize therapy to address communication difficulties, talk about his difficulty living with a family, identify his various moods and withdrawal from family members, and address conflicts when they occurred. He was subsequently able to satisfactorily leave this foster placement and move to a new home, limiting the risk for homelessness. Through ongoing mental health support, he is also able to address prior trauma and understand how it continues to impact his functioning.
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 ongoing collaboration.

TARGET POPULATION

The priority population is transitional age youth, 16-25 years of age, with serious emotional disturbances/serious mental illness. These youth may be aging out of the children’s system, child welfare and/or juvenile justice system or may be experiencing new mental health challenges that are seriously impacting their ability to function appropriately in their home and community 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 FY1617 out of 29 total clients one youth self-identified as Asian; 7% (N=2) identified as multiracial; 10% self-identified as African American (N=3); 28% self-identified as Latino (N=8); and 52% self-identified as white (N=15). The TAY Program has several bilingual Spanish speaking staff, so they have the needed capacity to work with Latino families requiring Spanish speaking staff. Parent support groups are offered in Spanish and English at the TAY offices. There were more males seen in the TAY Program: 17, compared to 12 females.
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 to manage their illness and accomplish their goals, avoiding deep end services, incarceration and homelessness. 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.

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 that provide a forum for healthy self-expression and a place 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. 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 FY2016-17, there were 29 unduplicated FSP clients in the TAY Program and 68 taking part in the partial and drop-in services.

1. The TAY Program will maintain 95% capacity (19 clients) or higher by active outreach.
2. Drop In Center Objective: Serve 45 unduplicated clients in FY1617
3. School/work Engagement By June 30, 2017 70% of FSPs will have engaged in work, vocational training or school.
4. Independent Living Skills Objective: By June 30, 2017, at least 50% of FSP in the TAY Program will have attended two or more activities designed to improve Independent living skills (ILS).
5. Substance Use Assessment: 100% of FSP clients will receive drug and alcohol screening. Clients identified with possible substance use issues will receive further assessment, intervention and treatment services.
6. TAY Housing Resource: Maintain full occupancy in TAY apartment (two FSPs) 80% of the time in FY1617.

Actual Outcomes

1. The TAY Program maintained a full caseload of 20 FSP clients throughout the fiscal year 2016-17 and served a total of 29 FSP clients.
2. From July 1, 2016 through June 30, 2017, TAY offered drop-in activities every day, Monday through Friday, except on major holidays—approximately 250 days total. The TAY drop-in served a total of 68 unduplicated drop-in clients, exceeding this objective Attendance also remains very strong for a core group of FSPs as mentioned in Objective 1—a total participation of 897 drop-in visits by our FSPs, averaging about 3.6 FSPs per day and an increase of 16% over last year.)
3. The TAY participants attained 79% engagement in either work, school/vocational programs or both. Of the 29 FSPs served, the following were involved in work and/or school:
1. 1 FSP (3%) engaged in school only;
2. 14 FSPs (48%) were engaged in work;
3. 9 FSPs (31%) were engaged in both school and work;

4. By June 30, 2017, at least 50% of Full Service Partners in the TAY Program will have attended two or more activities designed to improve independent living skills (ILS). Marin TAY achieved this goal, with 51% of FSPs attending two or more ILS group activities at the drop-in center.

5. 100% of FSP clients were assessed for drug/alcohol usage, utilizing the National Institute on Drug Abuse (NIDA) screening, a tool which guides clinicians through a series of questions to identify risky substance use. Clinical Case Managers administer the drug/alcohol screenings for our FSP clients as part of the client assessment and client plan development process. Marin TAY staff have also received additional awareness training in the areas of substance use services, since Sunny Hills Services has now begun to provide such services to adolescents in other programs.

6. The goal for the TAY housing was met at 95% overall occupancy. During nine months of the fiscal year the apartment was 100% occupied by two FSP clients. The apartment continues to be an excellent resource and training ground for independent living for FSPs.

<table>
<thead>
<tr>
<th>Outcomes FY2016/17</th>
<th>Goal</th>
<th>Actual FY2016-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients served:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• FSP</td>
<td>20</td>
<td>29</td>
</tr>
<tr>
<td>• Partial/drop-in</td>
<td>60</td>
<td>68</td>
</tr>
<tr>
<td>FSP clients engaged in work, vocational training or school</td>
<td>50%</td>
<td>79%</td>
</tr>
<tr>
<td>FSP clients engaged in activities designed to improve independent living skills</td>
<td>50%</td>
<td>51%</td>
</tr>
<tr>
<td>FSP clients screened for substance use.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Clients identified as having substance use issues that receive substance use services</td>
<td>50%</td>
<td>66%</td>
</tr>
</tbody>
</table>
PROGRAM CHALLENGES

1) With regard to Independent Living Skills for the FSPs: there is a group of clients who are not currently engaged in school/work and are therefore not progressing very quickly to independence and self-sufficiency. This is often due to acuity of mental health symptoms—these youth are profoundly impacted in daily functioning due to primarily severe psychotic symptoms. This percentage has remained relatively constant from the last fiscal year, hovering around 20%. We will continue to work as hard with them as with the other 79% to find meaningful, focused ways of achieving at least some skills and goals for more independent living.

2) Regarding substance use by FSPs, TAY FSP clients continue to under-report the use of marijuana. Of those who do appear to accurately self-report regular use, we often hear that “everyone smokes.” Marijuana/medical marijuana use is discussed/explored frequently during drop-in activities as well as within individual clinical case management/individual rehab work, utilizing Motivational Interviewing (MI) techniques. The focus is on harm reduction and discussing whether marijuana use is keeping them from their goals of work or school, as well as costing them a large portion of their spending money, and otherwise impacting daily life responsibilities;

Of the 29 FSPs served during this fiscal year, it is estimated that about 6 FSPs, or 20%, are using drugs or alcohol, including marijuana, to the point that it is impacting their overall daily functioning. Of these, only 2 were willing to either identify this as a treatment goal or work on it with their clinical case managers;

One youth seemed to have a serious issue with alcohol but was unwilling to address the issue, even from a harm reduction point of view.
CSS TAY FY2016-17:
Preferred Language (N=29)

- English: n=27, 93%
- Spanish: n=1, 4%
- Vietnamese: n=1, 3%

CSS TAY FY2016-17:
Age Group (N=29)

- <18: n=5, 17%
- 18-64: n=24, 83%
- 65 and over
CSS TAY FY2016-17:
Race/Ethnicity (N=29)

- Caucasian or White: n=15, 52%
- Hispanic: n=9, 31%
- Black or African American: n=4, 14%
- Vietnamese: n=1, 3%

CSS TAY FY2016-17:
Gender (N=29)

- Female (F): n=12, 41%
- Male (M): n=17, 59%
*For TAY who have been enrolled in the FSP for at least two years
Client Story

“Terry” has been enrolled as an FSP client for a little over a year. Her referral came from the local Crises Stabilization Unit post hospitalization for experiencing a psychotic episode. She was interviewed while still in the hospital and a connection was made with the TAY clinician. She had nowhere to live, no close friends or family and desperate for help. She recognized she needed help with her mental health issues and housing. She was accepted in to the TAY Program and an assessment, treatment plan and consultation with the psychiatrist was completed. With the support of the TAY team she was accepted in to a county housing program which provides temporary housing for several months.

The first few months of treatment were difficult for both the client and the clinical case manager—with immediate focus on stabilizing her mental health symptoms and insuring she had a safe place to live—but with many “emergencies” and setbacks. During this period, she did not work or attend school.

With support from the TAY staff and with encouragement from other TAY FSPs at the drop-in center, Terry was then able to reconnect with her family and live with them. After that, the clinical case manager helped Terry enroll in a program which supports job development skills in gardening/agriculture. This led to obtaining a full-time job, the purchase of her first car and the ability to move into shared housing with a friend.

Terry continues to meet regularly with her case manager, to ensure that she maintains mental health stability and has support in making good decisions around independent living skills and housing permanence. She has begun individual therapy with one of the TAY clinicians, adding this treatment component as other issues in her life stabilized. Terry continues to have ups and downs but has learned new coping skills to help her manage her mental health issues. She has also begun to understand more about her mental health diagnoses, the importance of taking medication consistently, and asking for help. Soon she will be ready to graduate from Marin TAY. Terry recently told her clinical case manager, “I can’t believe how much I’ve changed and how much I can do on my own now!”

Terry is a successful example of how the Marin TAY staff constantly learn and adapt how to meet clients where they are, and to engage with them in a way that supports their needs, goals, dreams and hopes for a life that includes a mental health diagnosis, but that is not defined by it.
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 either underserved or inappropriately served, leading to involvement with the criminal justice system. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition. STAR is committed to serving individuals from diverse backgrounds and lived experiences, regardless of gender, race, ethnicity, sexual preference, religion, or ability.

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, individual and group 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 offers services for family members through the County’s Family Partner Program, bringing the voice and perspective of families to the program and is available to provide outreach to family members of STAR Program.
participants. Starting in FY12017-18 the FSP will also cover the cost of short term residential placements.

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 (CIT), 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 expected to provide to 25-30 sworn officers annually. However, this year there were significantly more people trained.

EXPECTED OUTCOMES

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

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>GOAL</th>
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<tbody>
<tr>
<td>Decrease in homelessness</td>
<td>75%</td>
</tr>
<tr>
<td>Decrease in arrests</td>
<td>75%</td>
</tr>
<tr>
<td>Decrease in incarceration</td>
<td>80%</td>
</tr>
<tr>
<td>Decrease in hospitalization</td>
<td>40%</td>
</tr>
</tbody>
</table>
ACTUAL OUTCOMES

In FY2016-17, the STAR Program engaged 66 individuals who had serious mental illness and significant criminal justice involvement, surpassing the program’s target enrollment of 60. The number of days clients spent homeless was reduced by 58%, days spent incarcerated was reduced by 81%, and days psychiatrically hospitalized was reduced by 69% compared to the baseline year. Arrests were also decreased by 75% and mental health emergency events were decreased by 74%. Thirteen STAR clients were referred for employment services and life skills training. Fifty percent of the Job Development Clients were successfully employed, with 43% retaining the job for at least 4 months.

FY2016-17 was also a very big year for Crisis Intervention Training (CIT). 61 police officers were trained, enabling them to more effectively and safely identify and respond to crisis situations and mental health emergencies. This far surpassed the goal of 25-30 sworn officers. In addition to the 61 police officers, 19 additional probation officers and other related positions were trained, for a total of 80 people receiving the CIT training in FY2016-17.

PROGRAM CHALLENGES

Staffing remained an issue in FY2016-17, however in FY2017-18, we will have filled all previously opened positions and aim to maintain full staffing at anticipated levels. With recent stabilization of STAR staffing, working on increasing enrollment in FY2017-18 to the target of 60 clients. The STAR team is working on improving collaboration and coordinated care through establishing teams that include Service Coordinator and Primary Service Provider roles. The STAR team is also working on improving coordination of services with Jail Mental Health, Jail Re-entry Services, and Probation. The program has lost the services of the team’s volunteer family liaison and is working to develop improved consultation and coordinated services with Family Partners.
CSS STAR FY2016-17: Race/Ethnicity (N=66)

- Caucasian or White: n=52, 79%
- Hispanic: n=4, 6%
- Black or African American: n=4, 6%
- American Indian: n=2, 3%
- Chinese: n=1, 2%
- Native Hawaiian: n=1, 1%
- Other: n=2, 3%

CSS STAR FY2016-17: Preferred Language (N=66)

- English: n=64, 97%
- Spanish: n=2, 3%
CSS STAR FY2016-17:
Age Group (N=66)

- <18: n=2, 3%
- 18-64: n=64, 97%
- 65 and over: n=2, 3%

CSS STAR FY2016-17:
Gender (N=66)

- F - Female: n=11, 17%
- M - Male: n=55, 83%
CSS STAR FY2016-17: City of Residence (N=66)

CSS STAR FY2016-17: KEY EVENTS (N=66)

- Homelessness: 58% Decrease
- Incarceration: 81% Decrease
- Psychiatric Hospitalizations: 69% Decrease
CLIENT STORY 1- STAR FULL SERVICE PARTNERSHIP

“Ryan” has been diagnosed with schizoaffective disorder, panic disorder and poly substance use disorder. Ryan has a long history of legal entanglements, psychiatric hospitalizations, and chronic substance use, and 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, Ryan 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. Ryan is deeply engaged in his recovery, and has maintained sobriety for over 9 months! Ryan 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. Ryan 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 STAR, and says that STAR has helped him understand that he is deserving of the success he is working hard for.

CLIENT STORY 2- STAR FULL SERVICE PARTNERSHIP

The following story reflects the progressive nature of recovery and the link between independent living skills and vocational success. “John”, a STAR client, started vocational services in the previous fiscal year. Due to severity of his psych symptoms, namely internal voices and heightened anxiety, he was unsure of his own ability to work or to tolerate work environment. In order to help him test out a work environment, Integrated Community Services (ICS) developed a volunteer job for a local non-profit, where the environment was quiet, with no public interface and the staff were willing to be flexible regarding length of shift. In that capacity he worked alone in an office setting for only 2 hours, one day a week, doing data entry. He was able to use headphones to distract himself from voices by listening to music. ICS initially provided onsite job coaching, and then encouraging independence remained in contact with the client and employer on a regular basis. In the course of his volunteer work, he was able to add additional day for another 2 hours a shift. On his non-work days, independent living skills services focused on exercise and health goals and increased social interaction. He participated in some group activities such as tennis, and running with a partner. In this fiscal year, his volunteer supervisor offered him paid work; John also increased his work shift so that he is now able to work two 8-hour days a week for this agency. Consequently, he decided he wanted to find additional flexible work in the community so with vocational counseling and support from his STAR case manager, John is now also able to work as an on-call delivery driver.
HELPING OLDER PEOPLE EXCEL (HOPE) FULL SERVICE PARTNERSHIP

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 geropsychiatric assessment, individualized client-centered service planning, and provision of or linkages to all needed services and supports by a multi-disciplinary, multi-agency team. The team is staffed by Vietnamese, Spanish and English speaking clinicians.

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. Through our partnership with Road to Recovery, a substance abuse counselor can provide 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 reduction that will permit the program to evaluate its success in these key areas.
PROGRAM ALLOCATION FY2016-17 $159,990

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

ACTUAL OUTCOMES

In FY2016-17 the HOPE Program engaged 56 individual older adults, of which 45 have participated for at least 1 year. For those 45 individuals served for at least 1 year: homeless days were decreased by 68%, days incarcerated decreased by 98%, hospitalizations increased by 79%, mental health emergencies requiring crisis stabilization decreased by 27%, and the number of arrests were down 80%.

There were 1,425 client visits in Senior Peer Counselors program during FY2016-17, including 256 visits to seniors in West Marin, 544 to seniors in San Rafael, 461 to seniors in Novato, and 164 ACASA (our Spanish-speaking senior peer counselor group) visits.

SENIOR PEER COUNSELORS' CLIENT VISITS: FY 2016-2017
CSS HOPE FY2016-17: Preferred Language (N=56)

- English: n=48, 86%
- Spanish: n=5, 9%
- Vietnamese: n=3, 5%

CSS HOPE FY2016-17: Age Group (N=56)

- <18: n=14, 25%
- 18-64: n=42, 75%
- 65 and over
CSS HOPE FY2016-17:
Gender (N=56)

- F - Female: n=36, 64%
- M - Male: n=20, 36%

CSS HOPE FY2016-17:
Race/Ethnicity (N=56)

- Caucasian or White: n=42, 75%
- Hispanic: n=3, 5%
- Black or African American: n=2, 4%
- American Indian: n=3, 5%
- Vietnamese: n=1, 2%
- Other: n=5, 9%
CSS HOPE FY2016-17: City of Residence (N=56)

CSS HOPE FY2016-17: KEY EVENT (N=56)

- Homelessness: 68% Decrease
- Incarceration: 98% Decrease
- Psychiatric Hospitalizations: 79% Increase
PROGRAM CHALLENGES

In FY2016-17, the HOPE Program and Senior Peer Counseling continued to have challenges in working with older adults with severe and chronic mental illnesses with co-occurring neurocognitive disorders. Of primary concern was the lack of placement beds for those identified patients. Furthermore, addressing the interplay of the older adult’s comorbidities, chiefly those with chronic medical conditions, may support a decrease in hospitalization days for program participants. The lack of available affordable housing and placement options for older adults who suffer from chronic and persistent mental illness remained a major concern.

In FY2017-18, the HOPE Program and Senior Peer Counseling will participate in an older adult training offered through the County with a focus on better integration of mental health and primary care services. 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 90 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. Odyssey is committed to serving individuals from diverse backgrounds and lived experiences, regardless of gender, race, ethnicity, sexual preference, religion, or ability.

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. In addition, the FSP covers the cost of short-term therapeutic residential placements when a client needs additional support to meet their clinical goals. A limited amount of supportive housing is provided through partnerships with and Coordinated Entry, Marin Housing Authority’s Shelter Plus Care Program, 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 Five (5) mental health practitioners, one of whom is bilingual/bicultural Spanish speaking, four (4) 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 our 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.

EXPECTED OUTCOMES

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

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

Between the Odyssey FSP and the Step-down component, 136 individuals were served in FY2016-17, exceeding the goal of 120.

The Odyssey Program targets individuals who, by virtue of being unserved or underserved, are either homeless or at-risk of homelessness. In FY2016-17, the Full Service Partnership program engaged 109 individuals of whom 89 have participated for at least 1 year. During the baseline year prior to enrollment for those 89 individuals, they collectively spent 11,273 days homeless. During the first year they were enrolled in the FSP program, that was down to 3,976 days collectively—a 65% decrease. This still fell short of the goal of 80% decrease and will be discussed further in the Challenges section of this report. Days spent incarcerated almost tripled (+267%) due to a couple of outliers, falling very short of the goal of a 60% decrease. Hospitalization rates also increased this year up to 3.5% of days spent hospitalized from 2.1% in the baseline year, a 65% increase. Frequency of arrests decreased by 35% from 35 arrests in the baseline year to 21 in the first year of partnership in the FSP. Crises requiring evaluation by the Crises Stabilization Unit decreased by 40% year. On the positive side, the number of FSP partners living alone in an apartment increased by 79% from the baseline year.

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. More about their outcomes can be found in the Enterprise Resources Center section.

Independent Living Skills services were provided to 15 participants, exceeding the goal of 4-5. Of those 50% completed ILS Goals during the year. Vocational Rehabilitation Services were offered to 18 Participants: 9 (50%) engaged in job development, 26% were placed in employment and 46% of those remained at employed for at least 4 months this fiscal year.
CSS Odyssey FY2016-17:
Age Group (N=107)

- <18: n=10, 9%
- 18-64: n=97, 91%
- 65 and over: n=2, 2%

CSS Odyssey FY2016-17:
Preferred Language (N=107)

- English: n=98, 91%
- Spanish: n=1, 1%
- Farsi: n=5, 5%
- Other Non English: n=1, 1%
- Unknown / Not Reported: n=2, 2%
CSS Odyssey FY2016-17: Race/Ethnicity (N=107)

- Caucasian or White: n=80, 75%
- Hispanic: n=13, 12%
- Black or African American: n=7, 6%
- American Indian: n=2, 2%
- Chinese: n=2, 2%
- Other: n=1, 1%
- Unknown / Not Reported: n=5, 5%

CSS Odyssey FY2016-17: Gender (N=107)

- F - Female: n=53, 50%
- M - Male: n=54, 50%
CSS Odyssey FY2016-17: City of Residence (N=107)

CSS ODYSSEY FY2016-17: KEY EVENTS (N=107)
ODYSSEY STEP DOWN DATA

**Odyssey Step Down FY2016-17:**

**Preferred Language (N=26)**

- English: n=23, 88%
- Spanish: n=1, 4%
- Other Non English: n=1, 4%
- Unknown / Not Reported: n=1, 4%

**Age Group (N=26)**

- <18: n=5, 19%
- 18-64: n=21, 81%
- 65 and over: n=0, 0%
Odyssey Step Down FY2016-17: Race & Ethnicity (N=26)

- Caucasian or White: n=20, 77%
- Hispanic: n=3, 11%
- Black or African American: n=2, 8%
- American Indian: n=1, 4%

Odyssey Step Down FY2016-17: Gender (N=26)

- Female (F): n=15, 58%
- Male (M): n=11, 42%
Odyssey Step Down FY2016-17:
City of Residence (N=26)
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. In FY2017-18 we will move forward with incorporating the Odyssey Step-down program into our other services.

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.

Another change that has presented some challenges is with the recent institution in Marin county of the “Coordinated Entry”. The Odyssey program no longer has designated access to Shelter Plus care vouchers which has limited our capability to providing our consumers with independent housing opportunities. As “Coordinated Entry” evolves we are hoping to increase availability options to our most compromised consumers.

In FY2017-18 residential care for clients in the Odyssey FSP will be included when deemed clinically necessary as part of the “whatever it takes” approach, which will increase the allocation to this program as reflected on the budget section.
CLIENT STORY - ODYSSEY FULL SERVICE PARTNERSHIP

“Mary” entered the Odyssey program with multiple challenges in 2016. She was homeless, living out of her car and hopeless. Mary was struggling with severe Mental Health symptoms which resulted in emotional dysregulation, mood swings, suicidal Ideations and attempts. She was also in financial crisis with debt. Mary had been an abusive codependent relationship and without coping skills she used drugs to manage her symptoms. There were multiple uses of emergency services both psychiatric and medical throughout the year.

Mary has worked very hard since entering the Odyssey program and has many accomplishments. She moved through the shelter system to supported housing and now she is in her own apartment for the first time in her life. “I now have a home of my own which I have decorated myself!” Mary has been clean and sober for one year and is proud of her Narcotics Anonymous one year chip. She has gained coping skills by participating in multiple groups including DBT, Seeking Safety, Positive Changes, Woman’s Body Positive, the Graduate Group, and the Odyssey MTC harm reduction group. She also participates in individual psychotherapy and feels she is opening up and starting to discuss the trauma she has experienced. Mary has learned coping skills which have decreased her use of emergency services this year to two one-day visits to the Crisis Stabilization unit. She now has financial representative payee services and is hoping someday to manage and budget independently. She has happily reconnected with her children and grandchildren. She has made friends in the community and uses her YMCA membership regularly to support her self-care. Mary is considering volunteer employment hoping to eventually work again. Mary acknowledges how much her life has positively changed “I have too much to lose.”
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. This year the ERC averaged 1,150 visits per month.

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

<table>
<thead>
<tr>
<th>Goal</th>
<th>FY2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td># ERC first time visitors</td>
<td>200</td>
</tr>
<tr>
<td>Average daily attendance</td>
<td>35</td>
</tr>
<tr>
<td># Warm Line contacts</td>
<td>6,500</td>
</tr>
<tr>
<td>Average monthly contacts (unduplicated)-</td>
<td>100</td>
</tr>
<tr>
<td>CARE</td>
<td>57</td>
</tr>
</tbody>
</table>
ACTUAL OUTCOMES

The ERC continues to exceed many of the goals of the program. In FY2016-17, there were a total of 13,797 consumer visits, with an average daily attendance of 53 people. Of those attending, 11% self-identified as homeless. There were 245 first-time visitors, exceeding the goal of 200. Of the 245 first-timers, approximately 20% were Spanish speaking while 74% were English speaking. The other 6% varied from Vietnamese to Farsi.

The Warmline was able to assist callers with 6,969 contacts, surpassing the goal of 6,500. The 1108 Gallery, an Art Gallery showcasing consumer Artwork, celebrated its third year.

The peer counseling courses were reported by some as “life changing”.

The CARE team provided an average of 57 unduplicated contacts per month, significantly below the goal of 100. However, they provided increased case management services to people who were living on the streets and unwilling to engage in clinic-based care. The services they provided were more intensive than when the measure was first established.

They also provided services to clients throughout West Marin adding significant travel time. Metrics for evaluating the success of this program will be updated in the next fiscal year.
CSS ERC FY2016-17:
Gender (N=245)

- Male: n=131, 53%
- Female: n=107, 44%
- Transgender/ Other: n=3, 1%
- Unknown: n=4, 2%

CSS ERC FY2016-17:
RACE/ETHNICITY (N=245)

- White: n=158, 65%
- African American: n=44, 18%
- Asian: n=24, 10%
- Pacific Islander: n=5, 2%
- Native American: n=3, 1%
- Hispanic: n=3, 1%
- Multi: n=8, 3%
PROGRAM ALLOCATION FY2016-17 · $347,387

CSS ERC FY2016-17:
PRIMARY LANGUAGE(N=245)

n=2, 1%
n=2, 1%
n=2, 1%
n=8, 3%

n=1, 0%
English

n=1, 0%

Spanish
Farsi
Vietnamese
n=48, 20%

Cantonese
Mandarin
n=181, 74%

Tagalog
Arabic

CSS ERC FY2016-17:
AGE GROUP (N=245)

n=3, 1%

n=43, 18%

n=23,
9%
Child and Youth (0-15)
TAY (16-25)
n=176, 72%
Adults (26-59)

COMMUNITY SERVICES AND SUPPORTS (CSS) – ENTERPRISE RESOUCE CENTER (ERC) EXPANSION · SDOE-01

CSS · ENTERPRISE RESOURCE CENTER (ERC) EXPANSION

Older Adults (60+)
205


PROGRAM CHALLENGES

In FY2016-17 Although there are mandatory cultural competency trainings for all staff and volunteers the Enterprise Resource Center did not have a position on site that was bilingual. We arranged a Spanish speaking contact who was also a MH service provider familiar with the system that could refer clients to services. We also started negotiations for a .5FTE bilingual position at the ERC to be added.

FUTURE CHANGES

Building off of the expansion work done in this Three-Year Plan, a Consumer Operated Wellness Center was opened in Marin City with two months remaining in FY2016-17. Outcomes for this program will be included in the next annual update, covering the first 14 months of the program’s services.

PARTNER RESPONSE – ENTERPRISE RESOURCE CENTER

“I have a job now. I’m sober. My family is happy and grateful about this. I have healthy relationships. I feel that you all here at the ERC saw something in me that I could not see at that particular time (when I first arrived here). Now I feel that I’m in the process of living up to my full potential.”

“This is my favorite place to be. I love the activities and the outings. I am so happy that we have the ERC.”
ADULT SYSTEM OF CARE (ASOC) EXPANSION

PROGRAM OVERVIEW

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

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

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

The goals of the program are to promote recovery and self-sufficiency, improve the ability to function in the community, reduce isolation, and provide low-barrier access which welcomes unserved clients of Vietnamese and Hispanic/Latino origin.

TARGET POPULATION

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

PROGRAM DESCRIPTION

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

Increased Peer Specialist Services

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

Provide Outreach to and Engagement with Hispanic/Latino Individuals

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

Increased Outreach and Engagement to Vietnamese-Speaking Individuals

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

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

**Family Outreach, Engagement and Support Services**

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

**EXPECTED OUTCOMES**

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

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td># Served</td>
<td>325</td>
</tr>
<tr>
<td>% Hispanic</td>
<td>50%</td>
</tr>
<tr>
<td># Primary language-Spanish</td>
<td>100</td>
</tr>
<tr>
<td># Asian</td>
<td>15</td>
</tr>
<tr>
<td># Primary language-Vietnamese</td>
<td>10</td>
</tr>
<tr>
<td># Served – Outreach &amp; Engagement team</td>
<td>20</td>
</tr>
</tbody>
</table>
ACTUAL OUTCOMES

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 FY2016-17, the team provided 505 services to 42 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.

Note: The low number of contact during the last 2 months seem to be related to staff’s medical leave. One staff was out on FMLA starting May 11th and came back on July 5th.
PROGRAM CHALLENGES

In FY2016-17, the ASOC programs were 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 adding a clinical site in the town of Novato, where due to affordable housing locations, an expanding number of Medi-Cal beneficiaries 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 18 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 and Casa Rene Crisis Residential. The AIR team paused operations in October 2016 and prior to re-hiring is exploring alternative approaches and measures.

There is no FY16-17 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.

<table>
<thead>
<tr>
<th>GOAL</th>
<th>Actual FY2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients with mental health and substance use disorders</td>
<td>40</td>
</tr>
<tr>
<td>Reduced hospital days</td>
<td>30%</td>
</tr>
<tr>
<td>Reduced Crisis Stabilization Unit admissions</td>
<td>30%</td>
</tr>
<tr>
<td>Reduced homeless days</td>
<td>30%</td>
</tr>
<tr>
<td>Reduced criminal justice involvement</td>
<td>30%</td>
</tr>
</tbody>
</table>

*AIR paused on October 2016, so did not reach its targeted capacity.

CSS AIR FY2016-17: PRIMARY LANGUAGE (N=18)

- English: n=17, 97%
- Vietnamese: n=1, 3%
CSS AIR FY2016-17:
RACE/ETHNICITY (N=18)
- White
- African American
- Vietnamese
- Filipino
- Native
- Hispanic
- Other

CSS AIR FY2016-17:
AGE GROUP (N=18)
- 26-59

PROGRAM ALLOCATION FY2016-17 · $347,409
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. As the project ended in FY 2016-17, data reflecting the outcomes for staff and clients were not reported. Through this work, the following outcomes were achieved during the FY2016-17 project period:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Goal</th>
<th>Actual FY2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>50</td>
<td>8 Trainings</td>
</tr>
<tr>
<td>Number of mental health clients receiving substance use assessment, care management and other support services</td>
<td>75</td>
<td>62</td>
</tr>
<tr>
<td>Staff receiving consultation report increase in ability to address substance use issues</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Clients served will take recommended action in relationship to reducing substance use and/or related problems. Upon follow-up clients reported:</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>
CSS RCC FY2016-17:
AGE GROUP (N=62)

- 18-64: n=59, 95%
- 65+: n=3, 5%

CSS RCC FY2016-17:
PRIMARY LANGUAGE (N=62)

- English: n=62, 100%

CSS RCC FY2016-17:
RACE/ETHNICITY (N=62)

- White: n=42, 68%
- African American: n=10, 16%
- Asian: n=5, 8%
- Native: n=2, 3%
- Hispanic: n=1, 2%
- Multi: n=2, 3%
- Not Reported: n=2, 3%
Peer to Peer Tobacco Cessation Services

Most program objectives were met or exceeded during the FY2016-17 project period, including 102 clients participating in peer-led cessation and education services. Given challenges with assessing quit status at 3-month follow-up, the metric will be revised to 30-day follow-up.

Below is a summary of outcomes that were achieved during the FY2016-17 project period:

<table>
<thead>
<tr>
<th>Goal</th>
<th>Goal</th>
<th>Actual FY2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of peers receiving training and supervision to provide peer to peer smoking cessation services</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Number of mental health clients participating in smoking cessation services</td>
<td>75</td>
<td>102</td>
</tr>
<tr>
<td>Percentage of clients participating in peer-led cessation services who report reducing their tobacco use</td>
<td>60%</td>
<td>40%</td>
</tr>
<tr>
<td>Percentage of clients participating in peer-led cessation services who report attempting to quit smoking</td>
<td>75%</td>
<td>45%</td>
</tr>
<tr>
<td>Percentage of clients participating in peer-led cessation services who maintained their quit status at 3-month follow-up</td>
<td>30%</td>
<td>Unknown</td>
</tr>
<tr>
<td>Number of County and contractor agencies that integrate tobacco cessation support into their programs</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
**CSS TOBACCO CESSATION FY2016-17:**

### AGE GROUP (N=102)
- 0-15: n=43, 42%
- 16-25: n=38, 37%
- 26-59: n=4, 4%
- 60+: n=11, 11%
- unknown: n=10, 10%

### RACE/ETHNICITY (N=102)
- White: n=44, 43%
- African American: n=4, 4%
- Asian: n=7, 7%
- Native: n=1, <1%
- Hispanic: n=10, 10%
- Multi: n=43, 42%
- Other: n=4, 4%
- Not Reported: n=1, <1%

### PRIMARY LANGUAGE (N=102)
- English: n=52, 51%
- Spanish: n=43, 42%
- Not Reported: n=7, 7%
PROGRAM CHALLENGES

FY 16-17

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 and therapy services for individuals with co-occurring Serious Mental Illness and substance use disorders.

The 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.

FY 17-18

In the upcoming Three-Year Plan, it is recommended to integrate AIR services into existing programs and to provide outreach, engagement and therapy services to provide a comprehensive continuum of services for individuals with complex co-occurring Serious Mental Illness and substance use disorders.

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. As additional services now available through the County-operated Road to Recovery Program, workforce development initiatives should focus on staff and service co-occurring capacity building.
CRISIS CONTINUUM OF CARE

PROGRAM OVERVIEW

The Crisis Continuum of Care significantly expanded during FY2015-16. With the addition of funding from the SB82 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. In FY 2016-17 Community Action Marin Care Team 1 became a part of the Crisis Continuum of care. The additional services have been well received by consumers, families, and the larger community. Stakeholders have provided feedback that the capacity of these services is inadequate to meet the needs, and plans are in place to include expansion and sustainability of these efforts after the SB82 grants end using MHSA CSS funding. 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.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients and/or families that will receive Crisis Planning services.</td>
<td>80</td>
</tr>
<tr>
<td>Percent of clients receiving planning services that file a completed Crisis Plan in their medical records.</td>
<td>50%</td>
</tr>
</tbody>
</table>
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 FY2016-17, 120 individuals were supported to develop crisis plans. 78% of clients and/or families completing a Crisis Plan report increased understanding of the community resources available to them. 76% of clients completing a Crisis Plan report increased awareness of their individual symptoms and supports. 85% of clients agreed with the statement that after meeting with Crisis Planning Staff and creating their plan it can improve their experience if a crisis occurs. 104 of clients (87%) would recommend the Crisis Planning Services to others after completion of their own plan. 97 clients (81%) report an increased understanding of the types of choices available to them in a crisis situation.

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. All those with plans in effect are given the 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.
**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 Six days a week, Monday through Saturday 1-9pm. Since MCRT’s launch in July 2015 through June 2017, the teams have provided 1,913 services to 857 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.

In FY2016-17 MCRT received more referrals from Other Mobile Crisis Continuum programs such as Outreach and Engagement (O+E) and Transition team. This reflects these teams working across a continuum of service need. In addition MCRT follow up interventions increased.

The community has expressed a desire for increased and expanded services through this program, and it will be expanded as part of the next MHSA Three-Year Plan. 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. One Focus of expansion will be A.M. hours coverage to meet the needs of schools who report a great deal of their behavioral health crisis events occur in the A.M.
ACTUAL OUTCOMES

The Mobile Crisis Response Team began in July of 2015. Up through June 2017, the program has provided services to 857 individuals and provided 1,913 services. In FY2016-2017 MCRT served 493 individuals.

PROGRAM CHALLENGES

In FY2016-17, the Mobile Crisis Response Team was challenged by staffing changes and turnover.
By Age Group

- Children (0-15): 19%
- Transition Age Youth (16-25): 15%
- Adult (26-59): 44%
- Older Adult (60+): 16%
- Unknown/ Not Reported: 6%

Count of Contact per Month: July 2016 to June 2017

- Jul_16: 109
- Aug_16: 109
- Sep_16: 104
- Oct_16: 84
- Nov_16: 94
- Dec_16: 116
- Jan_17: 52
- Feb_17: 71
- Mar_17: 52
- Apr_17: 65
- May_17: 111
- Jun_17: 82
Mobile Crisis Response Team: Count of Contact (Cumulative)
July 2016 to June 2017

- # of Contact
- # of Unique Client
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 Accountablity 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/peer specialist. Services are provided Monday through Friday from 10am to 6pm. 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 3,991 services to 467 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.

ACTUAL OUTCOMES

The Transition Team launched in March of 2015 and have since (through June 30, 2017) served 476 individuals and provided 3,991 unique services to community members. In FY2016-17 the Transition Team served 236 individuals.

PROGRAM CHALLENGES

The funding for many of these positions is supported by a SB82 Investment in Mental Health and Wellness Act of 2013 Triage grant managed by the MHOAC which will come to an end on 6/30/18. In order to sustain the program through FY2018-19 we will only be adding one new Crisis Specialist in FY18-19 rather than two as planned in the 3-year plan as well as utilizing salary savings from unfilled program positions.
COMMUNITY SERVICES AND SUPPORTS (CSS) – CRISIS CONTINUUM OF CARE

PROGRAM ALLOCATION FY2016-17 · $600,000

By Race/ Ethnicity

- White: 35%
- Black: 6%
- Hispanic: 9%
- Other/Unknown: 20%

By Gender

- Male: 36%
- Female: 33%
- Unknown/ Not Reported: 6%

By Age Group

- Children (0-15): 7%
- Transition Age Youth (16-25): 2%
- Adult (26-59): 11%
- Older Adult (60+): 35%
- Unknown/ Not Reported: 46%
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

In FY2016-17 the family partner served a total of 103 family members, exceeding the goal of 100. Of these family members, 85 were Caucasian, 4 were Asian, 11 were Hispanic, 2 were mixed race, and one’s race was unknown.

PROGRAM CHALLENGES

In FY2016-17 the main challenge for this Family Partner has been managing the periods of time when CSU has had an infusion of clients as the number of clients seen has been steadily increasing overall, with periods of high usage. The number of family members seeking support has also increased. She refers Spanish-speakers to the bi-lingual Family Partner and has referred some families to the other Family Partner when her caseload is too full to serve them adequately.
CLIENT STORY

One family that received support from this Family Partner this past year was a family of Filipino heritage who’s 23 year old son had a psychotic break. The family was having a very difficult time accepting the severity of their son’s diagnosis. The Family Partner was able to meet them in their home and slowly educate them about the challenges of this diagnosis and the best treatment options to address his symptoms. They went from refusing to believe he had a mental illness to accepting, and became open to services to help their son.

The responses from the family members served by this Family Partner are the most moving. Many have sent written feedback about the importance of receiving this support at such a critical time. One example: “I have had the profound honor of working with_______on and off since January, 2017. My young adult son has mental health and substance abuse problems, and has had many severe, life threatening incidents in the past few years. Our family has worked with numerous mental health professionals, who have been somewhat helpful at times. But she has been the most helpful person we have ever had the great fortune to work with. She has helped our family grow through so many hard times. She is a blessing …The Family Partnership Program is the best agency we have ever come across. Thank you from the bottom of my heart.”

Crisis Residential – Casa René

PROGRAM DESCRIPTION

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

In FY2016-17 Casa René provided services to 166 unduplicated individuals, with 316 distinct admissions, with a total of 2641 bed days and an average of length of stay of 8.45 days. The occupancy rate averaged 72%, 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 (95%) were discharged to a lower level of formal support.

In 2016-17, 83% of all clients completed the satisfaction survey, 92% of whom rated the service at 4.0 or higher out of 5. Results are compiled in the Buckelew IBIS database system.
Program Allocation FY2016-17: $600,000

Crisis Residential FY2016-17:
Age Group (N=173)

- 80% Over 60
- 10% 0-17
- 2% 18-25
- 8% 26-60
CRISIS RESIDENTIAL FY2016-17: RACE/ETHNICITY (N=173)

- Caucasian or White: 73%
- Hispanic: 13%
- Black or African American: 7%
- Unknown / Not Reported: 1%
- American Indian: 2%
- Korean: 1%
- Filipino: 1%
- Other: 2%

CRISIS RESIDENTIAL FY2016-17: Gender (N=173)

- Male (M): 48%
- Female (F): 52%
PROGRAM CHALLENGES

There were several challenges identified in the FY2016-17. The primary challenge was to address lower than 85% occupancy rate and how to eliminate barriers in order to increase census. An evaluation report was prepared in collaboration with a Buckelew Quality and Compliance Staff and a BHRS County Staff addressing the problems with occupancy rate. This report was titled, *Casa René’s Occupancy Rate: A Program Evaluation*. Copies were provided to Buckelew and BHRS staff. Significant efforts have been made with identified Buckelew challenges by increasing availability of referrals received. By the end of the 2016/2017 fiscal year, Casa René was accepting referrals at any time of day/7 days a week. Additionally, there has been increased training to Buckelew staff to meet needs here. In the last few months of the reporting year, Casa René increased occupancy rate to 80%. Buckelew staff is confident that with continued collaboration with CSU and other BHRS staff, Casa René will continue to increase capacity numbers to meet 85% outcome objective.

In FY2016-17 efforts to provide excellent services and increase challenged occupancy rates have increased collaboration with CSU staff, Unit A staff, and CAM peer providers. This also led to a stronger relationship within Buckelew’s Marin Independent Living Program, Residential Supportive Services Program, and Helen Vine Detox Program in generating referrals to and from a client’s stay at Casa René.
CLIENT STORY

“Joe” is a middle-aged Caucasian chronic homeless man that was referred to Casa Rene twice from Unit A inpatient treatment program at Marin General Hospital. During his second admission, he was able to stabilize on medications, participate in social rehabilitation groups, and appeared to be less symptomatic behaving non-aggressively with peers and staff. Casa René staff supported Joe in linking to the Odyssey case management program, reconnected with several family and friends, and secured a housing discharge plan to Mill Street Homeless Services Program. While there, he was able to maintain connections with case management, continued to feel stable on medications, and was meeting regularly with his medical and psychiatric team. He is now in Voyager program, on a waitlist for a Section 8 Housing Voucher, and gaining skills for employment. Joe’s story is representative of many experiences witnessed in the Casa René program. In maintaining a welcoming and client centered stance at each admission, staff fostered a beneficial relationship that support Joe in gaining better insight, medication stabilization, and connection to community resources to support more independence and integration into the community.

FUTURE CHANGES FOR THE CRISIS CONTINUUM

The expansion of the Crisis Stabilization Unit will be completed in FY2018-19, partially funded through AB114 CFTN funding as described in the Spending Plan. The expansion will expand the capacity of the unit from 5 beds to 10, greatly increasing our Crisis Continuum capacity.
PROGRAM OVERVIEW

In August 2007, the State Department of Mental Health released the guidelines for the Mental Health Services Act (MHSA) Housing Program (MHSAHP), a collaborative program administered by the California Housing Finance Agency and the State Department of Mental Health. MHSAHP funds can be used to build or renovate rental housing or shared housing. Rental housing developments are 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. MHSAHP 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. MHSAHP 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 MHSAHP housing, an individual/family/household must also be homeless or at risk of becoming homeless, as defined by MHSAHP regulations. The household must be able to 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 MHSAHP 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 MHSAHP housing at the Fireside Apartments serves older adults (62 years and older) who, at the time of assessment for housing services, receive or qualify for Full Service Partnership (FSP) services and are either homeless or at-risk of homelessness. These are individuals with serious mental illness who have been 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 MHSAHP-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 MHSAHP-funded units. The first MHSAHP-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 FY2-16-17, all five (5) Fireside Senior Apartment MHSAHP-funded units continued to be occupied, continuing to indicate that this supportive housing project has been successful in reducing homelessness and enabling older adults with serious mental illness to maintain housing in the community and live independently.

**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)).

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.

Presentations by several housing providers were made to the Mental Health Services Act Advisory Committee and an RFP was released. It was awarded in FY2017-18 pending contract negotiations and Board of Supervisory Approval, to Resources for Community Development for their “Victory Village” project in Fairfax. This project will set-aside 6 units for older adults (62+) 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.

**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 FY2017-18, the funding was awarded through an RFP pending contract negotiation and Board of Supervisor approval. BHRS will work to ensure use of the funding before reversion occurs in December 2019.**
# Community Services and Supports (CSS)

## Numbers to Be Served

<table>
<thead>
<tr>
<th>Program</th>
<th>FY2016-17 Actual</th>
<th>FY2017-18 Projected</th>
<th>FY2017-18 Cost Per Person</th>
</tr>
</thead>
<tbody>
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<td>FSP-01</td>
<td>65</td>
<td>40</td>
<td>$16,231</td>
</tr>
<tr>
<td>FSP-02</td>
<td>29</td>
<td>25</td>
<td>$22,007</td>
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<tr>
<td>FSP-03</td>
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<tr>
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<td>Housing</td>
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<td>5</td>
<td></td>
</tr>
</tbody>
</table>

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

**Southern Marin Services Site (SMSS) ended June 30, 2016.
## MHSA COMMUNITY SERVICES AND SUPPORTS (CSS)
### MHSA THREE YEAR PLAN (FY2017-18 THROUGH FY2019-20)

<table>
<thead>
<tr>
<th>Program</th>
<th>FY2017-18</th>
<th>FY2018-19</th>
<th>FY2019-20</th>
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### Full Service Partnership (FSP)

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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)**

The purpose of the stipend program is to 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 FY2016-17, the Graduate Clinical Training Program included one post-graduate intern, six (6) psychology doctoral interns, five (5) Social Work interns, and five (5) psychology practicum trainees. 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 seventeen (17) interns, eight (8) brought bilingual/bicultural skills that enhanced service delivery: six (6) were fluent in Spanish, two in Vietnamese, one (1) in Tagalog. Other cultural identity factors that contributed to improved cultural match and workforce diversity included: 4 identified as Black/African-American, two (2) were family members of consumers, six (6) were first or second generation immigrants, and 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 Communidad Radio Program that is presented weekly by a county bilingual psychologist, a truly unique experience for those interns who are interested).

Of those completing their degree programs in this cohort, four (4) continued on to post-doctoral positions with Marin County Behavioral Health and Recovery Services. Others with completed doctoral internship hours went to the San Diego VA Psychosocial Recovery Program and to bilingual clinical programs in the Los Angeles area. Master’s level trainees still completing social work and psychology programs went on to settings such as the East Bay Sanctuary Project in Berkeley and the Sexual Offender Treatment Program in San Francisco. In all of the continuing settings the trainees are working with underserved populations in California.

**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.

In prior years a major challenge has been being unable to fill our full-time Latino Family Health internship positions in the initial APPIC National Match, despite having a strong field of applicants. After identifying that a key factor was the comparatively low stipend relative to other clinical training sites in the Bay Area, particularly for competitive bilingual placements, we proposed a substantive increase be made and this 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 FY2017-18**

Three goals were identified for FY2017-18:

1. More fully integrate interns into the interdisciplinary Full-Service Partnership and Bridge teams and continue to build the staff’s knowledge about when, how, and where to motivate and connect clients to therapy, psychological testing, and group services.

2. Support the development of social work training positions across adult and youth/family programs teams and expand psychology intern opportunities with first episode psychosis (FEP) and the crisis continuum.

3. Continue to expand and develop group psychotherapy services to provide steady availability of intern-led groups at both major clinic sites that are evidence-based, and trauma-informed.

**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.

The Scholarship for Consumers and Family Members program continued to offer and award scholarships to qualifying applicants in FY16/17. Awarded scholarship recipients continued to be representatives of underserved cultural and racial/ethnic communities.

A total of twenty one (21) scholarships were awarded. Of the 21, twelve (12) recipients enrolled in Substance Use Counseling offered by the California Consortium of Addiction Programs and Professionals (CCAPP); three (3) went on to enroll and eventually completed a Domestic Violence certification course through Center for Domestic Peace; and seven (7) eventually dropped out from the program prior to enrolling into any vocational counseling programs for various reasons. Some of the reasons cited for dropping out were 1) after getting matched with a mentor to further define or clarify their career/vocational goals, she/he realized that the behavioral healthcare field was not their ideal career/vocational goals, 2) others decided to enroll in the free BHRS-funded Peer Counseling program called Co-Occurring Peer Education (COPE) program and did not require any additional assistance and support from the Scholarship program and its mentors.
All recipients who enrolled in the Substance Use Counseling program are either on pace to graduate in December 2017 or Spring 2018 and continue to receive mentoring support from the Mentor program.

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.

The Peer Mentoring program continued to provide needed support to enrolled or interested scholarship recipients in FY16/17. Two (2) mentors were replaced by recent graduates of the COPE program and the Substance Use Counseling program. These changes represent the intent and spirit of the Mentor program as BHRS is committed to enriching the professional development of scholarship recipients by providing opportunities to successful graduates to become mentors to incoming scholarship recipients who need emotional/social supports.

FY17/18 experienced a different trend in the applicant pool of WET scholarship applicants and awardees. Most of the scholarship awardees applied to receive support to either help pay for the remaining balance of her/his tuition as current students or simply needed ancillary financial support to help pay for incidental expenses that support their continued education (i.e. transportation or childcare). Equally important, majority of the awardees were determined to not require active and ongoing mentoring throughout their coursework due to their high commitment and sustained success as students in their respective current course work. With these two findings, Peer Mentoring has become a lesser need, and FY18/19 is projected to have the same trend and profile of scholarship applicants with similar defined needs so the allocation for this program has been reduced and those funds have been transferred to the Training Initiatives section where they will be more readily utilized.

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.

The WET-funded Co-Occurring Peer Education (COPE) peer certification program continued to enjoy its successes by enrolling eighteen (18) consumers/family members to its program. The first six (6) cohorts who enrolled in the program successfully graduated and have found gainful employment as either Peer Specialists and/or have advanced to enroll in higher education to obtain their bachelor’s degree in Psychology or have enrolled
in an accredited substance use counseling education program that is administered by the California Consortium of Addiction Programs and Professionals. The remaining twelve (12) students who are enrolled in the COPE program are currently engaged in their coursework and is expected to graduate in October 2017.

BHRS devoted this fiscal year to provide substance use education and training to BHRS staff, agency partners and other stakeholders. A combination of fifteen (15) education presentations/consultation and trainings were conducted by BHRS’ Chief of Addiction Services on topics such as Narcan, DSM5, Co-Occurring Disorders, and Alcohol-related disorders.

PEER SPECIALIST AND AOD 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 area of WET’s overall program structure experienced one of the most significant growth and activity in FY16/17. A combination of either providing stipends directly to recipients of the Scholarships for Consumers and Family Members program upon completion of their coursework and successfully finding an internship site at a behavioral healthcare agency setting; or funding behavioral healthcare agencies who provide training opportunities to recently graduated and certified peer or substance use counselors, were administered. Six (6) graduates from either the substance use counseling or COPE programs interned at the Marin City Community Development Corporation, a new BHRS community partner that specializes in providing job rehabilitation services for people with developmental, behavioral health and physical disabilities. Five (5) graduates of the substance use counseling program interned at either Marin City Health and Wellness Clinic, Helen Vine Detox Center, Bay Area Community Resources or Marin Outpatient Recovery Services (MORS). One (1) community college student interned at Community Action Marin’s Enterprise Resource Center. A total of twelve (12) students were successfully placed in internship sites.

Five (5) of the 12 students were subsequently hired by the same organizations where they interned while the remaining seven (7) found gainful employment with another agency within the behavioral healthcare field. Other graduates who did not require or request an internship experience in a behavioral care agency setting simply found immediate employment immediately after or during their coursework within the field due to their extensive past work history as entry-level counselors from other disciplines.
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 as well as to better train those currently in the workforce.

The Consumer Focused Training program piloted a consumer advocacy course during this fiscal year. Unfortunately, the training program did not meet the expected outcomes or results that it had hoped to yield. One of the major challenges experienced by the course instructor/coordinator was the lack of access to consumers who may have been interested in enrolling in the course. Other challenges include, but not limited to, are the lack of facility to conduct the course and poor outreach/marketing of the course. Consequently, when the course began it experienced a consistently low number of students attended, thus, necessitating the program to cease.

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.

This area of WET’s overall program structure experienced the most significant growth and activity in FY16/17. WET planned for, coordinated and offered twenty-five (25) trainings for BHRS staff, agency partners, consumers/family members and other stakeholders. Major training initiatives included Motivational Interviewing, Cognitive Behavioral Therapy for Psychosis, DSM5, substance use and Cultural Competence trainings (monthly cultural competence case consultation clinics, LGBTQ, Military Veterans and use of interpreter services). Lastly, a presentation on the Role, Value and Importance of Peer Providers and Family Partners in Behavioral Healthcare was provided to service providers, consumers and family members was conducted in BHRS’ ongoing effort and commitment to promote and advocate for the use of peers in the behavioral healthcare system.

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 was successful in advancing its efforts to advocate for and create a newly developed classified positions of Peer Counselor I and II positions within the division. Plans are in place to advance the proposed positions to the County Board of Supervisors for approval in the early part of FY17/18. Once approved, recruitment to fill 4 Peer Counselor I
positions (two 1.0 FTE and two .5 FTE) will be advertised. Assignments of these positions have yet been determined.

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.

Nine (9) members of BHRS’ Cultural Competence Advisory Board attended CIBHS’ Cultural Competence Summit in the Spring 2017. Also, BHRS’ Ethnic Services and Training Manager routinely attended state and regional Steering committee meetings, seminars and summits offered by the Institute. More notably, BHRS’ Ethnic Services and Training Manager was invited to present on current strategies and practices that Marin County utilize in promoting and fostering Peer Specialist workforce development to the California Department of Correction’s Council on Mentally Ill Offenders (COMIO).

OTHER PROGRAM ACCOMPLISHMENTS

- Overhauled and vastly improved training coordination system by implementing new technology systems and protocols.
- Began to improve data collection of racial/ethnic staffing demographics of BHRS staff and its contract agency partners
- Slightly increased the number of bilingual/bicultural Spanish speaking scholarship recipients to become mental health peer, domestic violence and/or substance use counselors

PROGRAM CHALLENGES

Due to the high volume of work responsibilities that the WET coordinator, who also serves as the Ethnic Services Manager, and the limited administrative support provided to carry out WET’s goals and objectives, some of the stated FY16/17 goals were not accomplished. Goals that have yet to be accomplished in FY16/17 are:

- Establishment of Peer Counselor positions within BHRS
- Provide consistent and ongoing coaching and consultation system on some of the major training initiatives
GOALS FOR FY2017-18

- Continue to improve tracking of racial/ethnic demographics of BHRS staff and its contract agency partners
- Review and amend BHRS policy on minimum number of required hours for staff to attend
- Improve staff tracking system of trainings attended
- Begin to explore and understand the principles of Trauma Informed Systems and its proper application within BHRS
- Establish Peer Counselor positions within BHRS division
- Provide more consistent and ongoing coaching and consultation system on major training initiatives that will be identified in the next fiscal year
- Support interested BHRS supervisors, managers and directors to improve their skills in providing culturally sensitive supervision among their culturally and racially/ethnically diverse staff.

CHANGES FOR FY2018-19:

The final unspent totals from the last three-year plan exceeded the amount planned for ($80,000) in the new three-year plan. Thus, below is an update to the three-year plan on how we intend to utilize the additional unspent WET funds, a $189,000 increase.

New strategic initiative: In order to bring together many separate initiatives around connecting with the Latino community, $36,000 will be used to develop a new coordinated Latino WET strategic initiative with a focus on system transformation. This will include a stipend for a public health or public administration intern who will focus on ways to make the system more responsive to the needs of Latinos in our community. The intern will focus their work on the development of a strategic plan that BHRS can implement to better serve the Latino community.

We will be utilizing the rest of the unspent WET funds to expand three of our most successful WET initiatives:

1. Expanding the BHRS Graduate Clinical Training Program: We will increase the planned allocation for this program by $98,000 in order to be able to provide the testing and training materials (including translations) for the interns as well as adding additional stipends including for a new post-doctoral internship position in the First Episode Psychosis program.

2. Expanding the scholarship program. Another successful initiative that we will be expanding is the scholarship program for people with lived experience. The applications have seen a notable increase in the past year so an additional $25,000 will be allocated to scholarships to help support underserved groups in furthering their educational goals in the field.
3. **Expanding the Peer Specialist and AOD Intern Program:** In order to support a pipeline from the scholarship program we will also add $30,000 to the peer specialist, domestic violence and substance use intern stipend program. This program has been very successful and with the recent increase in consumers and family members graduating from their training programs, it will help provide opportunities for a next step to help the recent graduates gain work experience in the mental health and substance use fields.

In addition, as described in the Peer Mentoring section, $30,000 from Peer Mentoring will be shifted to Training Initiatives. See updated component budget on the following page.
### MHSA WORKFORCE EDUCATION AND TRAINING (WET)
### UPDATED MHSA THREE YEAR COMPONENT BUDGET

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#### One-Time Funding Sources:

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a) The $25,000 increase is from the additional unspent funds

b) The $30,000 increase to the training budget is reallocated from Peer Mentoring due to the reasons described in the WET Program Descriptions and Outcomes section

c) The $30,000 decrease in funding was reallocated to Training for the reasons described in the WET Program Descriptions and Outcomes section

d) The $98,000 increase is from the additional unspent funds

e) The $30,000 increase is from the additional unspent funds

f) This is a New Initiative as described in the narrative

g) The actual unspent funds were $189,000 higher than estimated in the 3-year plan funded by additional unspent funds

h) No change
CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS

ELECTRONIC HEALTH RECORD (EHR)

In FY2016-17 Marin focused on enhancing the Electronic Health Record, Clinicians Gateway (CG), to increase the efficiency and accuracy and completeness of the medical record. Enhancements to increase data collection capability, and reporting upgrades were made to the system. This includes the following:

- Electronic signature pad utilization was expanded to additional relevant applications, such as Releases of Information and Medication Consent forms.
- Full implementation of RxNT technology was obtained, virtually eliminating the need for paper prescriptions.
- Progress was made towards fully integrating electronic receipt of laboratory test findings into CG.
- Creation of “pre-consumer” functionality was piloted. This functionality will allow services such as the Crisis Stabilization Unit (CSU) transition to use of the EHR.
- 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 longitudinal client record and data repository among BHRS and external partners, including the Federally Qualified Health Centers (FQHC), Marin General Hospital and Emergency Medical Services, among other.
- Upgrades to become current with changing Meaningful Use and Physicians Quality Reporting System (PQRS) requirement were under development and/or implemented.
- Full Service Partnership reporting errors were identified as stemming from faulty CG forms and logic. These technical errors were fixed resulting in increased data capture and reporting of more than 10%.

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.
E-PRESCRIBING

Marin is currently utilizing RxNT to provide e-prescribing for the medical staff for all county-operated sites.

SCANNING PROJECT

This project has been discontinued due to technical issues and in anticipation of procuring a replacement EHR. Key elements of paper forms have been modeled into the EHR and are being completed with electronic signatures.

BEHAVIORAL HEALTH CROSSWALK

This project has been discontinued. Data from the Alcohol and Drug EHR (Marin WITS) and Clinician’s Gateway is being analyzed in tandem without a crosswalk. Stakeholders familiar with both the AOD and the MH EHRs will collaborate on the new EHR procurement, and will consider whether an integrated solution will be pursued.

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 IMPROVEMENTS

Facility improvement projects were identified to ensure that security needs, technological needs, safety, and longevity are meeting their respective operational needs/standards for MHSA. Based on that assessment, improvements were made at the Bon Air site, including painting, additional security cameras, and computer software and hardware upgrades.

FUTURE CHANGES

See the AB114 Spending Plan for a summary of spending priorities in CFTN through FY2019-20 including the Crisis Stabilization Unit expansion and the Coordinated Case Management System.
MHSA CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

<table>
<thead>
<tr>
<th>Program</th>
<th>FY2017-18</th>
<th>FY2018-19</th>
<th>FY2019-20</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Stabilization Unit (CSU) Expansion</td>
<td>$300,000</td>
<td>$385,000</td>
<td>$0</td>
<td>$685,000</td>
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<tr>
<td>Electronic Health Record and Practice Management System Enhancements</td>
<td>$305,311</td>
<td>$360,000</td>
<td>$338,697</td>
<td>$1,004,008</td>
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<td>Coordinated Case Management system</td>
<td>$137,165</td>
<td>$90,000</td>
<td>$28,500</td>
<td>$255,665</td>
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<tr>
<td><strong>Total</strong></td>
<td>$742,476</td>
<td>$835,000</td>
<td>$367,197</td>
<td>$1,944,673</td>
</tr>
</tbody>
</table>

**One-Time Funding Sources**

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB114 CFTN Funds</td>
<td>$1,444,673</td>
</tr>
<tr>
<td>One-time CSS* transfer</td>
<td>$500,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,944,673</td>
</tr>
</tbody>
</table>

*Note: this is a correction from the 3-year plan where it indicated the transfer would be from the accrued interest on all components. The transfer will in fact be from CSS.*
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 FY2018-19 reports on the third and final year (FY2016-17) of the MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17. The following encompasses the MHSA Stakeholder Process for the FY2018-19 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 FY2016-17 reporting period, the new MHSA Advisory Committee met monthly and below is an overview of the meeting dates:

- July 27, 2016
- August 24th, 2016
- September 28, 2016
- October 26, 2016
- November 15, 2016
- December 13, 2016
- January 25, 2017
- February 22, 2017
- March 29, 2017
- April 26, 2017
- June 28, 2017

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.
<table>
<thead>
<tr>
<th>Stakeholder Involved</th>
<th>Policy</th>
<th>Program Planning and Implementation</th>
<th>Monitoring</th>
<th>Quality Improvement</th>
<th>Evaluation</th>
<th>Budget Allocations</th>
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<td>Mental Health Board</td>
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<tr>
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<tr>
<td>PEI Committee</td>
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<tr>
<td>Policy Committee</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Alcohol &amp; Other Drug Advisory Board</td>
<td>X</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Quality Improvement/Management (QI/QM) Committee</td>
<td>X</td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cultural Competency Advisory Board</td>
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<td>X</td>
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<td></td>
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<tr>
<td>BHRS Contractor Meetings</td>
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<td>Board of Supervisors</td>
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**FY2018-19 ANNUAL UPDATE PROCESS**

This Annual Update is reporting on the third and final 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 **Saturday, May 12th, 2017** through **Monday, July 11th, 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 2018-19 were available at three local libraries – the main branch in San Rafael, the branch in Marin City, and the branch in Point Reyes Station – 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 FY2018-19 were also available for review at the Marin City Health and Wellness Clinic, 20 N. San Pedro Administration office, and the front desk at the Marin Health and Wellness 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 ran for three days 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, Cultural Competency Advisory Board, and other MHSA and BHRS related distribution lists and committees.

On **Tuesday, June 12th, 2018** 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 substantive comments are summarized below. The final MHSA Annual Update for FY 2018-19 went to the Board of Supervisors on June 19, 2018.

**SUBSTANTIVE COMMENTS AND RESPONSES:**

*Increase the funding and support for Veterans Outreach*

This Annual Update makes the rare mid-3 Year Plan budget adjustment for PEI to increase the allocation for Veterans Outreach by $10,000 from the PEI operational reserve. BHRS values the service of those who have worn the uniform and the unique mental health needs of our veteran community. Further expansion will be considered during the 3-year planning process.
Report meaningful clinical outcomes

With the input and guidance of the MHSA Advisory Committee, initial improvements have been made to the data collection and reporting for FY2017-18 that will be reflected in the next Annual Update. Further work remains to be done and the department is looking to implement recommendations from the Toolkit for Evaluation, Assessment, and Measurement for Adult Community Services and Supports Programs developed by the Health Services Research Center at the University of California San Diego in partnership with the Mental Health Services Oversight and Accountability Commission (MHSOAC). We appreciate the support of NAMI and others to help improve the standardization of clinical outcome measures where appropriate.

It would be very difficult for the Enterprise Resource Center (ERC) to gather more personal information or assessments as described in the previous comment. That would turn people away from seeking services.

BHRS acknowledges the difficulties adding additional data collection measures would entail and will work closely with providers to improve outcome reporting without compromising services.

Provide evidence-based training for providers/commit to evidence-based treatment

In addition to intensive case management services, peer support, and psychiatry services, the APA Clinical Graduate Intern Program, funded through MHSA’s Workforce Education and Training (WET) component, provides group and individual psychotherapy services using trauma-informed and evidence-based practices to adult clients across the Bridge Teams and Full-Service Partnerships (common modalities include CBT, CBTp, DBT, ACT, Mindfulness-based Practices, Social Skills Training, Seeking Safety, Anger Management, and Motivational Interviewing). They also deliver culturally responsive and linguistically appropriate services in Spanish, Vietnamese, Cantonese, and Mandarin to increase access to evidence-based treatment for underserved members of our community.

The Psychiatrists in our programs are well trained and have significant expertise including our STAR FSP psychiatrist (Dr. Epson) who has training as both a JD and MD—a rare combination particularly suited to the needs of our STAR clients with mental illness and involvement with the criminal justice. Our HOPE FSP psychiatrist (Dr. Ciranni) earned a Ph.D. in cognitive neuropsychology from UC Berkeley before attending medical school at UC San Francisco and later specializing in psychiatry at New York University, and has published articles in the areas of memory, attention, cognition, and the effects of psychiatric medications and teaches a seminar on the evaluation and treatment of older adults.

In FY2016-17 BHRS provided eleven (11) Evidence-Based trainings through MHSA funding including CBTp, Motivational Interviewing, Seeking Safety, and Mental Health
First Aid. Through the 3-Year Planning process a new position was created to spearhead coordination and training around Evidence Based Practices. Planning for this position is underway and funding for trainings has been increased.

**Despite the lower numbers, the CARE team provided more intensive services**

Metrics for the CARE team will be updated in the coming fiscal year to better evaluate the success of the program. The outcomes section of this report has been updated to reflect this comment.

**Request for clarification around the Coordinated Case Management System data sharing and privacy policies**

The system provides a HIPAA-compliant, cloud-based software platform designed for team-based care and collaborative services. The technology is purpose-built to support team-based care plans, interactions and collaborative workflows that involve a broad array of disciplines, including patients, families, and caregivers when appropriate. ACT.md allows for workflow automation across healthcare institutions, community based settings of care, social services and the home—all in the context of a person-centered care plan.

The system will allow users to easily connect care providers as “care teams,” and assign members of the care teams individual roles and access permissions, to accommodate HIPAA and 42 CRF Part 2 requirements. The system will have the capacity for end-to-end encrypted, user-friendly data transmissions for alerts and messaging, and the ability to track patient consent status, and storage of Release of Information (ROI) agreements for access by all team members.

The system will comply with all relevant client protections, including but not limited to HIPAA, 42 CRF Part 2, and Welfare & Institutions Code § 14184.60. Participating Entities and Authorized Users may access and use data through HISS only for permitted purposes, as defined in the Participation Agreement/Data Use Agreement. In general, requests for access to and the use of Confidential Information from the HISS will be permitted for an authorized purpose, such as, but not limited to; treatment, payment, healthcare operations, public health and the determination of eligibility for government benefits. A list of authorized purposes can be found within the “Purpose” section of the WPC ROI Authorization, and in the statute and regulations regarding the implementation of the WPC Pilot Project.
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. 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. 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 2016 population by race/ethnicity and age group, Medi-Cal population and County mental health clients.
TOTAL MHSA FUNDING ALLOCATION
MHSA THREE-YEAR PLAN
(FY2017-2018 through FY2019-2020)

<table>
<thead>
<tr>
<th>Components</th>
<th>FY2017-18</th>
<th>FY2018-19</th>
<th>FY2019-20</th>
<th>Total</th>
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<tbody>
<tr>
<td>Community Services and Support (CSS)</td>
<td>$9,635,667</td>
<td>$9,635,666</td>
<td>$9,635,667</td>
<td>$28,907,000</td>
</tr>
<tr>
<td>Prevention and Early Intervention (PEI)</td>
<td>$2,148,000</td>
<td>$2,370,000</td>
<td>$2,370,000</td>
<td>$6,888,000</td>
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<tr>
<td>Workforce Education and Training (WET)</td>
<td>$363,200</td>
<td>$509,200</td>
<td>$396,600</td>
<td>$1,269,000</td>
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<td>Capital Facilities and Technological Needs (CFTN)</td>
<td>$742,476</td>
<td>$835,000</td>
<td>$367,197</td>
<td>$1,944,673</td>
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<tr>
<td>Innovation (INN)</td>
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<td>$1,125,000</td>
<td>$343,067</td>
<td>$2,041,067</td>
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<tr>
<td>Total MHSA Funds Allocated</td>
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<td>$14,474,866</td>
<td>$13,112,531</td>
<td>$41,049,740</td>
</tr>
</tbody>
</table>

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

a) No change in CSS funds from Three-Year Plan
b) No change in total PEI funds from Three-Year Plan
c) Increase in funding for WET is from updated amount of unspent funds from previous years
d) Increase in funding for CFTN is from the AB114 funds which updated the amount of unspent from previous years
e) This is a change in how the INN budget is presented and it incorporates the AB114 funds. This budget accounts for the already approved project, the project in the community planning process, and planning costs.
f) Approximately $1.4m of CSS Housing funds have been awarded through an RFP at the end of FY17-18 pending contract negotiations and approval by the Board
g) Local Prudent Reserve are funds that have been set aside for use when MHSA funds are below recent averages adjusted by changes in the State population and the California Consumer Price Index, pursuant to WIC section 5847, subdivision (b)(7). Use of the funds requires State approval.
## APPENDIX I – MENTAL HEALTH SERVICES ACT (MHSA) ADVISORY COMMITTEE MEMBERS

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

#### Behavioral Health and Recovery Services Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Representation</th>
<th>Ethnicity</th>
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<tbody>
<tr>
<td>Darby Jaragosky</td>
<td>HHS Senior Program Coordinator</td>
<td>Caucasian</td>
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<tr>
<td>Marisol Munoz-Kiehne</td>
<td>Promotores Coordinator (Adult Team)</td>
<td>Latina</td>
</tr>
<tr>
<td>Brian Robinson</td>
<td>Unit Supervisor (Child Team)</td>
<td>Caucasian, LGBTQ</td>
</tr>
<tr>
<td>Cesar Lagleva</td>
<td>Ethnic Services Manager Mental Health Practitioner</td>
<td>Asian / Pacific Islander</td>
</tr>
<tr>
<td>Kristen Gardner</td>
<td>MHSA/PEI Coordinator</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Jessica Diaz</td>
<td>Mental Health Practitioner, Adult Case Management, (Adult Team)</td>
<td>Mixed Heritage</td>
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<tr>
<td>Cecilia Guillermo</td>
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<td>Robert Harris</td>
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<td>Ngoc Loi</td>
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<tr>
<td>Kristine Kwok</td>
<td>Unit Supervisor (Adult Team)</td>
<td>Asian / Pacific Islander</td>
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<tr>
<td>Cammie Duvall</td>
<td>Mental Health Practitioner</td>
<td>Caucasian, LGBTQ</td>
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<tr>
<td>Sadegh Nobari</td>
<td>Licensed Mental Health Practitioner</td>
<td>Middle Eastern</td>
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<td>Marta Flores</td>
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<td>Ellie Boldrick</td>
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</tr>
<tr>
<td>Angel Cassidy</td>
<td>Licensed Mental Health Practitioner</td>
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<tr>
<td>Gustavo Goncalves</td>
<td>Behavioral Health Administration</td>
<td>Latino, Transition Age Youth</td>
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#### Agency Partners

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<thead>
<tr>
<th>Name</th>
<th>Position/Representation</th>
<th>Ethnicity</th>
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</thead>
<tbody>
<tr>
<td>Leticia McCoy</td>
<td>Family Partner Community Action Marin</td>
<td>African American, Former Consumer</td>
</tr>
<tr>
<td>Vinh Luu</td>
<td>Asian Advocacy Project Marin Link</td>
<td>Asian / Pacific Islander</td>
</tr>
<tr>
<td>Douglas Mundo</td>
<td>Executive Director Canal Welcome Center</td>
<td>Latino</td>
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<tr>
<td>Julie Madjoubi-Lehman</td>
<td>Spahr Center</td>
<td>Palestinian, Former Consumer, LGBTQ</td>
</tr>
<tr>
<td>Sandy Ponek</td>
<td>Program Director, Canal Alliance</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Name</td>
<td>Position/Representation</td>
<td>Ethnicity</td>
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<tr>
<td>Daron Austin</td>
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<td>African American</td>
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<tr>
<td>Maya Gladstern</td>
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<tr>
<td>Cat Wilson</td>
<td>San Rafael</td>
<td>Jewish, Consumer</td>
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<tr>
<td>Cheryl August</td>
<td>San Rafael</td>
<td>Jewish, Former Consumer</td>
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<tr>
<td>Kerry Peirson</td>
<td>Mill Valley</td>
<td>African American, Family Member, Older Adult</td>
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<tr>
<td>Maria Benet</td>
<td>San Rafael</td>
<td>Caucasian</td>
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<tr>
<td>Alexis Wise</td>
<td>Marin City</td>
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</tr>
<tr>
<td>Oscar Curry</td>
<td>Mill Valley</td>
<td>African American</td>
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## Appendix III – Wet Steering Committee Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Representation</th>
<th>Ethnicity</th>
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<tbody>
<tr>
<td>Cesar Lagleva</td>
<td>BHRS’ Ethnic Services and Training Manager</td>
<td>Asian/Pacific Islander</td>
</tr>
<tr>
<td>Nick Avila</td>
<td>BHRS Bilingual Mental Health Practitioner</td>
<td>Latino</td>
</tr>
<tr>
<td>Barbara Coley</td>
<td>Community Action Marin-Enterprise Resource Center program supervisor</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Leticia McCoy</td>
<td>Community Action Marin-Family Partner</td>
<td>African American</td>
</tr>
<tr>
<td>Afriye Quamina</td>
<td>Family member representative</td>
<td>African American</td>
</tr>
<tr>
<td>Homer Hall</td>
<td>Consumer member representative</td>
<td>African American</td>
</tr>
<tr>
<td>Leah Fagundes</td>
<td>Community Action of Marin—ERC supervisor and family consumer representative</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Marisa Smith</td>
<td>Consumer member representative</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Mark Parker</td>
<td>Consumer member representative</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Maya Gladstern</td>
<td>Mental Health Advisory Board member, MHSA Advisory Board member, family member representative</td>
<td>Caucasian</td>
</tr>
<tr>
<td>Terry Fierer</td>
<td>Consumer member representative</td>
<td>Caucasian</td>
</tr>
</tbody>
</table>
California Mental Health Services Authority  
Statewide Prevention & Early Intervention (PEI) Project  

FY 2016-2017 Reach and Impact in Marin County

Marin County contribution to the Statewide PEI Project in FY 2016-2017: $75,000

The Statewide PEI Project: Achieving More Together
In Fiscal Year 2016-2017, 41 counties collectively pooled local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the Statewide PEI Project. The Statewide PEI Project is publicly known as Each Mind Matters: California’s Mental Health Movement, which represents an umbrella name and vision to amplify individual efforts from the county and other organizations that are taking place across California under a united movement to reduce stigma and discrimination and prevent suicides.

Strategies of the Statewide PEI Project in Fiscal Year 2016-2017
In Fiscal Year 2016-2017, funding to the Statewide PEI Project supported programs such as maintaining and expanding public awareness and education campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to county agencies, schools and community based organizations, providing mental health/stigma reduction trainings to diverse audiences, engaging youth through the Directing Change program, and building the capacities of schools to address mental health, stigma reduction and suicide prevention.

Outcomes to Date
Since counties began pooling funds through CalMHSA to implement the Statewide PEI Project in 2011, the following short-term outcomes have been achieved. Given the outcomes so far, independent evaluators of the Statewide PEI Project, the RAND Corporation, have identified the following outcomes from the Statewide PEI Project:

- 15.4% more Californians exposed to Each Mind Matters turn to help for mental health challenges.
- Over 50% of Californians were exposed to Know the Signs.
- Individuals exposed to the Know the Signs campaign report higher levels of confidence to intervene with someone at risk for suicide.¹
- The Know the Signs campaign was rated by experts to be aligned with best practices and be one of the best media campaigns on the subject.²

¹ https://www.rand.org/pubs/research_reports/RR1134.html  
² https://www.rand.org/pubs/research_reports/RR818.html
Students exposed to the Walk In Our Shoes website demonstrate significantly higher knowledge of mental health.3

63% of teachers and administrators who saw the Walk In Our Shoes performance started a conversation about mental health in the classroom.4

87% of students have a better understanding of mental illness and suicide after participating in Directing Change.5

97% of students who participated in Directing Change pledged to support a friend with a mental health challenge.6

87% of those who completed the Kognito training report that they are better prepared to identify, approach and refer students exhibiting signs of psychological distress.7

66% of California Community College faculty who completed Kognito training report an increase in the number of conversations they had with other faculty and staff about students that they were concerned about.8

Statewide achievements in FY 2016-2017

The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of Each Mind Matters is critical for creating a culture of mental health and wellness regardless of where individuals live, work or play. Key statewide achievements of the Statewide PEI Project in FY 2016-2017 include:

- Reaching the milestone of disseminating over 1 million lime green ribbons
- Over 1 million hardcopy materials were disseminated in counties, schools, and CBOs
- Over 450 people attended the inaugural Each Mind Matters webinar series
- Over $250,000 in mini-grant funds were provided to CBOs, NAMI affiliates, Active Minds Chapters and Community Colleges to host community outreach events utilizing Each Mind Matters resources and messaging
- The Directing Change Program received over 480 videos submissions from over 100 schools across California, engaging over 1,300 students
- Over 25 new Each Mind Matters culturally adapted resources were developed
- Over 70 news broadcasts, news articles and radio reports discussed programs implemented by the Statewide PEI Project
- Nearly 700 county agencies, schools, local and statewide organizations across California were touched by programs implemented by the Statewide PEI Project

3 http://walkinourshoes.org/content/NORCReportonWIOSWebsite.pdf
4 http://walkinourshoes.org/content/NORCReportonWIOSWebsite.pdf
7 https://www.rand.org/pubs/research_reports/RR954.html
8 https://www.rand.org/pubs/research_reports/RR954.html
Projected Outcomes of the Statewide PEI Project
Changing the current culture around mental health and suicide prevention requires a long-term commitment. Ongoing investment in the unprecedented statewide investment in strategies implemented by the Statewide PEI Project PEI will result in larger social impact (e.g., changing attitudes, increasing knowledge, and modifying behaviors) by implementing programs that can benefit counties regionally and statewide, procuring resources at lower cost (e.g., cost efficiencies), and ultimately making a significant impact on preventing mental illnesses from becoming severe.

Projected 10 year outcomes:
- Increased intervention and provision of support by a community helper
- Increased proactive inclusion of individuals with mental health challenges
- Increased community encouragement and acceptance of seeking services early
- Increased knowledge and skills for recognizing and facilitating help seeking

Projected 20 year outcomes:
- Reduced discrimination against persons with mental illnesses
- Reduced social isolation and self-stigma
- Improved functioning at school, work, home and in the community
- Reduced suicidal behavior
- Reduced societal costs related to untreated mental illness

The information below provides a comprehensive summary of activities that were implemented by CalMHSA Statewide PEI Project contractors and their subcontractors in 2016-2017:
- RSE
- The Directing Change Program and Film Contest
- Each Mind Matters Outreach & Engagement
- NAMI California
- Active Minds
- California Community Colleges Student Mental Health Program
- RAND Corporation

Organizations Reached
In FY 2016-2017, 8 local county agencies, schools and organizations received outreach materials, a training, technical assistance or a presentation about stigma reduction, suicide prevention and/or student mental health through the collective efforts of all programs implemented under the Statewide PEI Project. These include:
County agencies
- Marin County Mental Health and Substance Abuse Services

K-12 Schools and School Systems
- Redwood High School

Colleges & Universities
- College of Marin

Local Community Based Organizations
- FSA Marin Crisis Hotline
- The Spahr Center
- Suicide Prevention & Community Counseling Buckelew Programs
- Congregation Rodef Shalom
- NAMI Marin

Training, Presentations and Outreach

Trainings, presentations and other forms of in-person outreach provide additional skills and knowledge to communities about stigma reduction and suicide prevention. Multitudes of individuals were reached through trainings, presentations and various outreach efforts with stigma reduction, suicide prevention and student mental health messages, resources, tools and materials through the collective efforts of all programs implemented under the Statewide PEI Project. These include:

*Trainings*: Trainings allow community members to learn valuable skills in how to address stigma reduction and suicide prevention

- **Kognito Suicide Prevention and Mental Health trainings**: Online avatar-based suicide prevention and mental health trainings for college students, faculty and staff. All California Community Colleges staff and students were provided with the opportunity to utilize the Kognito training.
  - Total number of student, faculty and staff trained: 135
  - Campuses that participated in the training: College of Marin
- **Directing Change Judges Training**: Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, as a platform for judging submitted Directing Change videos
  - Total number of people trained: 1
  - Organizations that received the training: Comedy that Counts for Mental Health
- **Suicide Prevention Media Messaging Training**: In person trainings targeted to reach members of the media and public information officers and focused on how to appropriately create messages and report on suicide.
  - Total number of people trained: 8
- **California Community College Student Mental Health Trainings**: Distance learning training and technical assistance webinars for campus staff on relevant topics to improve local community colleges’ student mental health programs and services.
  - Total number of people trained: 1
  - Training topics: Crisis Text Line
  - Campuses receiving the training: College of Marin

*E-Newsletters*: Online communications for various audience to engage them in Each Mind Matters, stigma reduction and suicide prevention.

- **Each Mind Matters Insiders Newsletter**: A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California’s Mental Health Movement.
  - Total number of Each Mind Matters Insider Newsletter Subscribers: 2
  - Organizations subscribed: Congregation Rodef Sholom

### Technical Assistance

Technical assistance (TA) is provided by all Statewide PEI Project contractors, each targeting a different audience. Technical assistance includes providing crisis support, capacity building, guidance, and resource navigation on stigma reduction, suicide prevention and student mental health. It also includes building and maintaining a statewide network of providers and organizations who collaborate and learn from each other to implement more effective efforts and reach broader audiences. In addition, an Each Mind Matters Resource Navigation Team provides regular communication in the form of in person meetings and TA emails covering a range of topics with practical tools and information. During the FY 2016-2017, sixteen TA emails covered topics such as the Suicide Prevention and Mental Health Awareness Month Toolkits, Veteran’s Mental Health, Supporting PEI Efforts in Schools and others.

### Dissemination of Hardcopy Materials

Between July 1, 2016 and June 30, 2017, a total of **13,976** physical, hardcopy materials across Each Mind Matters programs and initiatives were disseminated throughout Marin County. In addition, county contacts received numerous emails to access and share resources electronically via the Each Mind Matters Resource Center (www.emmresourcecenter.org).
- Each Mind Matters Promotional Items: 2,120
- Each Mind Matters Educational Materials: 2,485
- SanaMente Materials: 521
- Know the Signs/El Suicidio Es Prevenible Educational Materials: 7,775
- Directing Change Materials: 15
- California Community College Student Mental Health Program Materials: 1,060

**Mini-Grants and Sponsorships**

As a part of the Statewide PEI Project, mini-grants and sponsorships are awarded to local community based organizations, schools, and clubs/chapters/affiliates to grow the Each Mind Matters movement across the state through increasing reach and dissemination, and implementing community events and activities. Mini-grants and sponsorships awarded in FY 2016-2017 include:

- **Each Mind Matters Mini-Grants**
  - Total funding amount granted: $4,000
  - Recipient name: Rodef Shalom
    - Activity: Mental Health Shabbat kickoff for mental health awareness month; Speaker Night featuring Mary & Elin Widdifield (authors of Behind the Wall: The True Story of Mental Illness)

- **NAMI Affiliate May is Mental Health Month Mini-Grant**
  - Total funding amount granted: $1,000
  - Recipient name: NAMI Marin
    - Activity: NAMI Marin “Cognitive Behavioral Therapy for Psychosis Conference”
      - NAMI Marin partnered with other local organizations to host a 3-day conference on cognitive behavioral therapy for psychosis which had over 140 attendees. The event targeted the African American and Latino communities.
The Directing Change program offers young people the exciting opportunity to participate in the movement by creating 60-second films about suicide prevention and mental health that are used to support awareness, education and advocacy efforts on these topics. NORC at the University of Chicago conducted a comprehensive cross-sectional control study in 2017. Findings from the study found Directing Change to be highly effective in increasing knowledge, behavior and attitudinal outcomes related to suicide prevention and mental health and demonstrated changes in school climate. In addition to providing technical assistance and social media engagement:

- Total number of films submitted: 1
- Schools, organizations and colleges/universities that submitted videos: Redwood High School
- Total number of youth participating: 10
California Mental Health Services Authority  
Statewide Prevention & Early Intervention (PEI) Project  

FY 2016/2017 Reach and Impact in California

The Statewide PEI Project: Achieving More Together
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² https://www.rand.org/pubs/research_reports/RR818.html
³ http://walkinourshoes.org/content/NORCReportonWIOSWebsite.pdf
● 63% of teachers and administrators who saw the Walk In Our Shoes performance started a conversation about mental health in the classroom.\(^4\)
● 87% of students have a better understanding of mental illness and suicide after participating in Directing Change.\(^5\)
● 97% of students who participated in Directing Change pledged to support a friend with a mental health challenge.\(^6\)
● 87% of those who completed the Kognito training report that they are better prepared to identify, approach and refer students exhibiting signs of psychological distress.\(^7\)
● 66% of California Community College faculty who completed Kognito training report an increase in the number of conversations they had with other faculty and staff about students that they were concerned about.\(^8\)

Statewide achievements in FY 2016-2017
The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of Each Mind Matters is critical for creating a culture of mental health and wellness regardless of where individuals live, work or play. Key statewide achievements of the Statewide PEI Project in FY 2016-2017 include:
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● Over 450 people attended the inaugural Each Mind Matters webinar series
● Over $250,000 in mini-grant funds were provided to CBOs, NAMI affiliates, Active Minds Chapters and Community Colleges to host community outreach events utilizing Each Mind Matters resources and messaging
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● Over 25 new Each Mind Matters culturally adapted resources were developed
● Over 70 news broadcasts, news articles and radio reports discussed programs implemented by the Statewide PEI Project
● Nearly 700 county agencies, schools, local and statewide organizations across California were touched by programs implemented by the Statewide PEI Project

Accolades from community members
Programs implemented under the Statewide PEI Project received numerous accolades from community members who benefit from these programs. A few examples include:

\(^4\) http://walkinourshoes.org/content/NORCReportonWIOSWebsite.pdf
\(^7\) https://www.rand.org/pubs/research_reports/RR954.html
\(^8\) https://www.rand.org/pubs/research_reports/RR954.html
The information, coupled with the fact that Black people are featured on the cover of this the African American Mental Health Support Guide serves to help reduce stigma for Black people and to help us understand that seeking help is a positive and a sign of strength and not a negative and a sign of weakness. — Community Member, Alameda County

We have been thanked for our messages and for wearing the lime green ribbons on several occasions. I was leaving an event and going to the airport and had my ribbon on. One passenger came to me and said, “Thank you for wearing your green ribbon, I know what it stands for and it means a lot to me”. Another passenger asked me about the ribbon. When I explained what it was for, he said that he needed to get one. I took mine off and handed it to him and he was so proud to put it on. — Valley Oak Children’s Services

We appreciated the training on AB 2246. Great content and format for the training and your passion shines through to support making a difference - Daryl Thiesen, Kern County Superintendent of Schools

I was really impressed with the quality of materials and down to earth professional trainers NAMI had for us that day of training. For me the strongest part of the training was how simple yet impacting the information provided was and how the trainers effectively delivered the information we will need as presenters. - MH101 Presenter at the MH101 Presenter Training

The Each Mind Matters mini-grant funds went to expand awareness into various Plumas County communities that may not have previously a full understanding of stigma and discrimination reduction. The return on this investment was quickly evidenced by the increased number of people coming into our sites - especially the Quincy and Portola Family Resource Centers - taking a moment to congregate, share and help one another with their obstacles, problems or celebrations! - Plumas Crisis Intervention & Resource Center

Hello, I just want to tell you that I am very excited that there are more resources in Spanish about mental health. I work at a nonprofit in Escondido, CA. and received a grant to develop a curriculum on mental health and spirituality. The resources that you offer will make it very useful to include in our training. — Received via the Contact Us form on SanaMente.org

After participating in the Directing Change program, students now can recognize that someone who appears to be in a great mood but is giving their stuff away may be suffering. They recognize behavior that is incongruous with apparent mood or general attitudes — Teacher participating in Directing Change

Projected Outcomes of the Statewide PEI Project
Changing the current culture around mental health and suicide prevention requires a long-term commitment. Ongoing investment in the unprecedented statewide investment in strategies
implemented by the Statewide PEI Project PEI will result in larger social impact (e.g., changing attitudes, increasing knowledge, and modifying behaviors) by implementing programs that can benefit counties regionally and statewide, procuring resources at lower cost (e.g., cost efficiencies), and ultimately making a significant impact on preventing mental illnesses from becoming severe.

Projected 10 year outcomes:
- Increased intervention and provision of support by a community helper
- Increased proactive inclusion of individuals with mental health challenges
- Increased community encouragement and acceptance of seeking services early
- Increased knowledge and skills for recognizing and facilitating help seeking

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- Reduced discrimination against persons with mental illnesses
- Reduced social isolation and self-stigma
- Improved functioning at school, work, home and in the community
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The information below provides a comprehensive summary of activities that were implemented by CalMHSA Statewide PEI Project contractors and their subcontractors in 2016-2017:
- RSE
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- Each Mind Matters Outreach & Engagement
- NAMI California
- Active Minds
- California Community Colleges Student Mental Health Program
- RAND Corporation

## Organizations Reached

In FY 2016-2017, **more than 700** local county agencies, schools and organizations received outreach materials, a training, technical assistance or a presentation about stigma reduction, suicide prevention and/or student mental health through the collective efforts of all programs implemented under the Statewide PEI Project. See Appendix A for a comprehensive list of organizations reached by the Statewide PEI Project.
Trainings, presentations and other forms of in-person outreach provide additional skills and knowledge to communities about stigma reduction and suicide prevention. Multitudes of individuals were reached through trainings, presentations and various outreach efforts with stigma reduction, suicide prevention and student mental health messages, resources, tools and materials through the collective efforts of all programs implemented under the Statewide PEI Project. These include:

**Trainings:**

- **Each Mind Matters webinars:** Online trainings available to all Californians that included an introduction to the movement, resources available, stigma and discrimination reduction, suicide prevention, and more.
  - Total number of webinars implemented: 6
  - Total number of people attending the webinars: 464 live attendees with 661 webinar recording views

- **Kognito Suicide Prevention and Mental Health trainings:** Online avatar-based suicide prevention and mental health trainings for college students, faculty and staff. All California Community Colleges staff and students were provided with the opportunity to utilize the Kognito training.
  - Total number of student, faculty and staff trained: 12,359
  - Campuses that participated in the training: 102

- **NAMI Mental Health 101 Training of Presenters:** In person training to develop new Mental Health 101 trainers. Participants were provided with in-depth information and tools to help them facilitate the presentation as well as to effectively tell their story within a limited timeframe.
  - Total number of presenters trained: 44

- **NAMI on Campus Trainings:** Mental health and stigma reduction trainings to support NAMI on Campus chapters
  - Total number of trainings provided: 3
  - Total number of people trained: 60

- **NAMI Ending the Silence Training:** In person presenter training which allows for NAMI affiliates that have never offered the program to get presenters trained
  - Total number of presenters trained: 8

- **Directing Change AB 2246 Trainings:** In person trainings on programs, policies and procedures that education systems can use to meet the requirements of AB 2246
  - Total number of people trained: 299
  - Total number of education systems that participated in training: 91

- **School-Based Trainings:** These trainings covered an overview of the spectrum of suicide prevention in the school setting, how to identify and respond to students at risk for suicide, postvention planning and an overview of additional suicide prevention trainings, resources and programs.
  - Total number of people trained: 248
  - Total number of schools and school systems that participated in the training: 19
- **Directing Change Judges Training**: Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, as a platform for judging submitted Directing Change videos
  - Total number of people trained: 217

- **QPR Trainings in Schools**: In person suicide prevention gatekeeper trainings
  - Total number of people trained: 340

- **Mental Health First Aid Trainings in Schools**: In person trainings about how to help a person who may be experiencing a mental health related crisis or problem
  - Total number of people trained: 59

- **El Rotafolio Suicide Prevention Training**: In person training prepares community health workers and others who work with Spanish-speaking community to conduct Spanish suicide prevention community presentations through a two-day Spanish workshop that provides SafeTALK, a review of the Reconozca Las Senales campaign and opportunity to practice the presentation with the aid of a Spanish language flipchart.
  - Total number of people trained: 84

- **Suicide Prevention Media Messaging Training**: In person trainings targeted to reach members of the media and public information officers and focused on how to appropriately create messages and report on suicide.
  - Total number of people trained: 58

- **California Community College Student Mental Health Trainings**: Distance learning training and technical assistance webinars on relevant topics to improve local community colleges’ student mental health programs and services.
  - Total number of people trained: 347
  - Training topics: Trauma Informed Care; HIPPA/FERPA; Crisis Text Line

- **Suicide Prevention Primary Care Training**: In person trainings on how primary care practices can address suicide prevention
  - Total number of people trained: 31

**Presentations**

- **Each Mind Matters Conferences and Presentations**
  - Total number of conferences: 15
  - Conferences receiving Each Mind Matters presentations: California Health and Science Association Student Leadership Conference; California Student Mental Wellness Conference; California Mental Health Advocates for Children and Youth Conference; Central Valley Latino Conference; “R U Okay?” Youth Suicide Prevention Summit; Fresno County Suicide Prevention Taskforce; Central Valley Truancy Summit; UC Diversity Conference; Didi Hirsch Suicide Prevention Gatekeeper Training; San Diego County Suicide Prevention Committee; San Diego County HHS Aging and Independent Services; NAMI San Diego Directing Change Screening; Live Well Collaborative; St Vincent School
• **NAMI Mental Health 101 Presentations:** In person presentations that give individuals an opportunity to learn about mental illness through presentations, personal testimonies and videos that represent a variety of cultures, beliefs and values
  - Total number of presentations conducted: 97
  - Total number of people in attendance: 1,372

• **NAMI Ending the Silence Presentations:** In-school presentations for students to learn about mental illness directly from family members and individuals living with mental illness themselves
  - Total number of presentations conducted: 151
  - Total number of students in attendance: 7,312

• **Active Minds Speakers Bureau Presentations:** In-person presentations by speakers who are trained to use their personal story to raise awareness about mental health
  - Total number of presentations conducted: 12
  - Total number of people in attendance: 3,235

**Outreach/Events:**

• **Active Minds Chapter Events:** Active Minds Chapters utilized Each Mind Matters materials and messaging to host outreach events on their higher education campuses
  - Total estimated number of attendees: 137,351
  - Total number of campuses where Active Minds Chapter Events occurred: 26

• **Community College Outreach Events:** The Foundation for California Community Colleges and their local campuses conduct mental health outreach to campuses utilizing Each Mind Matters materials and messaging
  - Total estimated number of attendees: 8,279
  - Total number of campuses where Community College Outreach Events occurred: 20

• **Each Mind Matters Tabling:** The Each Mind Matters Outreach & Engagement Team and Resource Navigators tabled at various conferences to engage conference attendees with Each Mind Matters materials and messages
  - Total number of conferences where Each Mind Matters tabling occurred: 9

• **Active Minds Send Silence Packing Exhibits:** Campuses across California received a discounted rate to receive the Send Silence Packing exhibit, which publicly displays backpacks on campus grounds representing youth suicide deaths to begin a conversation about suicide prevention.
  - Total estimated number of students reached: 34,000
  - Total number of campuses that displayed the Send Silence Packing Exhibit: 25

• **Each Mind Matters Youth Mixer:** Each Mind Matters hosted a Youth Mixer at the 2016 NAMI California conference, creating a safe space for young conference attendees to meet and engage in Each Mind Matters through social media contests, live performances, and lime green ribbon activities, while receiving Each Mind Matters resources
  - Total number of conference attendees reached: 50

**E-Newsletters:**
Each Mind Matters Insiders Newsletter: A monthly electronic newsletter created specifically for service providers that provides information about relevant resources, upcoming events and opportunities for providers to get involved in California’s Mental Health Movement.
- Total number of Each Mind Matters Insider Newsletter Subscribers: 312

Each Mind Matters Community Newsletter: A monthly electronic newsletter created for community members to engage all Californians in the mental health movement.
- Total number of Each Mind Matters Community Newsletter Subscribers: 4,960

The California Community Colleges Student Mental Health Program Newsletter: A monthly electronic newsletter that engages individuals from the California Community Colleges about mental health and includes information about Each Mind Matters resources.
- Total number of California Community College Newsletter Subscribers: 2,933

Technical Assistance

Technical assistance (TA) is provided by all Statewide PEI Project contractors, each targeting a different audience. Technical assistance includes providing crisis support, capacity building, guidance, and resource navigation on stigma reduction, suicide prevention and student mental health. It also includes building and maintaining a statewide network of providers and organizations who collaborate and learn from each other to implement more effective efforts and reach broader audiences. In addition, an Each Mind Matters Resource Navigation Team provides regular communication in the form of in person meetings and TA emails covering a range of topics with practical tools and information. During the FY 2016-2017, sixteen TA emails covered topics such as the Suicide Prevention and Mental Health Awareness Month Toolkits, Veteran’s Mental Health, Supporting PEI Efforts in Schools and others. During FY 2016-2017, specific TA consultations included:

- TA to counties
  - Total number of TA consultations: 335
- TA to CBOs
  - Total number of TA consultations: 131
- TA to schools
  - Total number of TA consultations: 43
- TA to NAMI affiliates and programs
  - Total number of TA consultations: 73
- TA to Active Minds Chapters
  - Total number of TA consultations: 686
  - Total number of new Active Minds Chapters that resulted from TA: 8

Dissemination and Website Visits
Between July 1, 2016 and June 30, 2017, a total of **1,098,863** physical, hardcopy materials across Each Mind Matters programs and initiatives were disseminated throughout California. In addition, individuals in the state received numerous emails to access and share resources electronically via the Each Mind Matters Resource Center (www.emmresourcecenter.org).

- **Each Mind Matters Promotional Items**: 213,400
- **Each Mind Matters Educational Materials**: 183,039
- **SanaMente Materials**: 51,958
- **Know the Signs/El Suicidio Es Prevenible Educational Materials**: 421,577
- **Directing Change Materials**: 3,682
- **Walk In Our Shoes/Ponte En Mis Zapatos Materials**: 1,795
- **California Community College Student Mental Health Program Materials**: 223,412

The Statewide PEI Project supports the following campaign and program websites. All resources encourage recipients to visit these websites to learn more about mental illness stigma, mental health and suicide prevention. These websites allow for all Californians to engage and learn about Each Mind Matters and join in the Mental Health Movement. In FY 2016-2017:

- **EachMindMatters.org**
  - Total visits to the website: 52,609
  - Total unique visitors to the website: 39,648
- **SanaMente.org**
  - Total visits to the website: 1,989
  - Total unique visitors to the website: 1,307
- **SuicideIsPreventable.org**
  - Total visits to the website: 26,636
  - Total unique visitors to the website: 20,941
- **ReconozcaLasSenales.org**
  - Total visits to the website: 3,481
  - Total unique visitors to the website: 2,751
- **DirectingChange.org**
  - Total visits to the website: 36,529
  - Total unique visitors to the website: 21,387
- **WalkInOurShoes.org**
  - Total visits to the website: 7,119
  - Total unique visitors to the website: 5,046
- **PonteEnMisZapatos.org**
  - Total visits to the website: 281
  - Total unique visitors to the website: 223
- **CCCStudentMentalHealth.org**
Total visits to the website: 240,085
Total unique visitors to the website: 40,772

**RAND’s CalMHSA Reports page** (The Statewide PEI Project does not fund the hosting or maintenance of this page)
Total visits to the website: 14,092
Total unique visitors to the website: 9,740

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### Mini-Grants and Sponsorships

As a part of the Statewide PEI Project, mini-grants and sponsorships are awarded to local community based organizations, schools, and clubs/chapters/affiliates to grow the Each Mind Matters movement across the state through increasing reach and dissemination, and implementing community events and activities. Mini-grants and sponsorships awarded in FY 2016-2017 include:

- **Each Mind Matters Mini-Grants**
  - Total number of recipients: 27
  - Total funding amount granted: $142,000
  - Recipients:
    - American Association of Marriage and Family Therapists
    - California Black Health Network
    - California Consortium for Urban Indian Health
    - California Youth Connection
    - Earth Mama Healing
    - Fresno Center for New Americans
    - Gay and Lesbian Community Services Center of Orange County
    - NAMI San Diego
    - Native Dad’s Network
    - Mental Health America of Northern California
    - Peers Envisioning and Engaging in Recovery Services
    - Rainbow Community Center
    - Rodef Shalom
    - The Village Project
    - The Wall Las Memorias Project
    - Transitions Mental Health Association
    - Alliance for Community Transformation and Wellness
    - Valley Oak Children’s Services
    - VietCARE
    - Stonewall Alliance of Chico
    - Northern Valley Catholic Social Services
    - Safe Haven Stamp Out Stigma Fund
    - United Way Monterey County
Advocates for Mentally Ill Housing
Tahoe Truckee Unified School District
Plumas Crisis Intervention and Resource Center

Each Mind Matters School Sponsorships
- Total number of recipients: 34
- Total funding amount granted: $17,000
- Recipients:
  - Diablo Valley College
  - Ohlone College
  - CSU East Bay
  - UC Berkeley
  - Bakersfield College
  - Artesia High School
  - Sierra Vista High School
  - CSU Dominguez Hills
  - CSU Los Angeles
  - Napa Valley College
  - Santa Ana College
  - Santiago Canyon College
  - Dana Hills High School
  - Savanna High School
  - UC Irvine
  - Tahquitz High School
  - Miramar College
  - Palomar College
  - San Diego City College
  - Helix Charter High School
  - Mount Everest High School
  - Preuss High School
  - San Marcos High School
  - CSU San Diego
  - CSU San Marcos
  - UC San Diego
  - City College of San Francisco
  - UC San Francisco
  - Santa Barbara City College
  - Gavilan College
  - West Valley College
  - UC Santa Cruz
  - Sonoma Valley High School
  - UC Davis

SanaMente Mini-Grants
- Total number of recipients: 4
- Total funding amount granted: $20,000
- Recipients:
  - Transitions Mental Health Association
  - LGBT Center Orange County
  - Latino Service Providers of Sonoma County
  - Health Education Council

Each Mind Matters/Directing Change Mini-Grants
- Total number of recipients: 13
- Total funding amount granted: $6,500
- Recipients:
- Boys & Girls Club of San Gorgonio Pass
- Claremont High School
- Torrey Pines High School
- Whitney High School
- Franklin High School
- Murrietta Valley High School
- San Juan Hills High School
- Kennedy High School
- Irvington High School
- Pleasant Valley High School
- Foothill High School
- Canyon High School
- Riverside Youth Treatment & Education Center

**NAMI Bebe Moore Campbell Minority Mental Health Awareness Month Mini-Grants**
- Total number of recipients: 8
- Total funding amount granted: $8,000
- Recipients:
  - NAMI Kern County
  - NAMI Urban Los Angeles
  - NAMI Antelope Valley
  - NAMI San Fernando Valley

**NAMI on Campus High School Club Mini-Grants**
- Total number of recipients: 8
- Total funding amount granted: $4,000
- Recipients:
  - Chino Hills High School NCHS Club
  - La Jolla High School NCHS Club
  - La Quinta High School NCHS Club
  - Sierra Vista High School NCHS Club
  - Los Altos High School NCHS Club
  - Olympian High School NCHS Club
  - Ruben S. Ayala High School NCHS Club
  - Torrey Pines High School NCHS Club

**NAMI Affiliate May is Mental Health Month Mini-Grant**
- Total number of recipients: 14
- Total funding amount granted: $14,000
- Recipients:
  - NAMI Santa Clara
  - NAMI San Diego
  - NAMI El Dorado County
  - NAMI Mt. San Jacinto
  - NAMI San Francisco
  - NAMI Pomona Valley
  - NAMI Sacramento
  - NAMI Western Riverside County
  - NAMI Solano County
Active Minds also provided mini-grants to a cohort of Active Minds Chapters to support the implementation of innovative mental health programs on their campuses to impact increase students' knowledge, attitude, and behaviors around mental health. These students also effectively implemented the longitudinal RAND program evaluation on their campuses.

- **Active Minds Program Implementation & Evaluation Cohort Mini-Grant**
  - Total number of recipients: 11
  - Total funding amount granted: $55,299
  - Recipients:
NAMI also provided sponsorships to NAMI affiliates to support the implementation of Mental Health 101 and Ending the Silence presentations for community members.

- **NAMI Mental Health 101 Sponsorships**
  - Total number of recipients: 7
  - Total funding amount granted: $12,375
  - Recipients:
    - NAMI Sonoma County
    - NAMI Mt. San Jacinto
    - NAMI San Francisco
    - NAMI Sacramento
    - NAMI San Gabriel
    - NAMI San Fernando
    - NAMI Alameda County South

- **NAMI Ending the Silence Sponsorships**
  - Total number of recipients: 4
  - Total funding amount granted: $18,750
  - Recipients:
    - NAMI Sonoma County
    - NAMI Mt. San Jacinto
    - NAMI San Francisco
    - NAMI Orange County

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**Directing Change**

The Directing Change program offers young people the exciting opportunity to participate in the movement by creating 60-second films about suicide prevention and mental health that are used to support awareness, education and advocacy efforts on these topics. NORC at the University of Chicago conducted a comprehensive cross sectional control study in 2017. Findings from the study found Directing Change to be highly effective in increasing knowledge, behavior and attitudinal outcomes related to suicide prevention and mental health and demonstrated changes in school climate. In addition to providing technical assistance and social media engagement:

- Total number of films submitted: 489
- Schools, organizations and colleges/universities that submitted videos: 113
- Total number of youth participating: 1,343
- Total number of views of Directing Change videos on YouTube: 34,701
New Materials and Resources

During FY 2016-2017, the Statewide PEI Project prioritized working with stakeholders to determine resource gaps in mental health awareness and suicide prevention materials and and developed new materials and resources to address these gaps. The new materials were developed by stakeholders with input from subject matter experts as needed, reviewed by multiple stakeholder groups across the state for feedback, and tested with target audience focus groups for additional input. The materials developed included:

For African American Communities:
- Mental Health Support Guide for the African American Community
- Know The Signs campaign refresh including a new poster reaching helpers in the African American Community

For Chinese Communities:
- Mental Health Support Guide for Chinese American Communities in Traditional and Simplified Chinese

For Community College Faculty & Staff:
- Trauma Informed Care Fact Sheet
- Mental Health 101 Primer
- Disabled Students Programs and Services (DSPS) for Students with Mental Health Disabilities

For General Public (English):
- An update of the Know the Signs campaign website, brochure and tent card
- September Suicide Prevention Awareness Week, October Mental Health Awareness Week, and May Mental Health Awareness Month toolkits with new activity ideas and guides
- NAMI Mental Health 101 Presentations for Diverse Communities training manual
- NAMI Affiliate Capacity Building Guide

For Latino Communities:
- Reconozca de Senales campaign refresh including new poster, updated brochure and tent card
- SanaMente website refresh and expansion
- SanaMente Mental Health Support Guide for Latino Communities
- SanaMente Mental Health Myths and Facts poster
- SanaMente Depression and Alcohol/Substance Abuse Fact sheets
- Fotonovela activity facilitation guides
- A refresh of the El Rotafolio suicide prevention flipchart
For LGBTQ+ Communities:
- Be True and Be You: A Basic Mental Health Guide for LGBTQ+ Youth guide updated
- LGBT Mental Health and Aging Support Guide
- Provider Fact Sheet on working with LGBTQ+ Latinx Youth

For Men in the Middle Years (English):
- A refresh of the Know the Signs campaign including a poster reaching helpers of men in the middle years
- A comprehensive toolkit including resources, talking points, data briefing, a presentation and activities to support outreach to this audience

For Punjabi Communities:
- Suicide prevention brochure and poster in Punjabi (based on the Know the Signs campaign)

For Russian Communities:
- Mental Health Guide in Russian
- Suicide Prevention Brochure in Russian (based on the Know the Signs campaign)

Evaluation Reports & Resources
- Evaluation Approaches for Mental Health Prevention and Early Intervention Programs Guide for Counties
Appendix A: Comprehensive List of Counties, Organizations and Schools reached through the Statewide PEI Project

**County agencies**

- Alameda County Behavioral Health
- Alpine County Behavioral Health Services
- Amador County Behavioral Health
- Butte County Behavioral Health
- Calaveras County Behavioral Health
- Colusa County Behavioral Health
- Contra Costa County Behavioral Health
- Contra Costa Juvenile Hall
- Del Norte County Behavioral Health
- El Dorado Health and Human Services Agency
- Fresno County Department of Behavioral Health
- Glenn County Mental Health Department
- Humboldt County Department of Health and Humans Services
- Imperial County Behavioral Health
- Inyo County Behavioral Health
- Kern County Mental Health Department
- Kings County Behavioral Health
- Lake County Behavioral Health
- Lassen County Behavioral Health
- Los Angeles Department of Mental Health
- Madera County Behavioral Health
- Marin County Mental Health and Substance Abuse Services
- Mariposa County Behavioral Health
- Mendocino County Behavioral Health, Mental Health and Health and Human Services
- Merced County Behavioral Health
- Modoc County Behavioral Health
- Mono County Behavioral Health
- Monterey County Department of Behavioral Health
- Napa County Health and Human Services Mental Health Division
- Orange County Health Care Agency
- Placer County Health and Human Services
- Placer County Youth Commission
- Placer County Department of Education
- Riverside Mental Health Department
- Riverside County Cultural Competence Program
- Riverside Probation Program
- Sacramento County Health and Human Services, Behavioral Health Services
- Sacramento County Health Education Council
- San Benito County Behavioral Health
- San Bernardino County Department of Behavioral Health
- San Diego County Health Human Services Agency
- San Francisco Department of Public Health
- San Francisco Department of Behavioral Health Services
- San Joaquin County Behavioral Health Services
- San Luis Obispo Behavioral Health
- San Mateo County Health System, Equity Behavioral Health & Recovery Services
- Santa Barbara Department of Alcohol, Drug and Mental Health Services
- Santa Barbara Department of Behavioral Wellness
- Santa Clara County Department of Mental Health
- Santa Cruz Behavioral Health
- Shasta County Public Health Department
- Sierra County Behavioral Health
- Siskiyou County Behavioral Health
- Solano County Health and Human Services, Mental Health Division
- Solano County Sherriff’s Office
- Sonoma County Department of Health Services
- Stanislaus County Behavioral Health and Recovery Services
- Sutter Yuba County Behavioral Health
- Tehama County Behavioral Health
- Tri City Mental Health Services
- Trinity County Behavioral Health
- Tulare County HHSA Mental Health Branch
- Tuolumne County Behavioral Health
- Ventura County Behavioral Health
- Yolo County Behavioral Health

### K-12 Schools and School Systems

**Alameda**
- John Muir Charter Schools
- Irvington High School
- Foothill High School
- James Logan High School
- Dublin High School
- Fremont Unified School District
- Oakland Unified School District

**Butte**
- Chico Unified School District
- Pleasant Valley High School

**Contra Costa**
- Pittsburg High School
- Acalanes High School
- Summit High School

**El Dorado**
- South Tahoe High School

**Butte**
- Central High School
- Buchanan High School
- Clovis East High School
- Coalinga High School
Humboldt
- Eureka High School
- Fortuna High School
- McKinleyville High School
- Mattole Valley Charter School

Imperial
- Calexico High School

Kern
- Cesar E. Chavez High School

Los Angeles
- Los Angeles Unified School District
- East Valley High School
- Claremont High School
- Claremont Unified School District
- Carson High School
- Cleveland Charter High School
- Environmental Charter High School
- John F. Kennedy High School
- Leuzinger High School
- Northview High School
- San Marino High School
- Saugus High School
- St. Lucy's Priory High School
- University High School
- Village Academy High School
- William J. Pete Knight High School
- Arcadia High School
- Beverly Hills High School
- Verdugo Hills High School
- Savanna High School
- Applied Technology Center High School
- Sato Academy of Math and Science
- Sierra Vista High School
- Artsies High School

Madera
- Minarets Charter High School
- Madera South High School

Marin
- Redwood High School

Monterey
- Monterey Peninsula Unified School District
- Greenfield School District
- Salinas Unified School District
- Salinas High School

Orange
- Conservation Corps Charter School
- County Office of Education
- San Juan Hills High School
- Buena Park High School
- Canyon High School
- Katella High School
- Pacific Coast High School
- Paloma Valley High School

The text is a list of high schools located in various counties in California, including Humboldt, Imperial, Kern, Los Angeles, Madera, Marin, Monterey, and Orange. Each county section lists specific high schools within that county.
• La Vista High School
• Pacifica High School
• Sunny Hills High School
• Rancho Alamitos High School
• Cerritos High School
• La Quinta High School
• Garden Grove Unified School District

Placer
• Chilton Middle School
• Whitney High School

Riverside
• Banning High School
• California School for the Deaf Riverside
• Centennial High School
• Encore High School
• Great Oak High School
• Hemet High School
• Jurupa Valley High School
• King High School
• Martin Luther King High School
• Murrieta Valley High School
• NOVA Academy Early College High School
• Nuview Bridge Early College High School
• Riverside Polytechnic High School
• San Jacinto High School
• SiaTech School for Integrated Students
• Temecula High School

Sacramento
• Sacramento County Office of Education
• Franklin High School

San Bernardino
• Valley View High School
• Vista Del Lago High School
• Vista Murrieta High School
• Xavier College Prep High School
• Coachella Valley High School
• Ramona High School
• Tahquitz High School
• Hamilton Elementary School
• Val Verde Unified School District
• Mira Loma Middle School
• San Jacinto School District
• Hyatt Elementary School
• Hamilton High School
• San Jacinto High School
• Hemet High School
• North Mountain Middle School

San Bernardino
• Center High School
• Luther Burbank High School
• San Bernardino County Office of the Superintendent
• Apple Valley High School
• Rim of the World High School

San Diego
• E3 Civic High School
• New Alternatives San Pasquel Academy
• Torrey Pines High School
• Valhalla High School
• Albert Einstein Academy
• Lowell High School

San Francisco
• Ruth Asawa San Francisco School of the Arts
• Make School
• Gateway High School
• Lincoln High School

San Joaquin
• Tracy High School
• Riverbank High School

San Luis Obispo
• Arroyo Grande High School
• Mission College Prep High School
• San Luis Obispo High School

San Mateo
• San Mateo Foster City School District
• Woodside High School
• Aragon High School
• Burlingame High School

Santa Clara
• Stanford Center of Youth Mental Health Well Being
• Evergreen Valley High School
• Los Altos High School

Shasta County
• University Preparatory School

Sonoma
• Windsor High School
• Analy High School
El Molina High School
Rancho Cotate High School
Sonoma Valley High School
San Antonio High School
Cloverdale High School

Casa Grande High School
Sonoma Mountain Alternative High School
Petaluma High School
Laguna High School
Santa Rosa High School

Stanislaus
Valley Charter High School

Tulare
Countryside High School
Redwood High School

Yolo
Davis Senior High School
Da Vinci Charter Academy

Colleges & Universities

Alameda
UC Berkeley
Samuel Merritt University
Chabot College
Berkeley City College
Chabot College

College of Alameda
Laney College
Merritt College
Ohlone College
Las Positas College

Butte
CSU Chico
Butte College

Contra Costa
CSU East Bay
Diablo Valley College

Contra Costa College
Los Medanos College

Del Norte
College of the Redwoods

El Dorado
Lake Tahoe Community College

Fresno
- Clovis Community College
- Fresno City College
- CSU Fresno

Reedley College
West Hills College Coalinga
Willow International Community College

**Humboldt**
- Humboldt State University
- College of the Redwoods

**Imperial**
- Imperial Valley College

**Kern**
- CSU Bakersfield
- Bakersfield College
- Cerro Coso Community College

Porterville College
Taft College

**Kings**
- West Hills College

**Los Angeles**
- USC
- USC Saks Institute
- El Camino College
- UCLA
- Occidental College
- Cal Poly Pomona
- CSU Long Beach
- Cerritos College
- Los Angeles Southwest College
- East Los Angeles College
- Chabot College
- Pepperdine University
- Rio Honda College
- Loyola Marymount University
- Argosy University Los Angeles
- California Lutheran University
- College of the Canyons
- Antelope Valley College

Citrus College
El Camino-Compton Center
Glendale Community College
Long Beach City College
Los Angeles Harbor College
Los Angeles Mission College
Los Angeles Pierce College
Los Angeles Trade-Technical College
Los Angeles Valley College
Mt. San Antonio College
Pasadena City College
Santa Monica College
West Los Angeles College
Compton Community College
Los Angeles City College
CSU Dominguez Hills
CSU Los Angeles

**Marin**
• College of Marin

**Mendocino**
• Mendocino College

**Merced**
• Merced College

**Monterey**
• Hartnell College
• Monterey Peninsula College

**Napa**
• Napa Valley College

**Orange**
• Santa Ana College
• UC Irvine
• Orange Coast College
• CSU Fullerton
• Santiago Canyon College
• Chapman University
• Argosy University Orange County

• Coastline College
• Cypress College
• Fullerton College
• Golden West College
• Saddleback College
• Irvine Valley College

**Placer**
• Sierra College

**Plumas**
• Feather River College

**Riverside**
• Riverside City College
• La Sierra University
• Mount San Jacinto Community College
• California Baptist University
• Moreno Valley College
• UC Riverside

• College of the Desert
• Norco College
• Palo Verde College
• Alliance for Community Transformation and Wellness

**Sacramento**
• Sacramento City College

• Sacramento State University
- American River College
- Folsom Lake College
- Universal Technical Institute
- Cosumnes River College

**San Bernardino**
- Chaffey College
- San Bernardino Valley College
- CSU San Bernardino
- Barstow College
- Crafton Hills College
- Copper Mountain College
- Victor Valley College
- University of the Redlands
- Alliance for Community Transformation and Wellness

**San Diego**
- CSU San Marcos
- Alliant University
- UC San Diego
- San Diego State University
- California Institute of Technology
- University of San Diego
- Argosy University of San Diego
- Cuyamaca College
- Grossmont College
- Mira Costa Community College
- Palomar College
- San Diego City College
- San Diego Mesa College
- San Diego Miramar College
- Southwestern College

**San Francisco**
- Alliant University
- San Francisco State University
- City College of San Francisco
- University of San Francisco
- UCSF

**San Joaquin**
- San Joaquin Delta College
- College of the Sequoias

**San Luis Obispo**
- Cal Poly San Luis Obispo University
- Cuesta College

**San Mateo**
- College of San Mateo
- Notre Dame de Namur University
- Canada College
- Skyline College

**Santa Barbara**
• UC Santa Barbara
• Westmont College

Santa Clara
• San Jose State University
• West Valley College
• Stanford University
• De Anza College
• Evergreen Valley College

Santa Cruz
• UC Santa Cruz
• Cabrillo College

Shasta
• Shasta College

Siskyou
• College of the Siskiyous

Sonoma
• Santa Rosa Junior College

Stanislaus
• Modesto Junior College

Sutter Yuba
• Yuba College
• Woodland Community College

Tulare
• Porterville College
• College of the Sequoias

Tuolumne
• Columbia College

Ventura
• Moorpark College
• Oxnard College
- Ventura College

**Yolo**
- UC Davis
- Woodland Community College

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<thead>
<tr>
<th>Local CBOs</th>
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<tbody>
<tr>
<td><strong>Alameda</strong></td>
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<tr>
<td>- Crisis Support Services of Alameda County</td>
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<tr>
<td>- Pacific Center for Human Growth</td>
</tr>
<tr>
<td>- Our Space – LGBT Youth Center</td>
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<tr>
<td>- Downtown TAY</td>
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<tr>
<td>- Open Source Wellness</td>
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<td>- PEERS</td>
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<tr>
<td>- The Social Changery</td>
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<td>- Alternatives for Action</td>
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<td>- EFS Scholar</td>
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<tr>
<td>- NAMI East Bay</td>
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<tr>
<td>- NAMI Alameda</td>
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</tbody>
</table>

| **Amador** |
| - Nexus Youth and Family Services |
| - NAMI Amador |

| **Butte** |
| - Stonewall Alliance of Chico |
| - Passages -Area Agency on Aging |
| - NAMI Butte County |
| - Valley Oak Children’s Services |

| **Calaveras** |
| - Wit’s End |

| **Colusa** |
| - Indigenous Circles United |
| - Safe Haven Stamp Out Stigma Fund |

| **Contra Costa** |
| - Contra Costa Crisis Center |
| - Culture to Culture Foundation |
| - Rainbow Community Center |
| - NAMI Contra Costa |
| - FaithNet |
| - Alpha Gamma Xi Military Sorority |

| **El Dorado** |
| - NAMI El Dorado County |

| **Fresno** |
| - Integral Community Solutions Institute |
| - Fresno LGBT Community Center |

Funded by counties through the voter approved Mental Health Services Act (Prop 63)
- Redbud Health Care District
- Fresno Pacific Biblical Seminary
- Youth Empower Centers Program
- Kings View Youth Empowerment
- NAMI Fresno

**Humboldt**
- Humboldt County Transition Age Youth Collaboration

**Kern**
- NAMI Kern County

**Lassen**
- Lassen Aurora Network

**Los Angeles**
- American Foundation for Suicide Prevention Greater Los Angeles
- Chinatown Service Center
- Asian Americans Advancing Justice
- Asian Pacific AIDS Intervention Team
- Pacific Clinics
- Institute for Multicultural Counseling and Education Services
- The Wall Las Memorias Project
- LGBT Center Long Beach
- Los Angeles LGBT Center
- San Fernando Valley LGBT Community Center
- NAMI Glendale

**Marin**
- FSA Marin Crisis Hotline
- The Spahr Center
- Suicide Prevention & Community Counseling Buckelew Programs

**Merced**
- NAMI Merced

- California School Nurses Organization
- Fresno Center for New Americans
- Comprehensive Youth Services
- The Fresno Bee

**Humboldt County Transition Age Youth Collaboration**

**Kern County**
- NAMI Kern County

**Lassen County**
- Lassen Aurora Network

**Los Angeles County**
- American Foundation for Suicide Prevention Greater Los Angeles
- Chinatown Service Center
- Asian Americans Advancing Justice
- Asian Pacific AIDS Intervention Team
- Pacific Clinics
- Institute for Multicultural Counseling and Education Services
- The Wall Las Memorias Project
- LGBT Center Long Beach
- Los Angeles LGBT Center
- San Fernando Valley LGBT Community Center
- NAMI Glendale

**Marin County**
- FSA Marin Crisis Hotline
- The Spahr Center
- Suicide Prevention & Community Counseling Buckelew Programs

**Merced County**
- NAMI Merced
- NAMI Long Beach
- NAMI Pomona Valley
- NAMI San Gabriel
- NAMI South Central LA
- NAMI San Fernando Valley
- NAMI Urban Los Angeles
- NAMI Antelope Valley
- San Gabriel Valley LGBTQ Center
- Penny Lane
- Thuerhur House Lacy Park
- Foundation Ours Inc.
- Unite Here Health
- Didi Hirsch
- Mental Health America Los Angeles

**Congregation Rodef Shalom**
- NAMI Marin
Monterey
- Village Project Inc
- FSA of the Central Coast
- Suicide Prevention Service of the Central Coast
- NAMI Monterey
- Interim Inc
- United Way Monterey

Orange
- Sheriffs Department Juvenile Services Bureau
- Fountain Valley Hospital
- LGBT Center of Orange County
- Saddleback Church
- Norooz Clinic Foundation
- NAMI Orange County
- Providence St. Joseph Medical Center
- Viet-Care
- Gay and Lesbian Community Services Center of Orange County

Placer
- NAMI Placer County
- PRISM-Q LGBT & Allies Resource Center
- Advocates for Mentally Ill Housing

Plumas
- Native Dad’s Network
- Plumas Crisis Intervention and Resource Center

Riverside
- LGBT Community Center of the Desert – Palm Springs
- Victor Community Youth Treatment and Education Center
- Operation SafeHouse Cup of Happy
- CFLC Planet Youth
- Building Resilience in African American Families Rites of Passage
- Safe House of the Desert
- NAMI Temecula Valley
- NAMI Western Riverside
- San Jacinto Unitarian Fellowship
- Innovative Healthcare Consultants
- Mead Valley Community Center – Grove Church
- Grove Community Church – Mead Valley
- Banning Presbyterian Church
- MFI San Jacinto
- CFLC – Hemet/San Jacinto
- St. Patrick Catholic Church
- CASA
- St. Mels Catholic Church
- Perris Lake Ranger Program
- NAMI Mt. San Jacinto
- Grace Lutheran Church
- San Jacinto Cristo Church
- Soboba Indian Reservation
- St. Charles Catholic Church Bloomington
- Sweeney St. Catholic Church
- Moreno Valley St. Patrick Church
- Boys and Girls Club of the San Gorgonio Pass
Sacramento
- Recovery Happens
- Friends for Survival
- Sutter Health Outpatient
- Earth Mama Healing
- Asian Resource Inc.
- Chinese American Council of Sacramento
- Sacramento Chinese Community Service Center
- Community Counseling Transcultural Wellness Center
- Run for Rhett
- Russian Information and Support Services

San Bernardino
- Vision Y Compromiso
- NAMI Inland Valley

San Diego
- St. James Catholic Mental Health Ministry
- North County LGBTQ Resource Center
- San Diego Gay Bisexual Transgender Community Center
- NAMI San Diego
- Urban Beats

San Francisco
- Culture to Culture Foundation
- Chinatown YMCA
- Chinese Community Health Resource Center
- Chinatown Public Health Center
- Southeast Child Family Therapy Center
- Chinatown Child Development Center
- Sunset Mental Health Services
- PEERS

San Joaquin
- The Wellness Center of San Joaquin County

- Slavic Assistance Center
- Community Outreach Academy
- AFISHA CInc
- Sacramento LGBT Community Center
- NAMI Sacramento
- Women Take Back The Night Organization
- UCD Medical Center
- Sierra Vista Hospital
- VA Northern California Health Care System
- Turning Point Community Programs
- Native Dads Network

- Health Rancho Cucamonga Youth Leaders

- Mission Television
- San Diego County Coalition for Mental Health
- California Consortium for Urban Indian Health at the San Diego American Indian Health Center

- RAMS
- Felton Institute
- Jewish Family & Children’s Services of San Francisco
- Curry Senior Center
- Institute on Aging
- San Francisco LGBT Center
- NAMI San Francisco
- Year Up
San Luis Obispo
- Transitions Mental Health Association
- NAMI San Luis Obispo

Santa Barbara
- Pacific Pride Foundation

Santa Clara
- Learning Partnership
- Santa Clara Suicide Prevention
- NAMI Santa Clara County
- Northern California Joining Community Forces
- Momentum for Mental Health

Santa Cruz
- Suicide Prevention Service of the Central Coast
- The Diversity Center
- The Santa Cruz LGBT Community Center
- NAMI Santa Cruz

Shasta
- Circle of Friends
- Hill Country Health and Wellness Center
- Northern Valley Catholic Social Services

Solano
- Solano Pride Center
- NAMI Solano County
- Genentech

Sonoma
- NAMI Sonoma County
- CHOPs Teen Center
- Counsel on Aging
- Graton Labor
- Liliput Children’s Services
- At Home Nursing
- Latino Service Providers of Sonoma County

Stanislaus
- MoPride Inc
- NAMI Stanislaus

Tulare
- The SOURCE LGBT Center
- Turning Point of Central California

Ventura
• American Foundation for Suicide Prevention
• Simi Valley Youth Council

Yolo
• Suicide Prevention and Crisis Services of Yolo County
• NAMI Yolo County
• Health Education Council

Statewide Organizations/Agencies
• California Department of Education
• Active Minds
• Foundation for California Community Colleges
• California State University Office of the Chancellor
• University of California Office of the President
• California Mental Health Advocates for Children and Youth
• Mental Health America of California
• California Alliance of Child and Family Services
• California Academy of Child and Adolescent Psychiatry
• California Association for Licensed Professional Clinical Counselors
• California Association of Health Facilities
• California Association for Marriage and Family Therapists
• California Association of Mental Health Patients Rights Advocates
• California Association of Social Rehabilitation Agencies
• California Council of Community Behavioral Health Agencies
• California Department of Corrections
• California Department of Health Care Services
• California Department of Managed Health Care
• California Hospital Association
• California Institute of Behavioral Health Solutions
• California Mental Health Caucus
• California Behavioral Health Directors Association
• California Mental Health Planning Council
• California Association of Mental Health Peer Run Organizations
• California Pan-Ethnic Health Network
• California Primary Care Association
• California Psychiatric Association
• California Psychological Association
• California Senate Select Committee on Mental Health
• California Society for Clinical Social Work
• California Women’s Mental Health Policy Council
• California Youth Empowerment Network
• Disability Rights California
• California Association of Rural Health Clinics
• California Elder Mental Health and Aging Coalition
• California Council on Mentally Ill Offenders
• Destination Dignity
• Mental Health Oversight and Accountability Commission
• NAMI California
• National Association of Social Workers – California Chapter
• National Institute for Civil Discourse
• Occupational Therapy Association of California
- Racial and Ethnic Mental Health Disparities Coalition
- Runyon Saltzman Einhorn
- RAND Corporation
- Substance Abuse and Mental Health Services Administration
- Steinberg Institute
- Sutter Health
- Your Social Marketer
- Marriage and Family Therapist Educators Regional Consortium
- Vietnam Veterans of America – California Chapters
- Reserve Officers Association
- Team AmVets
- Vet Center
- Youth Line
- Teen Line
- Crisis Text Line
- California Black Health Network
- California Consortium for Urban Indian Health
- California Pan-Ethnic Network
- California Supervisors of Child Welfare and Attendance
- Blue Shield
- Kaiser Permanente
- California School-Based Health Alliance
- Interagency Council on Veterans
- CalTrans
- California Youth Connection
- Mental Health America of Northern California
The Statewide PEI Project
FY 2016/2017
California Impact Statement

Ann Collentine, MPPA
Program Director – CalMHSA
The Statewide PEI Project: Achieving More Together

- In FY 16/17, 41 counties collectively pooled their funds to support 7 contractors in implementing the Statewide PEI Project, publicly known as Each Mind Matters: California’s Mental Health Movement
- Total contracted funding for Phase II (Fiscal Year 2015/2016 and 2016/2017): $10,176,000
- Implemented strategies:
  - Maintaining and expanding suicide prevention and stigma reduction public awareness and education campaigns
  - Creating new outreach materials for diverse audiences
  - Providing technical assistance
  - Providing trainings and presentations to diverse audiences
  - Engaging youth in the Directing Change programs
  - Building capacities of schools and organizations to address mental health, stigma and suicide prevention
Outcomes to date

- Since its inception in FY 2011/2012, the Statewide PEI Project has evaluated the effectiveness and reach of the implemented programs. Outcomes to date include:
  - 15.4% more Californians exposed to Each Mind Matters turn to help for mental health challenges.
  - Over 50% of Californians were exposed to Know the Signs.
  - Individuals exposed to the Know the Signs campaign report higher levels of confidence to intervene with someone at risk for suicide.
  - The Know the Signs campaign was rated by experts to be aligned with best practices and be one of the best media campaigns on the subject.
  - Students exposed to the Walk In Our Shoes website demonstrate significantly higher knowledge of mental health.
  - 63% of teachers and administrators who saw the Walk In Our Shoes performance started a conversation about mental health in the classroom.
Outcomes to date

• 87% of students have a better understanding of mental illness and suicide after participating in Directing Change.
• 97% of students who participated in Directing Change pledged to support a friend with a mental health challenge.
• 87% of those who completed the Kognito training report that they are better prepared to identify, approach and refer students exhibiting signs of psychological distress.
• 66% of California Community College faculty who completed Kognito training report an increase in the number of conversations they had with other faculty and staff about students that they were concerned about.
Public health initiatives like the Statewide PEI Project require long term investment in order to change the culture around mental health and suicide. With long term investments, the projected 10 and 20 year outcomes are as follows:

<table>
<thead>
<tr>
<th>10 year outcomes</th>
<th>20 year outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased intervention and provision of support by a community helper</td>
<td>• Reduced discrimination against persons with mental illnesses</td>
</tr>
<tr>
<td>• Increased proactive inclusion of individuals with mental health challenges</td>
<td>• Reduced social isolation and self-stigma</td>
</tr>
<tr>
<td>• Increased community encouragement and acceptance of seeking services early</td>
<td>• Improved functioning at school, work, home and in the community</td>
</tr>
<tr>
<td>• Increased knowledge and skills for recognizing and facilitating help seeking</td>
<td>• Reduced suicidal behavior</td>
</tr>
<tr>
<td></td>
<td>• Reduced societal costs related to untreated mental illness</td>
</tr>
</tbody>
</table>
Nearly **700** local county agencies, schools, and organizations were touched by the activities implemented by the Statewide PEI Project, including:

- All county behavioral health agencies
- All California community colleges
- Statewide agencies and organizations such as California Department of Education; Sutter Health; NAMI California; California Mental Health Planning Council; Wellbeing Trust
- Universities such as UCLA, University of the Redlands, CSU Long Beach
- Local organizations such as: American Foundation for Suicide Prevention, NAMI Sonoma County, Suicide Prevention Service of the Central Coast, Culture to Culture Foundation, Rodef Shalom
Over 15,000 people participated in a training offered by the Statewide PEI Project, which increased skills on how to address stigma reduction and suicide prevention. These trainings include:

- Each Mind Matters Webinars
- Kognito Suicide Prevention and Mental Health Trainings
- NAMI Mental Health 101 Training of Presenters
- NAMI on Campus Trainings
- Directing Change AB 2246 Trainings
- School Based Trainings
- Directing Change Judges Training
- QPR Suicide Prevention Training
- Mental Health First Aid in Schools Training
- El Rotafolio Suicide Prevention Training for Low Literacy Spanish Speakers
- Suicide Prevention Media Messaging Training
- California Community College Student Mental Health Trainings
- Suicide Prevention in Primary Care Trainings
Nearly 12,000 people participated in a presentation offered by the Statewide PEI Project, which increased knowledge and awareness about stigma reduction and suicide prevention. These presentations include:

- Conference presentations including the Central Valley Latino Conference, UC Diversity Conference, California Mental Wellness Conference, and others
- NAMI Mental Health 101 Presentations
- NAMI Ending the Silence Presentations
- Active Minds Speakers Bureau Presentations
Community Outreach Events

Community outreach events allowed for direct community conversations about mental health and suicide prevention, while providing a forum to disseminate Each Mind Matters resources. Numerous outreach events implemented by Active Minds chapters, Community Colleges, and the Each Mind Matters Outreach & Engagement team took place in following locations including:

- Chabot College
- Clovis Community College
- Construction Financial Management Association’s Suicide Prevention Summit
- NAMI CA Conference Youth Mixer
- Norooz Clinic Foundation’s 6th Unlocking Stigma Fair

Furthermore, counties received discounted rates to host an Active Minds Send Silence Packing Tour on college campuses, including:

- Sacramento State University
- San Jose State University
- UC Riverside
Regular electronic newsletters allowed Each Mind Matters to communicate to a broad audience, share resources, and engage the Mental Health Movement.

**Each Mind Matters Insider newsletter:** 312 subscribers  
**Each Mind Matters Community newsletter:** 4,960 subscribers  
**California Community Colleges Student Mental Health Program Newsletter:** 2,933 subscribers
Technical Assistance

Technical assistance provided by all Statewide PEI Project contractors provided the necessary support to community organizations and counties to fully utilize and integrate the resources and programs available through Each Mind Matters

TA to counties: 335 consultations
TA to CBOs: 131 consultations
TA to schools: 43 consultations
TA to NAMI affiliates & programs: 73 consultations
TA to Active Minds Chapters: 686 consultations

- TA resulted in the creation of 8 new Active Minds chapters in California
Over **1 million** hardcopy materials were sent to counties, schools, and local organizations throughout California. Furthermore, technical assistance emails and other communications highlighted the online availability of these resources through the Each Mind Matters Resource Center.

**Each Mind Matters Promotional Items:** 213,400  
**Each Mind Matters Educational Materials:** 183,039  
**SanaMente Materials:** 51,958  
**Know the Signs/El Suicidio Es Prevenible Materials:** 421,577  
**Directing Change Materials:** 3,682  
**Walk In Our Shoes/Ponte En Mis Zapatos Materials:** 1,795  
**California Community College Student Mental Health Program Materials:** 223,412
All resources encourage recipients to visit Campaign and Program websites to learn more about stigma, mental health, suicide prevention, and how to engage with Each Mind Matters and the mental health movement.

<table>
<thead>
<tr>
<th>Website</th>
<th>Total Visits</th>
<th>Unique Visitors</th>
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</thead>
<tbody>
<tr>
<td>EachMindMatters.org</td>
<td>52,609</td>
<td>39,648</td>
</tr>
<tr>
<td>SanaMente.org</td>
<td>1,989</td>
<td>1,307</td>
</tr>
<tr>
<td>SuicidelsPreventable.org</td>
<td>26,636</td>
<td>20,941</td>
</tr>
<tr>
<td>ReconozcaLasSenales.org</td>
<td>3,481</td>
<td>2,751</td>
</tr>
<tr>
<td>DirectingChange.org</td>
<td>36,529</td>
<td>21,387</td>
</tr>
<tr>
<td>WalkInOurShoes.org</td>
<td>7,119</td>
<td>5,406</td>
</tr>
<tr>
<td>PonteEnMisZapatos.org</td>
<td>281</td>
<td>223</td>
</tr>
<tr>
<td>CCCStudentMentalHealth.org</td>
<td>240,085</td>
<td>40,772</td>
</tr>
<tr>
<td>RAND CalMHSA Reports</td>
<td>14,092</td>
<td>9,740</td>
</tr>
</tbody>
</table>
Mini-Grants and Sponsorships

Over $250,000 in Mini-Grants and Sponsorships were awarded to over 140 local schools and organizations, allowing them to receive Each Mind Matters technical assistance, integrate local resources into their programs, and host Each Mind Matters events for their communities.
Directing Change entered its 5th year of implementation in FY 2016/2017. In addition to receiving the most video submissions, and the most school and student participation in its history, an independent evaluation by NORC found Directing Change to be highly effective in increasing knowledge, behavior and attitudinal outcomes related to suicide prevention and mental health and demonstrated changes in school climate.

Over 480 videos were submitted, representing 1,343 students from 113 schools. The Directing Change videos have been viewed nearly 35,000 times on YouTube.
New Materials and Resources

Over 25 new resources were developed to reach diverse communities and school audiences. These materials were developed by working with stakeholders to determine gaps in existing resources, and working with focus groups to ensure that materials were developed in a culturally appropriate manner. All resources are now available on the Each Mind Matters Resource Center.
Community comments about the Statewide PEI Project

We have been thanked for our messages and for wearing the lime green ribbons on several occasions...  
- Valley Oak Children’s Services

I just wanted to say that I am very excited that there are more resources in Spanish about Mental Health. These resources will be used in our non profit trainings  
- Public comment via sanamente.org

We appreciated the training on AB 2246. Great content and format for the training and your passion shines through to support and make a difference  
- Kern County Superintendent of Schools

Your stories were absolutely amazing! They changed my entire perspective! 
- NAMI Mental Health 101 Participant from NAMI Mt. San Jacinto