

BEHAVIORAL HEALTH AND RECOVERY SERVICES

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



MENTAL HEALTH SERVICES ACT (MHSA) FY2022/2023 ANNUAL UPDATE



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EXECUTIVE SUMMARY

OVERVIEW

The FY22/23 Annual Update provides an opportunity to make changes to the Mental Health Services Act (MHSA) FY20/21-22/23 Three Year Plan as well as report on outcomes and activities from FY20/21 (Fiscal Year from July 1, 2020-June 30, 2021). FY20/21 was the first year of implementation of the MHSA Three-Year Program and Expenditure Plan for FY20/21 through FY22/23. All MHSA related Annual Updates and the MHSA Three-Year Plan can be found at: www.MarinHHS.org/MHSA

KEY CHANGES IN THE FY22/23 ANNUAL UPDATE

After a slight decline in the early part of the pandemic in FY 19/20, MHSA revenues climbed more than 50% year-over-year in FY 20/21, and are on track to increase 15% further in FY 21/22.. In coordination with the County Administrator's Office and local Stakeholders, this Annual Update increases MHSA-funded programming accordingly. The Community Services and Supports (CSS) budget is increased by approximately \$2M, the Capital Facilities and Technology Needs (CFTN) by \$1.6M to support a transformation to a new Enterprise Health Records system; and the Prevention and Early Intervention budget is increased by approximately \$700K.

Of this \$3.3m increase across CSS, CFTN, and PEI, **22%** will go toward **County-administered services** including new positions and admin/indirect, **41%** will go to **contracts with community-based organizations**, and **37%** will go toward the new **Enterprise Health Record System** project.

Workforce challenges—especially for community-based organizations—were a prevailing issue in delivering planned services during the second year of the pandemic with local community-based organizations and county behavioral health services having difficulty recruiting, supporting, and retaining staff working in the behavioral health field. Many new remote-only opportunities sprung up in the Behavioral Health field making it even more difficult to recruit and retain staff for needed in-person services, especially when many staff have long commutes from areas with lower costs of living. Multiple of the top priorities highlighted during Community Planning were around supporting non-profit organizations to build sustainable local workforces. The overall sentiment from community planning meetings was to shore up existing services.

Priorities for the FY22/23 Annual Update:

- 1) Increase **outreach, wellness-focus**, and knowledge about programs and accomplishments, through:
 - a. Contract increases to support the Community Health Advocate outreach and engagement contracts including the *Promotoras* program in West Marin, Novato, and the Canal; the Marin Asian Advocacy Project; the Marin City First Missionary Baptist Church; and the Canal Alliance Behavioral Health navigation.
 - b. Increased peer support through the Access process (increased bilingual Peer Support for Access team from .5FTE to 1.0 FTE).

- c. Increased focus on community wellness, happiness, kindness, compassion, and reducing isolation (1.0 Sr. Program Coordinator)
 - d. Social media, traditional media, materials, and keeping the website up to date with new content and assistance with outreach. This position will also help share successes with the community as well as help in the promotion of MHSA activities and programs
- 2) **Promote recruitment and retention of behavioral health providers** throughout the county:
- a. Rationale:
 - i. Many **community-based organizations** that BHRS contracts with have vacant positions and quick turnover leaving them unable to meet the needs of those they are dedicated to serving. Many of the salaries have historically been below market-rate. Community-based providers have a harder time retaining or recruiting staff who want to work close to home but cannot afford to live in Marin given the high cost of living.
 - ii. Within BHRS there are a large number of vacancies, and the new positions that were created in the FY21/22 MHSA Annual Update are averaging over 7.5 months to fill.
 - b. Strategy:
 - i. Invest resources to support increased salaries, benefits, or wellness supports for direct service providers at **contracted non-profit organizations**
 - ii. Increase county Human Resources capacity by adding a second **Human Resources Analyst II** to support Behavioral Health and Recovery Services (BHRS)
- 3) **Promote pay equity for Peer Support Specialists** in alignment with new expectations around **certification and professionalization of the field**
- a. Rationale:
 - i. Contracted Peer Support Specialist have not been making a living wage
 - ii. New statewide regulations from SB 803 require significant shifts in training, experience, certification, continuing education requirements, etc., leading to a transformation and professionalization of the field and allowing the County to bill Medi-Cal for peer-specific services. To meet the demand, there is a need to increase the wage to a professional standard in line with the new requirements.
 - b. Strategies:
 - i. As this was a clear priority from stakeholders, especially from people with lived experience (clients/consumers and family members), and the MHSA Advisory Committee, BHRS released an **RFP for Peer Support Specialists** that was in alignment with the new SB 803 regulations and increased the available funding for contracted Peer Support Specialist positions (awarded to Mental Health Association of San Francisco in March 2022—new contract to start July 1, 2022; increasing wages from ~\$21/hr to ~\$29/hr)
 - ii. Continue to increase the number of **county peer support specialist positions** (2.5 FTE, one dedicated to Mill Street 2.0, one enhancing services for LGBTQ+ clients, and expanding the bilingual Peer position in Access to full time)

- iii. Increase **paid internship opportunities** for Peer Support Providers in training (through reprioritizing within the existing Workforce Education and Training (WET) Mental Health Career Pathways budget)
- 4) Prioritize the heightening **mental health needs of youth** in our community which has been exacerbated during the pandemic
 - a. Rationale:
 - i. The age group that experienced an increase in deaths by suicide and non-fatal Emergency Room department visits related to attempted suicide in Marin County in 2021 was youth under the age of 15.
 - ii. In 2019, 14.3% of 9th graders in Marin self-reported that they “seriously considered attempting suicide in the previous year” on the California Health Kids Survey.
 - iii. The Marin County Grand Jury report released in 2020 and the leadership from the State have both highlighted the growing need for more school-based and youth mental health services
 - b. Strategies:
 - i. Increased funding for **school-based mental health contracts** including adding an additional clinician in the Sausalito Marin City School district.
 - ii. Create a new partnership with **Edgewood’s Youth Hospital Diversion Program** in San Francisco to offer a residential housing alternative to psychiatric hospital or temporary placement for children in acute mental health distress
 - iii. Support the creation of a **Behavioral Health School Partnership Supervisor** position to oversee the growing need of School-Based and other youth-focused behavioral health contracts, lead partnership work with Marin County Office of Education, oversee the Mental Health Student Services Act grant program with local school districts, and the Student Wellness Ambassador Innovation project.
- 5) Plan and budget for a new **Electronic Health Record (EHR) System**
 - a. Rationale:
 - i. Clinicians Gateway and ShareCare (BHRS’ current EHR and Billing Software) technology systems are substantially outdated and limit the Department’s ability to implement best practices in care coordination and revenue recovery. The systems’ lack of integration abilities, and antiquated technology means that core processes such as maintaining client records and billing state agencies remain arduous and administratively intensive. A report developed by external consultants identified the need to find a new system in order to improve: client coordination, quality outcomes, tracking and data collection/reporting, revenue and claim adjudication, staff efficiency and reduction of duplication, transparency and accuracy of data, and access for clients to see their own medical records through API interface (e.g. accessing medical records on their cell phones).

- b. Strategies:
 - i. The County of Marin is working with CalMHSA on a 21-county initiative to pave the way for a cost-effective, coordinated and integrated Health Information Technology system.
 - ii. In order to fund this, transferring one-time MHSA funding in both an Amendment to FY21/22 Annual Update (\$800k) and in the new FY22/23 Plan (\$1,500,000)
 - iii. Creating a Senior Department Analyst position to oversee the EHR implementation
 - iv. Expanding the Medical Records Office Assistant III position to full time as they will have a critical role in ensuring medical records transfer smoothly into the new system and are all up to date in advance of the transition.
- 6) Provide **high quality supportive services** at permanent supportive housing sites
- a. In August 2022, **Mill Street 2.0** is expected to open with 15 units dedicated to individuals eligible for BHRS services. There will be a full-time Mental Health Practitioner-Bilingual as well as a half-time Peer Support Counselor dedicated to these 15 units in addition to 4 hours of medication services (Psychiatrist or Mental Health Nurse Practitioner) per week provided on site. The second half of the Peer Support Specialist position will be dedicated to providing outreach and engagement at the Mill Street site to other residents in the shelter or other permanent supportive housing units to help engage them in services.
 - b. **1251 S. Eliseo** is scheduled to open in the Spring of 2023 therefore there is a need for funding allocated for the final four months (March-June) of the year for a contract with Episcopal Community Services for supportive services for the projected 16 units designated (*pending results of the No Place Like Home application*) for people eligible for BHRS services. Episcopal Community Services will be the lead service provider and BHRS will also provide medication management and another other specialty mental health services to ensure the clients receive all the services they need to be successful.
- 7) **Care Coordination** in alignment with the Suicide Prevention Strategic Plan including Emergency-Room based peer response and follow-up support after a **suicide attempt or non-fatal overdose**
- a. This has risen from a need that has been highlighted in the Marin County Suicide Prevention Strategic Plan and with the hundreds of stakeholders who participate in the Suicide Prevention Collaborative. At the current time depending on insurance type, location, or type of self-harm behavior the intervention or follow-up after an attempt may be different or may not be in place at all. This new project will help launch the Care Coordination Action Team of the Suicide Prevention Collaborative and provide a new service county-wide to provide immediate support to anyone in Marin County who has attempted suicide or experienced a non-fatal overdose.
 - b. Individuals who have attempted suicide or experienced a non-fatal overdoses are at significantly higher risk of making another attempt if supports and interventions are not in place

- c. Coordinated cross-Behavioral Health (meaning spanning both Mental Health and Substance Use Services) approach to provide immediate support and consistent follow-up in the critical time after an attempted suicide or non-fatal overdose
- 8) Expand the **IMPACT** Full-Service Partnership by 10 clients up to 50 by adding 1.0 FTE Mental Health Practitioner to increase treatment planning, therapy, and assessment capacity.
 - a. Rationale:
 - i. Currently there is only one Mental Health Practitioner position within the IMPACT Full-Service partnership team who is responsible for all assessments and the development of treatment plans for each client. The IMPACT team is now exceeding the number of clients planned for and, in addition, there is significant need for more capacity.
 - ii. This additional Mental Health Practitioner will also expand the ability for IMPACT to provide additional therapy services, helping reduce the wait time for therapy in alignment with the multidisciplinary team structure of an Assertive Community Treatment model program.
- 6) Expand **therapy capacity** to reduce wait time for therapy services and expand the linguistic capacity of therapy services
 - a. In recent years, there has been an increased need for therapy services leading to a growing waitlist. Currently there is a 30-person waitlist (at least 3-months) to enroll in therapy services and the managed care providers report no additional capacity. This funding is earmarked to pilot additional solutions to expand access to therapy services for clients throughout our system of care, enabling us to meet the California Department of Health Care Services (DHCS) timeliness of service standards.
- 8) Expand and sustain **Mobile Crisis Response Team (MCRT)**
 - a. BHRS is awaiting notification in May 2022 regarding an extension of funding from California Health Facilities Financing Authority (CHFFA) for the two-youth focused MCRT positions
 - i. If that funding is **not** extended, then the earmarked MHSA funding in this plan will be used to sustain those positions
 - ii. If that funding is extended (the more likely scenario) then we would use this earmarked funding instead to add an additional Crisis Specialist to the Mobile Crisis Response team (to likely be matched by a second one funded by the Probation department) and add a contracted Peer Support Specialist
- 9) Additional supports for older adult clients including:
 - a. Pilot a new program to provide extensive **neuro-psychological evaluations** for older adults with potential complex dual mental health and cognitive disorders (such as dementia).
 - 1) Currently many older adult clients in the HOPE full-service partnership program have cognitive issues in addition to diagnoses of mental health disorders. However, without extensive neuro-psychological testing it is difficult to develop

the most effective treatment plan and bring partners in to further support the cognitive issues.

- 2) This would be paired with additional training around supporting individuals with dual cognitive and mental health diagnoses.
 - b. Fund earmarked to pilot a **nutrition** program within the HOPE Full-Service Partnership after experiencing the benefits of the *Great Plates* program during COVID. There is a growing body of evidence indicating that nutrition may play an important role in the management of mental health and cognitive diagnoses including depression, anxiety, schizophrenia, and dementia.
 - c. Create a new group and peer support around addressing **Collecting Behaviors** (also known as hoarding) which is a mental health challenge that most commonly effects older adults and was strongly advocated for during the MHSA Community Planning process.

IMPACT OF COVID-19

In March 2020 at the beginning of the COVID-19 pandemic the immediate focus within Behavioral Health and Recovery Services (BHRS) was on crisis support—including maintaining staffing levels for the Mobile Crisis Response Team and the Crisis Stabilization Unit—as well as maintaining Jail Mental Health Program and assessments through the Access team. Many other Behavioral Health programs made the quick switch to find new ways to connect with clients—either through phone calls or telehealth platforms, or going on walks outside. In the early months of COVID, BHRS also released numerous videos and infographics to provide education, training, and tips around mindfulness and self-care, coping with the stress of the pandemic, how to support children’s mental health during this time, and supporting the needs of caregivers, as well as launching our suicide prevention initiative in a virtual space. Our engagement efforts also needed to be done differently, for instance transitioning the Marin Mental Health Services Act Advisory Committee and the Mental Health Board to meet virtually rather than in person.

In addition to the on-going behavioral health needs, 42% of Behavioral Health and Recovery Services (BHRS) staff were deployed as Disaster Service Workers (DSW). Many were deployed to the hotels to implement Project Room Key (supporting at-risk individuals experiencing homelessness shelter-in-place in a safe environment), as well as staffing the COVID-19 county hotline or working at the testing or quarantine sites and food distribution centers.

During our extensive community planning process for the FY20/21-FY22-23 Three Year Plan we had been preparing our budgets with a \$5M increase for Community Services and Supports (CSS) to be applied to each of the three years. However, due to COVID and the uncertainty around the economy in the Spring of 2020, the budget was scaled back to a \$3.6M increase for each of the years. However, despite the uncertainty, MHSA funding was not affected the way that had been anticipated during the early months of the pandemic. The revenue source for the MHSA comes from a 1% tax on all personal income over \$1M and individuals who were in that tax bracket were not economically affected by the pandemic in the way that was anticipated. In the FY21/22 Annual Update the plan restored many of the hoped-for growth items that were cut during the early months of the pandemic prior to the release of the Three-Year Plan.

Throughout the COVID pandemic BHRS held over 100 events with the community to hear about how COVID has impacted their lives, to strategize around suicide prevention, provide support for family members and caregivers, provide training, continue the work of the MHSA Advisory Committee and the Mental Health Board, and to provide a space to come together as a community.

MENTAL HEALTH SERVICES ACT (MHSA) BACKGROUND

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:

1. 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.

2. 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.

3. 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.

4. 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.

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

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

MENTAL HEALTH SERVICES ACT (MHSA) HISTORY

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.

MARIN COUNTY CHARACTERISTICS

Marin County is a mid-sized county (as defined by the State as between 200,000 and 749,000 residents) with a **population of 262,879** and spanning 520 square miles of land. 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. 58% of land in Marin is considered protected open space comprised of local, state, and Federal parkland including the Golden Gate National Recreation Area and Point Reyes National Seashore. Factoring in Agricultural Land Trusts and zoning rules, **over 85% of Marin’s lands are protected from development** according to the Greenbelt Alliance 2012 report. Due in part to the land use restrictions and other factors there is **limited affordable housing** resulting in **62% of people who are employed in Marin commute into the county each day** for work.

Spanish is the only threshold language, although most county documents are also available in Vietnamese.

For the tenth time in 11 years, Marin County was ranked as the **healthiest county in California** by the Robert Wood Johnson Foundation. The 2021 County Health Rankings, released March 19, 2019, evaluated counties across the nation to measure how healthy residents are and how long they live. Marin scored **highest in life expectancy statewide**, with San Mateo and Santa Clara counties following closely.

2020 County Health Rankings for the 58 Ranked Counties in California

County	Health Outcomes	Health Factors	County	Health Outcomes	Health Factors	County	Health Outcomes	Health Factors	County	Health Outcomes	Health Factors
Alameda	7	5	Kings	32	55	Placer	4	3	Sierra	36	30
Alpine	33	49	Lake	58	52	Plumas	54	27	Siskiyou	57	37
Amador	25	14	Lassen	42	43	Riverside	26	35	Solano	24	21
Butte	43	33	Los Angeles	21	32	Sacramento	28	24	Sonoma	9	12
Calaveras	23	23	Madera	38	54	San Benito	20	25	Stanislaus	37	39
Colusa	30	44	Marin	1	1	San Bernardino	40	41	Sutter	31	31
Contra Costa	10	9	Mariposa	44	28	San Diego	13	18	Tehama	49	42
Del Norte	45	48	Mendocino	41	38	San Francisco	6	6	Trinity	56	46
El Dorado	17	8	Merced	39	53	San Joaquin	34	40	Tulare	53	56
Fresno	48	51	Modoc	55	45	San Luis Obispo	14	10	Tuolumne	27	20
Glenn	35	47	Mono	18	22	San Mateo	2	2	Ventura	11	15
Humboldt	47	34	Monterey	22	36	Santa Barbara	19	19	Yolo	15	13
Imperial	29	58	Napa	8	11	Santa Clara	3	4	Yuba	51	50
Inyo	50	26	Nevada	16	16	Santa Cruz	12	17			
Kern	52	57	Orange	5	7	Shasta	46	29			

For more information on how these ranks are calculated, view the tables at the end of this report and visit www.countyhealthrankings.org

While Marin scored near the top in most health factors, there were important exceptions. Housing affordability, income inequality, high rates of substance use, and racial disparities in health were highlighted as weaknesses in Marin’s health profile. Among 58 California counties in the 2019 data,

Marin ranked 39th in housing cost burden, 54th in income inequality, and 48th in high rates of binge drinking.

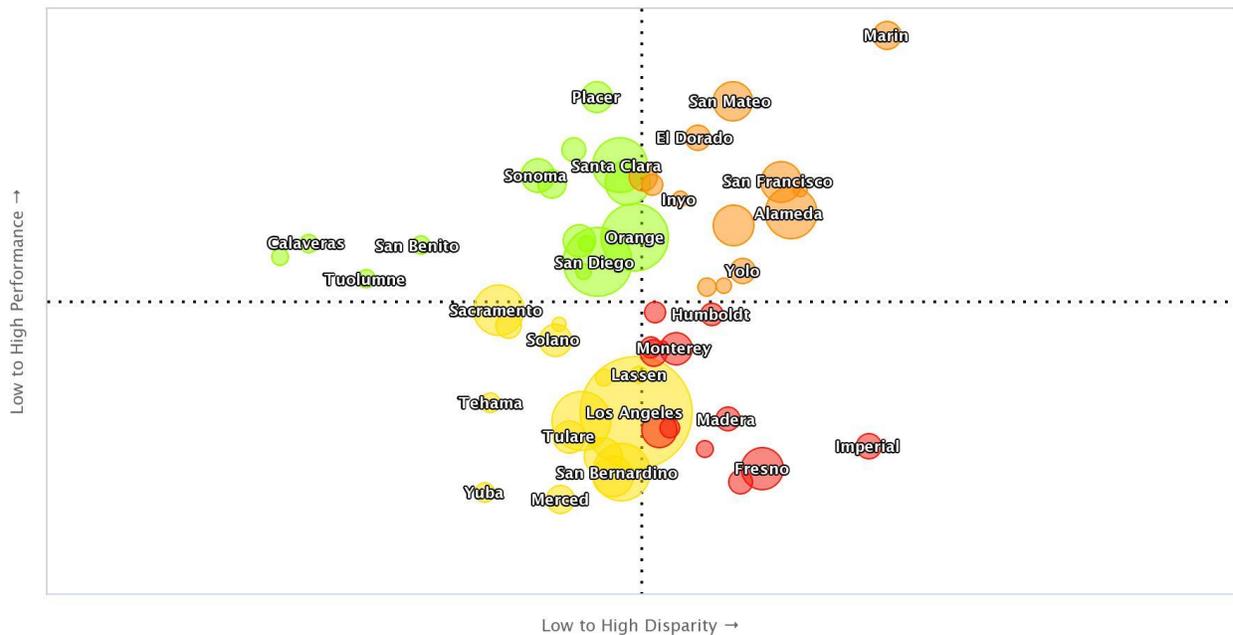
The results also show clear racial disparities in health in Marin. **African American and Latino children are four and eight times more likely, respectively, to live in poverty** than their white counterparts. While Marin ranks first in clinical care, these benefits differ greatly among racial groups. For example, mammography rates for African American women are less than half of the rates among white women.

Hand in hand with the longest life expectancy, Marin County has the **oldest population of any county in the state**, and it's estimated that one-third of the local population will be 60 or older by 2030.

In 2018 Marin County was ranked for the first time as the **most racially disparate county in California** by the Advancement Project ([RaceCounts.org](https://www.racecounts.org)). In the chart below you can see that Marin (in the top right) was ranked at the highest performance county as well as the county with the highest disparity. The issues analyzed with Economic Opportunity, Health Care Access, Education, Housing, Democracy, Crime & Justice, and Health Built Environment.

COUNTY RANKINGS Counties in California

© Advancement Project California; RACE COUNTS, racecounts.org, 2020
<https://www.racecounts.org/rankings/> (accessed January 16, 2020)
Data Source: ADVANCEMENT PROJECT, 2018
Our Partners: California Calls, USC Dornsife, PICO California



In December 2018, after a thorough data review combined with multiple perspectives gathered from clients, community members, community organizations, Marin County Department of Health and Human Services released a [Strategic Plan to Achieve Health and Wellness Equity\[PDF\]](#) focused on race.

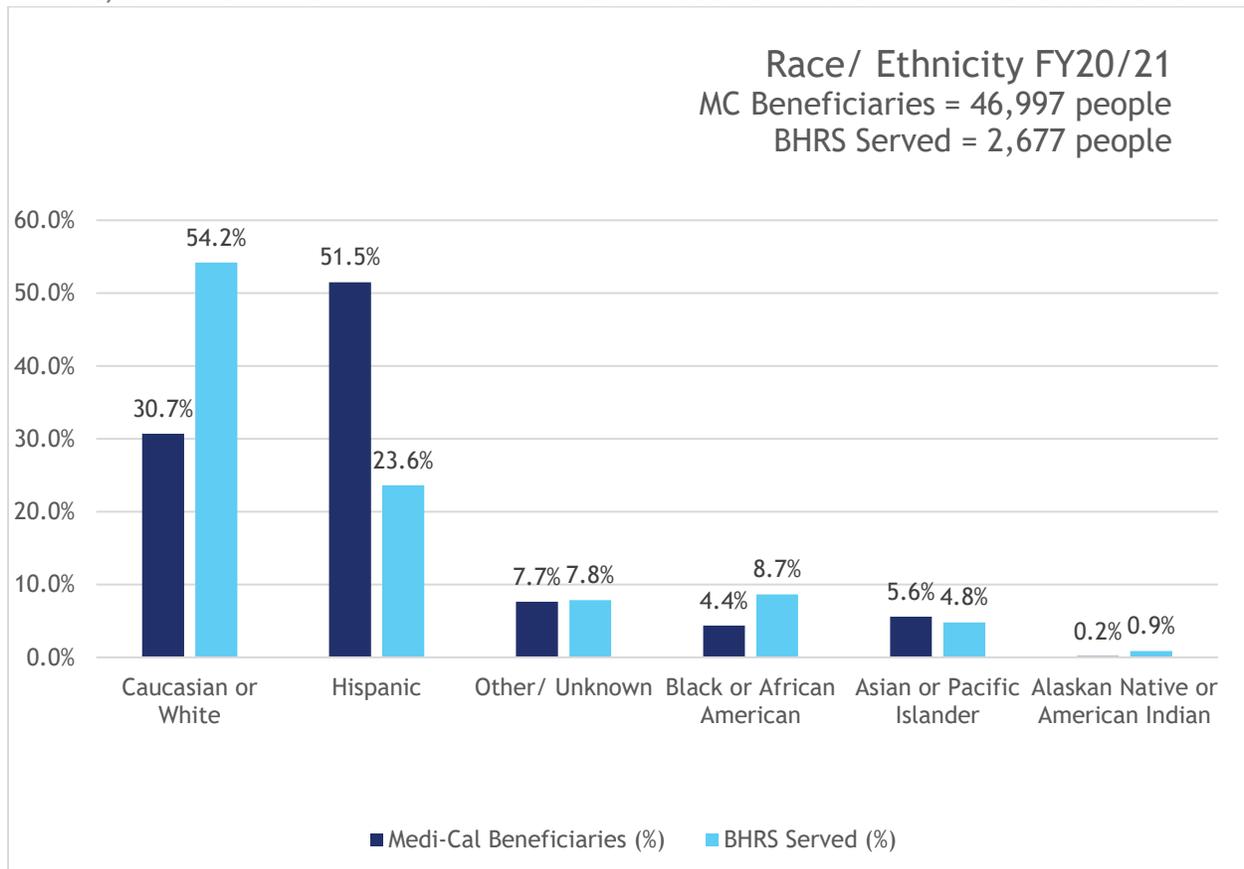
RACIAL/ETHNIC DISPARITIES IN SERVICE UTILIZATION:

During Marin’s initial 2004 MHSa planning process the adult Latinx population was identified as the most underserved racial/ethnic population by the existing County Mental Health Services. Despite ongoing and substantial efforts over the years to address this trend, this disparity remains true today. There was a slight increase in utilization going from 23.4% of those served by BHRS in FY18/19 to 24.0% in FY19/20 back to 23.6% in FY20/21. A Strategic Plan for improving services for the Latinx population is under development from the Equity Team with considerable input from the community.

Asian/Pacific Islanders were also categorized as underserved in the initial MHSa planning process however significant progress has been made on this front including the hiring of three bilingual Vietnamese providers and extensive Community Outreach and Engagement work focused on this population. When analyzing the FY19/20 utilization data, Asian/Pacific Islanders are now served at a substantially equivalent rate as the Medi-Cal population (5.6% served vs 5.9% of the Medi-Cal population). Asian/Pacific Islanders are also being served at a higher rate in Marin than they are in other medium sized counties or the state as a whole based on the Medi-Cal claims data.

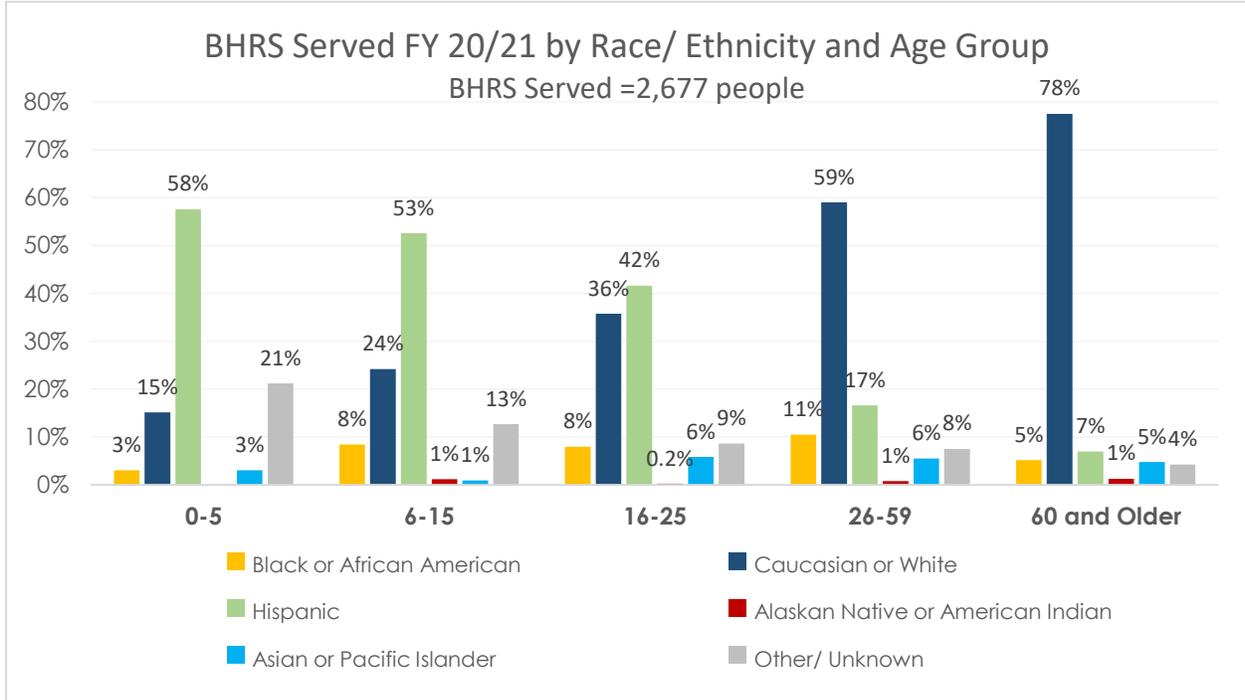
Designation of un/underserved populations is based on the distribution of Marin residents who are eligible for County mental health services—best represented by the "Medi-Cal Beneficiaries" dark blue bars in the following table—compared to the distribution of those receiving county mental health treatment services “BHRS Served” shown in lighter blue.

RACIAL/ETHNIC DISTRIBUTION OF MARIN MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS



When looking at the data for the race and ethnicity of those served by Behavioral Health and Recovery Services (BHRS) broken down by age group, there is a striking trend of the Latinx population receiving a significantly higher proportion of services as youth than adults.

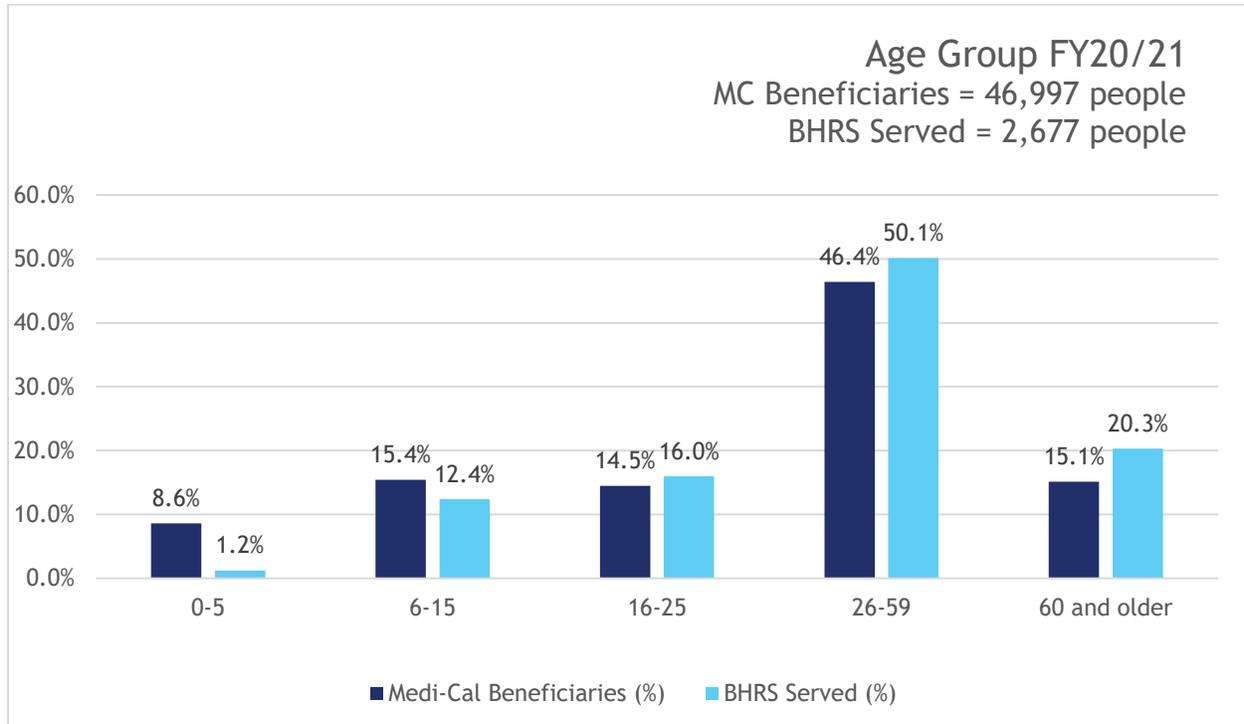
RACIAL/ETHNIC DISTRIBUTION OF THOSE SERVED BY BHRS BY AGE GROUP FY19/20



AGE DISPARITIES IN SERVICE UTILIZATION:

Young children are represented in those receiving county mental health treatment services at a much lower rate than their representation in the Medi-Cal population as a whole. This is unsurprising given developmental stages, however when comparing Marin County's Medi-Cal claims data for young children to the claims data for the State as a whole or to other medium sized counties, young children are served at a slightly lower rate in Marin.

AGE GROUP DISTRIBUTION OF MARIN MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS

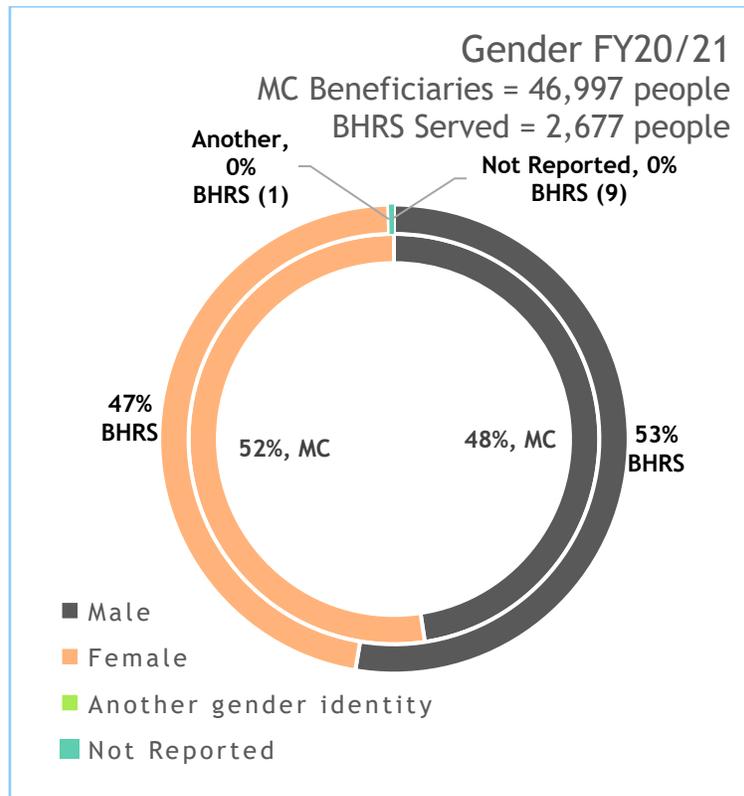


In 2004 it was also identified that Older Adults (60 and older) and Transition Aged Youth (TAY, between 16-25 years of age) were underserved. These two priority populations have been the focus of Marin's two most recent MHSA Innovation Projects to address this. At the culmination of the Growing Roots Innovation Project in 2018 and also true for FY19/20, BHRS had the highest penetration rate with TAY. However, in FY20/21 **Older Adults now have the highest penetration rate** of any age group, equivalent to 7.6% of the Medi-Cal population.

GENDER DISPARITIES IN SERVICE UTILIZATION:

Males continue to be served at a higher rate than females by BHRS mental health treatment programs. This is consistent with other counties as the Medi-Cal claims data indicates that males are served at a higher rate in the state as a whole, as well as in other medium-sized counties.

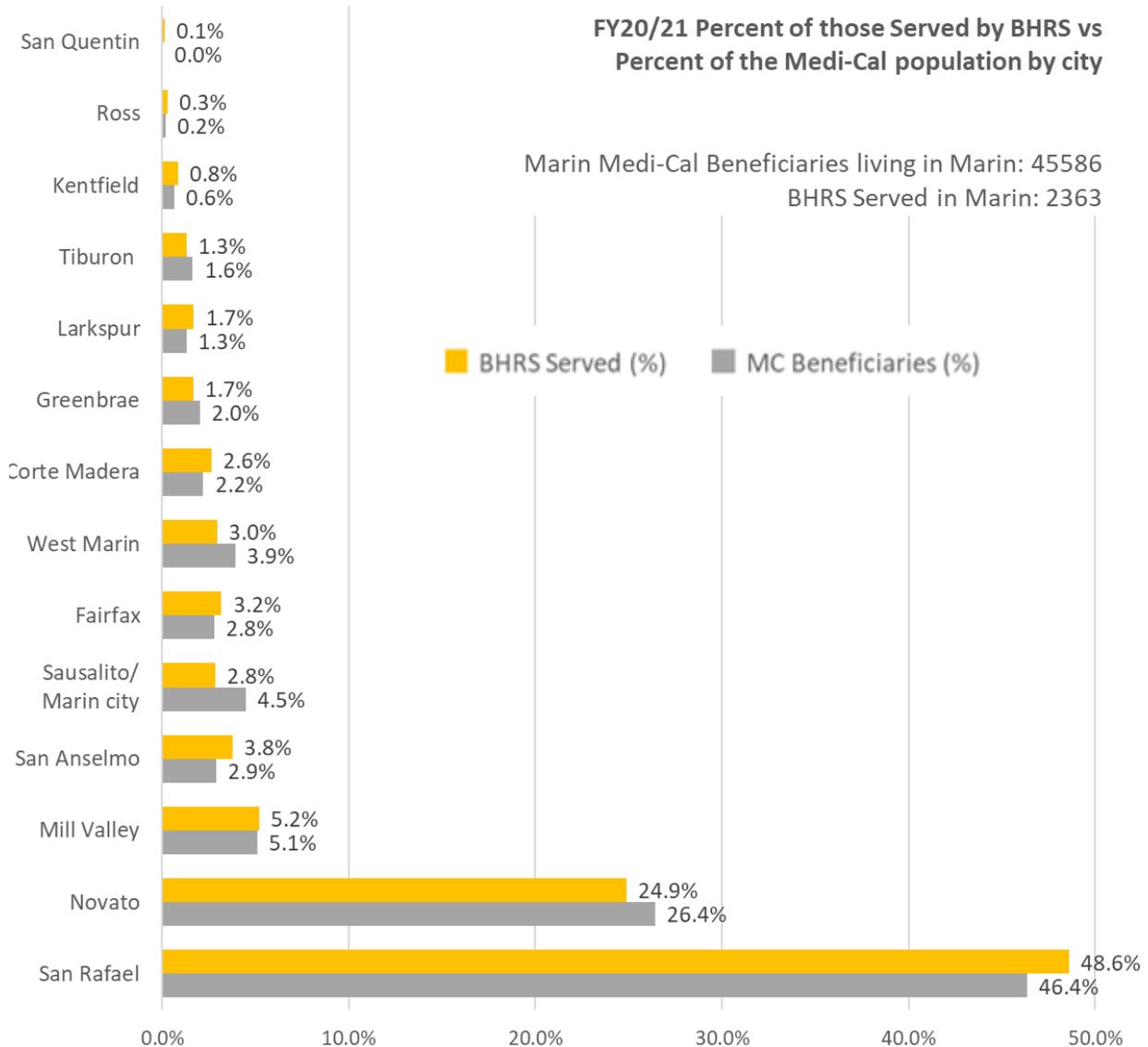
*GENDER DISTRIBUTION OF MEDI-CAL BENEFICIARIES
VS THOSE SERVED BY BHRS*



GEOGRAPHIC DISPARITIES IN SERVICE UTILIZATION:

Over 70% of Marin Medi-Cal beneficiaries live in either San Rafael or Novato which is very similar to the percentage served by BHRS in those geographic areas, with Novato being slightly less well served.

Marin City/Sausalito appears the most underserved with the proportion of beneficiaries (4.5%) living in Marin City/Sausalito significantly higher than their proportion of BHRS clients (2.8%). Marin County Health and Human Services is working to open a comprehensive cross-division hub in Marin City making services more easily accessible. In addition, the FQHC in Marin City, Marin City Health and Wellness, will have multiple “Care Coordinators” through the new Enhanced Care Management benefit through CalAIM which will increase coordination of services.



COMMUNITY PROGRAM PLANNING PROCESS (CPPP): STAKEHOLDER ENGAGEMENT

BACKGROUND

In 2004, before the first Mental Health Services Act (MHSA) funds were provided to counties, Marin conducted an extensive community stakeholder process to identify unmet needs and strategies for addressing those needs. Over 1,000 people participated in that planning process, including clients, their families, diverse community members, providers, and other sectors of the community. (For a copy of the original Community Services and Support Plan, visit the following web-link: 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. Every year, Marin County develops an MHSA Annual Update that reports on each program including the number of individuals served, average cost per client, outcomes for the reporting period, and identifies any challenges and changes to programs as needed.

Beginning in FY2014-15 the State required that all counties develop a MHSA Three-Year Program and Expenditure Plan for FY2014-15 through FY2016-17 that included all five (5) MHSA components. In May of 2016 Marin County began a third in-depth community planning process for the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 which includes all five (5) MHSA components.

In October of 2018, the County of Marin Behavioral Health and Recovery Services (BHRS) initiated a suicide prevention strategic planning process in collaboration with the Department of Public Health, the Marin County Office of Education, stakeholders and community partners. The first phase of this effort was a countywide Community Needs Assessment to better understand the specific context of suicidal behavior in Marin County. Once data was collected and analyzed, the Strategic Planning Committee—which was comprised of a wide range of stakeholders—developed comprehensive strategies, objectives, and activities aimed at promoting wellness and reducing suicide attempts and deaths across the county. The Suicide Prevention Strategic Plan was released in January 2020 and is a key part of the MHSA Three Year Plan.

In May of 2019, Marin County began the community planning process for the wider MHSA Three-Year Program and Expenditure Plan for FY2020-21 through FY2022-23 which includes all five (5) MHSA components. This Plan was developed with local stakeholders, including adults and seniors with serious mental illness, families of children, adults, and seniors with serious mental illness or serious emotional disorders, community-based providers of mental health and alcohol and other drug services, law enforcement, education, social services, veterans, health care organizations, representatives of unserved and/or underserved groups, and other important interests.

ONGOING STAKEHOLDER INPUT

Marin County's MHSA Community Planning Process includes a wide array of community stakeholders, system partners, consumers and families, and Marin County Health and Human Services (HHS) staff. The County receives input on an ongoing basis from stakeholders through a variety of forums, including through the Mental Health Board, the MHSA Advisory Committee, Cultural Competency Advisory Board/WET Steering Committee, the Mental Health subcommittee of the Marin County Youth Commission, and the Prevention and Early Intervention Steering Committee.

Behavioral Health and Recovery Services (BHRS) Division representatives regularly discuss MHSA services and supports with individuals, the Mental Health Board, MHSA Advisory Committee, Alcohol and Other Drug Advisory Board, the Quality Improvement Committee, Probation and other forums. Input received in these settings is brought to BHRS Senior Management, the MHSA component coordinators, and to the MHSA Advisory Committee, for consideration.

During the COVID pandemic all of these committees have been meeting virtually rather than in person.

MHSA Three-Year Planning Process for FY20/21 Through FY22/23

Program Evaluations

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

Training for Stakeholders

To kick off the MHSA Three Year Community Program Planning Process (CPPP) in Marin County, BHRS partnered with the *California Associate of Mental Health Peer Run Organizations (CAMHPRO)* to hold a **full day workshop for stakeholders called "Delivering the ABCs of Local Advocacy for Effective Participation in Community Planning" on April 5, 2019**. This training also included three webinars that were shared with all participants covering "*Advocacy Basics*," "*Best Community Planning*," and "*Community Planning: How to Work It*."

32 community members participated in the full day workshop. The learning objectives from the workshop included:

- Recognizing your rights to participate in stakeholder activities which may shape public policy and services for years to come.
- Identifying the background, values and mechanics to better act in the interests of your community.

- Locating County processes and venues for stakeholder involvement.
- Practicing skills needed to effectively participate.
- Collaborating to develop a plan for collective action.

To ensure all stakeholders who participated were trained in the CPPP process BHRS held a **stakeholder training at the beginning of each community planning meeting**. This training covered the **history of MHSa, the key regulations, the guiding values, and the steps of the community planning process**.

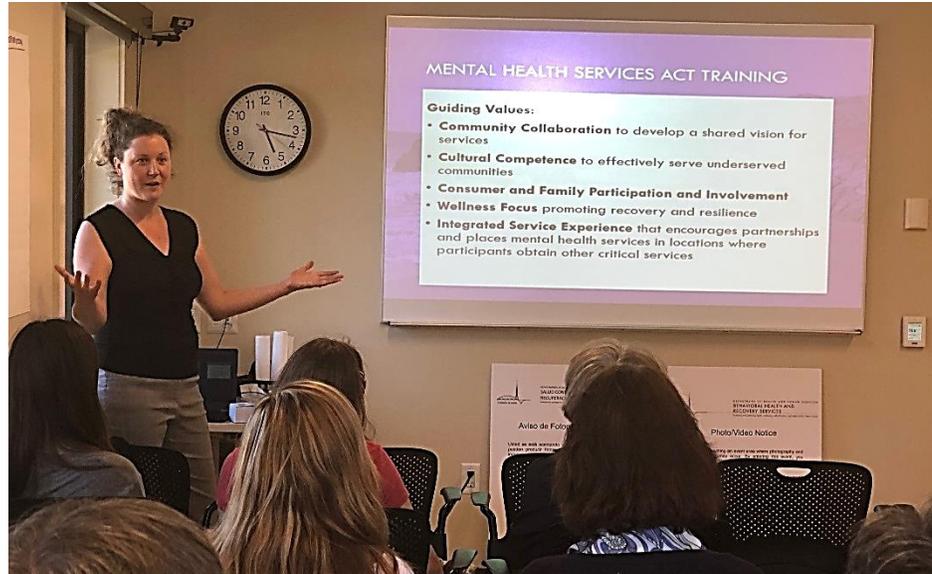


Image 2: Galen Main, MHSa Coordinator, providing MHSa Training for stakeholders participating in the Community Planning Process in West Marin on June 18, 2019

Documents provided at the meetings were available in English and Spanish. Interpreters were available on site at each of the regional community planning meeting for participants if needed.

Suicide Prevention Focus:

Based on community input, advocacy, and an analysis of the data, the County of Marin Behavioral Health and Recovery Services (BHRS) began the MHSa 3-Year Community Planning process wanting to take a focused look at how to prevent suicide in this county. In October of 2018, BHRS the initiated a suicide prevention strategic planning process in collaboration with the Department of Public Health, the Marin County Office of Education, stakeholders, and community partners.

The first phase of the Suicide Prevention Strategic Planning process was a county-wide Community Needs Assessment to better understand the specific context of suicidal behavior in Marin County. This consisted of:

- **9 community focus groups** (63 people) focused on suicide prevention, including groups of:
 - Transitional Age Youth
 - Middle School Students
 - Older Adults/people who work with older adults
 - Leaders in communities of color
 - Middle Aged men
- **1,307 responses** to the BHRS Suicide Prevention Community Survey
- **370 responses** to the Marin County Office of Education Student Survey

- **13 key informant interviews** around Suicide Prevention

Following the Suicide Prevention Needs Assessment, BHRS hosted a **Community Forum on May 2, 2019**, for residents of Marin County to provide input on the strategic planning process. After sharing key findings from the Needs Assessment, attendees participated in a series of brainstorming activities. Forum participants crowd-sourced ideas for strategic planning goals, new programs and services, and other key considerations, working in three different breakout groups:

1. Strategies to engage community members at heightened risk for suicide or suicidal ideation (i.e., middle-aged and older men, LGBTQ+ residents, people of color, youth in schools, veterans);
2. Strategies to increase community members' help-seeking behavior, and decrease stigma around discussing suicide and accessing mental health services; and
3. Strategies to enhance resilience and strengthen protective factors for all Marin County residents

Over 40 community members participated in the community forum, and their contributions laid the groundwork for the strategies, goals, and actions included in this strategic plan. In addition to participating in formal activities, attendees were able to network with each other and strengthen community ties.

Following the community forum, BHRS convened the Strategic Planning Committee, to participate in strategic planning sessions and establish priorities for the strategic plan. Over 30 key stakeholders—representing a variety of public agencies, health clinics, hospitals, community organizations, veterans groups, faith-based organizations, First Responders, commissions, neighborhoods, and lived experiences—gathered for a three-part series of strategic planning sessions, between June 3 and July 12, 2019. Strategic planning participants were integral in the development and refinement of the plan's core components and areas for action. Planning activities included:

- Developing, validating, and refining particular strategy areas, objectives, and action items
- Identifying ongoing programs and services in Marin County communities that could be linked to broader coordination efforts in suicide prevention
- Naming real-world challenges and barriers to the implementation of evidence-based practices
- Troubleshooting potential challenges in interagency collaboration and cross-systems coordination, such as standardizing care practices across sectors and improving the capacity of health care providers to share data
- Brainstorming lists of recommended partners for the strategic plan's priority areas and goals

Participants worked in a trio of breakout groups, which remained intact across all three sessions:

1. The **systems-level** breakout group focused on high-level, countywide strategies involving interagency collaboration, policy change, and cross-systems partnerships. Priority areas included the enhanced coordination of primary and behavioral health care networks; standardizing school programming and policies across school districts; and avenues for lethal means reduction.

2. The **community-level** breakout group focused on strategies and programs at the mid-level scale of cities, towns, and neighborhoods. Priority areas included on-campus programs and services at schools; training and education for service providers, clinicians, and community members; and programs to decrease isolation and improve connectedness between residents.
3. The **individual-level** breakout group focused on strategies to enhance individual residents' knowledge of suicide prevention resources, access to services, and willingness to seek help in times of stress or crisis. Priority areas included strategies for communicating with residents and raising public awareness; crafting targeted approaches to community members at heightened risk for suicide; and addressing culturally specific or age-related risk factors.

Each of the three planning sessions prioritized different phases in the suicide prevention continuum of care. The first two sessions emphasized strategies in suicide prevention and intervention; while the third session involved both a discussion of postvention strategies and a collaborative review of the strategies and activities that had been drafted to date.

Wider Three-Year Planning Community Program Planning Process:

For the wider MHSa Three-Year Community Program Planning Process, Marin County determined it was important to start it off by raising the voices of young people in talking about mental health. We began with a **Youth Mental Health summit** designed, presented, and lead by youth and held at the College of Marin on Saturday, **May 10th, 2019**. Following this, the **MHSa Transitional Age Youth (TAY) Advisory Council convened a forum** at the Marin County Office of Education on **June 26, 2019**, presenting on what they learned and recommendations for how it can be incorporated into the MHSa Three Year Plan.

This is the first time since the establishment of the Mental Health Services Act that the planning timeline **lined up with the Substance Use Services 5-Year Planning cycle**, so we took full advantage of that opportunity here in Marin. Given the high rates of co-occurring substance use and mental health, the similarity in many of our prevention efforts, and in order to help address self-medicating with other substances to address mental health concerns, we held many of our community planning meetings jointly. The breakout groups did not



Image 1: Kristen Gardner (MHSa Growing Roots Innovation Project Coordinator), Galen Main (MHSa Coordinator), Alyssa Martinez (TAY Advisory Council), and Nafesah Wadud (TAY Advisory Council), at the Youth Mental Health Summit on May 10, 2019 at College of Marin

separate by Substance Use and Mental Health, but rather by Prevention/Early Intervention and Treatment/Recovery Services. This was very effective at getting to address the many overlaps.

In addition, the Federal Grants division of the county **Community Development Agency (CDA)** also had their 4 year plan on the same cycle for a FY2020 start date. Due to the high housing costs, housing is often raised as the number one concern in our county and for our clients, so we coordinated our community planning efforts to invite CDA to participate in our community meetings as well to maximize the effectiveness of our stakeholder's time.

In this next major phase of the Community Program Planning Process BHRS held large meetings in each region of Marin County, starting with West Marin on June 18, 2019, and followed with more targeted and focused planning meetings. Please see a list below of the large community planning events for the MHSa Three Year Plan:

Kick-Off Community Forums:

- **Suicide Prevention Community Planning Forum, May 2, 2019**
- **Youth Mental Health Summit, May 10, 2019**
- **MHSa Transitional Age Youth (TAY) Advisory Council Growing Roots forum, June 26, 2019**

Large Regional MHSa Community Planning Meetings at different times to accommodate different schedules:

- **West Marin**—Point Reyes Station, **June 18, 2019 (5pm)**
- **North Marin**—Hamilton Field Community Center, Novato, **July 22, 2019 (7pm)**
- **San Rafael**—Marin County Office of Education, **August 1, 2019 (1pm)**
- **Southern Marin**—Bayside/Martin Luther King, Jr., Academy, Marin City, **August 5, 2019 (4pm)**
- **Central Marin**—College of Marin, Kentfield, **August 14, 2019 (6pm)**



Image 2: Participants, including Marin County Board of Supervisor Dennis Rodoni (second from the left), at the West Marin MHSA Community Planning Meeting in Point Reyes Station on June 18, 2019

These regional meetings were followed by more focused meetings around certain topics or target populations:

- **Prevention and Early Intervention-Focused** MHSA Planning Meeting—at the Health and Wellness Campus in San Rafael, **August 27, 2019 (4:30pm)**
- **Spanish** Language MHSA Planning Meeting—in the Canal District of San Rafael at Bahia Vista Elementary, **September 26, 2019 (6pm)**
- **Family Member-Focused** MHSA Community Planning Meeting, San Rafael, **October 9, 2019 (6pm)**
- **Older Adult-Focused** MHSA Community Planning Meeting, WhistleStop Senior Community Center, **October 24, 2019 (10am)**
- **Peer/Consumer-Focused** MHSA Planning Meeting, **November 4, 2019 (12pm)**



Image 3: Jane Ireland, Unit Supervisor for the Helping Older Adults Excel (HOPE) Full Service Partnership (FSP), answering questions at the Older Adult Focused Community Planning Meeting on October 24, 2019, also pictured is Jordan Hall, Program Manager for Substance Use Services

After the kick-off events, each meeting began with a brief PowerPoint presentation to provide training to the stakeholders on MHSA and the Community Planning Process including giving the history and an overview of MHSA's purpose, guiding principles, funding estimates, examples of MHSA programs from the current three year plan in that region of the county, and steps and timeline for plan approval and ways to remain involved. Following the training, there were a series of questions used to poll participants on their priorities for the upcoming plans using voting technology.

The vast majority of each meeting was spent in breakout groups as the goal was to hear from the community. There were three (3) breakout groups and participants were given the opportunity to rotate through their top two choices.

Break Out Groups (All community input received during the planning process is posted on our website: www.MarinHHS.org/MHSA):

- **Prevention and Early Intervention** (both mental health and substance use)
- **Treatment and Recovery Services** (both mental health and substance use); and
- **Housing and Public Services** (lead by the Community Development Agency)

Community meetings were conducted throughout the County and included translation and interpretation in Spanish (as well as breakout group discussions in Spanish lead by bilingual/bicultural

staff members at each meeting as well as a meeting held entirely in Spanish), in addition bus passes, food, non-alcoholic beverages, and childcare was provided. Invitations were distributed to community members, BHRS staff, BHRS contractors, all MHSA related committees, including the MHSA Advisory Committee, the Mental Health Board, the Alcohol and Other Drug Advisory Board, BHRS Stakeholder contact list, NAMI, Board of Supervisors and other interested parties. Flyers were displayed at MHSA program locations, libraries, laundromats, stores and other locations throughout the community. Gift cards and bus passes were given to participants with lived experience and raffles were held at meetings targeting underserved community members.

Stepping Up Planning

In addition to the targeted MHSA community planning meetings there were a series of Stepping Up planning meetings and single-issue workgroups. These included AB1810 Planning and Implementation meetings to develop procedures regarding Behavioral Health Diversion and to develop recommendations. These workgroups met on:

- **August 30, 2019**
- **October 24, 2019**
- **October 25, 2019**

In addition, there was a workgroup developed to focus on Behavioral Health Crisis Options for Law Enforcement which met on **December 3, 2019** to develop recommendations.

Community Planning Survey

In addition to the Suicide Prevention planning survey described in the suicide prevention section of the community planning process which had 1,307 responses, BHRS, in partnership with the Community Development Agency and the Substance Use Services team, released a community survey to gain input for our plans from people who might not be able to attend meetings in person in order to ensure stakeholders have an opportunity to participate. Behavioral Health questions included questions around barriers to accessing services and strategies that should be implemented in the Three Year Plan.

Online and paper surveys available in English, Spanish, and Vietnamese were used to gather community input to inform funding priorities. Surveys were disseminated in partnership with local nonprofit service and housing providers and County departments including the Community Development Agency and the Marin County Free Library. To enhance and encourage participation staff attended numerous community events, including weekly Health Hubs organized through the Marin Community Clinics in both Novato and San Rafael, the Canal Alliance food pantry, and events put together by local organizations, including Community Action Marin, the Marin Organizing Committee, and Performing Stars. **A total of 352 surveys were collected, with 259 in English, 92 in Spanish, and one (1) in Vietnamese.**

The answers to the key behavioral health related questions on the survey are displayed on the next two pages broken down to show the distribution of answers in both the Spanish version of the survey and the English version. The top three barriers identified for accessing behavioral health services were the perceived *Limited Availability of High Quality Treatment Options*, the *Belief that Services Won't Be Helpful Even if Accessed*, and *Unsure of How to Access Services*.

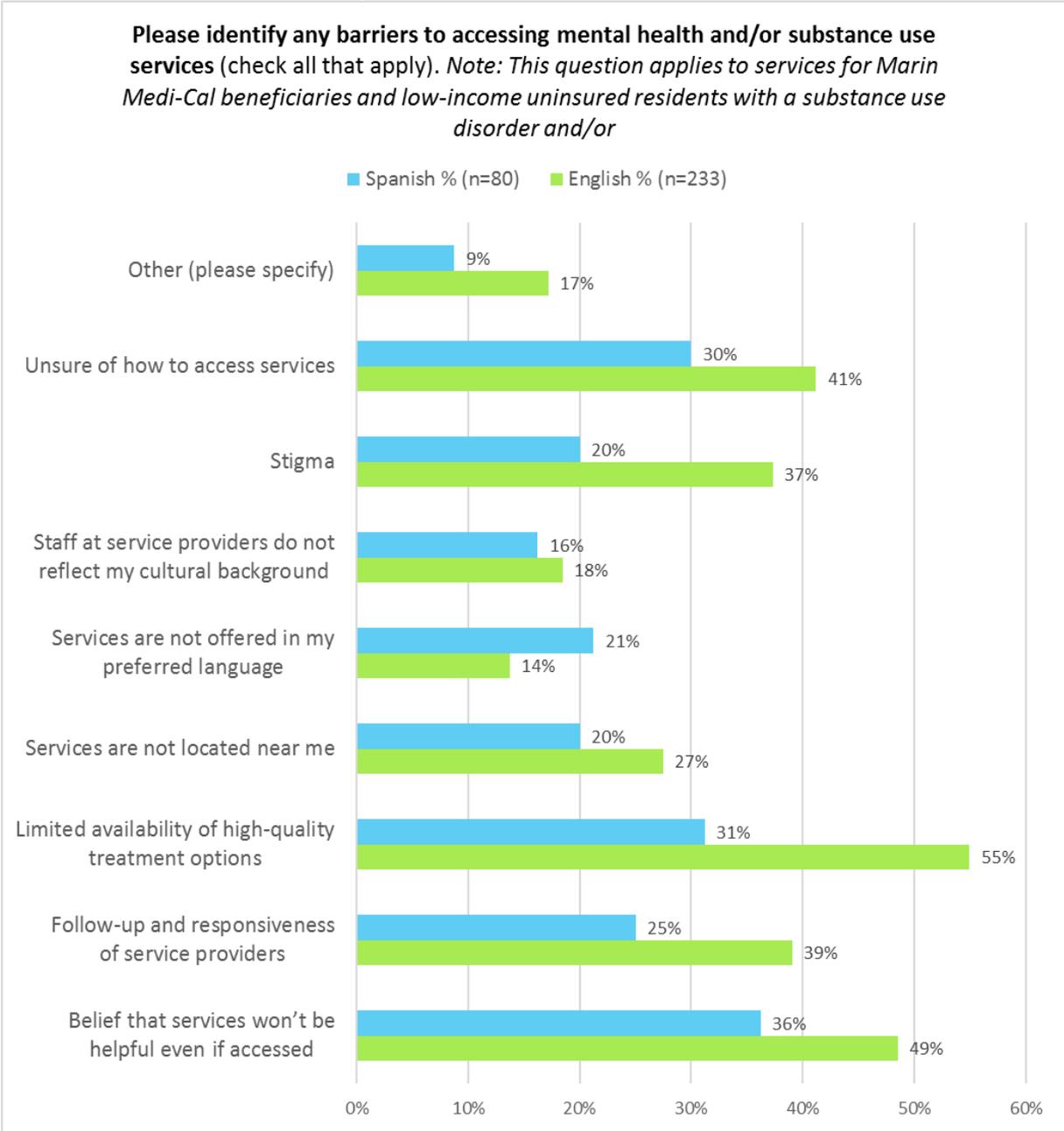
The top strategies that respondents thought would be the most effective for delivering behavioral health services were slightly different in the English response and the Spanish responses.

In English, the top three answers were:

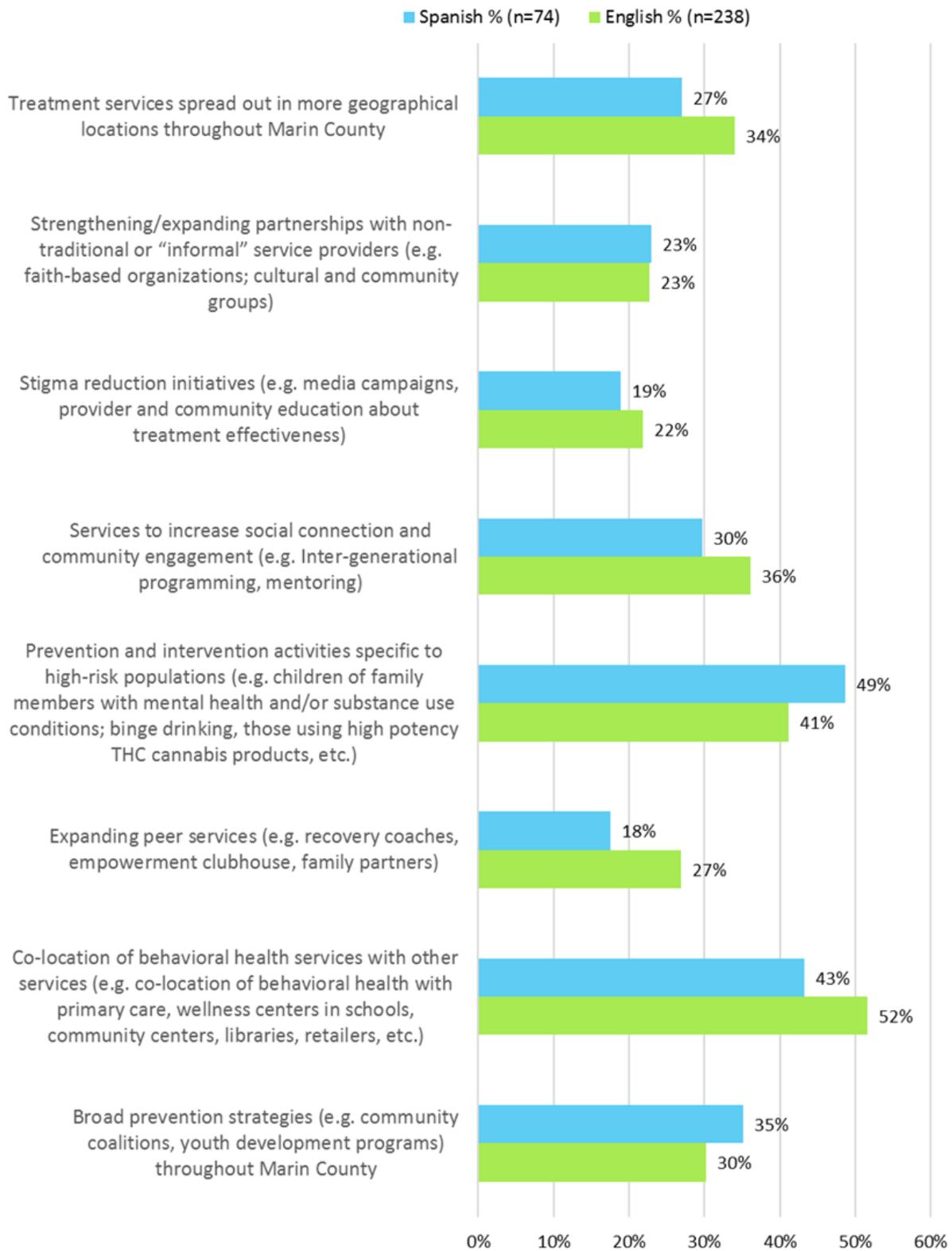
- 1) *Co-location of behavioral health services with other services*
- 2) *Prevention and Early Intervention activities targeted to high-risk populations, and*
- 3) *Services to Increase Social Connection and Community Engagement.*

In Spanish the top three answers were:

- 1) *Prevention and Early Intervention activities targeted to high-risk populations*
- 2) *Co-location of behavioral health services with other services, and*
- 3) *Broad Prevention Strategies*



Please select up to three (3) strategies that you think would be the most effective for delivering behavioral health services in your community



STAKEHOLDER PARTICIPATION DEMOGRAPHICS

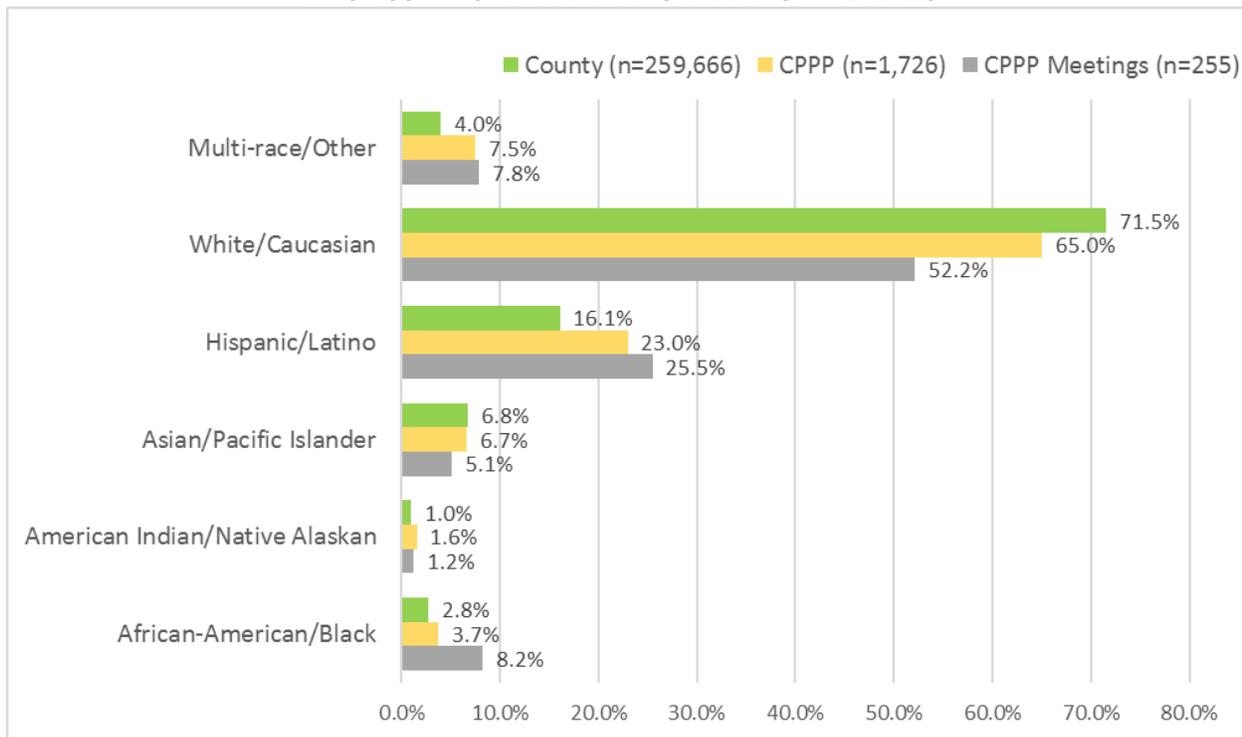
Overall, well **over 2,000 community members**, consumers, families, BHRS staff, providers of service, law enforcement/criminal justice, LGBTQ+ individuals, Veterans, and other interested parties attended the community meetings, participated in a focus group or key informant interview, or completed one of our online surveys (suicide prevention planning or community planning). Of those who participated, **1,726 people completed a demographic form**. Over 500 people attended the in person meetings with 255 completing the demographic survey.

BHRS conducted planning meetings in each region of the county to be sure to capture the input from individuals representing the full **geographic location diversity** of the county.

Females were over-represented in the community planning process so there were focus groups specifically targeting men for their input. 51.1% of the county identifies as female whereas 71.6% of those who participated in our community planning meetings identified as female. This community planning cycle we did have an increase of 4 percentage points for males as compared to the community planning cycle for the last 3-year plan, however engaging men to discuss topics of mental health remains a challenge.

Below is summary information of the racial and ethnic diversity of the county as a whole (green); participants in the community planning process—including both in person and online—(yellow); and attendees of the MHSA Community Planning meeting (grey).

RACIAL/ETHNIC DISTRIBUTION OF THE COUNTY VS
TOTAL MHSA COMMUNITY PLANNING PARTICIPANTS (INCLUDES SURVEYS) VS
MHSA COMMUNITY PLANNING MEETING ATTENDEES



The underserved and underserved racial/ethnic populations in Marin participated in the community program planning process at a higher rate than their white counterparts, for instance **the Latinx population represented 23% of the total community planning participants and 25.5% of the meeting participants, but only 16.1% of the county.**

Demographic forms were not collected at the youth mental health summit or the forum lead by the TAY Advisory council, however youth under 16 represented 2% of the participants who completed demographic forms in the regional and targeted community planning meetings (excluding the 30 plus children who participated in

the child care offered at the community planning meetings) and TAY made up 7.5% of the regional and targeted meeting participants. Adults between the ages of 26-59 made up 57.5% of participants in those meetings, and older adults between 60-74 made up 30%. Those over 75 year of age made up the final 5% of the participants. Given that Marin County is the oldest county in the state and has a rapidly aging population it was important to get input from older adults in the community.

In addition, 13.7% of MHS Community planning meeting participants identified as part of the **LGBTQ+ community (32 individuals)**. In addition, 7.3% of meeting participants unidentified themselves as **currently homeless (17 individuals)**. 1.7% identified as **veterans (4 individuals)** and 23.5% reported having a **disability (55 individuals)**, and 37.2% identified as a **service providers (87 individuals)**.

BHRS conducted significant outreach to clients with serious mental illness (SMI) and Serious Emotional Disturbances (SED) and their families to ensure the opportunity to participate in the Community Program Planning Process. Gift cards for their time and bus tickets were provided to all clients who participated in the community planning process.



Image 4: Stakeholders participating in the MHS Community Planning meeting held entirely in Spanish at Bahia Vista Elementary School in the Canal Neighborhood of San Rafael on September 26, 2019.

Outreach techniques included:

- Hosting specific targeted community planning meetings for consumers/peers and one focused on family members to ensure they felt welcome
- Individualized one-on-one outreach to clients from their case managers and from peers working and volunteering for the county
- Flyers and handouts in all the waiting rooms where BHRS services are provided
- Outreach through the Peer Wellness Programs including the Empowerment Clubhouse and Enterprise Resource Center
- Outreach through the National Alliance on Mental Illness (NAMI Marin) and other family member and consumer groups
- Through our all stakeholder email list

As a result of the intensive outreach to the consumers and family members throughout our system, **82 consumers attended community planning meetings making up 35% of the participants**. In addition, **94 family members participated, representing 40.2% of meeting attendees**.



Image 5: Jaime Faurot (left), Peer Advocate, Family Member, MHSA Advisory Committee Member, and Mental Health Board Member, participating in a community planning meeting. Jaime was an integral part of the MHSA Planning Process and was honored at the “Celebrating the Uncelebrated” Dinner this year honoring those individuals from the Behavioral Health Communities who have selflessly contributed to improving the lives of Marin residents. Jason Faurot (right) has also been a dedicated advocate and provided significant assistance during the MHSA Community Planning Process. A huge thank you to both of them!

ANNUAL UPDATE COMMUNITY PLANNING

Each year of this Three-Year Plan BHRS conducts an Annual Update community planning process to make any changes to the plan and to report on outcomes from programs. The MHSA Advisory Committee and Mental Health Board continued to meet virtually during the second year of the pandemic, discussing MHSA at each meeting. The MHSA Advisory Committee held open meetings to discuss outcomes and priorities and how these things may have shifted during COVID, reviewing outcomes and data trends, funding, and priorities for the Annual Update:

- Wednesday, **July 21, 2021** from 1:30-3pm via Zoom
- Wednesday, **September 22, 2021** from 1:30-3pm via Zoom
- Wednesday, **January 19, 2022** from 1:30-3pm via Zoom
- Wednesday, **March 9, 2022** from 1:30-3pm via Zoom
- Wednesday, **May 18, 2022** from 1:30-3pm via Zoom

Community-wide FY22/23 MHSA Annual Update planning meetings were held on the following times to get input from individuals who can more easily attend during the day or the evening:

TUESDAY
JANUARY 25, 2022
5:30-7pm via zoom

THURSDAY
JANUARY 27, 2022
10:30am-noon via zoom

Then we held a series of planning sessions to hear specifically from those with **lived experience**:

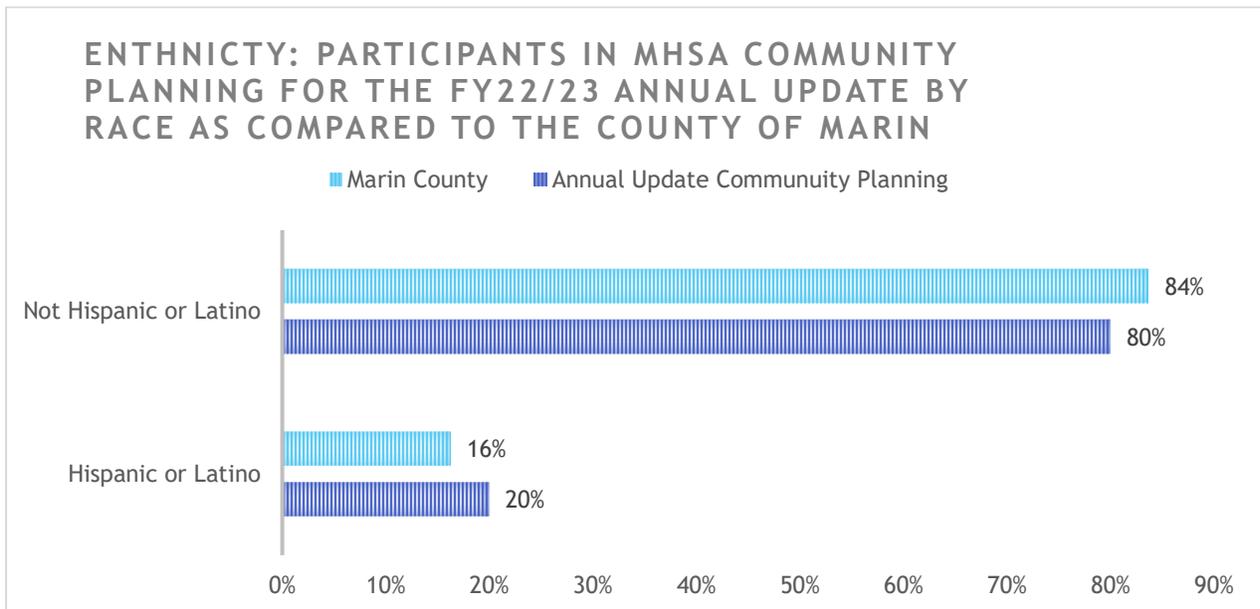
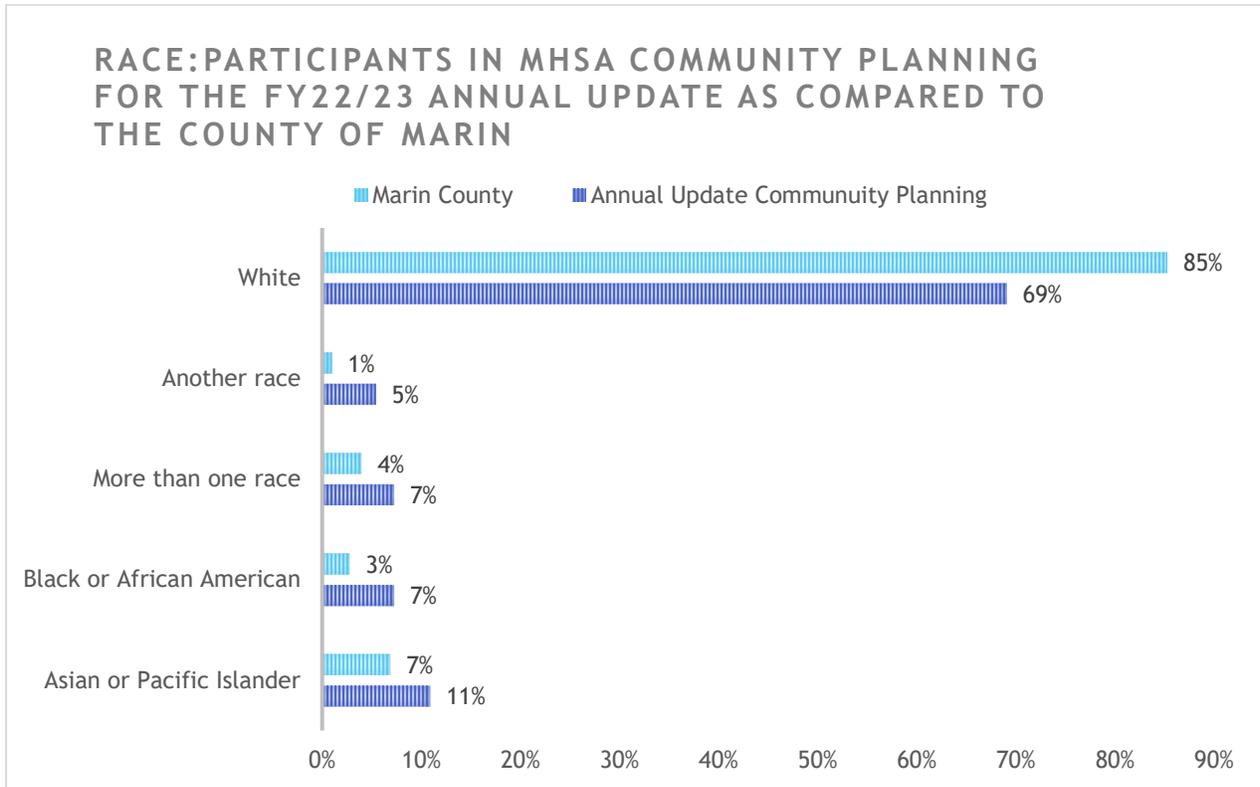
THURSDAY
FEBRUARY 3, 2022
12-1:30 via zoom

MONDAY
FEBRUARY 28, 2022
12-1:00 in-person at the Peer-Run Drop-In Center

In addition, we held sessions to gain further input with the Youth Action Committee, the Mental Health Board, and the Prevention and Early Intervention Committee.

DEMOGRAPHICS OF FY22/23 MHSA COMMUNITY PLANNING:

Over 100 people participated in these meetings including 60 who completed the demographic survey.



57% (34 individuals) of those who participated in the Community Planning for the FY22/23 MHSA Annual Update have lived experience as a **Family Member** of someone with mental health challenges

67% (40 individuals) identified as having **personal lived experience** with serious mental illness.

7% identified as being **veterans**.

14% identified as being a part of the **LGBTQ+** community

91% of individuals speak English as a primary language, **5%** speak Spanish as a primary language, **2%** Vietnamese, and **2%** another language.

23% of individuals identified as Male, **75%** female, and **2%** another gender identity.

MHSA FY22-23 ANNUAL UPDATE PUBLIC REVIEW PROCESS

The MHSA FY22-23 Annual Update will be posted for **30-day Public Comment** beginning on **April 11, 2022 and remain posted through May 10, 2022**. The Annual Update will be posted on Marin County's website at: MarinHHS.org/MHSA including instructions on how to receive a copy of the report, how to submit comments and the date of the Public Hearing. An email with a link to the website posting was sent to all Behavioral Health and Recovery Services (BHRS) staff, contracted providers, community-based organizations, Marin Mental Health Board, Alcohol and Other Drug Board, BHRS staff, MHSA Advisory Committee, and the BHRS Stakeholder email list. Notice of the posting will be published in the Marin Independent Journal.

On **Tuesday, May 10, 2022** a virtual Public Hearing will be hosted by the Mental Health Board at 6pm.

PUBLIC COMMENTS ON THE PROPOSED PLAN

Four (4) public comments were received during the public comment period and hearing.

- 1) Concerns about the low number of people served by the Older Adult Innovation Project (Help@Hand)

Response: The Older Adult Innovation project is focused on learning rather than implementation of services. However, the final year of the project will be shifting into how to spread what was learned through the pilot to maximize impact by partnering with community-based organizations and programs that serve older adults.

- 2) Support for the focus included in the plan on providing living wages for Peer Support Specialists
- 3) Advocating for programs specifically targeting youth and adults who have experienced or witnessed domestic violence to be included in this Annual Update or the next Three-Year Plan

Response: The MHSA Advisory Committee will invite the Center for Domestic Peace to present at a MHSA Advisory Committee and have a discussion around this topic as part of the Three-Year Planning Community Engagement process.

- 4) Support for the investment made in the Annual Update to support crisis services

SUBSTANTIVE CHANGES MADE DURING THE PUBLIC COMMENT PERIOD

No substantive changes were made to the proposed plan during or after the public comment period.

INNOVATION COMPONENT

OVERVIEW

The Mental Health Services 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 third Innovation Project, focused on innovative approaches to serving older adults, is ongoing and reports on progress during FY20-21 are shared on the following pages.

During in FY20-21 there was extensive community planning for the next MHSA Innovation Projects. Per recommendation from the MHSA Advisory Committee, two new projects were brought to the Mental Health Services Oversight and Accountability Commission for approval.

- *From Housing to Healing (H2H): A Re-Entry Community for Women*
- *Student Wellness Ambassador Program (SWAP): A County-Wide, Equity-Focused Approach*

OLDER ADULT TECHNOLOGY SUITE INNOVATION PROJECT

ANNUAL INN PROJECT REPORT

PROGRAM OVERVIEW

The Help@Hand Project (previously known as the Innovation Technology Suite) is a multi-county/city Innovation project designed to determine if, and how, technology fits within the behavioral health system of care. This project was approved by the MHSOAC in September of 2018 (during FY18/19) for a total project budget of \$1,580,000. Help@Hand provides support for Marin County older adults to access wellness apps and digital literacy training through 2023. The intent of this project in Marin is to understand if and how digital technology resources may support the wellness of older adults, particularly those who are socially isolated. Digital behavioral health is a rapidly emerging field, with over 10,000 apps in development and a robust evidence base showing that digital self-care technology has the potential to impact depression, anxiety, and loneliness for a broad range of populations.

Each county participating in Help@Hand is trying to reach a unique unserved or underserved population. During the FY2017-20 Three-Year Planning process and public comment period, Marin stakeholders identified a need for additional mental health resources to support the growing older adult community in Marin County, particularly those who are isolated, often due to lack of access to transportation, physical limitations, anxiety or depression, loss, or for fear of stigma related to mental illness or cognitive impairment. The Innovation proposal was developed based on a nine-month community planning process (November 2018- August 2019) involving community members, providers and other stakeholders. Based on the community planning process, Marin County has been focused on identifying an application, developing training curricula focused on meeting the needs of **isolated older adults, and learning what strategies and interventions best meet the needs of isolated older adults.**

TARGET POPULATION

The target population for Marin is:

- Socially isolated older adults, including those experiencing or at risk of loneliness or depression
- Older adults who are at risk for developing mental health symptoms or who are at risk for relapsing back into mental illness
- Older individuals with mild to moderate mental health symptom presentations, including those who may not recognize that they are experiencing symptoms
- Underserved older adults including those who are geographically isolated and residents whose primary language spoken is Spanish

PROGRAM DESCRIPTION

There are 5 key components of the project that Marin County is focused on are:

- **Identifying and selecting an app** for the older adult community: In 2020, Marin conducted focus groups (over 200 hours of product testing) with older adults and meetings with an advisory committee to determine which behavioral health app would be the best fit for this population and to strategize around best approaches to engaging older adults and supporting their use of the selected app. Using the feedback obtained from the focus groups, in January through April of 2021, Marin conducted a comprehensive pilot project with a carefully designed evaluation to assess the impact of the digital

literacy program and the selected behavioral health technology, myStrength™™, on the wellness of isolated older adults.

- **Digital Onboarding and Behavioral Health Literacy Training:** The purpose of this component is to help older adults develop or improve knowledge, skills, and behaviors to effectively and safely use digital devices with the aim of supporting them in accessing behavioral health technology. Marin has contracted with a non-profit, Technology4Life, that has extensive experience training older adults in the use of technology. For the pilot project, a digital literacy curriculum was designed and delivered in small group trainings prior to using a behavioral health self-management tool to ensure participant knowledge and safety prior to engaging with technology. Participants that did not have access to Wi-Fi were also provided accounts to enable connectivity.
- **Peers:** The vision of the peer role is to incorporate peer input, expertise, knowledge and lived experience at all levels of the project and to support the use of the technology through peer outreach and training. In Marin, the peer is broadly engaged in both the design, planning, implementation, and delivery of services.
- **Evaluation:** Our Marin team has been working closely with researchers from UC Irvine to develop evaluation tools and metrics to determine the impact of myStrength™ technology and the digital literacy training.
- **Marketing/Outreach - Detect and Connect:** One of the major initiatives of the first three years of this Marin Innovation Project was to expand outreach and marketing by partnering with the Aging Action Initiative on a training project around older adult mental health and dementia to a wide range of audiences to teach them about available resources. This training is called Detect and Connect and has been an avenue to promote education, provide outreach, and spread the word about Help@Hand and other resources.

In addition, Help@Hand continues to study the strategies for best reaching and engaging isolated older adults in behavioral health technology.

LEARNING OBJECTIVES AND EXPECTED OUTCOMES

The learning objectives for this project are to:

- Detect and acknowledge mental health symptoms sooner (in the older adult population)
- Reduce stigma associated with mental illness by promoting mental wellness
- Increase access to the appropriate level of support and care
- Increase purpose, belonging, and social connectedness of individuals served, and
- Analyze and collect data to improve mental health needs assessment and service delivery

Desired Outcomes include:

1. Increased social connectedness, belonging and purpose as measured subjectively by user
2. Reduced symptoms of depression, anxiety, and other mental health concerns
3. Increased public awareness of mental illness in older adult population and reduction in stigma as measured by pre and post workshop evaluations – detect and connect
4. Increased user ability to identify cognitive, emotional, and behavioral changes and actively engage in strategies to address them

HIGHLIGHTS AND OUTCOMES FROM FY 20/21

Fiscal year **2020/2021** was focused on designing and piloting a digital literacy/myStrength™ technology project with 30 isolated older adults to answer specific questions about how to reach this population and to understand

the impact of the technology on their wellness. The pilot was designed and conducted to ensure that any implementation considered or designed would have significant value for the County and the desired impact on isolated older adults. Many lessons were learned from piloting myStrength™ technology paired with digital literacy training. The results of the quantitative and qualitative evaluation conducted by the University of California at Irvine highlighted these learnings, and helped the County realize the need for a larger, coordinated digital literacy initiative to enhance access, as well as to build in a wellness component utilizing digital behavioral health technology and peer support. County Departments are now engaged in cross disciplinary discussions about how to build a needed larger digital literacy initiative tied to numerous county needs assessments and plans (i.e., Digital Marin, Age Forward, Suicide Prevention, and HHS Equity Plan).

DESCRIPTION OF GENERAL PILOT

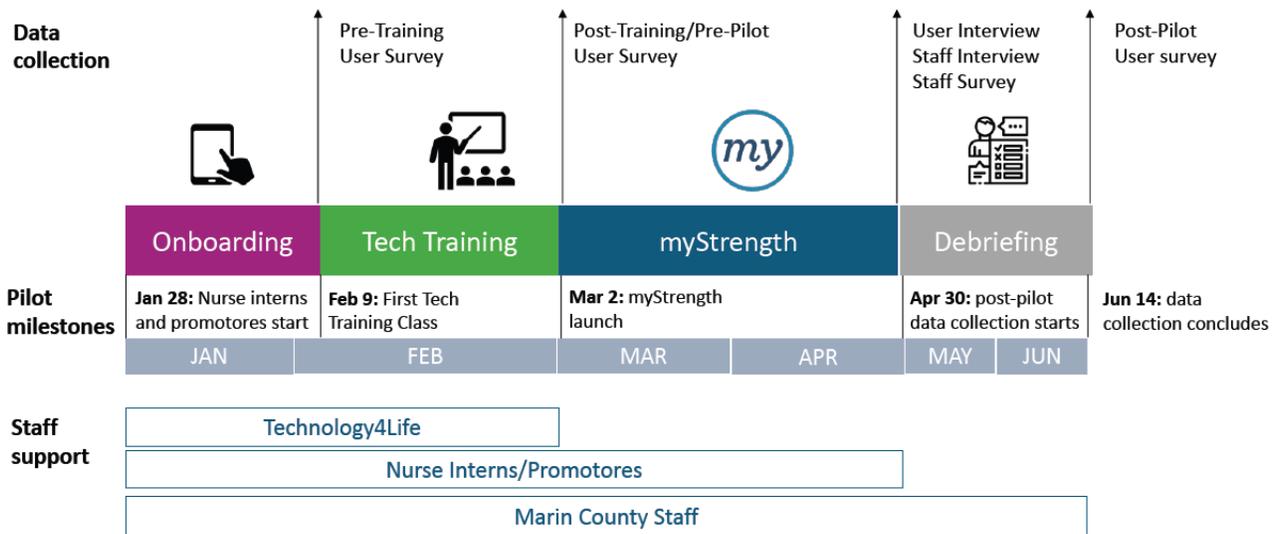
In the last quarter of 2020, Marin's pilot proposal was approved by the Inn Tech Suite Leadership. Between January and March 2021, Marin developed their pilot protocol, which included offering significant support to all potential participants. This support included providing hardware, setting up Internet access (e.g., connection to Wi-Fi), and facilitating digital literacy training conducted by Technology4Life, an organization whose mission is to teach adults of all ages how to use technology. Between March to June 2021, Marin County piloted MyStrength™ with isolated English and Spanish speaking older adults.

The purpose of the pilot was to engage isolated older adults with technology and to enhance their well-being and sense of social connectedness by offering them free access to myStrength™ for 8 weeks. MyStrength™ is a digital mental health platform that provides users with self-care resources to manage issues related to depression, anxiety, stress, substance use disorder, chronic pain, and sleep. The platform allows users to track their mood over time and access other educational and coping resources. MyStrength™ is accessible through a website and a phone app.

Thirty older adults were recruited for the pilot. Half of the pilot participants were English speaking while the other half were Spanish speaking. To support the older adult participants, Marin County enlisted the help of nurse interns from two local universities and *Promotores*, Spanish-speaking volunteers from North Marin Community Services. Working alongside the Marin County staff, the nurse interns, and *Promotores* specifically were tasked with supporting the older adults in their use of technology and more specifically, myStrength™. As part of the pilot, the participants and staff (staff members include the Marin County Help@Hand staff, nurse interns, and *Promotores*) voluntarily participated in digital literacy classes facilitated by Technology4Life. The curriculum consisted of 4 classes on the following topics: 1) Computer Basics 2) Internet Basics 3) Email Basics, and 4) myStrength™. Due to COVID-19, all classes were held via Zoom, and were voluntary for both participants and staff. Several participants also received individual in-person coaching taking all necessary Covid 19 safety precautions.

Figure 1 shows a timeline overview of the Marin myStrength™ pilot. The program involved 1) onboarding to get participants access to required resources, such as a device and Internet, to be able to take part in the program; 2) digital literacy training to improve participants' digital literacy skills; 3) participant engagement with myStrength™ for 2 months; and 4) debriefing participants to conclude the pilot. Evaluation data collection occurred at different time points throughout the program. Staff who were interviewed and surveyed included Marin staff, nurse interns, and *Promotores* as well as program participants.

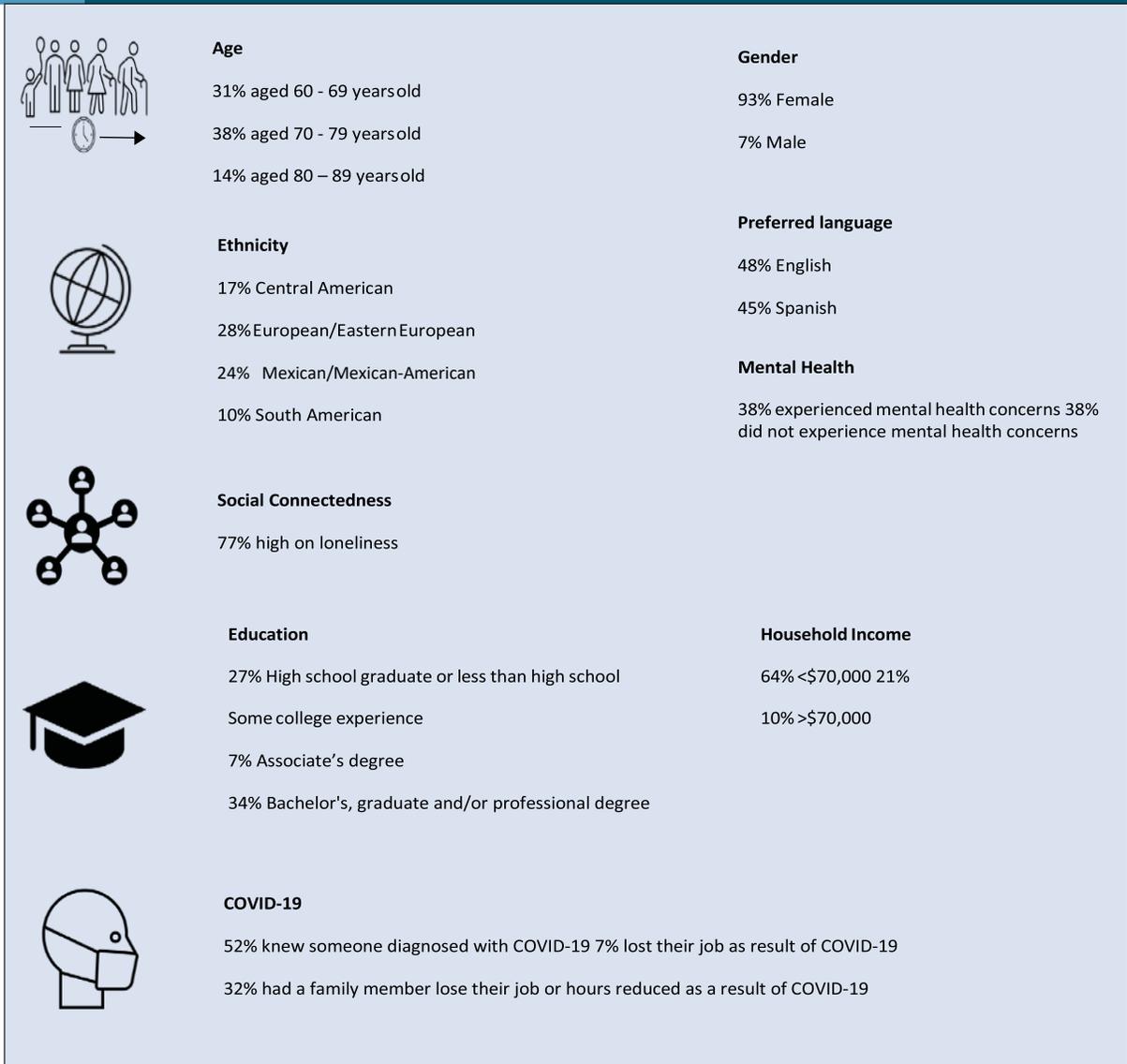
Figure 1. Overview of the Marin myStrength pilot.



DEMOGRAPHIC INFORMATION

Participant demographics for the pilot project:

Figure 2. English and Spanish speaking older adults participated in the pilot evaluation.



PILOT IMPACT AND LEARNING

As part of the evaluation design, Marin designed specific learning questions for the pilot to inform planning and implementation decisions. The following were some of the most significant data points that influenced the decision to consider full implementation:

Learning Objective 1: What changes do older adults report in their sense of social connectedness due to participation in this program

Key Findings

- Benefits of the overall program included feelings of connectedness, through interacting with other participants and by learning skills such as connecting with family/friends virtually.
- By participation in the program, there was a significant decrease in loneliness as well as social isolation among participants.
- Participants were overall satisfied with the program, and hoped more programs like this would be offered in the future.

Observed Changes in Older Adults' Sense of Social Connectedness

Participants were asked about their feelings of loneliness and feelings of being socially isolated at three timepoints. As **Figure 3** shows, both feelings of loneliness and feelings of being socially isolated significantly decreased from prior to the digital literacy training to after using myStrength™. This decrease may indicate that participation in the program reduced social isolation for some participants.

Figure 3. Participants' loneliness and social isolation scores decreased during the program (N=22).

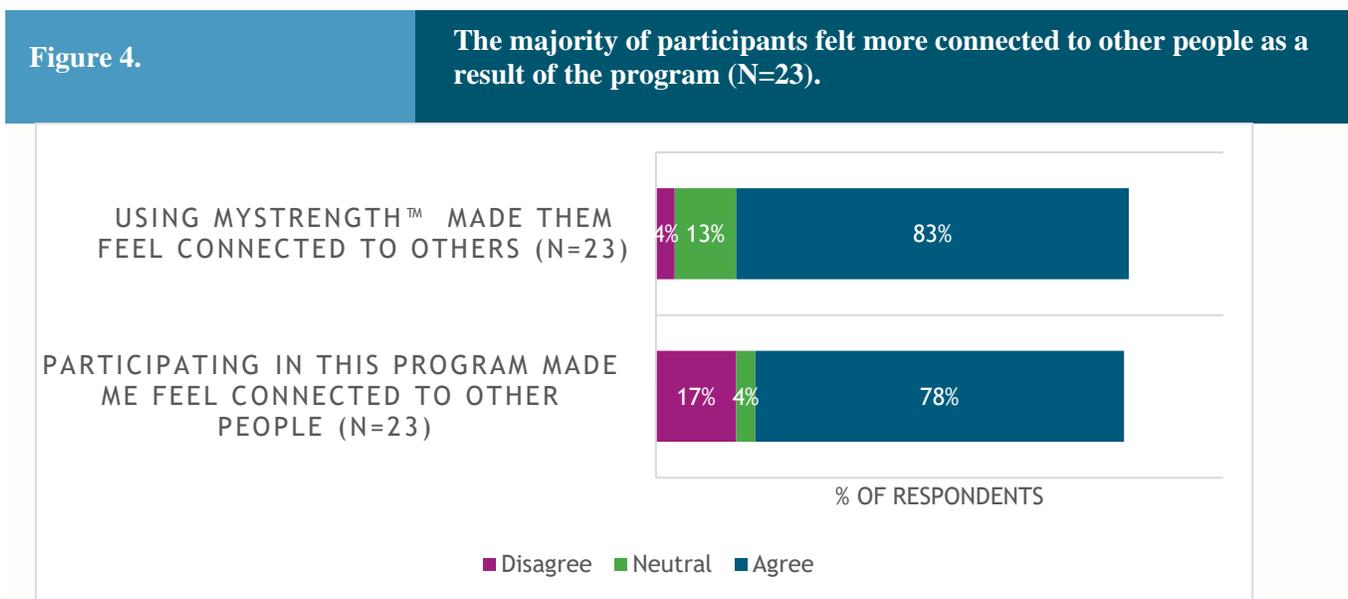


There was a statistically significant decrease in loneliness from the start of the program ($M = 6.0, SD = 1.7$) to the end of the program ($M = 5.5, SD = 2.1$), $t(21) = 3.04, p < .01$. As shown in **Figure 3**, at the start of the program 77% of participants scored high on loneliness; after digital literacy training, 59% scored high on loneliness, and at the end of the pilot after use of myStrength™, 41% scored high on loneliness. This decrease may indicate that

the program reduced loneliness for some participants. A statistically significant difference indicates that the change is strongly unlikely to be due to chance.

There was also a statistically significant decrease in social isolation from the start of the program (M = 7.4, SD = 4.0) to the end of the program (M = 9.2, SD = 5.0), $t(21) = -3.11, p < .01$. As shown in **Figure 3**, at the start of the program 32% of participants were considered socially isolated; after training, 27% were considered socially isolated, and at the end of the pilot, 18% were considered socially isolated.

Participants described how the global pandemic (also known as the coronavirus/COVID-19) affected them, including increased isolation, lack of social connection and activities (including evolving practices, tensions in personal safety/risk vs. social connection/mental health), safety measures, and even some having experienced the virus. In addition to the pandemic, many participants reported feeling isolated or lonely generally. For some, health conditions impacted feelings of isolation.



Learning Objective 2: What changes do older adults report in their sense of health and well-being due to participation in this program?

Figure 5. Changes in Older Adults’ Sense of Health and Well-being Following their Participation in the Program

Participants were asked how likely they were to have a moderate to severe mental distress prior to starting myStrength™ and after using myStrength™. They were also asked about their willingness to seek help prior to using myStrength™ and after using myStrength™.

Thought there were no significant changes in levels of distress before and after the use of myStrength™, more participants were willing to ask for help.

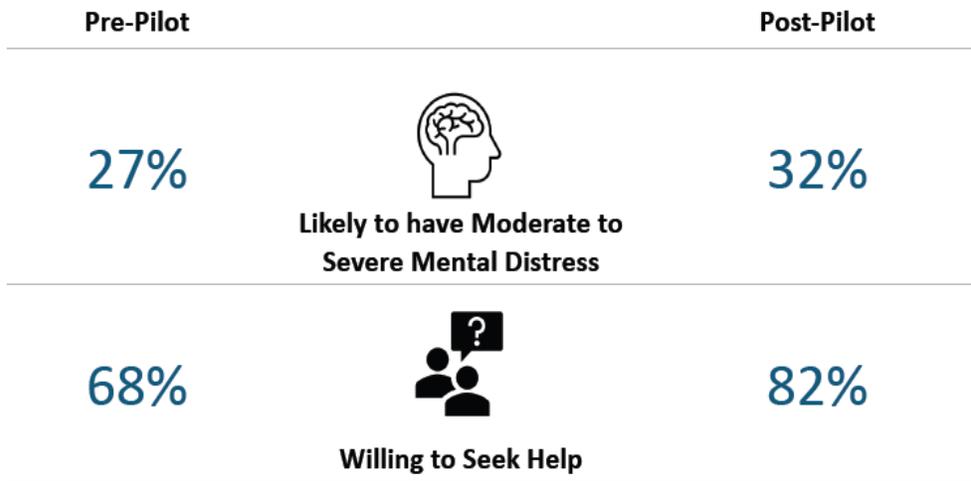


Figure 6. Change in use of technology to support well being

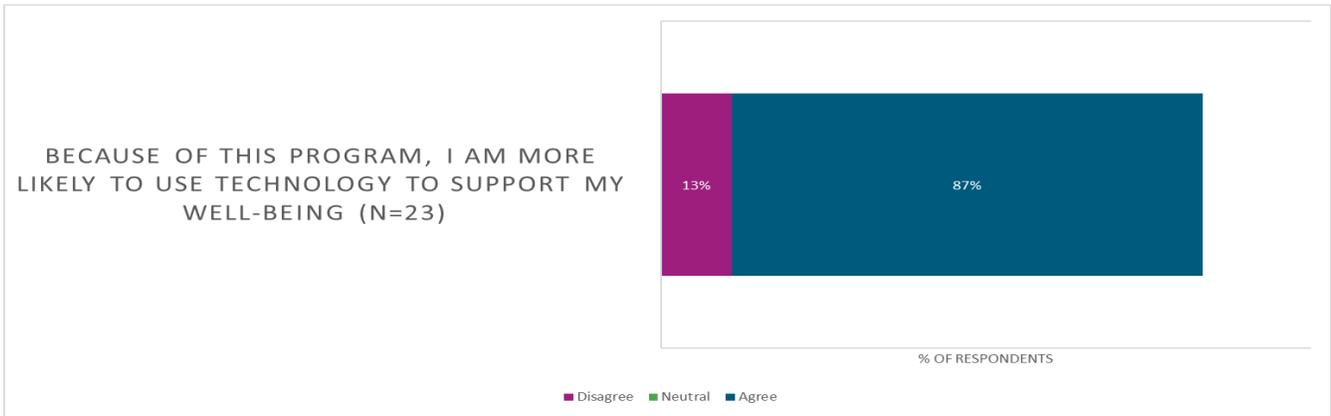
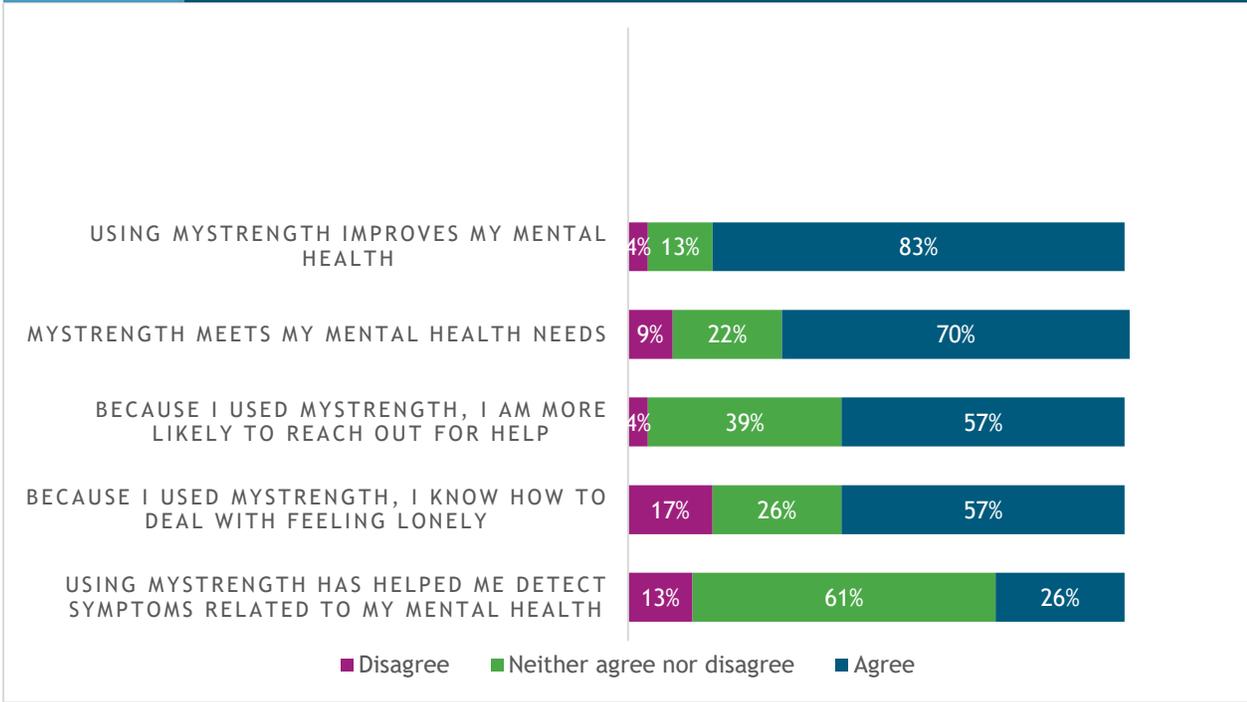
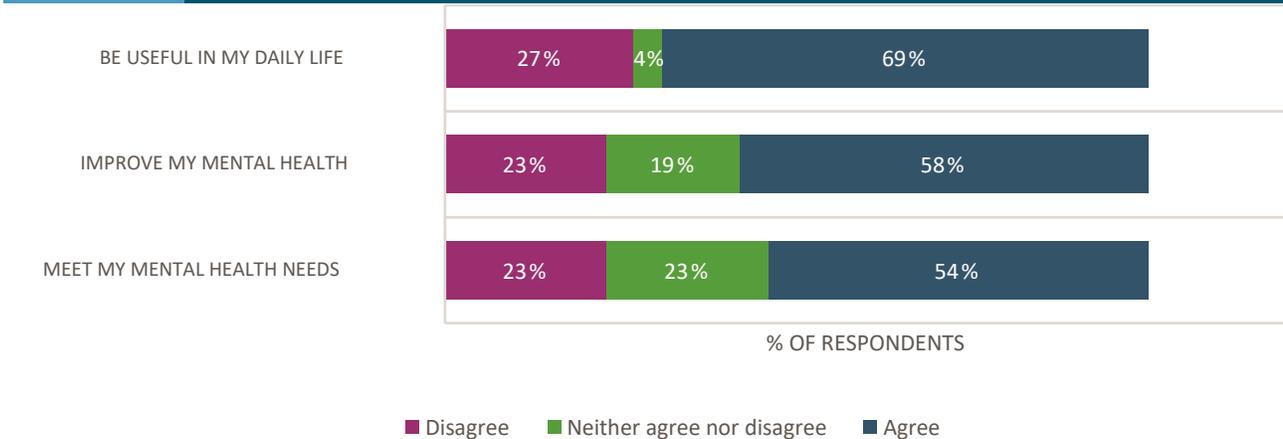


Figure 7. Participants' experience of myStrength™ (N=23)



At the start of the myStrength™ pilot, participants had positive expectations about myStrength™. For instance, as shown in **Figure 8**, the majority of participants felt that it would be useful in their daily life and improve their mental health (69% and 58%, respectively).

Figure 8. Participants had positive expectations about myStrength™ at the start of the pilot (N=26). The statements asked whether participants believed myStrength™ would...



Learning Objective 3: Are there changes in the attitudes towards digital health tools/technology after digital literacy training. Project participants experienced statistically significant changes in all categories.

Figure 9.

More participants were confident using technology to look up information and support their well-being after the training (N=26).

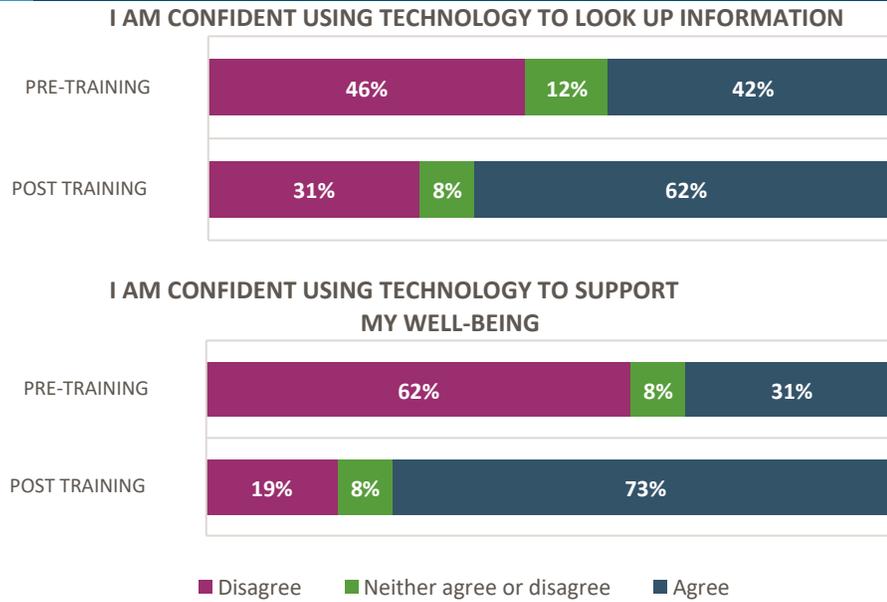
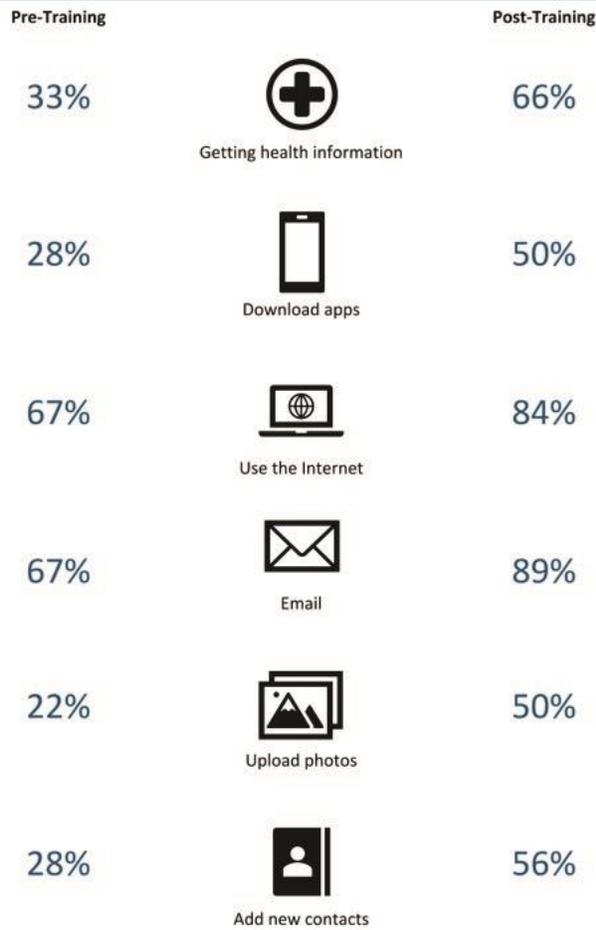


Figure 10.

By participating in the digital literacy training, participants became more comfortable using technology, e.g., to get health information and use email (N=18).



Additional unanticipated benefits gleaned from UC Irvine interview included that the program/myStrength™:

- Changed how participants think about mental health
- Helped participants learn strategies for supporting their mental health needs
- Helped participants learn how to recognize mental health symptoms and health improvements

An example of how engagement with myStrength™ changed how participants think about mental health is best reflected by comments from one project participant:

“Before I had longer periods of sadness and everything. And now, with myStrength™, it helped me a lot... In my mind, there were times when a lot of negative things came to me. Much, much... And I struggled because I kept thinking negative and thinking negative and thinking negative. OK. And then I would say: Let’s see, remember: Breathe. myStrength™ gave you the idea to breathe, to put yourself in a quiet place, watching the sky, seeing nature.” “Maybe it made me more aware so that when I got in this bad mood a couple weeks ago, that... I didn’t know. [chuckles] One of the sections of myStrength™ was – I think it was Depression... And I’ve never had depression. So, I don’t know what it’s like. But I think it was last week, all of a sudden for about two days, I think I felt what might be depression...And so, I mean to go back and check that out.”

Learning Objective 4: What are the most effective strategies for recruitment of older adults within the county?

While numerous strategies were employed to recruit older adults (e.g., radio, flyers, and video), only word of mouth from “trusted others” worked in successfully recruiting participants. Partnerships with agencies that already have access to isolated older adults, as well as *Promotores* were highly successful in recruiting participants.

Learning Objective 5: What is the motivation to participate in this pilot?

Older adults indicated that they opted to participate because they:

- Had an interest in learning something new
- Wanted to support a program aimed at helping people, and
- Believed in the recommendation from trusted others who had participated in other programs

DATA GAPS/LIMITATIONS

Help@Hand sought to gain more information on how differently or similarly English and Spanish speakers responded to the program. Unfortunately, because this analysis cuts the sample size in half (15), no reliable conclusions can be drawn from that small of a sample. However, anecdotally staff noticed the following trends and limitations:

- Spanish speakers enjoyed group digital literacy classes and wanted to have many more
- myStrength™ does not provide voice over in Spanish and instead uses only captioning which negatively impacts the experience of the program and creates unequal access issues for Spanish Speakers (e.g., when watching a video on mindfulness where you need to close your eyes, none of the content is available to Spanish speakers because one cannot read the captioning with their eyes closed). Further, requiring participants to read along can present both literacy challenges and visual acuity challenges for the user, and listening in one language while reading in another

can be disruptive to processing information. Participants commented on how they wish the product were fully functional in Spanish.

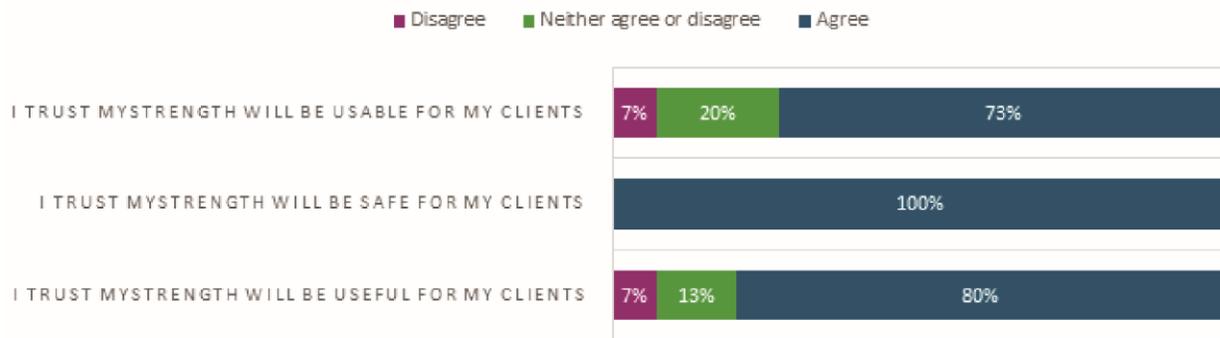
- Language capability in the field of digital behavioral health is limited and remains an area of unmet need

STAFF PERSECTIVE

The Marin County Help@Hand staff team is comprised of two individuals, a peer and a project coordinator, and is supported by the Prevention and Outreach Supervisor and the MHSA Coordinator. In order to effectively reach 30 isolated seniors in their homes during the peak of the pandemic, the Marin team needed to engage partners to coach and support project participants. In total, 13 nurse interns, 4 *Promotores* and one intern were onboarded to provide direct support in digital literacy and engagement with myStrength™. Marin County Help@Hand staff filled in the gaps in direct support as needed. Staff were interviewed about their experience and the perceived usefulness of myStrength™. Data showed that the majority of the intern/*promotora*/staff time was devoted to digital literacy and far less time engaging older adults in using the app. For older adults with low to no literacy, onboarding and training requires intensive and ongoing support and repetition.

Figure 11. The majority of staff professionals believed myStrength™ would be useful and usable for the clients (N=16).

Overall, staff perceived usefulness in Marin County was high, at 88% agreeing it would be useful in Marin.



Staff respondents were asked how much they agreed with the statements above. The scale was created with good reliability (alpha=0.9). Items were assessed on a 5-point scale (1= Completely Disagree, 2= Degree, 3= Neither Agree nor Disagree, 4= Agree, 5= Completely Agree, or 6= Not applicable).

OVERALL RECOMMENDATIONS FOR IMPLEMENTATION

Determine the unique needs of the target population.

- Older adults frequently face physical and/ or mental health conditions that limit or prohibit their participation. Be flexible with scheduling, support, and to adjust to their physical and mental health needs. For instance, some older adults experience fatigue and might need shorter but more frequent

sessions. Working with this population may require adjustable and flexible appointments, classes, and support to optimal times for the participants. This flexibility, however, might introduce additional complications when working with community partners, students, and/or volunteers whose time is often limited or fixed by school or program schedules. As such, consider including committed staff whose work schedules include flexibility.

Digital Literacy Training Should be Both Structured and Adaptable to Class Attendees.

- **Group classes are especially helpful for individuals with high digital literacy.** Older adults who had a general understanding of and experience with technology were able to learn new skills in the group classes.
- **Provide individual coaching opportunities for all participants regardless of skill level.** Individuals with low digital literacy needed extra time for repetition that was customized to their unique learning needs. Others appreciate the opportunity to ask about topics not covered in the class.
- **Provide description of each class including topics that will be covered and stick to it.** Include description of content to be covered during class so older adults can choose where and when they feel group classes would be instructive for their unique learning needs. Consider breaking materials down into smaller digestible components -- four class offerings were not enough and the 1.5 hour class was not optimal for those with health/fatigue issues.
- **Include time for hands on practice.** Prior to moving to a new topic, give individuals time to practice new skills. This is especially helpful for those who have a lower digital literacy level.
- **Offer classes on a variety of days and times to accommodate individual schedules.** Marin's target population included working and non-working older adults. Working adults could not attend classes during the day. Moreover, limiting classes to one or two days a week did not work for many older adults due to other conflicts (caregiving, work, social activities). The ability to offer classes at flexible times was limited by the need to align with the nurse intern schedules as well as the availability of the Technology4Life instructors.

Plan for and Provide Support for Participants New to Technology.

- **When designing an implementation, include additional time to support participants.** The time it took to onboard participants onto myStrength™ was much longer and more intensive than Marin originally planned for. Older adults needed support in accessing Wi-Fi, becoming digitally literate, onboarding onto the technology and understanding how to use the technology.
- **Prior to launching an implementation, make sure to have sufficient staff.** Older adults needed individual support throughout the implementation. Future implementations should consider each step of the process, type of support, how that support will be provided and estimate the additional time that will be needed to provide that support.
- **Consider partnering with outside agencies to support clients during an implementation or expand committed staff (perhaps by leveraging resources available through Peers).** Marin County leveraged several partnerships to support participants. Because of these partnerships they were able to provide the support their participants needed with accessing Wi-Fi, becoming digitally literate, onboarding, and utilizing myStrength™. However, the effort provided by community partners varied widely, and

supporting these activities with county staff might provide more consistent support. Expanding the peer model to support these activities could be beneficial.

- **Time to train and supervise all supporting staff should be included in the program design.** Twenty individuals were used to support participants use of myStrength™. Two were paid part-time staff, while the rest were unpaid nurse interns, *Promotores*, and a behavioral health intern. All were new to this type of support and to this project and required considerable training and expectation setting. Future implementations should account for time needed to orient all participating staff. This includes training on the technology (i.e., myStrength™) and tasks required to support individuals using a new technology. Nurse interns and *Promotores* were tasked with onboarding and supporting program participants. [Assess Target Populations Resources and Ability to Access Technology](#)
- **Determine if target population owns a device that'll connect them to the Internet and consider distributing devices to those who do not have access to a smartphone or tablet.** Many older adults do not own a device that will support a digital mental health program. That is, they may not own and/or understand how to use a smartphone or tablet. Furthermore, although some individuals may have Internet available to them, and can afford it, they need help connecting Wi-Fi in their homes. Service providers for low-income accounts expect self-installation, which many older adults do not feel they can do independently. Understanding early in the pilot process the need to provide support (both hardware, software, and soft skills) to participants, and developing strategies for addressing these complex needs were key strengths of this pilot program.
- **Cost of Wi-Fi may prohibit access to Wi-Fi.** Although individuals may have access to the Internet, its cost may prevent individuals from acquiring it. Paying for Wi-Fi on a month-to-month basis is more costly than a one-year contract. Moreover, even though reduced-price Internet programs may be available, requirements for qualifying may exclude some potential participants. In Marin, Comcast's Internet Essentials program offers reduced price Internet. Many older adults qualified for the program, but some did not for reasons that were not about their income level (e.g., they had a cable TV provider within the last 90 days).
- **There is a need to ensure County fiscal systems are structured to support payments for individual Internet service for participants.** Internet service providers either allow for payment for service from individuals or as groups ONLY if everyone resides at the same residence. For a larger community roll out of a technology program where participants need support with payments and have different addresses, there is no simple way to arrange billing to the County; there is a need to design a system to facilitate payment.

HELP@HAND THROUGH 2023

From the Pilot work conducted in 2021, it is clear that offering digital mental health support paired with digital literacy training has many positive impacts on program participants. The learning objectives of Help@Hand are to:

Analyze and collect data to improve mental health needs assessment and service delivery

Increase purpose, belonging and social connectedness of individuals served

Increase access to the appropriate level of support and care

Reduce stigma associated with mental illness by promoting mental wellness

Detect and acknowledge mental health symptoms sooner

The myStrength pilot met the learning objectives of Help@Hand and made clear that offering digital wellness tools paired with a digital literacy program has significant benefit to isolated older adults. One key learning is that to serve the most vulnerable, it is essential that a comprehensive digital literacy program be built to support this introduction of digital wellness tools.

Marin has many initiatives in play that align with development of a comprehensive digital literacy program including Digital Marin and their newly formed strategic plan and the Age Forward Plan from the Division of Aging and Adult Services in Marin County. Threading various initiatives together these initiatives will be important to build infrastructure to optimally serve isolated older adults in Marin County. Once a core digital literacy program in place, digital behavioral health supports can be added. Help@Hand has built the following tools and strategies to be paired with digital literacy training for isolated older adults:

- Legal agreements for using a behavioral health tool and participating in the program
- Device use agreements for providing participants with devices
- Course curriculum to introduce and use a behavioral health tool
- Comprehensive screening tool to ensure participants can benefit from a digital tool
- Proposed digital literacy curriculum and course structure to get an older adult from novice to skilled beginner
- Documented recruitment and partnership strategies to successfully engage older adults
- Proposed volunteer program to reinforce learning, address isolation and provide “just in time” learning opportunities between classes, as well as an outline of volunteer training
- Evaluation measures to determine impact of digital literacy training and use of behavioral health tools
- A Tool Kit documenting these lessons learned and the tools available ([link](#))

It is clear that underserved/unserved isolated older adults can benefit from using myStrength™ technology, particularly those left behind in the digital divide. However, it is clear that without comprehensive support and reinforcement to engage with a product like myStrength™, many older adults will not utilize it. Shortly after the pilot ended, participants stopped using the myStrength™ technology. Research is currently underway to determine the reasons for disengagement with the product myStrength™. Researchers are preparing to conduct phone surveys to determine why they no longer use myStrength™ and to understand whether or not they plan to use it again. This information will be critical to determining next steps for Help@Hand.

In Marin, there is a system gap in providing coordinated approach to offering digital literacy support for older adults, particularly those who are isolated or unable to leave home. Numerous County sponsored strategic plans call out the need for a more comprehensive infrastructure/support system for providing digital literacy training to older adults, such as the Digital Marin Strategic Plan ([link](#)), the Age Forward plan in the Division of Aging and Adult Services ([Link](#)) and efforts of the County libraries, but because these efforts cross divisions, departments and organizations, coordinating a larger plan will require a much larger effort than the charge of Help@Hand. In the coming months, staff will be looking more intensively as to determine how to utilize the lessons learned from Help@Hand to integrate with larger County initiatives to support digital literacy and the mental health needs of the most isolated older adults.

FROM HOUSING TO HEALING: A RE-ENTRY COMMUNITY FOR WOMEN

PROJECT DATES: January 15, 2022-January 14, 2027

PROJECT BUDGET: \$1,795,000 over 5 years

PROJECT APPROVAL: The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on May 27, 2021. The Marin County Board of Supervisors approved this project on June 8, 2021.

PROJECT DESCRIPTION: This project is healing-centered and holistic treatment for women with serious mental illness and potentially co-occurring substance use disorders who have been incarcerated or otherwise resided in a locked facility who have high Adverse Childhood Experiences (ACEs) scores. This program will promote a holistic view of healing from traumatic experiences and environments and shift the paradigm from lawbreaker past victims of traumatic events to “agents in the creation of their own wellbeing.” The approach will include a focus around understanding the widespread impact of trauma, learning to manage the subsequent maladaptive reactions and behaviors, and collective healing. Creating safety and building community are key bedrocks for this work. Part of the program will be a safe and welcoming home for 6 women (one of the women will be a peer provider) to focus on this healing before moving to permanent housing. This program will be uniquely geared toward managing the types of behavioral issues that women with a history of trauma tend to present with (intense interpersonal conflict, self-harm ideation, etc.) that can be a barrier to enrollment or successful completion of other treatment programs. As part of its innovation, services would begin prior to residency at the house—as part of their re-entry planning, the trauma therapist would work with women in the jail or other locked facility prior to release—to start building a foundation, connecting them with benefits, establishing rapport, and providing psychoeducation to help the women recognize how trauma could be impacting them. Often the focus of treatment for these women is the substance use or mental health diagnosis and the trauma does not get attention. Psychiatric medication and talk therapy alone are often insufficient to treat behavioral problems stemming from a history of trauma. When a client is in custody, it is often a unique time to talk with them about treatment as they are sober and often more motivated to talk with providers in a way they are not when in the community.

This program will focus on actively resisting re-traumatization and the women would remain engaged with the trauma healing after they move on from living in the house. Women would not graduate from this supportive housing environment without housing and ongoing support in place. When women do leave, they could continue therapy with the trauma therapist during a transitional period, so that treatment and connection do not abruptly end at the same time as a transition in housing is occurring. Knowledge about trauma and its impacts will be fully integrated into policies, procedures, practices, and settings, for instance if a woman departs the house abruptly in the context of an emotional or interpersonal breakdown, this will be managed in a Trauma Informed way and she would not be automatically discharged from the program as is often the case in residential programs. In addition to the Trauma Therapist, a variety of somatic, alternative, cultural, or other healing practices will be introduced to the women and they will play an active role in evaluating those therapies and selecting what should be introduced more broadly within Behavioral Health and Recovery Services (BHRS) in Marin. There will be a holistic approach, including strong coordination with other service providers throughout Health and Human Services and the community including substance use treatment. Nutrition will also be a key part of this program and all alumnae will be welcomed back for Sunday

dinners (as well as groups) to help foster the sense of community. To further complement the nutrition aspects of the program there will also be a vegetable garden where the women can learn about growing some of their own food. Only Sunday dinners and healthy snacks for groups will be purchased on an ongoing basis using MHSA INN funding as well as gardening supplies to grow vegetables and herbs. The women will have support ensuring they are able to access their benefits including CalFresh, etc. Learning in a supportive environment some of the necessary social skills and life skills around how to budget, how to go grocery shopping, and how to prepare healthy meals within that budget will help set the women up for success after they transition from the house. The goal is to help the women feel more control over their lives and learn skills to promote and sustain their own wellbeing while they are in a transitional supportive environment.

TARGET POPULATION

The target population for this proposal is women (trans-inclusive) with serious mental illness (often with co-occurring substance use disorders) who have been incarcerated or otherwise resided in a locked facility who have high Adverse Childhood Experiences (ACEs) scores. Based on the initial assessment, women in the Marin County Jail have significantly higher ACEs scores than the general population or even than the men in the jail. These women have histories of traumatic experiences in childhood and adulthood, criminal justice involvement, and typically exhibit impulsivity, self-harm ideation, intense interpersonal relational patterns, rapid mood cycling and other symptoms.

ESTIMATED NUMBERS TO BE SERVED

Estimated that there would be 6 women served in year one (including women undergoing re-entry support in the jail setting prior to release), with that number increasing by 8 each year as alumni of the program will stay significantly involved. Year two, 14 women would be served, year three 22 women would be served, year four there would be 30 women served, and year five there would be 38 women served. In addition, by year 5, another 100 individuals would be offered somatic or alternative therapy programs that the women in the house and alumni recommend. In all, approximately 138 individuals would be served, with a projected 38 women having resided in the house.

LEARNING GOALS

- Does centering the program on healing and addressing trauma result in higher rates of successful stabilization, decreased recidivism, increased housing stability, and increased feelings of psychological wellbeing?
- What somatic therapies are the most successful with this group of women and how can that be spread throughout the Behavioral Health and homelessness systems of care?
- Is this approach cost-effective?

PROJECT OUTCOMES:

This is a new project starting in FY21/22 so there are no outcomes to report for FY20/21.

STUDENT WELLNESS AMBASSADOR PROGRAM (SWAP): A COUNTY-WIDE, EQUITY-FOCUSED APPROACH

PROJECT DATES: March 1, 2022-July 31, 2025

PROJECT BUDGET: \$1,648,000 over 3.5 years

PROJECT APPROVAL: The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the project on September 23, 2021. The Marin County Board of Supervisors approved this project on November 2, 2021.

PROJECT DESCRIPTION: A key recommendation in the school strategy of Marin County’s [Suicide Prevention Strategic Plan](#) is expanding peer supports as a way of breaking down stigma around help seeking and increasing mental health resources on school campuses across the county. Research indicates that School-based peer mentoring programs lead to positive outcomes for both “mentors” and “mentees” including fostering empathy and moral reasoning, connectedness to school and peers, and interpersonal and communication skills¹ and can improve mental health outcomes. These programs can also “help with transition points in participants’ lives. Mentees in middle school benefit from having an older student help them through the challenges of moving to a new school and the accompanying changes in social relationships that brings. High school mentors build personal skills and confidence that can help prepare them for their lives after high school.” This project aims to support students during these critical transition points and throughout their high school years by creating a centralized a county-wide approach to peer wellness programming.

The key components of the Student Wellness Ambassador Program (SWAP) include:

- **A centralized county-wide coordination, training, and evaluation structure:**
 - *A Coordinator*, housed at the Marin County Office of Education, in coordination with BHRS’ Prevention and Outreach team, will develop and implement training, build on partnerships with schools, Community Based Organizations (CBOs) and county entities, oversee recruitment efforts, and provide outreach and support to sites around implementation.
 - *Leveraging partnerships* with existing Marin County youth advisory committees, such as the Marin Youth Action Team or Youth Leadership Institute, a committee will be assembled comprised of student wellness ambassador leads that will serve as an integral part of advising on the program and developing an evaluation. Additionally, the Marin Schools Wellness Collaborative (MSWC) has taken the lead in the implementation of the Suicide Prevention Strategic Plan school strategy and will play a key role in providing oversight and direction for this project. The MSWC was formed in 2019 with the leadership of BHRS, MCOE, Marin County school district representatives, and Community Based Organization leaders. The mission of the MSWC is to “foster communication and collaboration between Marin County schools and stakeholders in

¹ Geddes, 2016: [Los Angeles County Youth Mentorship Program](#)

order to develop, coordinate, implement, and improve policies and programs that will improve the mental health and wellbeing of students.”

- *A county-wide learning collaborative*, led by the Coordinator and youth leads, will allow site-based adult leads, Student Wellness Ambassadors (SWAs), and CBO partners to get to know one another, share resources, and develop processes by which students from different schools can engage with wellness ambassadors from other schools should they choose.
- **Robust training for both the Student Wellness Ambassadors and the site-based adult leads** so that Wellness Ambassadors and adult site leads feel supported and are equipped with the necessary skills to implement programs on their respective school sites.
 - *Training of Student Wellness Ambassadors* will allow for the incorporation of skill-building activities, reinforcement of self-regulation activities, engagement in individual and group activities, and social support to support student mental health needs. Student Wellness Ambassadors will learn mental health first aid for teens, boundary setting, mindfulness techniques, peer engagement strategies, conflict resolution, etc. Wellness Ambassador cohorts may then engage in mental health awareness and advocacy campaigns, peer conversations, and wellness centered activities and meetings to build skills and efficacy and offer peer support for students in need. They will also engage in activities that support the work of BHRS and the Suicide Prevention Collaborative such as Mental Health Awareness and Suicide Prevention Month activities. An emphasis will be placed on supporting students transitioning from elementary to middle and middle to high school. Curricula will be drawn upon from existing successful evidenced-based peer mentoring programs that serve underserved youth and are focused on justice, equity and inclusion such as the Madison Park Academy (Oakland) [training curriculum](#). Curricula will be adapted to support our county-wide approach with input from youth, staff, and CBO contractors.
 - *Training for adult site leads* will include, for example, cultural responsiveness, building leadership skills, Mental Health First Aid, trainings on suicide prevention, warning signs, mental health symptoms and treatment, and supporting student wellness and self-care.

An Equity-focused recruitment and engagement strategy: Student Wellness Ambassadors will be recruited from traditionally underserved communities to ensure that youth impacted by structural racism and other forms of discrimination and students for whom English is a second language are central to this project. CBO contractors with expertise and experience in working with Marin youth from underserved communities such as LGBTQ+, English language learners, and African American youth, will support recruitment and provide additional training and support to Wellness Ambassadors through an equity lens. CBO partners and Student Wellness Ambassadors will serve both as an advisory role for the overall project rollout and support sites to engage mentees from underserved backgrounds. Student mentees will be referred through wellness coordination systems (i.e. COST or Coordination of Services Team), teachers, CBO partners, or self-referral.

Career Pathways: In conjunction with the Equity-Focus of the program there will be career pathway presentations and panels developed to share information about different potential

behavioral health and other helping professions career pathways. Students will have opportunities to volunteer and shadow professionals in the field to gain “real life” experiences and skills that can be applied to future internships and careers. Student Wellness Ambassadors will “graduate” from the program not only with a resume documenting their experience and creating a pathway into helping professions, but with an understanding of their value, skills and abilities, and how they can continue to be of service to their community.

TARGET POPULATION

The target population is students enrolled in grades 6-12 in Marin County public schools. Student Wellness Ambassadors will be recruited by placing a focus on students that represent the following demographics including Newcomers and English Language Learners, African American, LatinX, and LGBTQ+ youth.

ESTIMATED NUMBERS TO BE SERVED

At the end of three and a half years, approximately 180 Student Wellness Ambassadors will be identified and trained across 16 school districts (LEAs).

16 school districts in Marin County will be participating in the program. Current enrollment figures suggest 30 separate schools have students eligible to participate. The program will work to identify one (1) grade level Student Wellness Ambassador for every 90 same grade students at a school. Given that 16,000 students are currently enrolled in grades 6-12, a total of 180 SWAs will be identified to participate in the program.

The proposed program has the potential to serve any of the roughly 16,000 6-12 grade students in Marin County. The Student Wellness Ambassadors will have direct impact at the school site by working with peers and opportunities for additional impact to the larger school community through their participation in workshops, events, and other campaigns they participate in to support wellness.

LEARNING GOALS

- Can a county-wide centralized coordination and training structure enhance the effectiveness and sustainability of student peer wellness support across Marin County schools?
- Does centralizing student peer wellness support county-wide increase equity in who accesses peer support?
- By engaging and supporting youth from traditionally underserved communities as lead wellness ambassadors, can we break down stigma around mental health and improve outcomes for youth of color and LGBTQ+ youth in our county?

PROJECT OUTCOMES:

This is a new project starting in FY21/22 so there are no outcomes to report for FY20/21.

INNOVATION COMPONENT BUDGET

Prior to spending Innovation funding a project must be approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) however, this budget below includes proposed budgets for future projects that have not yet been approved the MHSOAC to facilitate planning and community awareness. The full proposals for those projects can be found on www.MarinHHS.org/MHSA.

Program	FY20/21	FY21/22	FY22/23	Total	
Older Adult Focused Innovation Project: Help@Hand	\$415,580	\$402,485	\$293,849	\$1,111,914	note: project total is \$1,580,000 including prior fiscal years. Any additional unspent from FY21/22 will roll over to FY22/23.
From Housing to Healing, Re-Entry Community for Women		\$229,587	\$320,827	\$550,414	note: project total is \$1,795,000 including future fiscal years
Student Wellness Ambassador Program (SWAP): A County-Wide Equity-Focused Approach		\$231,250	\$466,500	\$697,750	note: project total is \$1,648,000 including future fiscal years
Total	\$518,443	\$863,322	\$978,313	\$2,360,078	

COMMUNITY SERVICES AND SUPPORTS (CSS)

OVERVIEW

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

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

Full-Service Partnerships (FSPs)

Designed to provide all necessary services and supports – a “whatever it takes” approach – for designated priority populations. Fifty-one percent of expenditures through CSS (including leveraged Medi-Cal revenue) is designated for FSPs per regulations—however in FY19/20 statewide COVID flexibilities temporarily suspended this requirement.

System Development (SD)

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

Outreach and Engagement (OE)

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

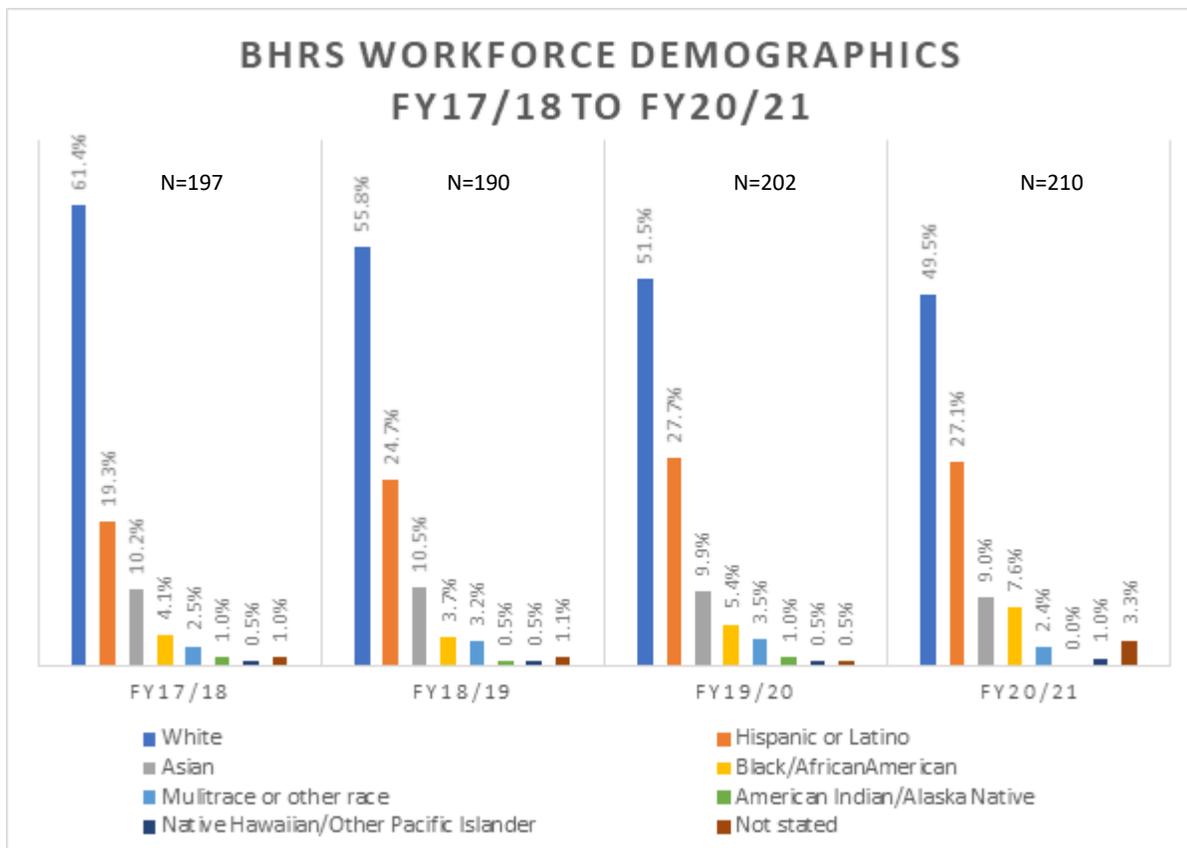
CSS in Marin County aims to increase the number of linguistically and culturally competent providers, provide outreach and engagement services, develop programs responsive to needs of specific target populations, and partner with Prevention and Early Intervention (PEI) programs to increase timely access to services. Program-specific strategies for reducing disparities are discussed in each program narrative.

CAPACITY ASSESSMENT

This capacity assessment is updated from the Three-Year Plan. Behavioral Health and Recovery Services and our partner service providers are dedicated to providing services that meet the needs of racially and ethnically diverse populations. There are many challenges and barriers to success as well as strengths and strategies being implemented to try to overcome many of the barriers.

STRENGTHS:

- BHRS and partner provider’s staff’s dedication and commitment to become more culturally sensitive, responsive and competent to meet the needs of ethnically diverse populations;
- Robust training, education and consultation opportunities around cultural competency-related subjects;
- The *Growing Roots: Young Adult Services* Innovation Project which worked to address service gaps for TAY population due to cultural and linguistic barriers.
- A growing BHRS clinical workforce who are culturally and linguistically competent and proficient including a 43.7% increase in Hispanic/Latino staff members since 2017 (from 19.3% of the staff to 27.7%).



CHALLENGES:

- Continuously increasing bilingual/bicultural staffing;
- BHRS' cultural competence-related trainings lack a systematic and follow-up/ongoing coaching and consultation to make the training offerings relevant, useful and applicable; and
- many contract agency partners are not held truly accountable nor are adequately provided with tools, resources and/or support to provide consistent culturally sensitive, responsive and competent services

BARRIERS TO PROGRAM IMPLEMENTATION:

- Difficulty recruiting bilingual bicultural staff
- lack of a system to strategically utilize existing bilingual/bicultural staff to serve and meet the needs of racially and ethnically diverse populations; and
- Inadequate language line;

STRATEGIES TO OVERCOME THESE BARRIERS:

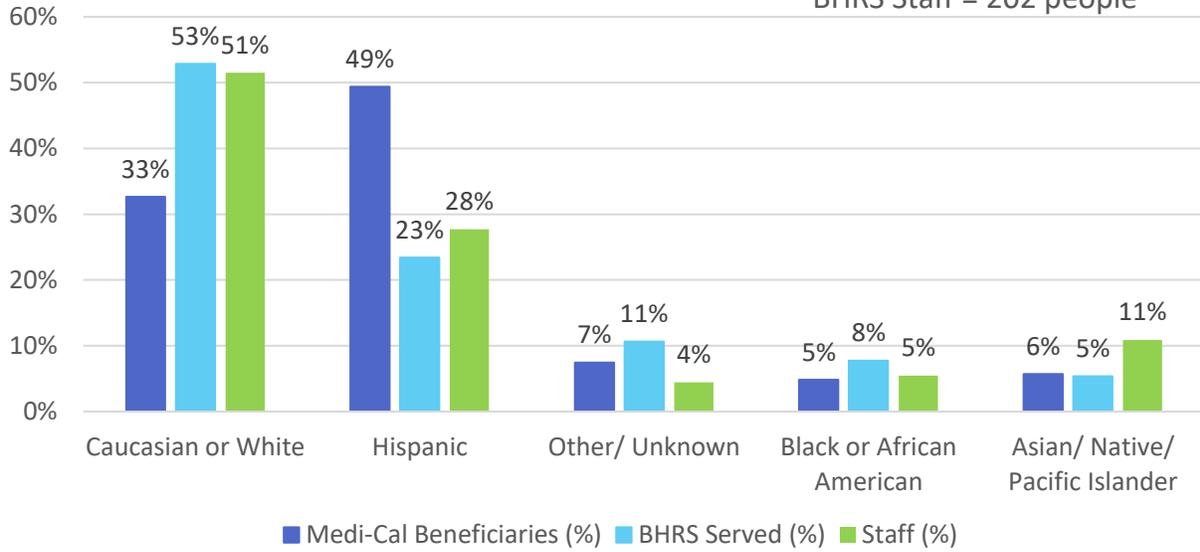
- Enhanced partnership with Human Resources
- Development of a BHRS *Division-Wide Action Plan* to address program staffing and increasing ways of supporting staff to reduce burn-out
- Hiring a BHRS Manager of Equity and Inclusion who will develop plans for utilizing staff and resources strategically
- Releasing a new Request for Proposals (RFP) for the Language Line services
- Continuing to work in partnership with the Cultural Competency Advisory Board
- Development of the Equity and Inclusion Committee to achieve organizational excellence in its commitment to the promotion of workplace inclusion and equity and to the retention of a diverse and thriving workforce

BILINGUAL PROFICIENCY IN THRESHOLD LANGUAGES:

Spanish is the only threshold language in Marin however official documents are often also translated into Vietnamese as that is our second largest population. Every Full-Service Partnership has at least one bilingual Spanish provider. In 2018 BHRS did an assessment of bilingual capabilities and race/ethnicity of service providers. 23.5% of service providers were bilingual in Spanish and 2% were bilingual in Vietnamese. 19 staff were bilingual in languages other than Spanish or Vietnamese including Farsi, Tagalog, Arabic, Afrikaans, Swahili, Russian, and Hindi.

Below is a graph showing the distribution of BHRS staff members, as compared to the distribution of the total population eligible for services (Medi-Cal Beneficiaries) and the total population being served.

Race/ Ethnicity FY18/19
 MC Beneficiaries = 39,632 people
 BHRS Served = 2,819 people
 BHRS Staff = 202 people



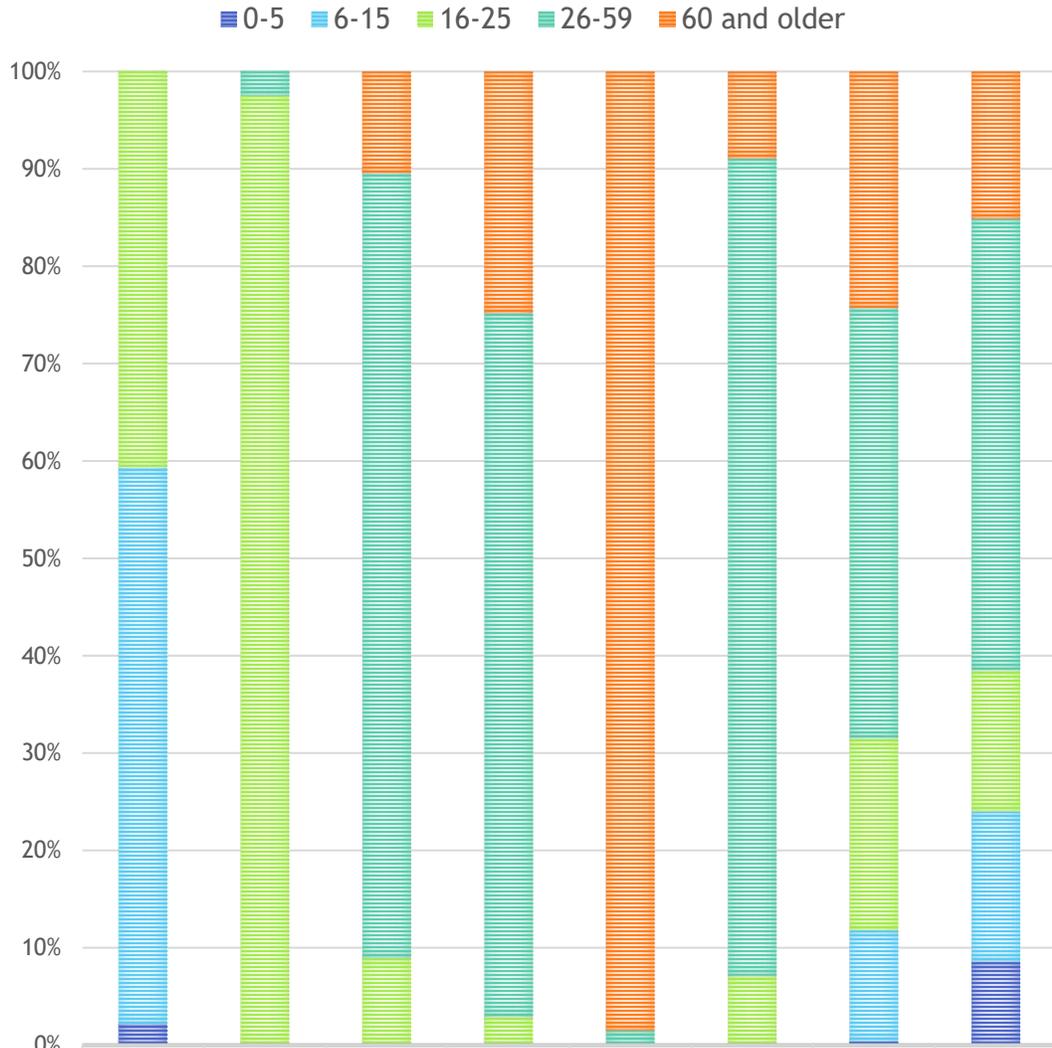
FULL-SERVICE PARTNERSHIP DEMOGRAPHICS

When determining how to reduce or eliminate disparities it is vital to look at the statistics on what disparities currently exist in our services. In order to do so we are looking at the Full-Service Partnership (FSP) data and comparing it to the Marin Medi-Cal population.

For each graph, each of our FSPs are listed then a total and then on the right side of the chart is the Marin Medi-Cal population data.

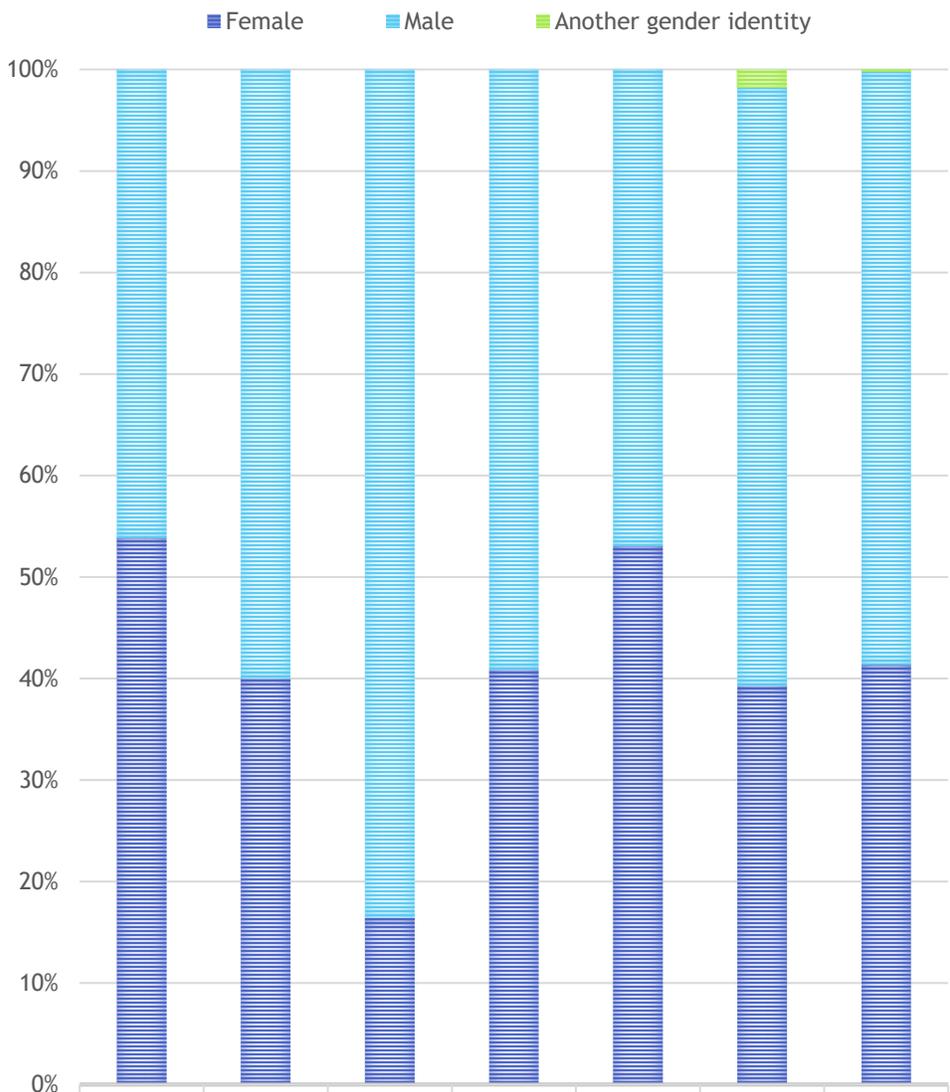


FY 20/21 FSP PARTNERS' AGE GROUP



	YES	TAY	STAR	Odyssey	HOPE	IMPACT	Total FSP	Marin Medi-Cal Pop
60 and older			7	34	65	5	111	7106
26-59		1	54	99	1	47	202	21814
16-25	37	39	6	4		4	90	6792
6-15	52						52	7237
0-5	2						2	4048

FY 20/21 FSP PARTNERS' GENDER



	YES	TAY	STAR	Odyssey	HOPE	IMPACT	Grand Total
Another gender identity						1	1
Male	42	24	56	81	31	33	267
Female	49	16	11	56	35	22	189

YOUTH EMPOWERMENT SERVICES (YES) FULL-SERVICE PARTNERSHIP: FSP 01

MHSA PROGRAM ALLOCATION FY22/23: \$950,064

PROGRAM OVERVIEW AND HISTORY: Marin County’s Youth Empowerment Services (YES) is a county-operated Full-Service Partnership (FSP) program providing services to high-risk youth up to their twenty-first birthday. A “whatever it takes” individualized plan is at the heart of the approach to engage youth around goals they have for themselves.

This program was originally implemented as a Children’s System of Care grant in the late nineties. In FY05/06 the Mental Health Services Act began supporting a major portion of the program which enabled the program to expand and hire Family Partners with lived experience with children who had been in the mental health system and/or the juvenile justice system.

Since FY14/15 the YES Program has broadened the referral base beyond the original juvenile justice system to include any child with a serious emotional disturbance or youth at risk for high end mental health services regardless of the system that originally served them.

In the FY17/18-FY19/20 Three-Year Plan, funding was approved for the Youth Empowerment Services (YES) Full-Service Partnership to expand by 12 slots, from 40 to 52, by hiring an additional Licensed Mental Health Practitioner and a supervisor to oversee the program.

In FY20/21-22/23 Three-Year Plan, the budget for YES was increased to support the cost of eating disorder treatment for FSP clients. In addition, in order to increase fidelity to the ACT model there will be an expansion of vocational and education support services.

PROVIDER: County-operated

TARGET POPULATION: YES serves youth up to age 21 who present with significant mental health issues that negatively affect their education, family relationships, and psychiatric stability. Clients typically present with impairments in functioning across many domains, including school, home, relationships, and self-care, as well as also presenting with legal and substance use issues. The YES program aims to serve youth who do not have ready access to other mental health resources or may not seek services at more traditional mental health clinics.

PROGRAM DESCRIPTION: The YES model is a supportive, strengths-based model with the goal of meeting youth and families in their homes, schools, and in the community to provide culturally appropriate mental health services. The FSP model operates from a “whatever it takes” philosophy which includes creative strategizing to maintain stability for clients and their families. This often includes intensive case management, psychiatric care, medication support, as well as collaboration with partner agencies (i.e., education, probation, drug court, etc.) to facilitate integrated care and ongoing family support. Providers in the YES program utilize a variety of interventions including: trauma focused Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), attachment and relational therapies, and substance use interventions related to harm reduction and motivational interviewing.

Clients and their families may also be supported by flex funds to help support treatment goals and promote stability, including financial support to secure stable housing during a short-term emergency or to support prosocial activities like sports. Family Partners, parents who have had a child in the mental health or juvenile justice system, also engage and support the parents in a unique way because of their

life experience. These partners provide both individual and group support and guidance to parents in navigating the various systems and with parenting youth engaged in high-risk behaviors. In addition, MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements (including eating disorder treatment) or inpatient stays necessary for stabilization and/or meeting treatment goals, for Full-Service Partnership clients as part of the “whatever it takes” approach.

Some youth experience early signs of psychosis and require intensive services early on to prevent further impairments in functioning and may require coordination with other providers in the BHRS system including the First Episode Psychosis program contracted with Felton Institute.

EXPECTED NUMBER TO BE SERVED: With a caseload of approximately 52 youth at any point in time, over the course of a year this program anticipates serving approximately 85 children and TAY.

EXPECTED OUTCOMES:

1. Decrease days spent in a psychiatric hospital
2. Decrease days homeless
3. Decrease days in residential placements
4. Decrease arrests

MEASUREMENT TOOL: The data for outcomes 1-4 will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP.

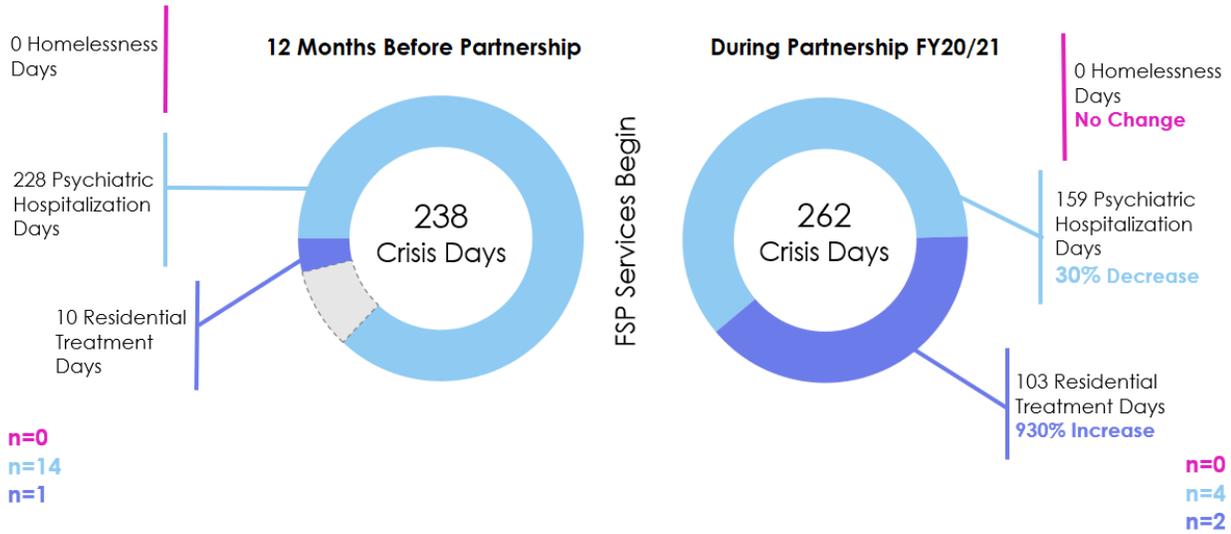
FY20/21 OUTCOMES:

In FY20/21 there were 91 partners served in YES including 52 youth (between the ages of 6 and 15) and 37 Transitional Age Youth (between the ages of 16 and 25). 56 of these partners were in the program for one year or longer at the end of FY20/21.

1. **30% Decrease in Psychiatric Hospitalization days:** Of the 56 partners who had been enrolled in YES for at least one year, 14 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 228 hospitalization days. In FY20/21, 4 of the 56 partners (71% decrease in the number of partners) experienced a psychiatric hospitalization in FY20/21, for a total of 159 hospitalization days—a 30% decrease from the baseline year.
2. **Zero days Homeless:** In the twelve months prior to entry into the FSP, none of the 75 partners had experienced homelessness in the year before services. In FY20/21 there were no days homeless.
3. **930% increase in Residential Treatment days:** In the twelve months prior to entry into the FSP, 1 of the 75 partners were in residential treatment for 10 days. In FY20/21, there were 2 partners who spent at least one night in residential treatment for a total of 130 days—a 930% increase in residential treatment days from the baseline year.
4. **81% Decrease in number of Arrests:** Of the 56 partners who had been enrolled in YES for at

least one year, 9 had experienced at least one arrest in the year prior to enrollment for a collective 16 arrests. In FY20/21, 2 of the 56 partners (84% decrease in number of partners) were arrested in FY19/20, for a total of 3 arrests—an 81% decrease from the baseline year.

FSP Youth Empowerment Services - YES (N=56)



PROGRAM CHANGES FOR FY21/22: Increased funding for eating disorder services.

TRANSITION AGE YOUTH (TAY) FULL-SERVICE PARTNERSHIP: FSP 02

MHSA PROGRAM ALLOCATION FY22/23: \$695,991

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

In November of 2017, a (0.5 FTE) Clinical Case Manager was added, increasing the caseload to 24. In FY19/20 additional Psychiatry time, administrative support, and flex funds were added increasing the program caseload to 28. In FY20/21 safety net funding was added for eating disorder treatment costs for TAY partners.

PROGRAM CHANGES: No changes.

PROVIDER: Side-By-Side, formerly known as Sunny Hills Services (a community-based organization), as well as additional organizations for eating disorder treatment as needed

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

PROGRAM DESCRIPTION: The TAY Program is a Full-Service Partnership (FSP) providing 16 to 25 year-olds with “whatever it takes” to move them toward their potential for self-sufficiency and appropriate independence, with natural supports in place from their family, friends, and community. Initial outreach and engagement is essential for you in this age cohort who are naturally striving toward independence and face more obstacles due to their mental illness than other youth. Independent living skills, employment services, housing supports, as well as comprehensive, culturally appropriate, integrated mental health and substance use services are available through the TAY Program. This program 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. MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or

inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full-Service Partnership clients as part of the “whatever it takes” approach.

The goals of the program are to provide treatment and skill-building to help TAY reach a level of self-sufficiency needed to manage their illness and accomplish their goals, thus avoiding high-end services, incarceration and homelessness. In addition, partial services, such as drop-in hours and activities, are available to TAY FSP as well as to TAY who are not a part of the Full-Service Partnership to give them the opportunity to explore how a program such as TAY could support them.

In order to decrease stigma around accessing FSP services, partial services are provided on a drop-in basis to full and partial clients. These services include an Anxiety Management Group, cooking groups, no cost physical activities such as hikes led by staff and job support and coaching. These activities provide a forum for healthy self-expression, an opportunity for participants to expand their cultural horizons, and a place to for them to practice their social skills. The monthly TAY calendar of activities is available in English and Spanish.

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 continue to be their main source of support.

EXPECTED NUMBERS TO BE SERVED: Anticipate that approximate 40 Transitional Age Youth will be served throughout the year with approximately ~28 TAY receiving FSP services at any point in time.

EXPECTED OUTCOMES:

- decrease psychiatric hospitalization
- decrease incarceration
- decrease homelessness
- increase engagement with school or work
- increase in independent living skills

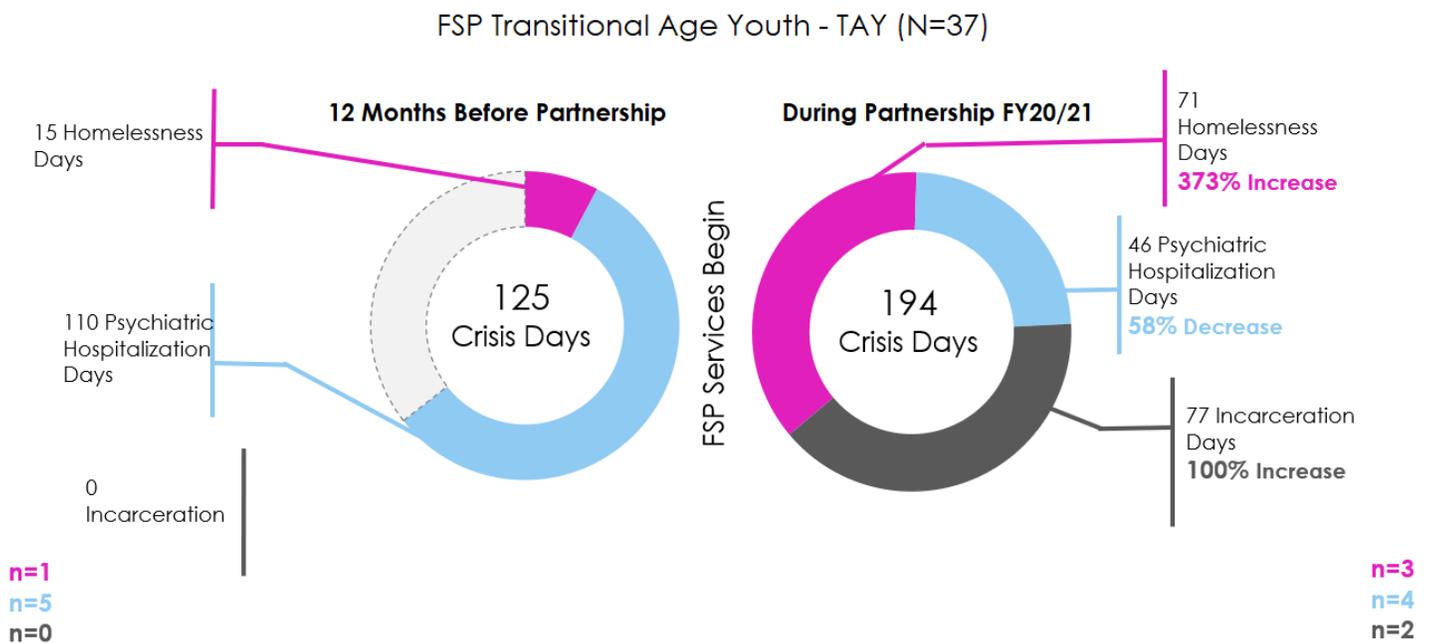
MEASUREMENT TOOL:

The data for the first 3 outcomes will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP. The final two outcomes will be measured using the case manager progress reports.

FY20/21 OUTCOMES:

In FY20/21 there were 40 partners served in TAY including 37 Transitional Age Youth (between the ages of 16 and 25) who had been in the program for one year or longer and were served during FY20/21.

1. **58% Decrease in Psychiatric Hospitalization days:** Of the 37 partners who had been enrolled in TAY for at least one year, 5 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 110 hospitalization days. In FY20/21, 4 of the 37 partners experienced a psychiatric hospitalization, for a collective total of 46 hospitalization days—a 58% decrease from the baseline year.
2. **373% increase in days homelessness:** In the twelve months prior to entry into the FSP, 1 partner had experienced homelessness in the year before services for a total of 15 days. In FY20/21, there were 3 clients who experienced homelessness for a collective total of 71 days—a 373% increase in days homeless.
3. **100% increase in incarceration days:** In the twelve months prior to entry into the FSP, 0 of the 37 partners were incarcerated. In FY20/21, 2 partners spent at least one day in jail for a collective 77 days.



4. 74% of TAY partners were engaged with either school or work (or both) during FY20/21.
5. The drop-in center re-opened on May 18, 2021. TAY was able to offer 24 days of drop-in activities and groups in the months of May & June 2021 before the fiscal year closed, including:
 - 12 days of independent living skill groups/activities
 - 12 days of other types of activities: games, art, music, exercise and lots of food & FUN
 - 84 total actual drop in visits, (24 FSPs & 7 new youth)

PROGRAM CHANGES FOR FY22/23: No changes.



SUPPORT AND TREATMENT AFTER RELEASE (STAR) FULL-SERVICE PARTNERSHIP: FSP 03

PROGRAM ALLOCATION FY22/23: \$722,623

PROGRAM OVERVIEW: The Marin County Support and Treatment After Release (STAR) Program has been an MHSA-funded county-operated 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. The STAR FSP, originally designed with a single point of referral – STAR mental health court – previously expanded to allow community referrals and to promote equity. This enabled the development of the STAR Community Program, a community-based program providing wraparound services to individuals not involved with STAR Court. Within the past year, the STAR FSP responded to the needs of the Superior Court and criminal justice partners by developing an additional specialized court process. This process, called the Marin Alternative Judicial Integration Court (MAJIC) has helped serve a sub-group of clients who had not benefitted from the highly structured elements of traditional STAR Court. In addition, in FY21/22 the STAR FSP expanded to provide services to individuals who meet the criteria for FSP services from State Parole (new in 2020 due to SB 389) as well as from Pre-Sentencing Diversion/Stepping Up (new in 2020 in response to AB 1810 and SB 215).

PROGRAM CHANGES: In FY22/23 we are moving the Assisted Outpatient Treatment (AOT) program back out to partner more closely with the Transition Outreach Team.

PROVIDER: County-operated

TARGET POPULATION: The target population of the STAR Program is adults, older adults, and Transitional Age Youth over 18, with serious mental illness who are involved in the criminal justice system.

PROGRAM DESCRIPTION: Operating in conjunction with Marin County Jail’s Re-Entry / Mental Health Team and the court, the FSP is a multi-disciplinary, treatment team comprised of professional and peer specialist staff. The team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psycho-education, employment services and provision of or linkages to all needed services and supports. Treatment for co-occurring substance abuse disorders for some clients is essential to their 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 with the goal of helping clients meet their treatment goals. In addition, MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full-Service Partnership clients as part of the “whatever it takes” approach.

Using multiple funding sources, the team consists of: a Supervisor (a Forensic-Clinical Psychologist); mental health case managers, one of whom is bilingual/bicultural Spanish speaking; a clinical psychologist; peer/lived-experienced specialist (contracted with Community Action Marin); a mental health nurse practitioner; a psychiatrist; an employment/vocational specialist (contracted with Integrated Community Services); a mental health-specialized Adult Probation Officer; two (2) Marin County Sheriff Deputies (as part of the Jail Re-Entry Team); psychology interns/therapists; an office assistant; and a substance use specialist (contracted with Marin Treatment Center). 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 substance abuse counselor provides appropriate group and individual counseling to participants as needed.

EXPECTED NUMBER TO BE SERVED: Expanded in FY20/21 to serve up to 65 individuals concurrently, but over the course of the year expecting to serve approximately 70 TAY, Adults, or Older Adults.

EXPECTED OUTCOMES:

1. Decrease in homelessness
2. Decrease in arrests
3. Decrease in incarceration
4. Decrease in hospitalization

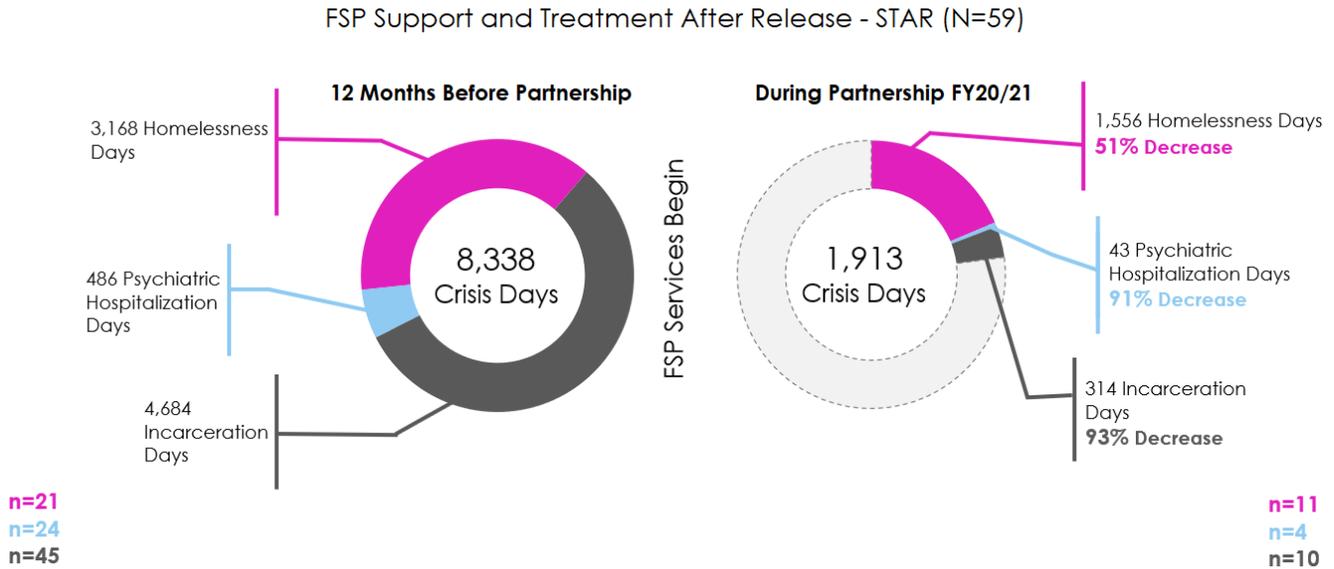
MEASUREMENT TOOL: The data for the 4 outcomes will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client upon enrollment in the FSP.

FY20/21 OUTCOMES:

In FY20/21 there were 67 partners served in STAR, 59 who had been in the program for one year or longer.

1. **91% Decrease in Psychiatric Hospitalization:** Of the 59 partners who had been enrolled in STAR for at least one year, 24 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 486 hospitalization days in their year before entering STAR. In FY20/21, there were 4 partners who had been enrolled in STAR for one year or more who experienced a psychiatric hospitalization in FY20/21, for a total of 43 hospitalization days.
2. **93% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 45 of the 59 partners had experienced incarceration for a collective 4,684 days in custody in the year before services. In FY20/21, 10 of these 59 partners spent a collective 314 days in custody during FY20/21, for a 93% decrease in incarceration days.

- 51% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 21 of the 59 partners had experienced homelessness for a collective 3,168 days homeless in the year before services. In FY20/21, 10 FSP partners who had been enrolled in STAR for over one-year experienced homelessness at any point during FY20/21 for a collective 1,556 days homeless, a 51% decrease.



Overall, in FY19/20 there was a 77% decrease in total “Crisis Days” for partners who had been enrolled for one year or longer in STAR.

PROGRAM CHANGES FOR FY22/23: In FY22/23 there will be an increase in funding for the contract with Marin Treatment Center to provide co-occurring support to clients.

HELPING OLDER PEOPLE EXCEL (HOPE) FULL-SERVICE PARTNERSHIP: FSP 04

PROGRAM ALLOCATION FY22/23: \$874,998

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

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

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

Senior Peer Counseling is also for people over the age of 60 but the focus is on supporting those who would benefit from a little extra support in their lives. Support is provided by trained volunteers who receive weekly supervision from a licensed MFT and/or Registered Nurse. Decreasing isolation, issues of aging, grief, and depression are common issues addressed in Senior Peer Counseling.

Also in 2014, the program was expanded to provide Independent Living Skills (ILS) training for targeted HOPE clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training is expected to be provided to 4-5 program participants annually.

In FY20/21 additional funding was added to cover the cost of eating disorder treatment. Additionally, in FY20/21 six older adults with serious mental illness who are chronically homeless will be moving into the MHS funded 6 one-bedroom apartments at Victory Village and receive support from the HOPE program (or other FSP programs if more appropriate). In addition, for the very first time in the program’s history, a mental health Peer Specialist will be embedded within the FSP team. The Peer

Specialist will come from a community-based provider and has experience providing services to the Specialty Mental Health Services population.

PROVIDER: County-operated with supplemental CBO contracts

TARGET POPULATION: The target population of the HOPE Program is older adults with serious mental illness, ages 60 and older, who are currently unserved by the mental health system, who have experienced or are experiencing a reduction in their personal or community functioning and, as a result, are at risk of hospitalization, institutionalization or homelessness. These older adults may or may not have a co-occurring substance abuse disorders and/or other serious health conditions including a secondary diagnosis of dementia or other Neurocognitive disorder. Transition age older adults, ages 55-59, may be included when appropriate.

PROGRAM DESCRIPTION: The HOPE Program is a Full-Service Partnership (FSP) 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.

The HOPE Program’s multi-disciplinary, assertive community treatment team provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, psychoeducation, assistance with money management, and linkages to/provision of all needed services and supports. The clinicians provide virtually all their services with this population at the client’s homes in order to make it as convenient as possible for older adults who might have limited mobility or difficulties accessing transportation. To protect the health of our client’s during the COVID-19 pandemic, field visitations are only provided on an as needed basis in addition to the telehealth options that are currently available to provide ongoing support.

Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided to those in need of co-occurring services. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation vouchers) that cannot be otherwise obtained. In addition, MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full-Service Partnership clients as part of the “whatever it takes” approach.

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

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

This program also works very closely with our two MHSAs Housing Programs for older adults with Serious Mental Illness, providing wrap-around support for clients residing at the Fireside Apartments and Victory Village.

EXPECTED NUMBER TO BE SERVED: Up to 50 concurrently, but over the course of the year expecting to serve approximately:

- 5 Adults (who are nearing the older adult age group and have a co-occurring physical health condition which could include a secondary diagnosis of early onset dementia)
- 50 Older Adults

EXPECTED OUTCOMES:

1. Decrease psychiatric hospitalization
2. decrease incarceration
3. decrease homelessness
4. Improved recovery based on decreased risk of harm or unsafe behaviors, increased engagement, and improved skills and supports

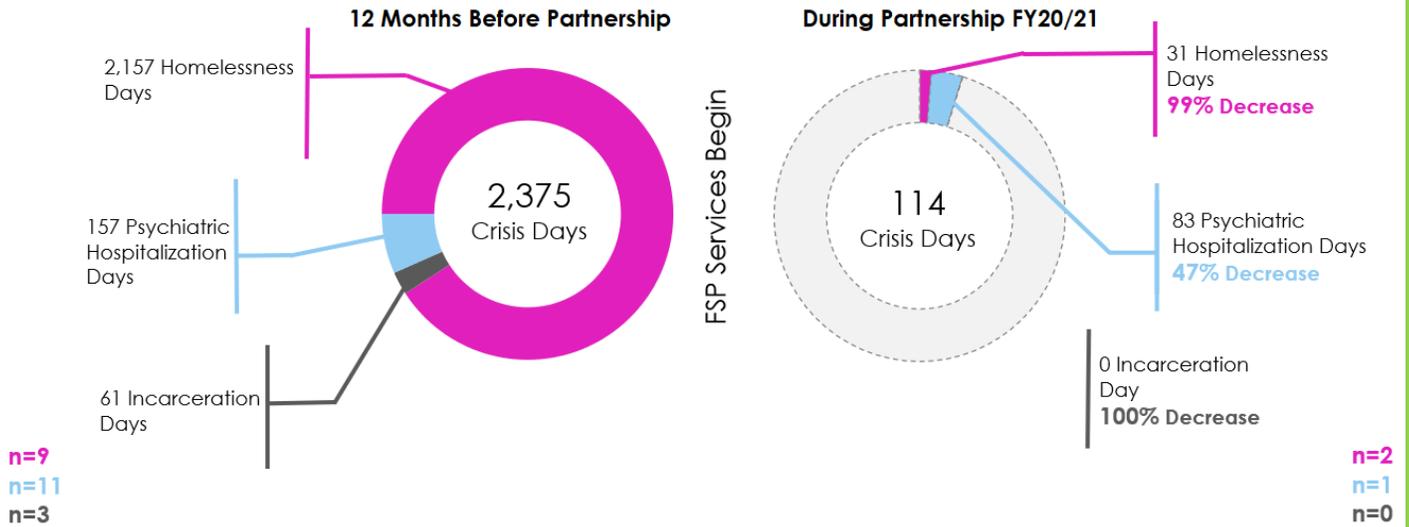
MEASUREMENT TOOL:

- The data for outcomes 1-3 will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP.
- *New in the MHSAs FY 2021-2023 Three Year Plan, so will be reported on in the FY22/23 Annual Update:* Outcome 4 will be measured using the Milestones of Recovery Scale (MORS). The MORS is administered on a quarterly basis by the Case Manager/Personal Service Coordinator and assesses the consumer's level of risk, level of engagement, and level of skills and supports. The scores on the Milestones of Recovery Scale range from 1-8:
 - 1. Extreme Risk
 - 2. High Risk / Not Engaged
 - 3. High Risk / Engaged
 - 4. Poorly Coping / Not Engaged
 - 5. Poorly Coping / Engaged
 - 6. Coping / Rehabilitating
 - 7. Early Recovery
 - 8. Advanced Recovery

FY20/21 OUTCOMES:

In FY20/21 there were 66 partners served in HOPE, 49 who had been in the program for one year or longer.

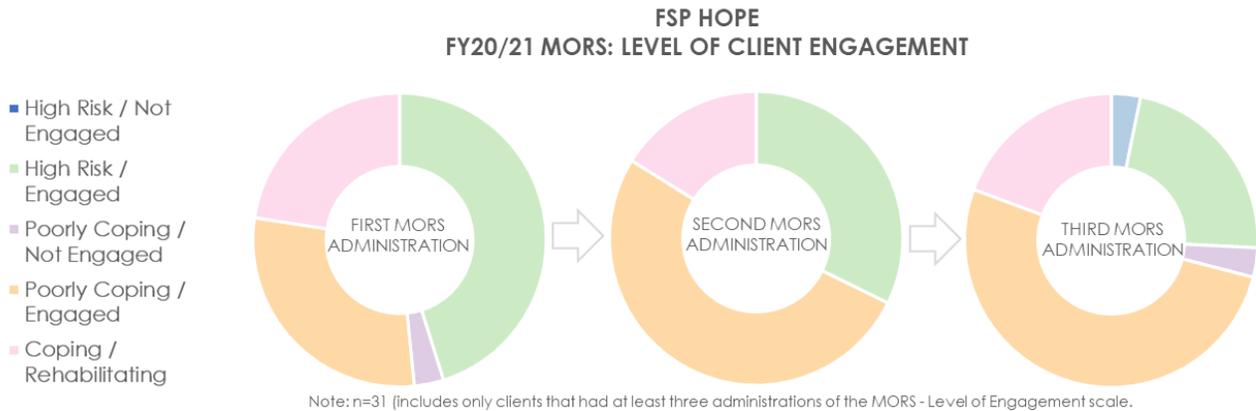
FSP Helping Older People Excel - HOPE (N=49)



- 47% Decrease in Psychiatric Hospitalization:** Of the 49 partners who had been enrolled in HOPE for at least one year, 11 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 157 hospitalization days. In FY20/21, there was only one partner who had been enrolled in HOPE for one year or more who experienced a psychiatric hospitalization in FY20/21, for a total of 83 hospitalization days.
- 100% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 3 of the 49 partners had experienced incarceration for a collective 61 days in custody in the year before services. In FY20/21, there was a 100% decrease in days custody as no FSP partners who had been enrolled in HOPE for over one year were incarcerated at any point during FY20/21.
- 99% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 9 of the 49 partners had experienced homelessness for a collective 2,157 days homeless in the year before services. In FY20/21, there was a 99% decrease in days homeless with 2 FSP partners who had been enrolled in HOPE for over one-year experienced a collective 31 days homeless in FY20/21.

Overall, in FY20/21 there was a 95% decrease in total “Crisis Days” for partners who had been enrolled for one year or longer in HOPE.

5. Full-Service Partnerships are designed to best serve clients who enter the program scoring between a 2-4 on the Milestones of Recovery Scale (MORS). Typically, those who score 1 for Extreme Risk are needing a higher level of care such as a locked facility or psychiatric hospital and those scoring 7s or 8s no longer need this level of care. For clients who had at least three administrations of the MORS in FY20/21 as part of the HOPE FSP, there was a **35% increase** in the number of partners with scores of 4 or higher between the first and third administrations with the same individuals.



PROGRAM CHANGES FOR FY22/23:

- d. Pilot a new program to provide extensive **neuro-psychological evaluations** for older adults with potential complex dual mental health and cognitive disorders (such as dementia).
 - 1) Currently many older adult clients in the HOPE full-service partnership program have cognitive issues in addition to diagnoses of mental health disorders. However, without extensive neuro-psychological testing it is difficult to develop the most effective treatment plan and bring partners in to further support the cognitive issues that are out of the scope of Behavioral Health services.
 - 2) This would be paired with additional training around supporting individuals with dual cognitive and mental health diagnoses.
- e. Fund earmarked to pilot a **nutrition** program within the HOPE Full-Service Partnership after experiencing the benefits of the *Great Plates* program during COVID. There is a growing body of evidence indicating that nutrition may play an important role in the management of mental health and cognitive diagnoses including depression, anxiety, schizophrenia, and dementia.
- f. Create a new group and peer support around addressing **Collecting Behaviors** (also known as hoarding).

ODYSSEY FULL-SERVICE PARTNERSHIP: FSP 05

MHSA PROGRAM ALLOCATION FY22/23: \$1,320,224

PROGRAM OVERVIEW AND HISTORY: The Odyssey Program has been an MHSA-funded county-operated Full-Service Partnership (FSP) serving adults with serious mental illness who are homeless or at-risk of homelessness since 2008. The goals of the program are to promote recovery and self-sufficiency; improve the ability to function independently in the community; reduce homelessness; reduce incarceration; and reduce hospitalization.

Following the loss of AB 2034 funding for Marin’s Homeless Assistance Program which had been in operation since 2001, key stakeholders and community partners fully supported the creation of a new FSP, the Odyssey Program, to continue serving the AB 2034 target population. The design of the new Odyssey program incorporated the valuable experiences and lessons learned from the AB 2034-funded services and in 2007, the program was approved as a new MSHA-funded CSS FSP providing culturally competent intensive, integrated services to 60 priority population adults who were homeless or at-risk of homelessness. Odyssey was designed to provide comprehensive assessment, individualized client-centered service planning, and linkages to/provision of all needed services and supports by a multi-disciplinary, multi-agency team.

A substantial percentage of program participants present with co-occurring substance use disorders, increasing the risk for suicide, aggressive behavior, homelessness, incarceration, hospitalization and serious physical health problems.

In 2012 the program added Independent Living Skills (ILS) training for targeted Odyssey clients. These services facilitate independence and recovery by providing training in specific activities of daily living essential to maintaining stable housing and greater community integration, including self-care, housecleaning, shopping, preparing nutritious meals, paying rent and managing a budget. ILS training was originally expected to be provided to four to five program participants annually, but has grown significantly in recent years with an average of 10 clients served each month in FY 19-20.

Beginning in 2011, MHSA funds were used to fund emergency housing in a 2-bedroom apartment for program participants who are homeless to provide a safe place for residents to live while seeking permanent housing. While in the emergency housing, program participants can save money for security and rent deposits and can work closely with program staff to develop budgeting and living skills needed for a successful transition to independent living. Emergency housing serves 5-10 program participants annually. In addition, MHSA FSP flexible funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full-Service Partnership clients as part of the “whatever it takes” approach.

In 2014 Odyssey implemented a “Step-Down” component, staffed by a Social Service Worker with lived experience and a Peer Specialist to serve those in the program who no longer need assertive community treatment services, but continue to require more support and service than is available through natural support systems. This program did not achieve the intended outcomes. Since implementation, the team has been challenged by needing to provide frequent transfers between this component and the assertive community treatment component of the team. However, in FY17/18 BHRS re-structured both components by integrating the two services in support of participants being able to access services at different intensities, depending on their needs, without the need to transfer between two separate FSP components.

In FY20/21, a Mental Health Registered Nurse was added to the team (split between Odyssey—0.6FTE— and IMPACT—0.4FTE). This additional team member will increase the capacity of Odyssey to serve 100 individuals and will help the team reach higher fidelity with ACT. Additional funding was also added to the budget to cover the cost of eating disorder treatment for FSP clients. In addition, some supportive contracts have been moved to the new program called “Homeless Support and Outreach” to be able to serve non-FSP homeless individuals as well.

PROVIDER: A combination of county and contracts

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

PROGRAM DESCRIPTION: The Odyssey Program is a Full-Service Partnership (FSP) that provides culturally competent intensive, integrated services at-risk adults who are homeless or at-risk of homelessness due to their mental health challenges. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be.

A multi-disciplinary, multi-agency assertive community treatment team comprised of professional, para-professional and peer specialist staff provides comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psychoeducation, co-occurring substance use expertise, employment services, independent living skills training, housing support, assistance with money management, and linkages to/provision of all needed services and supports.

Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided to those in need of co-occurring services with a team member who is a certified substance use counselor. The team has a pool of flexible funding to purchase needed goods and services (including emergency and transitional housing, medications, and transportation) that cannot be otherwise obtained.

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

A contract for vocational and independent living skills services provides situational assessments, job development and job placement services for program participants, and coordinates services with other vocational rehabilitation providers in the county. Where appropriate, participants are assisted to enroll in the Department of Rehabilitation to leverage funding for additional vocational services, including job coaching. Participants are also able to benefit from independent living skills to support them on their path to recovery.

In FY21/22, two new team members were added to the Odyssey team, a full-time county Peer Counselor II and a Substance Use Specialist.

EXPECTED NUMBER TO BE SERVED: Up to 115 concurrently, but over the course of the year expecting to serve approximately 130 TAY, Adults, and Older Adults.

EXPECTED OUTCOMES:

1. decrease psychiatric hospitalization
2. decrease incarceration
3. decrease homelessness
4. Improved recovery based on decreased risk of harm or unsafe behaviors, increased engagement, and improved skills and supports

MEASUREMENT TOOL:

- The data for outcomes 1-3 will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP.
- *New in the MHSA FY 2021-2023 Three Year Plan, so will be reported on in the FY22/23 Annual Update:* Outcome 4 will be measured using the Milestones of Recovery Scale (MORS). The MORS is administered on a quarterly basis by the Case Manager/Personal Service Coordinator and assesses the consumer’s level of risk, level of engagement, and level of skills and supports. The scores on the Milestones of Recovery Scale range from 1-8:
 - 1. Extreme Risk
 - 2. High Risk / Not Engaged
 - 3. High Risk / Engaged
 - 4. Poorly Coping / Not Engaged
 - 5. Poorly Coping / Engaged
 - 6. Coping / Rehabilitating
 - 7. Early Recovery
 - 8. Advanced Recovery

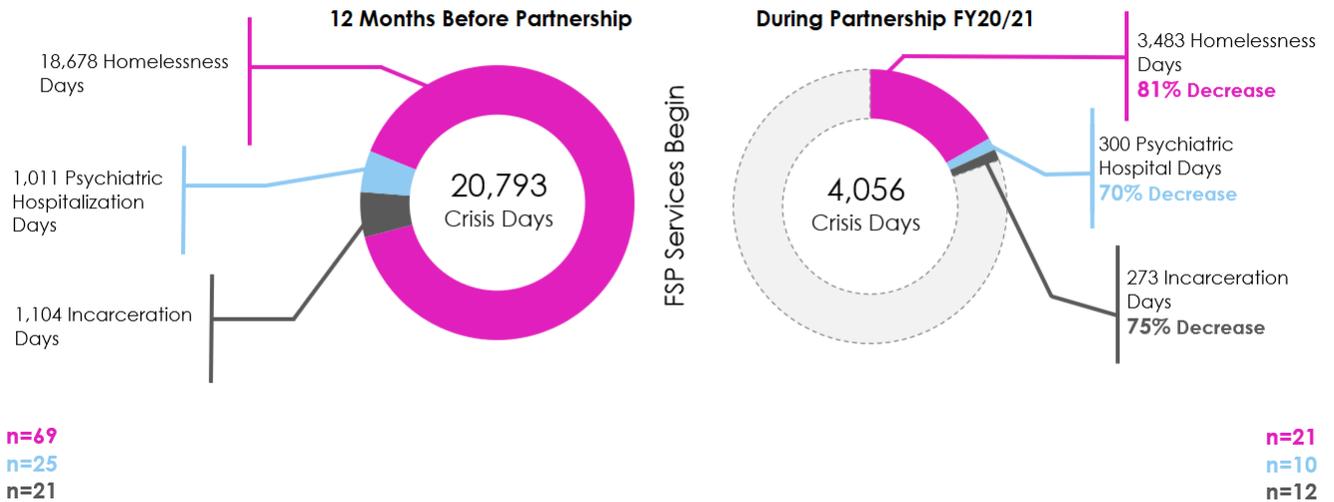
FY20/21 OUTCOMES:

In FY20/21 there were 137 partners served in Odyssey, 113 who had been in the program for one year or longer.

1. **70% decrease in Psychiatric Hospitalization:** Of the 113 partners who were enrolled in Odyssey for at least one year, 25 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 1,011 psychiatric hospitalization days. In FY20/21, 10 of the 113 partners experienced a psychiatric hospitalization in FY20/21, for a total of 300 psychiatric hospitalization days—a 70% decrease.
2. **75% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 21 of the 113 partners had experienced incarceration for a collective 1,104 days in custody in the year before services. In FY20/21, 12 of the 113 FSP partners spent 273 days collectively in custody—a 75% decrease in incarceration days.

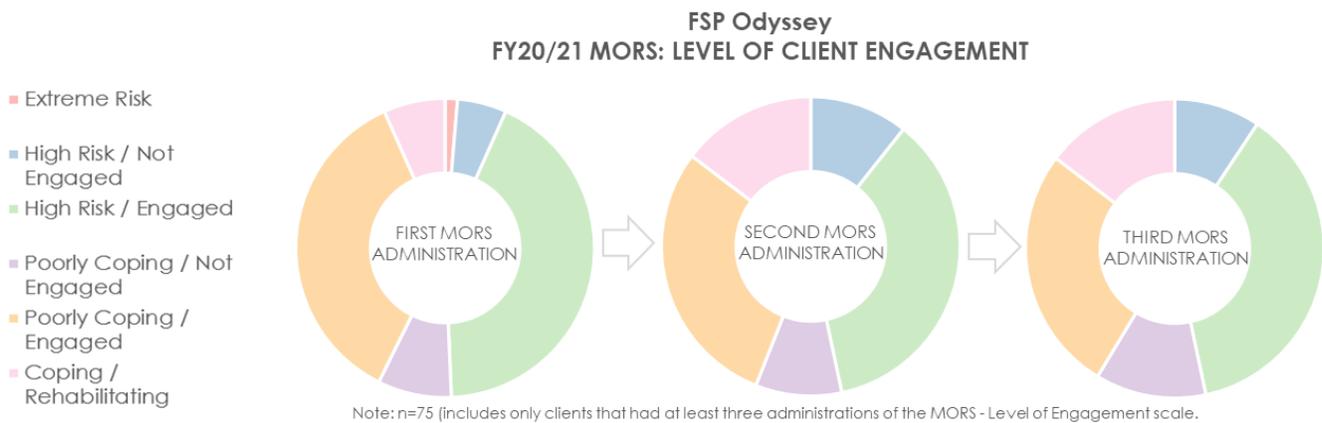
- 81% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 69 of the 113 partners had experienced homelessness for a collective 18,678 days homeless in the year before services (averaging 270 days homeless in the year before services). In FY20/21, there were 21 partners who experienced one day or more of homelessness, for a collective 3,483 days—an 81% decrease **resulting in 15,195 fewer collective days homeless in FY20/21 as compared to the baseline year.**

FSP Odyssey - Homeless (N=113)



Overall, in FY20/21 there was a 80% decrease in total “Crisis Days” for partners who had been enrolled in Odyssey for at least one year (to have a full 12-month comparison period).

- Improved recovery based on decreased risk of harm or unsafe behaviors, increased engagement, and improved skills and supports using the Milestones of Recovery Scale (MORS). There was a **120% increase** in the number of clients scoring 6 (Coping/Rehabilitating) on the MORS between the first and third administration during FY21/22 in the Odyssey program.



CHANGES FOR FY22/23: In August 2022 Mill Street 2.0 Permanent Supportive Housing site is scheduled to open. In a joint application with Homeward Bound of Marin, Marin County was awarded *No Place Like*

Home funding for capital costs to support 15 units of permanent supportive housing for people with serious mental illness. In exchange the County commits to provide supportive services for those units for at least 20 years. The 15 *No Place Like Home* units at Mill Street will be supported through the Odyssey Full-Service Partnership with the addition of a Mental Health Practitioner who will be based at the Mill Street site as well as a Peer Support Specialist who will be dedicated to supporting both the 15 residents in the No Place Like Home units (50% of their time) and providing outreach and engagement with the other residents and those in the shelter on the ground floor. Psychiatry and nursing time will also be increased to meet the need. In addition, with the addition of the Substance Use counselor to the team in FY21/22, the contract with Marin Treatment Center for co-occurring support will be shifted to fully support the STAR Full-Service Partnership.

INTEGRATED MULTI-SERVICE PARTNERSHIP ASSERTIVE COMMUNITY TREATMENT (IMPACT): FSP 06

MHSA PROGRAM ALLOCATION FY22/23: \$820,718

PROGRAM OVERVIEW AND HISTORY: In recent years, the Marin County Adult System of Care has struggled with an increasing number of individuals with serious mental illness who need more intensive services than those offered by either of the integrated clinics. The FY17/18-FY19/20 Three-Year plan implemented the IMPACT Full-Service Partnership set to serve those who do not necessarily fall into the one of the target populations of the other Full-Service Partnerships: homeless (Odyssey), Older Adults (HOPE), or involved with the criminal justice system (STAR).

In order to increase the programs fidelity to the ACT model, a .4FTE Mental Health Registered Nurse was added to the team in FY21/22 as well as increasing the Psychiatrist time by 4 hours per week. Additional funding was also added to the budget to cover the cost of eating disorder treatment for FSP clients.

In FY22/23 a second Mental Health Practitioner was added to the team, increasing capacity to 50 clients at a time.

PROVIDER: County-operated

TARGET POPULATION: IMPACT's target population are adults, transition age youth over 18, and older adults with serious mental illness, who are un-served by the mental health system or are so underserved that they are unable to stabilize in the community without additional support. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition.

PROGRAM DESCRIPTION: The IMPACT FSP was created in FY17/18 and provides culturally competent intensive, integrated services. The program is strengths-based and focused on recovery and relapse prevention, seeking out participants and serving them wherever they may be. The goals of the program are to promote recovery and self-sufficiency, improve the ability to function independently in the community, reduce homelessness, reduce incarceration, and reduce hospitalization.

Following the ACT model, a diverse multi-disciplinary team has been developed to provide comprehensive "wrap-around" services for individuals in need of the highest level of outpatient services. The team is comprised of mental health clinicians, a peer specialist, a family partner, vocational specialists, a psychiatrist, a Nurse Practitioner, and a Registered Nurse. Services include comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psycho-education, employment services, independent living skills training, assistance with money management, and linkages to/provision of all needed services and supports.

Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided to those in need of co-occurring services. 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. In addition, MHSA FSP funds can cover the county portion of the costs for short-term (12 months or fewer) residential placements or inpatient stays that are necessary for stabilization and/or meeting treatment goals for Full-Service Partnership clients as part of the "whatever it takes" approach.

EXPECTED NUMBER TO BE SERVED: Up to 50 concurrently, but over the course of the year expecting to serve approximately 60 TAY, Adults, and Older Adults.

EXPECTED OUTCOMES:

1. decrease hospitalization
2. decrease incarceration
3. decrease homelessness
4. Improved recovery based on decreased risk of harm or unsafe behaviors, increased engagement, and improved skills and supports

MEASUREMENT TOOL:

- The data for outcomes 1-3 will be pulled from the Full-Service Partnership dataset mandated by the State Department of Health Care Services. Data for days homeless, hospitalized, and arrests while enrolled in the programs is tracked by program staff using the Key Event Tracker (KET) forms and entered into the State database. The data for the baseline year, is based on the Partnership Assessment Form (PAF) data provided by the client and their family upon enrollment in the FSP.
- *New in the MHSA FY 2021-2023 Three Year Plan, so will be reported on in the FY22/23 Annual Update:* Outcome 4 will be measured using the Milestones of Recovery Scale (MORS). The MORS is administered on a quarterly basis by the Case Manager/Personal Service Coordinator and assesses the consumer’s level of risk, level of engagement, and level of skills and supports. The scores on the Milestones of Recovery Scale range from 1-8:
 - 1. Extreme Risk
 - 2. High Risk / Not Engaged
 - 3. High Risk / Engaged
 - 4. Poorly Coping / Not Engaged
 - 5. Poorly Coping / Engaged
 - 6. Coping / Rehabilitating
 - 7. Early Recovery
 - 8. Advanced Recovery

FY20/21 OUTCOMES:

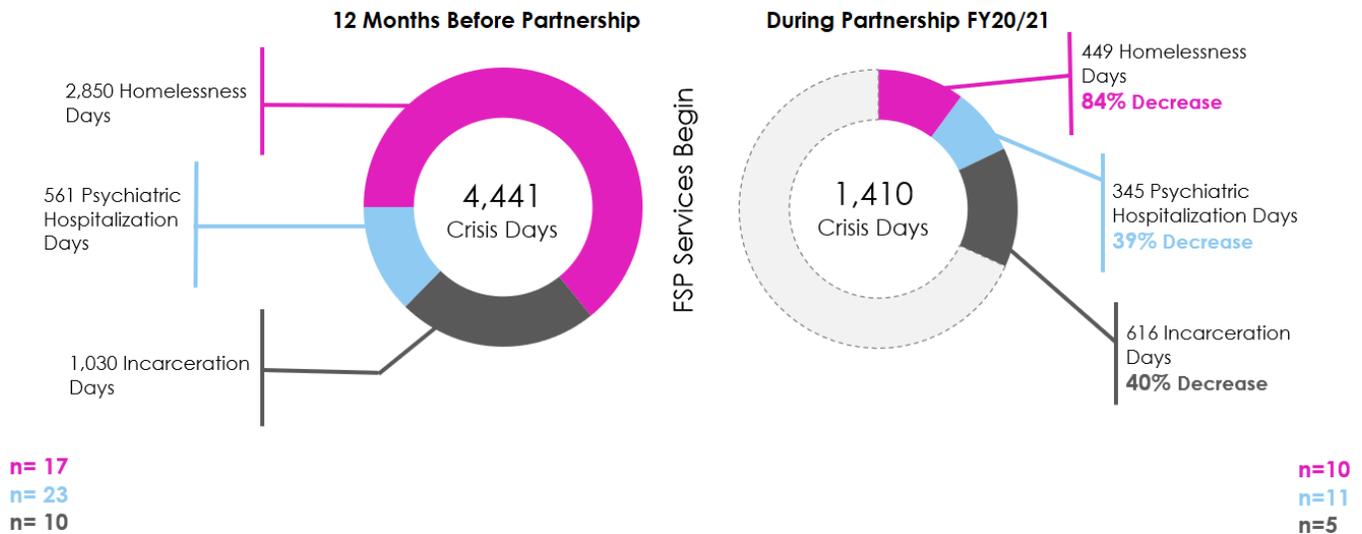
In FY20/21 there were 56 partners served in IMPACT, 38 who had been in the program for one year or longer.

5. **39% Decrease in Psychiatric Hospitalization:** Of the 38 partners who were enrolled in IMPACT for at least one year, 23 (60%) had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 561 psychiatric hospitalization days. In FY20/21, there were 11 partners who were enrolled in IMPACT for at least one year who experienced a psychiatric hospitalization in FY20/21, for a total of 345 psychiatric hospitalization days—a 39% decrease in hospitalization days and a 52% decrease in the number of people needing hospitalization.
6. **40% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 10 of the 38 partners had experienced incarceration for a collective 1,030 days in custody in the year before services. In FY20/21, there were 5 FSP partners who spent 616 days collectively in

custody—a 40% decrease in incarceration days.

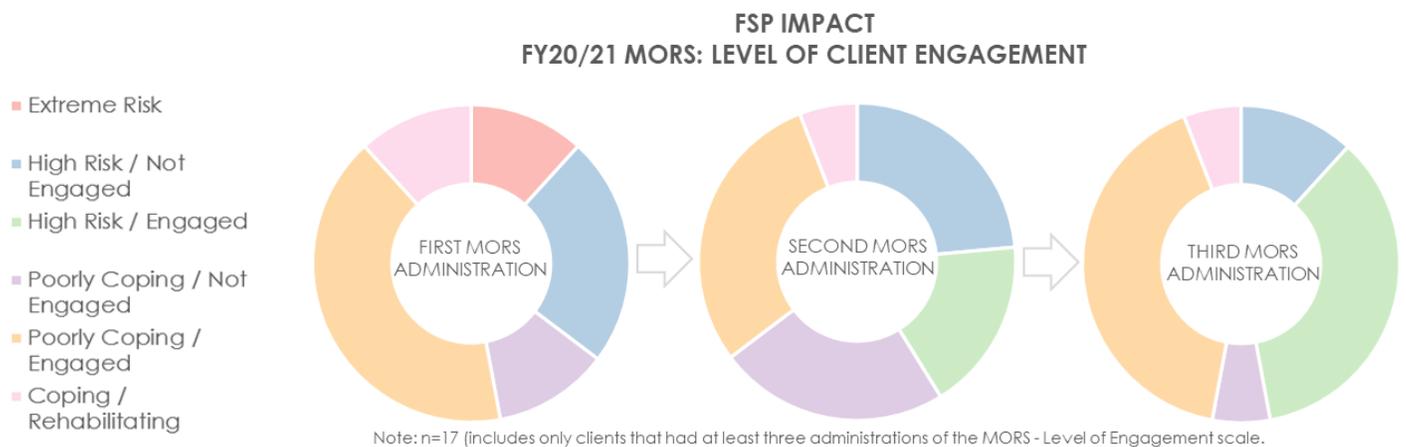
- 84% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 17 of the 38 partners had experienced homelessness for a collective 2,850 days homeless in the year before services. In FY20/21, there were 10 partners who experienced one day or more of homelessness, for a collective 449 days—a 84% decrease

FSP Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT)
(N=38)



Overall, in FY20/21 there was a 68% decrease in total “Crisis Days” for partners who had at least one year in IMPACT.

- Improved recovery based on decreased risk of harm or unsafe behaviors, increased engagement, and improved skills and supports using the Milestones of Recovery Scale (MORS). There was a **67% decrease** in the number of clients scoring 1s (Extreme Risk) or 2s (High Risk/Not Engaged) on the MORS between the first and third administration during FY21/22.



CHANGES FOR FY22/23: Expand the **IMPACT** Full-Service Partnership by 10 clients up to 50 by adding 1.0 FTE Mental Health Practitioner to increase treatment planning, therapy, and assessment capacity.

ENTERPRISE RESOURCE CENTER (ERC) EXPANSION: SDOE 01

MHSA PROGRAM ALLOCATION FY22/23: \$658,102

PROGRAM OVERVIEW: Since 2006, the ERC Expansion Program has been an MHSA-funded System Development/Outreach and Engagement (SDOE) project serving adults with serious mental illness who are reluctant to become involved in the public mental health system.

Prior to implementation of the MHSA, Marin's consumer-staffed Enterprise Resource Center averaged approximately 600 client visits per month in its small multi-purpose drop-in center and had outgrown its space and management infrastructure. In 2006, MHSA funding for the ERC Expansion Program was approved, adding new consumer management positions and establishing a Wellness/Recovery Center in central Marin through enlarging and co-locating the ERC with housing, employment and clinical services at the new Health & Human Services Health and Wellness Campus. In late FY07-08, the Enterprise Resource Center moved into its new facility at the Health and Wellness Campus. Also during FY07-08, MHSA expansion funds were used to increase consumer staffing to enable the ERC to increase its hours of operation to 7 days a week.

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

In FY20/21 BHRS released a Request for Proposals (RFP) for Peer-run services to ensure that county contracts allow for competition. The RFP process solicited bids for Peer-Run, Recovery-Oriented programs with a focus on ensuring equity along racial/ethnic and geographic lines. Peer-run programs must show their use of evidence-based or community-defined practices and how they will utilize a racial equity perspective. Funding for the Enterprise Resource Center was award via RFP to the Multicultural Center of Marin in collaboration with Mental Health Advocates of Marin starting in FY21/22.

The standardized outcome tool was also updated from the Flourishing Scale to the Questionnaire about the Process of Recovery (QPR-15).

PROVIDER: Multicultural Center of Marin in collaboration with the Mental Health Advocates of Marin starting July 1, 2021. Community Action Marin was the provider up through FY20/21.

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

PROGRAM DESCRIPTION: Known for its low-barrier access, the Enterprise Recovery Center (ERC) plays a key role in Marin's efforts to outreach to and engage with adults with serious mental illness in the county who are disenfranchised and reluctant to seek help and services. In addition to optimizing outreach and engagement possibilities the client-operated ERC is co-located on the Health & Wellness Campus with other services that promote and support recovery including the BRIDGE Kerner Case Management team and medication clinic, the STAR Full-Service Partnership, and Marin Community

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

ERC offers a full schedule of activities, classes and groups 7 days per week, as well as serving as host to such meetings as Dual Recovery Anonymous, Smokebusters, and NAMI Family Support Groups. ERC programs and services designed to provide personal support and foster growth and recovery include the Warm Line, the Linda Reed Activities Club, specialty groups and classes, supportive counseling with trained Peer Counselors, and a Peer Companion Program that outreaches to individuals who tend to isolate. The ERC also provides Peer Counseling and Case Management training programs and on-the-job internships for consumers seeking to work as service providers in the public mental health system.

During the COVID emergency the program provide virtual groups and warm line support.

EXPECTED NUMBER TO BE SERVED: 1000

OUTCOMES: in FY20/21 due to the COVID pandemic many of the ERC services were either put on hold or switched to a virtual format. The ERC was not open as a drop-in center. However, the warm-line was expanded and volunteers were trained to take calls from their own homes and provide a warm-line in Spanish.

Outcomes	Goal	Actuals
# Warm Line contacts	3,500	4,454

During the RFP process the outcomes were expanded for FY21/22 to include:

- Increased feelings of connection, recovery, and wellness
- Decrease in use of crisis services

These outcomes will be measured using standardized instruments (*exact tools subject to change*).

Proposed tools include:

- 1) **Questionnaire about the Process of Recovery (QPR-15):** Version 2.0 (Law, Neil, Dunn, & Morrison, 2014). This 15-item self-report questionnaire of consumers’ subjective rating of their own recovery jointly created by researchers and consumers that asks consumers to rate how strongly they agree or disagree with 15 statements related to their recovery process (e.g. “I feel better about myself”; “I am basically strongly motivated to get better”). Each item is rated on a 4-point scale (0= disagree strongly, 1= disagree, 2= neither agree nor disagree, 3= agree, 4= strongly agree). Total score can range from 0 to 60, with a higher score indicating greater overall subjective rating of personal recovery.
- 2) **A standardized *Satisfaction and Impact Survey*** will be administered annually, to quantify:
 - Quality and quantity of members’ participation with the program.
 - Self-reported impact that participation is having on members’ physical and mental health.
 - Self-reported use of crisis services.
 - Members’ satisfaction with various aspects of the program.

- Suggestions for improving the program

PROGRAM CHANGES FOR FY22/23: Funding for the Enterprise Resource Center was increased to provide living wage increases for staff to promote pay equity for peer providers. In addition, one-time funding is earmarked for the purchase of a program van.

CRISIS CONTINUUM OF CARE: SDOE 09

MHSA PROGRAM ALLOCATION FY22/23: \$2,310,923

OVERVIEW OF MHSA PROGRAMS WITHIN CRISIS CONTINUUM:

- **Mobile Teams** (Mobile Crisis Response Team (MCRT) and Transition Outreach Team)
- **Crisis Residential** programs (Casa René and Youth Hospital Diversion)
- **Crisis Stabilization Unit** (CSU)—peer support and crisis planning

PROVIDER: Combination of county-operated (Mobile Teams and CSU) as well as contracted (*Casa René - Buckelew Programs; Youth Hospital Diversion-Edgewood*, and peer support through Mental Health Association of San Francisco)

PROGRAM DESCRIPTION:

Mobile Teams (Mobile Crisis Response Team (MCRT) and Transition Outreach Team):

The **Mobile Crisis Response Team (MCRT)** provides an alternative to law enforcement response for individuals experiencing a behavioral health crisis in the community where by MCRT can intervene utilizing a therapeutic approach and spend additional time in resolving the crisis in the least restrictive manner. MCRT provides urgent field-based mental health crisis and risk assessments, conflict resolution, psychoeducation, safety planning, community referrals, and if warranted, can initiate a 5150. Our goal is always the least restrictive intervention and 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 consists of field-based clinicians on duty six days a week, and one on-duty (OD) clinician who conducts follow-up calls with previous contacts as well as acts as dispatcher and provides support to the primary response team when they are in the field by answering calls that come in. The OD is also able to act as a secondary responder to calls for service at safe locations, such as medical clinics or schools. This program is being expanded with the help of a California Health Facilities Financing Authority (CHFFA) grant covering the personnel costs for two additional clinicians and a vehicle for a second, youth-focused team which will expand the hours earlier in the day to 8am Monday through Friday to support the full school day.

The **Transition Outreach Team** provides two levels of care: short-term intensive support and linkage to any individual who is at risk of--or has recently experienced--a behavioral health crisis who voluntarily agrees to accept services. Initial contact efforts happen within one to three days of receiving the referral.

The team also provides very targeted engagement efforts focused on individuals presenting with a behavioral health crisis event but who are unwilling to voluntarily engage in services but would benefit from services that could help improve functional impairments. The team provides intensive services immediately following a behavioral health crisis to support ongoing stabilization without further need for emergency services or involuntary treatment. The program is staffed with mental health clinicians, Peer Specialists, and Family Partners. 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, as well as

provides outreach and in-service trainings to other crisis services and community-based partners to assure awareness of the resources available with the mobile teams.

Additionally, Transition Outreach Team members collaborate with the Assisted Outpatient Treatment (AOT) team (Laura's Law) to outreach adults who have been identified as meeting the criteria as a candidate under AOT, with the goal of getting them to engage in mental health treatment voluntarily.

Both MCRT and the Transition Outreach Team work actively to coordinate and collaborate with other service providers such as Marin County Jail Mental Health, Marin Community Clinics, Marin Health Medical Center, Juvenile Hall, Probation, and local schools, including individuals who have been referred by a family member expressing a concern about the behavioral health stability of their loved one.

Target Population: Anyone in the community can utilize these services

Crisis Residential Unit: Casa René and Edgewood Youth Hospital Diversion

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

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.

Target Population: Transitional Age Youth over 18, Adults, and older adults

Edgewood Youth Hospital Diversion in San Francisco to offer a residential housing alternative to psychiatric hospital and shelter care or temporary placement for children. They assess young people while initiating interventions that help them return home safely. The typical length of stay is ten to twelve days. The Hospital Diversion Program is intended for troubled children and youth between the ages of 12–17. The program serves youth and families experiencing acute stress due to emotional, behavioral, social, and or familial challenges. Participants exhibit multiple problem behaviors that threaten their health and safety. This may include youth with severe emotional disturbances. Often these youth experience acute symptoms related to mental illness, trauma, extreme conflict, and/or significant behavioral and developmental difficulties.

Crisis Stabilization Unit (CSU)—peer support and crisis planning

The Crisis Stabilization Unit has been enhanced with MHSA funds to provide Family Partner support and Peer Crisis Planning. Crisis Planning aims to:

- increase clients’ knowledge, skills and network of support to decrease crises
- provide crisis plans to the CSU that increase the role of the client and their network of support in case of a crisis; and
- to engage and support clients who are residing in the Crisis Residential Unit in the completion of a crisis plan.

The Family Partner provides support to people who stay at the Crisis Stabilization Unit as well as support to their families and help link them to information and resources.

Target Population: All ages with a separate section for youth

OUTCOMES:

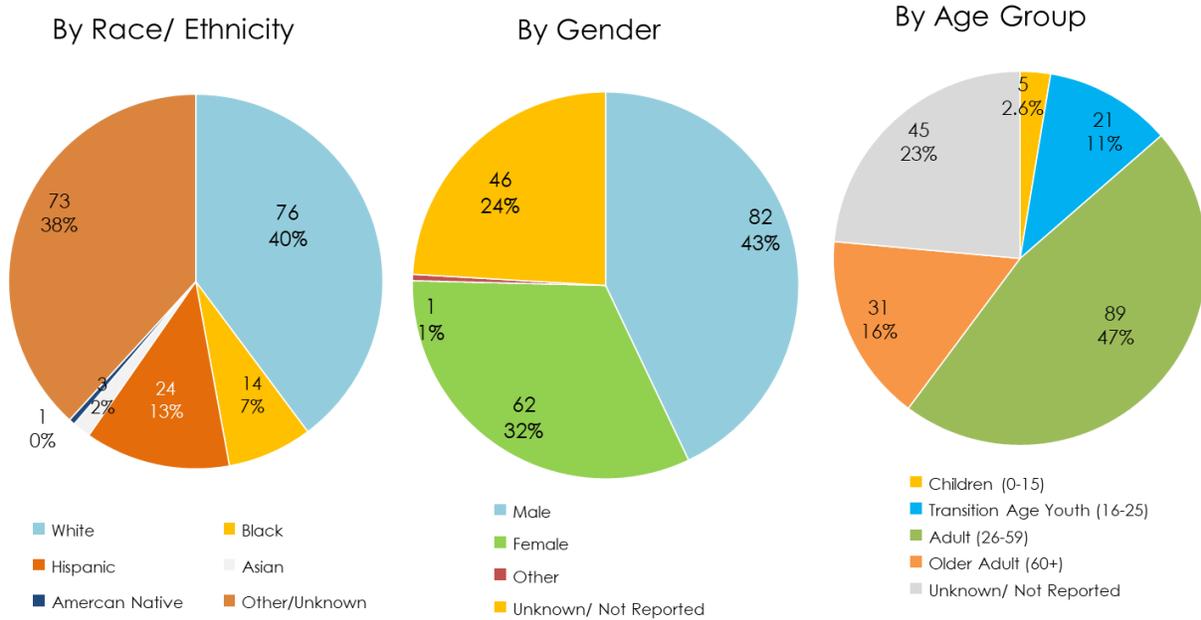
- 1) After a visit with the Mobile Crisis Response Team (MCRT) people experience decreased distress and increased reports that they would engage in services/support in the future should they need it.
- 2) Increase in feelings of hopefulness after an experience with the Mobile Crisis Response Team (MCRT)
- 3) Decrease in need for crisis services after being served by the Transition Outreach Team (TOT)
- 4) Potential clients who had recently experienced a mental health crisis but who were not engaged in on-going support, were successfully engaged using assertive outreach by the Transition Outreach Team (TOT)
- 5) 90% of the clients will be linked to outpatient services at discharge from *Casa René*
- 6) 90% of clients will be discharged to a lower level of care when discharged from *Casa René*
- 7) Clients who developed crisis plans in the Crisis Stabilization Unit reported that they were better able to identify and access community resources to decrease repeated use of crisis programs

MEASUREMENT TOOLS:

- Outcomes 1-2 will be tracked using data from the Marin Crisis Continuum Customer Satisfaction Survey. The data will be pulled from the two outcomes questions:
 - “As a result of my services I feel less distress and more likely to engage in services/support in the future should I need it.”
 - “As a results of these services I feel more hopeful.”
- Outcome 3 data will be pulled from the Electronic Health Records System comparing the number days an individual was in crisis that resulted in Crisis Stabilization Unit visits, Crisis Residential (*Casa René*) or Hospitalization, in the 3 months prior to the first contact with the Transitions Outreach Team as compared to the 3 months after services were completed.
- Outcome 4 will be tracked using the Pre-Consumer Log
- Outcomes 5 and 6 will be informed by contractor reports based on each client’s discharge plans.
- Outcome 7 will be informed by data from provider survey

FY20/21 DEMOGRAPHICS:

In FY20/21 the Transition Outreach Team (TOT) served 191 community members (14% increase from FY19/20), 152 of whom utilized this service for the first time in FY20/21. The demographics of those served by the TOT were as follows:

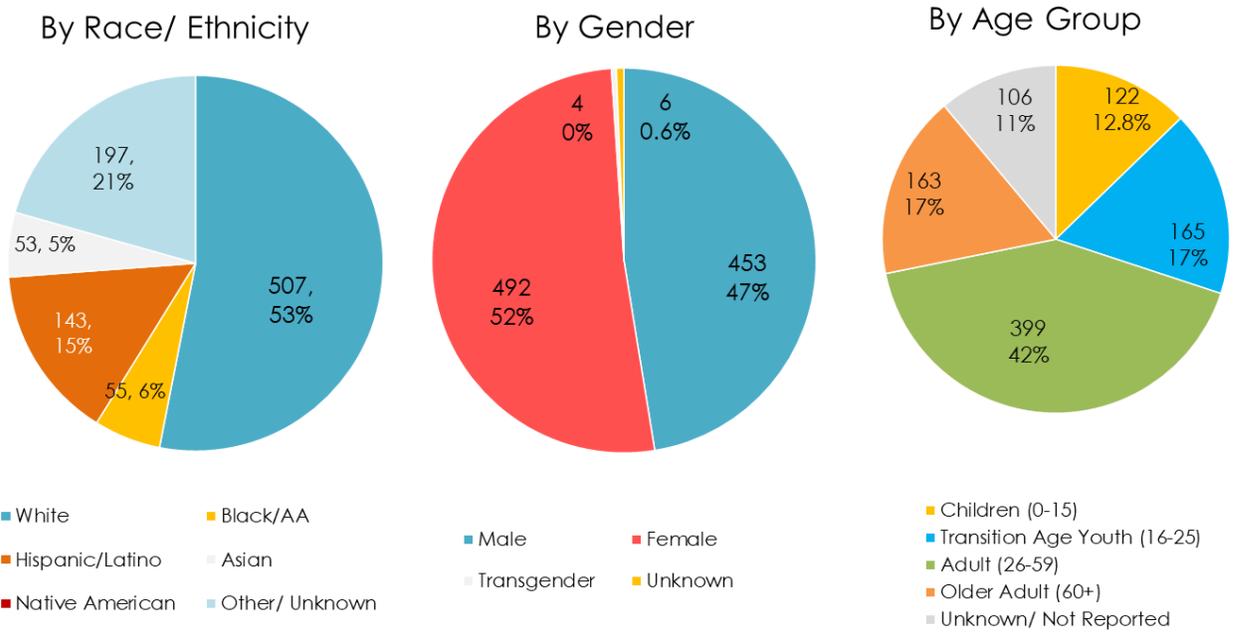


In FY20/21 the Mobile Crisis Response Team (MCRT) served **955 unique community members** (up 22% from FY19/20). 740 of these individuals utilized the service for the first time in FY20/21. By the end of FY20/21 8,518 unique community members in Marin have been served by the MCRT since its inception.

The top percent of referrals came for MCRT services in FY20/21:

- 46% from Self/Family/Spouse/Friends
- 17% from Law Enforcement
- 6% from private providers
- 3% from school staff

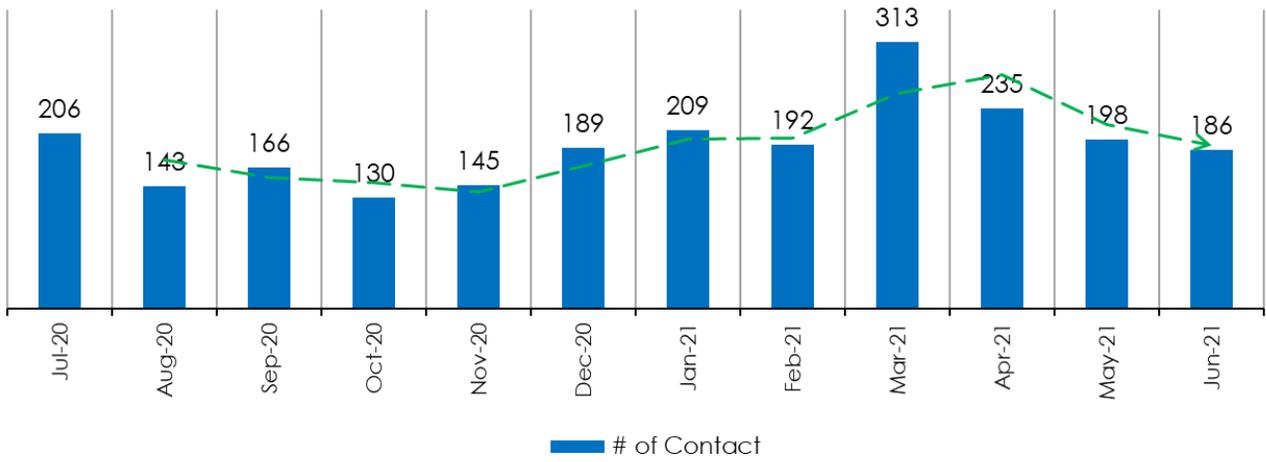
The demographics of those served by MCRT were as follows:



The number of youth age 15 or younger was the largest growing demographic change from FY19/20 with a 35.5% increase in the number of children served. This can be attributed to increase need and increased focus with the two additional youth-focused Mobile Crisis Clinicians added to the team in FY20/21.

In FY20/21 the MCRT had 2309 contacts with community members, up 31% from the previous fiscal year.

Count of Contact per Month: July 2020- June 2021

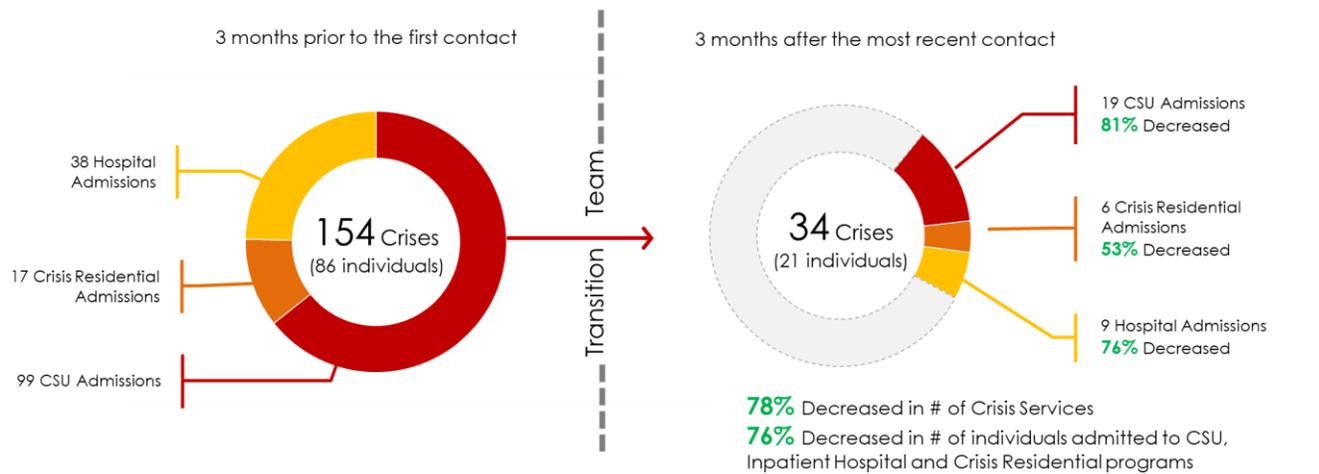


FY20/21 OUTCOMES:

- 1) Outcome 1: **75%** of people who used the MCRT and responded to the survey in FY20/21 reported that as a result of these services they **feel less distress** and **more likely to engage in services/support** in the future should they need it. (47/63 of people who completed this question on the survey)
- 2) Outcome 2: **63%** of people who responded to the survey in FY20/21 reported **increased feelings of hopefulness** after an experience with the Mobile Crisis Response Team (MCRT) (41/65 of people who completed this question on the survey)
- 3) Outcome 3: There was a **78% decrease** in the number of crisis services used by individuals in the three months after their last contact with the Transition Outreach Team (TOT) as compared to the three months prior (from 133 crises down to 32). In addition there was a **76% decrease in the number of individuals** admitted to the CSU, Inpatient hospital, and Crisis Residential Programs, a decrease from 74 individuals utilizing those services in the prior three months to 32 individuals utilizing those services in the 3 months after the last contact with the transition outreach team.

FY20/21 TRANSITION OUTREACH TEAM OUTCOMES
(N=154 individuals)

Contact date between 7/1/2020-6/30/2021



- 4) Outcome 4 was unable to be measured given staffing turnover during the COVID pandemic
- 5) Outcome 5: **90% of the 154 individuals served** were linked to services and had community supports identified and in place at time of discharge from *Casa René*
- 6) Outcome 6: **88.43% of the 154 individuals served** were discharged to a lower level of care when discharged from *Casa René*
- 8) Outcome 7: Out of the 63 people who completed crisis plans, 42 reported a decreased need for continued crisis emergency support or **66%**.

CLIENT STORY FOR FY20/21:

Mathew was referred to Casa Rene through the Marin County Jail Mental Health without housing, mental health treatment, struggling with grooming and independent skills, and lacking coping strategies to manage mental health symptoms. While at Casa Rene, he participated in case management, 1:1 daily support, support groups, and medication management. Casa Rene facilitated connection with his STAR case manager and was involved in the discharge planning process. Mathew was also offered crisis planning services to support deterrence from future anticipated crisis. At the end of his stay, Mathew was cheerful, cooperative, engaging, and well-groomed completing ADL's without daily prompting. He practiced learned coping strategies such as yoga, often engaging his peers to join in. He embraced health and nutrition concepts introduced and began participating in cooking while there. He was supportive of his peers struggling with their MH/ substance use recovery and was always willing to listen and support. Client recognized that he would benefit from continued support after discharge in continuing with STAR case management and entered into a sober living environment after completing his stay at Casa Rene. He moved into a SLE where continues to live, taking medications as prescribed, seeing his Psychiatrist monthly, attending classes online at college of Marin, and has successfully found part time employment. Client states "as long as I continue to take my medication, I have control over my actions and my life."

PROGRAM CHANGES FOR FY22/23: Staffing for MCRT will increase including an additional Licensed Crisis Specialist, as well as expanded Peer Support for the Crisis Continuum including support of a coordinated cross-Behavioral Health (meaning spanning both Mental Health and Substance Use Services) approach to provide immediate support and consistent follow-up in the critical time after an attempted suicide or non-fatal overdose. In addition, the Assisted Outpatient Treatment program will merge more formally with the Transition Outreach Team to expand capacity. In addition, Marin will partner with Edgewood in San Francisco to provide Youth Hospital Diversion. Increased expected number served for FY22/23 from 1,100 to 1,300.

FIRST EPISODE PSYCHOSIS (FEP): SDOE 10

MHSA PROGRAM ALLOCATION FY22/23: \$159,763

PROGRAM OVERVIEW: A Coordinated Specialty Care (CSC) team for First Episode Psychosis (FEP) that emphasizes a collaborative, recovery-oriented approach between individuals who receive services (target age 15 to 30), treatment team members, and when appropriate, family members and others who can provide support. Treatment planning is collaborative, involving shared decision making and addressing the following key areas: psychotherapy, pharmacotherapy, case management, supported education and employment, coordination with primary care, and family education and support. The goal will be to shorten the duration of untreated psychosis by providing access to specialized evidence-based early psychosis services as close as possible to the onset of symptoms. This program is jointly funded with a SAMHSA grant. This program is located in San Rafael’s Montecito Shopping Center at 361 Third Street, Suite B in San Rafael, CA 94901.

PROVIDER: Felton Institute (re)MIND™

TARGET POPULATION: The FEP program is designed to serve Individuals ages 15-30, with a focus on youth and transitional age youth (ages 16-25), within their first two years of onset of psychotic symptoms. Individuals are Medi-Cal beneficiaries experiencing acute psychosis as part of the onset of a “non-affective psychotic disorder.” Included diagnoses are Schizophrenia, Schizoaffective Disorder, Brief Psychotic Disorder, Schizophreniform Disorder, Delusional Disorder, and Other Specified/Unspecified Schizophrenia Spectrum and Other Psychotic Disorder. Many clients are now app

PROGRAM DESCRIPTION: This program offers an integrated package of evidence-based treatments designed for remission of early psychosis. There is a strong evidence base for this array of treatments in promoting positive outcomes for people struggling with early psychosis, and collectively they address the impact of psychosis in multiple areas of functioning. In addition, the contract with Felton (re)MIND™ will serve clients’ families and the wider community through a public educational and community outreach campaign. The core (re)MIND™ Marin Team services include:

- **Cognitive Behavioral Therapy for Psychosis (CBTp):** Widely available in England and Australia but not in the US, this formulation-based approach helps clients understand and manage their symptoms, avoid triggers that make symptoms worse, and collaboratively develop a relapse prevention plan.
- **Algorithm-Based Medication Management:** Algorithm developed by Dr. Demian Rose (UCSF), adapted from the Texas Medication Algorithm to focus specifically on medication for young adults in the early stages of psychosis. The primary goal of the medication algorithm is to guide the prescriber, the client, and the family toward finding a medication regimen that the client is much more likely to adhere to long-term. (re)MIND™ Marin Team will also work with individuals who do not wish to take medications and will offer regular appointments with the prescriber for review of symptoms and treatment options.
- **Early, Rigorous Diagnosis:** The (re)MIND™ Marin Team diagnosis and assessment is both rigorous and comprehensive, utilizing the SCID (Structured Clinical Interview for DSM Diagnoses), which addresses not only the psychotic disorder but also co-occurring mental health or substance abuse issues.
- **Strength-Based Care Management:** Intensive care management will ensure that the broad

spectrum of clients and family needs are addressed. The (re)MIND™ Marin Team model approaches services with a "whatever it takes" attitude. (re)MIND™ Marin Team staff provides services wherever the client and/or family are most comfortable, whether that is in office, client's home, schools, or other community locations, geographically anywhere in Marin County.

- **Family Psychoeducation:** Designed to increase social support and teach families and supporters a problem-solving format to cope effectively with illness-related behaviors, and to provide on-going education about symptoms, medication, enhancing involvement in school, work, and community life.
- **Public Education and Outreach:** The (re)MIND™ Marin Team is actively involved in the community, engaging schools, families, advocacy groups, and other non-profits to spread the word that schizophrenia can be effectively treated. The (re)MIND™ Marin Team educates service providers, parents, and other professionals on the warning signs for early psychosis and spreads the message that recovery is possible with early detection and treatment. The (re)MIND™ website (feltonearlypsychosis.org) provides information about early psychosis, as well as a pre-assessment questionnaire.
- **Supported Employment and Education:** The (re)MIND™ model adopts the *Individual Placement and Support* (IPS) model of supported employment. This model was developed at Dartmouth specifically for individuals with severe mental health problems to find and retain competitive employment and has documented effectiveness for young adults with psychosis.
- **Peer Support:** Provided through partnership with Marin County BHRS (site placement). Peer support contributes to increased social connectedness, engagement in treatment, and instills hope.

Clients are offered all modalities of individual and family services, based on their individual needs and willingness to participate. Services are offered intensively, often weekly with client centered treatment plans which are reviewed during the course of treatment and measured against an array of baseline measures taken during the assessment. Engagement and treatment progress will be reviewed at weekly clinical case conference and frequency of services is determined by individual needs and phase of treatment. Services will be provided on-site and/or in community locations, as determined by client and/or family. The length of treatment is up to two years.

Services will be delivered by direct service team formed by:

- Clinical Supervisor/Team Leader (1.0) FTE
- Clinical Care Manager (1.0) FTE
- Psychiatric Nurse Practitioner (0.12 FTE) with weekly supervision provided by licensed psychiatrist
- Employment and Education Specialist (0.6)
- Office Manager /Admin Support (0.2 FTE)

EXPECTED NUMBER TO BE SERVED: 25

ACTUAL NUMBER SERVED IN FY20/21: 11. During Felton (re)MIND® Marin's inaugural year, FY20-21, the program served a total of 11 clients with a contracted target of 20-25. In addition, Felton served 10 parents or caregivers. Immediately after filling key positions and starting community outreach and

engagement in February 2020, the program began accepting referrals. Although the program has been in operation and taking referrals for a total of 14 months all of which were in the context of COVID-19 and the varied public health landscape that includes the local Shelter in Place public health order, surges, and the State's re-opening in June 2021.

9% of clients served identified as Black or African-American, 54% as White or Caucasian, 27% as another race, and 9% unknown. 18% of clients in FY20/21 were Hispanic or latino. 63% identified as Male, 36% as female, and no one identified as another gender identity. 82% of clients were age 15 or younger, 9% between 16-25, and 9% age 26 or older

EXPECTED OUTCOMES:

1. Reduce individuals' adverse events including hospitalizations, utilization of crisis services, and arrests or incarcerations;
2. Increase the individuals' quality of life in the areas of vocation, education, social and interpersonal relationships and independent living, thereby moving toward recovery and living a meaningful life.

MEASUREMENT TOOLS: These outcomes will be measured using the health records database.

1. At least 50% of clients enrolled in Felton (re)MIND™ Team Marin County for 6 months or more will demonstrate decrease in total number of acute inpatient setting episodes or days in inpatient services compared to 12-month period prior to engagement in Felton (re)MIND™ services, as documented in electronic health records.
2. At least 30% of clients enrolled in Felton (re)MIND™ Team Marin County for 6 months or more will demonstrate satisfactory participation in school, vocational training, and/or employment, as measured by enrollment numbers documented in electronic health records.

OUTCOMES FOR FY20/21:

1. **Outcome 1:** Of the 11 clients served, 6 were served for six months or longer. Of these 6 clients, 5 clients had acute inpatient setting episodes in the year prior to services. **5 of the 5 (100%)** clients with previous hospitalization history experienced a decrease in acute inpatient setting episodes compared to 12-month period prior to engagement in Felton (re)MIND®. Program clients saw an overall reduction in days hospitalized from 93 in the year before program enrollment to 10 days following program enrollment, an **89.2% reduction in days hospitalized**.
2. Of the 11 clients served, 6 were served for six months or longer. Of these 6 clients, 5 clients **(83.3%)** have been ongoingly involved in school, employment and training opportunities or are making the transition from training to employment.

PROGRAM CHANGES FOR FY22/23: No changes.

CONSUMER-OPERATED WELLNESS PROGRAM: SDOE 11 (EMPOWERMENT CLUBHOUSE)

MHSA PROGRAM ALLOCATION FY22/23: \$361,251

OVERVIEW AND HISTORY: In May of 2017 Marin City Community Development Corporation (MCCDC) responded to an RFP to bring a clubhouse to Marin County. MCCDC was awarded a 3-year MHSA contract overseen by Marin County BHRS that began on July 1, 2017.

On November 13, 2017, Empowerment Clubhouse enrolled its first four members (residents of Marin City) and began planning the Empowerment Clubhouse Grand Opening with the support of members, peers, and staff alike. The Empowerment Clubhouse was officially established on November 29, 2017, and welcomed over 60 county residents, community stakeholders, and county officials at the Grand Opening.

The Clubhouse Model is a strengths-based, recovery-oriented approach to mental health rehabilitation that uses the power of collaborative work and meaningful relationships to help individuals living with mental illness develop hope, purpose, self-efficacy and independence. Under the Clubhouse Model, program participants are referred to as members, not patients or clients, and are engaged in all aspects of Clubhouse operations. Members also receive health and wellness programming, access to educational and employment support and opportunities, advocacy, and connection to social services. While there are over 350 Clubhouses in operation around the world, Empowerment Clubhouse is the only Clubhouse operating in Marin County.

Equity and inclusivity are core values of the Clubhouse Model, and as such all decisions about programmatic growth and development in a Clubhouse are made with the aim of increasing opportunity and accessibility. Clubhouses strive to make it as easy as possible for adults living with mental health challenges to become members, and to ensure that once they become members they have every opportunity to learn and grow through their participation. This approach is the primary catalyst for positive change in members' lives, and results in members overcoming the barriers of stigma, symptoms and self-doubt, in order to travel down the path of recovery.

PROVIDER: Marin City Community Development Corporation (MCCDC)

TARGET POPULATION: The Empowerment Clubhouse target population includes any Marin County resident 18 years of age or older living with a diagnosed mental illness or acknowledged mental health challenge. While the Clubhouse Model is designed to be a transdiagnostic intervention, membership is primarily drawn from individuals with the following diagnoses: Bipolar Disorder, Schizophrenia, Schizoaffective Disorder, and Major Depressive Disorder.

Empowerment Clubhouse also targets populations of underserved and unserved individuals in Marin County that have been hospitalized, traumatized, incarcerated, and who are not yet affiliated with the mental health system. Many of these individuals experience significant barriers to obtaining services such as: low-income, lack of insurance, and stigma. Underserved and unserved individuals in Marin County include at-risk populations, such as those who have experienced disempowerment in the forms of poverty and social exclusion due to their mental illness. Empowerment Clubhouse also targets young Marin County residents that are aging out of Transition Age Youth Services after the age of 25, and older adults.

PROGRAM DESCRIPTION: The Empowerment Clubhouse is located in the Burgess Estate – a Victorian mansion built in the late 1800’s on a 4.2 acre wooded, rustic, terrain replete with deer families and a small creek. The Clubhouse location is peaceful, tranquil, and calm—providing a state of relaxation and healing. Empowerment Clubhouse has a mission of: *offering a safe and restorative community where individuals working toward mental health recovery become empowered through meaningful work and supportive relationships.* This mission is pursued by offering the following services:

Work-Ordered Day: A seven-hour period, occurring 9:30am – 4:30pm, Monday through Friday. Members of the Clubhouse voluntarily work together to successfully run the day-to-day operations of Empowerment Clubhouse’s Culinary/Hospitality/Gardening and Business/Clerical Units.

Decision-Making and Self-Efficacy Training and Practice: Collective decision-making and governance are a crucial part of Empowerment Clubhouse. All members and staff attend meetings and reach consensus about policy issues, activities, and future planning for the Clubhouse.

Social and Recreational Activities: Members develop meaningful and lasting friendships through recreation and occasional weekend and holiday gatherings and special events. Members have the opportunity to participate in a weekly art class, and to organize special recreational outings. Past outings and events have included: movies, beach trips, holiday BBQs, visits to museums, hikes, meals at local restaurants, and kayaking.

Benefits of participation in the Clubhouse Work Units: Members learn culinary, housekeeping, gardening, clerical, business operation, and leadership skills in a safe and supportive environment, and develop the soft skills needed for future success in the workplace.

- Culinary/Hospitality/Gardening Unit- Members who choose to work in the Culinary/Hospitality/Gardening Unit develop skills by participating in the following activities:
 - Menu planning
 - Budgeting
 - Food shopping
 - Meal preparation and service
 - Revenue collection and accounting
 - General housekeeping
 - Growing vegetables from seed
 - Composting

- Business/Clerical Unit- Members who choose to work in the Business/Clerical Unit develop skills and receive training in the following areas:
 - Filing and mailing/emailing
 - The use of Word, Excel, and Publisher
 - Producing a bi-monthly newsletter
 - Receptionist duties
 - Money management
 - Leadership skills
 - Presentation skills

Health and Wellness: The promotion of healthy lifestyle habits is a primary focus of the day-to-day operation of the Clubhouse. The lunches prepared and served by the Culinary Unit are nutritious, balanced, and use fresh organic produce when available. Members of the Clubhouse are able to enjoy these nutritious lunches free of charge. Healthy living is also the focus of “Wellness Wednesday” activities, including lectures by health educators, physical activities such as yoga and hiking, and cooking demonstrations.

Advocacy and Connection to Support Services: Members receive support accessing care and navigating through the network of social services in the community while developing their ability to self-advocate. These supports include help with entitlements, housing, legal issues, developing healthy lifestyles, connecting with quality medical, psychological, psychiatric, and dental care.

EXPECTED NUMBER TO BE SERVED: 80 members including TAY, Adults, and Older Adults

EXPECTED OUTCOMES:

- Program average daily attendance (ADA) of at least 12
- Clubhouse members are expected to show an **increase in wellness and recovery**, such as:
 - Increased access to resources
 - Increased resiliency factors, such as feeling of belonging to a supportive community
- **Member Defined Goals:** Members choose the way they utilize the Clubhouse and can join for a myriad of reasons, including to:
 - Reduce isolation and increase socialization
 - Develop work skills in preparation for a return to employment
 - Engage in social and recreational activities
 - Get support around returning to school
 - Become a productive member of a supportive community

MEASUREMENT TOOLS:

- 1) The Average Daily Attendance (ADA) is calculated by using the following formula provided by Clubhouse International: (Total Number of Attendances/ Total Number of Work-Ordered Days).
- 2) **Standardized Psychological Measures:** The following validated measures will be administered biannually:
 - *The Recovery Assessment Scale-Domains and Stages (RAS-DS):* A 38-item self-report instrument that measures the mental health recovery process and is designed to aid collaborative intervention planning between individuals engaged in mental health recovery and mental healthcare providers.
 - *The Flourishing Scale (FS):* A 8-item self-report instrument that measures self-perceived success in important life-domains such as: relationships, purpose, self-esteem, and competence. The overall score provides a single measure of psychological well-being.
 - UPDATE: FY21/22 outcomes will instead use the Questionnaire about the Process of Recovery (QPR-15). Version 2.0 (Law, Neil, Dunn, & Morrison, 2014). This 15-item self-report questionnaire of consumers’ subjective rating of their own recovery jointly created by researchers and consumers that asks consumers to rate how strongly they agree or disagree with 15 statements related to their recovery process (e.g. “I feel better about myself”; “I am basically strongly motivated to get better”). Each item is rated on a 4-point scale (0=

disagree strongly, 1= disagree, 2= neither agree nor disagree, 3= agree, 4= strongly agree). Total score can range from 0 to 60, with a higher score indicating greater overall subjective rating of personal recovery.

- 3) In addition, a 31-item survey to assess **Member Satisfaction and Empowerment Clubhouse Impact** will be administered biannually, to quantify:
 - The quality and quantity of members' participation with Empowerment Clubhouse.
 - The impact that participation is having on members' physical and mental health.
 - Members' satisfaction with various aspects of the Empowerment Clubhouse program.
 - Suggestions for improving Empowerment Clubhouse.
- 4) Each **member defined goal** is treated as valid and valued, and can be linked to concrete, measurable goals that can be progressed toward and accomplished through their participation at Empowerment Clubhouse. During the intake process members are asked to identify their reason(s) for membership, and an Individualized Service Plan (ISP) is developed to provide the framework for tracking progress and creating mutual accountability between member and staff around the attainment of these goals for each member.

FY20/21 ACTIVITIES AND OUTCOMES: In FY20/21, Marin City Community Development Corporation (MCCDC) expanded Empowerment Clubhouse membership to 80. The Clubhouse managed to remain a cohesive community despite the pandemic. The members continued to do meaningful work and enhanced their technological skills through engaging in a "Virtual Clubhouse which fused into a "hybrid" model. Members and staff worked together to prepare and deliver nutritious meals to homebound members. Through the efforts of staff and members we were also able to have a slight uptick in membership and expand our programming during unprecedented times.

One way in which the program thrived during the pandemic was the wellness component that was implemented in partnership with the Marin County Parks and Recreation. Members, many of whom were unwilling to participate with the program in-person due to safety concerns, were much more willing to attend wellness activities outdoors at local parks. The time during these trips also served as an ideal opportunity to meet one-on-one with members exploring their employment and education goals. These trips rendered the largest in-person numbers for the program this fiscal year – the largest of which was 20 members and guest. Because of members willingness to engage more in outdoor activities, program meals were shifted to dining outdoors (weather permitting), so that members felt safe while without mask. Finally, there was an increased interest in the gardening project as this too provided an opportunity to participate outdoors. In FY20/21 MCCDC donated a plot of land to the Empowerment Clubhouse to start a garden. Previously the gardening was done in a community garden in Marin City, now MCCDC was able to fence a plot of land for the use of the clubhouse's gardening projects. There has been increased interest in the Garden Unit as participation in outdoor activities has offered a safe way to participate in the work-ordered day.

The standardized impact tools were not able to be collected and analyzed during the pandemic.

"For years I thought that I would never live on my own, but working at Empowerment Clubhouse has made me believe that I can: get a job, get an apartment, and live on my own" Although new to the clubhouse, this member has fully immersed themselves in the Clubhouse community. Originally referred by the department of rehabilitation,

this member was unsure if the program would be a fit. Since then, they have taken the Servsafe food handlers training and passed with flying colors. With the support of Empowerment Clubhouse the member is currently seeking employment.”

PROGRAM CHALLENGES: During FY20-21 the Empowerment Clubhouse saw a turnover in all staff positions due in part to the pandemic. Staff, interns, and members all reported higher levels of fatigue and burnout in FY21/22 due to a combination of the pandemic, economic, and other factors. This has necessitated the need to re-imagine the workforce structure within the clubhouse. While the director and program coordinator positions will remain unchanged, the social practitioner position will be split into two part-time positions allowing for: additional side-by-side member engagement, transportation assistance, and support and management of work units.

PROGRAM CHANGES FOR FY22/23: There will be budget increase to promote recruitment and retention of staff and an increased in expected number of individuals served for FY22/23 from 70 to 80.

RECOVERY-ORIENTED SYSTEM DEVELOPMENT: SDOE-13

MHSA PROGRAM ALLOCATION FY22/23: \$1,363,877

PROGRAM DESCRIPTION: *Recovery Oriented System Development (ROSD)*—This program focuses on building the supports necessary throughout our system of care for clients to lead the way to meeting their goals. This recovery-oriented framework acknowledges that each individual is an expert on their own life and that recovery involves working in partnership with individuals and their families to provide support in a way that makes sense to them. This was a new program in FY20/21 though it incorporates some elements of the ended “Adult System of Care (ASOC) Expansion” program but expands it across the age groups and coordinates other pieces from throughout the system to be lead through a recovery-oriented perspective.

In FY21/22 funding was added to increase ability for step downs from FSPs to the BRIDGE Team by adding a case manager to the BRIDGE Bon Air team. The BRIDGE Bon Air Mental Health Practitioner will be a recruitment specifically for someone with experience in alternative and cultural healing practices to widen the array and cultural competency of the services offered within BHRS.

In addition, awarded via RFP, the Multicultural Center of Marin provided new peer-led expansion programming in FY21/22, including:

- Peer-led wellness hikes for Transitional Age Youth (TAY)
- Sunset Meditation on the beach in Spanish and Vietnamese
- Healing Circles (yoga and sound healing, drumming, and mindfulness)
- Drawing and painting for emotional expression focusing on underserved groups and artistic traditions such as *papel picado* that are tied to Latinx, Vietnamese, and other cultures
- Cooking traditional foods and sharing communal meals

Strategies include:

- 1) Peer providers will receive enhanced support and training **including an expansion of *Wellness Recovery Action Planning* (WRAP)** lead by the newly created **Peer Lead** position. In addition, expanded Peer Services and the continuation of the Peer-led Tobacco Cessation program emphasizing personal empowerment.
- 2) Enhance **support, education, and skill-building for family members** including family groups and Family Partners embedded in Behavioral Health programs with additional support.
- 3) Increasing recovery-oriented practices for **co-occurring** disorders including increased training and consultation support in a harm-reduction, recovery-oriented way
- 4) Enhancing services and supports for **LGBTQ+** clients, families, and staff to ensure BHRS is a welcoming program to all
- 5) Providing culturally competent and **culturally relevant peer programming**
- 6) A focus on recovery and enhancing the ability for individuals to **step down** to lower levels of care as needed

PROVIDER: Combination of county-operated and contracted (Multicultural Center of Marin, National Alliance of Mental Illness, Bay Area Community Resources, Mental Health Association of San Francisco)

TARGET POPULATION: Transitional Age Youth, Adults, and Older Adults with serious mental illness served throughout the public mental health system

EXPECTED NUMBER TO BE SERVED: 750

OUTCOMES:

- 1) At least 70% of clients will report feeling that staff believe that they can grow, change, and recover
- 2) At least 70% of clients will report that staff helped them obtain the information they needed so that they could take charge of managing their illness
- 3) At least 70% of clients will identify that as a direct result of the services they received, they are better able to participate in activities that are meaningful to them

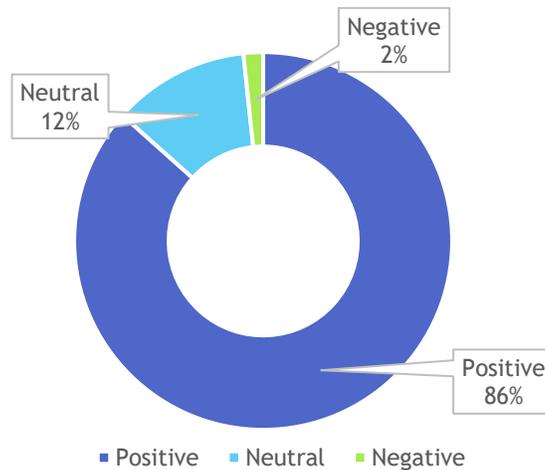
MEASUREMENT TOOLS:

- 1) Outcomes 1-3 will be measured using the Performance Outcomes and Quality Improvement (POQI) MHSIP Consumer Perception Survey which was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services. “Met” will include all adults who answered *Agree* or *Strongly Agree* to the following statements:
 - *“Staff here believe that I can grow, change and recover” (#10)*
 - *“Staff helped me obtain the information I needed so that I could take charge of managing my illness.” (#19)*
 - *“As a direct result of the services I received, I do things that are more meaningful to me” (#29)*

OUTCOMES FOR FY20/21:

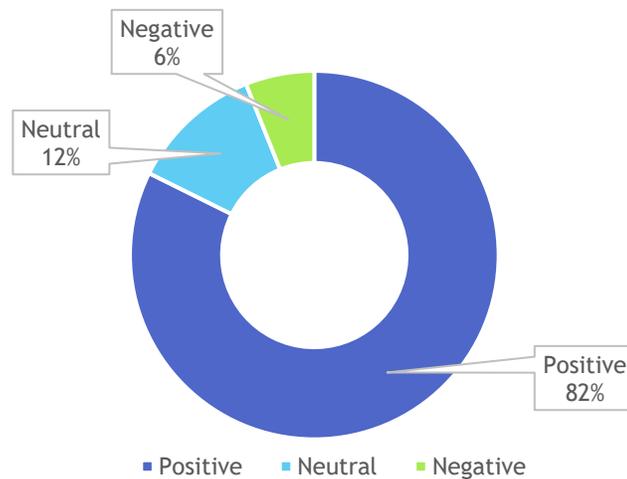
- 1) In FY20/21, **86%** of clients reported feeling that **staff believe that they can grow, change, and recover:**

"Staff here believe that I can grow, change and recover" (N=239)



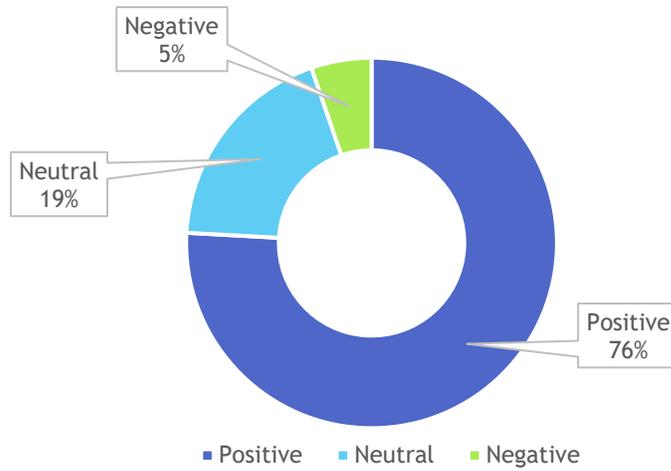
- 2) **82%** of clients reported in FY20/21 that staff helped them obtain the information they needed so that they could **take charge** of managing their illness:

"Staff helped me obtain the information I needed so that I could take charge of managing my illness." (N=232)



- 3) Despite the ongoing pandemic, **76%** of clients reported in FY20/21 that as a direct result of the services they received, they are better able to participate in **activities that are meaningful** to them

“As a direct result of the services I received, I do things that are more meaningful to me” (N=228)



PROGRAM CHANGES FOR FY22/23: Funding is added to add an additional County Peer Counselor II position as well as increase funding for contracted peers and other recovery-oriented system development contracts. In addition, a new position that focuses on Wellness will be created and a new contract to expand therapy capacity to reduce wait time for therapy services and expand the linguistic capacity of therapy services. Increased the expected number served through this program for FY22/23 from 525 to 750.

MHSA STEPPING-UP PROGRAM: SDOE-14

MHSA PROGRAM ALLOCATION FY22/23: \$443,110

PROGRAM DESCRIPTION: The goal of Stepping-Up programs around the country is to reduce the number of people with Serious Mental Illness in jail. The County of Marin formally joined the Stepping-Up initiative with a resolution by the Board of Supervisors in March of 2017. The goals of this program is aimed to facilitate the diversion of individuals with behavioral health disorders out of the criminal justice system and into treatment.

As part of the larger Stepping-Up work the county is doing, the MHSA-funded Stepping-Up General System Development program will have three main components: Re-Entry support, Pre-sentencing diversion (AB1810), and Crisis Intervention Training (CIT) for law enforcement officers. The Stepping-Up program will be rooted in racial equity, and data on referrals and outcomes will also be analyzed by race.

Re-Entry Support: Using other sources of funding, the Jail Mental Health (JMH) team is staffed with 4.5 FTE Mental Health Crisis Specialists to cover shifts 20 hours per day, 7 days per week. The JMH staff are focused on provided in-custody psychiatric services, assessments, safety cell evaluations, and counseling. This new MHSA program fills a need because the Crisis Specialists are unable to focus on re-entry planning and treatment interventions that might involve collaborating with the court, external agencies, and aftercare. This program will fund a Full-Time Re-Entry Mental Health Practitioner focused on supporting people with serious mental illness. Anticipated duties include completing PC 4011.6 and WIC 5150 evaluations, collaborating with the court and criminal justice partners on complex cases (including those involving acute inmates refusing treatment and needing hospitalization), helping with restoration of competency for defendants charged with misdemeanors, collaborating with community partners for justice-involved behavioral health clients, working with family members of those incarcerated, and creating and supporting re-entry planning that meets the needs of the clients. This position would work with clients during and after incarceration, ensuring appropriate warm handoffs to other county services and community agencies, and collaborating with the courts and family members. Given the changes to Court and Jail procedures due to COVID-19, this position will fill important roles by assisting with communication and planning between external providers and clients in-custody and providing rapid referrals and re-entry resources for those clients with very short-term bookings into the Jail.

Pre-Sentencing Diversion (AB1810): In 2018, Assembly Bill 1810 was made into law which provides a pathway for individuals with behavioral health conditions who have been charged with an offense to enter a mental health program before going to trial on these charges. Upon successful completion of this program, the charges will be dropped. Based on Marin Superior Court estimates, approximately 200 defendants may apply for this pre-sentencing diversion each year. Of those, it is estimated that approximately 100 will meet basic screening criteria and be evaluated further by the Psychologist. Of those, approximately 25-50 are projected to be found eligible for behavioral health treatment with Court oversight. Racial equity will be a cornerstone of this program, and analysis of the race and ethnicity of those who make it through each step of this process will be analyzed and reported on. Where racial inequities appear, a plan will be included in the Annual Update to directly address any disparities that are present.

This program will fund one Full-Time Mental Health practitioner to work closely with the Court to track referrals, complete screenings for eligibility, make referrals to appropriate behavioral health services, report progress to the Court, provide case management, and to coordinate with criminal

justice partners including probation, public defender, and district attorney. This program will also fund half of a clinical psychologist who will perform the formal evaluations and risk-assessments.

Crisis Intervention Training (CIT): CIT is a 32-hour POST-certified training program for law enforcement personnel to enable them to more effectively and safely identify and respond to crisis situations and behavioral health emergencies. The primary goals of CIT are to appropriately redirect mental health consumers from the judicial system to the services and support needed to stabilize consumers and reduce contact with police reduce injuries to mental health consumers and officers during contacts. A component of CIT is a training academy where officers learn to safely handle mental health consumers in crisis. Because earlier trainings were successful and popular, the program has been extended through FY22/23 and shifted to become a formal part of the MHSA Stepping Up initiative. This training is provided to 40-50 sworn law enforcement personnel each year and has been expanded to also include personnel from Probation, the District Attorney’s Office, and Animal Control. This year the program will be expanded to go further in depth on issues of implicit bias and racial equity. In future years, the program will be further expanded to offer additional ongoing training continuing education to officers who have completed the initial 32-hour program.

PROVIDER: County-operated

TARGET POPULATION: Transitional Age Youth, Adults, and Older Adults with serious mental illness who are incarcerated in—or at risk of incarceration in—the Marin County Jail.

EXPECTED NUMBERS TO BE SERVED: 150 individuals with serious mental illness as well as training 50+ law enforcement officers who will be engaging with thousands of individuals throughout the community

EXPECTED OUTCOMES: The overarching goal is to reduce the number of people with Serious Mental Illness in the county jail. We are also dedicated to ensuring people of different racial backgrounds are equitably provided support and access to criminal justice alternatives.

Effectiveness of each part of the MHSA Stepping Up program will also be analyzed based on the following metrics.

For those utilizing the Re-Entry support:

- Outcome 1: reduce recidivism (as evidenced by a reduction in clients re-entering county jail within 6 months of release—and for subsequent reporting periods including recidivism rate after 1 and 2 years.)
- Outcome 2: increase access to care and engagement with services after release (as evidenced by clients receiving 3 or more mental health services in the 6 months following release)

AB1810 Diversion Program:

- Outcome 3: For those who were granted AB1810 diversion, at least 75% of individuals who have been approved for AB 1810 pre-sentencing diversion will remain out of custody by meeting the requirements—or being on track to meet the requirements—of their treatment plan.

Crisis Intervention Training (CIT):

- Outcome 4: 85%+ of law enforcement officers who took the CIT training will report they learned how to identify and respond appropriately to individuals with mental illness who are in crisis.
- Outcomes 5: by the end of the Three-Year Plan at least 75% of officers and deputies in Marin will have completed the CIT training

MEASUREMENT TOOL:

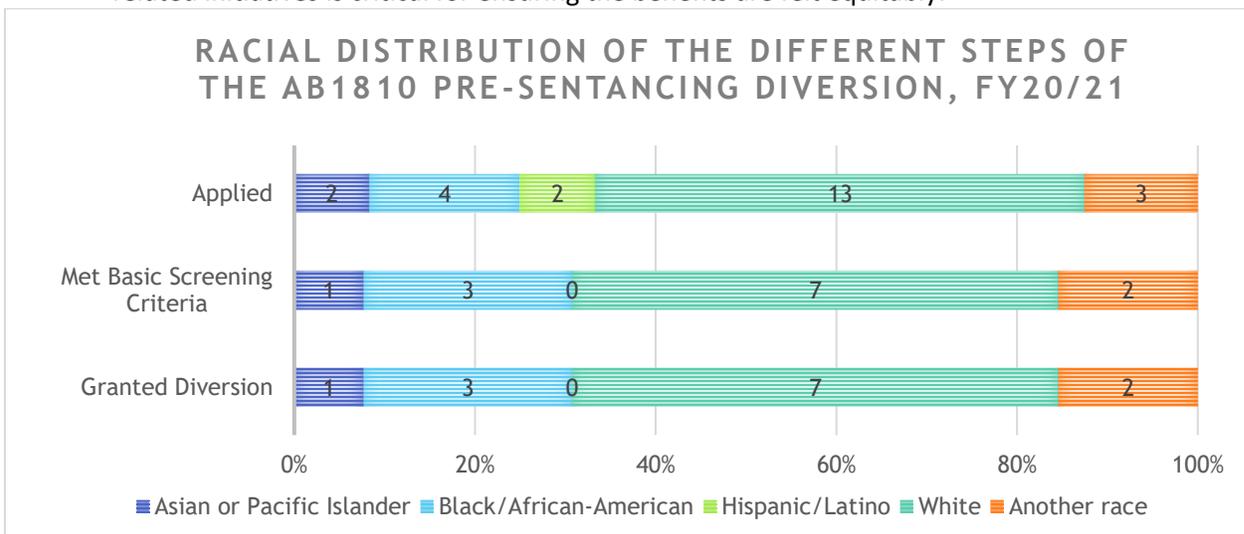
- Outcome 1: will be measured using the Jail Mental Health database to determine if clients have re-entered the Jail system within 6 months (*as well as within 1 or 2 years*) after release.
- Outcome 2: will be measured by assessing how many clients who were referred for BHRS services received 3 or more mental health services in the 6 months following release, as documented in the county behavioral health electronic records system.
- Outcome 3: will be measured by court minutes and data from criminal justice partners about program continuation/termination
- Outcome 4: will be measured using an evaluation survey and answers of “agree” or “strongly agree” will count toward this measure.
- Outcome 5: will be measured and reported on with subtotals by each jurisdiction

OUTCOMES FOR FY20/21:

The Jail Re-Entry support portion of the Stepping Up initiative was unable to launch during FY20/21 because of an inability to recruit a candidate for the position. Therefore, there are no outcomes to report for **Outcome 1 or 2**.

AB1810 Diversion Program

- **Outcome 3:** Of the **13 individuals** who were granted AB1810 diversion, **100%** remained out of custody by meeting the requirements—or being on track to meet the requirements—of their treatment plan.
- Closely monitoring the racial distribution of who is benefiting from new criminal-justice related initiatives is critical for ensuring the benefits are felt equitably.



In FY20/21, we saw a disparity emerging for Latinx/Hispanic individuals—2 applied for pre-sentencing diversion but neither met the basic screening criteria. To spread the word about the new opportunity and increase knowledge about how to apply and what the criteria are, BHRS released an RFP for bilingual Spanish outreach to support the AB1810 diversion program. This contract was awarded to the Multicultural Center of Marin.

Crisis Intervention Training (CIT):

- **Outcome 4: 100%** of law enforcement officers who took the CIT training in FY20/21 reported that they **learned how to identify and respond appropriately to individuals with mental illness who are in crisis.**
- **Outcomes 5:** by the end of the Three-Year Plan at least 75% of officers and deputies in Marin will have completed the CIT training. By the end of FY20/21 this goal has been achieved and will continue to expand to reach at least 90% of officers by the end of the 3-year plan. With 46 new program graduates in FY20/21, the overall number rose to 85% by the end of the FY. Data for each jurisdiction presented below:
 - Belvedere PD: 83%
 - Central Marin Police Authority: 79%
 - California Highway Patrol: 92%
 - College of Marin PD: 100%
 - Fairfax PD: 64%
 - Marin County Sheriff's Office: 72%
 - Mill Valley PD: 80%
 - Marin Municipal Water District PD: 100%
 - Novato PD: 89%
 - Ross PD: 57%
 - San Rafael PD: 96%
 - Sausalito PD: 78%
 - Tiburon PD: 100%

CHANGES FOR FY22/23: No changes

COMMUNITY OUTREACH AND ENGAGEMENT: SDOE-15

MHSA PROGRAM ALLOCATION FY22/23: \$818,668

PROGRAM DESCRIPTION: This program focuses on supporting underserved communities and identifying unserved individuals in order to engage them, and when appropriate their families, in the mental health system so that they receive the appropriate services. Strategies:

- 1) Engaging unserved individuals where they are and removing barriers to accessing BHRS services, by:
 - a. Providing field-based assessments around the county via a bilingual field-based health navigator (focused on reaching unserved individuals from underserved populations including the Canal neighborhood of San Rafael, Marin City, and West Marin)
 - b. Providing peer/family partner/or recovery coach support through the assessment process to help potential clients and family members navigate the system, answer questions, and problem-solve around any potential barriers
 - c. Increasing understanding around financial options and resources
- 2) Reducing ethnic/racial disparities by funding and investing more resources, training, and support for Community Health Advocate programs (including *Promotores*) in underserved communities (including Latinx individuals, mono-lingual Asian populations, and people living in Marin City)
- 3) Increasing coordination with grassroots, faith-based and other informal providers as well as strengthen partnerships with other formal community organizations and groups.
- 4) Providing community groups in Spanish such as parenting and anger management classes to introduce more people to BHRS services

PROVIDER: Combination of county-operated and contracted. Community Health Advocate RFPs were released in FY20/21 and awarded to: Marin City First Missionary Baptist Church, Marin Asian Advocacy Project, and North Marin Community Services.

PROGRAM CHANGES: This is a new program in FY20/21, however it incorporates some elements that were formerly in *Prevention and Early Intervention*.

TARGET POPULATION: Unserved individuals who may be eligible for services, with an emphasis on targeting underserved populations in our mental health system including the Latinx population, mono-lingual Asian and Pacific Islander populations, and people living in Marin City and West Marin.

EXPECTED NUMBERS TO BE SERVED: 5,000

OUTCOMES:

- Increase knowledge of service options and how and when to access them
- Increase number of unserved individuals from underserved populations who receive assessments

MEASUREMENT TOOL:

- Outcome 1: Community Health Advocates surveys
- Outcomes 2: Health Records System report on number and demographics of assessments

OUTCOMES FROM FY20/21:

Community Health Advocates/*Promotores* Program

North Marin Community Services provides training and support to *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. They support hard to reach populations, are trusted community members and 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 factors, and linkages to services. This program increases the efficacy of existing mental health programs by reducing 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.

North Marin Community Services- <i>Promotores</i> Program	Goal FY 20/21	Actual FY 20/21
<i>Promotores</i> from Novato, San Rafael and West Marin will participate in trainings, to learn about mental health resources, and recognize symptoms of a mental health problem or crisis.	10 Hours of training	28 Hours
<i>Promotores</i> will reach Latinx community members face-to-face, and by phone, text and video contacts	210 Latinx community members	1158 persons were reached
Facilitate at least 10 workshops (talleres) on mental health stigma, stress management or suicide prevention in local groups (ELAC’s, church groups, etc.) reaching individuals	100 individuals	91 Individuals reached 7workshops conducted
<i>Promotores</i> will provide one-on-one support to individuals and provide informal counseling, screening and referrals (1:1 emotional support) to Latinx individuals and family members	110 Latinx individuals and family members	111 Latinx individuals were reached
Total referrals to County Behavioral Health (BHRS)	N/A	12
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	0
Total referrals to other PEI providers	N/A	56
Total referrals to other mental health services or resources for basic needs	N/A	46

Promotora Quote:
 “North Marin Community service has helped my family and my community with mental health support. Your programs have helped me to be a better advocate and give my community the resourceful help and emotional support they need. Thank you so much North Marin Community Service!”

Client Story (provided by Promotora):

When I started talking to this client, she was going through a separation from her husband. She was going through a severe depression, had difficulties concentrating and a sad look in her face. Every day she lost more weight, to the point of reaching 112 pounds when she was 5.5 in height. Her situation was worrisome. When she returned from work, she would cook for her children and the rest of the time she spent crying and sleeping in her bedroom. Thanks to the trainings that I have received as a Promotora, I had the knowledge to offer her help, listening to her in an environment where she felt safe and not judged. She was not only going through the grief of separation but also through an economic crisis. Her income was \$1500 per month, which was not enough for her basic needs, having 5 children in her care. I provided emotional support, motivated her to contact Petaluma Health Center for medical assistance, and helped her get another job where she earns \$25 per hour. Today, this client is doing much better. Her gaze looks calmer, and she can focus on her work and enjoy the company of her family—West Marin Promotora

First Missionary Baptist Church- This new program in FY20-21, supports Community Health Advocates connect and facilitate access for vulnerable populations that experience barriers to culturally appropriate health and wellness services. They are representatives of the communities they serve and are considered a trusted community resource. The Community Health Advocates team at First Missionary Baptist Church works with the Marin City Community to provide services and resources related to mental health. These services include weekly phone calls, resources, referrals, dispute resolution/mediation, and mental health awareness/workshops.

First Missionary Baptist Church	Goal FY 20/21	Actual FY 20/21
Community Health Advocates will participate in no less than 15 hours of training to increase their knowledge around conflict resolution, outreach and engagement and how to reach out to someone who may be dealing with a mental health problem or crisis.	8 Community Health Advocates	8 Community Health Advocates
Provide informal Counselling to Marin City residents	100 individuals	75 Individuals
Facilitate workshops that focus on addressing mental health stigma, mental health needs within the community and linking to additional sources.	8 monthly	5 monthly
Community advocates will participate in no less than 15 hours of training related to recognizing and responding to early signs of mental illness, suicide prevention and intervention, conflict resolution, motivational interviewing, case discussion, connecting to mental health and other services, leadership, engagement, and advocacy.	100%	100%



CLIENT STORY:

Client reached out to a Community Health Advocate (CHA) and shared they were feeling like “giving up”. CHA was able to support the client and refer them to the other resources to address the situation. The CHA has kept regular contact with this client and was told that her intervention was integral in client’s overall improvement.

The Marin Asian Advocacy Project engages the Vietnamese community in behavioral health outreach, education and prevention efforts and targets members of the Vietnamese community experiencing risk factors including trauma, poverty, racism, social inequality, prolonged isolation, and others. This 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.

Outcomes	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Community Health Advocates (CHAs) will receive training in: <ul style="list-style-type: none"> CHA Basics: role, confidentiality, outreach and engagement, making referrals, etc. Mental Health First Aid 	3	3	3	3	3	3
CHAs will receive at least 6 hours each of group or individual supervision	100%	100%	100%	100%	100%	100%
Individuals receiving information about mental health and access to services via tabling and other outreach strategies	100	100	100	23	100	60
Individuals participating in prevention activities (field trips, community building)	120	230	120	40	50	58
Individuals participating in individual/family consultations	50	60	40	30	40	40
Total referrals to County Behavioral Health (BHRS)	N/A	10	N/A	9	N/A	12
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	2	N/A	3	N/A	0
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	4	N/A	2	N/A	N/A
Total referrals to other PEI providers	N/A	10	N/A	9	N/A	56

Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	2	N/A	3	N/A	N/A
Average time in weeks between when a referral was given to individual by your program and the individual's first in person appointment with the PEI-funded provider	N/A	4	N/A	4	N/A	N/A
Total referrals to other mental health services or resources for basic needs	N/A	80	N/A	85	N/A	46

CLIENT STORY:

Mr. H. and his wife with 3 children came to the US almost 5 years ago. Despite having limited English ability, they both worked hard full-time. Mr. H. is a caregiver, and his wife is a manicurist. During the peak of the Covid-19 pandemic in Marin, the County issued a stay-at home order. Mr. H. was very worried and fearful because he did not know what to do to get help from the government. Someone gave him the phone number of the Marin Asian Advocacy Project. After listening to Mr. H. present the situation over the phone, staff immediately helped him fill out an unemployment insurance benefits application online. In addition, staff assisted, his family in filling out applications for Medi-Cal and Calfresh. As a result of these efforts, his family has received unemployment insurance benefits, Calfresh and Medi-Cal from the government. Staff members also successfully assisted the family in applying for emergency financial assistance through a local non-profit organization, CAM. Mr. H's family is one of hundreds of people our organization has helped during the pandemic.

BHRS Spanish Language Groups:

During the **FY20/21**, the BHRS Outreach and Engagement Coordinator collaborated with school and community partners to provide several groups in Spanish. These included:

- Parent Conversation Series in collaboration with Marin County Office of Education for Spanish speakers. This series of events engaged parents/caretakers in monthly conversations about suicide prevention, coping skills, anxiety, grief, and meditation.
- *Hablemos sobre la Prevencion del Suicidio* (Let's talk about Suicide Prevention). This Spanish language only workshop provided basis foundation and introduction to suicide prevention. 15 people attended the training.
- Crianza Saludable (Healthy Parenting). A series of five (5) presentations in collaboration with Bay Area Community Resources (BACR) for parents/caretakers of Newcomer students about positive parenting, how to manage stress, self-care, discipline and communication. Attendance ranged from 6-12 individuals per session.
- Suicide prevention presentation for Spanish speakers, in collaboration with Bay Area Community Resources for parents and caretakers of newcomer students. This training discussed suicide

prevention for teenagers, myths, signs and symptoms, protective factors and risks and how to help someone. Outreach for the event was successful with 11 people attending the training.

- Weekly Parenting Class for Spanish speakers. Lessons on effective communication, positive discipline, stress and anger management, child abuse prevention, enhancement of health and self-concept, and accessing community resources. Attendance ranged from 10-15 people each week.
- A Series of three presentations during May Mental Health Awareness Month were held in collaboration with Shoreline Unified School District for Parents and Caretakers in West Marin. Between 12 and 15 people attended each session.
- Mental Health First Aid Training for Spanish speakers. This course provided information on how to help an adult who is experiencing a mental health or addiction challenge or is in crisis. It includes a 5-step action plan for how to help people in both crisis and non-crisis situations. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, eating disorders and disruptive behavior disorders (including ADHD). Eleven people attended training. Only one training was done during this fiscal year due to the COVID-19 Shelter in Place order and the MHFA curriculum not being available virtually for Spanish speakers.

CHANGES FOR FY22/23: In FY22/23 we are expanding this program to provide increase to the contractors, expanding the Access Peer Support Specialist to be a full-time position, and adding a Media Specialist position to help spread the word about how to access services, keep the website up to date, and share outcomes. Increased expected number served for FY22/23 from 3,000 to 5,000 with enhanced digital outreach.

HOMELESS-FOCUSED SUPPORT AND OUTREACH: SDOE-16

MHSA PROGRAM ALLOCATION FY22/23: \$1,276,686

PROGRAM DESCRIPTION: Homeless Outreach and Engagement focuses on identifying unserved individuals experiencing homelessness in order to engage them, and when appropriate their families, in the mental health system so that they receive the appropriate services. Strategies:

- 1) Peer outreach and engagement: a mobile peer team with lived experience who work to engage and build trust with individuals experiencing homelessness who potentially have a serious mental illness by providing wellness checks and connecting them to resources.
- 2) Field-Based assessments for individuals experiencing homelessness
- 3) Outreach with a focus on identifying unserved individuals in order to engage them in services.
- 4) Provide coordinated supportive services to assist clients who are homeless or at-risk of homelessness achieve housing stability by supporting clients in finding and maintaining housing and navigating housing voucher bureaucracy via Shelter+Care.
- 5) Overall coordination of housing contracts including outcomes and needs assessment
- 6) Outreach and engagement at the shelter including peer-led outreach and groups and low-barrier psychiatry services offered on-site at Mill Street 2.0
- 7) Supportive services at Permanent Supportive Housing sites including 1251 S. Eliseo

PROVIDER: Combination of county-operated and contracted

TARGET POPULATION: Adults, older adults, or transitional age youth with serious mental illness who are either:

- currently experiencing homelessness,
- have a history of homelessness, or
- are at-risk of homelessness

EXPECTED NUMBERS TO BE SERVED FOR FY22/23: 227

NUMBERS SERVED IN FY20/21: 244 (87 individuals supported by CARE Team 1, 64 individuals were assessed by the Access while unhoused, 93 individuals were supported through Shelter+Care)

OUTCOMES:

- Outcome 1: Increase number of individuals who are experiencing homelessness who receive assessments
- Outcome 2: Decrease the number of people with mental illness who are experiencing homelessness
- Outcome 3: At least 100 formerly homeless clients will be housed, with at least 50% remaining stably housed for 2 years or more

MEASUREMENT TOOL:

- Outcome 1: Health Records System report on number and housing status of assessments
- Outcome 2: Measured using the Point-in-Time Count conducted every two years, during the last 10 days of January

- Outcome 3: will be measured using reports from the Marin Housing Authority

OUTCOMES FOR FY20/21:

- Outcome 1: 64 individuals received access assessments in FY20/21 who were homeless at the time of assessment (including 62 adults or older adults and 2 children).
- Outcome 2: Decrease the number of people with mental illness who are experiencing homelessness. As a result of social distancing and public health safety precautions for the COVID-19 pandemic, the 2021 Point-in-Time (PIT) unsheltered Count and Survey was postponed to the end of January 2022.
- Outcome 3: 93 formerly homeless clients were housed, with 73% remaining stably housed for 2 years or more.

CHANGES FOR FY22/23: Addition of a half-time Peer Support Specialist position to support outreach and engagement at Mill Street 2.0 (will be a full-time position splitting their time supporting the Odyssey FSP clients at that site and doing outreach and engagement with potential future clients in the shelter and other supportive housing units). In addition, funding is earmarked for a supportive services contract with Episcopal Community Services to support 16 units at 1251 S. Eliseo which is projected to open up in the Spring of 2023. In addition there are minor contract increases to support recruitment and retention of staff at MHSA contract community-based organizations providing homeless-focused support and outreach. Increased expected numbers served from 211 to 227 for FY22/23.

MHSA HOUSING PROGRAM: MHSA HP

PROGRAM HISTORY AND OVERVIEW: In August 2007, the guidelines for the Mental Health Services Act (MHSA) Housing Program (MHAHP), a collaborative program administered by the California Housing Finance Agency and the State Department of Mental Health, were released. MHAHP funds could 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. MHAHP 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. MHAHP 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 MHAHP housing, an individual/family/household must also be homeless or at risk of becoming homeless, as defined by MHAHP regulations. The household must be able to pay rent, and the household income must be less than a specified maximum amount.

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. Any proposed housing project had to follow CalHFA requirements as well as be feasible in Marin’s high-cost housing market.

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 had 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 FY17/18 to Resources for Community Development (RCD) for their “Victory Village” project in Fairfax. This project 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. The Victory Village project opened for occupancy in the Summer of 2020 in the midst of the COVID pandemic.

PROGRAM DESCRIPTION

Fireside Senior Apartments

In FY08/09, Marin County received approval of our proposal to use MHSAP funds to leverage a set-aside of five (5) furnished housing units (studio and one-bedroom) for seniors in the Fireside Apartments. Fireside Apartments are a 50-unit affordable housing development for low-income families and seniors located in Tamalpais Valley in unincorporated Marin. The MHSAP housing at the Fireside Apartments serves older adults (62 years and older) who, at the time of assessment for housing services, receive or qualify for Full-Service Partnership (FSP) services and are either homeless or at-risk of homelessness. These are individuals with serious mental illness who have been 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 FSP Program. The tenants of the MHSAP-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 FY09/10 and opened on December 3, 2009, when community members began the application process for the MHSAP-funded units. The first MHSAP-funded unit was occupied on January 25, 2010 and all five (5) units were occupied as of June 6, 2010.

Victory Village Apartments

In FY17/18, with the funding returned from the State, the county released a Request for Proposals (RFP). The remaining housing funding, \$1,479,581 was awarded to Fairfax Affordable Housing, L.P./Resources for Community Development (RCD) to leverage a set-aside of six (6) furnished housing units for seniors in the Victory Village complex. Victory Village is a 54-unit affordable housing development for low-income seniors located in Fairfax. The MHSAP housing at Victory Village 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. Intensive community treatment and housing support services are provided by the Full-Service Partnership Programs (directly operated by the County of Marin) in conjunction with the housing management.

All 6 units are filled. These clients were placed through Coordinated Entry and had been chronically homeless for years prior to residency in these apartments and are supported by the Full-Service Partnership teams.

COMMUNITY SERVICES AND SUPPORTS (CSS) COMPONENT BUDGET

Program	FY20/21	FY21/22	FY22/23	Total
FSP-01 Youth Empowerment Services (YES)	\$728,555	\$830,064	\$950,064	\$2,508,683
FSP-02 Transitional Age Youth (TAY) Program	\$695,991	\$695,991	\$695,991	\$2,087,974
FSP-03 Support and Treatment After Release (STAR)	\$810,175	\$810,175	\$722,623	\$2,342,973
FSP-04 Helping Older People Excel (HOPE)	\$749,088	\$824,366	\$874,998	\$2,448,452
FSP-05 Odyssey	\$1,121,717	\$1,246,314	\$1,320,224	\$3,688,255
FSP-06 Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT)	\$879,101	\$759,442	\$820,718	\$2,459,261
SDOE-01 Enterprise Resource Center (ERC)	\$477,102	\$477,102	\$658,102	\$1,612,307
SDOE-09 Crisis Continuum of Care	\$1,585,536	\$1,585,536	\$2,310,923	\$5,481,995
SDOE-10 First Episode Psychosis (FEP)	\$159,763	\$159,763	\$159,763	\$479,289
SDOE-11 Consumer Operated Wellness Center (Empowerment Clubhouse)	\$330,899	\$330,899	\$361,251	\$1,023,049
SDOE-13 Recovery-Oriented System Development	\$946,845	\$1,033,061	\$1,363,877	\$3,343,783
SDOE-14 Stepping Up	\$389,771	\$443,110	\$443,110	\$1,275,991
SDOE-15 Community Outreach and Engagement	\$412,921	\$530,008	\$818,668	\$1,761,597
SDOE-16 Homeless Support and Outreach	\$551,314	\$1,134,390	\$1,276,686	\$2,962,390
Subtotal	\$9,838,778	\$10,860,221	\$12,776,999	\$33,475,999
MHSA Coordinator and Ethnic Services Manager	\$235,851	\$235,851	\$235,851	\$707,553
FSP Program Support	\$229,425	\$229,425	\$229,425	\$688,275
Administration and Indirect	\$1,848,242	\$2,015,386	\$2,144,798	\$6,008,426
Community Planning	\$50,000	\$50,000	\$100,000	\$200,000
Contingency (indigent)	\$99,771	\$118,903	\$118,903	\$337,577
Total	\$12,302,067	\$13,509,786	\$15,605,976	\$41,417,830
Transfer to Workforce Education and Training	\$202,034	\$465,344	\$465,344	\$1,132,722
Transfer to Capital Facilities and Technological Needs	\$730,226	\$1,952,846	\$2,198,043	\$4,881,115
Total Transfers out of CSS	\$932,260	\$2,418,190	\$2,663,387	\$6,013,837
TOTAL INCLUDING TRANSFERS	\$13,234,327	\$15,927,976	\$18,269,363	\$47,431,666

FSP = Full-Service Partnership SDOE = System Development/Outreach and Engagement

FULL-SERVICE PARTNERSHIP (FSP) ESTIMATES FOR NUMBER TO BE SERVED BY AGE GROUP

The chart below shows the estimated number of clients who will be served in each age group across all FSP programs for each of the three years of this plan. Many of the FSP programs serve people from more than one age group so the numbers are reported collectively to be in compliance with MHSA Regulations.

The projections below have been updated from the start of the Three-Year plan with the same projected total. In the FY20/21-22/23 Three-Year plan we had projected 38 Children, 105 TAY, 178 Adults, and 95 Older Adults to be served each year for a total of 416. The projections for FY22/23 are continuing to increase given the need in the community.

Full-Service Partnership Age Groups	ACTUALS FROM FY19/20	ACTUALS FROM FY20/21	PROJECTED FY22/23
Children (0-15)	50	54	55
TAY (16-25)	93	90	90
Adult (26-59)	172	202	200
Older Adult (60+)	100	111	115
<i>Total:</i>	415	457	460

COMMUNITY SERVICES AND SUPPORTS (CSS) COST PER PERSON ESTIMATES FOR FY22/23

Program	FY22/23 Budget Allocation	FY22/23 Projected Number Served	FY22/23 Projected Cost Per Person
FSP-01 Youth Empowerment Services (YES)	\$950,064	85	\$11,177
FSP-02 Transitional Age Youth (TAY) Program	\$695,991	40	\$17,400
FSP-03 Support and Treatment After Release (STAR)	\$722,623	65	\$11,117
FSP-04 Helping Older People Excel (HOPE)	\$874,998	65	\$13,462
FSP-05 Odyssey	\$1,320,224	130	\$10,156
FSP-06 Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT)	\$820,718	60	\$13,679
SDOE-01 Enterprise Resource Center (ERC)	\$658,102	1,000	\$658
SDOE-09 Crisis Continuum of Care	\$2,310,923	1,100	\$2,101
SDOE-10 First Episode Psychosis (FEP)	\$159,763	25	\$6,391
SDOE-11 Consumer Operated Wellness Center (Empowerment Clubhouse)	\$361,251	80	\$4,516
SDOE-13 Recovery-Oriented System Development	\$1,363,877	750	\$1,819
SDOE-14 Stepping Up	\$443,110	150	\$2,954
SDOE-15 Community Outreach and Engagement	\$818,668	5,000	\$164
SDOE-16 Homeless Support and Outreach	\$1,276,686	227	\$5,624

FSP = Full-Service Partnership

SDOE = System Development/Outreach and Engagement

WORKFORCE EDUCATION AND TRAINING (WET)

COMPONENT OVERVIEW

MHSA WET programs address the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, provides client/family driven mental health services, and adheres to wellness, recovery, and resilience values. The Workforce Education and Training (WET) component of MHSA provides dedicated funding to address the shortage of qualified individuals and to enhance the skills of the current workforce 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/or substance use disorders as well as their family members.

The 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 current and emerging client populations. WET partners with other county divisions and community-based organizations, including primary care providers, to support the development and employment of a diverse workforce.

Trainings are open to staff, interns, and volunteers from county, Community-Based Organizations (CBO), peer programs, 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. In this Three Year Plan, as prioritized during the MHSA Community Program Planning Process, there will be a focus on strengthening the implementation of the goals of the Health and Human Services Race Equity Plan (MarinHHS.org/equity-plan) including developing a unified trauma informed system of care throughout Health and Human Services and with our partner agencies.

The programs in the Marin County WET FY2020-21 through 2022-23 Three-Year Plan are consolidated into four categories that align with the MHSA Regulations. These are: 1) Training and Technical Assistance, 2) Mental Health Career Pathways, 3) Financial Incentive Program, and 4) Workforce Staffing Support.

In November 2020 the County of Marin hired a new WET Coordinator:

Rebecca Stein, Psy.D
BHRS Unit Supervisor
WET (Workforce, Education, and Training) Program
Pronouns: She/Hers/Her
3270 Kerner Blvd, Room 105, San Rafael, CA 94901
(415) 473-4274, fax (415) 473-3850
rstein@marincounty.org

TRAINING AND TECHNICAL ASSISTANCE

DESCRIPTION: BHRS will continue to utilize WET Training and Technical Assistance funds to fund trainings, technical assistance, curriculum development, and consultation services. These will focus on cultural humility, anti-racism, trauma informed care, resiliency, client/family driven mental health services, recovery and other evidence-based and community driven strategies to improve services and integrate the MHSa general standards. In FY19/20 BHRS performed a survey of staff to determine training priorities which is being used to inform the next training plan. In addition, funding will be used for trainings for consumers and family members.

In addition, new in this Three-Year Plan—and consistent with the Health and Human Services Race Equity Plan (MarinHHS.org/equity-plan)—there will be a focus on developing a unified trauma informed system of care throughout Health and Human Services and with our partner agencies. Employees, contractors and volunteers in non-mental health systems, such as criminal justice, social services and health care may participate in programs and activities under this funding category. This unified trauma informed system development work has the long-term goal of decreasing exposure to trauma and increasing resilience.

OBJECTIVES: Promote cultural humility and the other MHSa General Standards; support the participation of clients and family members in the public mental health system; provide increased training, technical assistance, and consultation opportunities to improve the efficacy of services.

FUNDING CATEGORY: Training and Technical Assistance.

WORKFORCE NEED ADDRESSED: Current staff and CBO partners need ongoing training to provide culturally humble and evidence-based services; staff from across systems need a comprehensive training, consultation, and technical assistance strategy to implement unified trauma informed practices.

STRATEGIES IMPLEMENTED: Training, technical assistance, consultation, and curriculum development.

BUDGET NARRATIVE: This budget for this program includes funding for unified trauma informed system of care development and other trainings/technical assistance including cultural humility trainings and trainings around wellness, resilience, and other evidence-based and community driven practices.

FY20/21 ACTIVITIES Training, technical assistance, consultation, and curriculum development. Some of these trainings included:

- National Council for Behavioral Health: *Trauma-Informed Resilience-Oriented and Equitable Care*—12 month learning collaborative
- Critical Clinical Conversations About Race, Racial Identity, and Racism
- Disordered Eating Training/Consultation
- Trauma Stewardship
- Law and Ethics
- LGBTQ+ Training and Consultation
- Training series on improving clinical care for Asian and Pacific Islander clients

CHANGES FOR FY22/23: Projected unspent training funds from FY21/22 are being carried over to FY22/23.

MENTAL HEALTH CAREER PATHWAYS

DESCRIPTION: This program implements three main strategies:

Programs to prepare clients and/or family members of clients for employment and/or volunteer work in the Public Mental Health System utilizing three strategies:

- 1) Providing scholarships for culturally diverse consumers and family members to complete other vocational/certificate courses in mental health, substance use and/or domestic violence peer counseling.
- 2) Placement Program: Internship stipends to mental health, substance use, and domestic violence peer counselor graduates who are placed as interns in public behavioral healthcare settings (including contracted partners).
- 3) Mentoring/career counseling support for interns and scholarship recipients—as well as for individuals from other groups that are underrepresented in the Public Mental Health system (PMHS)—to promote successful completion of those programs and to increase access to employment.

OBJECTIVES: Prepare clients and/or family members of clients for employment and/or volunteer work in the Public Mental Health System (PMHS); Increase access to employment in the PMHS to groups such as immigrant communities, Native Americans and racial/ethnic, cultural and linguistic groups that are underrepresented in the PMHS, as underrepresentation is defined in Section 11139.6 of the Government Code.

FUNDING CATEGORY: Mental Health Career Pathway Programs

WORKFORCE NEED ADDRESSED: Increase number of people with lived experience and diverse backgrounds in the PMHS (including contracted partners).

STRATEGIES IMPLEMENTED: Career counseling, training, and placement programs

BUDGET NARRATIVE: An average annual allocation of \$125,000 for the 3 years (with unspent carried over between years leading to a \$165,000 FY22/23 budget). This includes approximately \$70,000 for scholarships for people with lived experience to complete training programs, \$60,000 for internship stipends for people with lived experience placed in the PMHS/contracted partners, and \$35,000 for mentoring/career counseling.

FY20/21 ACTIVITIES:

- 5 individuals with lived experience were served by COPE in FY20/21 as cohorts were delayed due to the COVID pandemic but resumed in person at the Empowerment Clubhouse facility in April 2021.
- After the scholarship program was on hold for two cycles (Spring and Fall 2020) due to the COVID pandemic and staff being reassigned to work at Disaster Service Workers, halting all non-essential activities, the scholarship program came back in the Spring of 2021 and 6 individuals were awarded scholarships.
- 2 internships for people with lived experience in the Public Mental Health System were supported through WET funding in FY20/21
- Switched the Scholarship program to have 4 cycles per year (rather than 2 cycles) in order to be more responsive to the needs of the community and accessible throughout the year.

CHANGES FOR FY22/23: The COPE Program was selected as one of the SB 802 Peer Certification Training programs for FY22/23 so will be funded through CalMHSA using funding allocated from the Department

of Health Care Services. Funding that had been allocated to this training program is being shifted within WET Mental Health Career Pathways to support more internship, scholarship, and mentoring opportunities.

FINANCIAL INCENTIVE PROGRAM

DESCRIPTION: In January 2019, the California Behavioral Health Planning Council approved the Statewide 2020-2025 Mental Health Services Act (MHSA) Workforce Education and Training (WET) Five-Year Plan developed by Office of Statewide Health Planning and Development (OSHPD). Their plan included a focus on supporting individuals through MHSA *Regional Partnerships*. The Greater Bay Area Regional Partnership will implement a loan repayment program for hard-to-fill and hard-to-retain Public Mental Health System (PMHS) personnel (including contracted partners) with educational loans.

In January 2019, the California Behavioral Health Planning Council approved the Statewide 2020-2025 Mental Health Services Act (MHSA) Workforce Education and Training (WET) Five Year Plan developed by Office of Statewide Health Planning and Development (OSHPD). This plan included a focus on supporting individuals through MHSA Regional Partnerships. The Greater Bay Area (GBA) Regional Partnership will implement a loan repayment program for hard-to-fill and hard-to-retain Public Mental Health System (PMHS) personnel (including contracted partners) with professional education loans. The FY 2019-20 State budget provided \$7,978,104 to the GBA Regional Partnership via OSHPD. This funding required a 33% local match from the 13 GBA counties, which was calculated at a one-time investment of \$79,333 from Marin which was included in Marin's FY 2021-2022 MHSA Annual Update approved by the Board of Supervisors on July 27, 2021. However, since initial calculation, Sonoma County was no longer able to meet with their local match and withdrew from the GBA and their match was divided between the 12 remaining counties. Marin is asked to contribute an additional \$4,843 in MHSA FY 2022-2023 funding (which will be included in the FY 2022-2023 MHSA Annual Update), bringing Marin's contribution to \$84,176 which will leverage a match from the State for Marin County of \$255,080 in State General funds.

This MHSA WET program will address retention of hard-to-fill and hard-to-retain positions including—but not limited to—Licensed Mental Health Practitioners, Licensed Crisis Specialists, and Mental Health Nurse Practitioners with an emphasis on bilingual classifications in the public mental health system. It will do so through a Regional Partnership with the Greater Bay Area (GBA) counties and lead by CalMHSA. This one-time funding will generate approximately 20 awards for Public Behavioral Health System staff in Marin County in the amount of \$15,000 each for student loan repayment for student loans accrued in pursuit of professional clinical degrees as well as administrative costs for CalMHSA. Staff who receive these awards will, in doing so, commit to working in the Public Behavioral Health System for 2 years from the award date.

CalMHSA will act as the administrative and fiscal point for this program. As such, they will manage the application review and acceptance process as well as the distribution of the awards. Award contracts will be created directly between the award recipient and CalMHSA.

In addition, in FY22/23 BHRS is also adding Financial Incentive Funding for a Post-Doctoral intern position. The post-graduate intern will be training to work in the Public Mental Health System.

OBJECTIVES: Promote recruitment and retention of hard-to-fill and hard-to-retain personnel.

FUNDING CATEGORY: Financial Incentive Programs

WORKFORCE NEED ADDRESSED: Recruitment and retention of staff in hard-to-fill and hard-to-retain positions including—but not limited to—Licensed Mental Health Practitioners, Licensed Crisis Specialists, Mental Health Nurse Practitioners, Clinical Psychologists, and Psychiatrists, with an emphasis on bilingual classifications in the public mental health system.

STRATEGIES IMPLEMENTED: Mental Health Loan Assumption; Stipends.

BUDGET NARRATIVE: In order to leverage further state funding, counties are asked to collectively match 33% of the state allocation. Based on our proportional allocation of MHSA funding, Marin's is expected to contribute \$84,176.33 in one-time funding which will leverage significantly more in State funding at the regional level. The Regional Partnership is anticipating receiving the first \$79,333 in FY21/22 and the final \$4,843 in FY22/23. \$91,560 is earmarked for the full costs for the Post-Doctoral intern position.

OUTCOMES FOR FY20/21: No outcomes for FY20/21. This program was launched by CalMHSA in FY21/22.

CHANGES FOR FY22/23: Additional funding was earmarked for Loan Assumption program to cover the gap from another county withdrawing. In addition, funding was earmarked for a Post-Graduate intern.

WORKFORCE STAFFING SUPPORT

DESCRIPTION: This funding will support the salary, benefits, and operating costs of the Workforce Education and Training (WET) Coordinator as required in WIC Section 3810(b) and WET Administrative Services Technician. These positions will plan, recruit, coordinate, administer, support, and evaluate Workforce Education and Training programs and be responsible for:

- developing and implementing the Training and Technical Assistance plan including a focus on evidence-based practices,
- performing regular workforce needs assessments,
- supporting the internship program, and
- acting as a liaison to appropriate committees, regional partnerships, and oversight bodies.

OBJECTIVES: Implement, evaluate, and sustain WET programs aimed to train and support current staff and promote MHSA General Standards, as well as to increase recruitment and retention of staff in hard-to-fill and hard-to-retain positions.

FUNDING CATEGORY: Workforce Staffing Support

WORKFORCE NEED ADDRESSED: Training and support for current staff, promotion of MHSA General Standards, and increase recruitment and retention of staff in hard-to-fill and hard-to-retain positions.

STRATEGIES IMPLEMENTED: Implementation of the WET programs; coordination; evaluation.

BUDGET NARRATIVE: \$292,648 to cover salaries, benefits, and operating costs directly associated with the WET Coordinator and Administrative Services Technician-Bilingual.

CHANGES FOR FY22/23: No changes

WORKFORCE EDUCATION AND TRAINING (WET) COMPONENT BUDGET

PROGRAM NAME	FY20/21	FY21/22	FY22/23	Total
Training and Technical Assistance	\$58,000	\$170,000	\$290,000	\$518,000
Mental Health Career Pathways	\$65,000	\$145,000	\$165,000	\$375,000
Financial Incentive Programs	-	\$80,000	\$96,404	\$176,404
Workforce Staffing Support	\$175,682	\$196,244	\$292,648	\$664,573
Admin/Indirect (15%)	\$44,802	\$88,687	\$126,608	\$260,097
TOTAL	\$343,484	\$679,930	\$970,660	\$1,994,074

WET is funded in this 3-Year plan by a combination of funding already in the WET Component as well as new funding transferred from CSS.

Note: WET funding that was unspent in FY20/21 or FY21/22 due to COVID delays was shifted to the same program category for FY21/22 with the exception of unspent Workforce Staffing Support funding being shifted to the Financial Incentive Programs category.

CAPITAL FACILITIES AND TECHNOLOGY NEEDS (CFTN)

ELECTRONIC HEALTH RECORD AND PRACTICE MANAGEMENT SYSTEM ENHANCEMENTS

MHSA ALLOCATION FY22/23: \$579,528 for FY22/23 expenditures and \$1,500,000 earmarked for the investment for a new Health Information Technology System

PROGRAM DESCRIPTION: With the Technology Needs (TN) Project, Marin County will continue to improve the performance of the electronic health record (EHR) system to support optimal clinical effectiveness and provide accessible and meaningful consumer outcome data with a focus on improvements for reporting both for state requirements and local evaluation efforts; enhancing care coordination efforts through enhanced client care teams; and using technology to improve our overall system of care. Marin County will also further improve the efficiency of the practice management system to ensure preparedness for the upcoming shift to alternate payment methodologies, including value-based payments.

Marin's TN Project is designed to use technological resources and strategies to modernize and transform clinical and administrative information systems through the follow components:

1. Disaster recovery preparedness.
2. Ongoing Electronic Health Record (EHR) and Practice Management (PM) upgrades to remain compliant with current and future requirements.
3. Clinical enhancements to improve service coordination
4. Planning and saving for a new Health Information Technology System

EXPECTED OUTCOMES: The expected outcomes for the TN Component are as follows:

- Improve integration of the EHR and PM systems.
- Transition EHR from a hybrid paper/digital format to an entirely digital format by supporting electronic client signatures, electronic medication, and laboratory orders.
- Support capture of clinical information in the field, where services are delivered.
- Become and remain current with State and Federal clinical quality documentation and reporting standards.
- Participate in the Marin Health Gateway, the local Health Information Exchange (HIE).

FY22/23 UPDATES: The County of Marin is working with CalMHSA on a 21-county initiative to pave the way for cost-effective and coordinated Health Information Technology system.

COORDINATED CASE MANAGEMENT SYSTEM

MHSA PROJECT ALLOCATION: \$260,000 over three years

PROGRAM DESCRIPTION: This project began in FY2017/18 in partnership with Whole Person Care (WPC) and will be continued in this Three-Year Plan. 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.

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:

- MHSA and other Behavioral Health and Recovery Services (BHRS)
- Epidemiology
- Social Services
- Adult Protective Services
- Emergency Services (EMS)
- Marin County Jail

In 2018 Marin County Health and Human Services Whole Person Care implemented case management/care coordination platform, branded as “WIZARD” for Marin. Since implementation, the number of client profiles, active system users, and overall system activity have grown steadily.

True to the MHSA Guiding Principle of promoting an Integrated Service Experience, this program helps break down barriers to holistic care in hospitals, jail, clinics, street services, and mental health care run by and contracted by the county. Caring professionals throughout the systems of care can see if a client is enrolled in case management, can connect with the case manager securely through the coordinated case management system, and can refer new potential clients to the program if they aren’t already in the system. The ability to have access to data (following confidentiality rules) allows for better coordination of care for MHSA and other programs.

FY20/21 UPDATE: The MHSA-funded Transition Outreach Team continued to become even more active in the WIZARD system throughout the pandemic, promoting coordinated care throughout our Crisis systems and Community Based Partners.

CHANGES FOR FY22/23: The ongoing maintenance costs are lower than the initial budget so the budget has been decreased for FY22/23 to match actual expenditures.

TELE-HEALTH IMPROVEMENTS

MHSA PROJECT ALLOCATION: \$72,000 total to be spent over three years

PROGRAM DESCRIPTION: In response to the COVID-19 pandemic, which has quickly changed the way behavioral health services are offered, BHRS is dedicating resources to strengthening telehealth options, including the ability to provide group services via telehealth. This funding would be used for software and hardware investments for client use to allow them to access telehealth services in locations throughout the county (including kiosks or personal devices as needed). BHRS is looking to install Kiosk locations in areas of the county that are being underserved. Potential sites include community spaces and satellite sites.

WEBSITE ENHANCEMENTS

MHSA PROJECT ALLOCATION: \$105,100 total over three years

PROGRAM DESCRIPTION: In response to the community planning process, BHRS will invest in an overhaul of the public facing website to make it easier for the community to navigate and learn about services and supports BHRS offers. This user-friendly website for people of all ages, that provides access to digital events including family groups, suicide prevention resources, peer-run groups, etc., as well as information on how to access mental health and substance use services, including how to get an assessment and information about different programs. Enhancing our website will help to keep our community informed through up to date information related to any changes to our services and supports in an ever-changing time.

FY20/21 OUTCOMES: In FY20/21 BHRS launched a new website focused on Prevention and Outreach: www.BHRSPrevention.org. This new website connects community members to resources, spreads awareness about the MHSA Prevention and Early Intervention programs and Community Outreach and Engagement programs, shares updates and highlights, and has a calendar inviting all the community members to trainings, support groups, and events.

In FY21/22 BHRS also successfully launched the full new BHRS website: www.MarinBHRS.org more details on that in the next Annual Update reporting on FY21/22 outcomes.

CHANGES FOR FY22/23: In FY22/23 unspent funds for FY21/22 will carry-forward to be utilized to enhance and complete the websites and enhance data sharing on the website.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) COMPONENT BUDGET

PROGRAM NAME		FY20/21	FY21/22	FY22/23	Total
Electronic Health Record and Practice Management System Enhancements	ongoing costs	\$328,479	\$428,479	\$579,528	\$1,336,486
	Investment for new HITS (inclusive of admin/indirect)		\$1,200,000	\$1,500,000	\$2,700,000
Coordinated Case Management system		\$150,000	\$150,000	\$55,000	\$355,000
Telehealth Expansions		\$14,933	\$24,000	\$33,067	\$72,000
Website Enhancements		\$23,500	\$28,300	\$53,300	\$105,100
Admin/Indirect		\$90,147	\$162,117	\$108,134	\$360,398
TOTAL		\$607,059	\$1,992,896	\$2,329,029	\$4,928,984

*\$50,000 unspent from Website Enhancements from FY21/22 was moved forward to FY22/23.

PREVENTION AND EARLY INTERVENTION (PEI)

OVERVIEW

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

PEI emphasizes improving timely access to services for underserved populations and incorporating robust data collection methods to measure quality and outcomes of services. Programs incorporate strategies to reduce negative outcomes of untreated mental illness: **suicide; incarcerations; school failure or dropout; unemployment; prolonged suffering; homelessness; and removal of children from their homes.**

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
- Efforts and Strategies related to **Suicide Prevention**

A focus of PEI is to reach unserved 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 and/or geographically 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

PEI strategies are aligned with BHRS efforts to reduce inequities in service delivery and Marin County Health and Human Services Equity and Operational Plan. This includes strengthening accessibility and cultural responsiveness of services and integrating service delivery to support clients (such as building school-based coordination teams and building learning communities to share resources and best practices).

PREVENTION AND EARLY INTERVENTION (PEI) PRIORITIES FOR FY20/21 THROUGH FY22/23

During the MHSA community planning process as well as the suicide prevention strategic planning process that was conducted between November 2018 and July of 2019 (details to be discussed later in this document), community members, providers and county staff identified a range of Prevention and Early Intervention program priorities. The themes that emerged from the discussions and the surveys that were collected guided our PEI program and service priorities for the next three years. These four priorities included:

Priority One: Expanding School-Age Prevention and Early Intervention Services, with a focus on enhancing school climate and coordination systems.

Priority Two: Enhancing services for newly arrived immigrant youth or “Newcomers” by partnering with schools and community-based organizations to increase coordination and linkages to health and wellness supports.

Priority Three: Building capacity of individuals, organizations, and schools to implement culturally responsive, best practices around mental health and wellness across the lifespan. This includes supporting and facilitating professional development workshops and trainings, providing coaching and consultation, and promoting youth-led activities that raise awareness and build community.

Priority Four: Implementing newly released Suicide Prevention Strategic Plan, including funding a full-time Suicide Prevention Coordinator to engage key county and community partners in prioritizing and carrying out the objectives and activities outlined in the plan.

RATIONALE FOR KEY PRIORITY AREAS

Priority One: Expanding School-Age Prevention and Early Intervention Services with a focus on enhancing school climate and coordination systems:

During the MHSA planning process, stakeholders emphasized the need for expanded school-based mental health supports for students and families to address student depression, anxiety and lack of school connectedness. They identified the need for additional mental health counseling, streamlined coordination systems and school climate/prevention efforts. Primary and secondary data from the Suicide Prevention needs assessment highlighted similar concerns around student mental health and wellness. Per the 2015-2017 California Healthy Kids Survey, over one-quarter of Marin County high school students (25% of 9th graders and 28% of 11th graders) reported feeling chronic sad or hopeless feelings in the 12 months prior to taking the survey. Around one in eight high schoolers (14% of 9th graders and 11% of 11th graders) had seriously considered attempting suicide in the past 12 months.

The expansion of school-based PEI services in this 3-year plan was intended to address some of the gaps identified by stakeholders. School-based mental health programs help to build resiliency, increase protective factors and create meaningful connections between students, staff and caregivers. By providing linkages to appropriate supports, consultation and training, counseling, coordination of services, and supporting the implementation of school climate initiatives, school-based PEI programs play an instrumental role in promoting the healthy social-emotional development and academic success of students.

Priority Two: Enhancing supports for “Newcomers” by partnering with schools and community-based organizations to increase coordination and linkages to health and wellness supports.

“Newcomers”- or recently arrived immigrant youth, often from Central American countries- were identified by stakeholders as needing additional, targeted and coordinated support. Many of these young people are unaccompanied and have not only fled violence and exploitation in their home countries but have endured additional trauma during their dangerous journeys to the border. The urgency of addressing the unique mental health and related challenges that Newcomers face is underscored by the current political climate and recent trends that show a significant increase in the numbers of Newcomers in Marin County schools. According to school district enrollment data, in 2019 alone, over 400 Newcomers entered San Rafael and Novato Unified secondary schools, with hundreds more at schools throughout the county. This unique, vulnerable population is at heightened risk for school drop-out, homelessness and long-term mental health challenges. Newcomers supports in this MHSa 3-year plan are designed to intervene early to address the emotional, social, and physical health needs of these youth by assessing, actively linking to school and community resources and providing targeted mental health support.

Priority Three: Building capacity of individuals, organizations and schools to implement culturally responsive, best practices around mental health and wellness across the lifespan:

During the MHSa planning process, stakeholders emphasized the importance of building the skills, knowledge and leadership capacity of community members, school staff and providers in order to improve service delivery and build community. Investing in the development of community members, providers and organizations strengthens our county’s ability to implement culturally responsive, best practices and achieve shared goals around wellness and equity. Through training, coaching, consultation and other capacity building efforts, we can impact practices and systems on a larger scale and improve our collective understanding of how to best address the mental health and wellness needs of the communities we serve. We can also help to ensure that resources are aligned and prioritized to meet the needs of communities with limited opportunity and access to supports.

Priority Four: Implementing Suicide Prevention Plan including funding a full-time Suicide Prevention Coordinator to engage key county and community partners in prioritizing and carrying out the objectives and activities outlined in the [Strategic Plan](#):

Despite being one of the healthiest and wealthiest counties in the state, Marin County has among the highest suicide rates in all of the Bay Area and the highest among all metropolitan counties in California. Between 2017-2019, 16.2 people per 100,000 died by suicide in Marin County, well above the state average over the same period (11.1) Marin County’s proximity to the Golden Gate Bridge makes the bridge an accessible lethal mean for those who are in distress. Our County has experienced the tragic loss of several youth to suicide. Additional data from FY20-21 can be found in the Marin County Suicide Prevention Collaborative [Annual Report](#) attached to this report and found on the newly launched [website \(https://prevention.marinbhhs.org/\)](https://prevention.marinbhhs.org/).

CHANGES FOR FY22/23: The major priority for FY22/23 was to increase recruitment and retention of PEI provider organizations. PEI Providers were invited to submit contract increase requests to better promote recruitment and retention of staff and expanded needed services.

SB 1004 PEI PROGRAM PRIORITY AREAS

All PEI programs are required to comply with WIC Section 5840.7 enacted by Senate Bill 1004 which requires counties to specify how they are incorporating the following six Commission-identified priorities in the FY20-23 MHSA plan:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;
2. Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan;
3. Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs;
4. Culturally competent and linguistically appropriate prevention and intervention;
5. Strategies targeting the mental health needs of older adults;
6. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis

Each of these priorities outlined in WIC Section 5840.7/SB 1004 are integrated into our plan and aligned with our previously outlined strategies which are consistent with our community planning process (see subsequent sections for details).

Per WIC Section 5840.7/SB 1004, counties are also required to provide an estimate of the share of PEI funding allocated to each priority. The following table provides these estimates:

SB 1004 PRIORITY CATEGORIES:	Percentage of Funding Allocated to Priority:
1: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs	44%
2: Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan	61%
3: Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs	46%
4: Culturally competent and linguistically appropriate prevention and intervention	83%
5: Strategies targeting the mental health needs of older adults	14%
6: Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	52%

INTRODUCTION TO PEI PROGRAMS FOR FY20/21 THROUGH FY22/23

Many of the existing PEI programs have been successful in reaching underserved communities and achieving mental health related goals (see FY2019/20 Annual Update) and therefore will be continued in this Three-Year Plan. In response to stakeholder input, evaluations of existing PEI programs, and the gaps identified through these processes, some of the ongoing programs will be changed or expanded and several new programs will be started in FY20/21. Requests for Proposals (RFP) were released in the Spring of 2020 for all continued and new PEI programs.

In order to expand and strengthen the Community Health Advocates (CHA) programs *Promotores*, these programs were moved to the Outreach and Engagement component of Community Services and Supports (CSS). This will consist of RFPs (to be released later this Fall) for three (3) Community Health Advocates programs targeting the following underserved populations:

1. Latinx individuals with a focus on West Marin, Novato, and the Canal District of San Rafael (*Promotores*)
2. Vietnamese and other Asian/Pacific Islander populations with a focus on mono-lingual and recent immigrants from Asian and the Pacific Islands.
3. Marin City residents

In addition to other responsibilities, the new Outreach and Engagement coordinator will provide structured support of the three contracts and coordinate additional training opportunities. They will also provide a structure where the CHA programs can learn from each other.

OVERVIEW OF FY 20/21 PROGRAMS (OUTCOMES REPORTING YEAR)

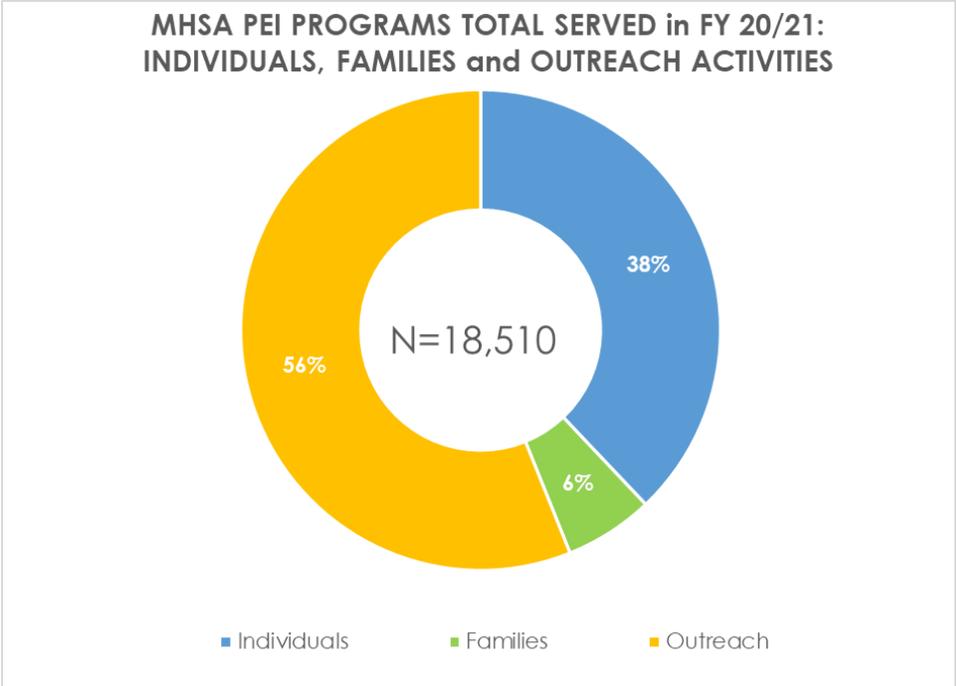
MHSA Prevention and Early Intervention (PEI) funds are intended to help prevent mental illnesses from becoming severe and disabling. This includes:

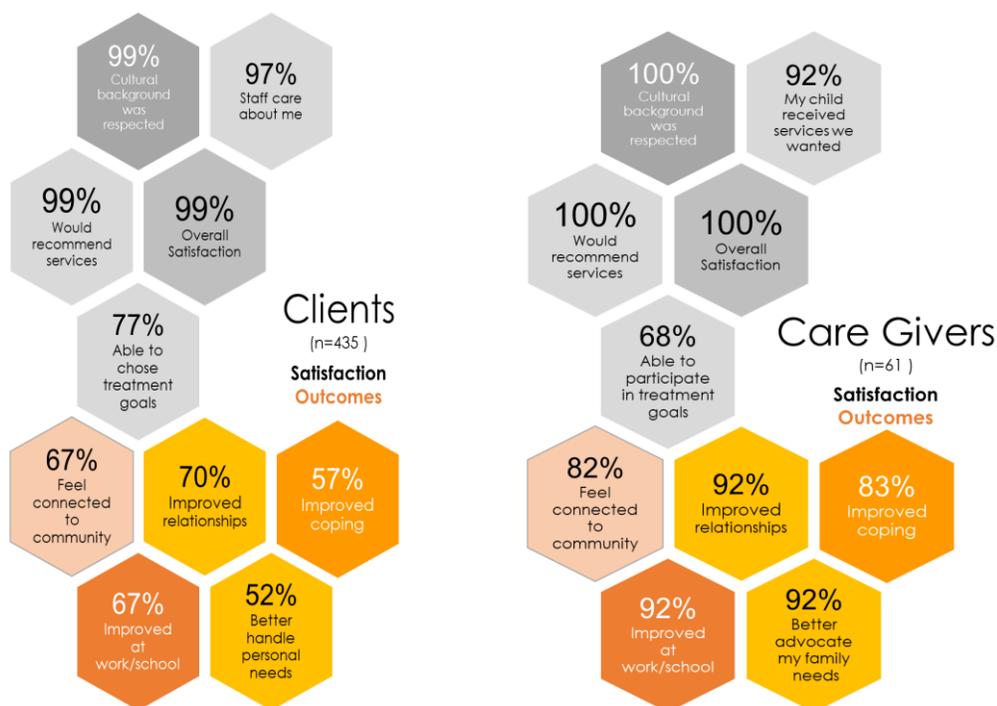
- **Prevention:** Reduce risk factors and build protective factors associated with mental illness
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A focus of PEI is to reach unserved and underserved populations. Some of the strategies employed are:

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

A minimum of 51% of PEI funds are required to be dedicated to youth and transition age youth (0-25 years old). In FY22/23, 64% of direct service funding is budgeted for youth—which is 53% of the total PEI budget. Recognizing that increased funding and services are not by themselves sufficient to reach PEI goals, the PEI Coordinator convenes the PEI Providers quarterly, conducts three site visits annually, attends various PEI provider events and trainings and convenes short-term work groups as needed to strategize around prevention efforts related to specific populations.





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) and expanding school-aged services 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. This is also validated by the results of satisfaction surveys completed by clients. The program narratives in this report include program descriptions, outcomes, and client stories.

COMPLIANCE WITH REGULATIONS

BACKGROUND

New PEI Regulations were adopted effective July 1, 2018.

COMPLIANCE PLAN

There are many areas of the regulations that Marin was already in compliance with prior to the adoption of previous regulations that were effective October 6, 2015. 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 were implemented in FY 17/18 in compliance with new July 2018 regulations and continued to be strengthened:

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 were 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 works with the programs to determine which activities are appropriate for gathering demographic data. New demographic forms were developed for the 20/21 FY through provider input in order to improve cultural sensitivity of the questions. The forms remain in compliance with MHSAs PEI regulations for demographic data collection.

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). As of July 1, 2018, the programs began collecting information on the setting, type of responder and demographics, when appropriate. For Mental Health First Aid, we collect type of participant and demographic information at registration, which is done online.

Access and Linkage to Treatment

As of July 1, 2016, PEI providers began collecting information on referrals to the County of Marin Access Line. As of July 1, 2018, PEI providers are all required to collect and provide data to the County the:

- number of referrals to ACCESS (or other county mental health providers such as a school-based EPSDT clinician)
- percent of total referrals that were connected to service
- average time between referral and connection, and
- duration of untreated mental illness, as required by PEI regulations

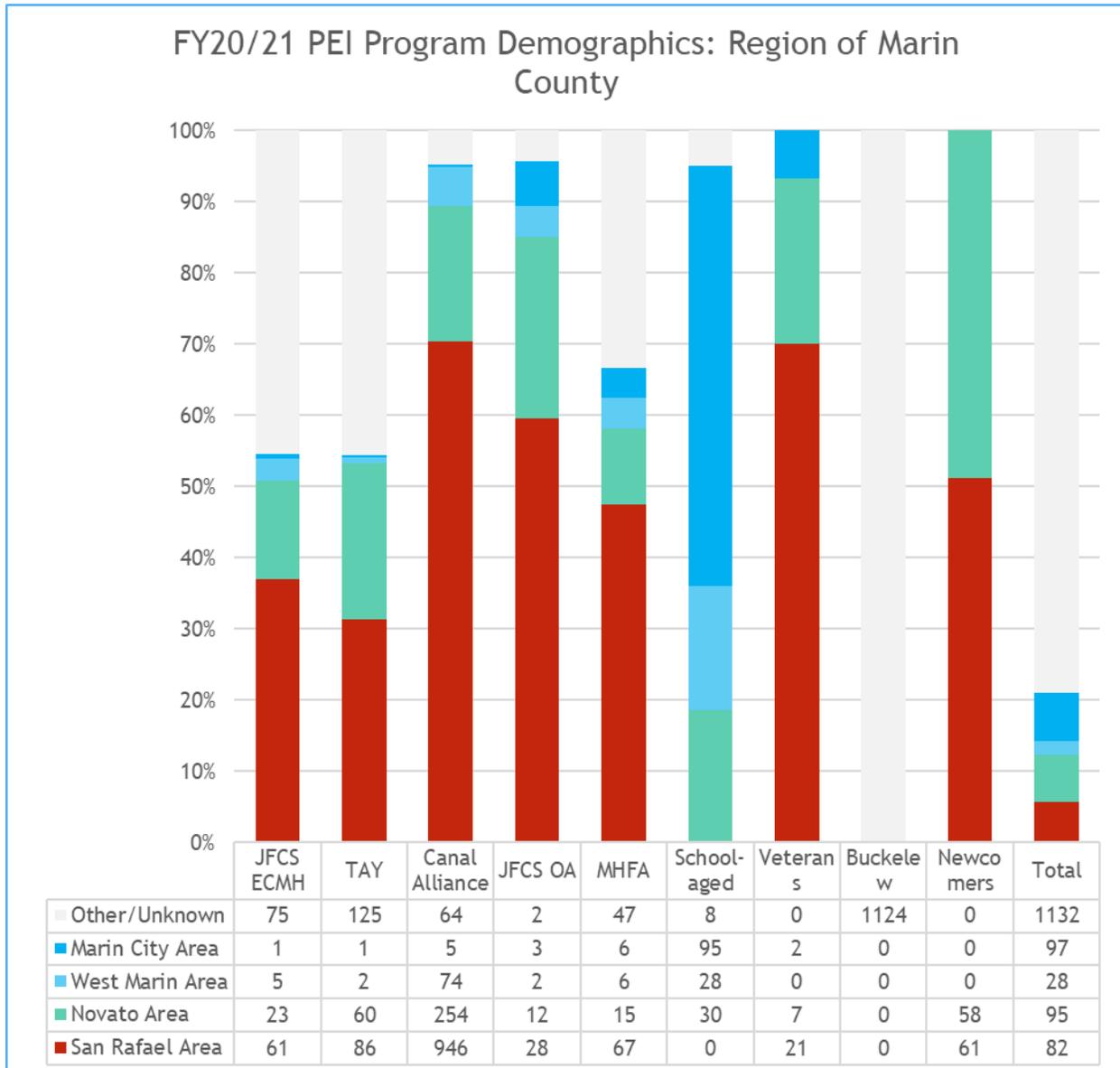
Improve Timely Access

PEI providers began collecting data on referrals to other PEI programs as of July 1, 2018. 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.

FY 20/21 DEMOGRAPHICS

A breakdown of the of the populations served by PEI program in FY 20/21 is provided below. Demographics are collected for Prevention and Early Intervention programs that include services such as support groups, counseling, skill building, training and service navigation and advocacy.

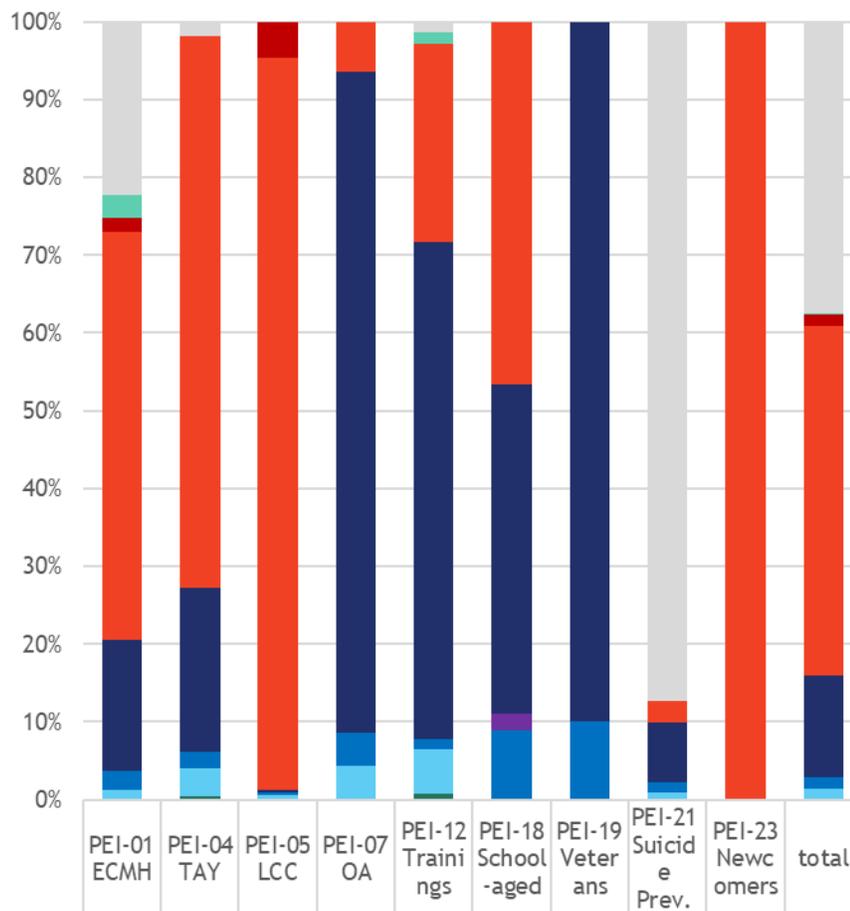
Note: demographics were not able to be collected for all clients.



Note: PEI-21 Suicide Prevention was excluded from the Total column as they did not collect region for any of the callers.

In FY 20/21, the breakdown of PEI clients by region was as follows: 56% San Rafael area, 5% Marin City, 20% Novato, 5% West Marin, and 14% other or unknown. This closely mirrors the Medi-Cal population in Marin.

FY20/21 PEI Program Demographics: PEI Race

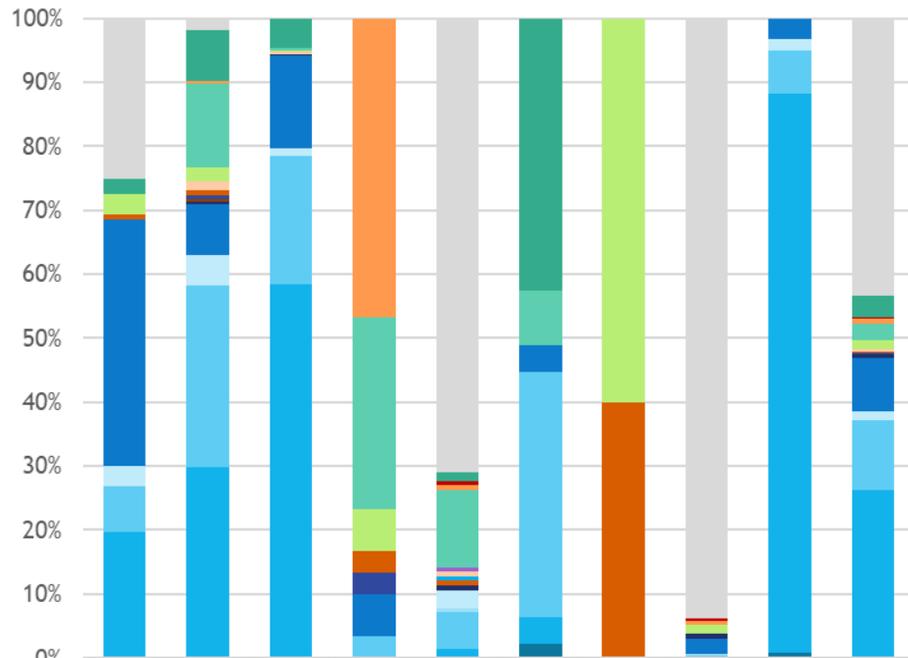


	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Trainings	PEI-18 School- aged	PEI-19 Veterans	PEI-21 Suicide Prev.	PEI-23 Newcomers	total
■ Missing or declined to answer	37	5	0	0	2	0	0	964	0	1008
■ More than one race	5	0	0	0	2	0	0	0	0	7
■ Other	3	0	36	0	0	0	0	0	0	39
■ Hispanic or Latino	87	195	720	3	36	21	0	30	119	1211
■ White (Non-Hispanic)	28	58	2	40	90	19	27	86	0	350
■ Native Hawaiian or other Pacific Islander	0	0	0	0	0	1	0	0	0	1
■ Black or African American	4	6	2	2	2	4	3	14	0	37
■ Asian	2	10	5	2	8	0	0	10	0	37
■ American Indian or Alaska Native	0	1	0	0	1	0	0	0	0	2

Note: Suicide Prevention data is not included in the Total as the demographic data collection requirements are different for Suicide Prevention programs. The School-Based contract for Sausalito Marin City School district was also unable to collect demographic data in FY20/21 due to COVID.

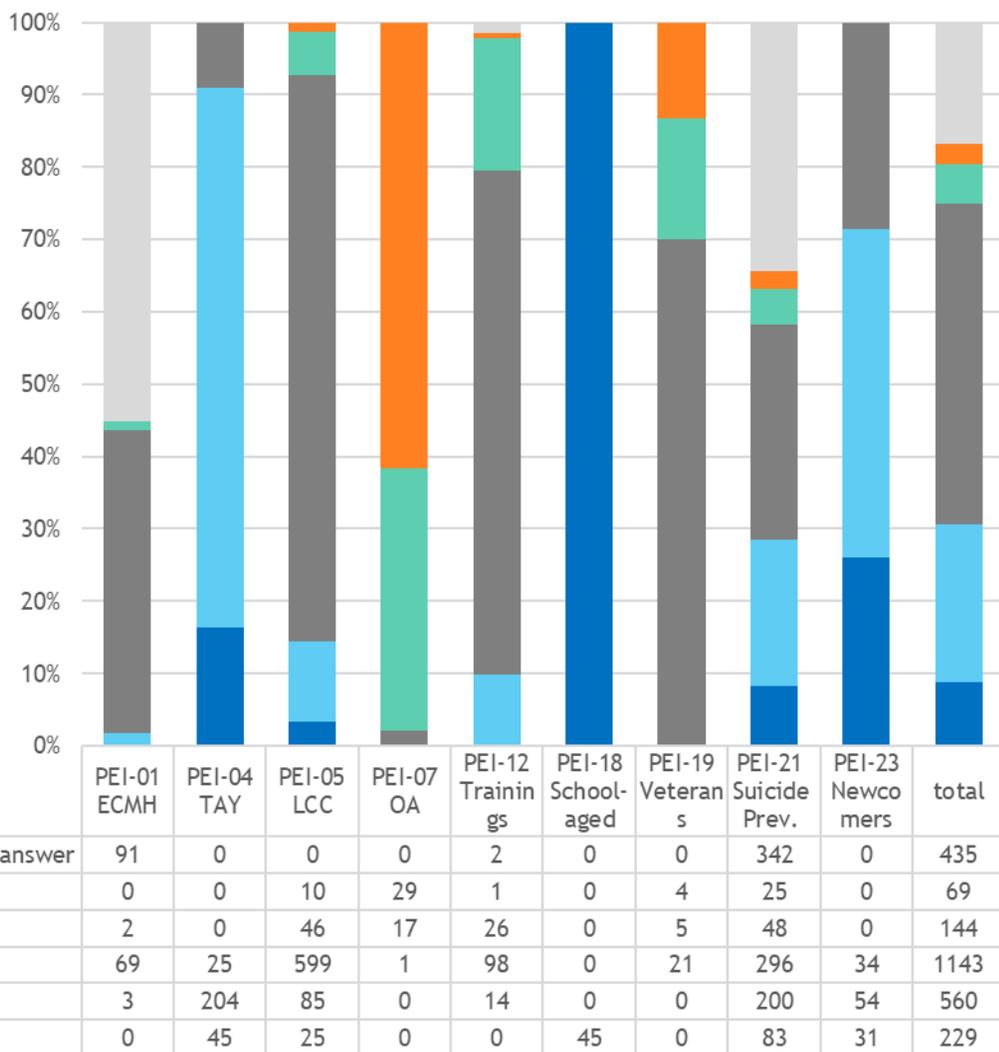
74% of those served by MHSa Prevention and Early Intervention programs identified as Hispanic or Latino.

FY20/21 PEI Programs Demographics: Ethnicity

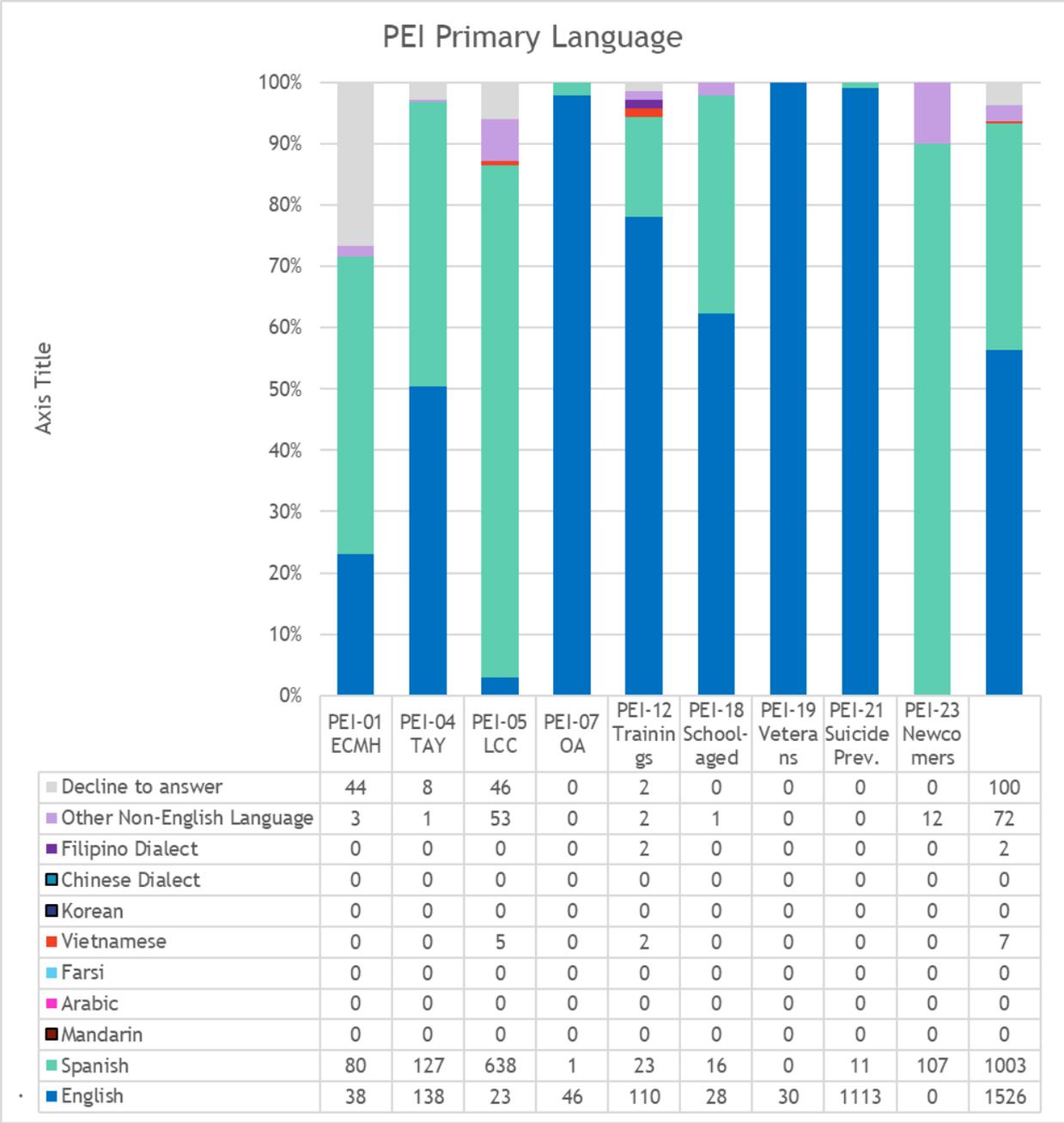


	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Trainings	PEI-18 School- aged	PEI-19 Veterans	PEI-21 Suicide Prev.	PEI-23 Newcomers	total
Missing or decline to answer	32	5	0	0	100	0	0	964	0	1101
More than one ethnicity	0	0	0	0	0	0	0	0	0	0
Other	3	22	36	0	2	20	0	0	0	83
Middle Eastern	0	0	0	0	1	0	0	5	0	6
Eastern European	0	1	0	14	1	0	0	5	0	21
European	0	36	2	9	17	4	0	0	0	68
African American	4	6	2	2	0	0	3	14	0	31
African	0	0	0	0	1	0	0	0	0	1
Vietnamese	0	4	4	0	1	0	0	0	0	9
Korean	0	0	0	0	0	0	0	0	0	0
Japanese	0	0	0	0	1	0	0	0	0	1
Filipino	1	2	0	1	1	0	2	0	0	7
Chinese	0	2	0	1	0	0	0	0	0	3
Cambodian	0	1	0	0	0	0	0	0	0	1
Asian Indian/South Asian	0	1	1	0	1	0	0	10	0	13
Other Latino not listed	49	22	111	2	0	2	0	24	4	214
South American	4	13	9	0	4	0	0	1	2	33
Puerto Rican	0	0	0	0	1	0	0	0	0	1
Mexican/Mexican American	9	78	153	1	8	18	0	5	8	280
Central American	25	82	447	0	2	2	0	0	104	662
Caribbean	0	0	0	0	0	1	0	0	1	2

FY20/21 PEI Programs Demographics: Age Group

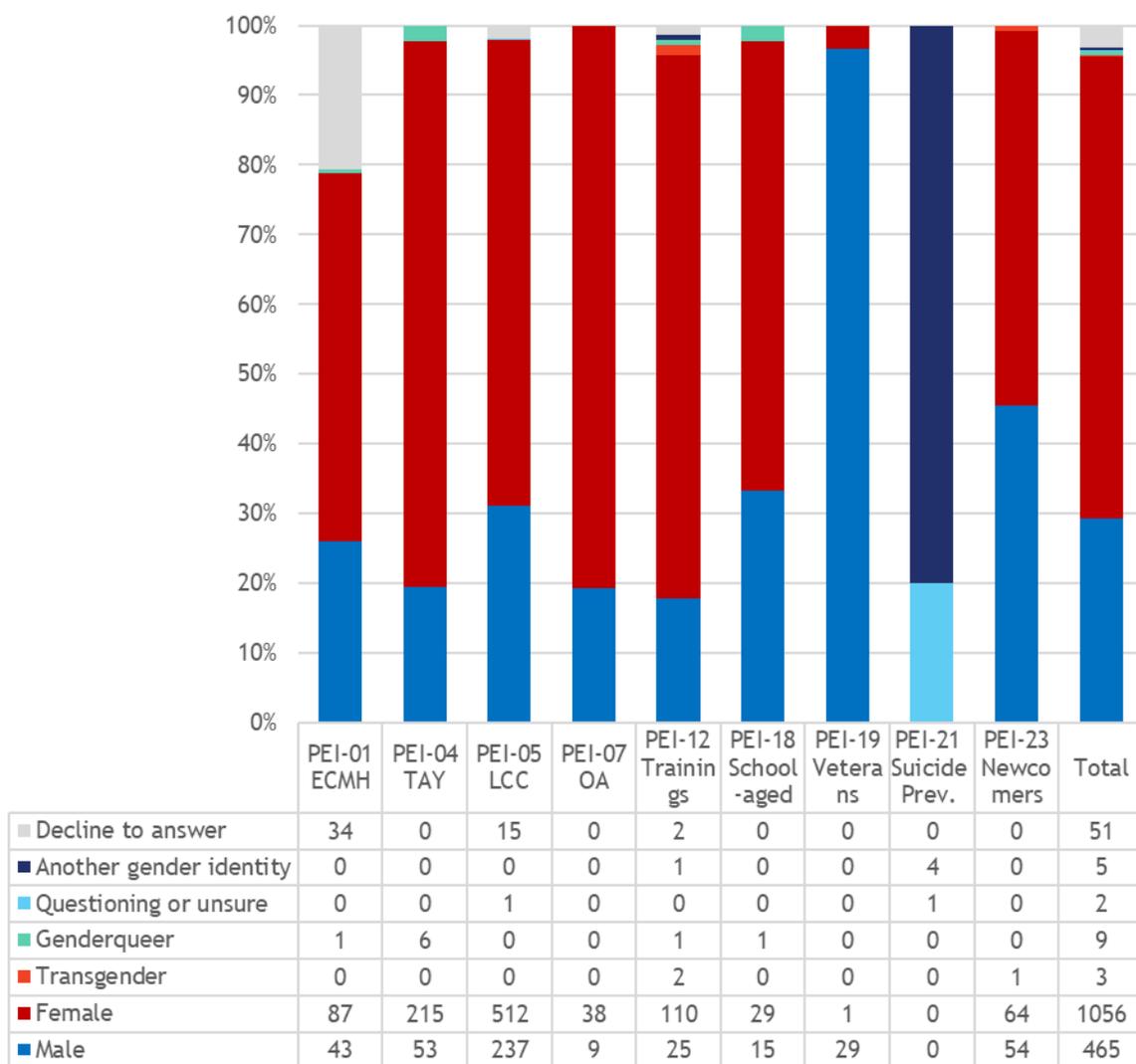


Note: Some programs reflect the age group of the person being trained rather than the target population of that training. I.E. Early Childhood Mental Health indicates the age group of the childcare providers receiving the training, however 100% of that funding is dedicated to supporting youth by providing training and support for the adults in their lives.



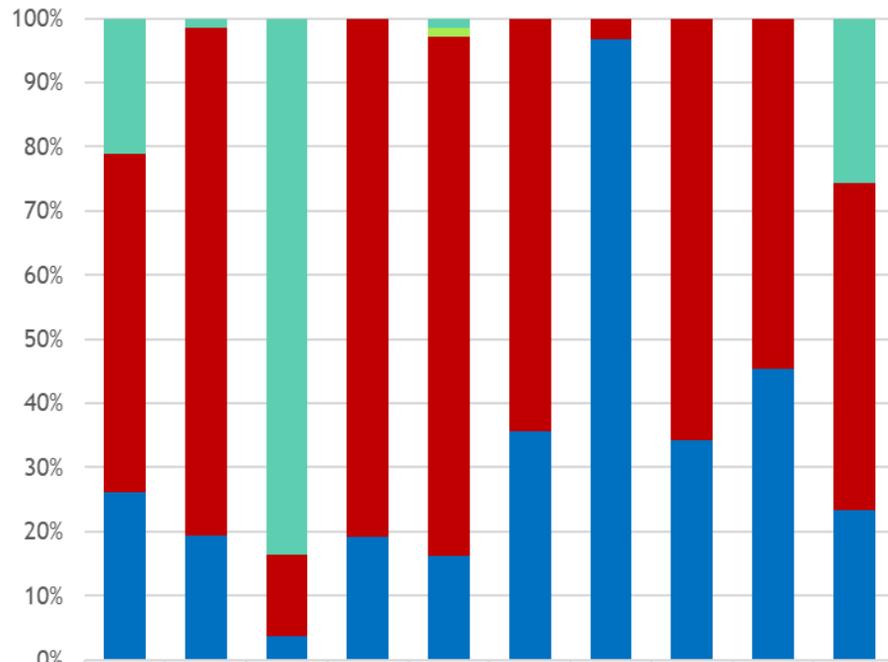
Spanish speaking clients represented 37% of PEI clients.

FY20/21 PEI Program Demographics: Gender Identity



49% of PEI clients identified as female, 23% identified as male, 1.2% identified as transgender, genderqueer, questioning, or another gender identity.

FY20/21 PEI Program Demographics: Sex Assigned at Birth

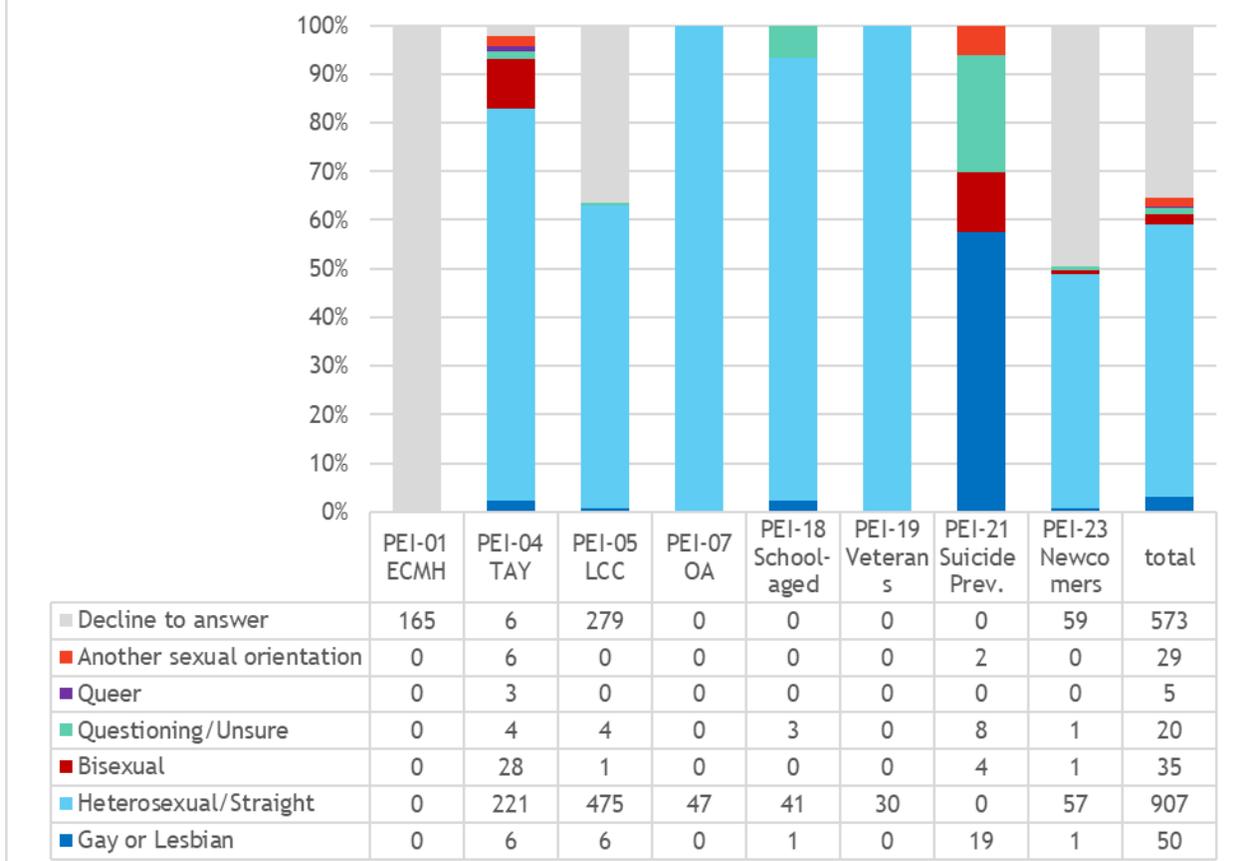


*Demographics not collected for all clients.

	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Trainings	PEI-18 School-aged	PEI-19 Veterans	PEI-21 Suicide Prev.	PEI-23 Newcomers	
Decline to answer	35	4	639	0	2	0	0	0	0	680
Other sex not listed (intersex)	0	0	0	0	2	0	0	0	0	2
Female	87	217	98	38	114	29	1	705	65	1354
Male	43	53	28	9	23	16	29	367	54	622

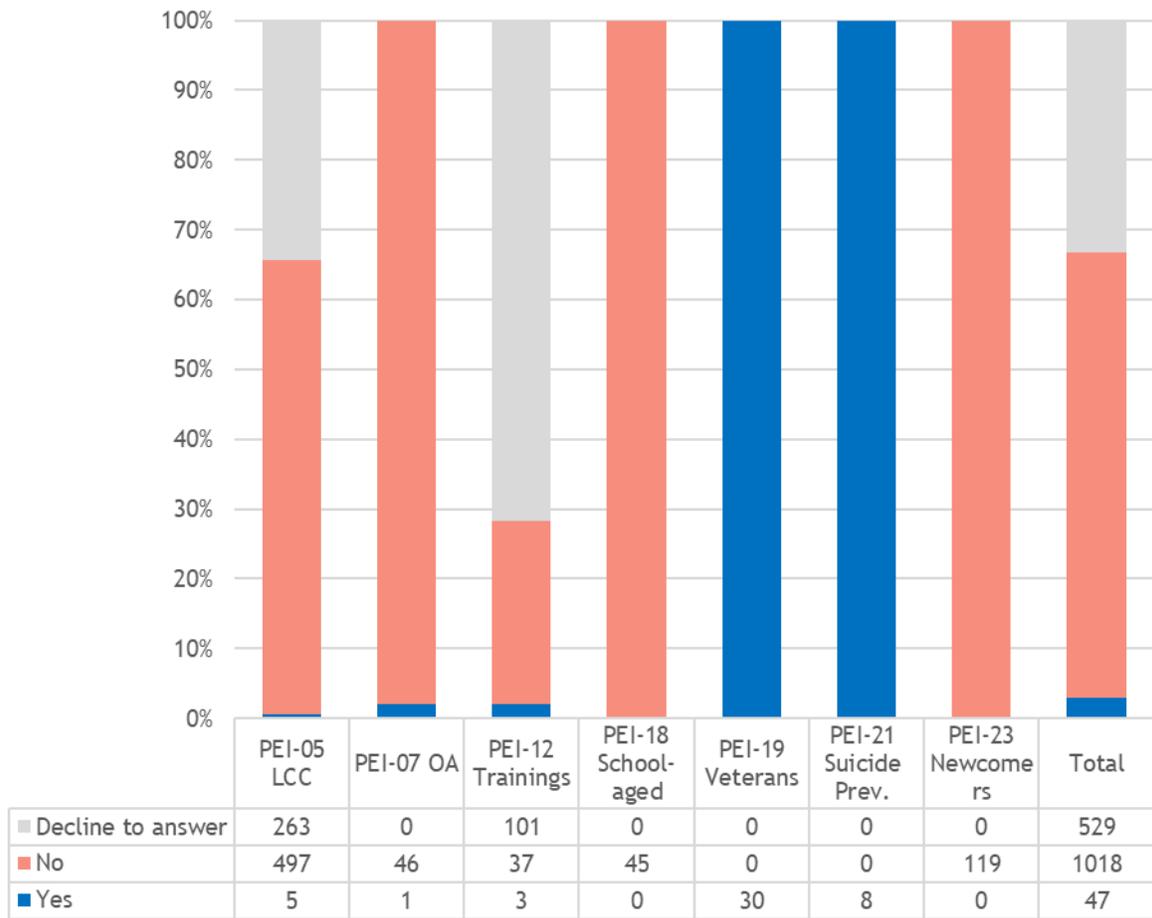
27% of respondents declined to state their sex assigned at birth. Overall, programs serve more females than males

FY20/21 PEI Programs Demographics: Sexual Orientation



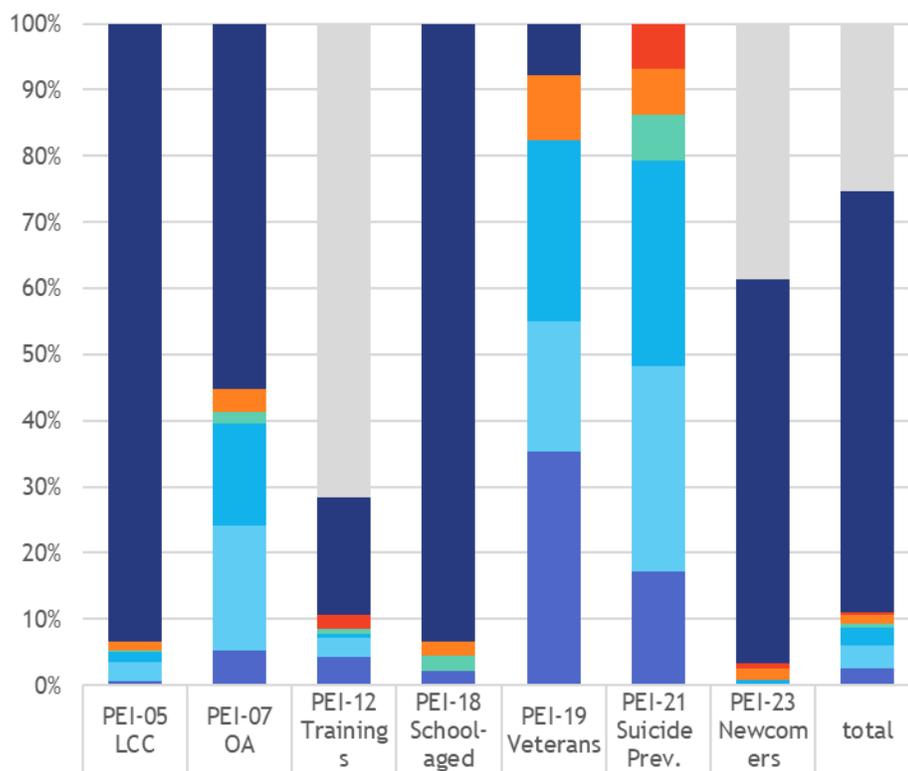
13% of clients that noted their sexual orientation identified as Gay or Lesbian, Bisexual, Questioning/Unsure, Queer, or Another sexual orientation.

FY20/21 PEI Program Demographics: Veteran Status



47 (or 3%) of total clients identified as Veterans, 67% of which were served through the PEI Veterans Case Management program.

FY20/21 PEI Program Demographics: Disability Status



	PEI-05 LCC	PEI-07 OA	PEI-12 Trainings	PEI-18 School-aged	PEI-19 Veterans	PEI-21 Suicide Prev.	PEI-23 Newcomers	total
■ Decline to State		0	101	0	0	0	46	418
■ No Disability	714	32	25	42	4	0	69	1047
■ Another type of disability	1	0	3	0	0	2	1	8
■ Difficulty Seeing	10	2	0	1	5	2	2	22
■ Difficulty Hearing	2	1	1	1	0	2	0	7
■ Chronic Health Condition	11	9	1	0	14	9	1	45
■ Physical	22	11	4	0	10	9	0	57
■ Mental	5	3	6	1	18	5	0	43

15% of clients that noted their disability status identified as having one or more disabilities.

Note: A disability for this data collection as defined by the State is “a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.”

EARLY CHILDHOOD MENTAL HEALTH (ECMH) (PEI 01)

SERVICE CATEGORY: PREVENTION

SB 1004 PRIORITY CATEGORIZATION: #1, #4

MARIN PEI PRIORITY STRATEGY AREA: Capacity Building

PROVIDER: Jewish Family and Children's Services

TARGET POPULATION: Pre-school students (0-5), caregivers, providers and school/childcare staff.

EXPECTED NUMBERS TO BE SERVED: 500

TARGET POPULATION

The target population is pre-school students (0-5) who attend subsidized pre-schools, and their families. The children and families face risk factors including poverty, racism, social inequality, trauma, adverse childhood experiences, substance use, and others. In addition, the staff at the subsidized pre-schools are the target population for the training in recognizing and responding to risk factors and signs of emotional disorders.

PROGRAM DESCRIPTION

The Early Childhood Mental Health Program at Jewish Family and Children's Services increases the availability of early interventions for emotional or behavioral health issues by providing highly trained mental health consultants in childcare centers throughout Marin County that serve low-income families with children from birth to age five. Direct intervention by consultants includes assessment of children with social/emotional risk factors utilizing evidence-based tools and, development and facilitation of intervention plans for at-risk children, including consultation and psycho-education with parents and linkages to community resources. 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. The ECMH PEI program aims to reduce Prolonged Suffering by providing:

Training for teachers and childcare providers: Early Childhood Mental Health Consultation 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.

ECMH

SUMMARY FY20-21

88% of Childcare providers receiving ECMH consultation reported increased ability to identify, intervene with, and support children in their care with emotional/behavioral health issues.

Assessment and brief intervention: 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. 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.

75% of parents/families reported that, as a result of ECMH services, their child is doing better in preschool/childcare (academically, socially)

Timely Access to Services: The program improves access 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 identified as mental health related.

Access and linkage to Treatment: 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 (BHRS), clients, families, and other key agencies to facilitate successful collaboration.

One parent who received support commented: “Your support does us well so we can get ahead with the pandemic.”

One home visitor supporting 10-12 families with children ages 0-3 commented in the end of year provider survey that “[Her ECMH Consultant] was able to provide [her] with a lot of support during this pandemic. [My Consultant] is wonderful. Thank you.”

DATA COLLECTION METHODS

The following data is reported to BHRS 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 number and types of individuals trained, types of trainings provided and demographics
- Participant/provider surveys are conducted to show changes in knowledge and skill for those receiving training
- Client/family demographics and satisfaction surveys to show impact of services provided (see PEI overview section)
- Referral data to show improved recovery through access and linkage to services
- Results of validated clinical tools (DECA-C) used to measure changes in child behaviors and staff and parent questionnaires to measure changes in skills and knowledge
- Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable. The ECMH program provided an adapted survey to school staff and administrators
- Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire - Social Emotional (ASQ-SE)

Anticipated data collection changes and additions for FY 21/22: The JFCS program will continue to work closely with supervisors and directors to improve systems so that teachers and site supervisors are reviewing the ASQs and the ASQ-SEs scores and using the screening tool to identify areas of concern, as well as to share the results with our program. In addition, they will work with supervisors throughout the 2021-22 school year to have parents complete ASQs and ASQ-SEs not just at the beginning of the school year, but also at the next appropriate interval to follow up, for any child for whom the ECMH Program has opened a case (i.e., 3-6 months later).

OUTCOMES

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

Outcomes	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Children that received prevention services through staff consultation (number of students at school site)	535	636	535	622	250-535	472
Percent of these children that come from un/underserved cultural populations (Latino, Asian, African American, West Marin).	70%	88% N=560	70%	90% N=442	70%	93% N=439

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.	65	82	65	92	65	114
Children in childcare settings served by ECMH Consultants retained in their current program or transitioned to a more appropriate setting. <i>*Case notes</i>	100%	99.8%	95%	100%	95%	100%
Parents/primary caregivers of families receiving intensive services who report increased understanding of their child’s development and improved parenting strategies. <i>*JFCS multi-county parent questionnaire</i>	85%	98% N=67	85%	94% N=21	85%	97% N=23
Caregivers reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)* <i>(PEI Caregiver Survey)</i>	75%	96% N=23	75%	100% N=21	75%	92% N=22
Total referrals to County Behavioral Health (BHRS)	N/A	6	N/A	7	N/A	11
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	1	N/A	1	N/A	5
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	2	N/A	8	N/A	6
Total referrals to other PEI providers	N/A	0	N/A	13	N/A	2
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	N/A	N/A	13	N/A	2
Average time in weeks between when a referral was	N/A	N/A	N/A	N/A	N/A	N/A

given to individual by your program and the individual's first in person appointment with the PEI-funded provider						
Total referrals to other mental health services or to resources for basic needs	N/A	79	N/A	58	N/A	14
Early Childhood Education Sites Receiving Services	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
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	85%	99% N=23	85%	88% N=27	85%	88% N=30
Staff receiving ECMH Consultation services who report satisfaction with the services (would use again, would recommend, were helpful). *PEI survey	75%	95% N=67	75%	99% N=27	75%	96% N=33

*Data Collection Method

EQUITY STRATEGIES:

JFCS serves primarily low-income clients, predominantly Spanish speaking Latinx and other families of color. To deliver services that are non-stigmatizing and non-discriminatory, JFCS provides bilingual Early Child Mental Health Consultants and all staff with training and support to integrate cultural humility practices with clients and families. Staff focuses on identifying the cultural and racial issues involved with each of their clients, acknowledging the systemic racism and barriers for people of color and other marginalized communities, and learning how to be an ally in helping families access services. JFCS' priority is delivering personalized support that addresses a family's unique needs and focusing on and building upon families' strengths rather than pathologizing.

CHALLENGES AND UPCOMING CHANGES

In FY 2020-21, this program was implemented as described in the MHS A Three-Year Program and Expenditure Plan for FY2020-21 through FY2022-23, although services continued to be impacted by COVID-19. It proved to be a challenging year for the sites the ECMH program serves. Data collection was limited despite efforts to outreach. A shift to digital data collection was implemented to accommodate providing services to families and teachers. While JFCS was able to collect similar quantity of surveys as in pre-COVID years, they did not get as many as they had hoped. Next year, JFCS plans to elicit more feedback from parents and teachers regarding cases to get additional outcome data. From the surveys

that they did receive, it does appear that many staff members were not able to participate in ECMH meetings due to covid restrictions and that the consultants were able to continue to provide high quality services and support to staff and parents despite the challenges during the pandemic. JFCS also worked with sites to utilize the ASQ and ASQ-SE as an evaluation tool. However, this tool proved to be impractical under COVID restrictions, which limited access to the sites. Therefore, they were not able to collect any follow-up ASQs. They continued to use the ASQs as a useful tool to identify specific areas of concern for the children served.

JFCS ECMH PEI program goals for **FY 22/23** include:

- Implementing therapeutic playgroups and social and emotional activities in partnership with preschool teachers at preschool sites, and
- Building upon their commitment to align Teaching Pyramid - preschool social and emotional curriculum in the classroom – with parents’ ability to learn the same strategies to provide consistency, enhancing relationships between teachers and parents and helping parents learn positive parenting strategies

Client Story

JoJo was an adorable three-year-old who began preschool in for the first time during the COVID pandemic. She had been diagnosed on the autism spectrum prior to entering preschool. The preschool supervisor alerted the Early Childhood Mental Health Consultant that this child would be starting at their school and that her mother had already requested additional support. The child’s mother had expressed concern for her child’s starting in a new school and was particularly worried about her difficulty with separation, due to some issues in her young life. JoJo’s parents had recently separated and were having some difficulty in coparenting. JoJo’s mom also struggled with anxiety, which was exacerbated by not being able to enter the classroom due to COVID restrictions. This prevented her participation in the transition as would typically happen when a child enters a new preschool. The Early Childhood Mental Health Consultant met with the site supervisor, who initially felt frustrated by JoJo’s parents’ calls to the school with concerns about their child. The Consultant also met with JoJo’s mom early on. The mother’s anxiety sometimes came across as irritation with how the teachers were doing their jobs. While this was a regular preschool, not a preschool for children with special needs, teachers at this preschool are skilled at and open to understanding and meeting each child’s unique needs. The Consultant met with the lead teacher in JoJo’s classroom, who expressed feeling that mom was not pleased with her approach as a teacher. The lead teacher spent a lot of time one-to-one with JoJo to help with her adjustment, but due to the fact that the lead teacher had many responsibilities in the classroom, she was not able to be with JoJo every minute of every day, as mom seemed to wish. Quickly, JoJo bonded with not just the lead teacher but with all of her teachers. The Consultant brought in JFCS’ pediatric occupational therapist, who reviewed reports relating to JoJo’s history and diagnosis of Autism Spectrum Disorder. Due to COVID restrictions at JoJo’s school, neither the Consultant nor the Occupational Therapist could observe JoJo in the classroom or even outside in the playground. So with the permission of JoJo’s mom and the supervisor of JoJo’s school, teachers took video clips of JoJo engaging in various activities at school. The Consultant and Occupational Therapist met with the teaching team at the preschool, assessing for areas where they felt they could use more support in meeting JoJo’s needs and also sharing what mom knew about what works to help her daughter and what the occupational therapist could offer in terms of specific strategies that help children on the autism spectrum for staff to use with JoJo. The trusting relationship that the Consultant had developed with this parent helped bridge the relationship between the parents and the teachers. Initially JoJo’s mom wanted the Consultant to be the go-between between herself and the school because she felt exhausted

having to train others to help her child. A few months into consultation, mom agreed to meet with the preschool supervisor and teaching staff to problem solve together and collaborate regarding the needs of her daughter in the classroom. Another key factor was the Consultant's support for mom during the many transitions in JoJo's life, including living in two separate homes, aging out of services from the regional center soon after JoJo turned 3, and being assessed by JoJo's school district. As a result of ECMH Consultation, the teacher responded "Strongly Agree" on 100% of survey questions. And mom responded "Agree" or "Strongly Agree" on 100% of survey questions, including "strongly" agreeing that "[her] child's relationships have gotten better with [her], with his/her other parent(s), teachers, friends and/or family" and that "[she is] better able to advocate for [her] child's and/or her family's needs."

TRANSITION AGE YOUTH (TAY) PREVENTION AND EARLY INTERVENTION (PEI 04)

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #1, #3, #4, #6

PROGRAM OVERVIEW

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. Providers conduct psychosocial screening at health access points, direct linkage to mental health counseling, substance use counseling or case management, school-based groups, individual and/or family counseling, targeted supports for immigrant and LGBTQ students, as well as trainings for educators on supporting LGBT students.

PROVIDERS: Huckleberry Youth Programs, North Marin Community Services, and the Spahr Center.

TARGET POPULATION: The target population is 16-25 year-olds, and some younger teens, from underserved populations such as LGBTQ youth and school staff and providers who receive training and consultation.

EXPECTED NUMBERS TO BE SERVED: 850

PROGRAM DESCRIPTION

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. To accomplish this, Huckleberry Youth Programs, North Marin Community Services and the Spahr Center provide:

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 U.S. 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.

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

PEI TAY

SUMMARY FY2020-21

Clients Served: FY2020-21

520 Individuals

231 Families

957 reached through Outreach/Training

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. The Spahr Center provides short-term counseling for a LGBTQ++ youth, with an emphasis on gender questioning and gender expansive youth.

Training for School Staff: The Spahr Center provides a series of trainings for educators and service providers regarding allyship with LGBTQ+ youth and the contribution they make to creating a safer and more welcoming environment in Marin’s middle and high schools.

Access and Linkage to Treatment: Mental Health and substance use screening is conducted for all clients of the teen health clinic and counseling clients. Clients screening positive are then assessed by a clinician and, if identified as experiencing serious mental illness, linked to medically necessary services. Individuals at risk or showing signs of developing emotional disturbance are linked to additional risk reduction services, early interventions, and other resources as needed. 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 to facilitate successful collaboration.

Timely Access to 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.

DATA COLLECTION METHODS

The following data is reported to BHRS 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.

- Number of clients screened at Teen Clinics are tracked
- Client/family demographics and satisfaction surveys to show impact of services provided (see PEI overview section)
- Referral data to show improved recovery through access and linkage to services
- Health Education Presentation surveys

Health Education Workshop Surveys:

41% of survey respondents report having experienced mental health challenges.

As a result of the health education presentations and outreach efforts, 97% of participants were able to identify 3 options for birth control prevention and 96% were able to identify two places to go in Marin County for reproductive and behavioral health care services

- Results of validated clinical tools ((Global Appraisal of Individual Needs (GAIN-SS, Partners for Change Outcome Measurement System (PCOMS)) used to measure changes in functioning overtime. 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). Clients are asked to complete 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 is evaluated for clients that participate in three or more sessions
- Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable
- Beginning in FY 19/20, The Spahr Center began utilizing the Child and Adolescent Needs and Strengths (CANS) as an additional tool to measure client outcomes

Anticipated data collection changes and additions for FY 21/22: North Marin Community Services will replace the GAIN-SS with the Rapid Adolescent Prevention Screening (RAAPS).

OUTCOMES

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

Huckleberry Youth Programs (HYP) provides early identification of TAY youth with behavioral problems and increased timely access to early intervention and subsequent screening and referral services, including services that increase protective factors and decrease risk factors.

Outcomes: Huckleberry Youth Programs*	Goal FY18/19	Actual FY 18/19	Goal FY19/20	Actual FY 19/20	Goal FY20/21	Actual FY 20/21
TAY screened for behavioral health concerns	350	360	350	261	165	170
TAY participating in individual and/or family counseling in school or clinic settings	200	291	200	714	100	133
Family members participating in TAY counseling in support of the client	50	176	50	364	50	63
TAY participating in at least 3 sessions of counseling showing statistically significant improvement in client well-being.* PCOMS: Outcome Rating Scale Those not included either did not complete the PCOMS or	60%	60% N=62	60%	78% N=68	75%	100% N=41

had initial scores that precluded statistically significant change						
TAY participating in at least 3 sessions of counseling showing a validated positive therapeutic alliance, a significant predictor of clinical outcomes; *PCOMS: Session Rating Scale	60%	60% N=62	75%	97% N=68	75%	100% N=41
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	N/A	100% N=27	N/A	93% N=70	75%	98% N=41
Total referrals to County Behavioral Health (BHRS)	N/A	8	N/A	23	N/A	30
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	5	N/A	15	N/A	30
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	24	N/A	Unknown	N/A	Unknown
Total referrals to other PEI providers	N/A	3	N/A	49	N/A	30
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	Unknown	N/A	45	N/A	Unknown
Average time in weeks between when a referral was given to individual by your program and the individual's first in person appointment with the PEI-funded provider	N/A	Unknown	N/A	Unknown	N/A	N/A
Total referrals to other mental health services or to resources for basic needs	N/A	126	N/A	159	N/A	40

**Data Collection Method*

**HYP was previously combined with NMCS. Data has now been separated by organization for FY 20/21.*

North Marin Community Services (NMCS) provides screening and brief intervention for behavioral health and reproductive health concerns at the Novato Teen Clinic, in schools and the community. In addition, NMCS provides direct linkages to mental health counseling, substance use counseling or case management, school-based groups, individual and/or family counseling, as well as targeted supports for immigrant and LGBTQ students.

Outcomes: North Marin Community Services*	Goal FY18/19	Actual FY 18/19	Goal FY19/20	Actual FY 19/20	Goal FY20/21	Actual FY 20/21
PHP will serve annually as ambassadors to the NTC.	N/A	N/A	N/A	N/A	7	8
TAY screened for behavioral health concerns	350	360	350	261	200	164
Youth will receive education and outreach annually	N/A	N/A	N/A	N/A	500	541
Youth will be reached through NTC's social media presence	N/A	N/A	N/A	N/A	3,500	3,500
TAY participating in at least 5 sessions of school-based skill building groups showing statistically significant improvement in client well-being. PCOMS: Outcome Rating Scale Those not included either did not complete the PCOMS or had initial scores that precluded statistically significant change	60%	77% N=63	60%	65% N=49	N/A	N/A
TAY participating in individual and/or counseling in school or clinic settings	200	291	200	714	75	47
Family members participating in TAY counseling in support of the client	50	176	50	364	N/A	N/A

Youth participating in follow-up visits with the mental health clinician will demonstrate improvement in wellbeing, as measured by PHQ and GAD scores	60%	60% N=62	60%	78% N=68	60%	70% N=33
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	N/A	100% N=27	N/A	93% N=70	75%	Exit surveys not completed due to pandemic
Total referrals to County Behavioral Health (BHRS)	N/A	8	N/A	23	N/A	6
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	5	N/A	15	N/A	3
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	24	N/A	Unknown	N/A	Unknown
Total referrals to other PEI providers	N/A	3	N/A	49	N/A	3
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	Unknown	N/A	45	N/A	3
Average time in weeks between when a referral was given to individual by your program and the individual's first in person appointment with the PEI-funded provider	N/A	Unknown	N/A	Unknown	N/A	Unknown
Total referrals to other mental health services or to resources for basic needs	N/A	126	N/A	159	N/A	24

*NMCS was previously combined with HYP. Data has now been separated by organization for FY 20/21.

The Spahr Center provides clinic-based individual therapy to LGBTQ+ youth throughout Marin County.

Outcomes: SPAHR Center	Goal FY18/19	Actual FY 18/19	Goal FY19/20	Actual FY 19/20	Goal FY20/21	Actual FY 20/21
Provide a minimum of 130 hours of individual counseling for a minimum of 15 LGBTQ++ youth, with an emphasis on gender questioning and gender expansive youth	130	194	130	272	200	200
Provide Training for educators in a minimum of 5 middle and high schools	5	7	5	5	5	5
PEI clients completing more than 3 sessions of therapy will indicate a positive therapeutic alliance, a significant predictor of clinical outcomes.	N/A	N/A	N/A	N/A	75% of PEI clients	100% N=10
Increase self knowledge and self confidence for LGBTQ+ youth seen for at least 24 sessions	N/A	N/A	N/A	N/A	85% LGBTQ+ youth	100%
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	N/A	100% N=11	N/A	92% N=15	75%	100% N=10
Total referrals to County Behavioral Health (BHRS)	N/A	0	N/A	1	N/A	3
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	N/A	N/A	1	N/A	0
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	N/A	N/A	N/A	N/A	N/A
Total referrals to other PEI providers	N/A	0	N/A	2	N/A	4

Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	N/A	N/A	0	N/A	4
Average time in weeks between when a referral was given to individual by your program and the individual's first in person appointment with the PEI-funded provider	N/A	N/A	N/A	N/A	N/A	1
Total referrals to other mental health services or to resources for basic needs	N/A	0	N/A	1	N/A	17

EQUITY STRATEGIES:

PEI TAY programs are designed to engage TAY in developing and implementing outreach activities to increase access to mental health services, as well as to facilitate ease of access to care through the provision of no-cost, confidential services that can be obtained both remotely and in-person. Screenings and brief behavioral health interventions are provided, as well as referrals to treatment for those TAY requiring a higher level of care. All youth receive information about how to access services through BHRS ACCESS, as well as information about the mobile crisis and suicide hotline, as clinically indicated. Social media is a primary mechanism used for outreach as well as peer-led outreach activities in high schools and on college campuses. The programs provide essential access to services that they would otherwise not have in a community that lacks school-based health clinics. Services are provided by staff that are bicultural, bilingual and have participated in more than six hours of training related to trauma-informed and culturally responsive care. Most staff are representative of the BIPOC and LTBTQ+ communities, as we know representation matters and TAY youth feel more comfortable receiving services from providers that reflect their gender and ethnic identities. Spahr’s clinicians are queer women of color who are able to provide culturally responsive care to the clients they serve.

CHALLENGES AND UPCOMING CHANGES

In **FY 2020-21**, this program was implemented as described in the MHSa Three-Year Program and Expenditure Plan for **FY2020-21** through **FY2022-23** although services continued to be impacted by COVID-19. It proved to be exceedingly difficult to collect client satisfaction surveys this year. At the onset of the pandemic, the move to telehealth created many forms that youth and families had to fill out. The required and additional Covid-screener added time to the process if it was an onsite client, and if it was a telehealth visit, the surveys were required to be sent at the end of services, and providers had no manner of ensuring their completion. To address this, programs create Google Docs to make it easier for clients to fill out forms and tried to implement time for them to do in session, but as many were under time constraints and needed more time to ensure safety at the end of sessions, therapists often decided not to use the time for surveys. Once again, therapist requested clients to fill out the surveys, but they did not. When the programs were able to resume onsite services, Covid-19 protocols required different levels of guiding clients through the center, cleaning, and providing space between appointments. All staff were in continuous rotation of support services and ensuring onsite protocols were kept. For mental health clients, there was also a focus on addressing their concerns within the

allotted time and completing all the scales necessary for their treatment. Therefore, surveys were not completed as anticipated.

TAY PEI program goals for **FY22/23** include:

- Collaborating more intentionally with Wellness Centers in schools
- Integrating AOD and YOR (Youth Opioid Response) work with TAY services
- Increasing access to care through the provision of telehealth and hybrid clinic services while managing health risks associated with the Covid-19 pandemic

CLIENT STORIES

Client Story 1: *Sergio*, a 17-year old teen, was very nervous when he called in to make an appointment at Huckleberry Youth Programs’ Teen Tuesday Clinic. When he arrived at the clinic, a member of our highly trained staff swiftly guided him to a private room to discuss the reason for his visit and perform a comprehensive health screening. Sergio shared that the weekend before, he had gotten intoxicated at a party and engaged in unprotected sex with someone he had just met. Sergio explained that he had never done anything like that before, and that he was worried that he may have contracted something. He also mentioned that this was his first time discussing his sexual health with someone who was not a sexual partner, and his first time getting tested for STIs.*

Huckleberry staff member listened intently to Sergio’s concerns, and provided both support and information on testing, taking their time to explain the steps in the process and the additional services available. The Huckleberry staff reassured Sergio that his visit would remain confidential, free-of-charge, and that staff would be available to answer any questions he had, explain the test results, and provide resources and referrals as needed. Sergio expressed feeling extremely safe, supported and validated during his visit and was able to access the health services he was seeking.

**Name changed to protect client confidentiality*

Client Story 2: *As a result of the pandemic, NMCS staff are identifying teens and transitional age youth with increased levels of anxiety and depressive symptoms, many report feeling isolated, and some disclose thoughts of suicide. The experience of Janiene (not real name), a Novato Teen Clinic client, exemplifies this. At 15 years old, Janiene called the Novato Teen Clinic intake line asking for a reproductive health appointment, fearful that she may have a sexually transmitted infection. As part of the intake process, Janiene was screened for behavioral health and substance use; she disclosed having had thoughts of suicide, as well as a history of an attempt that she had not disclosed to anyone. Novato Teen Clinic staff immediately conducted a thorough risk assessment and engaged in developing a Care and Safety Plan with Janiene and her mother. She was linked to a primary care provider at Marin Community Clinic and agreed to begin behavioral health services on a weekly basis. Through brief therapy, she worked on increasing her sense of connection to family, friends, and school;. She also engaged in art activities that helped increase her sense of self-esteem. The Novato Teen Clinic behavioral health provider helped her monitor her mood using the PHQ-A, which demonstrated overall improvement. She no longer experiences suicidal ideation and reports feeling happier and more confident.*

LATINO COMMUNITY CONNECTION (LCC) (PEI 05)

SERVICE CATEGORY: EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #4, #6

MARIN PEI PRIORITY STRATEGY AREA(S): Suicide Prevention, Newcomers Supports

PROGRAM OVERVIEW

Latino Community Connection (LCC) is a multi-layered program that provides behavioral health outreach, engagement, and prevention services in the Latino community. 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. Bilingual behavioral health providers provide brief interventions for individuals, groups, couples, and families including psycho-education, coping skills, communication skills, and referrals to appropriate behavioral health services. Clients may also be referred to trauma, stress management, depression/anxiety groups that help them develop coping and stress reduction strategies. In addition, PEI funds co-sponsor a radio show, “*Cuerpo Corazon Comunidad*”, in Spanish on health issues, including mental health and substance use through the Multicultural Center of Marin (formerly Canal Welcome Center).

PROVIDERS: Canal Alliance, North Marin Community Services and Multicultural Center of Marin

TARGET POPULATION

The target population is Latinos throughout the County, especially newer immigrants facing many stressors and barriers to accessing services. The Latino population faces numerous 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

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. LCC provides:

- **Outreach for Increasing Recognition**
- **Radio Show “*Cuerpo Corazón Comunidad*”:** *Cuerpo Corazón Comunidad* is a one-hour weekly radio program/podcast in Spanish on topics related to the integral health and wellness of Latino

Latino CC

SUMMARY FY2020-21

Clients Served: FY2020-21

765 Individuals

49 Families

93 reached through Outreach/Training*

*does not include radio show listeners

individuals, families and communities. Its primary goals are to: increase community access to reliable information promoting health, help de-stigmatize relevant sensitive subjects (e.g., mental illness, addictions, LGBTQ+), and link community members to health resources. In each program, the host and guests present practical information in clear and engaging ways. It is broadcasted from stations in central Marin, West Marin and other regions in California. MCM provides **outreach** to the community to promote the show in a variety of ways including: social media, websites, newsletters, and short promos that are distributed to partner organizations before each show. Many partner organizations further share the information via social media, email, and text messaging in collaboration with community partners. Flyers are also distributed in food bags at MCM’s Saturday food distribution, with 300-600 recipients each week.

- **Counseling and Case Management:** Individuals referred to the program are assessed for PTSD using the Posttraumatic Stress Disorder Checklist (PCL-C) at Canal Alliance. Those determined eligible are referred to ongoing groups provided at Canal Alliance for increasing coping skills and functioning. The groups utilize the framework developed by the Institute on Violence, Abuse and Trauma (IVAT) for addressing complex trauma, such as emotional regulation, stress reactions, psycho-education on trauma, dissociation, and other relational aspects. Partners for Change Outcome Measurement System (PCOMS) is used at North Marin Community Services used to measure changes in functioning overtime. 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 psycho-education sessions addressing coping skills, communication, and linkages to appropriate services.
- **Timely Access to 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.
- **Access and linkage to Treatment:** 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 through the “Access and Assessment line,” enabling the County to track referrals, timeliness of services, and services received. PEI staff maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, County Behavioral Health and Recovery Services, clients, families, and other key agencies in order to facilitate successful collaboration.

*In the **FY 20-21**, The *Promotores* program has moved to CSS as part of our *Promotores/Community Health Advocates Outreach and Engagement Strategy*.

DATA COLLECTION METHODS

The following data is reported to BHRS 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 number and types of individuals trained, types of trainings provided and demographics (see PEI overview section)
- Participant surveys are conducted to show changes in knowledge and skill for those receiving training
- Client/family demographics and satisfaction surveys to show impact of services provided (see PEI overview section)

94% of clients served built stronger relationships with family or friends

83% felt better connected to their community, as a result of services.

- Number of individuals reached through outreach activities (tabling, resource fairs, etc.)
- Referral data to show improved recovery through access and linkage to services
- Results of validated clinical tools (PLC-C and PCOMS) used to measure changes in child behaviors and staff and parent questionnaires to measure changes in skills and knowledge
- Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.
- Multicultural Center of Marin quarterly and end-of-year listener surveys on Facebook and on paper to assess knowledge and skills attained through radio show

Anticipated data collection changes and additions: No anticipated changes in **FY 21/22**.

OUTCOMES

Please note that in the FY 20/21 Canal Alliance and North Marin Community Services became two separate contracts. Therefore, data for FY 20/21 is separated by agency (FYs 18/19-19/20 were combined)

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

Canal Alliance	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Individuals participating in support groups or individual/family sessions	150	121	150	171	50	115

Family members participating in support of the client	30	38	30	40	30	9
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) * <i>PEI Satisfaction survey</i>	N/A	99% N=132	N/A	84% N=128	75%	100% N=52
Total referrals to County Behavioral Health (BHRS)	N/A	49	N/A	55	N/A	6
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	Unknown	N/A	11	N/A	2
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	52	N/A	8	N/A	12
Total referrals to other PEI providers	N/A	0	N/A	19	N/A	14
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	N/A	N/A	19	N/A	7
Average time in weeks between when a referral was given to individual by your program and the individual's first in person appointment with the PEI-funded provider	N/A	N/A	N/A	N/A	N/A	N/A
Total referrals to other mental health services or resources for basic needs	N/A	230	N/A	574	N/A	83

*percentage that agree or strongly agree

North Marin Community Services	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Individuals receiving health information and support from <i>Promotores</i> or Family Resource Advocates	900	1,109	900	999	See CSS Section	See CSS Section
Individuals participating in support groups or individual/family sessions	150	121	150	171	70	90
Family members participating in support of the client	30	38	30	40	30	9
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) * <i>PEI Satisfaction survey</i>	N/A	99% N=132	N/A	84% N=128	N/A	Data unavailable
Total referrals to County Behavioral Health (BHRS)	N/A	49	N/A	55	N/A	16
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	Unknown	N/A	11	N/A	Unknown
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	52	N/A	8	N/A	52
Total referrals to other PEI providers	N/A	0	N/A	19	N/A	11
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	N/A	N/A	19	N/A	11
Average time in weeks between when a referral was given to individual by your program and the individual's first in person	N/A	N/A	N/A	N/A	N/A	N/A

appointment with the PEI-funded provider						
Total referrals to other mental health services or resources for basic needs	N/A	230	N/A	574	N/A	26

*percentage that agree or strongly agree

Outcomes: Multicultural Center of Marin	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Provide weekly one-hour radio show on topics of health and wellness of Latino individuals, families and communities, with a focus on mental health knowledge, signs, symptoms, skills, and related community resources, including PSAs and a community calendar for related events and services.	52	52	52	52	52	51
Radio Show Listener Survey Responses:						
<i>"I have a better understanding of resources in my community"</i>	N/A	93%* N=98	N/A	95%* N=18	N/A	90% N= 59
<i>"I learned something about mental health (emotional wellbeing) that I didn't know before"</i>	N/A	95%* N=99	N/A	89%* N=18	N/A	80% N= 59
<i>"I would recommend this radio show to a friend or family member"</i>	N/A	99%* N=98	N/A	95%* N=18	N/A	97% N= 59

EQUITY STRATEGIES:

Canal Alliance and North Marin Community Services provide a continuum of community-based, culturally and linguistically responsive services for at-risk, low-income, Latino residents in Marin County. All social services are provided at no cost to clients, are highly-trauma informed, and the service design reflects the language and cultural norms of the Latino community they serve. All services are designed to meet the unique needs of this community with easy to access and drop-in services, bilingual and bicultural staff, and trauma-informed design. An important aspect of their capacity to address equity, inclusion and accessibility is their ability to provide quality mental health services for clients regardless of citizenship or access to insurance. The organizations strive to on-board staff and volunteers who reflect the diversity of their clients. More than half of their staff members are bilingual, which enables them to serve a culturally and socio-economically diverse mix of families in a manner that integrates and unites the community. The Mental Health Navigation Line is staffed with bilingual person who is trained in culturally-responsive practices and motivational interviewing which has helped to triage, screen, and connect callers to appropriate levels of care. When appropriate, staff, clinician and case managers change their language for appropriateness to be non-stigmatizing. For example, using “emotional support services” as opposed to “therapy” or “psychological services”. Staff clinician regularly normalizes that life can be challenging and everyone can benefit from a safe and confidential space to express their concerns and receive emotional support at various times in life.

The target audience of Multi-cultural Center of Marin’s Radio program is the Latinx population. The radio medium serves individuals who do not read, and the stations reach those who do not access media in English. The West Marin stations that air the program serve those who live in the more isolated rural regions of the county. During the **FY 20/21** year, the Latinx community in Marin County suffered the effects of the COVID-19 virus. *Cuerpo Corazon Comunidad* made it a priority to announce locations for where to get tested for the virus, where to receive rental assistance due to job loss, and vaccination sites once those became available. The importance of mental health was also a priority for the program which addressed people’s concerns over the virus, how to address parent and child mental health, and how to deal with loneliness during the quarantine period.

CHALLENGES AND UPCOMING CHANGES

In FY 2020-21, this program was implemented as described in the MHS A Three-Year Program and Expenditure Plan for **FY2020-21** through **FY2022-23**, although services continued to be impacted by COVID-19. Data collected proved to be a challenge even with modifications made after the first year of the pandemic. NMCS struggled in getting responses from LCC program participants via Survey Monkey despite making individualized phone calls and sending multiple emails and requests for completion. Paper surveys proved much more effective for this population, and it became critical to disseminate surveys immediately at the close of an episode of care, rather than wait until the end of the program year as the program did due to the pandemic.

Latino Community Connection program goals for **FY 21/22** include:

- Increase collaboration across agencies that provide *Promotores* programmatic staff to identify opportunities for collaboration and intra-agency support, which might include consultation, trainings, or outreach support, and

- Strengthen closed loop referrals, specifically with BHRS ACCESS team by documenting length of time between referral and access to assessment/treatment. The radio show will launch a Media Studio where community members and organizations can come into the studio to record music, commercials, podcasts, and much more

In **20/21**, Canal Alliance’s contract will be expanded to include a Behavioral Health Navigator. This will allow them to do more warm-handoffs and support clients in navigating complex mental health care systems. The position will be funded through PEI and CSS.

CLIENT STORY

A 46-year-old man from Mexico who was recommended to therapy by his wife (who had previously received therapy with same clinician). This client presented with severe anxiety, panic attacks and depression. He reported that he woke up each morning with a feeling that “someone is squeezing my heart”. He also reported that he had begun to isolate himself from his family, had lost interest in things he previously enjoyed, and was having lapses in memory where he would forget how he arrived at certain locations. In our first session, this client had difficulty identifying what it was that was causing his so much anxiety and depression. As we worked together the client was able to identify the recent stressors he had in his life and how they had accumulated. Through psycho-education around psychosomatic symptoms the client and I worked on identifying the connection between the stressors he felt and physical symptoms, and identifying techniques to manage his psychosomatic symptoms. We explored cultural factors related to work, being a father, husband, and immigrant, and how the expectations society had placed on him are impacting his mental health. We set achievable goals for the client to begin to reconnect with his family. I used the GAD-7 and CES-D to measure the client's symptoms. At session 1, the client scored a 9 on the GAD-7 and 28 on the CES-D. At the 6th session the client's scores dropped to a 1 on the GAD-7 and a 4 on the CES-D. The client now reports that he has regained a sense of motivation and excitement about his life, is reconnecting with his family by taking afternoon walks and day trips together and he has placed healthy boundaries around his work schedule. He has had no panic attacks and no longer wakes up with the pressure on his chest. The client reports he still experiences some anxiety but it is brief/mild and he is able to manage it effectively with the breathing and relaxation techniques he has learned in treatment. This client will be having his last session in two weeks.

CLIENT STORY

Maria (not her real name), an 8th grade newcomer student, was referred to the NMCS LCC Bilingual Clinician from NMCS’ School Works Initiative program staff upon learning that she was experiencing suicidal ideation and engaging in self-harming behaviors. The clinician first conducted a thorough risk assessment using the C-SSRS/SAFE-T then engaged the student and her guardians in developing a detailed Care and Safety Plan. The student did not yet have health coverage due to her status as a newcomer so the clinician worked with the NMCS case management team to support the family in accessing insurance through referral to Marin Community Clinics. After engaging in brief therapy with the student and family through telehealth, the clinician learned that Maria experienced significant trauma in her home country and was experiencing additional trauma related to separating from her mother during the course of her immigration journey. Within the first month of engaging with the clinician, Maria’s mental health symptoms continued to worsen. After experiencing a second mental

health crisis and utilizing the County's crisis services, the clinician made a referral to the BHRS ACCESS team. The NMCS clinician provided comprehensive clinical case management and both she and the Director of Wellness Programs advocated effectively to ensure this student and family became connected to the higher level of care needed. After a fourth psychiatric crisis, the student and family successfully entered into treatment with the BHRS Youth and Family Team. She and her family are now reporting significant improvement in her mood, she denies SI, self-harm and she has just recently begun freshman year at a new school.

OLDER ADULT PREVENTION AND EARLY INTERVENTION (PEI 07)

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #2, #4, #5

PROGRAM OVERVIEW

Older adults continue to represent a growing percentage of the population of Marin and face many risks for mental illness. Jewish Family and Children’s Services (JFCS) provides community education about mental health concerns in older adults and early intervention services for depression and anxiety. The program receives referrals of older adults diagnosed with depression and anxiety, often in connection with their medical issues, loss, or other difficult life transitions. JFCS’s model involves effective engagement with older adults through home visits and well as consistent collaboration with family members and health providers.

PROVIDER: Jewish Family and Children’s Services, Spahr Center and an additional JFCS program starting FY21/22

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 the ACASA peer-counseling program provided by Behavioral Health and Recovery Services (BHRS) as part of the Helping Older Adults Excel (HOPE) program.

PROGRAM DESCRIPTION

Research and data show that 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. At Jewish Family and Children’s Services, the BOOST Program provides Marin County seniors with screening for depression, anxiety, and trauma, as well as services that assist them in managing these mental health challenges. Many of the clients the BOOST Program serves are isolated and have undergone, or are going through, a major life transition (retirement, medical event, loss of spouse, etc.) and can struggle as they try to deal with these stressors and changes in their lives. These major transitions can often precipitate depressive symptoms in older adults or heighten their anxiety, both of which can affect their ability to function, and impair their relationship with others. The Older Adult PEI program aims to **reduce Prolonged Suffering** by providing:

Older Adult

SUMMARY FY2019-20

Clients Served: FY20/21

47 Individuals

21 Families

557 reached through Outreach/Training

- **Brief Intervention:** JFCS’ BOOST provides clinic or home-based early identification and intervention for those experiencing early onset of depression and/or anxiety by reducing symptoms and improving related functioning. For clients completing treatment, including Cognitive Behavioral Therapy 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 reports. Changes in scores are tracked by individual and reported in aggregate. JFCS also works with clients to seek out and engage family members, when appropriate, to strengthen their support network.

- **Training/psychoeducation:** 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.

83% of clients reported feeling that, as a result of services, they were better able to cope when things go wrong

90% reported feeling better able to advocate for their needs and things that are important to them

- **Timely Access to Services:** The JFCS 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.

- **Access and linkage to Treatment:** Individuals at risk or showing signs of developing mental illness are linked to additional risk reduction services, early interventions, and other resources as needed. JFCS’s licensed mental health providers

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.

Client feedback on BOOST program:

“A miracle. Thank you all that made this possible.”

“Being part of the BOOST program has been VERY VERY helpful to my daily life! It is a great program- a must to keep.”

DATA COLLECTION METHODS

The following data is reported to BHRS 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 number and types of individuals trained, types of trainings provided and demographics (see PEI overview section)
- Participant surveys are conducted to show changes in knowledge and skill for those receiving training
- Client/family demographics and satisfaction surveys to show impact of services provided

- Referral data to show improved recovery through access and linkage to services
- Results of validated clinical tools (PHQ9 and GAD7) used to measure changes or reductions in severity of symptoms
- Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.

Anticipated data collection changes and additions: No anticipated changes in **FY 21/22**.

OUTCOMES

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

Outcomes	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Individuals receiving education regarding behavioral health signs and symptoms in older adults	100	300	100	240	100	557
Seniors at Home clients screened for behavioral health concerns *PHQ9, substance use	150	162	150	150	150	156
Low income clients receiving brief intervention services	50	52	50	49	50	109
Low income clients receiving brief intervention services who are from underserved populations	20%	31% N=16	20%	24% N=12	20%	21% N=10
Clients completing a short-term treatment protocol for depression or anxiety	70%	90% N=47	70%	85% N=49	70%	85% N=40
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) *PHQ9, GDS, GAD7	60%	68% N=32	60%	100% N=49	60%	78% N=46
Clients receiving brief intervention reporting satisfaction (strongly	75%	100% N=24	75%	100% N=27	75%	96% N=45

agree or agree) with services (would use again, recommend) *PEI Satisfaction survey							<i>*Data</i>
Total referrals to County Behavioral Health (BHRS)	N/A	4	N/A	2	N/A	4	
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	0	N/A	0	N/A	2	
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Unknown	N/A	17 days	N/A	19 days	
Total referrals to other PEI providers	N/A	2	N/A	5	N/A	2	
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	0	N/A	2	N/A	2	
Average time in weeks between when a referral was given to individual by your program and the individual's first in person appointment with the PEI-funded provider	N/A	N/A	N/A	N/A	N/A	2	
Total referrals to other of mental health services or resources for basic needs	N/A	115	N/A	114	N/A	110	

Collection Method

EQUITY STRATEGIES:

JFCS BOOST Clinicians gather information around services designed for underserved populations, working to link clients with any beneficial services, as well as addressing individual barriers to treatment. During the FY 20/21, BOOST providers worked closely with the Multipurpose Senior Services Program (MSSP) to increase services to very low-income clients, and clients in West Marin through extensive outreach and psychoeducation for MSSP staff and ongoing close collaboration. In addition, BOOST staff took advantage of support services launched at JFCS in response to the COVID-19 pandemic emergency to link clients to additional services, such as: online support groups for isolated seniors; Safe At Home calls to isolated seniors in rural areas to provide socialization and identify if any additional services were needed; and connecting seniors with JFCS volunteers for assistance in using technology that could help

keep them connected (Zoom, etc.). JFCS’ “no wrong door” approach helps to ensure that once providers make contact with a senior, they are proactive in connecting them to any additional assistance they might need. This helps to reduce any feelings of embarrassment that may inhibit a senior for asking for support (such as food assistance) and helps us promote the highest level of functioning and wellbeing in our clients. Community outreach is conducted in partnership with other organizations to help us reach broader and more diverse swaths of the senior community.

CHALLENGES AND UPCOMING CHANGES

In FY 2020-21, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2020-21 through FY2022-23 although services continued to be impacted by COVID-19.

JFCS Older Adult PEI program goals for FY 22/23 include:

- Increase services to low-income (Medi/Medi) seniors throughout Marin County by collaborating with JFCS’ Multipurpose Senior Services Program (MSSP) staff toward serving clients, developing and providing at least one training and/or outreach event for MSSP staff around referral process/ BOOST programing etc.
- Attending MSSP case presentations for mutual clients as appropriate, and
- Develop a formalized partnership and collaboration between BOOST program and Help@ Hand. A BOOST representative will serve on the Help@Hand advisory committee and attend collaborative meetings; BOOST clinicians will collaborate with Help @ Hand staff around clients; BOOST staff will attend pertinent trainings to understand the Help @ Hand program and serve mutual clients as Help@Hand finalizes an implementation plan.

CLIENT STORY

Anne is a 75 year old woman living at home alone in West Marin. She was referred by her worked through the MSSP program, which serves very low-income seniors. Despite health challenges, Anne had always attended various programs in West Marin, and had reported feeling fulfilled; however, when Covid hit, Anne’s social opportunities came to a halt, and she experienced a significant increase in anxiety, reporting numerous panic attacks that resulted in six 911 calls. Anne’s MSSP caseworker and her newly assigned BOOST clinician were able to collaborate toward comprehensive care to ensure Anne’s needs were met. Her clinician provided pragmatic strategies to assist Anne in understanding and managing her symptoms of anxiety and panic (such that she made no calls to 911 once BOOST treatment started). Her clinician noted the extent of her social isolation due to the Shelter In Place mandate and living in a rural area, and linked her with programing to access technology so she could videochat, and with a volunteer through JFCS to make daily phone calls. In addition, her clinician enrolled her in a BOOST support group for isolated seniors, wherein she developed relationships with others and accessed additional support toward addressing her anxiety. In a letter to her clinician she wrote “your programs got me through the very worst of times and made them some of the best of times for me. I cannot thank you enough. I think perhaps you saved my life.”

VIETNAMESE COMMUNITY CONNECTION (PEI 11) (ENDED FY19/20—THE 19/20 UPDATE INCLUDED HERE FOR 3-YEAR PEI EVALUATION REPORT)

PROGRAM ALLOCATION FY19/20: \$56,460

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.

PROVIDER: Marin Asian Advocacy Project

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

The Vietnamese Community Connection program aims to **reduce prolonged suffering** due to unaddressed mental illness by increasing identification of individuals with mental health difficulties and increasing protective factors for those with significantly higher risk for mental illness. Marin Asian Advocacy Project (MAAP) provides:

- **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.

Vietnamese CC

SUMMARY FY2019-20

Clients Served: FY2019-20

60 Individuals

30 Families

23 reached through Outreach/Training

- **Reducing risk and Building Protective Factors:** CHAs 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.
- **Timely Access to Services:** The program improves timely access to services for underserved populations by being provided by a trusted multi-service agency, as well as reaching hard-to-reach communities through CHAs. 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.
- **Access and linkage to Treatment:** 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.

DATA COLLECTION METHODS

The following data is reported to BHRS 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 number and types of individuals trained, types of trainings provided and demographics (see PEI overview section)
- The number and type of Outreach Activities and types of participants reached
- Client/family demographics and satisfaction surveys to show impact of services provided
- Referral data to show improved recovery through access and linkage to services Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.

OUTCOMES:

Outcomes	Goal FY 16/17	Actual FY 16/17	Goal FY 17/18	Actual FY 17/18	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20
Community Health Advocates (CHAs) will receive training in: <ul style="list-style-type: none"> ○ CHA Basics: role, confidentiality, outreach and engagement, making referrals, etc. ○ Mental Health First Aid 	5	4 0	5	4 1	3	3 3	3	3 3
CHAs will receive at least 6 hours each of group or individual supervision	100%	100%	100%	100%	100%	100%	100%	100%
Individuals receiving information about mental health and access to services via tabling and other outreach strategies	75	120	70	67	100	100	100	23
Individuals participating in prevention activities (field trips, community building)	120	260	120	225	120	230	120	40
Individuals participating in individual/family consultations	N/A	N/A	N/A	N/A	50	60	40	30
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	5	N/A	10	N/A	9
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	N/A	N/A	N/A	N/A	2	N/A	3
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	N/A	N/A	N/A	N/A	4	N/A	2
Total referrals to other PEI providers	N/A	N/A	N/A	N/A	N/A	10	N/A	9
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	N/A	N/A	N/A	N/A	2	N/A	3

Average time in weeks between when a referral was given to individual by your program and the individual's first in person appointment with the PEI-funded provider	N/A	N/A	N/A	N/A	N/A	4	N/A	4
Total referrals to other mental health services or resources for basic needs	N/A	N/A	N/A	100	N/A	80	N/A	85

EQUITY AND CULTURAL RESPONSIVENESS:

The Goal of MAAP is to advocate for the rights and assist the Asian American communities in Marin, especially recent immigrants, in accessing healthcare and social services. MAAP also supports these communities in going through the naturalization process, and provides community activities and field trips as part of a preventive mental health program to reduce stress and isolation.

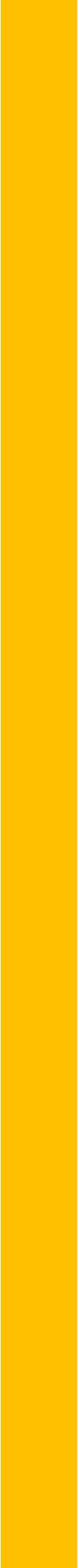
CHALLENGES AND UPCOMING CHANGES

In FY 2019-20, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2017-18 through FY2019-20 for the first part of the year until services were impacted by COVID-19. With COVID, MAAP continued to communicate frequently by phones, texting messages, Facebook and messenger with members of the Vietnamese community. The program also continued to help low income older adult seniors apply for an emergency financial assistance, and to promote everyday preventive actions (Wear masks and Implement physical distancing guidelines) as well as accessing mental health supports throughout their community.

In FY20/21, this program was moved under CSS and no longer be funded under PEI. Funding was awarded based on the results of Requests for Proposals that was released for the Community Health Advocates Program in the fall as part of the CSS Community Outreach and Engagement program. MAAP was awarded the Community Health Advocate contract under CSS starting in FY2020-21.

CLIENT STORY

Mrs. C. lived in Marin County for 30 years with her daughters. She participated in regular activities with the Vietnamese community. During October 2019, we realized that Mrs. C. was often absent from activities like karaoke and dancing exercises organized by us. Through talking to her friends and family of Mrs. C., we learned that she had not recently contacted her friends, even wandering around the neighborhood, and crying alone. We saw unusual signs from Mrs. C., and immediately invited her to the office to find out. When Mrs. C. came to our office that we could not recognize her even though we had just met her a few weeks earlier. She looked incredibly sad and depressed. Moreover, when talking to us, she revealed confused thoughts and reduced ability to concentrate. After a long discussion, we realized that Mrs. C. had many concerning symptoms and needed to be referred for treatment immediately. We contacted the Access right away to help her. Overtime, with the support of a therapist, Mrs. C is doing much better. Months later, she contacted our office and said: "Thank you for being so dedicated to help me. Thank you from the bottom of my heart."



COMMUNITY TRAINING AND SUPPORTS (PEI 12)

SERVICE CATEGORY: STIGMA
REDUCTION

SB 1004 PRIORITY CATEGORIZATION: #2,
#4, #6

**MARIN PEI PRIORITY STRATEGY
AREA(S):** Capacity Building, Suicide
Prevention

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 suicide prevention; 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.

Individuals Served: FY2020-21
2400+ reached through
Outreach/Training

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

This program has two main components:

- Stigma and Discrimination Reduction Efforts, and
- 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, five to seven trainings have been offered per year. Trainings include standard, youth, Spanish and Vietnamese. 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 throughout the year. 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 is trained in identifying signs/symptoms and responding appropriately, 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.

DATA COLLECTION METHODS

The following data is reported to BHRS 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.

MHFA conducts pre and post surveys to assess change in knowledge and behavior.

In **FY 18-19** BHRS implemented a 3-month post survey to assess retention of knowledge and skills over-time. Data for the **FY 20/21** is reported in the Outcomes section below.

OUTCOMES

BHRS hosted four Mental Health First Aid Trainings during FY 20/21.

Mental Health First Aid Outcomes	FY 18/19	FY 19/20	FY 20/21
Number of Marin County community members that participated in MHFA.	146	146	46
Participants reporting increased knowledge about mental illness signs/symptoms. (0-5 scale) “As a result of this training, [Participants] feel more confident [they] can recognize the signs that someone may be dealing with a mental health problem or crisis.” (0-5 scale)	4.26	4.27	4.56

Mental Health First Aid Outcomes	FY 18/19	FY 19/20	FY 20/21
Participants recognize and correct misconceptions about mental health and mental illness as [they] encounter them (0-5 scale)	3.9	4.48	4.5
Participants are aware of [their] feelings and views about mental health problems and disorders. (0-5 scale)	4.21	4.31	4.4
Participants reporting ability to assist somebody experiencing a mental health problem or crisis to connect with community, peer or personal support. (0-5 scale)	4.26	4.22	4.3
Participants reporting feeling able to offer a distressed person basic “first aid” information and reassurance about mental health. (0-5 scale)	4.3	4.27	4.32
Participants reporting ability to assist somebody experiencing a mental health problem or crisis to seek appropriate professional help. (0-5 scale)	4.25	4.25	4.36

Mental Health First Aid Outcomes: 3 Month Follow-up	FY 18/19	FY 19/20	FY 20/21
Participants recognize and correct misconceptions about mental health and mental illness as [they] encounter them. (0-5 scale)	4.14 N=7	3.76 N=13	4.2 N=4
Participants reporting feeling more confident that they can reach out to someone who may be dealing with a mental health problem or crisis. (0-5 scale)	4.42 N=7	3.84 N=13	4.3 N=4
Participants reporting ability to assist somebody experiencing a mental health problem or crisis to connect with community, peer or personal supports. (0-5 scale)	4.14 N=7	3.92 N=13	4.2 N=4
Participants reporting ability to assist somebody experiencing a mental health problem or crisis to seek appropriate professional help. (0-5 scale)	4.42 N=7	3.92 N=13	4.4

			N=4
Settings where participants might use MHFA	Number Served 18/19	Number Served 19/20	Number Served 20/21
Community Members	24	20	11
Family Member of Person with Serious Mental Illness	0	5	5
Providers			
County Behavioral Health and Recovery Services	5	7	6
Community-based Mental Health and/or Substance Use Provider	11	27	15
Education (including High School Students)	21	25	1
Law Enforcement	3	5	0
Primary Health Care	23	6	1
Senior Centers/Services	28	13	1
Social Services (County and Community)	0	15	2
Veterans	15	1	0
Faith-based	10	3	1
Shelters/Homeless Services/Public Housing	0	3	1
Libraries	0	4	0
Public Transit	0	0	0
Employment	0	9	0
Other – List: DV, BOS, Parks Svcs, PH	6	3	1
Security, Emergency Svcs	0	0	0
Unknown	0	0	1

OTHER OUTREACH AND TRAINING ACTIVIES IN FY2020-21

Participation in community outreach and education events including “Day of the Dead” in the Latino community.



Photos by Multicultural Center of Marin. October/November 2020

MARIN COUNTY SUICIDE PREVENTION COLLABORATIVE

The Marin County Suicide Prevention Collaborative launched in August 2020. The focus of the

County of Marin FY22/23 Mental Health Services Act (MHSA) Annual Update

Collaborative is to build connection and community, create awareness and education, and implement the seven-strategy strategic plan, including: “Providing evidence-based training and education to Marin County residents (Strategy 4)” and “Provide outreach and engagement and support to all residents with targeted efforts to groups disproportionately affected by suicide (Strategy 5).”

The Training and Education Action Team is one of eight Community Actions Teams within the Collaborative providing recommendations and support in implementing the Strategic Plan with a focus on Strategies 4 and 5.

TRAINING AND EDUCATION ACCOMPLISHMENTS

During a 10-month period, the Collaborative hosted over 70 community events with BHRS and community-based partners, including three Spanish language only trainings, trainings for older adults, and a series of events held during September Suicide Prevention and Recovery Month 2020 and May Mental Health Month 2021. Over 2300 community members received a training or presentation addressing a cross section of suicide prevention and behavioral health education. Our training and education accomplishments include but are not limited to:

- Offered presentations or events on mental health, lived experience, suicidality, and the connection between suicide and substance use evidence-based trainings to support mental health providers, including two safety planning trainings for clients and a free training about lethal means counseling on the BHRS Prevention and Outreach [website](#).
- Hosted September Suicide Prevention and Recovery Months ([2020](#), [2021](#)) and May Mental Health events, trainings, presentations, and Resolutions to raise awareness, including a Youth Art and Film Showcase ([2020](#), [2021](#)).
- Established a Schools Team and a Training and Education Team to review recommendations for suicide prevention trainings to be implemented and supported at various levels in our community.
- Launched the BHRS Prevention and Outreach website, providing a centralized and coordinated information hub for suicide prevention and other behavioral health resources and services for our community, including a [Training and Education](#) section promoting Gatekeeper Trainings, Community Trainings, and Trainings for Mental Health Providers and Health Professionals.
- Established contract with [Crisis Text Line \(CTL\)](#) with co-branding for Marin (text MARIN to 741741). Conducted a CTL social media toolkit training led by students for county-wide dissemination. This new Text Line has been promoted throughout trainings and events.
- Provided recommendations for training, including: American Foundation for Suicide Prevention Talk Saves Lives, Buckelew Programs, Question-Persuade-Refer (QPR) and Mental Health First Aid (MHFA). Supported free QPR for 200 seats for the community.

Question. Persuade. Refer. QPR

Three steps anyone can learn to help prevent suicide.

Help Play a Role in Suicide Prevention!

Sign up for this 1-hour FREE online, self-directed Suicide Prevention and Awareness Training.

Limited to 200 users.

KEY COMPONENTS COVERED IN TRAINING:

- How to Question, Persuade and Refer someone who may be in distress
- How to get help for yourself or learn more about preventing suicide
- The common causes of suicidal behavior
- The warning signs of suicide
- How to get help for someone in distress

FOLLOW THESE INSTRUCTIONS:

1. Navigate to: qprtraining.com/setup
2. Enter the organization code MCDHHS
3. Select **Create Account**
4. Complete and submit **student registration form**
5. QPR will display and email the newly created **Username and Password.**
6. Login to begin using the provided username and password at qprtraining.com

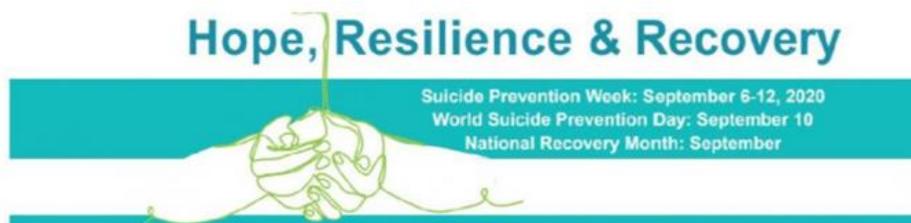
MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

Questions?
BHRSPreventionandOutreach@marincounty.org

MARIN COUNTY OFFICE OF EDUCATION | BEHAVIORAL HEALTH AND RECOVERY SERVICES | SAFE MARIN

- Hosted the Buckelew Programs SOS Allies in Hope monthly support group for suicide loss survivors in partnership with BHRSP. This support group is promoted at all our trainings and events.
- Hosted 11 Collaborative monthly meetings addressing a variety of topics, including: SP 101 theory and communication strategy presented by Stan Collins, postvention LOSS Teams, data, and more.
- Hosted a Lean on Me: How to Ask for Help meeting. This supportive and piloted discussion focused on the basics of giving yourself permission to ask for help.
- Partnered with Marin County Office of Education to provide “Parent Conversation: Suicide Prevention.” This event engaged parents on youth suicide and how to keep a youth safe.
- Presented at the Board of Supervisors Meeting (September 2022) to adopt a resolution proclaiming September as “National Suicide Prevention and Recovery Month”
- Offered a training, “Breaking the Silence: How to Recognize and Discuss the Signs of Suicide in your Teenager.” This community event addressed ways to keep youth safe and resources for connection and recovery.
- Supported NAMI’s “Opening Up: Where Healing Begins and Stigma Fades” event focusing on two friends who both lost their mothers to suicide in the late 1950’s.
- Provided Hablemos sobre la Prevencion del Suicidio. This Spanish language only workshop provided basis foundation and introduction to suicide prevention.
- Fostered discussion around behavioral health issues addressing, “Suicide and Substance Use Prevention: What Role Can you Play?”
- Hosted and pilot tested a Train the Trainer event with the American Foundation for Suicide Prevention to build community capacity in suicide prevention presenters.
- Expanded Community Health Advocates and *Promotores* model to support suicide prevention efforts among mental health ambassadors in communities of color and vulnerable populations that experience barriers to equitable and culturally appropriate health and wellness services.

- Supported community-based organization in hosting speaker series for residents from diverse communities with lived experiences around suicide to share their experiences in safe community spaces.
- Supported the development of the Toolkit Teach Pride, Reach Wide. This Toolkit was designed by Spahr Center staff and student leaders to help educators and staff build the skills to become stronger allies and advocates in classrooms for LGBTQ+ students.
- Established a Suicide Risk Assessment Team to create a uniformed district wide risk assessment tool based on the Mental Health Provider Trainings addressing student suicide risk for school-based providers. Content from this training will be customized for an online training platform to be utilized by district providers.
- Conducted more than 15 presentations for parents and community members hosted by American Foundation for Suicide Prevention reaching over 160 individuals.
- Update student ID card with new 3-digit 988 number for Fall 2022
- Hosted two panel discussions with Rx Safe Marin and Marin Healthy Youth Partnerships, a nonprofit organization working to reduce underage substance use, on the connection between suicidality and substance use including, “Collaborating Across Behavioral Health Fields: Substance Use Awareness for Suicide Prevention” at the Suicide Prevention Collaborative meeting in April 2021. Provide the free and virtual Zero Suicide’s Counseling for the Assessment of Lethal Means (CALM) featured on the BHRS website
- Promoted the September Suicide Prevention and Recovery Months (2020, 2021) events County wide through social media, print and digital banners and advertisements, and bus kiosks in English and Spanish and described in following sections in this report, including:



Hope, Resilience & Recovery

Suicide Prevention Week: September 6-12, 2020
World Suicide Prevention Day: September 10
National Recovery Month: September

Behavioral Health and Recovery Services: Community Webinar Events
Questions? Contact: kconnors@marincounty.org or visit the [BHRS Website](#) for future events

<p>September 3 at 12:00 pm Held monthly, first Thursday at 12:00 pm. Lean on Me: How to Ask for Help. Facilitators: Maria Rea, LMFT and Kara Connors, MPH, BHRS</p> <p>September 8 at 12:00 pm Held monthly, first Tuesday at 12:00 pm MCOE Parent Conversation: Suicide Prevention. Facilitators: Junita Zuniga, PsyD and Kara Connors, MPH, BHRS</p> <p>September 9 at 2:00 pm Held monthly, first Wednesday beginning October 7 at 2:00 pm Marin County Suicide Prevention Collaborative Meeting.</p> <p>September 9 at 7:00 pm Held monthly, second Wednesday at 7:00 pm SOS Allies for Hope. Survivors of Suicide Bereavement Support Group. Contact 415-492-0614 to get a Zoom link or SOSinfo@Buckelew.org</p> <p>September 15 at 9:00 am Board of Supervisor’s meeting. Suicide Prevention and Recovery Resolutions presented.</p>	<p>September 15 at 7:00 pm Breaking the Silence: How to Recognize and Discuss the Signs of Suicide in your Teenager. Presenters: Tim Lea, Buckelew Programs, Jessica Colvin, MSW, MPH, Tam Wellness, and Kara Connors, MPH, BHRS</p> <p>September 22 at 12:00 pm Noon Opening Up: Where Healing Begins and Stigma Fades. A Lunch and Learn Conversation with David Pincus and Richard Knapp, Authors of <i>Sons of Suicide</i> with Kelli Finley, NAMI, REAL at Rodef Sholom and Kara Connors, MPH, BHRS. Hosted by: NAMI-Marin</p> <p>September 29 at 6:30 pm Hablemos sobre la Prevención del Suicidio. Presentación en español. Presentadoras: Berta Campos-Anicetti, North Marin Community Services and Maria Rea, LMFT, BHRS</p> <p>September 30 at 1:00 pm Suicide and Substance Use Prevention: What Role Can You Play? Presenters: Jeff Devido, MD, MTS, FASAM, Marin HHS, Kara Connors, MPH, BHRS, and Linda Henn, Marin Healthy Youth Partnership</p>
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The image shows two side-by-side flyer images for suicide prevention events. The left flyer is titled "Supportive Transitions" and "September Suicide Prevention and Recovery Month Events. Join Us!". It lists various events with dates, times, and registration links. The right flyer is titled "Mes de Prevención del Suicidio 2021" and "Septiembre Mes de Prevención y Recuperación del Suicidio Eventos. ¡Únete a nosotros!". It lists various events with dates, times, and registration links. Both flyers include logos for Marin Outreach & Prevention Team and other organizations.

In support of Mental Health Awareness Month, May, 2021, Marin County Behavioral Health and Recovery Services promoted themes of connection, equity, hope and recovery by hosting over fifteen different events. These included:

- A Board of Supervisors Proclamation. The Marin County Board of Supervisors [proclaimed\[PDF\]](#) the month of May as Mental Health Awareness Month
- The Mental Health Youth Summit. During these two interactive and youth-led sessions, participants will learn about demystifying mental health, suicide prevention, and how to support themselves and their peers with mental health struggles. Guest speaker: Kelechi Ubozo, author, poet, mental health activist.
- Suicide Prevention Awareness for Parents and Teens. Hosted by PEI program, Jewish Children and Family Services. Speaker Tim Lea, Outreach and Education Coordinator for Suicide Prevention, Buckelew Programs will discuss with parents what to do if your child, or their friend, is in distress. Teens welcome.
- "The Practice of Self Compassion." Speaker: Oren Jay Sofer. Participants learned about self-compassion practices, motivate oneself from a place of kindness rather than criticism, combat caregiver fatigue, and cultivate self-appreciation and resilience.

- "Breaking the Silence: A Conversation with Men and Boys About Mental Health." Leaders across the life span from Marin share ways they cope with distress and thoughts they have for engaging men and boys in our community for improved well-being.
- What Helps Me Youth Art Campaign. Youth in Marin were invited to tell their story of emotions and mental health through art.
- Safety Planning for Those in Distress: Implications for LGBTQ+ Youth and Adults. Learn how safety planning can reduce distress and foster resilience.
- Youth Mental Health First Aid Training. This training allowed adults who work with youth the skills needed to reach out and provide initial support to youth (ages 6-18) who may be developing a mental health or substance use problem and help connect them to care.
- Building a Safe Community for Older Adults in Marin: A Suicide Prevention Training. Participants learned how to care, respond and connect with an older adult who may be in distress.
- AFSP Talk Saves Lives suicide prevention foundation training supported the facts about suicide ("Talk Saves Lives").
- Trauma through Decolonizing Mental Health discussed the ways in which trauma impacts people of color through the lens of decolonizing mental health to liberate and empower the communities we serve and ourselves in the process.



In FY 2021-22, there will be a focus on:

- May Mental Health Month 2022 will include addressing men and boys' mental health along with a campaign, youth, Mental Health First Aid, and events by community partners, including NAMI, Buckelew, Opening the World and others. Each Mind Matters materials will be distributed among identified school districts.

- Expansion of training efforts addressing specific populations including Black, Indigenous and People of Color (BIPOC), LGBTQ+ youth and adults, and middle age/older men.
- Training volunteers for the LOSS Team to support bereaved individuals.
- Conducting trainings for school and County based mental health providers utilizing the Suicide Risk Assessment Online Training program.
- Planning for May Mental Health and Suicide Prevention month events in September 2022 in collaboration with BHRS community-based organization partners and Each Mind Matters.
- Contracting with a community-based organization to host training for primary care providers working with older adults to identify mental health and suicide risk.
- Expanding Spanish only language suicide prevention trainings in partnership with community-based partners throughout Marin.
- Hosting 2-4 safety planning trainings for families and mental health providers.
- Hosting meetings for loss survivors to engage their ideas and solutions for building suicide prevention awareness activities and outreach.
- Hosting a LOSS Team training for volunteers supporting bereaved families following a suicide.
- Serving on a multi-county suicide prevention summit planning team for upcoming regional event.
- Implementing the county-wide Newcomer’s Wellness Toolkit for school partnerships.
- Implementing MHSA Innovations Student Wellness Ambassadors Program (SWAP), a County-Wide Equity-Focused program focusing on enhancing peer wellness supports for Marin students grades 6-12 through a centralized coordination, training and evaluation structure.
- Increasing community awareness of gun safety through a series of community conversations with expert panelists on specific actions community members can take to keep guns stored.
- Continuing to promote the Counseling for Assessment of Lethal Means (CALM) training for use by providers

SPEAKERS BUREAU TRAININGS WITH THE NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) MARIN:

In September thru May, NAMI hosted an online Speakers Bureau to raise awareness of mental health, suicide and substance use. NAMI events during the **FY 20/21** included:

- Opening Up: Where Healing Begins and Stigma Fades. This NAMI hosted event in September 2020 focused on two friends who both lost their mothers to suicide in the late 1950’s.
- NAMI Marin Story Telling Series. This Five-Part Series featured people with lived experience with mental health challenges.
- NAMI Virtual Walk was hosted in October 2020.

MENTAL HEALTH FIRST AID

In **FY2020-21**, four (4) MHFA trainings were offered, including 2 adult (virtual), 1 youth and 1 in Spanish (in person). Five (5) in person trainings were cancel due to the shelter in place order. Trainings continue to be very well received by the community. Schools and Community Based Organizations have expressed increasing interest in having their staff trained.

Continued funding was determined by the MHSA Three Year planning process for **FY2020-21** through **FY2022-23**. In the upcoming Fiscal Year, there will be focused suicide prevention trainings for the community and high-risk groups as well as a continuation of MHFA and other evidenced based community trainings and capacity building activities.

Below is a list of MHFA trainings that will be offered during FY 2021-22.

- [November 9, 2021, 8:30am - 5pm - Adult - In Person](#)
- [January 22, 2022, 8:30am - 5pm - Youth - In Person -For Spanish Speakers](#)
- [February 24, 2022, 8:30am - 5pm - Adult - In Person](#)
- [March 24, 2022, 9am - 3:30pm - Adult - Virtual](#)
- [April 16, 2022, 8:30am - 5pm - Adult - In Person](#)
- [May 19, 2022, 8:30am - 5pm - Adult - In Person -For Spanish Speakers](#)
- [June 14, 2022, 8:30am - 5pm - Youth - In Person](#)

In FY2022-23, additional suicide prevention events will be held. The challenge and opportunity is to continue to expand our audience to ensure we are reaching as many people in our community as possible. We rely on our BHRS network of over 2,000 people to help with outreach and in the upcoming year will be attending a CBO networking program that allows for coordinated and aligned networking and resource sharing. In addition, we have been able to provide suicide prevention in Spanish language, but a key challenge is to determine creative ways to engaging populations where there are cultural taboos associated with suicide. By participating in the state-wide learning Collaborative, there are learning exchanges and lessons learned that we can apply in our communities to breakthrough stigma and resistance to discussing suicide openly through training and education. Building our collective competency is a continued focus in our training efforts.

In addition, in FY22/23 we expect the launch of the West Marin training/event series around Mental Health.

SCHOOL-AGED PEI (PEI 18)

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #1, #2, #3, #4, #6

MARIN PEI PRIORITY STRATEGY AREA: School-Aged Prevention and Early Intervention

PROGRAM OVERVIEW:

During the FY 20/21-22/23 MHSA planning process, stakeholders emphasized the need for expanded school-based mental health supports for students and families to address student depression, anxiety, and lack of school connectedness. They identified the need for additional mental health counseling, streamlined coordination systems and school climate/prevention efforts.

The expansion of school-based PEI services in this 3-year plan is intended to address some of the gaps identified by stakeholders. School-based mental health programs help to build resiliency, increase protective factors and create meaningful connections between students, staff, and caregivers. By providing linkages to appropriate supports, consultation and training, counseling, coordination of services, and supporting the implementation of school climate initiatives, school-based PEI programs play an instrumental role in promoting the healthy social-emotional development and academic success of students. Services to Spanish speaking students and families were added to Shoreline Unified (through Petaluma Health Center) and Novato Unified (through a contract with North Marin Community Services).

School-aged Programs

SUMMARY FY2020-21

Individuals Served: FY2020-21

139 Individuals

53 Families

186 reached through Outreach/Training

PROVIDERS:

- West Marin (Shoreline Unified):
Petaluma Health Center (Formerly Coastal Health Alliance)

- Novato (Novato Unified): North Marin Community Services

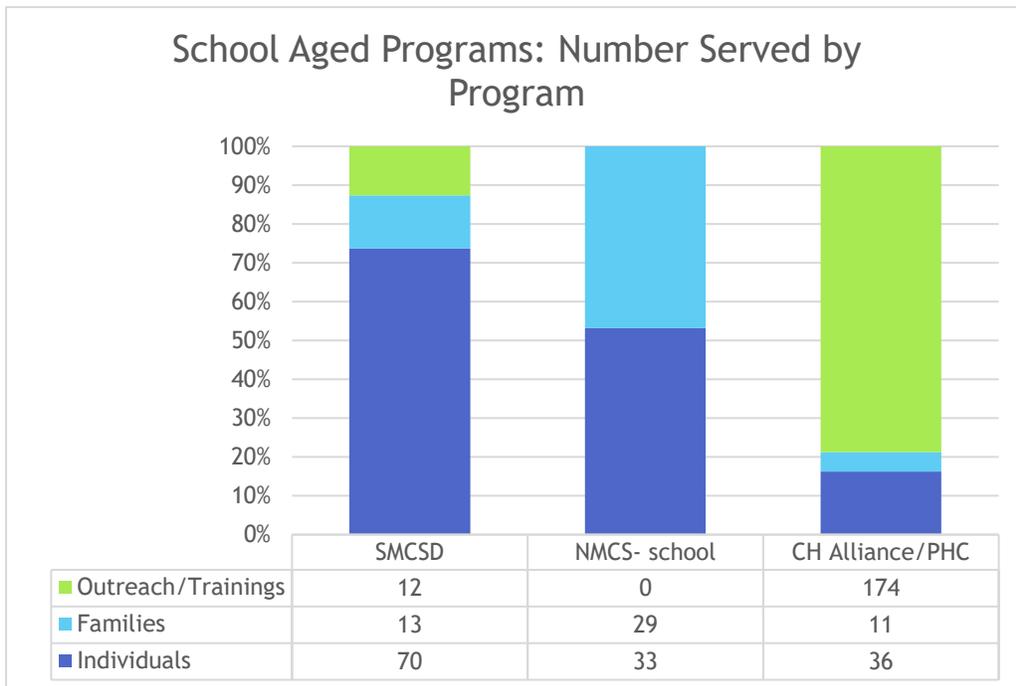
- Marin City (Sausalito Marin City School District): Sausalito Marin City School District, Seneca Family of Agencies

- County-wide: Spahr Center

TARGET POPULATION:

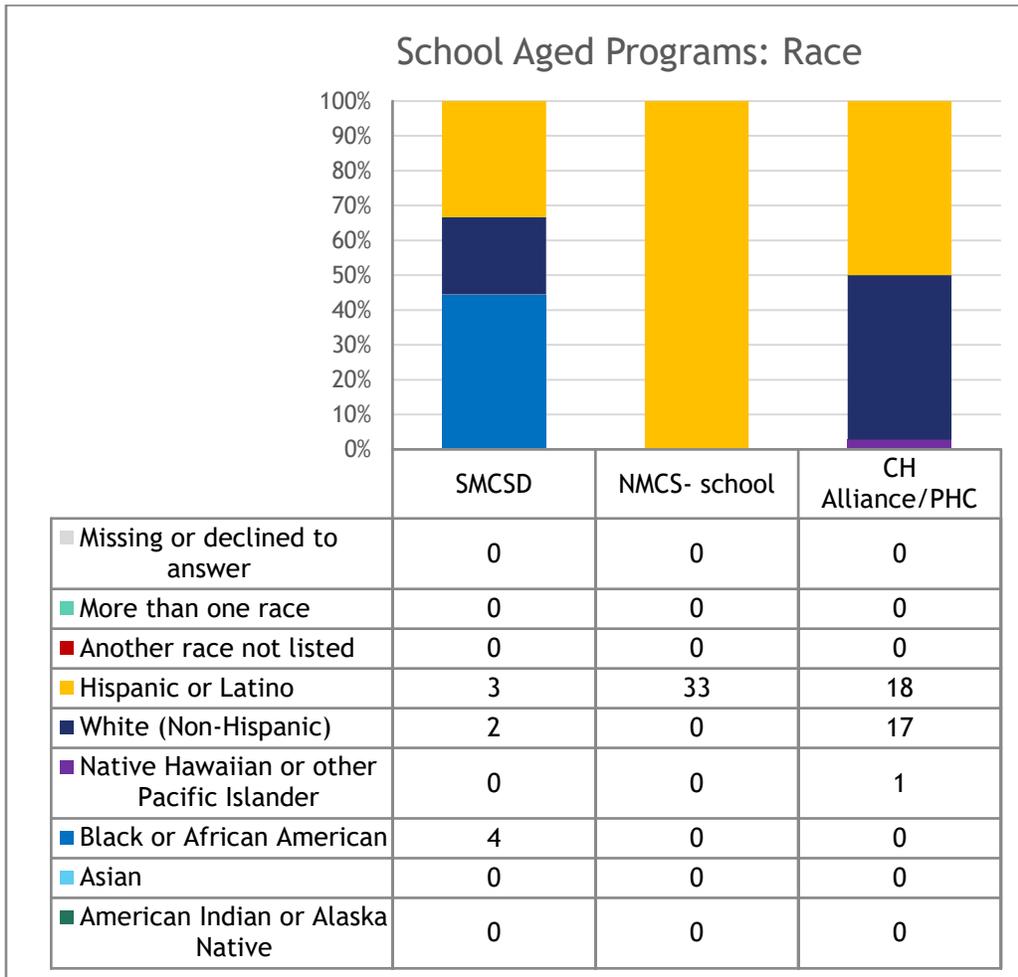
The target population for school-aged programming is kindergarten through twelfth grade students (ages 5-18) who may be experiencing emotional disturbance or are at significantly higher risk due to adverse childhood experiences, severe trauma, poverty, family conflict or domestic violence, racism and social inequality or other factors. Classrooms and students may be referred for services through school staff, Coordination of Services Teams (COST), Success/Study Teams (SST), or Student Attendance Review Teams (SART) and Boards (SARB). Students are then be assessed to determine whether they are appropriate for PEI services or are linked to other services. In FY 20/21, the program targeted three areas of Marin County.

Target Schools	Latino	American Indian	Asian	African American	Multiple Races	English Learners	Free and Reduced Meals
West Marin Schools	62.2%	0.6%	1.0%	0.0%	2.2%	37%	59.2%
Sausalito/Marin City Schools	32.4%	0.9%	1.9%	50.9%	6.5%	14.2%	47.3%
Novato	14.8%	0.7%	4.4%	0.4%	5.9%	15.9%	35.7%



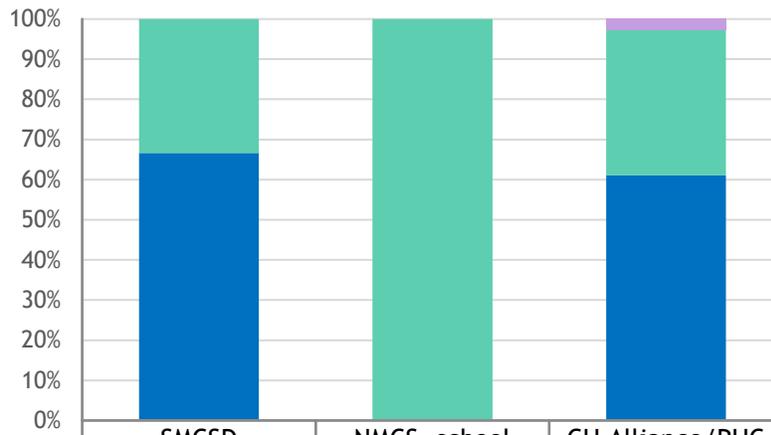
*In FY 20/21, PEI school-based providers provided individual and group counseling to **139** youth and family counseling and support to **53** caregivers. Seneca continued to support Sausalito Marin City School*

District to strengthen their Coordination of Services Team (COST) process at Bayside MLK (Marin City).



Latinx youth represented **69%** of individuals served, Whites represented **24%**, African Americans represented **1%**, other races or those that identified as “more than one race” represented **6%**.

School Aged Programs: Primary Language



	SMCS	NMCS- school	CH Alliance/PHC
Decline to answer/unknown	0	0	0
Other non-English languages	0	0	1
Filipino Dialect	0	0	0
Chinese Dialect	0	0	0
Korean	0	0	0
Vietnamese	0	0	0
Farsi	0	0	0
Arabic	0	0	0
Mam	0	0	0
Spanish	3	33	13
English	6	0	22

Spanish speaking clients represented 63% of individuals served through school-aged programs

PROGRAM DESCRIPTION OF SERVICES PROVIDED IN FY 20/21:

The program aims to **reduce prolonged suffering** for those at significantly higher risk of mental illness by increasing protective factors and reducing risk factors. School-based mental health programs help to build resiliency, increase protective factors and help to create meaningful connections between students, staff and caregivers. Providers support the implementation of **Multi-Tiered Systems of Supports (MTSS)** and provide a range of services and supports including:

- **Individual and group mental health counseling** to increase the students' protective factors, reduce the risk of developing signs of emotional disturbance and increase the likelihood of success in school
- **Training/Capacity Building** for parents, school staff and community providers to identify and respond to signs of mental illness and support student wellness

- **Coordination of Services** through multidisciplinary teams (COST) to improve coordination, communication and collaboration across disciplines, and identify and address student needs holistically
- **Supporting the implementation of school climate activities** such as Positive Behavior Intervention and Supports (PBIS), Social Emotional Learning (SEL) and Restorative Practices to help promote a school culture that is engaging and responsive to the needs of all students and their families
- **Building partnerships** to support the positive and healthy youth development which engages youth as active leaders and resources in their communities
- **Conducting Assessments:** Assessments using validated tools (such as CANS) are 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 are analyzed to measure amount of change over time. Results for all individuals are aggregated and reported. This data, as well as student 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
- **Timely Access to Services:** This program improves timely access to services for underserved populations by being in schools with high rates of underserved students/families, ensuring service providers are culturally and linguistically competent, and being offered at no-cost. Services are non-stigmatizing in that they are initiated through the school and identified as assisting with school success, rather than specifically mental health related, and
- **Access and Linkage to Treatment:** Individuals/families at risk or showing signs of developing serious emotional disturbance or mental illness are 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 are referred to those resources. Individuals experiencing symptoms of serious mental illness or emotional disturbance are 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.

Each school district has a different service provider or multiple service providers with a program designed based on community needs and existing gaps. Program descriptions by school district are provided in the Outcomes Section of this report.

DATA COLLECTION METHODS

The following data is reported to BHRS 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 number and types of individuals trained, types of trainings provided and demographics
- Participant surveys to show changes in knowledge and skill for those receiving training
- Client/family demographics and satisfaction surveys to show impact of services provided
 - Referral data to show improved recovery through access and linkage to services

- Results of validated clinical tools, if applicable, used to measure changes in child behaviors and staff and parent questionnaires to measure changes in skills and knowledge
- Staff training surveys
- COST rubric to measure impact of coordination team and assess progress in identified areas of improvement
- Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable, and
- School discipline and attendance records

Anticipated data collection changes and additions: Given significant challenges in implementing CANS this FY, providers will receive additional training and/or explore alternative tools that could be implemented in the school-based setting more efficiently. NMCS was unable to obtain disability status of family members due to administration of demographic survey via telehealth during the pandemic. This will be addressed with a revision of their Apricot electronic health records system, to allow for improved communication with participants in the future. NMCS has hired a data analyst to help improve data collection and analysis, which has proven particularly challenging as our efforts had to focus on shifting to a fully virtual and/or hybrid virtual/in-person service administration due to the Covid-19 pandemic.

OUTCOMES

Petaluma Health Center:

Petaluma Health Center provides an array of services, including stigma reduction which 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. Individual services are provided for students and families at school and through home visits.

Petaluma Health Center	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
School staff participating in trainings reporting awareness of risks, signs, and symptoms of children experiencing emotional disturbances and/or risk of abuse *(Post-survey)	80%	100% N=45	80%	95% N=30	75%	75% N=35

Students participating in Social Emotional Learning curriculum	185	185	185	185	185	185
Students with mild to moderate mental health concerns receiving at least 3 sessions of individual or group counseling	25	57	25	55	25	28
Students (or parents of) receiving at least 3 sessions reporting improvement on the SDQ or PEI survey (emotional problems, conduct problems, hyperactivity problems, peer problems and/or socialization)* (PEI Survey)	65%	72% N=39	65%	Satisfaction surveys not collected due to clinician going on maternity leave	65%	66% N=18
Students completing at least 3 sessions showing improved attendance or improved school performance* (PEI Survey)	65%	73% N=15	65%	Satisfaction surveys not collected due to clinician going on maternity leave	65%	66% N=18
Parents completing at least 3 sessions family counseling	N/A	N/A	10	12	10	2
Parents whose child received 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 * (PEI Survey)	65%	83% N=35	65%	Satisfaction surveys not collected due to clinician going on maternity leave	65%	73% N=7
Caregivers receiving 3 or more counseling services reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)* (PEI Caregiver Survey)	N/A	100% N=44	65%	Satisfaction surveys not collected due to clinician going on maternity leave	75%	83% N=8
Total referrals to County Behavioral Health (BHRS)	N/A	4	N/A	1	N/A	2

Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	5	N/A	1	N/A	1
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	2	N/A	2	N/A	1
Total referrals to other PEI providers	N/A	4	N/A	0	N/A	0
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	0	N/A	0	N/A	N/A
Average time in weeks between when a referral was given to individual by program and the individual's first in person appointment with the PEI funded provider	N/A	N/A	N/A	N/A	N/A	N/A
Total referrals to other mental health services or resources for basic needs	N/A	5	N/A	3	N/A	2

**Data Collection Method*

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

Seneca Family of Agencies:

Seneca’s Unconditional Education (UE) model empowers the entire school community with the skills and resources required to implement a multi-tiered system of academic, behavioral, and social emotional supports. A primary focus of the UE model is to increase the achievement of struggling students, including students with disabilities, within inclusive education settings. Unconditional Education is a modular approach that allows schools to identify key areas of internal capacity while leveraging the expertise of Seneca to help address identified gaps and create a truly comprehensive system of supports for all students, family, and staff. The UE coach facilitates the multidisciplinary Coordination of Services Team (COST) and provides data monitoring to track student progress. Seneca PEI program provides capacity building and support to Bayside MLK in Sausalito Marin City School District to strengthen their Coordination of Services Team process and train staff of trauma informed practices.

Seneca Family of Agencies	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Provide trainings for school staff on topics TBD related to social-emotional wellness of students	3-4	3	4	4	3	1
90% of participants will report that these workshops helped them to better support the learning and health and wellness needs of students and caregivers	90%	93%	90%	94%	90%	90%
100% of school staff, administrators and onsite providers will be trained on COST referral process	100%	100% N=123	100%	100% N=81	100%	100% N=27
90% of staff will report that they agree or strongly agree that when they have a student who needs extra support, they know the process for seeking that support	90%	93% N=114	90%	67% N=81	90%	82% N=17
COST Team will demonstrate improvement in at least 3 areas of the COST rubric (rubric ratings determined collectively by COST team)	3	1	3	5	3	3
Total referrals to County Behavioral Health (BHRS)	N/A	27	N/A	10	N/A	N/A
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	9	N/A	2	N/A	N/A
Average duration in weeks of signs of	N/A	2	N/A	1		

untreated mental illness (per client or caregiver report)					N/A	N/A
Total referrals to other PEI providers	N/A	18	N/A	14	N/A	N/A
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	18	N/A	13	N/A	N/A
Average time in weeks between when a referral was given to individual by program and the individual's first in person appointment with the PEI funded provider	N/A	1	N/A	1	N/A	N/A
Total referrals to other mental health services or resources for basic needs	N/A	2	N/A	21	N/A	N/A

Survey of school staff after being trained on coordination processes by Seneca PEI providers:

■ Strongly agree
 ■ Agree
 ■ Slightly agree
 ■ Disagree

	STRONGLY AGREE	AGREE	SLIGHTLY AGREE	DISAGREE	TOTAL	WEIGHTED AVERAGE
If I have a student who needs additional support, I know the process for seeking that support.	47.06% 8	35.29% 6	17.65% 3	0.00% 0	17	3.29
When I seek additional support, I get a response from those responsible for coordinating service.	47.06% 8	41.18% 7	5.88% 1	5.88% 1	17	3.29
My school offers the training and resources I need to effectively provide differentiated instruction in my classroom.	17.65% 3	35.29% 6	23.53% 4	23.53% 4	17	2.47
Teachers, administrators, and student support providers strive to establish shared values and vision	17.65% 3	58.82% 10	11.76% 2	11.76% 2	17	2.82
Teachers, administrators, and student support providers are creative and think outside the box for solutions.	31.25% 5	31.25% 5	18.75% 3	18.75% 3	16	2.75
Teachers, administrators, and student support providers demonstrate perseverance in the face of adversity in their efforts to meet students' needs	17.65% 3	41.18% 7	29.41% 5	11.76% 2	17	2.65

Spahr Center:

The Spahr Center School-based PEI program facilitates middle school and high school youth leadership programs to support students in addressing LGBTQ+ inequities in their schools. Students gain leadership experience and professional skills. Both groups collaborate with schools to provide professional development to staff and address infrastructural issues to ensure LGBTQ+ student needs are more fully met.

Spahr Center	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Youth will participate in advocacy projects	N/A	N/A	N/A	N/A	10 youth	11
Spahr will provide at leadership development training for 10 youth	N/A	N/A	N/A	N/A	5 hours	5 hours
Spahr will hold youth meeting time	N/A	N/A	N/A	N/A	60 hours	60 hours
Youth engaged in program will report that they have learned new skills, feel empowered to take action to improve LGBTQ+ equity in	N/A	N/A	N/A	N/A	85% of youth	100%

Marin, and feel their voices are heard in work to strengthen school culture.						
Provide capacity building to schools	N/A	N/A	N/A	N/A	5 Schools	5 schools
Meet with school liaisons and conduct initial survey to determine issue areas and places for improvement	N/A	N/A	N/A	N/A	5 school liaisons	5 liaisons
75% of staff participating in program will report that they: Understand LGBTQ+ identities, feel equipped to support LGBTQ+ students, and know the resources on and off campus available to support LGBTQ+ students	N/A	N/A	N/A	N/A	75% of staff	Trainings were not provided this year due to Covid

**North
Marin**

Community Services (New School-based Program in FY 20/21):

NMCS school-based PEI program provides comprehensive clinical supports to Spanish speaking Latinx students and families at Novato High School. A part-time masters-level bilingual clinician works closely with NMCS' Latinx Youth Wellness Coordinator, as well as NUSD's Newcomer Counselor, school administrators, counselors and other school staff to engage Spanish speaking students in mental health services and connects them and their families to appropriate school and community-based resources, including NMCS' Case Management services and the Novato Teen Clinic.

North Marin Community Services	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Students will receive school based mental health services (screening, assessments, brief interventions and referrals to treatment and/or case management)	N/A	N/A	N/A	N/A	35 students	33
Students will participate in group therapy	N/A	N/A	N/A	N/A	8-12 students	8
Student will complete at least 3 sessions will demonstrate improvement in school performance and	N/A	N/A	N/A	N/A	65% of students	67% N=22

another identified area in the CANS						
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	N/A	N/A	1
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	N/A	N/A	N/A	N/A	1
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	N/A	N/A	N/A	N/A	8
Total referrals to other PEI providers	N/A	N/A	N/A	N/A	N/A	5
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	N/A	N/A	N/A	N/A	5
Average time in weeks between when a referral was given to individual by program and the individual's first in person appointment with the PEI funded provider	N/A	N/A	N/A	N/A	N/A	1
Total referrals to other mental health services or resources for basic needs	N/A	N/A	N/A	N/A	N/A	4

Sausalito Marin City School District:

School-based Case manager provides individual and group emotional support and social skills development. Case manager coordinates services, in classroom SEL classes, and support and training to staff members. Services provided to Sausalito Marin City School District children K-8 and their families.

Sausalito Marin City School District	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Students with mild to moderate mental health concerns will receive at	N/A	N/A	N/A	N/A	30 Students	28

least 3 sessions of individual or group counseling.						
Families with mild to moderate mental health concerns will receive at least 2 sessions of family counseling.	N/A	N/A	N/A	N/A	10 Families	7
Individuals served will accomplish two or more of the following: Doing better in school (i.e. academically, socially) and /or work; Stronger relationships with family/friends/teachers or others; Better able to cope when things go wrong; More connected to community; Better able to advocate for needs	N/A	N/A	N/A	N/A	65% of students	N/A CANS not implemented
Caregivers of individuals served with at least 3 or more counseling sessions will report overall satisfaction with the received	N/A	N/A	N/A	N/A	75%	100% N=9
Caregivers of individuals served will report that their child accomplished two or more of the following (PEI Caregiver Satisfaction survey): agree or strongly agree that their child is doing better in school; agree or strongly agree that their child has built stronger relationships with family, friends, teachers, or others; agree or strongly agree their child is better able to cope when things are going wrong; agree or strongly agree that they have people they feel	N/A	N/A	N/A	N/A	75%	100% N=9

comfortable talking with about their child's problem(s); agree or strongly agree they are better able to advocate for their child's and/or family's needs						
Parents/teachers of students (under age 11) receiving at least 3 sessions will report a reduction in children's/student's difficulties in one or more of the following areas: emotional problems, conduct problems, hyperactivity problems, peer problems, and/or socialization (CANS assessment).	N/A	N/A	N/A	N/A	65% of students	N/A CANS not implemented
Conduct home visits for students/caregivers identified through COST or administration	N/A	N/A	N/A	N/A	10	8
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	N/A	N/A	8
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	N/A	N/A	N/A	N/A	4
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	N/A	N/A	N/A	N/A	N/A
Total referrals to other PEI providers	N/A	N/A	N/A	N/A	N/A	1
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	N/A	N/A	N/A	N/A	0
Average time in weeks between when a referral was given to individual by	N/A	N/A	N/A	N/A	N/A	N/A

program and the individual's first in person appointment with the PEI funded provider						
Total referrals to other mental health services or resources for basic needs	N/A	N/A	N/A	N/A	N/A	3

**Data Collection Method*

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

EQUITY STRATEGIES:

PEI school-based providers collaborate extensively with school and community partners to support connection/access to services, specifically for families with limited access due language, socio-economic status, and geographic location (such as in West Marin). Providers utilize the support of Family Advocates to support relationship building and connecting families with services, including basic needs. Placing a bilingual mental health clinician at Novato High School has provided access for Monolingual Spanish-speaking individuals (EL and Newcomer students) who otherwise had none. The Spahr Center provides LGBTQ+ centered support services to youth, and a large part of the leadership program focuses on youth developing their voices and ability to self-advocate. This means they are better able to get the services they need now, and in the future, because they've learned how to find and access them. In FY 20/21, Spahr increased its efforts to target outreach to queer and trans youth and youth of color and to create community norms around social justice and equity. At Bayside MLK in Marin City, having a robust Coordination of Services Team (COST) has supported the school's efforts in implementing the MTSS (multi-tiered systems and supports) framework. The school is working hard to implement MTSS in order to provide targeted support to students who are experiencing barriers to accessing their education, focusing on the "whole child."

CHALLENGES AND UPCOMING CHANGES

In **FY 2020-21**, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for **FY2020-21** through **FY2022-23** although services continued to be impacted by COVID-19. Programs attempted to implement CANS this year but were not successful despite training and support being provided by BHRS. Additional training will be offered to providers during the FY 21/22 as well as support in identifying an alternative clinical assessment tool that would fit their needs. It also proved challenging for providers to collect demographic information and Client Satisfaction Surveys. Prior to the pandemic, providers administered these forms in-person immediately and ensured they were completed prior to the client's departure during face-to-face encounters. As a result of the pandemic, NMCS shifted to using a confidential Survey Monkey link sent to all participants involved in services and outreach events. Despite multiple attempts to obtain responses and specific follow up by both clinicians and support staff at the end of the year, NMCS had a significant decrease in response rate/participant engagement. Petaluma Health Center was unable to hire a clinician for the 20/21 FY but the position was filled for the 21/22 FY.

School-based provider program goals for **FY22/23** include:

- Increase the support provided to non-English speaking community in SMCS D
- Enhance support for caregivers through additional workshops, trainings and family counseling if appropriate
- Increase outreach on the Novato High School campus to promote availability of bilingual (Spanish/English) mental health clinicians onsite
- Increase referrals to community resources and outside behavioral health providers (ACCESS, PEI Providers, etc.)
- Implement Newcomers groups and counseling to Spanish speaking students in Shoreline Unified, and
- Implement coaching and consultation model through Seneca to PEI coordinators in Services Teams in their respective sites/districts in alignment with the implementation of the Mental Health Student Services Act Grant.

CHANGES FOR FY22/23: Addition of a School Partnership Supervisor in the Children’s System of Care as well as a second clinician for the Sausalito Marin City School district so one can be present at each school site.

CLIENT STORY

Client Story 1: *Child in middle school, self-referred to therapy due to suicide ideation. The student didn’t get parent consent for her to have treatment. However, due to her age, she was able to self-consent. She was provided one on one support, small group support, and her class had SEL class provided by the case manager who worked with her one on one. The interventions used with her were strength based, solution focused, and narrative, CBT techniques to decrease negative feeling states and thoughts, and improve the student’s motivation to learn. By the end of the school-year she reported a reduced thinking related to suicidal ideation, she was able to identify protective factors in her life, for example natural supports in her family and surrounding community. In conclusion, she has improved on her self-awareness, which has raised her overall self-esteem, and improved mood.*

Client Story 2: *Anita (not real name) is a 15-year-old high school student whose father died as a result of suicide in December and prior to that, there had been a long history of DV in the home. Anita had been experiencing significant distress, with a rapid loss in grades (from A’s to D’s) in the months prior to the loss. After the death, she also exhibited school avoidance, fighting (physical and verbal) with her sibling, and overall agitation per mother and school. NMCS was already providing case management services to the family, offering concrete supports such as emergency rental assistance, food and referrals to other resources for the mother (including Center for Domestic Peace). The NMCS Case Manager alerted the Director of Wellness Programs who immediately connected this student to the bilingual school-based mental health clinician*

(via PEI). After several brief interventions, it became clear to the clinician that Anita required a higher level of care and a referral was made to the BHRS ACCESS team.

Systems Success Story:

A major success this year was the creation of the Shoreline Unified Wellness Team. A goal for this past year was to collaborate more across the district to ensure that mental health services were universal for all students. To do this, the PEI Provider brought all mental health providers within the district together to meet once a month to touch base and coordinate services. We also met monthly with the administration to ensure that they were included in the process of identifying needs and implementing strategies and programs district wide with their support. This helped the team to stay connected and provided the district with a much more cohesive mental health program.

VETERANS COMMUNITY CONNECTION (PEI 19)

SERVICE CATEGORY: OUTREACH

SB 1004 PRIORITY CATEGORIZATION: #2, #4, #6

MARIN PEI PRIORITY STRATEGY AREA: Suicide Prevention

PROGRAM ALLOCATION: \$73,000

PROGRAM OVERVIEW: Veterans are recognized as being at high risk for mental illness and suicide, 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. MHSA PEI funds the Marin County Veterans’ Service Office, within the Department of Health and Human Services, to provide supportive services for veterans with a mental illness through a part-time Case Manager. This program continues to provide outreach to veterans throughout the county, particularly those who are homeless or involved in the criminal justice system, to link them to medically necessary mental health services.

TARGET POPULATION: The target population is Marin County veterans who are homeless or involved in the criminal justice system. Most of the target population may be experiencing Post Traumatic Stress Disorder (PTSD), while some may experience depression or other concerns.

PROGRAM DESCRIPTION

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 and substance use disorders, as well as recidivism. The program aims to **Reduce Prolonged Suffering** by ensuring veterans experiencing symptoms of mental illness engage in services expected to reduce their symptoms and increase their functioning. The PEI Case Manager (CM) provides:

- **Outreach and Engagement:** Clients are identified through outreach, in-reach and referrals from the VA.

Veteran’s Community Connection

SUMMARY FY2020-21

Clients Served: FY2020-21

82 Individuals

6 Families

22 permanently housed

- Case Management:** The PEI Case Manager links clients to housing, behavioral health services, and more. In addition, the CM assists with logistical barriers to completing a treatment plan, provides ongoing contact to increase likelihood of engaging with services and services for significant support people, such as family. The CM also assists with obtaining other forms of support available to the veterans and their families, such as financial benefits or community resources.
- Timely Access to Services:** The program improves 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:** 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 PEI Case Manager, who is a licensed mental health provider. The Case Manager makes 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. A significant number of referrals are made to the Veteran’s Administration for health and mental health services.

DATA COLLECTION METHODS

The following data is reported to BHRS 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.

- Client/family demographics and satisfaction surveys to show impact of services provided
 - Referral data to show improved recovery through access and linkage to services
 - Marin County PEI client satisfaction survey that looks at both quality of service and outcomes based on various indicators. All Prevention and Early Intervention providers are asked to administer this ten-question survey to clients and caregivers if applicable.

Anticipated data collection changes and additions: No anticipated changes in **FY 21/22**.

OUTCOMES

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

Outcomes	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Number of veterans that received support services to increase likelihood of completing the	100	138	100	39	100	82

veteran’s mental health treatment plan. (Average number of services: 8)						
Number of family members that received services to increase their capacity to support the client	20	19	20	8	20	6
75% of veterans receiving support achieved at least one goal towards stability and recovery	75%	85% N=117	75%	92% N=36	75%	75% N=62
Clients receiving 3 or more counseling services reporting satisfaction (strongly agree or agree) with the PEI services (would recommend, use again, etc)* (PEI Survey)	N/A	100% N=26	N/A	89% N=27	N/A	91% N=10
Total referrals to County Behavioral Health (BHRS)	N/A	2	N/A	0	N/A	0
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	2	N/A	N/A	N/A	N/A
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	<1	N/A	N/A	N/A	N/A
Total referrals to other PEI providers	N/A	0	N/A	0	N/A	0
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	0	N/A	N/A	N/A	N/A
Average time in weeks between when a	N/A	N/A	N/A	N/A	N/A	N/A

referral was given to individual by program and the individual's first in person appointment with the PEI funded provider						
Total referrals to other mental health services or resources for basic needs	N/A	157	N/A	125	N/A	80

EQUITY STRATEGIES:

The goals of the HHS Veterans PEI program are to provide comprehensive services to veterans that have lost housing or are at risk of losing housing in an effort to end veteran homelessness in Marin County. Working in conjunction with the VA Healthcare System, the program conducts outreach throughout Marin County, focusing on homeless and incarcerated veterans. Serious mental illness often is evident in this population. The program provides transportation and warm hand offs for those experiencing SMI to appropriate providers within the VA system. Additionally, Marin County has just formed the Veteran's Treatment Court. The HHS PEI Veterans team currently work with the DA, Public Defenders Office, Jail Mental Health, Probation and Parole departments to intervene in court cases and provide advocacy, and linkages to local resources including healthcare and housing. Many veterans are unsure of the benefits they are entitled to. The Case Manager provides education, enrollment, and specific referrals for homeless and incarcerated veterans. The program also does outreach to encampments, hotels, jails, car campers etc. and has expanded its services to include veterans that did not complete their tour, received less than honorable discharges.

CHALLENGES AND UPCOMING CHANGES

In FY 2020-21, this program was implemented as described in the MHSA Three-Year Program and Expenditure Plan for FY2020-21 through FY2022-23 although services continued to be impacted by COVID-19. There were some challenges in collecting surveys as many clients Many were a bit suspicious and/or not ready to make a judgment on the services. The pandemic had an impact on the Case Manager's ability to physically engage with the homeless population. This was in conjunction with the directives and guidance that the County Health Department issued. In addition, the acuity of the individual cases has increased. Currently, there are 29 homeless veterans identified in Marin County and the majority of them are far more challenging to collaborate with on issues such as recovery, MH treatment, sobriety, medication, etc. Therefore, while there has been a dent made in homelessness amongst veterans, the heavy lifting has just begun because the cases are more time consuming and complex.

PEI Veterans program goals for **the next Fiscal Year** include:

- Continuing to work to end homelessness amongst the veteran population in Marin County by working on “Built for Zero”
- Collaborating with Coordinated Entry to find housing for the remaining 29 veterans that are homeless in Marin County, and
- Supporting Veteran’s Treatment Court by providing advocacy in court, holding offenders accountable, responsible through weekly counseling and follow up with court reports

CLIENT STORY

CG is a 69 y/o veteran that has been living in his care for 7 years. He does not qualify for VA benefits because he had an “Other than Honorable” discharge from the Army. He takes care of his ex wife who has been diagnosed with Alzheimers disease. He parks his care outside of her apartment. After much advocacy, we were able to get him a main stream Section 8 voucher. He is skeptical and ‘has been here before’ with poor outcomes. However, he is in the later stages of a long application process and things look very promising. This time around, with much advocacy and effort, things have come together..

PEI STATEWIDE (PEI 20)

SERVICE CATEGORY: STIGMA REDUCTION

SB 1004 PRIORITY CATEGORIZATION: #2

MARIN PEI PRIORITY STRATEGY AREA: Suicide Prevention

PROGRAM ALLOCATION: \$81,000

PROGRAM DESCRIPTION

Marin County contributes 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.

CalMHSA's current strategies include:

- **Statewide social marketing 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
- **Facilitate collaboration and partnerships between counties** to create opportunities for shared learning and forging productive working relationships.

TARGET POPULATION: CalMHSA targets all California residents with additional resources geared towards targeting high priority groups such as the Latino/Hispanic community, rural populations and youth.

OUTCOMES:

- Reduced Mental Illness Stigma and Increased Confidence to Intervene
- Increased Knowledge and Improved Attitudes Toward Mental Illness and
- Increased capacity within counties to develop and implement comprehensive suicide prevention strategies

In **20/21**, funding to the PEI Project supported programs such as:

- Expanding public awareness and education campaigns
- Creating new outreach and poster campaign materials for diverse audiences
- Providing technical assistance and outreach to county agencies, schools, and community-based organizations
- Providing mental health/stigma reduction/suicide prevention trainings to diverse audiences
- Engaging youth through Each Mind Matters (September and May activities)
- Building the capacities of schools to address mental health, stigma reduction, and suicide prevention

LEARNING COLLABORATIVES AND TECHNICAL ASSISTANCE:

Each Mind Matters Learning Collaboratives: The Learning Collaborative utilizes a public health approach to suicide prevention and has supported 23 county teams (including Marin) in creating strategic plans for suicide prevention using national models aligning with the newly released California Strategic Plan for Suicide Prevention. Support has been provided through a combination of in-person meetings in Sacramento, online learning modules, and individual technical assistance.

- Modules included: Strategic Planning Framework; Using Data; Selecting Interventions; Means Safety; Population-Level Strategies, Reaching High Risk Populations, Postvention, Building and Maintaining a Coalition, Logic Models and Evaluation, and Messaging
- Highlight- Marin County Behavioral Health and Recovery Services (BHRS): Through participation in the Learning Collaborative after joining in October 2018, BHRS staff members were guided through the process to develop a strategic plan for suicide prevention. Through support from the Learning Collaborative Team, a draft plan was edited, updated, and revised to result in the final plan being approved and released in February 2020

CaIMHSA TECHNICAL ASSISTANCE TO MARIN COUNTY:

Technical assistance (TA) is provided by all PEI Project contractors, each targeting a different audience. TA 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 member provides regular communication in the form of in-person meetings, phone calls, and TA emails covering a range of topics with practical tools and information. During the FY **20/21**, over 15 TA emails covered topics such as Suicide Prevention and Recovery month, week and day, SanaMente, a Holiday series, self-care during the COVID-19 pandemic, May is Mental Health Month, and more. During **FY 20/21**, specific TA consultations included to Marin County included:

- The EMM TA Team engaged with the SP Team on the development of an implementation plan for the advancement of the strategic plan and to be carried out by the respective Community Action Teams
- The EMM TA Team led a county-wide suicide prevention training with members of the Marin police force. This training provided foundational information on suicide prevention,

stigma reduction for this population, and a call to action to engage with police force mental health services

- The EMM TA Team led and presented to the Marin County Suicide Prevention Collaborative on a variety of topics, including suicide prevention theory, communication, postvention, and the EMM Toolkit, including Directing Change
- The EMM TA Team worked with MCOE on postvention response following youth suicides in first quarter 2021. This included participating on one community-based panel discussion and two school events, including San Rafael and Novato (“A Community Conversation about Suicide Prevention”) that drew a community-wide attendance. The Team consulted on appropriate postvention responses by youth and what would be considered safe ways to acknowledge the death of a classmate by suicide
 - The EMM TA Team provided a presentation to the Marin Schools Wellness Collaborative and the Youth Action Team on Directing Change and school engagement. Current efforts are taking place now to implement Directing Change at schools throughout Marin in 2022
 - The EMM TA Team participated in the Marin Schools Wellness Collaborative School-based Risk Assessment Team. In this capacity, the Team provided feedback on a uniformed and coordinated risk assessment tool to be delivered on an online platform and available to all school-based providers in January 2022
 - The EMM TA Team reviewed the Collaborative’s First Annual Report disseminated in June 2021 to over 2,000 emails, and
 - The BHRS Prevention Team presented to the state-wide Collaborative on the development of our annual report

In addition, in **FY 20/21**, over 5 local schools (San Marin High, SR Terra Linda, Novato High School, Sinaloa, San Jose Middle School and Dominican University) received outreach materials, a training, or a presentation about stigma reduction, suicide prevention, and/or student mental health through the collective efforts of all programs implemented under the PEI Project. Active engagement and partnership with the Marin County Office of Education and local CBO’s utilizing EMM ensures suicide prevention and mental health activities are coordinated and aligned for the school and broader community.

CHALLENGES AND UPCOMING CHANGES: No anticipated changes for FY22/23.

SUICIDE PREVENTION (PEI 21)

SERVICE CATEGORY: SUICIDE PREVENTION

SB 1004 PRIORITY CATEGORIZATION: #2, #3, #4, #5

MARIN PEI PRIORITY STRATEGY AREA: Suicide Prevention

PROGRAM OVERVIEW: In June of 2020, BHRS hired a full-time Suicide Prevention Coordinator to coordinate all aspects of the strategic plan implementation advanced by the Marin County Suicide Prevention Collaborative. Meetings are held the first Wednesday of each month at 2 pm and are open to the community. Community Action Teams provide leadership and implementation support of our plan. These Teams meet monthly and are actively engaged in carrying out our efforts.

To address the issue of suicide in our county, in October 2018, Marin County Behavioral Health and Recovery Services (BHRS) initiated a suicide prevention strategic planning process in collaboration with the Department of Public Health, the Marin County Office of Education and community partners. The first phase of this effort was a countywide Community Needs Assessment to better understand the specific context of suicidal behavior in Marin County. Once data was collected and analyzed, the Strategic Planning Committee-which was comprised of a wide range of stakeholders- developed comprehensive strategies, objectives, and activities aimed at promoting wellness and reducing suicide attempts and deaths across the county. The Suicide Prevention Strategic Plan, which is Marin County's first comprehensive plan, was released in January 2020 and is implemented by the County's Suicide Prevention Collaborative.

By June 2020, a full-time Suicide Prevention Coordinator was hired for coordinating the implementation of the seven key strategic areas of the suicide strategic plan. The Coordinator's role is to ensure accountability, chair oversight for the Collaborative and the Community Action Teams, coordinate data collection amongst key entities, enhance data collection/sharing systems, and represent the county on regional and statewide suicide prevention collaboratives. The Collaborative conducts monthly meetings that are open to the public and attended virtually by an average of 50-60 participants.

Marin County Suicide Prevention Collaborative

SUMMARY FY2020-21

Individuals Served: FY2020-21

11 Meetings
50 participants
(average) per meeting



Building Resilience, Connections & Hope

Behavioral Health Prevention & Outreach in Marin

<p>Access and Assessment Line</p> <p>(888) 818-1115</p> <p>National Suicide Prevention Lifeline</p> <p>(800) 273-8255</p>	<p>Crisis Stabilization Unit (CSU)</p> <p>(415) 473-6666</p> <p>Línea de Prevención del Suicidio</p> <p>(888) 628-9454</p>	<p>Crisis Text Line</p> <p>Text MARIN to 741741</p>
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Suicide Prevention

While suicide is a complex public health issue, we know that it can be prevented. It takes a whole community to prevent suicide. Let's work together to create hope, foster connection and support recovery for those in distress and create a safe community for all. Learn more about the role you can play by joining the Marin County Suicide Prevention Collaborative and reading about our first year's accomplishments in our newly released [2021-22 Annual Report](#).



Join us!

The next Suicide Prevention Collaborative meeting is scheduled for Wednesday March 2 at 2 pm. [Please register here.](#)

Upcoming Winter-Spring suicide prevention events (will be updated periodically).

[Join the Collaborative](#)

Need Help Now?

Call the National Suicide Prevention Lifeline

[800-273-8255](#)

Marin's Strategic Plan for Suicide Prevention



Marin County Board of Supervisors approved the County's first Suicide Prevention Strategic Plan in February 2020. This seven-strategy plan is our call to action to reduce deaths by suicide and suicide attempts in our community. At the heart of this plan is the knowledge that preventing suicide is achievable. Together, we are challenging our long-held beliefs and perceptions about suicide and creating a new way to work across agencies and institutions to prevent suicide. To learn more about the work we've accomplished in our first year, please read the newly released [Annual Report: 2021-22](#).



MARIN OUTREACH & PREVENTION TEAM MARIN COUNTY SUICIDE PREVENTION COLLABORATIVE
Upcoming Meetings – Join us!

Upcoming Meeting Dates:

September 1 at 2 pm:
Suicide Prevention & Recovery Month:
Supportive Transitions, Resilience and Resources

October 6 at 2 pm:
Equitable and Culturally Responsive Suicide
Prevention: Building Equity in Communities

November 3 at 2 pm:
Gun Violence Restraining Order Training and
Community Action Team Reporting



[Register here](#) for all
upcoming meetings!

Questions?
Email: BHRSPreventionandoutreach@marincounty.org
Or visit www.BHRSPrevention.org



TARGET POPULATION: All residents of Marin County including veterans, middle-aged and older adults, LGBTQ+ and other residents at disproportionate risk for suicide, as well as community-based organizations, school districts and county partners.

ACCOMPLISHMENTS AND NEXT STEPS

Examples of the Collaborative's and Community Action Teams activities in FY2020-21 follow:

Strategy 1: Establish infrastructure to provide leadership, oversight, and accountability to the Strategic Plan

- Established leadership and operational structure. Hired Suicide Prevention Program Coordinator and identified Collaborative leadership to facilitate monthly meetings.
- Recruited Collaborative membership and participation averaging 60 participants at each monthly meeting.
- Launched and strengthened the role of the Marin County Schools Wellness Collaborative with increased focus on suicide prevention implementation in collaboration with the Schools Team.
- Established a Schools Team and a Training and Education Team to review recommendations for suicide prevention trainings to be implemented and supported at various levels in our community.

Strategy 2: Develop a coordinated system of care to promote suicide prevention and wellness

- Offered evidence-based trainings to support mental health providers, including two safety planning trainings for clients and a free training about lethal means counseling on the BHRS Prevention and Outreach website.
- Released an RFP in spring of 2021 to implement a LOSS (Local Outreach to Suicide Survivors) Team. The purpose of this Project is to address the postvention services for loss survivors (eg., family, witnesses, etc.) immediately following a suicide through the implementation of a LOSS Team. In addition to the LOSS Team, funding includes the development of a Youth Suicide Loss Support Group and an Adult Attempt Survivor's Group. This contract was awarded to the Felton Institute and the start date for this contract is December 2021.
- Launched the Buckelew SOS Allies for Hope Loss Survivor Support Group in July 2020 to provide essential community support for suicide loss survivors. Hosted twice monthly for as many as 20 participants at a given support group.

Strategy 3: Implement public campaigns to raise awareness about warning signs, promote available resources, and increase help-seeking

- Launched the BHRS Prevention and Outreach website, providing a centralized and coordinated information hub for suicide prevention and other behavioral health resources and services for our community.
- Pilot tested first men’s “Movember” grassroots mental health campaign to reduce stigma and create awareness of men’s mental health in November 2020.
- Established contract with Crisis Text Line (CTL) with co-branding for Marin (text MARIN to 741741). Created CTL social media toolkit for county-wide dissemination.

Strategy 4: Provide evidence-based suicide prevention trainings and education to Marin County residents

- Provided recommendations for training, including: American Foundation for Suicide Prevention Talk Saves Lives, Buckelew Programs, Question-Persuade-Refer (QPR) and Mental Health First Aid (MHFA). Supported free QPR for 200 community individuals.
- Hosted over 70 community events with BHRS and community-based partners, including three Spanish language only trainings, trainings for older adults, September Suicide Prevention and Recovery Month 2020 and May Mental Health Month 2021. Engaged over 2300 community members in suicide prevention and mental health education and training events.
- Created [two videos addressing the mental health needs of men and boys](#) promoting self care, help seeking and awareness.
- Hosted and pilot tested a Train the Trainer event with the American Foundation for Suicide Prevention to build community capacity in suicide prevention presenters.

Strategy 5: Provide outreach, engagement, and support to all residents with targeted efforts to groups disproportionately affected by suicide

- Expanded Community Health Advocates and Promotores model to support suicide prevention efforts among mental health ambassadors in communities of color and vulnerable populations that experience barriers to equitable and culturally appropriate health and wellness services.
- Supported community-based organization in hosting speaker series for residents from diverse communities with lived experiences around suicide to share their experiences in safe community spaces.
- Supported the development of the Toolkit Teach Pride, Reach Wide. This Toolkit was designed by Spahr Center staff and student leaders to help educators and staff build the skills to become stronger allies and advocates in classrooms for LGBTQ+ students.

Strategy 6: Foster safe and healthy environments on all school campuses

- Established a Suicide Risk Assessment Team to create a uniformed district wide risk assessment tool, which is in process. This tool incorporates evidence-based practices including questions from the Columbia Suicide Severity Rating Scale (C-SSRS).
- Updated student ID card with new 3-digit 988 number for Fall 2022

Strategy 7: Reduce access to lethal means for those at risk of suicide

- Launched a Lethal Means Team focusing on substance use, bridge, and firearm means reduction.
- Partnered with the newly established Marin County Gun Safety Collaborative.
- Engaged the Golden Gate Bridge Patrol Team on the Collaborative Data Action Team

Upcoming in 2021-22:

- Expansion of efforts addressing specific populations including Black, Indigenous and People of Color (BIPOC), LGBTQ+ youth and adults, and middle age/older men.
- Implement pre-planning for an evaluation and performance measures for each Strategic Plan strategy.
- Launch the LOSS Team Program, including the development of formal protocol for dispatch, resources for families and witnesses, marketing and recruitment and training of volunteers.
- Finalize suicide risk assessment tool for training and implementation by school-based mental health providers.
- Continue men and boy's mental health campaign to reach groups disproportionately impacted by suicide and mental health in our community. This grassroots effort will draw upon the leadership and influence of the Men and Boys Action Team.
- Host a series of September Suicide Prevention month events in September 2022 in collaboration with BHRS community-based organization partners and Each Mind Matters.

CHALLENGES AND UPCOMING CHANGES

- **In FY2020-21**, the Marin County Suicide Prevention Collaborative met 11 times, all virtually. The Collaborative is very intentional about creating learning opportunities and establishing shared language and understanding. The Collaborative brings in different community speakers and experts, and addresses a variety of prevention, intervention and postvention topics already mentioned. A future challenge will be to determine the safest time to convene in public, but there is concern that attendance will drop if meetings move to in person. We are fortunate for attendance being maintained by an average of 50 people monthly with new people attending each month.
- **In FY2020-21**, leadership changes have occurred among Co-Chairs in the Collaborative. One stepped down after a full year commitment. We are in the process of identifying a new Co-Chair. We want to be sure that leadership is shared with community wide perspective and understanding. There has been no changes in our Community Action Team Leaders. These Teams are incredibly active and producing significant work in advancing the Strategic Plan. However, some Teams have inconsistent participation and the work can often fall on certain individuals. A key challenge will be to ensure that recruitment and engagement is maintained at the current levels. Requesting consistent and active participation by those bereaved by suicide is a challenge as well due to the emotional and difficult nature of this work. As mentioned above, we host suicide loss survivor "meet ups" and will continue that effort. Similarly, engaging attempt survivors will be facilitated by the development of support groups for attempt survivors and youth loss survivors to launch in this year. It is critical to ensure that their voices are fully represented in our efforts.

- **In FY2020-21**, a challenge has been creating awareness of suicide and the Collaborative among communities of color, which has been difficult due to Covid. However, we have been very active in providing suicide prevention trainings for Spanish speaking populations and creating community outreach engagement activities, including campaigns. BHRS implemented two community wide behavioral health campaigns in English and Spanish with fine tuning one campaign with a simple message: “Need Support?” This featured stock images of men across the life span and those who identify as LGBTQ and were featured at bus kiosks, bus shelters, transit and local media.

The campaign included paid ads (Marin IJ, transit buses, radio, digital banners, video ads, bus shelter kiosks, social media etc.). These ran in 2020 and 2021 to raise community awareness of the importance of mental health and resources in Marin. Outreach campaigns ran utilizing geo-targeted social media (FB/Instagram), paid Spanish ads on the Univision digital network and radio spots. Univision digital ads included a video on the importance of mental health that ran on Univision digital networks and featured our Outreach and Prevention Coordinator, digital banners, print ads, geo-targeted e-mail newsletters, and outdoor advertising. Additional paid print, outdoor, and social media ads ran for May is Mental Health Month outreach in May 2021. The campaign also included outdoor advertising on transit buses and transit shelter kiosks. These ads are far reaching and generated an estimated 1,962,915 impressions. In 2021, we continued the “Need Support” campaign in English and Spanish on 40 bus shelter kiosks with ads running from February to May 2021. In May 2021, we ran additional creative that promoted awareness of May is Mental Health month events and resources.

Behavioral Health Resources
 MARINHHS.ORG/BHRS

NEED SUPPORT?
 Call Marin BHRS Access Line
 (888) 818-1115
 Text SHARE to 741741

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

Behavioral Health Resources

**YOU ARE NOT ALONE.
 WE ARE HERE TO HELP.**

Local Suicide Prevention Hotline:
 415-499-1100

CA Peer-run warm-line 24/7 provided by the
 Mental Health Association of SF:
 1-855-845-7415

Community Action Marin (CAM) warm-line
 Sun-midnight:
 415-459-8330

The National Suicide Prevention Lifeline (24/7):
 1-800-273-8255

Behavioral Health and Recovery Services
 Access Line:
 1-888-818-1115

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

MARINHHS.ORG/BHRS

1966

Servicio y tratamiento de salud mental

**No estás solo.
 Estamos aquí para ayudar.**

MARINHHS.ORG/BHRS
 1-888-818-1115

Recursos de Salud Mental
 MARINHHS.ORG/BHRS

¿NECESITA AYUDA?

Llame a la línea de Acceso de Marin BHRS
 (888) 818-1115

O llame a la línea de Acción Comunitaria de Marin
 (Lunes a Sábado de 1pm a 6pm)
 (415) 457-4026

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

BUCKELEW’S NORTH BAY SUICIDE PREVENTION PROGRAM

Funding under Suicide Prevention continues to fund Buckelew’s North Bay Suicide Prevention Program which 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. Services are available in a wide range of languages through a phone interpreter service. Additional PEI suicide prevention funds will be used to provide community and targeted suicide prevention trainings by an Outreach and Education Coordinator for those at disproportionate risk of suicide.

In addition, in July 2020, Buckelew launched the SOS Allies for Hope Suicide Loss Survivor Support Group. This group meets twice monthly and is facilitated by a person with lived experience. This group has been attended by 60 unique individuals and provides essential support for those bereaved by suicide.

PROGRAM DESCRIPTION

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

- **Training and Outreach:** This program provides training and outreach to diverse community stakeholder groups on recognizing and responding to warning signs of suicide as well as serving on community panels for the school community
- **Timely Access to Services:** The hotline serves underserved populations by providing free and accessible help 24/7 which allows access for people of all ages and socioeconomic status. It is accessible by anyone who has access to a telephone including those who may have limited access to services due to geographic location or mobility issues. The translation services used by the program offer translation in over 200 languages allowing individuals whose primary language is not English to access the hotline. In addition, the Hotline has an ongoing contract with the National Suicide Prevention Lifeline to answer calls from Veterans who prefer not to call the Veteran’s Lifeline or other Veteran resources due to stigma around mental health issues, and
- **Access and linkage to Treatment:** The Hotline collaborates with Marin County’s Crisis Stabilization Unit (CSU) and refers individuals needing face-to-face crisis evaluation and intervention to County Behavioral Health and Recovery Services (BHRS) crisis services. Likewise,

FY2020-21:

3807 Hotline Calls

193 Families reached

1103 Individuals reached

60 unique support group members

CSU staff frequently refer people to the Hotline in order to help prevent a crisis from escalating and to keep them safe and at a lower level of care. In addition, the Hotline maintains ongoing collaboration with Marin County law enforcement, who are a primary resource used by phone counselors in managing suicidal emergency calls, as well as Federally Qualified Health Clinics (Marin Community Clinics, Ritter Center, Coastal Health Alliance and Marin City Health and Wellness Center), primary health clinics serving low and moderate-income residents, who distribute Hotline resource materials. Callers are routinely referred to BHRS Access Line for appropriate assessment and referral. PEI staff members maintain relationships with referral sites and participate in the PEI Committee that includes representatives from all PEI programs, BHRS, clients, families, and other key agencies in order to facilitate successful collaboration

DATA COLLECTION METHODS FOR SUICIDE PREVENTION HOTLINE

The following data is reported to BHRS 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 number and types of individuals trained, types of trainings provided, demographics (see PEI overview section), and the number of support groups attended, including number of participants per session
- Participant surveys are conducted to show changes in knowledge and skill for those receiving training
- The number of callers and caller demographics. In FY 20/21 demographics were collected for 1,124 callers (out of 3807 of callers)
- Referral data to show improved recovery through access and linkage to services and
- An additional pre and post assessment of training and education participants to measure change in skills and knowledge of suicide prevention was implemented

OUTCOMES

N = the total number in the sample (i.e., total number who received services or completed a survey). N/A refers to data not being collected.

Outcomes	Goal FY 18/19	Actual FY 18/19	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21
Calls to hotline originating in Marin County	6-8000	6,424	6000	5361	5000	3807
Callers who express a reduction in level of suicidal risk by 1 level or	80%	86% N=984	80%	82% N=428	N/A	N/A

maintain Low (Low, Medium, High)						
Agencies receiving suicide prevention campaign materials	20	20+	50	37	50	20+
Community members receiving training that report they can describe suicide warning signs (agree/strongly agree)	50%	99% N=189	50%	100% N=229	50%	N/A
Community members receiving training that feel prepared to help a friend/loved one who is feeling suicidal or in a crisis situation (agree/strongly agree)	50%	94% N=189	50%	93% N=229	50%	N/A
Community members receiving training that can describe the work of Buckelew Suicide Prevention Hotline and Program (agree/strongly agree)	50%	77% N=189	50%	93% N=229	50%	N/A
Training participants that would recommend the training to a friend or loved one (agree/strongly agree)	50%	66% N=189	50%	96% N=229	50%	N/A
Total referrals to County Behavioral Health (BHRS)	N/A	53	N/A	68	N/A	17
Total referrals to other PEI providers	N/A	0	N/A	2	N/A	15
Total referrals to other mental health services or resources for basic needs	N/A	46	N/A	19	N/A	63

EQUITY AND CULTURAL RESPONSIVENESS:

The hotline staff participated in a minimum of 4 hours of training around cultural competency with regards to age, communication, LGBTQ+, Tribal Communities, Race, Ethnicity, and Implicit Bias. Efforts continue to be made to expand language capacity of hotline volunteers.

CHALLENGES AND UPCOMING CHANGES

In **FY 2020-21**, this program was implemented as described in the MHSa Three-Year Program and Expenditure Plan for **FY2020/21-22/23** and continued despite COVID-19. With COVID, the hotline continued without disruption with a consistently steady number of calls averaging 130 unduplicated callers per month. Hotline volunteers identified an increase in caller anxiety, fear about job loss, caring for children and general concerns about COVID-19 and its impact on their family and health. All networking and outreach meetings were held virtually on Zoom or by phone. Buckelew increased coordination with other Bay Area/Marin community-based organizations to raise awareness of the Hotline and Signs of Suicide (SOS) group via Covid Response Networks and Marin Advocates Network. Buckelew staff have utilized outreach in-person, by phone and via Zoom to participate in various community meetings, press interviews, panel discussions, support group facilitation, and postvention events in order to promote hotline utilization and to de-stigmatize its use within the community.

During **FY 20/21**, Buckelew began offering SOS Allies for Hope, an ongoing monthly support group, rather than a formal 8-session grief counseling group. Having the SOS group on an ongoing basis ensures there is a place for someone to “go” to get support for their grief in a group of peers who share similar losses. The groups were facilitated by a loss survivor and hotline counselor with over 25+ years of experience. There were 21 groups offered and a total of 60 unique members participated. (paragraph below needs editing but is in some weird format that can't be edited)

A key challenge is collecting demographic data, particularly for hotline clients in crisis. Asking demographic questions can interrupt the first priority of creating a warm connection and resolving the suicidal crisis---and ensuring that a positive experience will lead to future utilization of the hotline. For example, asking demographic questions over the phone with callers who are in acute/subacute states in such a fashion can impact their comfort with calling back. With a buildup of staff capacity, greater familiarity of staff training on the call system, continued efforts will be made to collect demographic information more regularly. Plans are underway to collect demographic information for trainings and support groups in the coming year.

In addition, the collection of data was disrupted due to Covid-19. Many of the hotline volunteers were older adults who did not feel comfortable working inside, and modifications were necessary to make accommodations. Some volunteers who had been with the hotline for many years left due to Covid-19. While all calls were answered, having a smaller workforce impacted the ability to collect data.

The ability to collect data for training and outreach was also impacted by Covid-19 in the following ways:

- 1) Changes in best practices: The field of suicide prevention needs to determine the impact of safety when conducting trainings virtually as best practice is based on only in-person trainings. The field overall adjusted to this new norm for training. As national organizations led the way, it became easier to conduct trainings virtually but that impacted the overall training goals and fewer trainings were provided.

Continued funding was deemed necessary through the MHSa Three Year planning process for **FY2020-21** through **FY2022-23**. The Buckelew Hotline will continue to be funded through HHS as it was in the previous 3-year plan. Programmatic goals for the Hotline for **next Fiscal Year** include:

- Preparing for the implementation of 988 for both phone and text capacity
- Increasing the number of non-English speaking clients served by hiring more Spanish speaking staff, and

- Implementing culturally responsive hotline trainings and community-based workshops that more explicitly address culture and equity

CLIENT STORY

A Transition Age Youth (TAY) caller contacted the hotline during the early morning. The caller was at imminent risk of suicide and had identified the Golden Gate Bridge as the plan. The hotline counselor worked to develop a rapport with the caller and listened to the story that brought them to the point that a suicide act was in progress. The hotline counselor was able to intervene quickly and collaborate with the caller on dispatching the Bridge alert staff to make contact with the caller and save their life. The GGB staff were informed of the caller's willingness to voluntarily receive hospitalization.

NEWCOMERS SUPPORT AND COORDINATION (PEI 23)

SERVICE CATEGORY: ACCESS AND LINKAGE

SB 1004 PRIORITY CATEGORIZATION: #1, #3, #4, #6

MARIN PEI PRIORITY STRATEGY AREA(S): Newcomers Supports; School-Based Mental Health

PROVIDERS: North Marin Community Services, Canal Alliances, Bay Area Community Resources, Huckleberry Youth Programs

PROGRAM ALLOCATION: \$130,000

PROGRAM DESCRIPTION: This program targets newly arrived immigrant youth primarily in middle and high schools in San Rafael and Novato. Utilizing a multi-tiered system of support (MTSS) framework, the program is designed to support these young people in navigating school and community resources and accessing academic, legal, and mental health supports. Interventions are intended to build on their strength and resilience in order to help them to succeed in school and beyond. Coordinators provide assessment, linkage to resources, and short-term case management for students at San Rafael secondary schools. Newcomer providers also conduct training for school staff on how to understand the unique needs of this population and support their educational and social-emotional development. Providers also facilitate school-based newcomer groups that focus on issues such as grief, loss, acculturation, and building resources and supports.

TARGET POPULATION: Recently arrived immigrant youth in Marin County schools.

EXPECTED NUMBERS TO BE SERVED: 400

KEY OUTCOMES:

- Improved school attendance and retention
- Reduced likelihood of behavioral problems and school failure and/or unemployment
- Reduce Prolonged Suffering by increasing protective factors and reducing risk factors
- Improved school and community connectedness
- Increased capacity of teachers to support Newcomers and understand the impact of trauma on learning, and
- Increased service integration, more effective linkage to/engagement with school and community resources for Newcomers.

Newcomers Supports

SUMMARY FY2020-21

Individuals Served: FY2020-21

325 Individuals

199 Families

3088 reached through Outreach/Training

DATA COLLECTION METHODS

The following data is reported to BHRS 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 number and types of individuals trained, types of trainings provided, demographics (see PEI overview section), and training evaluations
 - The number and type of outreach activities and participants reached client/family demographics and satisfaction surveys to show impact of services provided
 - Referral data to show access and linkage to services in Marin County

**All Prevention and Early Intervention providers are asked to administer a ten-question survey to clients and caregivers, if applicable. This survey examines both quality of service and outcomes based on various indicators.*

Anticipated data collection changes and additions for FY 21/22: No anticipated changes in **FY 21/22**.

OUTCOMES

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

North Marin Community Services (NMCS) partners with the Novato Unified School District to conduct outreach, screening and implement school-based Newcomer groups in middle and high schools focused on issues such as grief and loss, acculturation, and building resources and supports.

Outcomes: North Marin Community Services	Goal FY 20/21	Actual FY 20/21
EL Level 1 and targeted EL Level 2 students will receive information about the Newcomer Workshops (via attendance at classes, ELAC and newcomer parent meetings, etc).	100%	100%
Students will participate in Newcomer Workshops at Novato High Schools.	50-60 Students	58

Individuals served will report overall satisfaction with received.	75%	93% N= 39
Total referrals to County Behavioral Health (BHRS)	N/A	9
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	0
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Unknown
Total referrals to other PEI providers	N/A	10
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	7
Average time in weeks between when a referral was given to individual by program and the individual's first in person appointment with the PEI funded provider	N/A	N/A
Total referrals to other mental health services or resources for basic needs	N/A	12

Client Satisfaction Surveys for Newcomers Programs:
90% of clients reported feeling that their counselor respected their identity (i.e. ethnic/cultural/religious background, sexual orientation, gender identity)
71% reported feeling that, as a result of services, they are better able to cope when things go wrong
82% of parents reported that their child has built stronger relationships with family/friends/teachers or others.
90% Students agreed that during sessions they were able to express their thoughts and create goals they want to achieve
98% agreed that the workshop facilitators were able to communicate the information in an effective way
93% agreed that after participating in the program they now know where to go for support related to their mental health
100% agreed that after participating in the program they understand what sexual assault and harassment are

Huckleberry Youth Programs (HYP) provides early identification of San Rafael high school and TAY Newcomer youth experiencing issues connected with immigration, and offers a bridge to aid in acculturation, exposure to community resources, addressing grief, loss, and trauma, as well as leadership opportunities through peer health education.

Outcomes: Huckleberry Youth Programs	Goal FY 20/21	Actual FY 20/21
Students at San Rafael and Terra Linda High Schools will engage in one of 8 groups that are offered throughout the 20-21 school year	75 students 8 groups	31 students engaged 8 groups
Individuals served will report overall satisfaction with services received	75%	72%
Youth trained through “Nuestra Salud” initiative	15	15
Youth served through outreach events	N/A	100

Total referrals to County Behavioral Health (BHRS)	N/A	0
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	N/A
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	N/A
Total referrals to other PEI providers	N/A	15
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	15
Average time in weeks between when a referral was given to individual by program and the individual's first in person appointment with the PEI funded provider	N/A	Unknown
Total referrals to other mental health services or resources for basic needs	N/A	2



Canal Alliance PEI Newcomers contract provides reunification groups for newly arrived immigrant youth and their families primarily in the San Rafael area of Marin County.

Outcomes: Canal Alliance	Goal FY 20/21	Actual FY 20/21
Serve 27 youth paired with an individual mentor with a minimum of a one-year commitment between the youth and mentor.	27 individuals served	10 youth paired with individual mentors 17 youth are in mentor group settings
Total referrals to County Behavioral Health (BHRS)	N/A	0
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	N/A

Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	N/A
Total referrals to other PEI providers	N/A	0
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	0
Average time in weeks between when a referral was given to individual by program and the individual's first in person appointment with the PEI funded provider	N/A	151
Total referrals to other mental health services or resources for basic needs	N/A	12

Bay Area Community Resources (BACR) provides support to students at Davidson Middle School and will have a half time Coordinator to support the San Rafael High Bridge Program, starting in FY 21/22. In coordination with school staff, BACR facilitates assessment, short-term case management and referral for Newcomer students, in addition to working with families. BACR also trains staff and leads parent workshops to build the capacity of adult support systems in the lives of Newcomer youth benefiting from intensive supports.

Outcomes: Bay Area Community Resources	Goal FY 20/21	Actual FY 20/21
NFC will run groups in Year 1 with an average of 10 family members per group for 2-4 weeks each.	4 groups	1 group
By the end of the school year the newcomer youth and their families will have completed 2 sessions to learn about how to cope	50% completed	48% completed

with stress, recognize signs of substance abuse and the health and legal consequences of using substances.		
By the end of the school year, newcomer students will participate in cultural circles with former newcomer students .	50% of Newcomer students	20% of newcomer students
By the end of the school year, newcomer students will participate in out of school time activities that will help them gain access to academic language, enrichment and recreational opportunities	60% of newcomer students	64% of newcomer students
By the end of the school year, Newcomers will attend at least one tutoring session per week with a school teacher from an academic subject they are struggling with.	50% of newcomer students	33% of newcomer students
By the end of the school year teachers working with Newcomers will have completed at least 2 of the training offerings	75% of teachers	75% of teachers participated in professional development workshops
PEI Satisfaction Survey will be responded to by the parents who received support from the NFC, or were contacted by the NFC staff at least 3 times.	75% of parents	75% of parents
Total referrals to County Behavioral Health (BHRS)	N/A	23
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	0
Average duration in weeks of signs of untreated	N/A	Unknown

mental illness (per client or caregiver report)		
Total referrals to other PEI providers	N/A	2
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	2
Average time in weeks between when a referral was given to individual by program and the individual's first in person appointment with the PEI funded provider	N/A	Unknown
Total referrals to other mental health services or resources for basic needs	N/A	154



Thank You Alicia!

Our families had a blast thanks to your help at Slide Ranch Fieldtrip!

With appreciation,
Davidson Middle School Newcomer Families
BACR Newcomer Family Services



EQUITY STRATEGIES:

Newcomers PEI providers create linkages to services for Newcomers, immigrants, Monolingual Spanish-speakers, LGBTQ+, Unaccompanied minors. They build on their resiliency by providing guidance and connecting them to safety net systems, providing concrete supports, creating safe spaces to connect to their peers, and other supportive adults in their community. Program staff are all bilingual and bicultural and immigrants and can easily build trust with students and their families to better connect them to services. Throughout the pandemic, Newcomers PEI programs were able to offer telehealth and electronic signature to ensure that clients were served without a lapse in support. They partnered with school districts and other CBOs to ensure that clients and families had access to internet, and computers and phones to be able to access services and continue studying and working. Outreach strategies utilize non-traditional methods to engage youth and deliver services, including activities such as, soccer training and games, group



picnics, group chats, and individual meetings for coffee or a meal. Providing Newcomers support for mental health and basic needs are a fundamental part of service delivery for all PEI Newcomers providers. To strengthen coordination, identify trends, and address challenges, PEI funded Newcomers Providers began meeting monthly in FY 20/21. These “workgroups” are led by the BHRS PEI Supervisor.

CHALLENGES AND UPCOMING CHANGES:

In **FY 2020-21**, this program was implemented as described in the MHSa Three-Year Program and Expenditure Plan for **FY2020-21** through **FY2022-23** although services continued to be impacted by COVID-19. Complete data gathering proved very challenging to complete this year for Newcomer youth. The virtual formats are not applicable for working with youth who have never met providers before as the questions asked are personal and require building connection with youth. The technological ability required to fill out an online survey of this type was not present in some of the youth and was an additional barrier to data collection. A positive outcome of the pandemic was that the interpersonal (?) challenges encouraged community partners to increase their connections (even virtually) to make sure that Newcomer students wouldn't fall through the cracks. The community liaison at Novato and San Rafael High schools, the academic school counselors, and the district newcomer counselors were in frequent communication with the PEI Newcomers providers to discuss student referrals, consult and connect to resources.

PEI Newcomers program goals for **Fiscal Year 21/22** include: Maintaining the stronger communication; Maintaining and solidifying virtual/telehealth services in order to support equity; Implementing the FUERTE training and curriculum in partnership with UCSF; working with school districts, CBO's, MCOE, and County programs to define and support TAY that are aging out, through linkages to career training, mentorship, language acquisition and academic advancement; Continuing PEI provider workgroup in collaboration with Marin County Office of Education and; In partnership with Marin County Office of Education, implementing Newcomers Toolkit [“Championing Newcomer Success: Best Practices & Approaches”](#) that was developed by the PEI funded Newcomers providers and the BHRS Prevention and Outreach team in early **FY 21/22**.

Additional Newcomers program changes for the **FY 21/22** include adding a half-time Coordinator added under BACR contract to support the BRIDGE program at San Rafael High.

CLIENT STORY

A newcomer student arrived in the US and Davidson Middle School last October. He arrived with his 2 youngest sisters, to stay with his aunt. The student was successfully enrolled in virtual classes. He quickly learned to advocate for himself, visiting the DMS family center to request more support with his Aeries account, and emailing me to help him register for his electives at San Rafael High School. Eventually he was invited to be part of the HUB, an opportunity that helped him continue to improve academically; he graduated middle school with straight A grades. In November, his aunt was struggling financially, so staff connected with coordinator and the student and his family received clothing for 5 children and gift cards for the family. Four months ago, his mother reunited with him and his siblings. Mom is working

and with staff support, she registered her student in High School and her little daughter in kindergarten. Right now, the student is participating in the DMS summer program and receiving leadership academy workshops that are preparing him to transition into high school.

CLIENT STORY

Client is a 16-year-old newcomer student who attended our 5-session Social Emotional Newcomer workshop Series at Novato High School (NHS). Before client was connected to services, they were going through a difficult time. When the Latinx Youth Wellness Coordinator met with the student during their one-on-one session, the GAIN screener was administered and the student scored relatively high. As a result, mental health services were offered through our NMCS school-based clinician serving NHS students. Unfortunately, the student had denied services during the one-on-one session. At that time, the student was told that our door will always be open. A month later the student reached out to the Latinx Youth Wellness Coordinator stating that they would like to be connected to our school-based clinician, and the connection was made. The community liaison later contacted us, asking if we could connect this student with Marin Community Clinic (MCC) to help setup their health insurance coverage. The student had not received any medical care because they didn't have health insurance. The Latinx Youth Wellness Coordinator connected with MCC to help coordinate care for this student so that they could receive coverage and have access to medical care. The student was enrolled in Medi-Cal, is receiving medical care and counseling support all due to their participation in the Newcomer workshops.

STORYTELLING PROGRAMS (PEI 24)

SERVICE CATEGORY: STIGMA REDUCTION

SB 1004 PRIORITY CATEGORIZATION: #2, #4

MARIN PEI PRIORITY STRATEGY AREA(S): Capacity building, Suicide Prevention

PROGRAM ALLOCATION: \$50,000

PROVIDERS: National Alliance on Mental Illness (NAMI) and Opening the World (OTW)

TARGET POPULATION: Community members and those with lived mental health and substance use experiences. Transition Age Youth (TAY) and the broader community benefit from the development of these mental health educational and awareness raising videos.

EXPECTED NUMBERS TO BE SERVED: 500

PROGRAM DESCRIPTION

Marin County Storytelling Program was created in FY20/21 and is designed to raise awareness of mental health, suicide and substance use, create safe and healthy environments for sharing and increase knowledge of community resources. In this 3-year MHSA plan, the Storytelling Program under PEI is expanded (through an RFP process) to include a digital storytelling component. Participants in the digital storytelling program will have the opportunity to create short videos that share their personal experiences with mental illness, substance use, and recovery.

DATA COLLECTION METHODS:

The following data is reported to BHRS 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 number and types of individuals trained, types of trainings provided, demographics (see PEI overview section), and training evaluations
 - The number and type of outreach activities and participants reached client/family demographics and satisfaction surveys to show impact of services provided
 - OTW collects data based on the number of views of their story telling videos. To date, there have been a total of 189 views of videos. Included in each video is a link for a survey ([example here](#)) for viewers to complete.

Anticipated data collection changes and additions for FY 22/23: For community trainings, we anticipate using the CIBHS Measurements, Outcomes, and Quality Assessment (MOQA) participant questionnaire, speakers' evaluations to measure skill development and satisfaction with training component of program. PEI will also incorporate evidenced based strategies to evaluate stigma

Story Telling Program

SUMMARY FY2020-21

**Clients Served:
FY2020-21**

2239

Individuals Served

189

Views of Digital Stories

reduction programs and outcomes such as utilizing tools from Patrick Corrigan’s stigma evaluation toolkit.

KEY OUTCOMES:

- Increased understanding of mental health, suicide prevention and substance use disorders;
- increased knowledge about signs and symptoms of issues such as depression, anxiety, psychosis, and substance abuse;
- reduced negative attitudes and beliefs about people with symptoms of mental health disorders;
- increased skills for responding to people with signs of mental illness and connecting individual to services;
- increased knowledge of resources available;
- improved skills and comfort level amongst speakers in public speaking and sharing their stories.

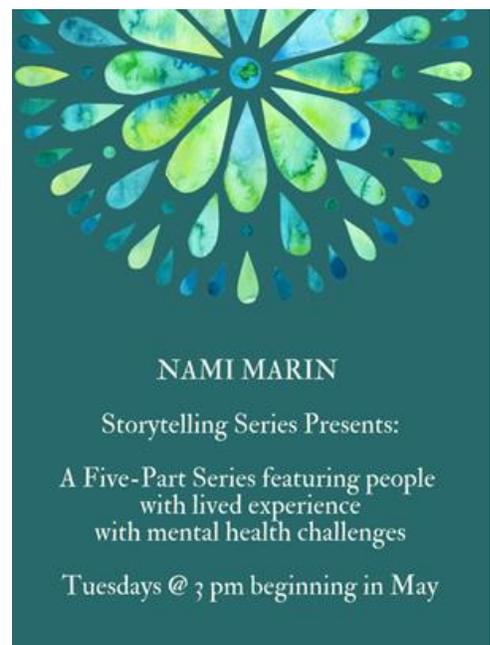
NAMI-MARIN

In **FY 20/21**, National Alliance on Mental Illness (NAMI)-Marin continued with their “In Our Own Voices” (IOOV) storytelling series. The program is designed to create healthy environments of compassion, kindness, respect, non-judgment, and support.

IOOV is a unique public education program in which trained speakers share compelling personal stories about living with mental illness and achieving recovery. IOOV presentations are given to people going through a mental health challenge, including students, law enforcement officials, hospitals, educators, providers, faith community members, interested civic groups and more.

In **FY20-21**, NAMI recruited **5+** diverse speakers of family members or individuals who have lived experience with substance abuse, mental illness and/or suicide loss and suicide survivors that span the spectrums of race, religion, age, gender, socio-economic and cultural backgrounds, romantic affiliation, ethnicity, and experience.

This program helps to dispel many myths surrounding mental illness. Audiences benefit from this type of presentation because they learn, firsthand, what it means to have a serious mental illness and how the recovery process works. All IOOV presenters complete a 16-hour NAMI training course. Presenters often find that participating in this program helps build self-esteem. Presenters may learn new coping strategies from one another and are given hope and strength by finding a community of peers.



Outcomes: NAMI-Marin	Goal FY 20/21	Actual FY 20/21
By the end of the year, recruit speakers through outreach and engagement	N=8	N=8 speakers
By the end of the year, train speakers in the Speaker Training “In Our Own Voice.” Improve skills and comfort level amongst speakers in public speaking and sharing their stories	N=5	N=5
By the end of the year, complete a minimum of 4 hours of training annually to stay abreast of new learning regarding cultural humility, racial equity and trauma-informed practices	Yes	Yes

OPENING THE WORLD:

Opening the World (OTW) serves underprivileged, transitional age youth (ages 16 to 26) from culturally diverse backgrounds who have experienced trauma, relational conflicts, loss, substance abuse, homelessness, educational challenges, and poverty. The OTW program connects these young adults with OTW senior peers who have lived through similar challenges but are now able to share their stories of struggle, hope, growth, and success.

Young adults learn quality film techniques that will transfer to community short film clips (one to four minutes in length) that increase the public’s knowledge about the cause or impact of mental health issues. Following each video, resources are provided and a survey for completion. The final videos can be found at the Opening the World [website](#).



Outcomes: Opening the World	Goal FY 20/21	Actual FY 20/21
By the end of the year, instruct two youth interns to develop short film clips on mental health	N=2	N=2
By the end of the year, develop 6-8 short film clips	N=6	N=6

EQUITY STRATEGIES:

The OTW and NAMI took a minimum of 4 hours of training around cultural humility, racial equity and trauma-informed practices by completing the Marin County Leadership and Equity training. OTW and NAMI utilizes the power of story telling to address mental health among populations impacted, particularly during this period of Covid. By highlighting these issues and identifying sources of support, the story telling series are showcasing that recovery is possible and that help is available.

CHALLENGES AND UPCOMING CHANGES

Due to Covid, in **FY20-21**, there was a disruption in some events presented and/or student engagement in the film making process. However, even in light of these disruptions NAMI and OTW were able to provide engaging programs with revised planning. For example, while NAMI historically held events in person with the event theme centered around the speaker with their favorite type of food or music to help set the tone, etc, that was more challenging from a virtual perspective. Completion of evaluations is an ongoing challenge. There are plans to create a flyer with a listing of all of the videos and a description with a link to complete demographic and survey information and NAMI will be sending out evaluations after each event.

CLIENT STORY

“I appreciated this video tremendously and [the interviewee] gave profound insight into the “critical” place in time we’ve been under in the past few years. I can see this as a great conversation piece for our organization’s learning series as well!”

CLIENT STORY

I found these stories to be so much more beneficial than support groups because I loved hearing from people who have made it to the other side of emotional pain. I could attend these weekly. It was very healing and hopeful to me.

PEI COMPONENT BUDGET

Program	FY20-21	FY2021-22	FY2022-23	% of budget for youth 25/under	FY22-23 \$ to be spent on youth	Total
PEI-01 Early Childhood Mental Health Consultation ECMH	\$230,000	\$240,000	\$290,000	100%	\$290,000	\$760,000
PEI-04 Transition Age Youth (TAY) PEI	\$240,000	\$265,000	\$310,000	100%	\$310,000	\$815,000
PEI-05 Latino Community Connection	\$280,000	\$315,000	\$444,924	11%	\$48,942	\$1,039,924
PEI-07 Older Adult PEI	\$156,000	\$235,000	\$290,000	0%	\$0	\$681,000
PEI-12 Community Training and Supports	\$195,314	\$94,000	\$74,000	46%	\$34,040	\$363,314
PEI-18 School Age PEI	\$406,666	\$444,875	\$786,942	100%	\$786,942	\$1,638,483
PEI-19 Veteran's Community Connection	\$73,000	\$73,000	\$73,000	8%	\$5,840	\$219,000
PEI-20 Statewide PEI	\$81,000	\$81,000	\$81,000	58%	\$46,980	\$243,000
PEI-21 Suicide Prevention	\$317,813	\$502,620	\$470,620	40%	\$188,248	\$1,291,053
PEI-23 Newcomer Supports	\$130,500	\$265,500	\$289,941	100%	\$289,941	\$685,941
PEI-24 Storytelling programs	\$42,500	\$65,000	\$85,000	40%	\$34,000	\$192,500
Subtotal Direct Services	\$2,152,793	\$2,580,995	\$3,195,427	64%	\$2,034,933	\$7,929,215
PEI Supervisor	\$124,000	\$124,000	\$124,000			\$372,000
Administration and Indirect	\$341,519	\$405,749	\$497,914			\$1,245,182
Total	\$2,618,312	\$3,110,744	\$3,817,341	53%		\$9,546,397

PREVENTION AND EARLY INTERVENTION (PEI) EXPECTED NUMBERS TO BE SERVED AND COST PER PERSON

Program	Individuals						Family Members	Providers	FY22/23 Budget	FY22/23 Cost per Person Projected
	0-15	16-25	26-59	60-74	75+	Total				
PEI-01 Early Childhood Mental Health Consultation ECMH	622					622	165	215	\$290,000	\$289
PEI-04 Transition Age Youth (TAY) PEI	376	397	11			784	368		\$310,000	\$269
PEI-05 Latino Community Connection	24	63	923	81	22	1,113	50	100	\$444,924	\$352
PEI-07 Older Adult PEI				23	26	49	20	560	\$290,000	\$461
PEI-12 Community Training and Supports		41	114	20		175	2000	250	\$74,000	\$31
PEI-18 School Age PEI	190	6	35			231	41	60	\$786,942	\$2,370
PEI-19 Veteran's Community Connection		11	14	38	16	79	8	37	\$73,000	\$589
PEI-20 Statewide PEI									\$81,000	N/A
PEI-21 Suicide Prevention	515	1275	3000	625	125	5540 calls	500	250	\$470,620	\$75
PEI-23 Newcomer Supports	300	100				400			\$289,941	\$725
PEI-24 Storytelling programs	50	100	200	100	50	500	200		\$85,000	\$121

TOTAL BUDGET

	FY20/21	FY21/22	FY22/23	Total
Community Services and Supports (CSS)	\$12,302,067	\$13,509,786	\$15,605,976	\$41,417,830
Capital Facilities and Technology Needs (CFTN)	\$607,059	\$1,992,896	\$2,329,029	\$4,928,984
Workforce Education and Training (WET)	\$250,700	\$772,714	\$970,660	\$1,994,074
Innovation (INN)	\$518,443	\$863,322	\$978,313	\$2,360,078
Prevention and Early Intervention (PEI)	\$2,618,312	\$3,110,744	\$3,817,341	\$9,546,397
TOTAL	\$16,296,581	\$20,249,462	\$23,701,319	\$60,247,363

Appendix 1: Board of Supervisors Approval



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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



Benita McLaren, FACHE
DIRECTOR

20 North San Pedro Road
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San Rafael, CA 94903
415 473 6924 T
415 473 3344 TTY
www.marincounty.org/hhs

June 14, 2022

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 (BHRS) requests approval of the Mental Health Services Act (MHSA) FY 2022-23 Annual Update reporting on FY 2020-21 outcomes and changes for FY 2022-23.

Dear Supervisors:

RECOMMENDATION:

1. Authorize your Board to approve the Mental Health Services Act (MHSA) FY 2022-23 Annual Update.

SUMMARY: The Mental Health Services Act (MHSA) FY 2022-23 Annual Update provides information on the MHSA funded programs and service outcomes for the FY 2020-21 reporting period, the first year of Marin's MHSA Three-Year Program and Expenditure Plan for FY 2021-23. 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.

After a slight decline in the early part of the COVID-19 pandemic in FY 2019-20, MHSA revenues climbed more than 50% year-over-year in FY 2020-21 and are on track to increase 15% further in FY 2021-22. In coordination with the County Administrator's Office and local Stakeholders, this Annual Update increases MHSA-funded programming accordingly to meet the expanding needs for mental health services.

As compared to the FY 2021-22 budget, the proposed budget in the FY 2022-23 MHSA plan increases the Community Services and Supports (CSS) expenditures by \$2,096,190; Capital Facilities and Technology Needs (CFTN) by \$312,185; and Prevention and Early Intervention (PEI) by \$706,597. Of this \$3,114,972 in additional funding across CSS, CFTN, and PEI, 57% will go to contracts with community-based organizations (CBO), 33% will go toward County-administered services including new positions and administration/indirect costs, and 10% will go toward the new Enterprise Health Record System project. The Department will return to your Board in early FY 2022-23 for approval of proposed added positions and new CBO contracts.

Addressing the rising costs and workforce challenges of community-based organizations has been prioritized through this Annual Update. Workforce challenges were a prevailing issue in delivering planned services during the second year of the COVID-19 pandemic, with local community-based

COUNTY OF MARIN

HEALTH AND HUMAN SERVICES 20 North San Pedro Road Suite 2002 San Rafael, CA 94903

CA56

organizations and County behavioral health services having difficulty recruiting, supporting, and retaining staff working in the behavioral health field.

Key changes in the FY 2022-23 Annual Update include:

- Increasing funding to target the heightening youth mental health needs in our community
- Increasing cost-of-living for community-based providers to support recruitment and retention of staff serving vulnerable community members throughout Marin
- Supporting Peer Support Specialists in alignment with new expectations around certification and professionalization of the field through Senate Bill 803 (include short description here of SB 803)
- Planning and budgeting for a new Electronic Health Record (EHR) system for Behavioral Health clients
- Providing high quality supportive services at new permanent supportive housing sites
- Expanding and sustaining field-based services including the Mobile Crisis Response Team (MCRT)
- Enhancing services for older adults including piloting full neuro-psychological evaluations
- Increasing outreach, wellness-focus, and knowledge about programs and accomplishments including a new Wellness Coordinator position
- Expanding treatment service capacity including therapy capacity and the Integrated Multi-Service Partnership Assertive Community Treatment (IMPACT) Full-Service Partnership
- Piloting further care coordination in alignment with the Suicide Prevention Strategic Plan including peer-based follow-up support after a suicide attempt or non-fatal overdose

This MHSAs Annual Update 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. 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. This included six community planning sessions and an ongoing MHSAs Advisory Committee with diverse representation in addition to input from the Mental Health Board.

The draft MHSAs Annual Update was posted for a thirty (30) day public comment period on the Marin County Mental Health Services Act [webpage](#) beginning on April 11, 2022 and ending on May 10, 2022. On Tuesday, May 10, 2022, the Mental Health Board hosted a public hearing. All input received has been considered, and adjustments made as appropriate and incorporated into the presented MHSAs FY 2022-23 Annual Update. The State requires that the Annual Update developed as a result of this process be approved by the County Board of Supervisors after which it will be submitted to the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission.

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. This MHSA Annual Update will enable the County to better serve people most in need, including those involved in the criminal justice system and individuals experiencing chronically homelessness, by making it easier to access and engage in mental health services.

EQUITY IMPACT: This Annual Update focuses on increasing access to high-quality mental health services for underserved populations by promoting recruitment and retention of staff in community-based organizations that are trusted sources of support. Seventy-four (74%) of those served in FY 2020-21 utilizing MHSA Prevention and Early Intervention funding—largely through contracts with community-based organizations—identified as Hispanic or Latino. In addition, this Annual Update expands funding to provide high quality supportive services to those who are experiencing or at-risk of being unhoused, which are vastly disproportionately people of color in Marin County compared to the larger population as a whole.

FISCAL IMPACT: There will be no increase in General Fund Net County cost as a result of your Board's approval. The Department will work with the County Administrator's Office in FY 2022-23 to make the necessary budget adjustments, including the one shown below, to reconcile the annual funding allocation with the funds already budgeted in the MHSA program baseline budgets. Updated FY 2022-23 revenues for the Mental Health Services Act Fund 2380 were already budgeted as a part of the FY 2022-23 County Baseline Budget Process.

Action	Fund	Munis Org Code	Program Name	Object Code	Object Code Name	FY 2022/23 Budget Adjustment
Decrease	2380	23821141	MHSA-Community Services and Supports	511220	Salaries and Wages – Extra Hire (budget holding)	(\$1,114,518)
Increase	2380	23821141	MHSA-Community Services and Supports	522710	CBO	\$1,033,388
Increase	2380	23821142	MHSA-Prevention and Early Intervention	522710	CBO	\$705,347
Increase	2380	23821143	MHSA-Capital Facilities and Tech Needs	522710	CBO	\$1,177,024
Increase	2380	23821144	MHSA-Workforce Education and Training	522710	CBO	\$411,293
Total Expense:						\$2,212,534
Net Fund 2380 Adjustment:						\$2,212,534

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

Respectfully submitted,



Benita McLarin
Director

Appendix 2: MHSA County Compliance Certification

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Marin County

Local Mental Health Director	Program Lead
Name: Jei Africa	Name: Galen Main
Telephone Number: 415.473.7595	Telephone Number: 415.473.6238
E-mail: JAfrica@MarinCounty.org	E-mail: GMain@MarinCounty.org
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 statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 14, 2022.

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)



 Signature 6/30/2022
Date

County: Marin County

Date: 6/30/2022

Appendix 3: MHSa County Fiscal Accountability Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION¹

County/City: Marin County

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Jei Africa	Name: Mina Martinovich
Telephone Number: 415.473.7595	Telephone Number: 415-473-6989
E-mail: JAfrica@MarinCounty.org	E-mail: mmartinovich@MarinCounty.org
Local 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 the Three-Year Program and Expenditure Plan, **Annual Update** or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5847, 5891 and 5892; and Title 9 of the California Code of Regulations section 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

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

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

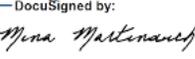
DocuSigned by:

 6/8/2022
 Signature Date

I hereby certify that for the fiscal year ended June 30, **2021**, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated **March 31, 2022**, for the fiscal year that ended June 30, **2021**. I further certify that for the fiscal year ended June 30, **2021**, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Mina Martinovich
 County Auditor Controller / City Financial Officer (PRINT)

DocuSigned by:

 6/14/2022
 Signature Date

¹ Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
 Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)