County of Marin
Health & Human Services
BEHAVIORAL HEALTH AND RECOVERY SERVICES

MENTAL HEALTH SERVICES ACT (MHSA) FY2024/2025 ANNUAL UPDATE

Draft for Public Comment
Posted 4/12/2024

COUNTY OF MARIN

Table of Contents

EXECUTIVE SUMMARY

OVERVIEW

The Fiscal Year (FY) 24/25 Annual Update is an opportunity to make changes to the Mental Health Services Act (MHSA) FY23/24-25/26 Three Year Plan as well as to report on outcomes and activities from FY22/23 (Fiscal Year from July 1, 2022-June 30, 2023). FY22/23 was the last 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: MarinBHRS.org/MHSA

Currently of note are upcoming changes to MHSA. Proposition 1, passed in March 2024, significantly alters funding allocations and focuses on housing, substance use services, and the construction of treatment beds and housing units. Included in its passage is renaming MHSA to the Behavioral Health Services Act (BHSA), reflecting the emphasis on mental health and substance use services. Also included in the reform are new reporting requirements on all behavioral health funding sources which will necessitate a significant administrative effort to achieve. Additionally, beginning in July 2026, funding categories will be restructured into three main areas: housing (30%), full-service partnerships (35%), and behavioral health services and supports (35%). Counties will no longer receive prevention and workforce training funding, the innovation component will be eliminated, and the state will increase their allocation from 5% to 10% resulting in around $140 million annually of MHSA funds shifting from counties to the State.

KEY CHANGES IN THE FY24/25 ANNUAL UPDATE

State projections in January 2024, were 23.6% lower than those in March 2023, resulting in a projected $16M less in MHSA revenue for Marin during the current 3-year plan period. In coordination with the County Administrator's Office and local Stakeholders, this Annual Update decreases the Community Services and Supports (CSS) budget by approximately $4.3M including a decrease in transfers from CSS by $1.8M; and decreases the Prevention and Early Intervention (PEI) budget by approximately $300K. Changes to the FY24/25 Annual Update reflect recent State projections and the passage of Proposition 1. We will closely monitor State projections in the next year, and if additional reductions are necessary during FY25/26, we will include those in our FY25/26 Annual Update.

Changes for the FY24/25 Annual Update were informed by Stakeholder feedback on community and system of care needs and rooted in a fiscally responsible approach. Additionally, changes were made using the following funding principles in partnership with Stakeholders:

- **Maximizing** all funding sources (e.g., Medi-Cal billing) and finding **alternatives** to MHSA wherever possible
- Not starting **new** on-going programs, initiatives, or projects which do not have a path to sustainability under BHSA reform
    - Not setting-up community-based partners to have short-term funding that will go away in a couple of years
    - Not creating or filling positions that would lead to layoffs
- **Prioritizing** direct services to clients
- Critically **evaluate** all potential reduction or allocation scenarios, including the potential impact of Proposition 1

- Where not in line with Proposition 1 priorities, eliminating **vacant** county position(s) and shrinking contracts which have significant current vacant positions or do not align with the future BHSA funding framework

There will be **minimal** cuts to existing services and programs in the changes. The majority of changes focused on leveraging other sources of funding and not starting any new projects FY24/25 with the exception of the State-mandated Community Assistance, Recovery and Empowerment (CARE) Act.

Priorities highlighted during the Community Planning process focused on addressing potential changes with the passage of Proposition 1; Full-Service Partnership (FSP) program needs; and increasing housing options in general, particularly supportive housing. The overall feedback from community planning meetings was to strengthen existing services.

Changes for the FY24/25 Annual Update:

1) Decreases in Community Services and Supports Budget
    a. Strategy:
        i. Reduce Capital Facilities and Technology Needs (CFTN)/Workforce Education and Training (WET) transfers
        ii. Crisis Intervention Training Coordinator position fully funded by County of Marin Probation Department
        iii. Will not recruit for vacant Human Resources Analyst II position
        iv. Pause new community health advocates program expansion by not releasing planned Request for Proposals or establishing the new Community Ambassador program
        v. Community Alternative Response and Engagement Team contract to be shifted to other County funding sources with no reduction in services
        vi. Reduce Mental Health Association of San Francisco contract in second half of FY24/25
        vii. Add Behavioral Health and Recovery Services (BHRS) Peer Support Counselor position to Support and Treatment After Release FSP to provide services to existing clients and future CARE Act clients
        viii. Add Social Service Worker position to Helping Older People Excel FSP to increase bilingual Spanish-speaking capacity, provide services to existing clients and future CARE Act clients, and strengthen fidelity to the Assertive Community Treatment model
        ix. Invest funds in housing vouchers for CARE Act implementation (December 2024)
        x. Support Enterprise Resource Center to bill Medi-Cal to offset costs
        xi. Will not commission independent report on the impact of 20 years of MHSA in Marin

2) Decreases in Workforce Education and Training Budget
    a. Strategy:
        i. Pausing development of new Behavioral Health internship/workforce development Consortium
        ii. Discontinue WET Post Doctoral position
        iii. Discontinue WET funded scholarships, continue to utilize California Mental Health Services Authority (CalMHSA) Peer Support Specialist Program
3) Decreases in Prevention and Early Intervention Budget
    a. Strategies:
        i. Discontinue involvement in PEI Statewide initiatives with CalMHSA
        ii. Reduction in discretionary funds across all PEI
        iii. Mental Health First Aid (MHFA) program will no longer be offered through the Community Training and Supports services PEI program, MHFA training available online where courses are offered in both virtual and in-person formats
        iv. Contracts formerly held by Spahr Center will not be funded for FY24/25 as BHRS explores alternative providers

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 MHSA services or for administrative offices. TN funds are to develop or improve technological systems, such as electronic health records.

MENTAL HEALTH SERVICES ACT (MHSA) 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 both the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) within thirty (30) days after Board of Supervisor adoption.

MARIN COUNTY CHARACTERISTICS

Marin County is a mid-sized county located in the northwestern part of in the San Francisco Bay Area (as defined by the State as between 200,000 and 749,000 residents) with a **population of 254,407** US Census. Marin is known for its combination of rural and suburban lifestyle, excellent schools, entertainment, recreational activities, and mild year-round climate.

Factoring in Agricultural Land Trusts and zoning rules, **over 85% of Marin's lands are protected from development**. Marin County's natural sites include the Muir Woods redwood forest, the Marin Headlands, Stinson Beach, the Point Reyes National Seashore, and Mount Tamalpais. Marin County is one of the highest income counties by per capita income and median household income. Due to the **lack of affordable housing**, **roughly two-thirds of Marin's workforce commutes into the county each day** from neighboring counties and from as a far as Sacramento.

Spanish is the only threshold language, although most county documents are also available in Vietnamese. The US Census 2022 ACS 5-Year Survey found:

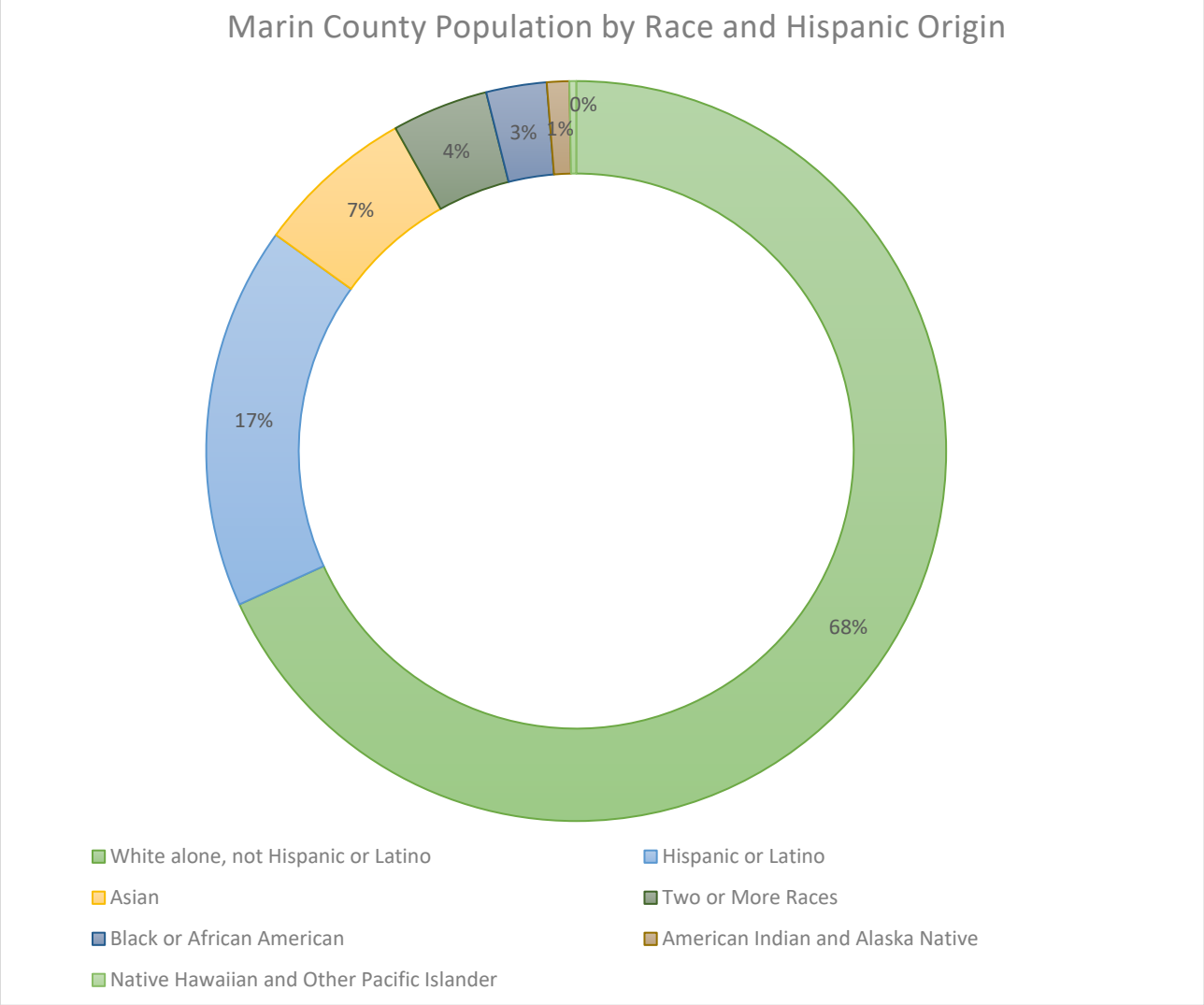
- 78.9% of residents in Marin speak only English,

- 11.2% speak Spanish (46.4% of whom speak English less than "very well"),
- 5.4% speak another Indo-European language (21.2% of whom speak English less than "very well")
- 3.4% speak an Asian or Pacific Island language (48.4% of whom speak English less than "very well")
- 1.1% speak other languages (51.8% of whom speak English less than "very well")

According to the Marin County Health Rankings and Roadmaps released in March 2023, Marin ranked first in the healthiest of California's 58 counties when considering health outcomes such as quality of life, in addition to health behaviors such as social factors, economic factors, and clinical care. The annual report, released by the Robert Wood Johnson Foundation and the University of Wisconsin ranked Marin based on the counties which scored within the 90th percentile. The report evaluated counties across the nation to measure how healthy residents are and estimated life expectancy. 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.

While Marin scored near the top in most health factors, there were important exceptions. Housing affordability, income inequality, suicide rates, and racial disparities in health were highlighted as weaknesses in Marin's health profile. Among 58 California counties, **Marin ranked 54th in income inequality and 39th in housing cost burdens. The median household income in Marin county is $126,373 with a poverty rate of 7.6%.**

In 2023, Marin County was ranked as the **third most racially disparate county in California** by the Advancement Project RaceCounts. Marin County's high racial disparities in crime and justice, health access, and housing stand out most in comparison to other counties. Black/African American residents were the most impacted by racial disparities in Marin.



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 focused on race.

Marin County had the **highest suicide rate in the Bay Area** based on data from 2018 - 2020 (California Department of Public Health, overview of Age-Adjusted Suicide Rate by County in CA, 2018 - 2020). The data found white middle-aged and older men were disproportionately impacted by suicide, consistent with national trends. Additionally, data has shown that LGBTQ+ youth in Marin report higher levels of suicidal ideation and depression-related feelings, which is consistent with Statewide findings (California School Climate, Health, and Learning Surveys, 2017 - 2019). Suicide remains a public health concern across the lifespan and affects individuals of all races, sexual orientations, and gender identities.

Black/African American and Latine youth of Marin County have experienced an increase of trauma from adverse childhood experiences negatively affecting health and well-being. Marin county has been proactive in creating spaces and places where youth/adults of all gender orientations, and all ethnicities can receive help and healing.

RACIAL/ETHNIC DISPARITIES IN SERVICE UTILIZATION

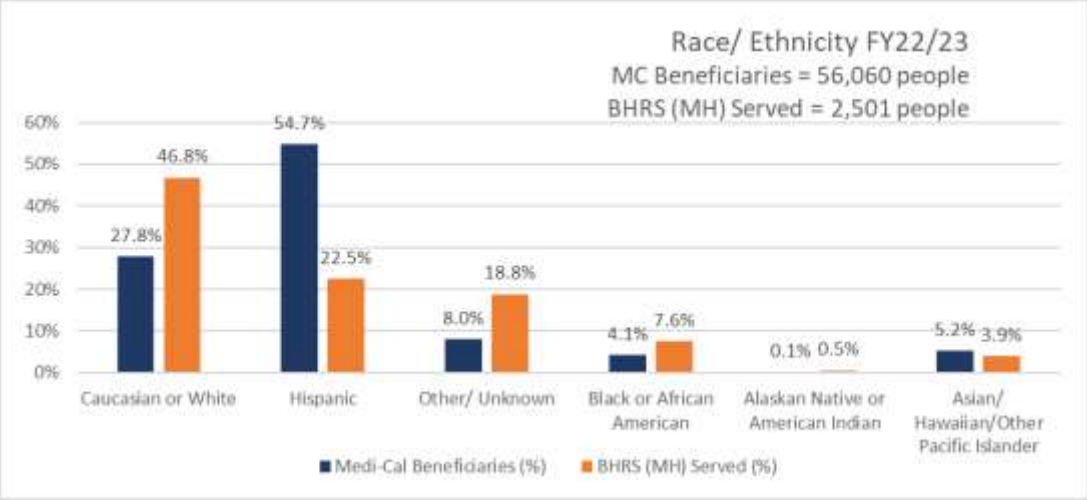
During Marin's initial 2004 MHSA planning process the adult Latine population was identified as the most underserved racial/ethnic population by the existing County Mental Health Services. Despite ongoing and substantial efforts over the years to address this trend, the disparity remains. Marin has addressed this disparity by continued partnership with Latino Community Connection who provides training and support to *Promotores. Promotores* has expanded community health advocates to be able to provide outreach, education, support and linkages to services in Central, North, and West Marin.

Ensuring the Latine population is aware of all services Marin County has to offer allows for underserved populations to be better served. Marin has 50% of Latine adults on Medi-Cal who have restricted Medi-Cal rather than full scope Medi-Cal. Restricted scope benefits provide limited health care coverage such as emergency services and pregnancy-related services. Restricted scope Medi-Cal are available to individuals who meet the eligibility criteria and whose immigration status has not been determined, who are not United States citizens/nationals, or who do not have satisfactory immigration status. In 2020 all Transitional Age Youth became eligible for full scope Medi-Cal regardless of immigration status as long as they meet all other eligibility requirements and in 2022 all adults 50 years or older became eligible for full scope Medi-Cal benefits. Beginning January 2024, under the adult Expansion policy change, all adults of ages 26 through 49 years are eligible for full scope Medi-Cal benefits regardless of immigration status, as long as they meet all other eligibility requirements.

When analyzing the FY22/23 utilization data, the Asian/Hawaiian/Other Pacific Islander population was served at a lower rate in Marin than the Medi-Cal population (3.9% served vs 5.2% of the Medi-Cal population). Marin continues to focus on this population.

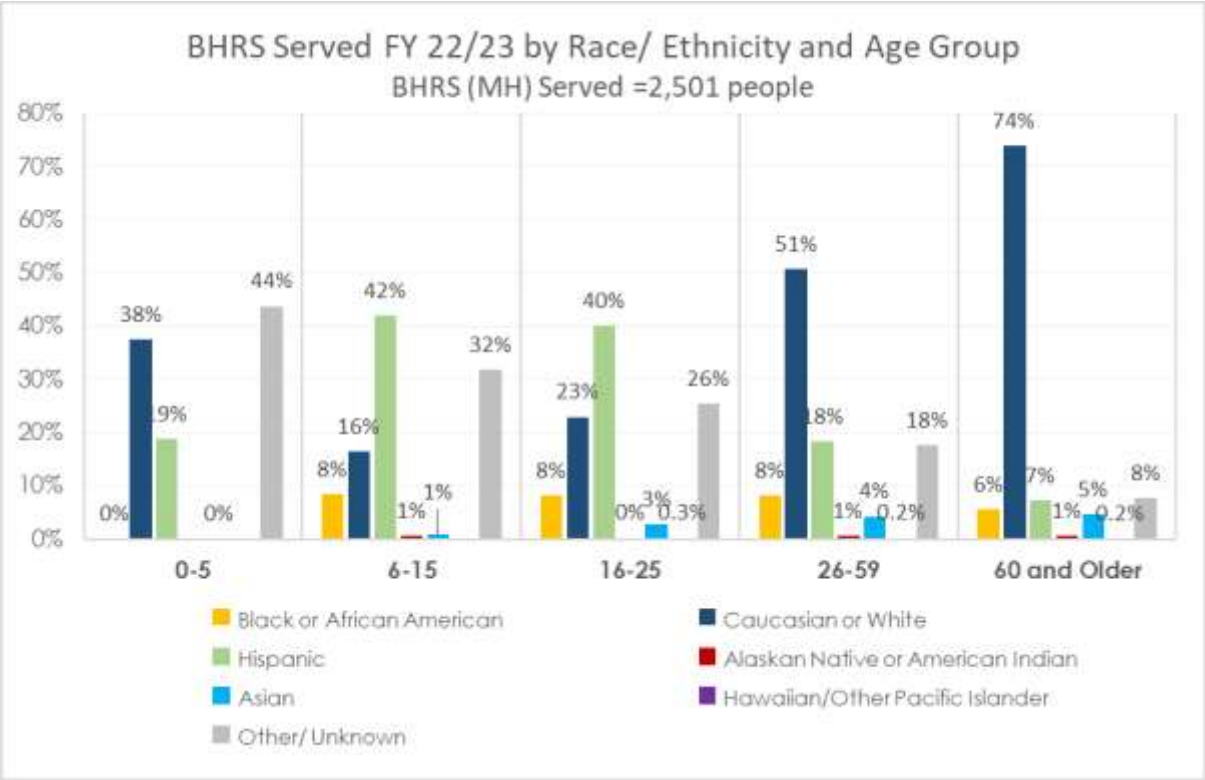
Designation of un/underserved populations is based on the distribution of Marin residents who are eligible for County mental health services. This is represented in the following charts by the comparison of "Medi-Cal Beneficiaries" to the distribution of those receiving county mental health treatment services, "BHRS Served."

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) in FY22/23 broken down by age group, the trend of the Latine population receiving a significantly higher proportion of services as youth than adults has remained the same as the prior year. This trend is consistent with previous data analyses of BHRS clients served by race/ethnicity and age group.

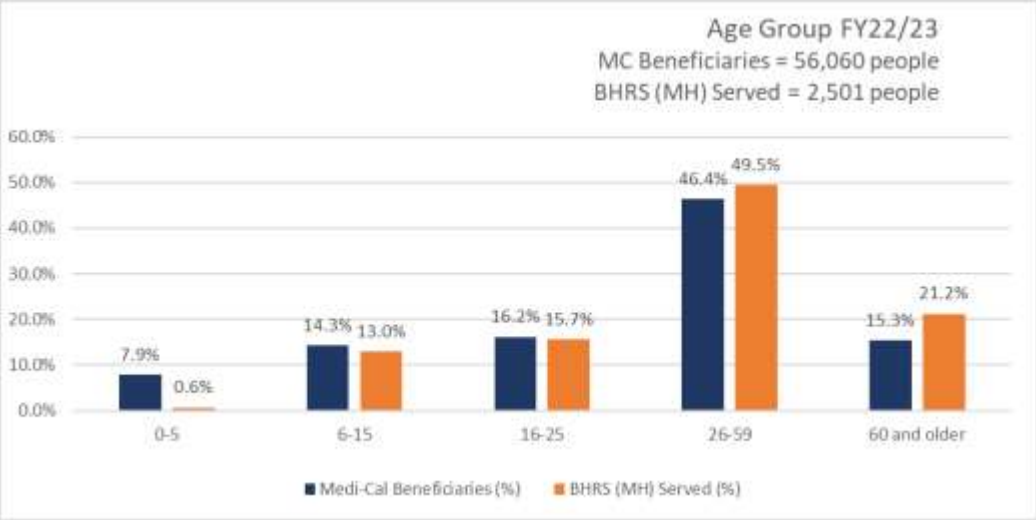
RACIAL/ETHNIC DISTRIBUTION OF THOSE SERVED BY BHRS BY AGE GROUP



AGE DISPARITIES IN SERVICE UTILIZATION

Young children were 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. Older adults make up 15.3% of the Medi-Cal population and 21.2% were served by BHRS.

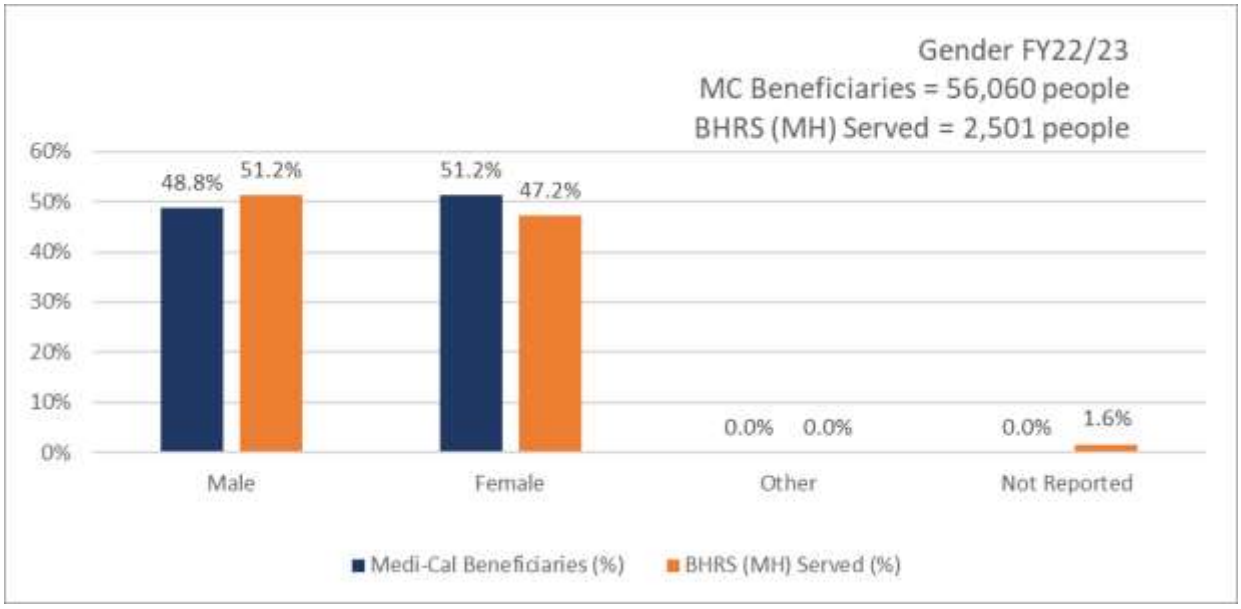
AGE GROUP DISTRIBUTION OF MARIN MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS



GENDER DISPARITIES IN SERVICE UTILIZATION

Males continue to be served at a higher rate than the female population by BHRS mental health treatment programs.

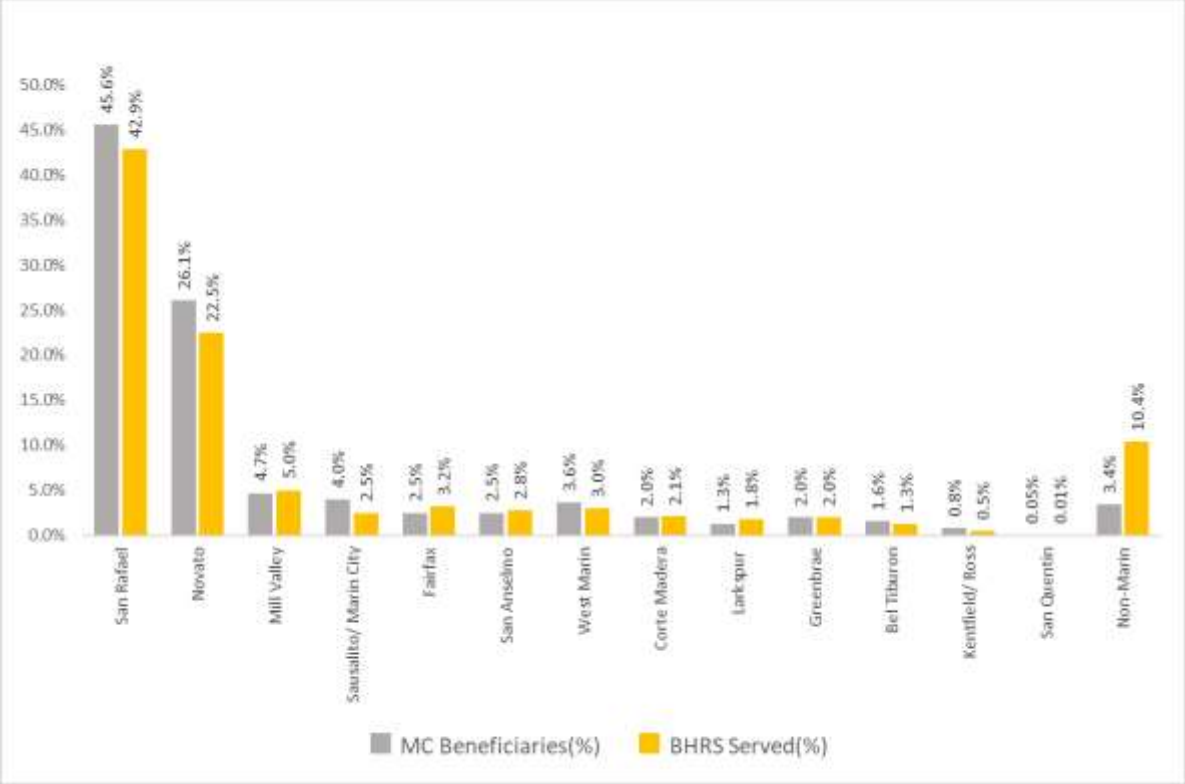
GENDER DISTRIBUTION OF MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS



GEOGRAPHIC DISPARITIES IN SERVICE UTILIZATION

Of Marin Medi-Cal beneficiaries, 71.7% live in either San Rafael or Novato which is somewhat reflected in the percentage served by BHRS in those geographic areas. Novato was slightly underserved in FY22/23 with 26.1% of the Medi-Cal population and 22.5% of the beneficiaries served by BHRS. Both West Marin and Marin City/Sausalito remain underserved. Additional efforts are required to increase the proportion of individuals served in Marin City/Sausalito. Multiple departments within Health and Human Services, including BHRS, will provide services at a future hub in Marin City when a physical location opens.

PERCENT OF MARIN MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS BY CITY OF RESIDENCE: FY22/23



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: http://www.marinhhs.org/MHSA). The results of this process developed the underlying framework for ensuing MHSA component plans.

The funding for the five (5) components of the Mental Health Services Act was released at different times after the Act was approved by voters. For each MHSA component, additional community stakeholder processes were conducted to develop the specific component plans. These are posted on the MHSA website at: https://prevention.marinbhrs.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 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 September 2022, Marin County began the community planning process for the MHSA Three-Year Program and Expenditure Plan for Fiscal Year (FY) 2023-24 through FY2025-26 which includes all five (5) MHSA components. This Plan was developed with local stakeholders, including transitional age youth, adults, and older adult with serious mental illness, families of children 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

In order for clients and family members to have meaningful stakeholder involvement on mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations, BHRS gathers broad, inclusive, and ongoing input from community stakeholders with lived experience during the development of MHSA Three-Year Plans and Annual Updates, and in MHSA program planning. This includes through the ongoing MHSA Advisory Committee (which has a majority of people with lived experience), the Behavioral Health Board, the Equity and Community Partnership Committee (ECPC), the Recovery Change Team (which is entirely peer led), and the Enterprise Resource Center Advocacy Committee (also entirely peer-led). These spaces provide an opportunity for stakeholders to have ongoing input for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes.

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

MHSA Three-Year Planning Process for FY23/24 Through FY25/26

Overall Approach:

This planning cycle we worked to maximize input from community members to inform both the MHSA Three-Year Plan and the BHRS Cultural Competency Plan with the MHSA Coordinator and the Equity Program Manager co-leading the community planning process this year. Target outreach was utilized to reach consumers, family members, and underserved populations and included:

- 20 MHSA Community Planning meetings between October 2022 and April 2023 (7 in person, 2 Hybrid, and 11 virtual – 4 meetings entirely in Spanish, 1 entirely in Vietnamese, 4 with interpreters)
- 524 responses to the MHSA Planning Survey
- 18 Peer-led 1:1 interviews
- 28 key informant interviews (a total of 63 individuals)

The chief goal this year was to develop strategies to engage people in a way where they could provide their most authentic and honest input without feeling shame or fear or facing unnecessary obstacles. In order to do this, we used a number of strategies this year:

- Peer-led "one on one" interviews to ensure people with serious mental illness who may not feel comfortable sharing their input in a group setting are heard;
- Partnering with trusted community-based organizations to create welcoming and culturally relevant spaces for underserved communities to share their input for MHSA planning with food, childcare, gift cards, trusted faces, and meeting space where they are comfortable attending;
- Creating a digital form of providing input through the survey with a balance of open-ended and choice questions to maximize input. In prior community planning cycles, there was significantly less input from males but this year the online survey was a method that generated a significant response from men who may be less comfortable sharing in a group setting;
- A series of meetings entirely in Spanish and Vietnamese rather than relying on interpretation which leaves some individuals at a disadvantage;
- Meetings held at both the Peer-run drop-in center and the Empowerment Clubhouse to ensure individuals with lived experience can share their input in a place where they feel comfortable;
- Partnering with NAMI to hold a meeting specifically for family members to discuss issues from a family perspective with other family members;
- Partnering with LGBTQ+ advocates and community leaders to hold spaces specifically discussing the mental health needs of LGBTQ+ people of all ages in Marin and support the distribution of the survey throughout the LGBTQ+ community in Marin;
- Creating spaces with disability advocates that included ASL and CDI interpretation and CART captions.

Key Highlights:

The Community Program Planning Process (CPPP) took place between October of 2022 and February of 2023. Key themes that emerged were:

- Expand and Improve Behavioral Health Crisis Response Services (including bilingual capabilities)
- Strengthen Peer and Family Supports
- Expand Partnerships to Address Resource Gaps
- Improve Data Collection and Transparency
- Increase Accessibility of Services across the continuum
- Support Workforce Development & Career pathways/retention
- Expand Training and Community Outreach
- Enhance Integration of Substance Use & Mental Health Services
- Support Housing Availability, Access & Retention

Program Evaluations

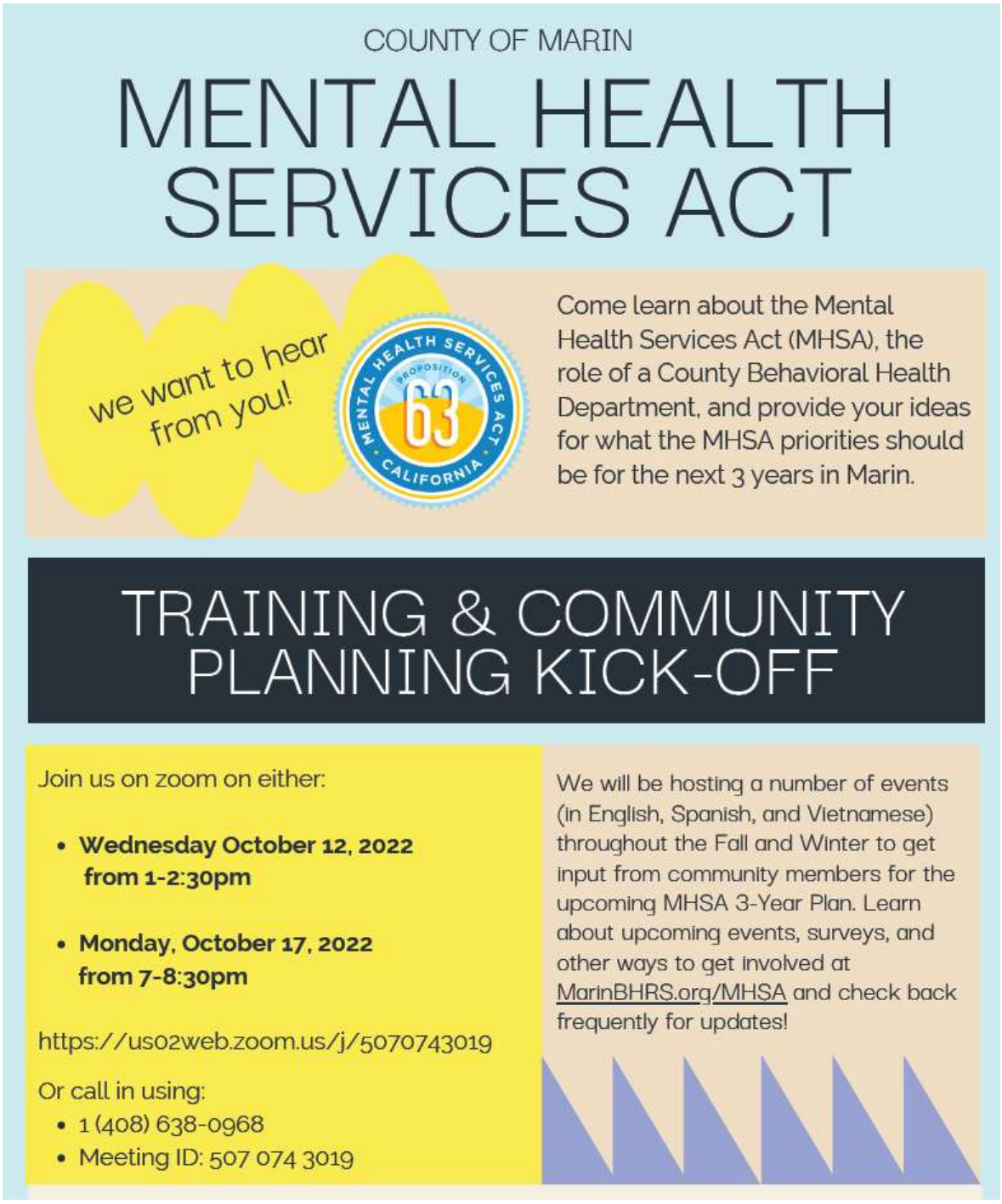
All MHSA programs submit outcome data at least annually (many on a monthly or biannual basis) and that information is provided in the MHSA **Annual Updates**. This data is used to make adjustments to the existing programs each year. In preparation for the MHSA Three-Year Program and Expenditure Plan, 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 held two community-wide trainings.

44 community members participated in these special training events that were held via zoom. One event was held during the workday (1-2:30pm on Wednesday, October 12, 2022) and the other in the evening (7-8:30pm on Monday October 17, 2022) to try to provide flexibility to meet different community member's schedules. The topics covered in the MHSA Planning events were as follows:

- What is the role of a Public Behavioral Health system?
- What is the Mental Health Services Act and what are the Guiding Values?
- What are the rules and regulations around how MHSA funding can be utilized?
- How much funding is there? And how is changed over time?
- What programs and services are currently funded by MHSA and at what percent of each component budget?
- What were the 10 top priorities from the prior three-year planning process and what progress has been made on those efforts?
- How do the penetration rates for Specialty Mental Health Services in Marin compare to other Medium Sized Counties and the State as a whole
- What is the BHRS Cultural Humility Plan and how is it related to the MHSA 3-Year Plan?



In addition to the special training events held at the beginning of the MHSA Planning Cycle, BHRS worked to ensure all stakeholders who participated were trained in the CPPP process by holding 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**.

Community Planning Meetings

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, regulations for the components of MHSA, and steps and timeline for plan approval and ways to remain involved.

The following 20 community planning sessions for this MHSA Three Year Plan:

- 10/6, Thursday (10-noon): **Early Childhood** (0-13 y.o.) Mental Health Round Table with Early Childhood Mental Health Providers (in partnership with First 5). In person at the Kerner Connection Center.
- 10/12, Wednesday (1:00-2:30pm) **Training and Community Planning Kick-Off** Day-time Meeting (virtual)
- 10/17, Monday (7-8:30pm) **Training and Community Planning Kick-Off** Evening Meeting (virtual)
- 10/20, Thursday (1-2:30) **Lived Experience** planning meeting (HYBRID in **Marin City**, Empowerment Clubhouse and virtual).
- 10/25, Tuesday (6:30-8pm): **Family Member** focused MHSA planning meeting (in person—Kerner Connection Center) English with Spanish interpretation.
- 10/27, Thursday (2-3:30pm): **Equity and Community Partnerships Committee** MHSA planning meeting (virtual)
- 12/8, Thursday (10:30am-12pm): **Older Adult** focused MHSA planning meeting (virtual)
- 12/12, Monday (12-2pm): **Lived Experience** MHSA planning meeting (in person), Enterprise Resource Center, 3270 Kerner Blvd, San Rafael (lunch provided)
- 12/15, Thursday (6-7:30pm): **LGBTQ+** listening session (virtual). English with Spanish interpretation.
- 1/10, Tuesday (6-8pm): Behavioral Health Services for those Experiencing **Disability** (virtual: ASL and CDI interpretation and CART captions available).
- 1/13. Friday (3-5pm): In person meeting for **Vietnamese speaking individuals** at the Multicultural Center of Marin (in partnership with MAAP) — *meeting held in Vietnamese*

- 1/18, Wednesday (6-7:30pm): In person meeting for **Spanish speaking individuals with lived experience in Northern Marin** (in partnership with North Marin Community Services (NMCS))—*meeting held in Spanish*

- 1/19, Thursday (10am-12pm): Professionals Providing Services to People Experiencing **Disabilities** (virtual: ASL and CDI interpretation and CART captions available).

- 1/24, Tuesday (6pm-7:30pm): In person meeting focused on reaching **Marin City residents with lived experience** at First Missionary Baptist Church (in partnership with FMBC)

- 1/25, Wednesday (2pm-3:30pm): **"Career Pathways, Internships, Recruitment, and Retention"**

- 1/25, Wednesday (6-7:30pm): In person meeting for **Spanish speaking individuals with lived experience in West Marin** (in partnership with NMCS)—*meeting held in Spanish*

- 1/27, Friday (6-7:30pm): In person meeting for **Spanish speaking individuals with lived experience in the Canal** Neighborhood of San Rafael (in partnership with Canal Alliance)—*meeting held in Spanish*

- 1/31, Tuesday (10am-11:30am): **Training and Continuing Education for Providers**

- 1/31, Tuesday (6-7:30pm): Virtual MHSA Planning session in **Spanish** (in partnership with NMCS)—*meeting held in Spanish*

- 4/13, Thursday (6pm-7pm): **Marin City Follow-Up MHSA Planning Session**

This planning cycle we held four meetings entirely in Spanish, one meeting entirely in Vietnamese, and had interpretation at several other events as well that were targeted on specific areas like LGBTQ+ issues or family members with a loved one with serious mental illness. Community meetings were conducted throughout the County and held virtually and at different times of day to accommodate different schedules. Many of the in person meetings included bus passes, food, non-alcoholic beverages, and childcare. 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. Gift cards and bus passes were given to participants with lived experience and raffles were held at meetings targeting underserved community members.

Community Planning Survey

Online and paper surveys were available in English and Spanish were used to gather community input to inform funding priorities. A **total of 524 surveys were collected, with 503 in English and 21 in Spanish.**

The answers to the key behavioral health related questions on the survey are displayed on the next two pages:

The top five priorities of Marin County's Public Behavioral Health System over the next three years should be:

1. *Behavioral health crisis alternative response (e.g. Mobile Crisis Response Team, or other options) and training for law enforcement*

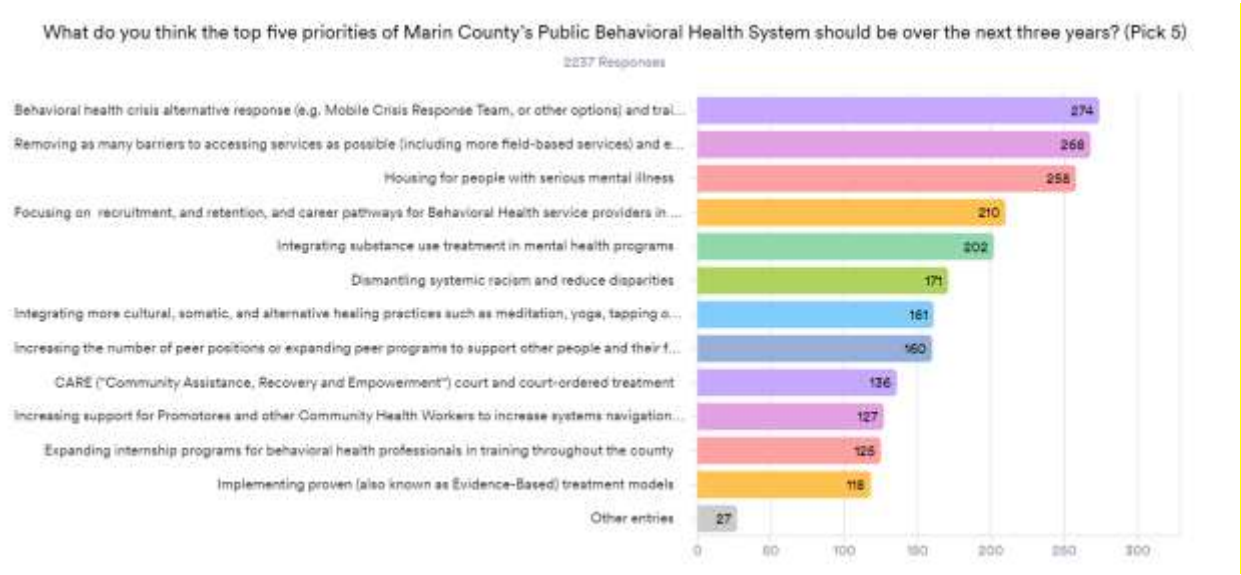
2. *Removing as many barriers to accessing services as possible (including more field-based services) and expanding outreach and engagement efforts*

3. *Housing for people with serious mental illness*

4. *Focusing on recruitment, and retention, and career pathways for Behavioral Health service providers in Marin with an emphasis on bilingual and bicultural behavioral health provider*

5. *Integrating substance use treatment in mental health programs*

These five items will be referred to as *Key Community Planning Survey Priorities* throughout this 3-Year Plan to show how this input has been integrated.



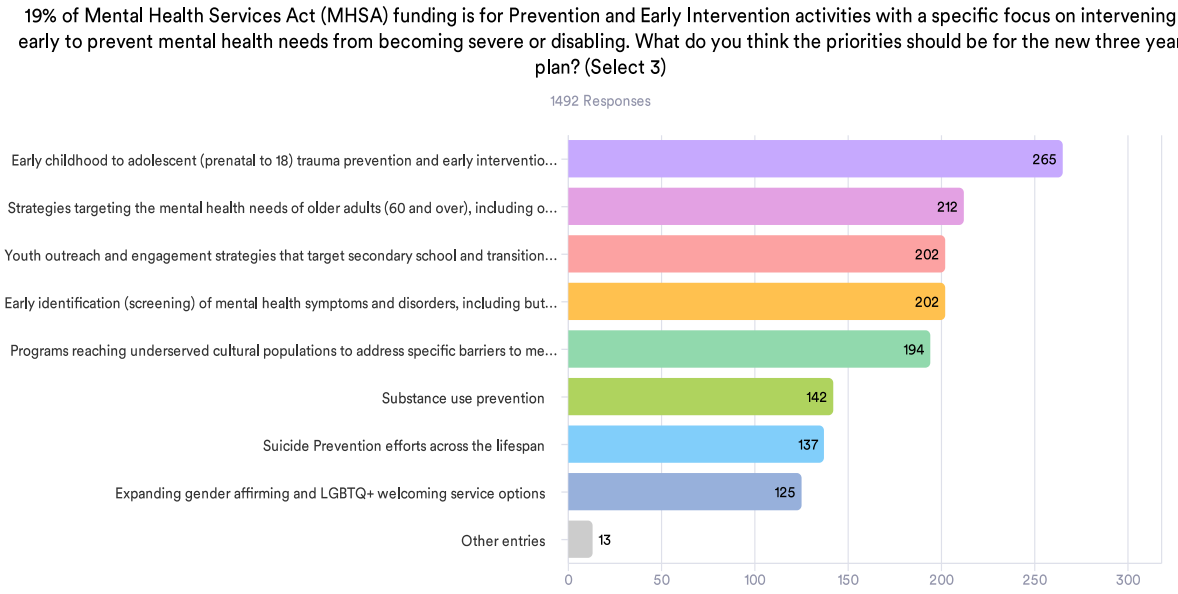
The top 3 priorities for Prevention and Early Intervention funding were:

1) Early Childhood to adolescent trauma prevention and early intervention

2) Strategies targeting the mental health needs of older adults (60 and over)

3) Youth outreach and engagement strategies that target secondary school and Transition Aged Youth

MHSA 3-Year Planning Survey



<u>Peer-Led Interviews:</u>

New in this Community Program Planning Process was the incorporation of Peer-Led "one on one" interviews. We have found that many people are most comfortable sharing their perspectives in a one-on-one setting with someone who is trained in listening and honoring their experiences and perspectives. Individuals who participated in the peer interviews received gift cards to local restaurants. 18 individuals from diverse backgrounds participated in these Peer-led interviews, many of whom were unhoused.

Jaime Yan Faurot (pictured to the right) is a key Peer Advocate and volunteer for MHSA in Marin helping ensure the peer and community voice is involved in every step of the process from MHSA program development, recruitment, and evaluation, with a key focus on ensuring diverse perspectives are included and that there is never a one-size-fits all approach. Jaime led the peer interview process for this MHSA planning cycle.

Key Informant Interviews:

29 interviews with staff, key stakeholders, and community partners to share critical insights into BHRS strengths, areas for improvement, and emerging opportunities. A total of 62 voices were engaged during these interviews. Each interview session was one-hour long and conducted virtually. The interviews were conducted both individually and in small groups. To provide opportunities for stakeholder to honestly discuss concerns or issues, the interviews were conducted confidentially, and responses have been aggregated and are reported without attribution by a consultant team from MIG working to support strategic planning for the department. The interviews started with a set of basic questions and tailored the conversation to each interviewee's expertise and background.

Interviews were conducted with the following types of stakeholders:

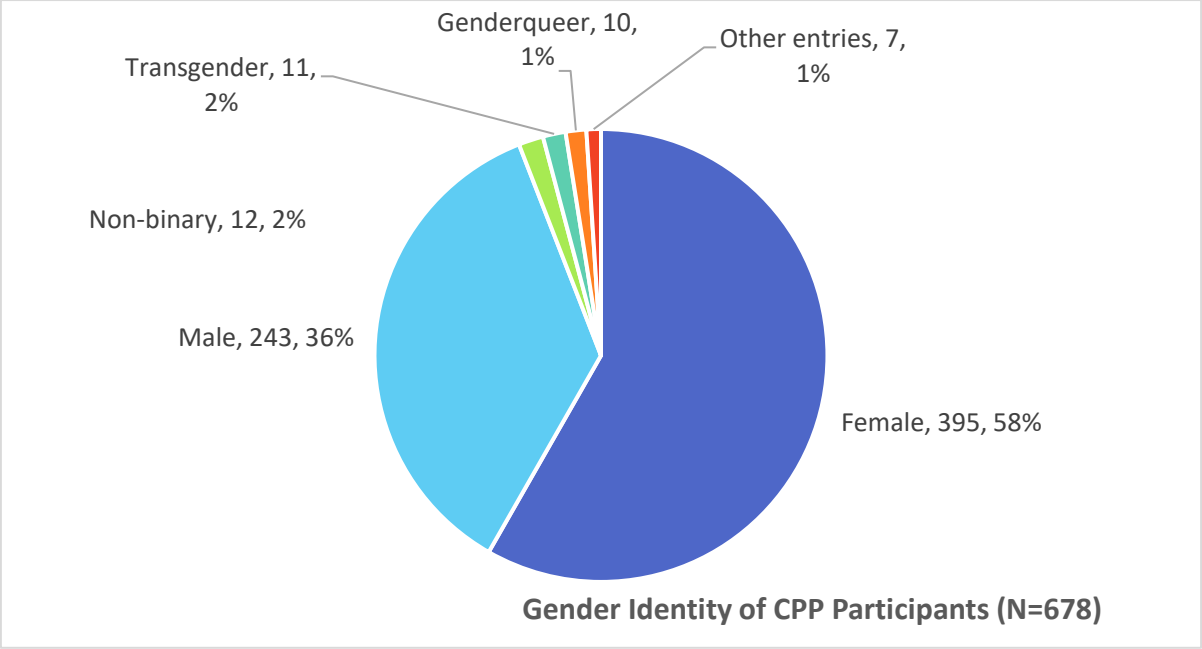
- Mental Health Board
- Advisory Board on Alcohol and Other Drugs
- Behavioral Health and Recovery Services Senior Management Team
- Community Partners (including San Rafael Police Department, Canal Alliance, NAMI Staff, and Marin Community Foundation, Marin Community Clinics Pediatrician)
- Mental Health Contractors
- HHS Partners
- Contractors with lived experiences
- Substance Use Disorder Contractors
- BHRS Staff
- Marin County Health and Human Services Director

THREE-YEAR PLAN STAKEHOLDER PARTICIPATION DEMOGRAPHICS

Overall, well **over 900 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 the online community planning survey. Of those who participated, **711 people completed a demographic form**.

BHRS conducted virtual and in person 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.

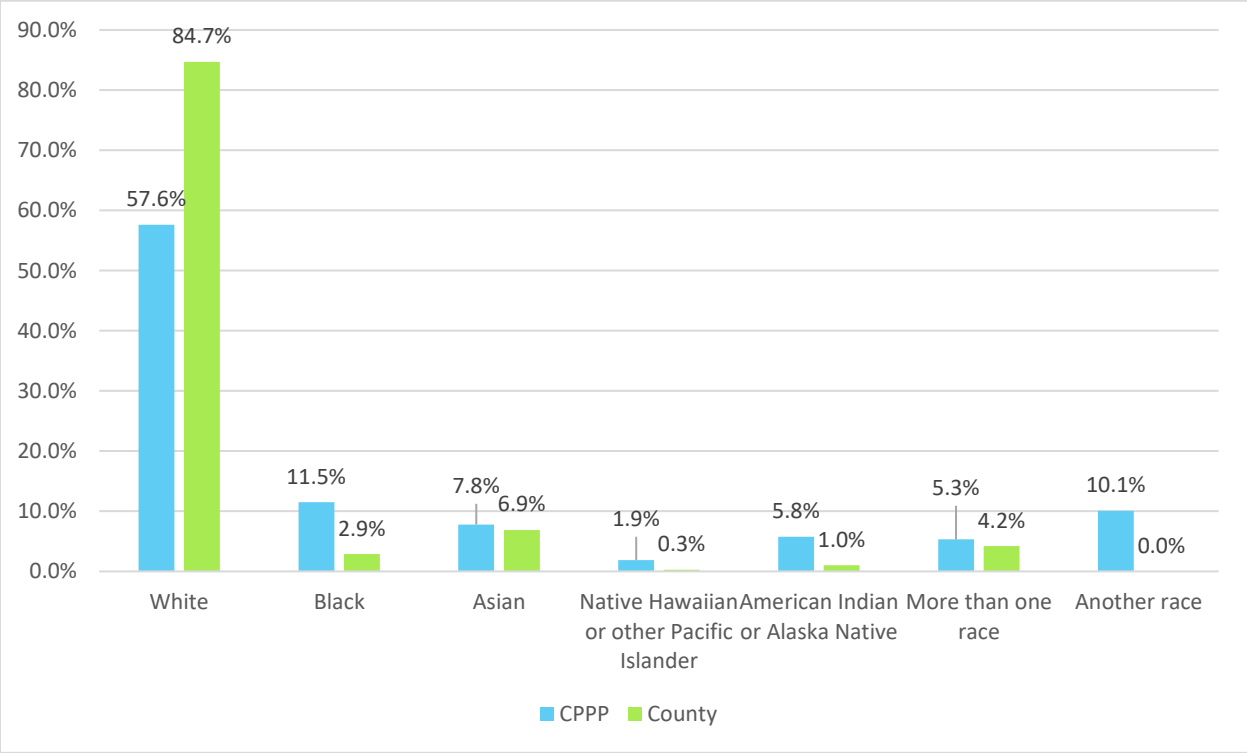
As with previous Community Planning processes, females were slightly over-represented in the community planning process however there was significantly **more engagement with individuals who identified as male, non-binary, transgender, genderqueer, and other gender identities than previous planning cycles.**



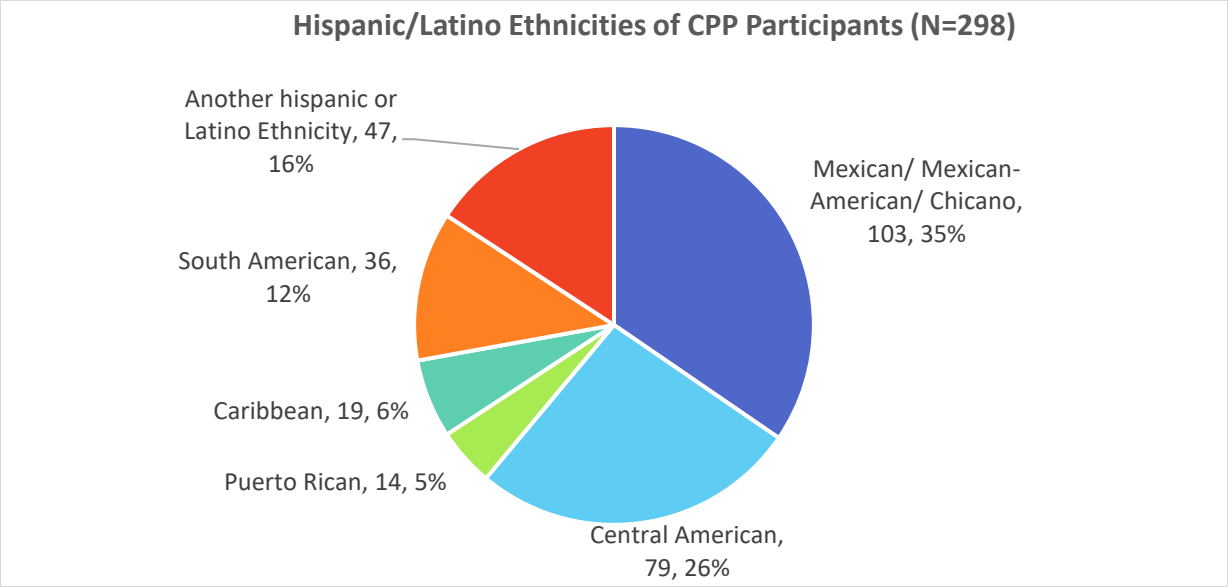
The unserved and underserved racial/ethnic populations in Marin participated in the community program planning process at a higher rate than their white counterparts, for instance, **Black or African Americans represented 11.5% of CPPP participants, but only 2.9% of the county population**.

RACIAL DISTRIBUTION OF THE COUNTY VS

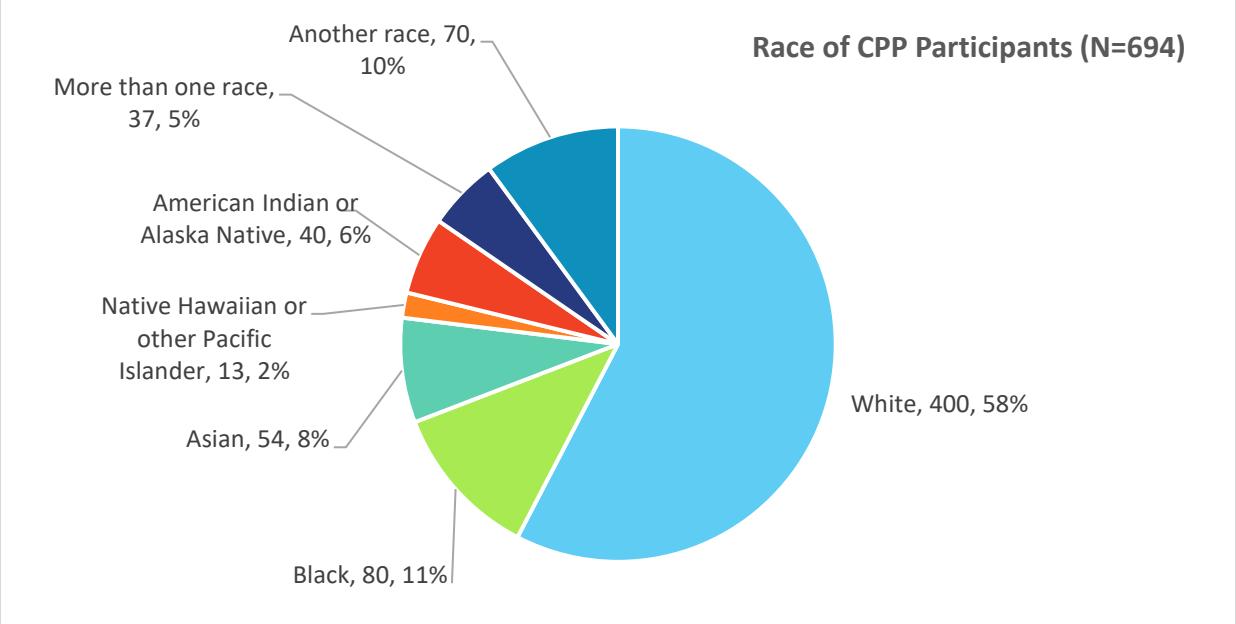
TOTAL 3YR PLANNING COMMUNITY PROGRAM PLANNING PARTICIPANTS (CPPP)



In addition to the racial breakdown, individuals who identified with a **Hispanic/Latine ethnicity represented 41.9% of CPPP participants, but only 16.1% of the county.**

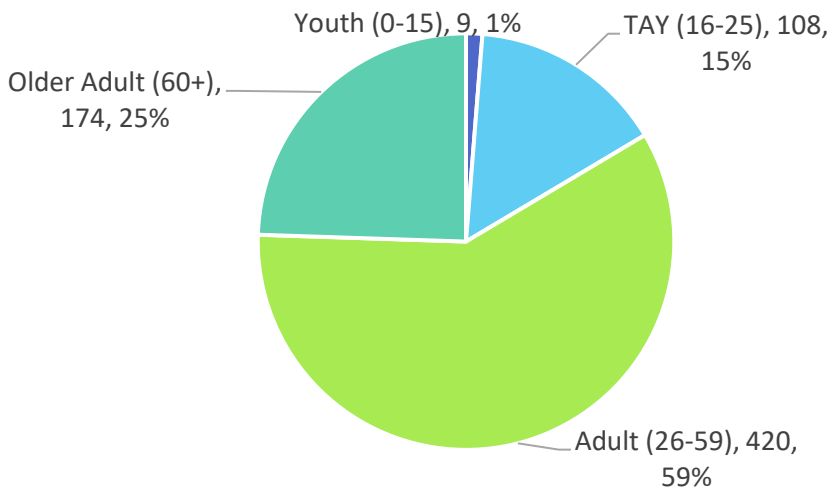


Here is another view of the demographic breakdown of the CPPP by Race:

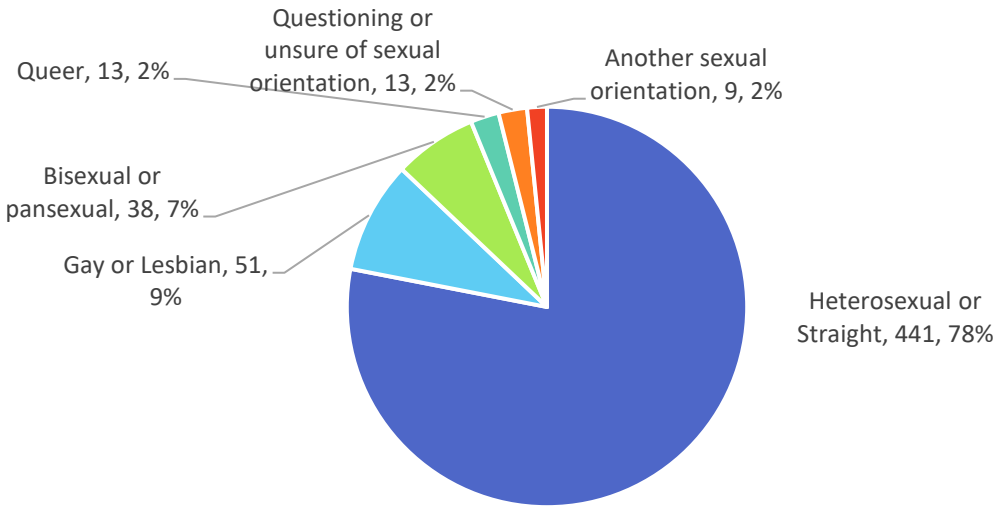


Youth under 16 represented 1% of the participants who completed demographic forms and **TAY made up 15%** of CPPP participants. Adults between the ages of **26-59 made up 59%** of participants in those meetings, and older adults between **60 and up made up 25%.** Given that Marin County is the oldest county in the state and has a rapidly aging population it is always important to get input from older adults in the community.

Age Group of CPP Participants (N=711):



In addition, 22% of MHSA CPPP participants identified as part of the **LGBTQ+ community (124 individuals)** including 9% Gay or Lesbian, 7% Bisexual or Pansexual, 2% Queer, 2% questioning or unsure of their sexual orientation and 2% identified with another sexual orientation.



Sexual Orientation of CPP Participants (N=565)

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. Different methods were used for encouraging meeting attendance for people with lived experience including gift cards for their time and bus tickets to ease transportation. In addition, everyone in attendance could take part in raffles and meals.

Outreach techniques included:

- A special peer-led one-on-one interview process
- 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, **382 individuals with experience as a family member** of someone who has experienced mental health challenges participated in this round of MHSA planning (**53.7% of participants**); **341 individuals with personal lived experience with mental health challenges (47.9% of participants);** and 213 individuals with experience as a service provider (29.9%). Individuals could select more than one option. In addition, 8.6% of individuals who participated identified as veterans.

FY24/25 MHSA ANNUAL UPDATE COMMUNITY PLANNING

Marin County Behavioral Health and Recovery Services (BHRS) gathers broad, inclusive, and ongoing input from community stakeholders during the annual process of developing our MHSA Three-Year Plans and Annual Updates, and in MHSA program planning. This input includes meaningful community stakeholder involvement throughout the process on mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.

Ongoing involvement occurs through existing standing stakeholder committees (e.g., MHSA Advisory Committee; Behavioral Health Board; Equity and Community Partnerships Committee; Alcohol and Drug Advisory Board) in addition to outreaching to stakeholders for input on mental health policy, program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations. Ongoing stakeholder involvement also occurred through the HHS Homeless Policy Steering Committee, BHRS Latine Steering Committee, BHRS Access Workgroup, BHRS Quality Improvement Committee, Newcomers meetings, BHRS Contractor meetings, and BHRS Network Provider meetings. Additionally, stakeholder outreach and input is regularly sought in collaboration with OD Free Marin, Marin 9 to 25, Marin Prevention Network, and with a Wellness Collaborative which brings together school providers.

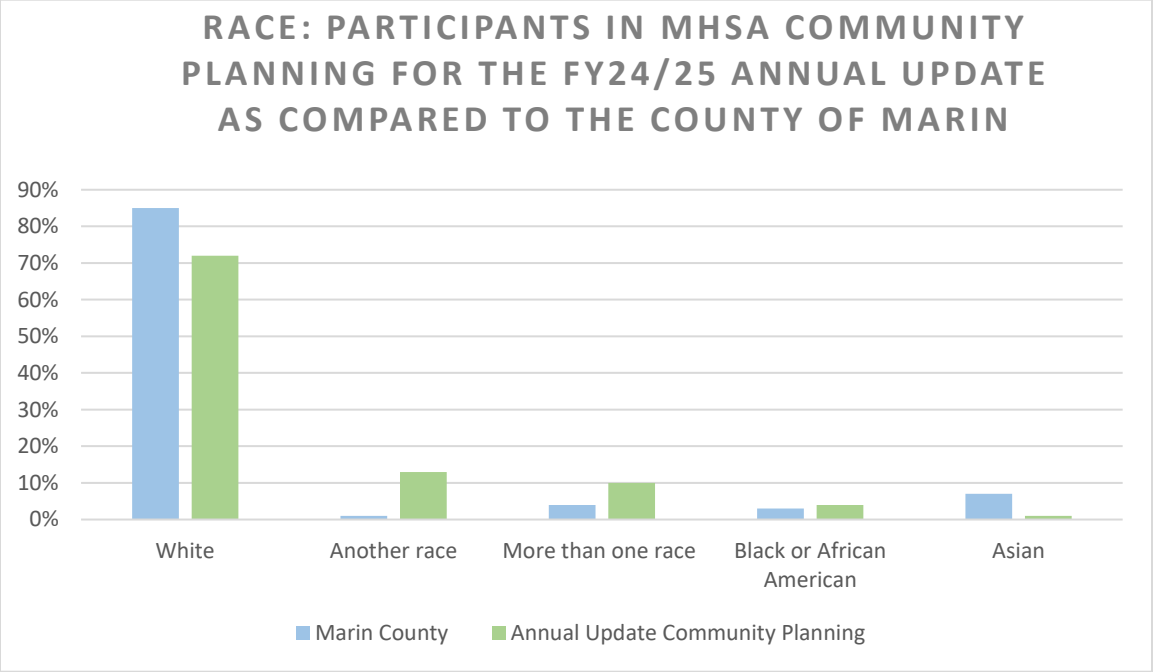
Annual Updates

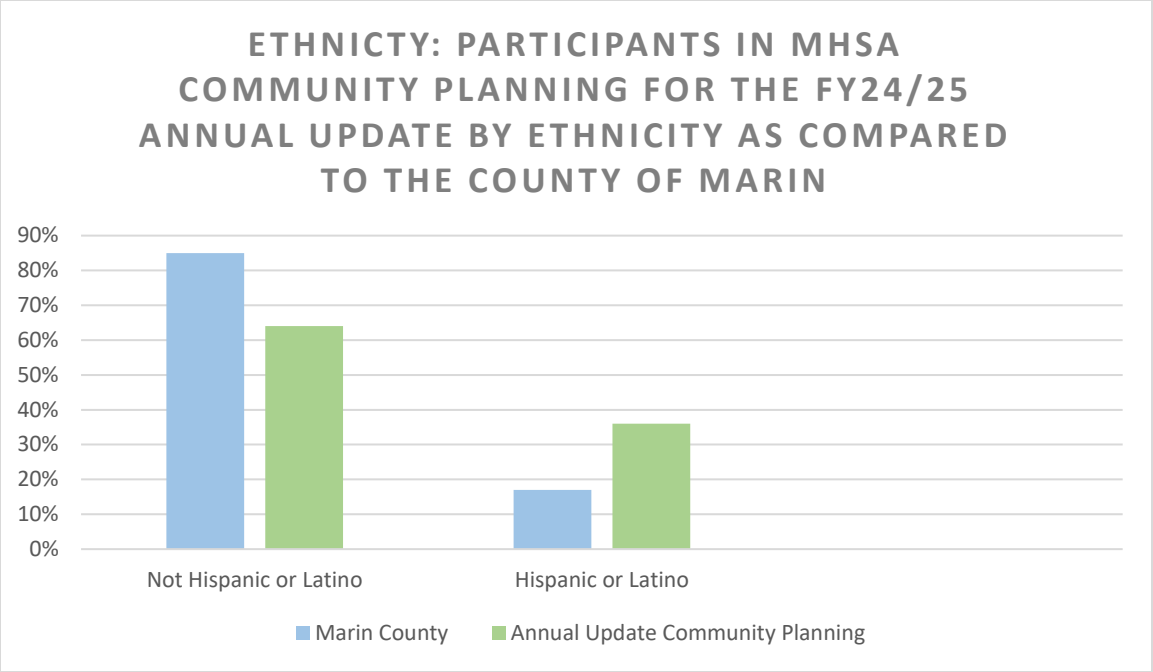
Each year of the Three-Year Plan BHRS will conduct an Annual Update community planning process to make any changes to the plan and to report on outcomes from each program. During this past year, the MHSA Advisory Committee and Behavioral Health Board continued to convene, discussing MHSA at each meeting. Additionally, both in-person and virtual MHSA community planning meetings were held:

- Wednesday February 7, 2024 from 12 – 1:30pm **Training and Community Planning Kick-Off** afternoon meeting via Zoom
- Thursday February 8, 2024 from 5:30 – 7pm **Training and Community Planning Kick-Off** evening meeting via Zoom
- Monday February 12, 2024 from 10 – 11:30am **Provider** focused MHSA planning morning meeting via Zoom
- Wednesday February 14, 2024 from 12 – 1:30pm **Provider** focused MHSA planning afternoon meeting via Zoom
- Thursday, February 15, 2024 from 6:00 – 7:30pm **Family Member** focused MHSA planning with a presentation on CARE Act meeting at 20 N. San Pedro Road, San Rafael
- Friday February 16, 2024 from 12 – 1:30pm **Lived Experience** MHSA planning with a presentation on CARE Act meeting at Enterprise Resource Center, 3270 Kerner Blvd., San Rafael
- Thursday February 29, 2024 from 2 – 3pm **Equity and Community Partnerships Committee** MHSA planning meeting via Zoom

DEMOGRAPHICS OF FY24/25 MHSA ANNUAL UPDATE COMMUNITY PLANNING:

Over 100 people participated in these meetings including 72 who completed the demographic survey.





57% (41 individuals) of those who participated in the community planning for the FY24/25 MHSA Annual Update have lived experience as a **family member** of someone with mental health challenges

57% (41 individuals) identified as having **personal lived experience** with serious mental illness

88% of individuals speak English as a primary language**, 7%** speak Spanish as a primary language, **1%** Mandarin, **1%** Vietnamese, **1%** Armenian, and **1%** another language

18% identified as being a part of the **LGBTQ+** community

FY24/25 MHSA ANNUAL UPDATE PLAN PUBLIC REVIEW PROCESS

The MHSA Annual Update and Expenditure Plan for FY24/25 will be posted for **30-day Public Comment** beginning on **April 12, 2024, and will remain posted through May 13, 2024**. The MHSA Annual Update and Expenditure Plan for FY24/25 and prior Three-Year Plans and Annual Updates are posted on Marin County's website at: MarinBHRS.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 Behavioral Health Board, Alcohol and Other Drug Board, MHSA Advisory Committee, and the BHRS Stakeholder email list. An infographic with links to the Annual Update and full report, information about how to leave public comments, and how to attend the public hearing was shared via the Marin County Health and Human Services' Facebook Page, Instagram account, and Twitter account.

On **Tuesday May 14, 2024,** a Public Hearing will be held by the Behavioral Health Board at 6pm in the Point Reyes Room of 20 North San Pedro Rd, San Rafael, CA.

PUBLIC COMMENTS ON THE PROPOSED PLAN

To be added after the close of the Public Comment period.

SUBSTANTIVE CHANGES MADE DURING THE PUBLIC COMMENT PERIOD

To be added after the close of the Public Comment period.

COMMUNITY SERVICES AND SUPPORTS (CSS)

COMPONENT 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. The Behavioral Health and Recovery Services (BHRS) system of care is dedicated to service provision that meets the needs of Marin's racially, ethnically, and linguistically diverse populations. This assessment includes the following:

- Percentages of diverse cultural, racial/ethnic, and linguistic groups represented among direct service providers, as compared to percentage of the total population needing services and the total population being served; and
- Evaluation of bilingual proficiency in threshold languages; and
- Strengths and the challenges of the County and service providers that impact our ability to meet the needs of Marin's diverse populations, identification of possible barriers to implementing the proposed program/services, and methods of addressing barriers.

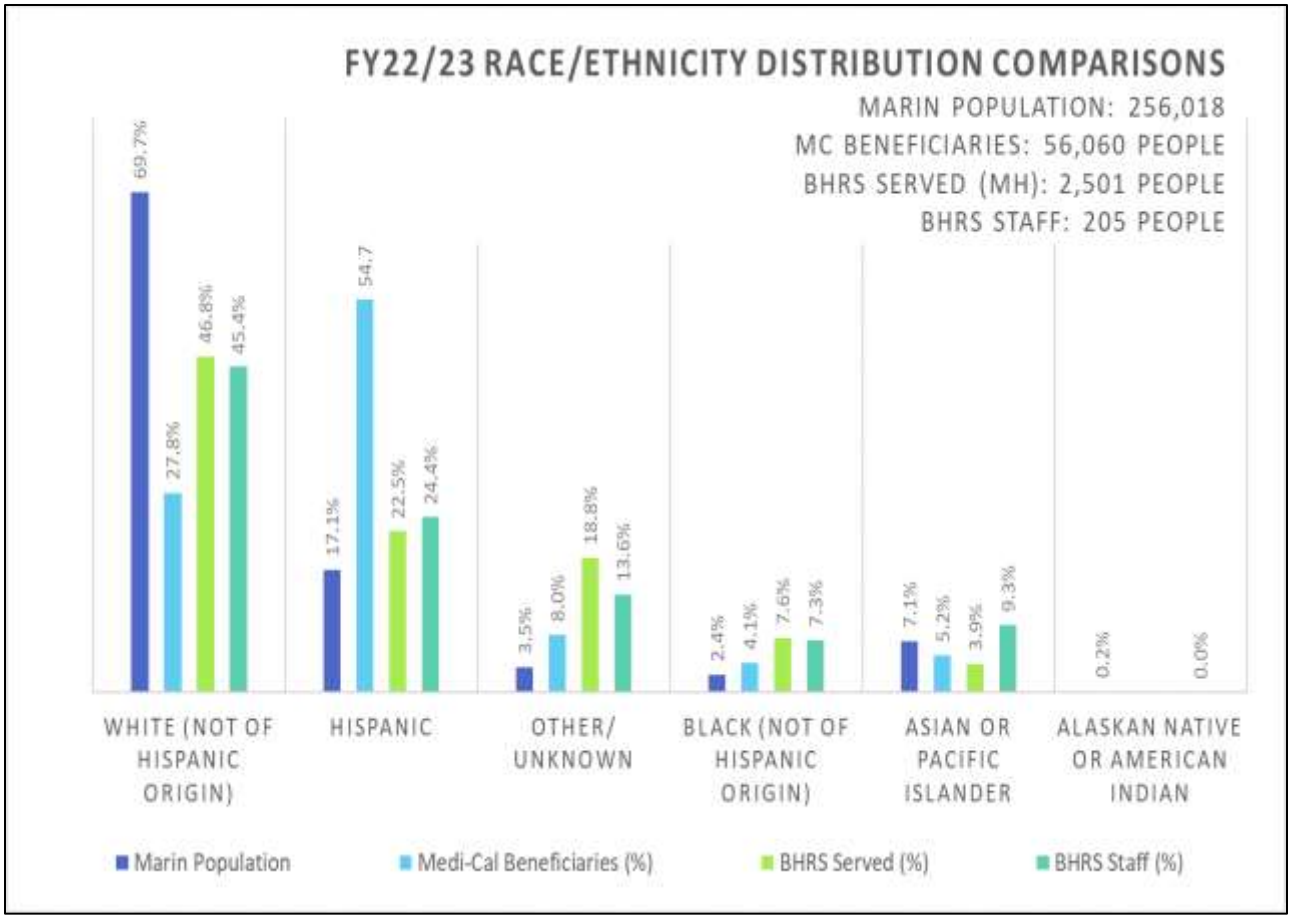
PERCENTAGES OF DIVERSE CULTURAL, RACIAL/ETHNIC, AND LINGUISTIC GROUPS

As you can reference from Behavioral Health and Recovery Services (BHRS)'s Cultural Humility and Responsivity Plan for FY 22/23[1], in the FY 21/22 race/ethnicity distribution comparison chart featured in Criterion 6 of the report, the Marin County population = 262,387, the Marin Medi-Cal beneficiaries = 50,918 people, BHRS served = 2,564 people, and BHRS staff = 198 people. Below is the same chart but for FY 22/23, the most recent full fiscal year.

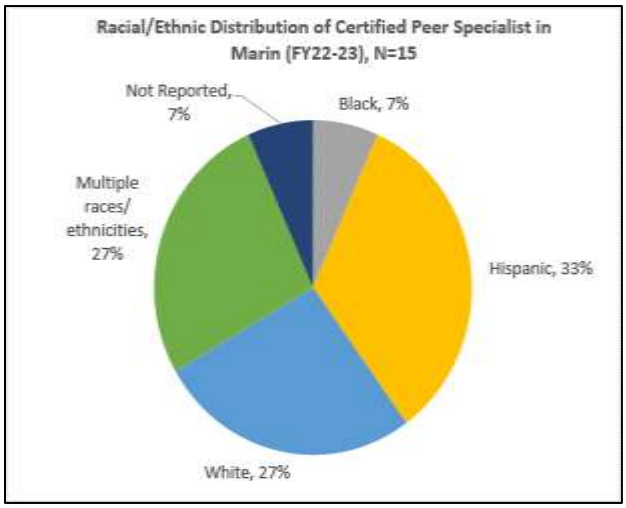
The most notable changes between FY 21-22 to FY 22/23 are:

- A growing number of Marin general population and Medi-Cal beneficiaries, yet a decrease in number of BHRS served; and
- A growing percentage of BHRS served in the "other/unknown" category; and
- Relatively stable number of BHRS staff; and
- A decrease in the percentage of BHRS staff in the "other/unknown" category and an increase in percentage of BHRS staff in all other categories, likely due to an adjustment made in the way demographic information was collected and reported between fiscal years.

[1] https://www.marinbhrs.org/sites/default/files/2024-01/Marin%20County%20BHRS%20CHRP%20FY%202023-2024.pdf



Additionally, there are now a total of 15 Certified Peer Specialists in Marin County. The graph below shows the racial and ethnic distribution of Certified Peer Specialists throughout Marin, which demonstrates a more diverse distribution in comparison to BHRS employees.

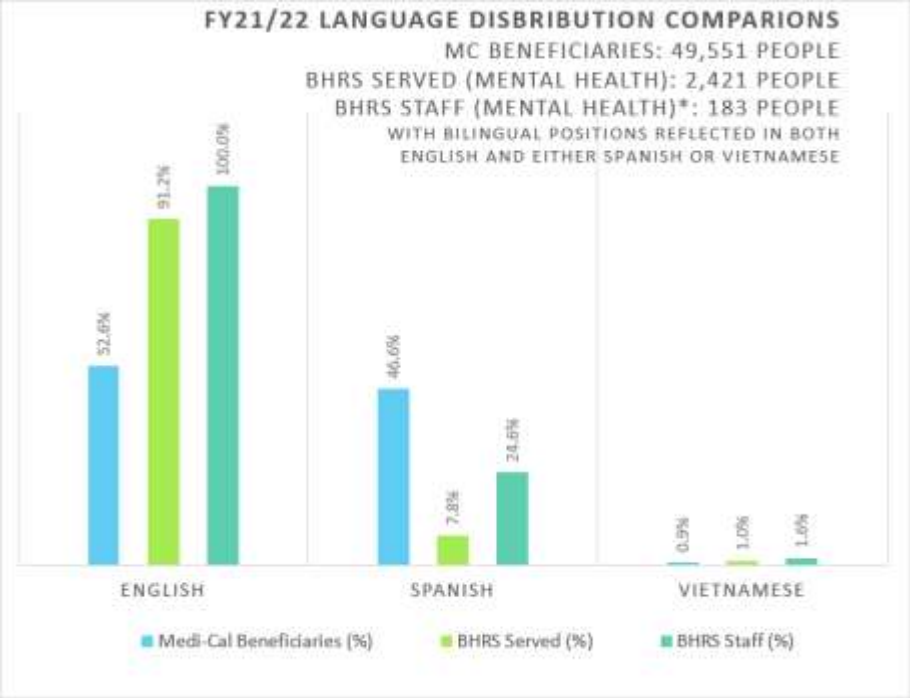


BHRS aims to collect our own demographic data and not be reliant on data through Human Resources. It is difficult to evaluate trends in workforce demographics if from year-to-year adjustments in collection methods dramatically alter any one category. BHRS continues to strategize methods for demographic data collection that are reliable.

BILINGUAL PROFICIENCY IN THRESHOLD LANGUAGES:

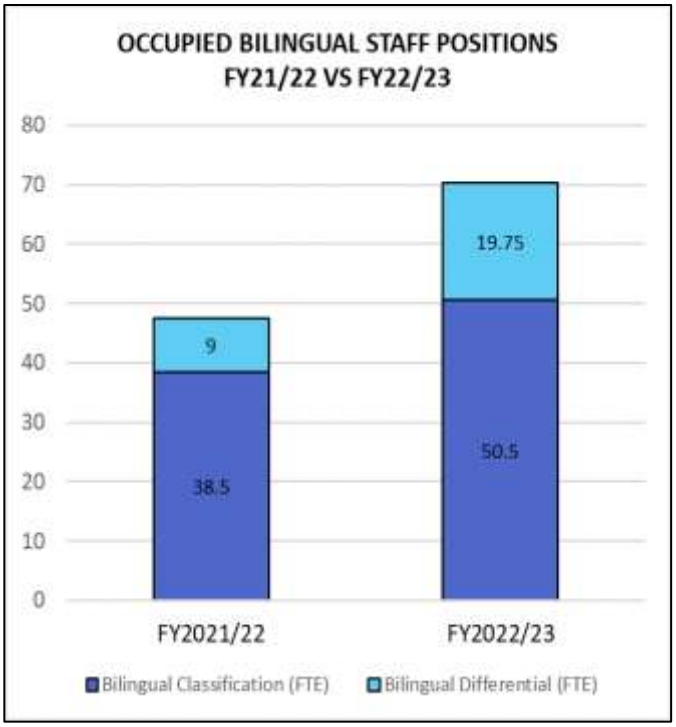
Spanish is the only threshold language in Marin however official documents are often also translated into Vietnamese as that is our second largest population. On the Mental Health Plan side, for the provider linguistic capacity, 93.75% of clients served during CY2021 had services provided in their preferred language, as documented in the EMR, demonstrating a slight decrease from FY20-21 (95.3%).

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 for FY 21/22.



The number of BHRS staff who are in Bilingual Spanish classifications is not adequate to meet the needs of the community. However, the percentage of our Bilingual Spanish classified staff does outnumber the percentage of Spanish speaking community currently being served by BHRS. For our Vietnamese-speaking capacity, the distribution is on par with the percentage of Vietnamese speakers in the community.

Though we were not able to collect the above information for FY 22/23, to the right you can see a graph that demonstrates the number of occupied bilingual positions within BHRS from FY 21/22 to FY 22/23. There is an increase of occupied bilingual positions, including bilingual classification and bilingual differential, between FY 21/22 and FY 22/23. It is a 48% increase, which could easily be due to poor data quality from FY 21/22. Next year, BHRS plans to utilize language information from the 274 so that we can disaggregate by language the number of bilingual positions more easily.



STRENGTHS, CHALLENGES, BARRIERS, STRATEGIES:

Strengths:

- BHRS and service providers' dedication and commitment to become more culturally and linguistically responsive to meet the needs of racially, ethnically, and linguistically diverse populations; and
- Robust training, education, and consultation opportunities and mandates around cultural humility; and
- BHRS commitment to Peer workforce development and program expansion; and
- BHRS value of community-driven solutions and community-based partnerships.

Challenges and Barriers:

- Limited ability to collect culturally and linguistically inclusive and responsive data and a subsequent reliance on this data for decision-making; and
- Disparities noted in who is referred for services; and
- Eligibility for Medi-Cal: 50% of our adult Latine population is eligible for restricted Medi-Cal only, and BHRS is only able to seek Medi-Cal reimbursement for individuals with Full Scope Medi-Cal, however given the changes that went into effect January 2024 we expect these numbers to change in future years; and
- Lack of culturally responsive assessment of functional impairments and risk factors, leading to ethnically diverse populations being referred out; and
- Lengthy assessments causing slower turn-around of completed assessments; and

- System navigation challenges, including clients navigating complicated processes, requirements, and criteria (i.e., share of cost); and
- Lack of bilingual/bicultural staff in Crisis programs; and
- Bilingual proficiency exam considered by many bilingual staff to be unreliable and exam not evaluating knowledge of interpretation/translation specifics in behavioral health care settings; and
- Bilingual classification and differential challenges, including insufficient clarity in policies and procedures, barriers to availability of bilingual positions in BHRS leadership, and variation in individual supervisor approaches to using bilingual/bicultural staff; and
- Insufficient diversity at the leadership level of BHRS, including managers and directors; and
- Continuous turnover of professionals in key positions; and
- Difficulty recruiting bilingual/bicultural staff; and
- Inability to contract manage language line vendors at the BHRS level; and
- Lack of subject matter expert to develop a system to strategically utilize existing bilingual/bicultural staff to serve and meet the needs of racially, ethnically, and linguistically diverse populations; and
- Lack of clear policies and procedures to protect staff time, including bilingual staff time.

FY 22/23 Strategies to Overcome Challenges and Barriers:

- Increased contract amounts with the Community Health Advocate (CHA) programs; and
- Integrated the MHSA and Culturally Humility and Responsivity planning processes; and
- Formalized a Data Equity Workgroup to focus on client demographic data collection and entering into Electronic Health Record; and
- Increased partnerships with community-based organizations to improve capacity in serving diverse populations; and
- Transitioned Access clinician to West Marin to increase Spanish-speaking access to mental health services and linkage in that community; and
- Implemented mandatory anti-racism coaching for BHRS leadership; and
- Implemented Working with Interpreters training; and
- Formalized a BHRS *Latine* Steering Committee to develop and implement a Quality Improvement Project to address Spanish-speaking and *Latine* disparities in accessing and engaging in BHRS services; and
- Hired an Outreach and Engagement Senior Program Coordinator, who will work directly with the Program Manager of Equity and Inclusion; and
- Developed ongoing clinical and culturally and linguistically relevant trainings, including offering trainings in Spanish and Vietnamese; and
- Maintained Peer scholarship to focus recruitment of racially and ethnically diverse people with lived experience; and
- Maintained Psychology Internship Training program that offers a Latino Family Health track for interns who are bilingual/bicultural in the Spanish-speaking language.

FY 23/24 Strategies to Overcome Challenges and Barriers:

Goal Area 1: Language Access	
Strategy	**Status**
Create a process for written translation requests, leaning on contracted language partners for primary translation of documents, using BHRS bilingual staff for secondary review, and engaging community members via a stipend program for tertiary review.	**Updated goal:** BHRS will develop a process to implement the community-translation stipend. **Updated goal:** Develop and implement a language access plan in partnership with HHS to cover challenges on contract management, interpretation/translation vendor reliability and relevance, bilingual proficiency exams, etc. (i.e., Language Access Coordinator role and/or HHS holding of language contracts). **Updated goal:** Update BHRS' internal policy on use of bilingual staff and working with interpreters. **Updated goal:** Pull bilingual staff data from 274 in 2024 to evaluate distribution of bilingual staff and language capacity across BHRS. **Updated goal:** Continue to increase the number of trainings provided in commonly spoken languages (i.e., Spanish and Vietnamese).

Goal Area 2: Disparities in *Latine* Service Utilization	
Strategy	**Status**
Focus outreach and engagement on points of entry and system and financial navigation.	**Updated goal:** BHRS *Latine* Steering Committee will formally document and steward BHRS' Quality Improvement Project (QIP) of 5 strategies to create system navigation tools. **Updated goal:** Outreach and Engagement Senior Program Coordinator will lead efforts to develop system navigation tools in partnership with ACCESS and *Latine* Steering Committee, will monitor and implement the Quality Improvement Plan targeted to address disparities within the *Latine* and Spanish speaking communities of

	Marin, and will develop a cultural ambassador program. **Updated goal:** Outreach and Engagement Senior Program Coordinator will work with BHRS Program Managers to create an outreach strategy utilizing bilingual mental health practitioners.
Increase therapy capacity for Spanish speakers in all ASOC programs by moving from the case management (primary) model to the case management and therapy integrative model of service delivery.	**Updated goal:** Present policy to supervisors and engage in formal review with the Medical Director, ACCESS Supervisor, staff, and members of CSOC, Forensics, Residential Team, and Crisis Team.

Goal Area 3: Cultural Humility, Anti-Racism, and Trauma-Informed Frameworks	
Strategy	**Status**
1. Create a cultural context within BHRS that supports restorative approaches to conflict, affinity and accountability spaces, and anti-oppressive practice. 2. Implement cultural humility training through an anti-racist and trauma-informed lens.	**Updated goal:** Develop and implement a DEIB plan within BHRS and work cross departmentally to advocate for an HHS holding of this work within the upcoming HHS Equity Plan. **Updated goal:** Re-launch DEIB supervision space for supervisors to maintain space for culturally responsive supervision.

Goal Area 4: Workforce and Training	
Strategy	**Status**
Develop a WET Training Plan that identifies the theory of change, focuses training topics in priority areas, supports learning in between training, and incorporates cultural-humility, anti-racist, and trauma-informed frameworks.	**Updated goal:** Complete a WET training plan that integrates both MHSA community planning and organizational assessment input. **Updated goal:** Simplify and streamline current cultural humility training policy and tracking system via feedback from listening sessions completed in 2023. **Updated goal:** Add additional training to PESI platform that satisfies cultural humility and

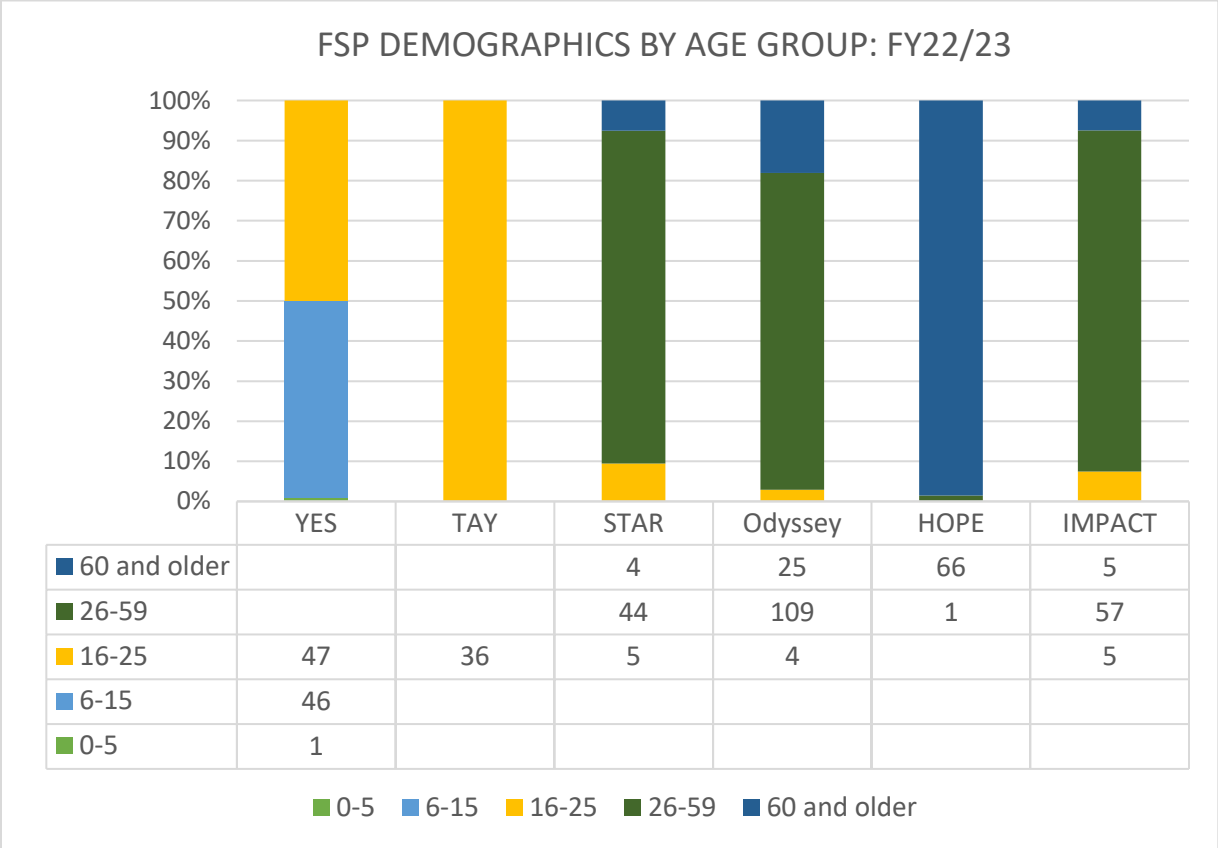
	LGBTQ+ training requirements.
Identify recruitment and retention strategies, for bilingual staff.	**Updated goal:** Identify and implement recruitment and retention strategies of bilingual staff, (i.e., protecting bilingual staff time, make bilingual differential/classification available to leadership positions, hosting a monthly Spanish speaking behavioral health group for Spanish speakers). **Updated goal:** Working cross departmentally to advocate for an HHS holding of this work within the upcoming HHS Equity Plan. **Updated goal:** Implement a *Latine* Learning Academy for BHRS staff and contracted providers to support focused learning with Spanish speaking and *Latine* clients.
1. Track number of bilingual/bicultural staff, the team they are on, their role within the county, and what language they are bilingual in. 2. Track new and current clients who need or request bilingual services, where they are referred/placed, how long it takes them to get bilingual services/wait for bilingual services. 3. Work with the SUS team to identify how to track bilingual capacity within the provider network.	**Updated goal:** Use 274 in 2024 to track the number of bilingual staff, the team they are on, and what language(s) they are bilingual in. **Updated goal:** Use new EHR to track # of clients who need or request bilingual services, where they are referred/placed, and how long it takes them to get bilingual services. **Updated goal:** Implement Workforce Equity Survey to track demographics at the leadership level.
	Updated goal: Complete DEIB Plan in response to Dr. Hardy's organizational assessment.

Goal Area 5: Engagement with Underserved or Inappropriately Served Communities	
Strategy	**Status**
1. Create deliberate partnerships with Native/Indigenous communities of Marin. 2. Identify outreach and engagement strategies to target Pacific Islander and	**Updated goal:** BHRS Outreach and Engagement Senior Program Coordinator will identify new opportunities for partnership with impacted groups in Marin by developing.

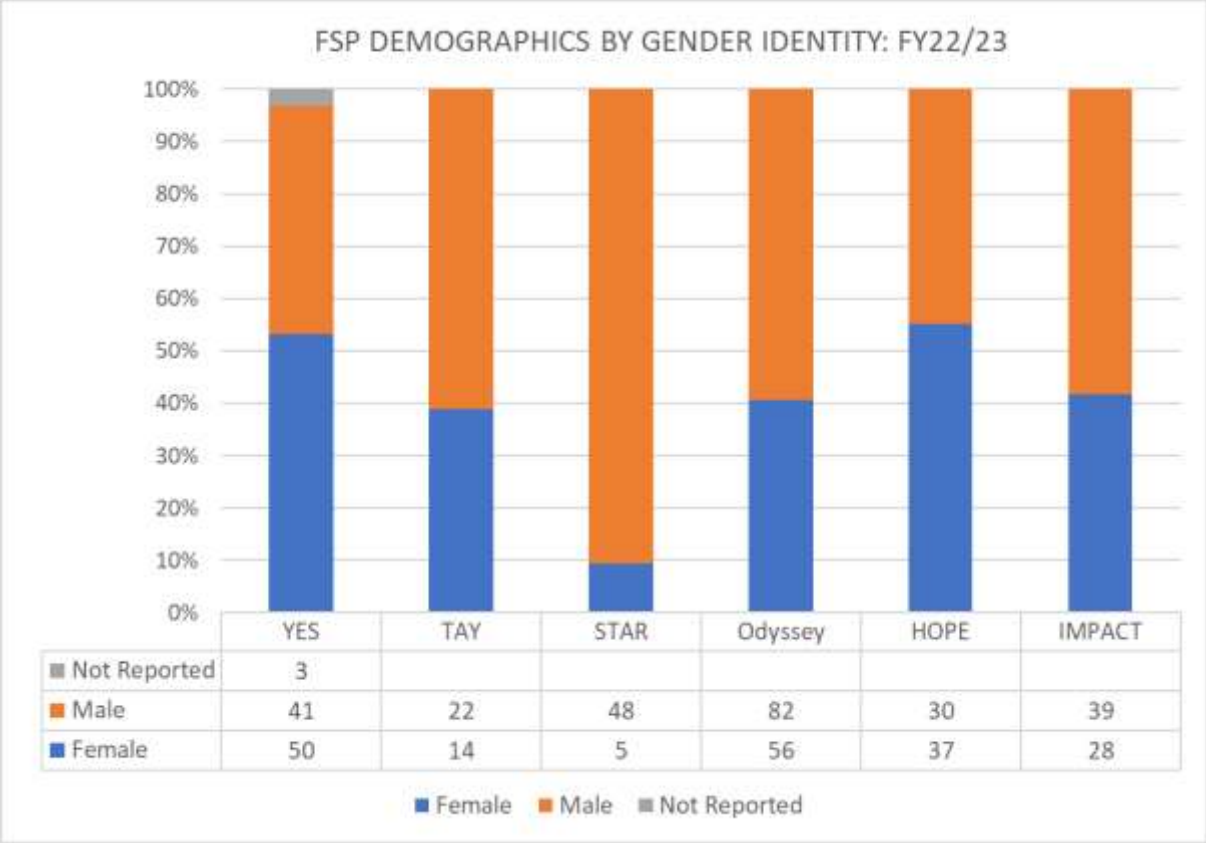
LGBTQ+ communities, potential beneficiaries, and current beneficiaries.	
Develop behavioral health indicators that move beyond the limitations of "penetration" rate data (i.e., tracking access to care, engagement timeframes in services, and impact of treatment).	**Updated goal:** BHRS will identify how their new EHR system can be equipped to effectively measure outcomes. **Updated goal:** The Equity Data Workgroup will lead conversations around Sexual Orientation and Gender Identity (SOGI) and Race, Ethnicity, and Language (REAL) to identify inclusive data metrics for mapping to the new EHR and will support the development of roadshows to train staff on inputting information into the new EHR. **Updated goal:** Identify process for CSU to follow-up with clients with "not reported/unknown" race/ethnicity in client profile. **Updated goal:** Identify engagement strategies to close the disparate gap in race/ethnicity after 15 services. **Updated goal:** Improve contract monitoring outcomes including developing and monitoring better equity outcomes and tracking cultural humility training efforts. **Updated goal:** Develop strategies to increase participation in POQI and TPS surveys.

FULL-SERVICE PARTNERSHIP DEMOGRAPHICS

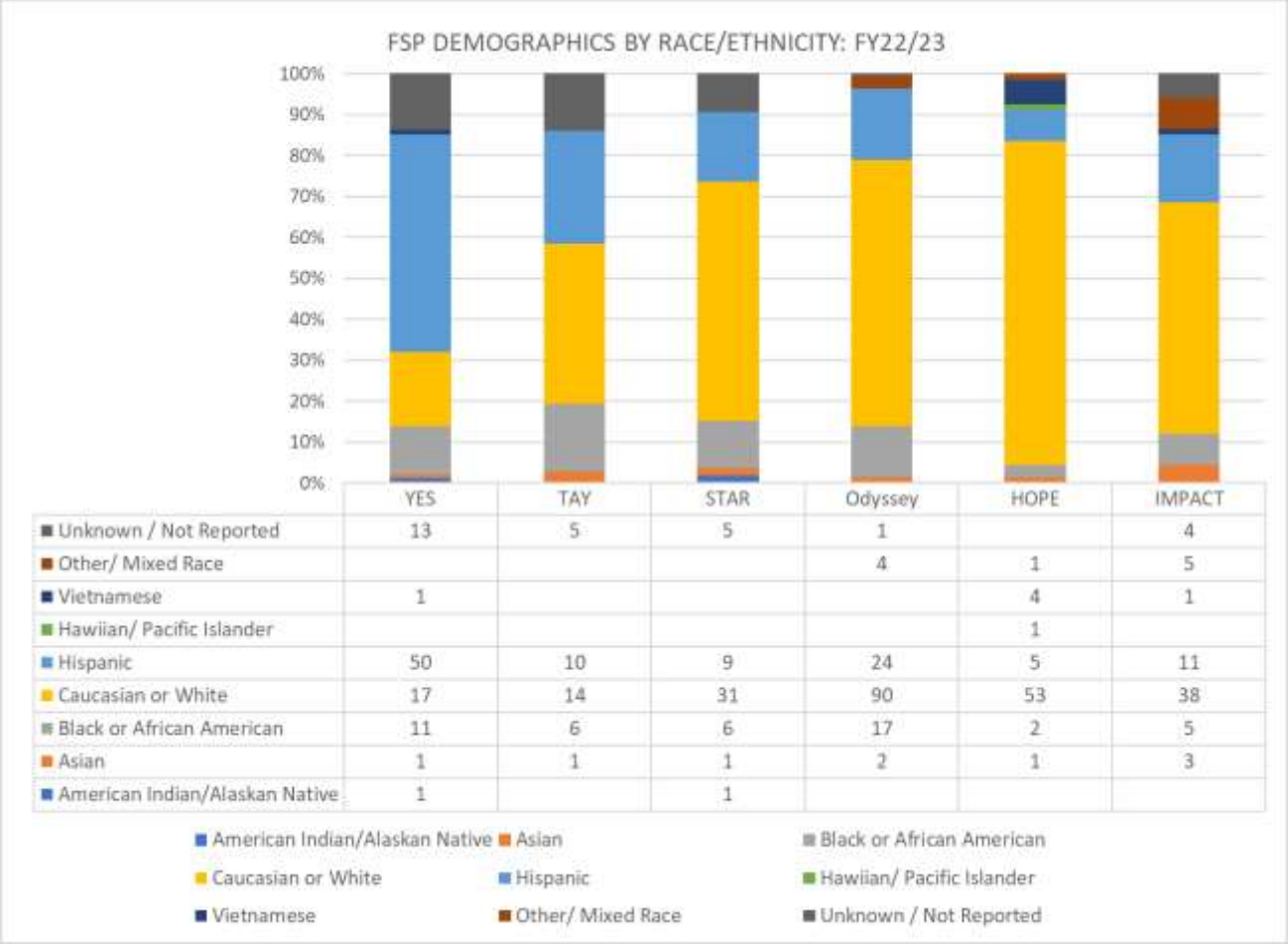
In an effort to show a more comprehensive picture and context for our Full-Service Partnership program the demographics are consolidated in this opening section rather than distributed with each individual FSP program.



	YES	TAY	STAR	Odyssey	HOPE	IMPACT
60 and older			4	25	66	5
26-59			44	109	1	57
16-25	47	36	5	4		5
6-15	46					
0-5	1					



	YES	TAY	STAR	Odyssey	HOPE	IMPACT
Not Reported	3					
Male	41	22	48	82	30	39
Female	50	14	5	56	37	28



	YES	TAY	STAR	Odyssey	HOPE	IMPACT
Unknown / Not Reported	13	5	5	1		4
Other/ Mixed Race				4	1	5
Vietnamese	1				4	1
Hawiian/ Pacific Islander					1	
Hispanic	50	10	9	24	5	11
Caucasian or White	17	14	31	90	53	38
Black or African American	11	6	6	17	2	5
Asian	1	1	1	2	1	3
American Indian/Alaskan Native	1		1			

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

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.

In the FY23/24-25/26 Three-Year Plan a contracted Recovery Coach will be added to the team to better support the co-occurring substance use challenges of youth in the Full-Service Partnership. In FY23/24 there was an increased focus on adjunctive supports for the YES clients, including expanding the workforce of Family Partners and Peer Support Specialists who provide mentoring to youth and support to their caregivers. These additional supports expanded the team of providers who can support very complex and difficult situations for our clients and their families. These changes will help reduce acuity over time, lessen the need for psychiatric hospitalizations, and increase collaboration with other providers.

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 63 youth at any point in time, over the course of a year this program anticipates serving approximately 95 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.

FY22/23 OUTCOMES:

In FY22/23 there were 94 children and youth served by the YES program, including 1 young children (between 0-5), 46 youth (between the ages of 6 and 15) and 47 Transitional Age Youth (between the ages of 16 and 25). 91 of these partners were in the program for one year or longer at the end of FY22/23.

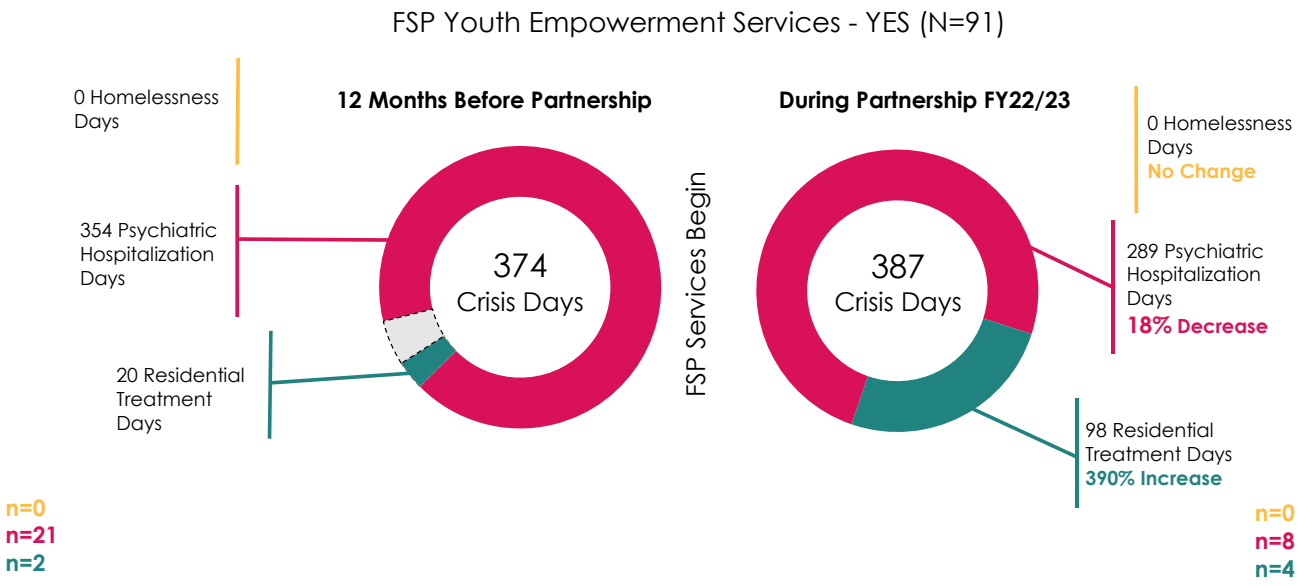
1. For the fiscal year 22/23, there was a **18% decrease in total psychiatric hospitalization days**: Of the clients who had been enrolled in YES for at least one year, 21 had experienced at least one psychiatric hospitalization in the year prior to enrollment, for a collective 354 hospitalization days. In FY22/23, 8 of the YES clients experienced a psychiatric hospitalization for a total of 289 hospitalization days (an 18% decrease).

2. **Zero days Homeless:** In the twelve months prior to entry into the FSP, none of the partners had experienced homelessness in the year before services. In FY22/23 there were no days homeless.

3. In the twelve months prior to entry into the FSP, 2 partners were in residential treatment for 20 days. In FY22/23, there were 4 partners who spent at least one night in residential treatment for a total of 98 days—a **390% increase in residential treatment days** from the baseline year.

4. **68% Decrease in number of Arrests:** Of the 91 partners who had been enrolled in YES for at least one year, 10 had experienced at least one arrest in the year prior to enrollment for a collective 19 arrests. In FY22/23, 3 of the 91 partners (70% decrease in number of partners) for a total of 6 arrests—a 68% decrease from the baseline year.

PROGRAM CHANGES FOR FY24/25: None.



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

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.

In FY23/24 in alignment with the new CalAIM changes this contract was converted to a fee-for-service set up with the County, maximizing face-to-face time with clients. In addition, increased support for those experiencing co-occurring substance use disorders will be provided through a contracted Recovery Coach integrated on the substance use team. There was an increased focus on supporting clients stepping down from psychiatric facilities or juvenile hall. Because these clients generally enter the TAY program with a longstanding pattern of moderate-to-severe symptomology, escalation in their symptoms sometimes results in psychiatric hospitalization or incarceration, which the program is seeking to mitigate. This year the TAY program has been increasing the delivery of services to youth while they are in these institutional settings, to assist with discharge planning and to ensure that the youth have a solid transition plan back to the community. Sometimes this means increasing the frequency or changing the modality of services. This increase in focus has shown positive results in reducing the number of youth discharged with no plan or safety net.

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 45 Transitional Age Youth will be served throughout the year with approximately ~40 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.

FY22/23 OUTCOMES:

In FY22/23 there were 36 partners served in TAY (between the ages of 16 and 25), 35 of whom had been in the program for one year or longer and were served during FY22/23.

1. **45% Decrease in Psychiatric Hospitalization days:** Of the 35 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 80 hospitalization days. In FY22/23, 5 of the 35 partners experienced a psychiatric hospitalization, for a collective total of 44 hospitalization days—a 45% decrease from the baseline year.

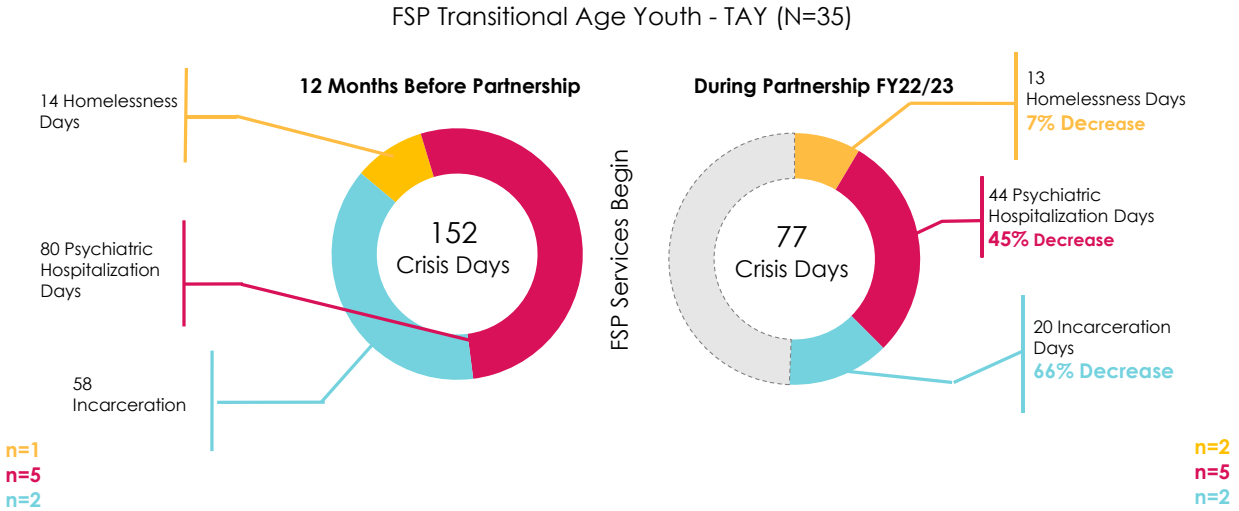
2. **7% Decrease in days homelessness:** In the twelve months prior to entry into the FSP, 1 partners had experienced homelessness for a collective total of 14 days in the year before services. In FY22/23, there were 2 clients who experienced homelessness for a collective total of 13 days—a 7% decrease in days homeless.

3. **66% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 2 of the 35 partners were incarcerated for a total of 58 days. In FY22/23, 2 partners spent at least one day in jail for a collective 20 days, a decrease of 66% in incarceration days.

4. 83% of TAY partners were engaged with either school or work (or both) during FY22/23.

5. 48% of TAY partners attended two or more activities at the drop-in center or in the community designed to improve their independent living skills. This was partially due to the reduced schedule at the beginning of the fiscal year. Peer advocates and clinical case managers worked with TAY partners to expand their development in independent living skills, which included:
    - Supporting school enrollment
    - Obtaining job opportunities
    - Practicing job interviewing skills
    - Demonstrating how to make and manage medical appointments
    - Navigating transportation options

PROGRAM CHANGES FOR FY24/25: None.



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

MHSA PROGRAM ALLOCATION FY24/25:

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).

In the FY23/24-25/26 Three-Year Plan a contracted Recovery Coach will be added to the team to better support the co-occurring substance use challenges of individuals in the Full-Service Partnership.

PROGRAM CHANGES: In FY23/24 the STAR program moved to the Adult System of Care.

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; mental health case managers, one of whom is bilingual/bicultural Spanish speaking; peer/lived-experienced specialist; 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 FY21/22 to serve up to 57 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.

FY22/23 OUTCOMES:

In FY22/23 there were 53 partners served in STAR, including 5 Transitional Age Youth (between 16-25), 44 adults (between 26-59), and 4 older adults (60+). 50 of these partners had been in the program for one year or longer by the end of FY22/23.

1. **78% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 22 of the 50 partners experienced homelessness for a collective 4,133 days homeless in the year before services. In FY22/23, 8 FSP partners who had been enrolled in STAR for over one-year experienced homelessness at any point during FY22/23 for a collective 899 days homeless, a 78% decrease.

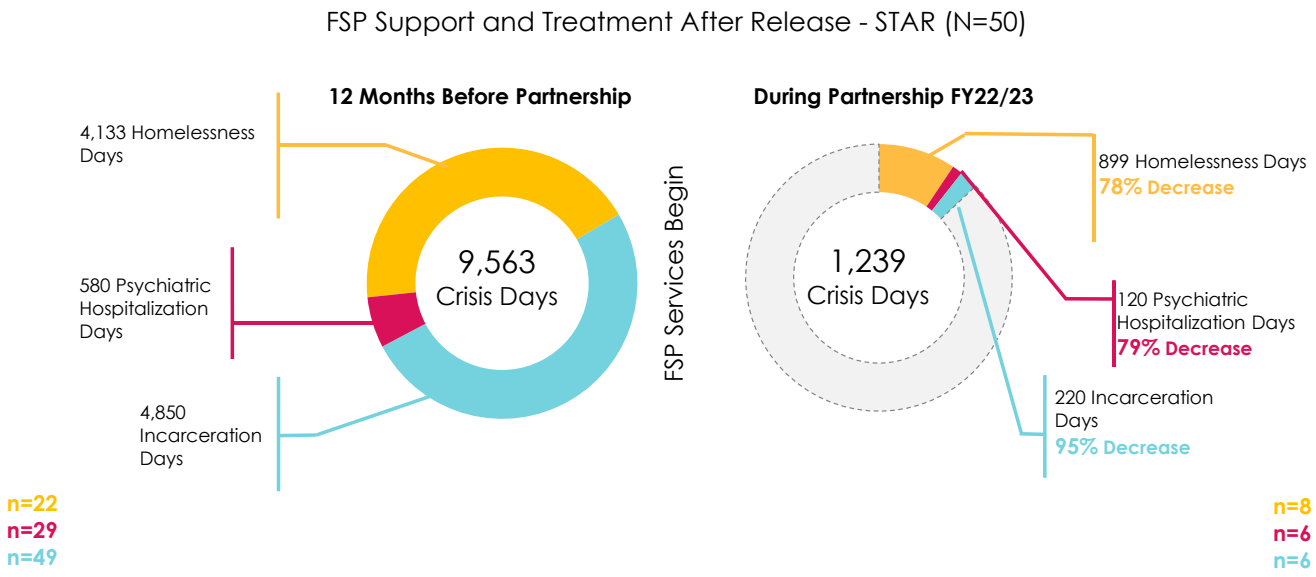
2. **64% decrease in arrests:** In the twelve months prior to entry, all of the 50 partners had at least one arrest for a collective total of 81 arrests. In FY 22/23, there were 12 partners who had been enrolled in STAR for one year or more had at least one arrest for a total of 29 arrests, a 64%

decrease in arrests.

3. **95% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 49 of the 50 partners had experienced incarceration for a collective 4,850 days in custody in the year before services. In FY22/23, 6 partners spent a collective 220 days in custody during FY22/23, for a 95% decrease in incarceration days.

4. **79% decrease in psychiatric hospitalization:** Of the 50 partners who had been enrolled in STAR for at least one year, 29 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 580 hospitalization days in their year before entering STAR. In FY22/23, there were 6 partners who had been enrolled in STAR for one year or more who experienced a psychiatric hospitalization for a total of 120 hospitalization days, a 79% decrease.

PROGRAM CHANGES FOR FY24/25: Add Peer Support Counselor position and MHSA-funded Behavioral Health Practitioner to provide services to existing clients and future CARE Act clients. In addition, the Psychologist position will be shifted to provide more assessments on the front end and support the CARE Court process.



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

PROGRAM OVERVIEW AND HISTORY: The Helping Older People Excel (HOPE) Program has been an MHSA-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 MHSA, Marin County did not operate a comprehensive integrated system of care for older adults with serious mental illness. Due to limited resources and service capacity, the existing Older Adult Services County mental health program had been unable to provide much more than assessment and peer support services. Of all the age groups served by Marin's public mental health services, older adults had received the least services and had the lowest penetration rates, despite the fact that they constituted the fastest growing age cohort in Marin.

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

In FY22/23, funding was added to provide extensive neuro-psychological evaluations for older adults with potential complex dual mental health and cognitive disorders (such as dementia), as well as additional funding 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.

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 MHSA 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 65 concurrently, but over the course of the year expecting to serve approximately:

- 2 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)
- 70 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 (this has been discontinued for FY21/22 forward)

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 was the intention to report of* Milestones of Recovery Scale (MORS). This was reported on for FY20/21, however for FY21/22 and forward this will no longer be continued given the significant amount of paperwork required to report on this and the divisions desire to be in better alignment with the paperwork reduction aspects of CalAIM.

FY22/23 OUTCOMES:

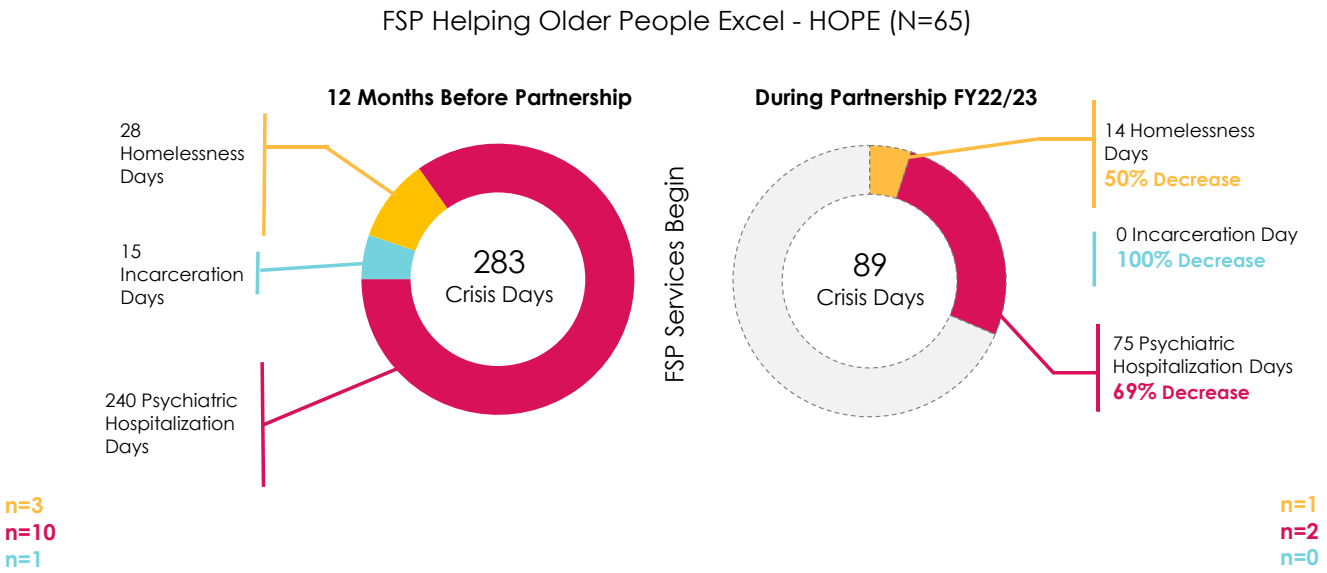
In FY22/23 there were 67 partners served in HOPE, 65 who had been in the program for one year or longer at the end of FY22/23.

1. **69% Decrease in Psychiatric Hospitalization:** Of the 65 partners who had been enrolled in HOPE for at least one year, 10 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 240 hospitalization days. In FY22/23, there were 2 partners who had been enrolled in HOPE for one year or more who experienced a psychiatric hospitalization in FY22/23, for a total of 75 hospitalization days, a 69% decrease.

2. **100% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 1 of the 65 partners had experienced incarceration for a collective 15 days in custody in the year before services. In FY22/23, 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 FY22/23.

3. **50% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 3 of the 65 partners experienced homelessness for a collective 28 days homeless in the year before services. In FY22/23, there was a 50% decrease in days homeless with 1 FSP partner who had been enrolled in HOPE for over one-year experienced homelessness for a collective 14 days homeless in FY22/23.

PROGRAM CHANGES FOR FY24/25: Add a bilingual Social Service Worker position to HOPE FSP to increase bilingual Spanish-speaking capacity, provide the ability for old adults from other FSP programs to transfer to HOPE as they age creating room on those other FSP teams to services take on new clients including CARE Act clients, and to strengthen fidelity to the ACT model.



ODYSSEY FULL-SERVICE PARTNERSHIP: FSP 05

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.

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 increasing capacity up to 115 clients at a time. In FY22/23, an additional Mental Health Practitioner and Peer Support Specialist were added to the team to support clients residing at Mill Street 2.0, now known as Jonathan's Place.

In the FY23/24-FY25/26 Three-Year Plan the Odyssey Team is being split into two smaller teams, each with 60 clients. The number of clients served by Odyssey has continued to grow over the years so to better meet the needs of the individuals and to be able to successfully achieve many of the key elements of the ACT model such as shared caseloads, the team will be divided into two with the second team taking on the name of "IMPACT South".

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. In FY22/23, an additional Mental Health Practitioner and Peer Support Specialist were added to the team to support clients residing at Mill Street 2.0, now known as Jonathan's Place.

EXPECTED NUMBER TO BE SERVED: Up to 60 concurrently, but over the course of the year expecting to serve approximately 65 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 (this has been discontinued for FY21/22 forward)

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 was the intention to report of* Milestones of Recovery Scale (MORS). This was reported on for FY20/21, however for FY21/22 and forward this will no longer be continued given the significant amount of paperwork required to report on this and the divisions desire to be in better alignment with the paperwork reduction aspects of CalAIM.

FY22/23 OUTCOMES:

In FY22/23 there were 138 partners served in Odyssey, including 4 Transitional Age Youth (16-25 years old), 109 adults (26-59 years old), and 25 older adults (60+). 130 of these partners had been in the program for one year or longer by the end of FY21/22.

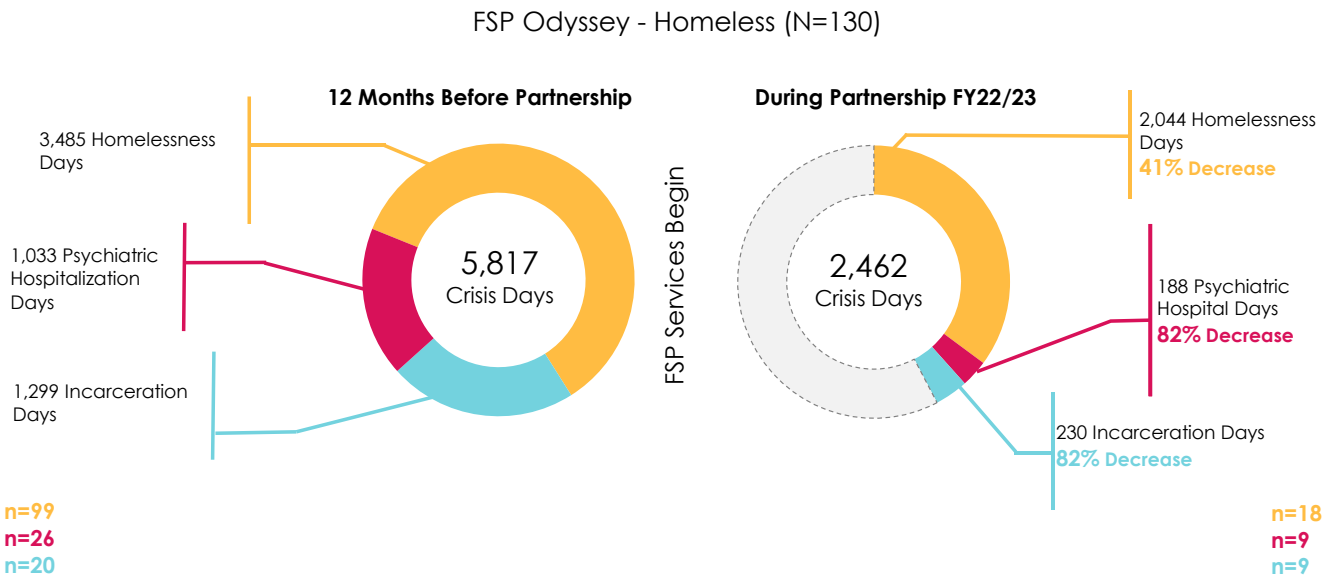
1. **82% decrease in Psychiatric Hospitalization:** Of the 130 partners who were enrolled in Odyssey for at least one year, 26 experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 1,033 psychiatric hospitalization days. In FY22/23, 9 partners experienced a psychiatric hospitalization in FY22/23, for a total of 188 psychiatric hospitalization days—a 82% decrease.

2. **82% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 20 of the 130 partners experienced incarceration for a collective 1,299 days in custody in the year before

services. In FY22/23, 9 partners spent 230 days collectively in custody—a 82% decrease in incarceration days.

3. **41% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 99 of the 130 partners experienced homelessness for a collective 3,485 days homeless in the year before services (averaging 27 days homeless in the year before services). In FY22/23, there were 18 partners who experienced one day or more of homelessness, for a collective 2,044 days—an 91% decrease ***resulting in 1,441 fewer collective days homeless in FY22/23 as compared to the baseline year***.

PROGRAM CHANGES FOR FY24/25: Decrease caseload and focus population served on chronic homelessness, build in ability to transfer to IMPACT programs when housing achieved and stability met for 2 years.



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

NOTE: This FSP was re-named IMPACT - North from "IMPACT" in FY23/24.

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. In FY23/24 the program renamed "IMPACT - North" adding a geographic focus to the program of Novato, Northern San Rafael, and West Marin.

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 60 concurrently, but over the course of the year expecting to serve approximately 65 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 (this has been discontinued for FY21/22 forward)

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 was the intention to report of* Milestones of Recovery Scale (MORS). This was reported on for FY20/21, however for FY21/22 and forward this will no longer be continued given the significant amount of paperwork required to report on this and the divisions desire to be in better alignment with the paperwork reduction aspects of CalAIM.

FY22/23 OUTCOMES:

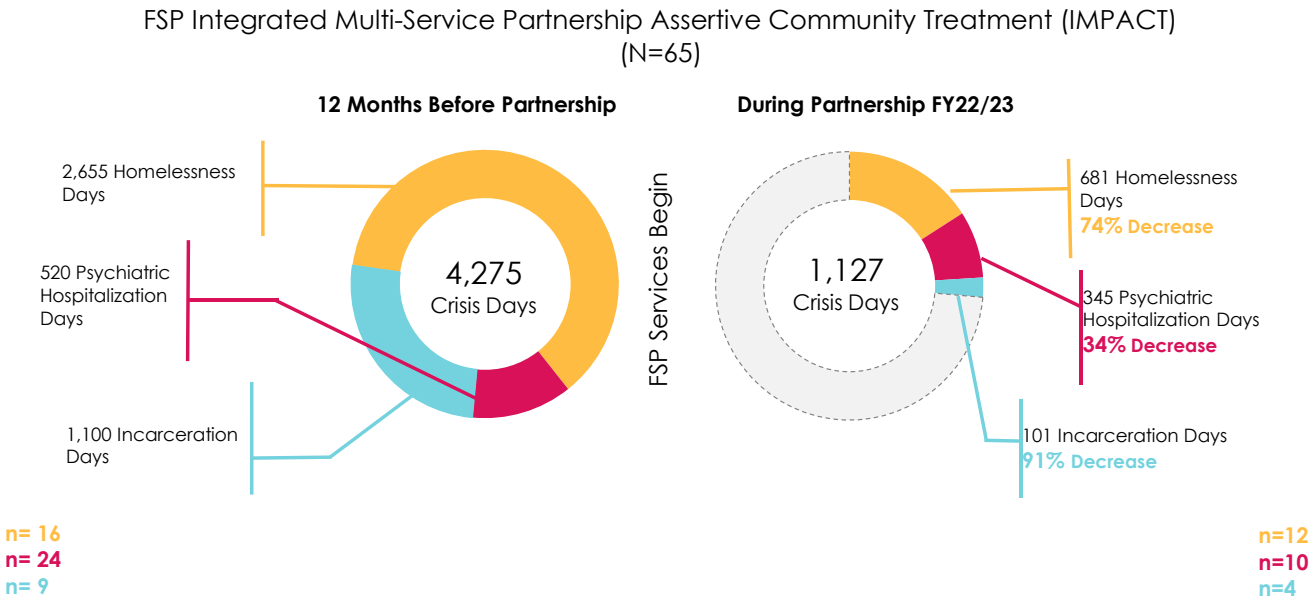
In FY22/23 there were 67 partners served in IMPACT, including 5 Transitional Age Youth (16-25 year olds), 57 adults (26-59), and 5 older adults (60+). 65 of these partners had been in the program for one year or longer by the end of FY22/23.

1. **34% decrease in Psychiatric Hospitalization:** Of the 65 partners who were enrolled in IMPACT for at least one year, 24 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 520 psychiatric hospitalization days. In FY22/23, there were 10 partners who experienced a psychiatric hospitalization for a total of 345 psychiatric hospitalization days—a 34% decrease in hospitalization days and a 58% decrease in the number of people needing hospitalization.

2. **91% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 9 of the 65 partners had experienced incarceration for a collective 1,100 days in custody in the year before services. In FY22/23, there were 4 partners who spent 101 days collectively in custody—a 91% decrease in incarceration days.

3. **74% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 16 of the 65 partners had experienced homelessness for a collective 2,655 days homeless in the year before services. In FY22/23, there were 12 partners who experienced one day or more of homelessness, for a collective 681 days—a 74% decrease.

PROGRAM CHANGES FOR FY24/25: None.



INTEGRATED MULTI-SERVICE PARTNERSHIP ASSERTIVE COMMUNITY TREATMENT (IMPACT) - SOUTH: FSP 07

PROGRAM OVERVIEW AND HISTORY: This Full-Service Partnership program began in FY23/24. This program launched from a desire to better serve southern Marin (including Marin City) and to stabilize the size of the full-service partnership programs. This program started with a division of the Odyssey FSP program which had expanded beyond the Assertive Community Treatment model.

PROVIDER: County-operated

TARGET POPULATION: IMPACT South'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. This program will have an emphasis on serving individuals who are homeless or precariously housed but it is not a requirement of the program. These individuals may or may not have a co-occurring substance abuse disorder and/or other serious health condition. This program is focused on increasing capacity in Marin City and serving individuals living in Southern and Central Marin.

PROGRAM DESCRIPTION: IMPACT South will provide 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 Assertive Community Treatment (ACT) model, a diverse multi-disciplinary team will be developed to provide comprehensive "wrap-around" services for individuals in need of the highest level of outpatient services. The staffing for this full-service partnership program is proposed as follows:

- 1.0 FTE Team Leader/Unit Supervisor
- 1.0 FTE Social Service Worker
- 1.0 FTE Support Service Worker
- 1.0 FTE Peer Specialist
- 1.0 FTE Behavioral Health Practitioner—Bilingual Spanish
- 2.0 FTE Behavioral Health Practitioners
- 1.0 FTE Mental Health Registered Nurse
- 0.5 FTE Mental Health Nurse Practitioner
- 0.3 FTE Psychiatrist

This is a 1:8.6 staff to client ratio excluding the medication providers, well within the Assertive Community Treatment (ACT) model guidelines. Even when one position is vacant, this team will still meet the 10:1 client to staff ratio as defined under the guidelines for an ACT program.

Services include comprehensive assessment, individualized client-centered service planning, crisis management, therapy services, peer counseling and support, medication support, psychoeducation, employment services, independent living skills training, assistance with money management, and linkages to/provision of all needed services and supports.

Treatment for co-occurring substance abuse disorders is essential to successful recovery and is provided 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 or transitional 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 60 concurrently, but over the course of the year expecting to serve approximately 65 TAY, Adults, and Older Adults. Given start up efforts, it is anticipated that in FY23/24 this FSP will serve 32 TAY, Adults, and Older Adults in the first year.

EXPECTED OUTCOMES:

1. decrease hospitalization
2. decrease incarceration
3. decrease homelessness

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.

FY22/23 OUTCOMES: None. This program was created in the new Three-Year plan and scheduled to open in FY23/24 so the first outcomes will be reported in the FY25/26 Annual Update.

PROGRAM CHANGES FOR FY24/25: None.

ENTERPRISE RESOURCE CENTER (ERC) EXPANSION: SDOE 01

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.

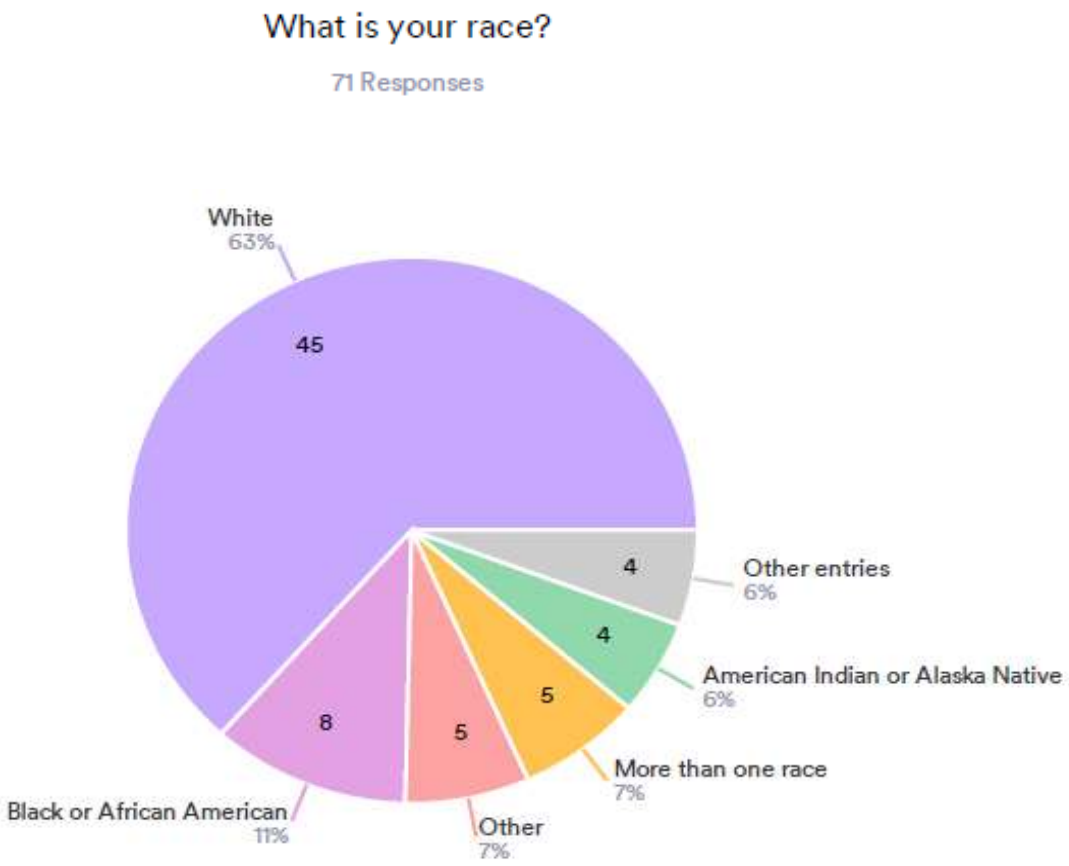
In FY20/21 BHRS released a Request for Proposals (RFP) for Peer-run services to ensure that county contracts allow for competition. The RFP process solicited bids for Peer-Run, Recovery-Oriented programs with a focus on ensuring equity along racial/ethnic and geographic lines. Peer-run programs must 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).

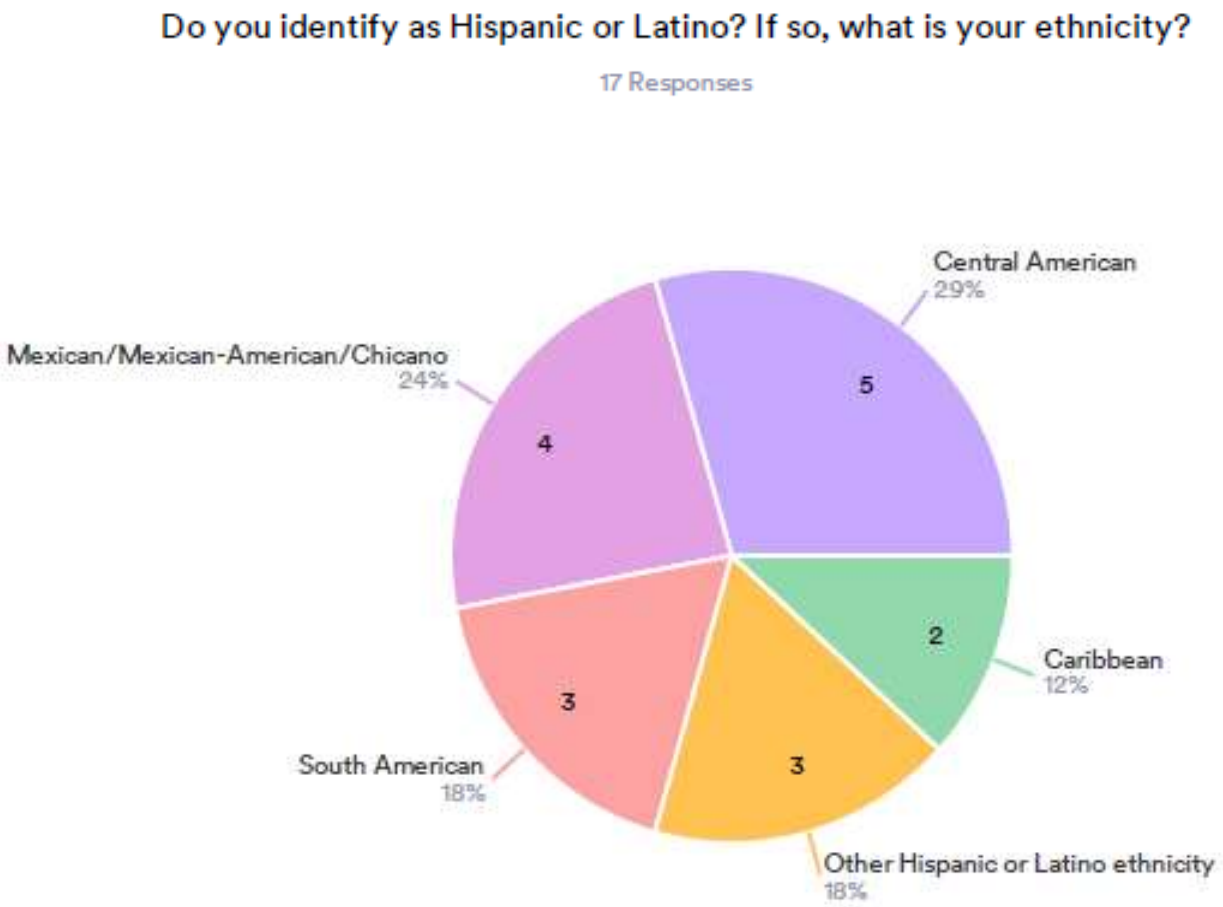
PROVIDER: Mental Health Advocates of Marin through the fiscal sponsorship of MarinLInk.

TARGET POPULATION: The target population of the ERC Program is to serve those with mental health challenges and or substance use disorder offering hope using evidenced based and evidence informed support groups, activities, field trips and one on one peer to peer support. The ERC is an entirely peer run organization from their Board to their volunteers.

PROGRAM DESCRIPTION: The Matt Tasley Social Activities Club is contracted to have a daily attendance average of 8 participants. They served an average of 6 which is 75%. The ERC believes that once they have transportation the numbers will increase. The Matt Tasley program is primarily for socialization and getting folks there can be a challenging. The ERC currently pick participants up at their Board and Care facility, their hope is to expand the areas they provide transportation to with the purchase of a van. During the COVID emergency the program provide virtual groups and warm line support.

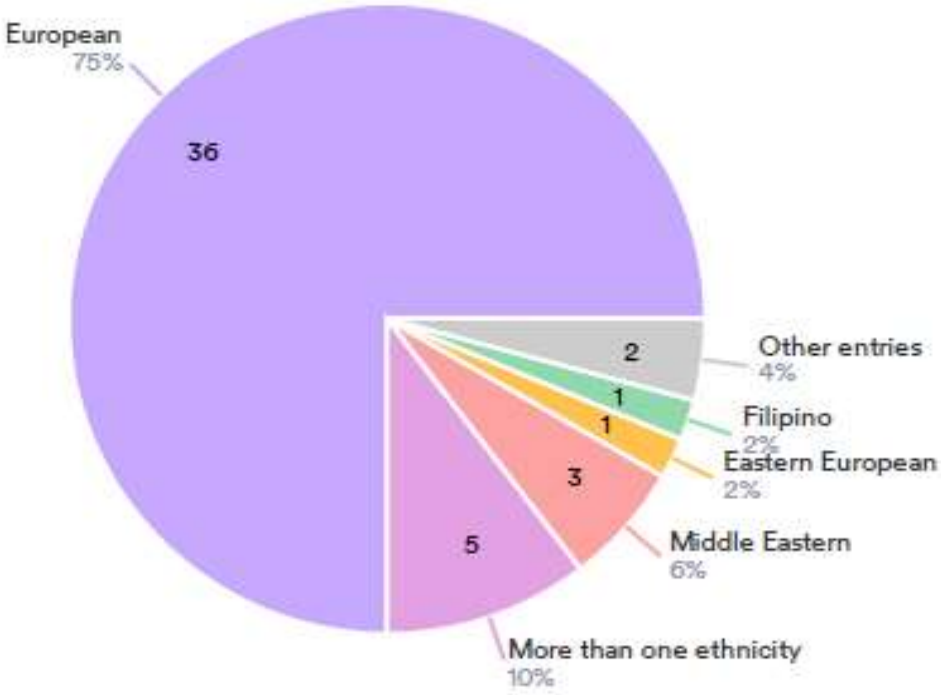
FY22/23 NUMBERS SERVED: 9,725 participant visits (duplicated) and 3,870 Warm Line calls. 133 unduplicated individuals signed in.

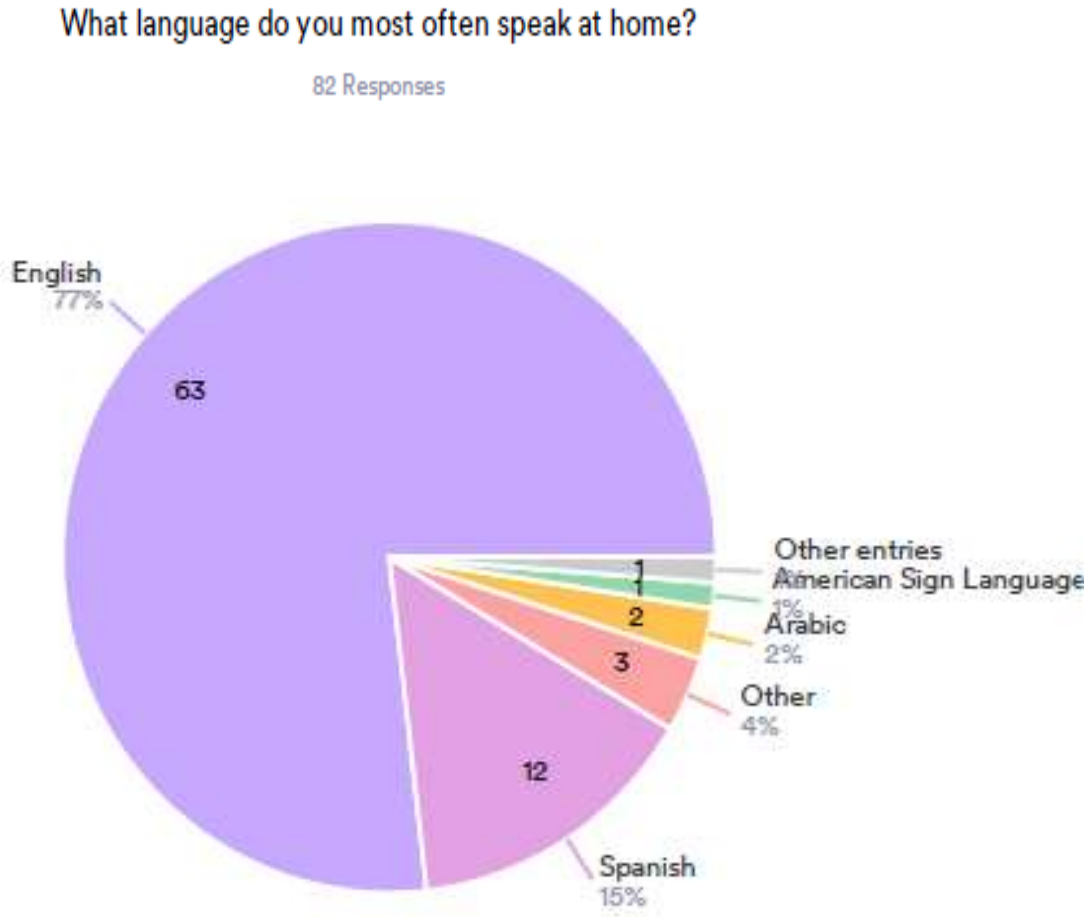

What is your race?
71 Responses
White
63%
45
Other entries
6%
4
American Indian or Alaska Native
6%
4
More than one race
7%
5
Other
7%
5
Black or African American
11%
8

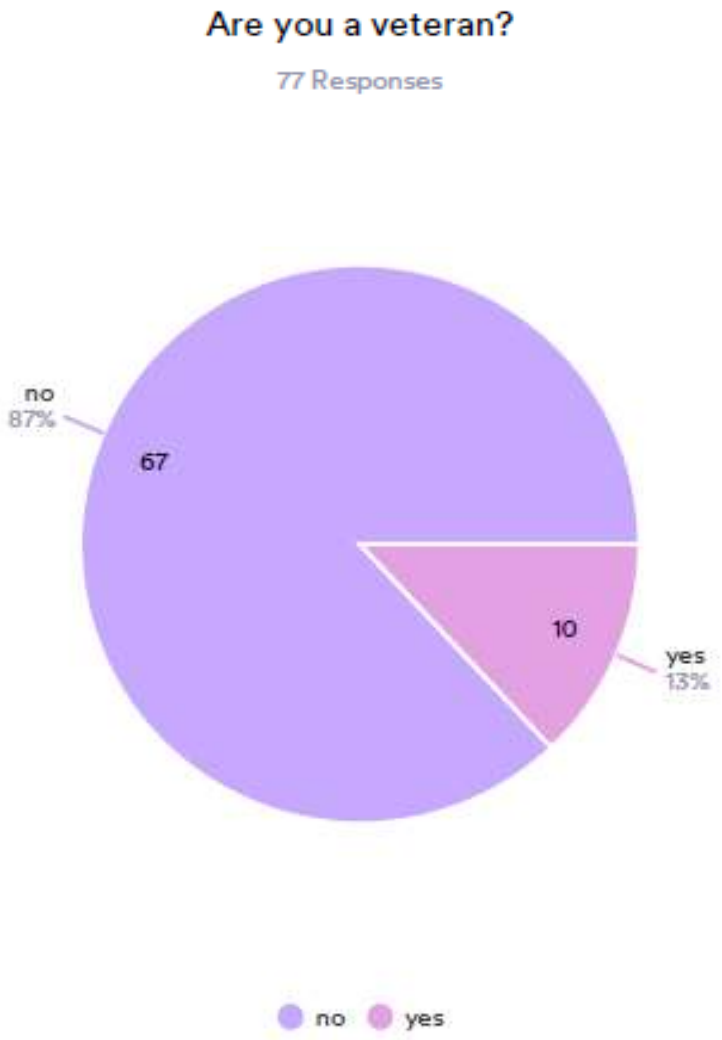

Do you identify as Hispanic or Latino? If so, what is your ethnicity?
17 Responses
Central American
29%
5
Mexican/Mexican-American/Chicano
24%
4
2
Caribbean
12%
3
South American
18%
3
Other Hispanic or Latino ethnicity
18%

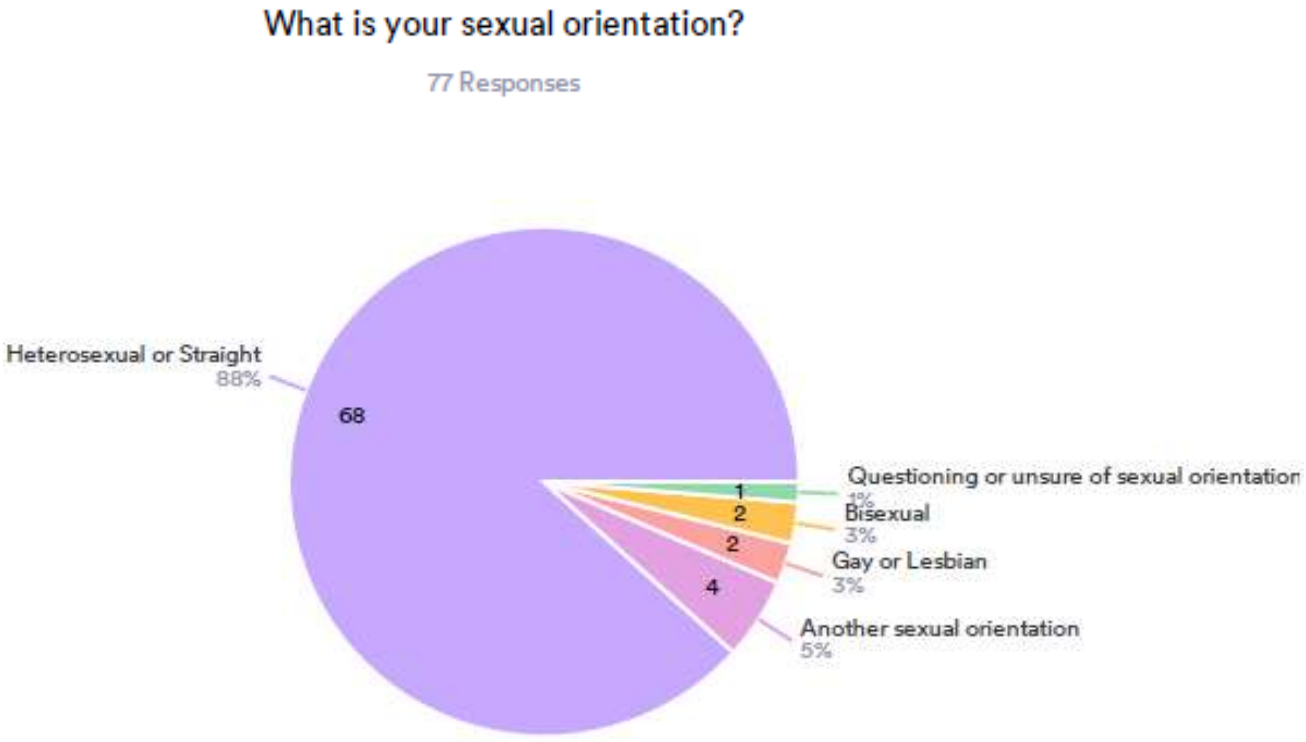
If you do not identify as Hispanic or Latino, what is your ethnicity?

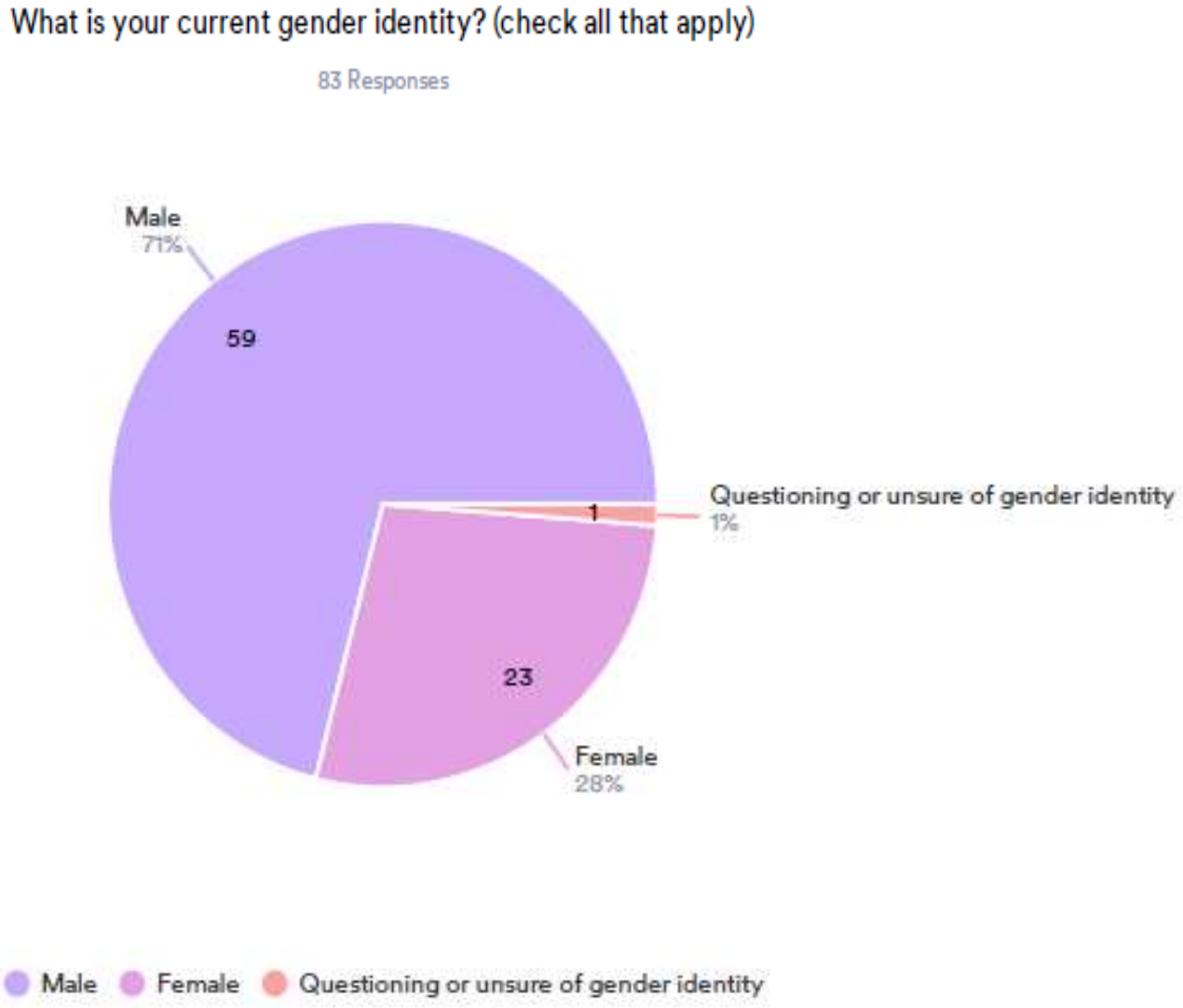
48 Responses

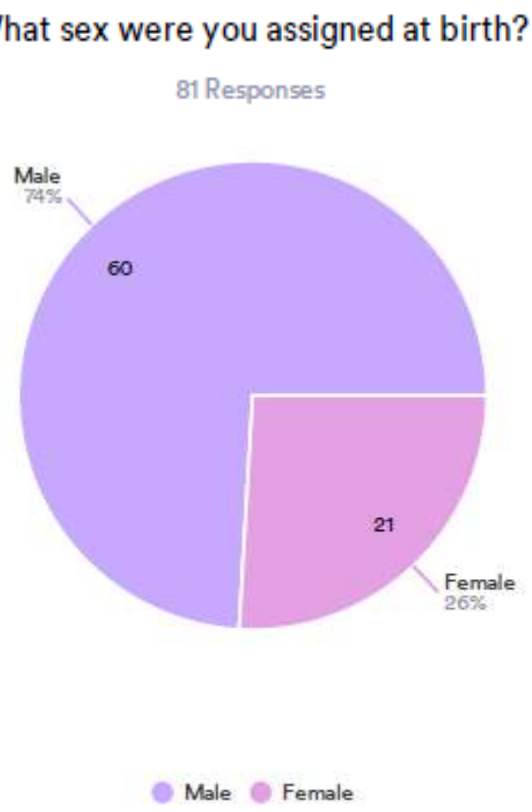



What language do you most often speak at home?
82 Responses
English
77%
63
Other entries
1
American Sign Language
1%
1
Arabic
2%
2
Other
4%
3
12
Spanish
15%


Are you a veteran?
77 Responses
no
87%
67
10
yes
13%
no
yes


What is your sexual orientation?
77 Responses
Heterosexual or Straight
88%
68
Questioning or unsure of sexual orientation
1%
1
Bisexual
3%
2
Gay or Lesbian
3%
2
Another sexual orientation
5%
4


What is your current gender identity? (check all that apply)
83 Responses
Male
71%
59
1
Questioning or unsure of gender identity
1%
23
Female
28%
Male
Female
Questioning or unsure of gender identity



OUTCOMES: In FY22/23, the Enterprise Resource Center conducted three evidence-based groups weekly and an average of fifteen evidence-informed groups per week. In addition, they offered daily board games, a morning walk, ping-pong, and movies in the afternoon. Scheduled activities included:

- Mental Health in the Black Community
- ERC Advocacy Team
- Social Groups
- A variety of Support Groups
- Yoga
- Ted Talks Group
- WRAP
- Peer Education

FY22/23 GROUP SCHEDULE:

MONDAY
10AM-11AM Mental Health in the Black Community
11AM-12PM Anxiety Support Group
12PM-1PM ERC Advocacy Team
1PM-2PM Life Skills Group
2PM-3PM Ted Talks Group
6PM-8PM Spanish Support Group

TUESDAY
10AM-11AM Women's Support Group
12PM-1PM Technology Class
1PM-2PM Men's Support Group
2PM-3:30PM SMART Recovery Group
2PM-4PM WRAP **Dates vary call for details*
4PM-5:30PM Peer Education *(*Sign up required)*
WEDNESDAY
11AM-12:30PM Hearing Voices & Negative Thoughts Support Group (**Zoom & In-person)*
1PM-2PM Depression Support Group
THURSDAY
10AM-11AM Yoga (YouTube)
11AM-12PM Bipolar Support Group
12PM-1PM Peer Companion Group
4PM-5:30PM Peer Education *(*Sign up required)*
FRIDAY
10:30AM-11AM ½ Hour Meditation
12PM-1PM Vietnamese Social Group
1PM-2PM Making Friends Group
2PM-4PM Massage Group *(Every other Friday)*
SATURDAY
12PM-1PM Peer to Peer Support Group
12PM-2PM Movies in the Group Room
1PM-4PM Art Group
2PM-4PM Spanish Group – Healing the Immigrants Journey
(First & Third Saturday of the month)
SUNDAY
1PM-2PM Peer to Peer Support Group
2PM-4PM Movies in the Group Room

PARTICIPANT STORY FROM FY22/23:

Story #1:

> *A participant who comes to the ERC regularly wrote us a letter. He wrote, "The ERC has given me a place where I can feel at home with other people with challenges similar to mine. The place has been great and wonderful. I love the support I receive. It is amazing. Living with a mental health challenge has not been easy, but having a place like the ERC has been a blessing. I thank god every day for the ERC. I really don't know where I would be without the family and care I get from the ERC"*

PROGRAM CHANGES FOR FY24/25: Supporting the Enterprise Resource Center to bill Medi-Cal to offset costs.

CRISIS CONTINUUM OF CARE: SDOE 09

OVERVIEW OF MHSA PROGRAMS WITHIN CRISIS CONTINUUM:

- **Mobile Teams** (Mobile Crisis Response Team (MCRT) and Transition Outreach Team)
- **Crisis Residential** programs (Casa René and Edgewood 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; 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 whereby MCRT can intervene utilizing a therapeutic approach and spend additional time in resolving the crisis in the least restrictive manner. MCRT clinicians provide 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. 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.

In FY23/24 MCRT began providing services 24 hours a day and 7 days a week in January 2024. In addition to the expanded hours, there was an expanded scope to provide services to individuals in a substance use crisis as well as provide follow-up services. In order to do so, the MHSA three-year plan added funding for 2.5 FTE Social Service Worker II-bilingual positions with co-occurring expertise or training and an additional contracted 2.75 FTE bilingual Peer Support Specialist positions. These changes help staff the MCRT in a way that can be more culturally and linguistically responsive and create a multidisciplinary team.

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 programing focused on principles of wellness and recovery. Crisis residential staff works with each individual's circle of support: family, friends, treatment professionals, substance abuse counselors, health care providers, naturally occurring resources including faith-based organizations, 12-step programs and any other resources that support the individual's recovery. Individuals are also be offered individual, group and family therapy.

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:

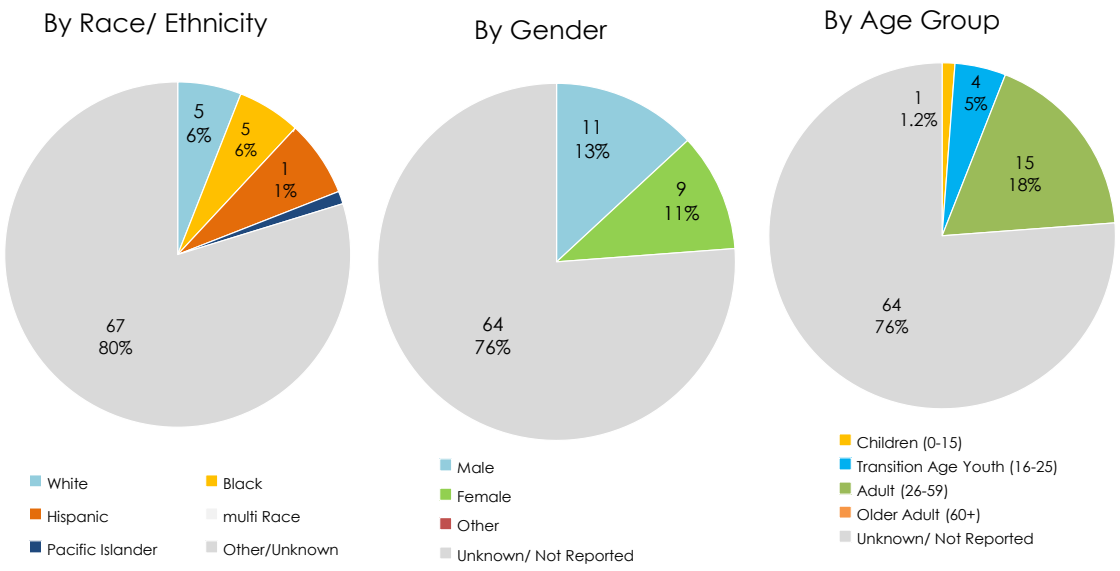
1) After a visit with the Mobile Crisis Response Team (MCRT) people experience decreased distress and increased reports that they would engage in services/support in the future should they need it.
2) Increase in feelings of hopefulness after an experience with the Mobile Crisis Response Team (MCRT)
3) Decrease in need for crisis services after being served by the Transition Outreach Team (TOT)
4) 90% of the clients will be linked to outpatient services at discharge from *Casa René*
5) 90% of clients will be discharged to a lower level of care when discharged from *Casa René*
6) 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.

MEASURMENT TOOLS:

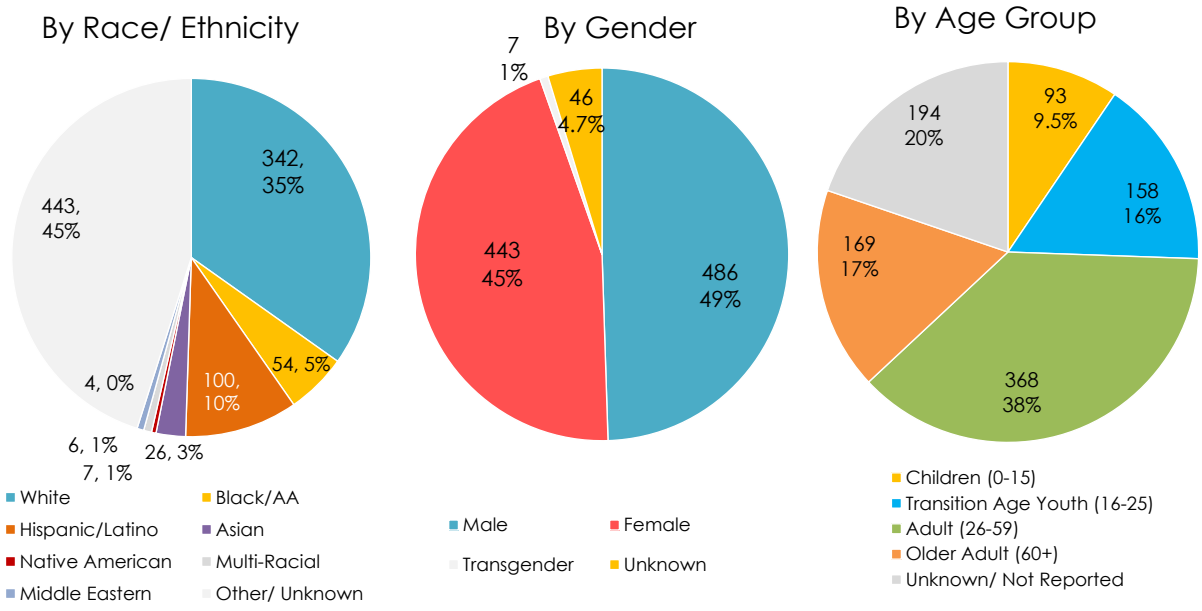
- Outcomes 1-2 will be tracked using data from the Marin Crisis Continuum Customer Satisfaction Survey. The data will be pulled from the two outcomes questions:
  - "As a result of my services I feel less distress and more likely to engage in services/support in the future should I need it."
  - "As 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.
- Outcomes 4 and 5 will be informed by contractor reports based on each client's discharge plans.
- Outcome 6 will be informed by data from provider survey.

FY22/23 DEMOGRAPHICS:

In FY22/23 the Transition Outreach Team (TOT) **served 84 community members** with 979 total contacts. The demographics of those served by the TOT were as follows:

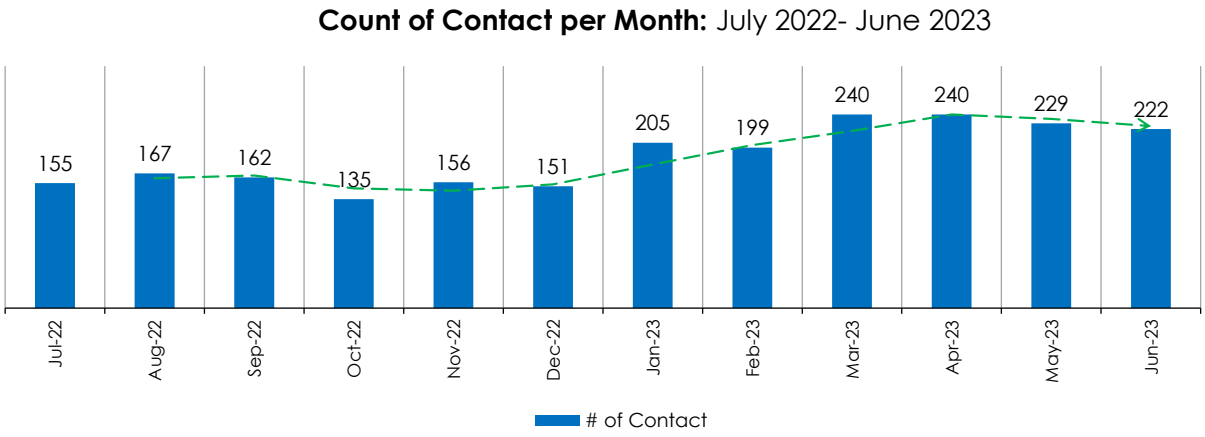


In FY22/23 the Mobile Crisis Response Team (MCRT) served **982 unique community members** (down 23% from FY21/22). The demographics of those served by MCRT were as follows:



Overall, demographics across age, race, and gender were consistent from FY 21/22 to FY 22/23 with a slight increase in Hispanic/Latino individuals served and an increase in the number of adults served.

In FY22/23, the MCRT had **2,261 contacts with community members.**

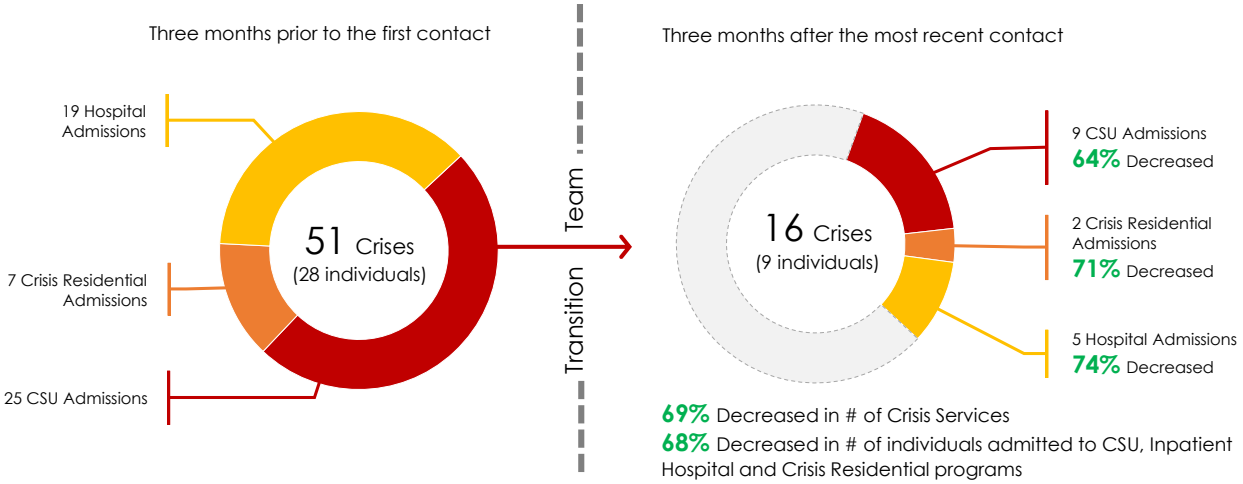


FY22/23 OUTCOMES:

1) Outcomes 1 and 2: Due to logistical challenges no surveys were collected for FY22/23.

2) Outcome 3: There was a **69% 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 51 crises down to 16). In addition, there was **68% decrease in the number of individuals** admitted to the CSU, Inpatient hospital, and Crisis Residential Programs.

Contact date between 7/1/2022-6/30/2023
FY22/23 TRANSITION OUTREACH TEAM OUTCOMES
(N=84 individuals)



3) Outcome 4: **93% of the 191 individuals served** were linked to services and had community supports identified and in place at time of discharge from *Casa René.*

4) Outcome 5: **94% of the 191 individuals served** were discharged to a lower level of care when discharged from *Casa René.*

5) Outcome 6: The provider survey was not collected during FY22/23.

PROGRAM CHANGES FOR FY24/25: None.

FIRST EPISODE PSYCHOSIS (FEP): SDOE 10

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.

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 FY 22/23: In FY21-22, the census was 9; in FY22-23, the program was able to admit an additional 9 clients, reaching a census of 18. While this is less than the goal of 25 unduplicated clients, it represents substantial progress in building the program's census. There were 2 barriers to achieving this goal: low numbers of referrals and staff shortages.

Of the 12 referrals the program received during FY 22-23, 9 (75.0%) were admitted and received early psychosis services. Of the 12 referrals received, 2 (16.7%) clearly did not meet diagnostic or age criteria

for early psychosis. One referral (8.3%) was not eligible for services due to private insurance. Overall, a total of 3 (25.0%) referrals did not meet program eligibility criteria.

In terms of client demographics, two out of the 18 clients served in FY 22-23 identified as Black or African-American, 5 identified as White or Caucasian, 9 (50%) as Hispanic or Latino, and two clients identified as more than one ethnicity. Three of said clients identified as Male, 15 (83%) identified as female. 14 of the 18 clients served in 22-23 were between 16-25 years of age.

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 heath 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 FY22/23:

1. Of the 18 clients served during this reporting period, 15 were served for six months or longer. Of these 15 clients, 11 had acute inpatient setting episodes in the year prior to services. 8 of the 11 (72.3%) 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®. Of the 3 remaining clients that experienced acute inpatient setting episodes, 1 did not experience an increase in those episodes while in treatment and 2 experienced an increase in those episodes.

2. Of the 18 clients served during this reporting period, 15 were served for six months or longer. Of these 15 clients, 13 clients (86.7%) have been ongoingly involved in school, employment and training opportunities or are making the transition from training to employment.

FY 22/23 Client Story:

One of major success stories involves a transition age youth who was first referred to the (re)MIND® Marin Program in February of 2021. When the client was first referred to the program, they had recently been hospitalized for threatening suicide; it was their second hospitalization in 2 months. They had struggled with hearing derogatory voices; they believed that demons were talking to them, telling them that they were "no good" and "better off dead." They also were displaying gross disorganization, poor hygiene and voicing suicidal ideation. They also engaged in self-harm, banging their head against the wall when frustrated.

Under the care of the (re)MIND® team, the client steadily improved. During the next year in the program, the client worked closely with the program's psychiatrist to develop a medication regimen that worked for them; they are currently taking a long-acting injectable antipsychotic medication that is working well for them. In addition, the client worked closely with the program's therapist to improve their coping skills; the client worked to better manage their voices, to better communicate their needs and to better assert themselves. Working with the program's case manager, the client was able to obtain and maintain employment; the client was recently making $2000/month! The client also chose to take several classes at a local college; the client was also able to develop a relationship with a fellow student. They are also actively pursuing a career in film and rap. Given their stability, the client recently graduated from the (re)MIND® program; they are currently receiving ongoing psychiatric and case management services from a local outpatient clinic. At last report, their primary struggle is to find a good balance between work, school and love life. The client attributed their progress to the services they received through the (re)MIND® program.

PROGRAM CHANGES FOR FY24/25: None.

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

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 voluntary 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: 85 members including TAY, Adults, and Older Adults

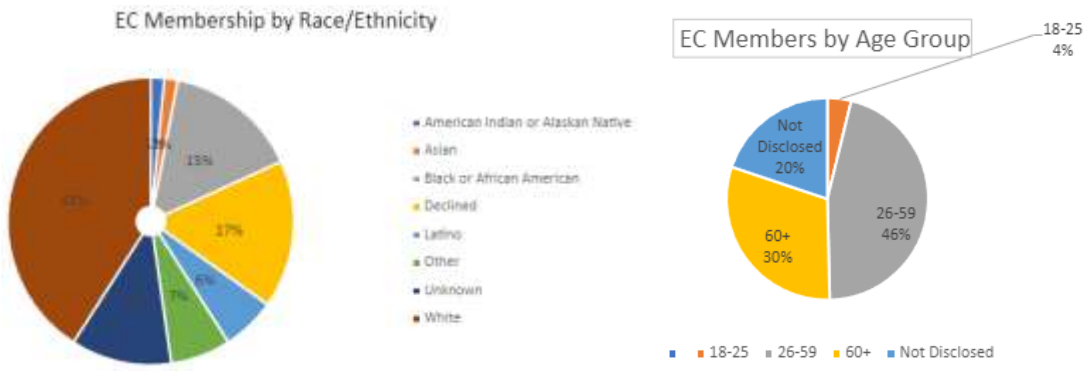
EXPECTED OUTCOMES:

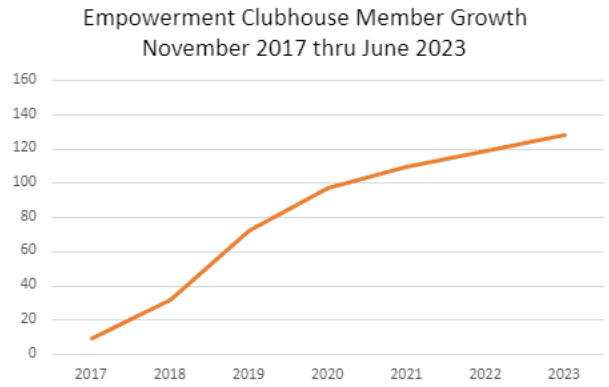
- Program average daily attendance (ADA) of at least 12
- Clubhouse members are expected to show an **increase in wellness and recovery**, such as:
    - Increased access to resources
    - Increased resiliency factors, such as feeling of belonging to a supportive community
- ***Member Defined Goals***: 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

FY22/23 ACTIVITES AND IMPACT: This Fiscal Year 2022/2023 and while coming out of the global pandemic, the main objective of the Empowerment Clubhouse (EC) was to continue to provide and expand recovery opportunities for people 18 years and older. The Empowerment Clubhouse launched new Work Ordered Day Units and Programs to better serve Members. In addition, the EC made necessary enhancements to adhere to Clubhouse International (CI) 37 Standards. The EC passed their CI onsite survey in January 2023 and was awarded their three-year CI Accreditation in June 2023. As of 5/31/23, the EC has 128 Members.

FY22/23 outcomes include:

- 15+ average daily attendance
- Increased number of new members
- Successfully designed and launched Hospitality and THRIVE Units
- New ADA workstation created in the THRIVE Unit
- Received official three-year Clubhouse International Accreditation





Impact on members:

"I can come here to get ideas about my job hunting endeavors and get a job if I can. My chances of getting a job are a lot better when I have people on my side."

"Clubhouse is a second family, gets me away from my problems. And I like to do chores."

"I am a different person, I am changed. The trauma and craziness that I went through to know myself to love myself. I started to have value, to know myself. I had people that believed in me. Empowerment Clubhouse says it all, I am more than lucky to know about this place and be here."

"I was overwhelmed sitting in this room with people all around me at this job fair. I did not know what I wanted and started to leave. I felt lost. Then this woman came to check on me and asked if I was ok. I said no. She then got me some water and sat down near me. She was the boss there and I was surprised she was talking with me, like why? So, I told her that I was not sure why I came. She, Christina, told me not to worry and that she and her team would help me. I felt embarrassed because I wasted everyone's time in that room. But she then told me not to worry that there would be other opportunities. She then told me about the Empowerment Clubhouse. I never knew something like this existed. So, I met with the Members and enrolled. It felt great. But it also felt weird that these people were all there working. I did not get it. But the more I stopped by and saw what work was being done, it was really cool!

I later took the Construction Trades cohort and finished the entire 8 weeks. But then my son got arrested and I got robbed. It felt like I lost everything and I just gave up. I drank for an entire week and missed my graduation. I got all these calls because people in the clubhouse were looking for me to see if I was ok. I could not get out of bed, I just spiraled. And then, one day it hit me, I remembered the people at the clubhouse and I just got up. I hoped they would not be mad at me because I ignored them. But when I got there, I walked in during lunch time and they all looked up and smiled at me. Lunch was almost over and someone gave me their plate. I felt like I belonged somewhere and suddenly forgot about my problems. I talked with the director and then met with some other members and got back on track. I have not drank for over two weeks, I also met with my probation officer, and now have all of my construction certificates I need to get a union job. I feel so much better and will always be a member here. I am going to help with the garden and around the clubhouse. I am ready to work because this is my life."

PROGRAM CHANGES FOR FY24/25: None.

RECOVERY-ORIENTED SYSTEM DEVELOPMENT: SDOE 13

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 FY22/23 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 FY22/23, 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 Latine, 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:

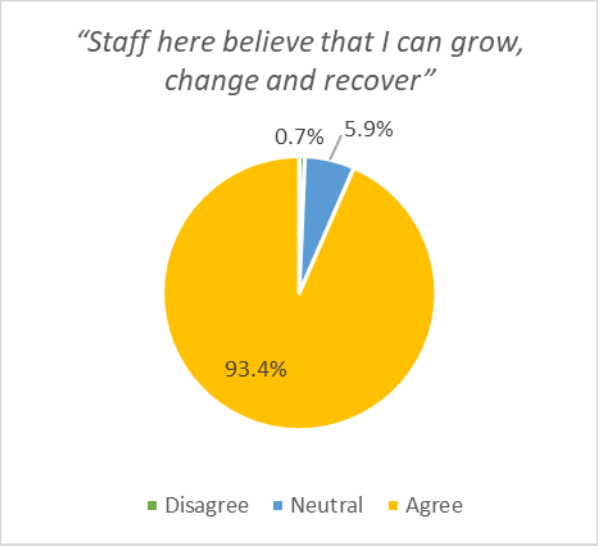
1) At least 70% of clients will report feeling that staff believe that they can grow, change, and recover
2) At least 70% of clients will report that staff helped them obtain the information they needed so that they could take charge of managing their illness
3) At least 70% of clients will identify 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:

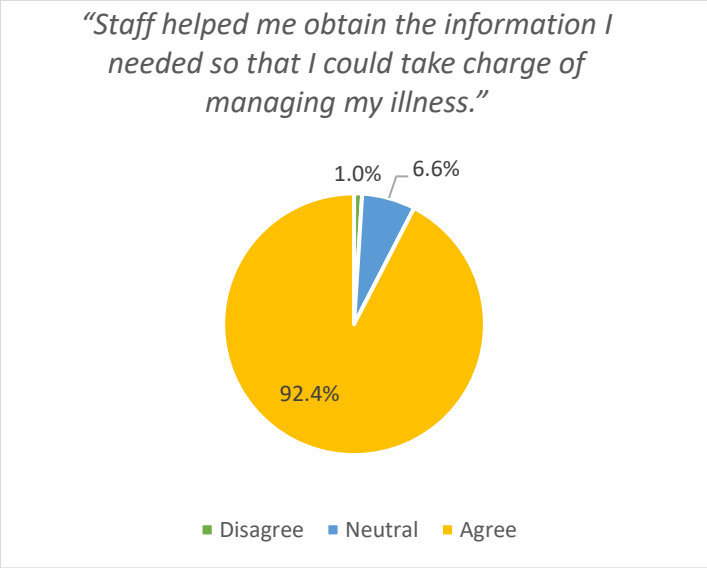
1) Outcomes 1-3 will be measured using the Performance Outcomes and Quality Improvement (POQI) MHSIP Consumer Perception Survey, which was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services. "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 FY22/23:

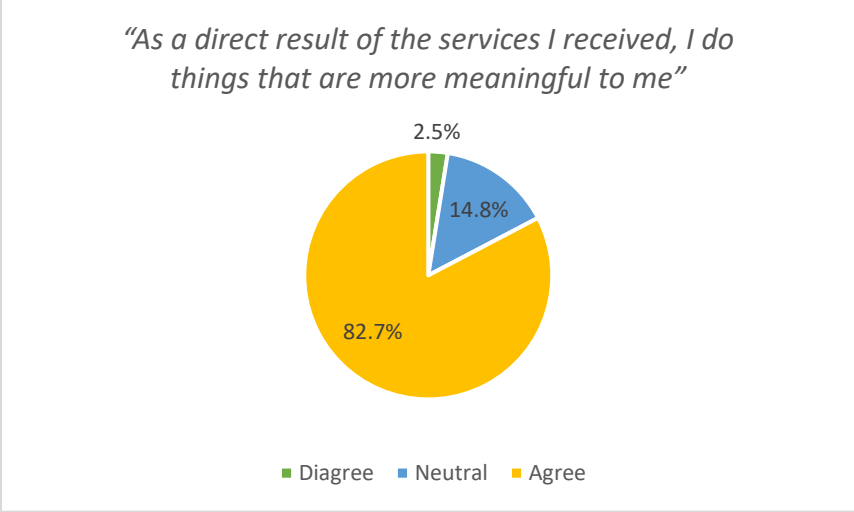
1) In FY22/23, **93.4%** of clients reported feeling that **staff believe that they can grow, change, and recover** (same as the prior year):



2) **92.4%** of clients reported in FY22/23 that staff helped them obtain the information they needed so that they could **take charge** of managing their illness:



3) Despite the ongoing pandemic, 82.7% of clients reported in FY22/23 that as a direct result of the services they received, they are better able to **do things that are meaningful** to them (the same as previous year).



PROGRAM CHANGES FOR FY24/25: Reduce MHASF contract in second half of FY24/25.

MHSA STEPPING-UP PROGRAM: SDOE 14

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 goal 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

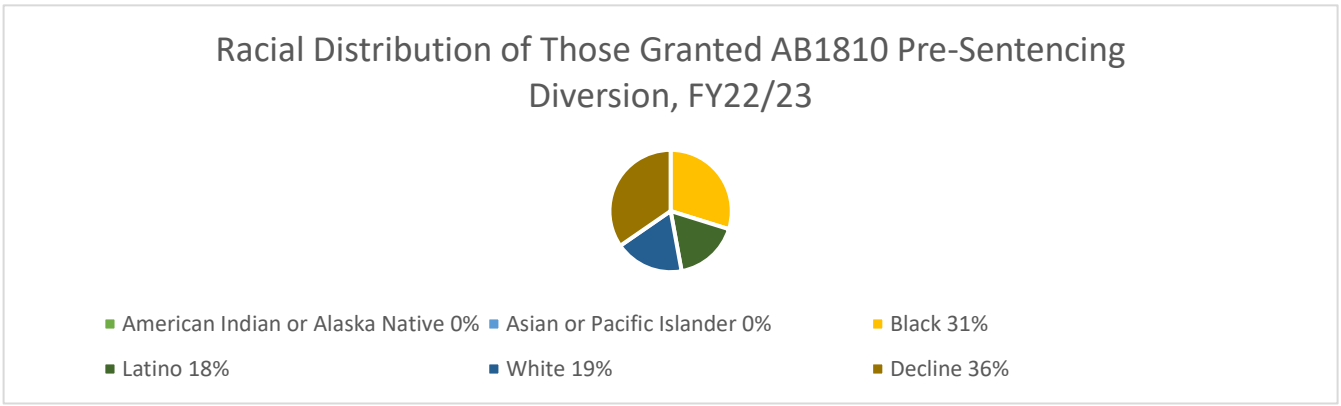
OUTCOMES FOR FY22/23:

The Jail Re-Entry support portion of the Stepping Up initiative was unable to launch during FY21/22 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 **21 individuals** who were granted AB1810 diversion, **85%** remained out of custody by meeting the requirements—or being on track to meet the requirements—of their treatment plan.

- *Analysis of Equitable Impact:* Overall, 88% of those who applied for AB1810 Diversion met the basic screening criteria. 24% of those who met the screening criteria ended up being granted diversion. This included 31% (6/19) of the Black applicants, 18% (2/11) of the Latino applicants, 0% (0/1) of the American Indian or Alaska Native, 19% (9/46)of the White applicants, and 36% (4/11) of those who declined to state their race.



Crisis Intervention Training (CIT):

- **Outcome 4: 100%** 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 FY22/23 approximately **74%** of officers and deputies in Marin have completed the CIT training, almost meeting the goal of 75%. This includes:

    - San Rafael PD: 86%
    - Sausalito PD: 70%
    - Fairfax PD: 56%
    - Central Marin PD: 94%
    - Mill Valley PD: 88%
    - College of Marin PD: 100%
    - Marin County Sheriff's Office: 25%

PROGRAM CHANGES FOR FY24/25: CIT Coordinator position fully funded by County of Marin Probation Department.

COMMUNITY OUTREACH AND ENGAGEMENT: SDOE 15

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 Latine 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 classes and Mental Health First Aid to introduce more people to behavioral health services and supports

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, Multicultural Center of Marin/Marin Asian Advocacy Project, and North Marin Community Services.

TARGET POPULATION: Unserved individuals who may be eligible for services, with an emphasis on targeting underserved populations in our mental health system including the Latine 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 FY22/23:

Community Health Advocates/*Promotores* Programs

North Marin Community Services

North Marin Community Services (NMCS) 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.

***Promotora* Quote:**
"During this year I have learned many things that have helped me be a better person and *Promotora* and that way I could help my community in a more efficient way. I learned how to conduct a roundtable discussion, how to speak in public, do presentations, know terminology related to LGBTQ+, how to help with and recognize a mental health emergency, and how to practice self-care."

North Marin Community Services- *Promotores* Program	**Goal FY 22/23**	**Actual FY 22/23**
11 *Promotores* from will participate in at least **15** hours of training.	**15**	**28**
As a result of the trainings provided by NMCS, at least **85%** of *Promotores* will agree or strongly agree that they: - Experienced growth as community leaders due to participating in the *Promotores* Program; - Know at least 2 places in Marin where they can refer clients for bilingual mental health services; - Are better able to recognize the signs that someone may be dealing with a mental health problem or crisis; and - Are better able to reach out to someone who may be dealing with a mental health problem or crisis.	**85%**	- **95%** of *Promotores* agreed that they had experienced growth due to their participation in the *Promotores* Program - **100%** of *Promotores* stated that they knew 2 places in Marin where they can refer clients for bilingual mental health services - **95%** agreed that they are better able to recognize the signs that someone may be dealing with a mental health problem or crisis - **100%** agree that they are better able to reach out to someone who may be dealing with a mental health problem or crisis.

Promotores will: - Reach **450** Latine community members via face to face, phone, text and video contacts; - Facilitate at least **10** talleres (workshops) on mental health stigma, stress management or suicide prevention in local groups (ELAC's, church groups, etc.) reaching an estimated **100** individuals; and - Provide informal counseling, screening and referrals (1:1 emotional support) to **155** Latine individuals and family members.	- **450** community members - **10** workshops reaching **100** people - Informal counseling to **155** Latine individuals and families	- **2,953** community members - **12** workshops reaching **157** people - Informal counseling to **180** Latine individuals and families
NMCS staff will complete **2** hours annually to stay abreast of new learning regarding cultural humility, racial equity and trauma-informed practices.	- **2** hours of training with **1** hour in cultural humility and **1** hour in LGBTQ+	- All staff completed the **2** hours of cultural humility and LGBTQ+ training
NMCS will attend at least **75%** of MHSA Committee meetings and relevant sub-committee meetings	- **75%**	- **100%**
Clinical Director and Latine Services Manager will attend at least **80%** of *Promotores* meetings	- **80%**	- **100%**
Latine Program Assistant will participate in at least **4** collaborative meetings at the local and state level	- **4**	- **4,** including Healthy Novato Initiative, Novato Community Coalition for Substance Prevention, Marin County CHW Collaborative, and Department of Health Care Access and Information regarding CHW Certification

Client Story (provided by NMCS *Promotora*):

A mother is experiencing domestic violence and she is struggling with a mental health condition. She has 3 daughters and was having difficulties taking care of them. I spent a lot of time listening and supporting her until she was ready to be referred to bilingual therapy from North Marin Community Services. As she continues her therapy sessions she was able to understand that her mental health struggles were related to the domestic violence her family was experiencing. She has started to implement strategies to be more present with her kids and take better care of herself."

First Missionary Baptist Church

First Missionary Baptist Church (FMBC) supports Community Health Advocates to 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 22/23	Actual FY 22/23
Provide informal counseling and referrals to at least **100** individuals and family members	**100**	**150**
By June 30th, 2023, Marin City Advocates program in Marin City will provide **12** training opportunities for advocates, with an open invitation to community members on topics such as mental health, stress management, conflict resolution, reaching an estimate of **50** people.	**12** trainings reaching **50** people	**19** workshops, including monthly workshops on mental health, stress management, and conflict resolution, 3 sessions on suicide prevention and 4 sessions on fatherhood mentoring, in total reaching **358** people.
By June 30, 2023, Marin City Advocates will reach at least **150** individuals via face-to-face, video call, or phone/text/calls.	**150**	Advocates met with over **300** people.

The Marin Asian Advocacy Project

The Marin Asian Advocacy Project (MAAP) 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.

Marin Asian Advocacy Program	Goal FY 22/23	Actual FY 22/23
By September 2022, at least **3** Community Health Advocates (CHAs) will receive training in CHA basics and leadership development. • **100%** of CHAs will show a base level of knowledge/ability as evidenced by post test • **100%** of CHAs will receive at least **6** hours each of formal group or individual supervision.	**3** **100%** **100%/6 hours**	**5** **100%** **100%/6 hours**
By December 2022, MAAP will help to fill out at least **20** flu vaccination forms.	**20**	**40**
By June 2023, on average **5** people will attend MAAP support groups.	**5**	**8**
By June 2023, the average participants in social gatherings will be **12** people	**12**	**20**


AAPI Perspectives
on Mental Health Care
An Educational Event for the General Public
Marin Asian Advocacy Project
What are the unique contexts, needs, & challenges in AAPI mental health support? How do ethnic, religious, & communal identities factor into the sense of well-being in AAPI communities?
Speakers
Friday May 26, 11am-1pm
Multicultural Center of Marin
709 Fifth Ave, San Rafael
Lunch will be provided
Ven. De Hong
Co-Founder of Engaged Buddhist Alliance
Free admission, registration required (by 5/24)
For more info and to register, visit AAAMarin.org
Jaime Yan Faurot
Volunteer
BIPOC Peer & Community Advocate
BHRS Marin
Co-Sponsors
MULTICULTURAL CENTER MARIN
Engaged Buddhist Alliance
ASIAN AMERICAN ALLIANCE OF MARIN

BHRS Spanish Language Groups:

- Weekly Parenting Class for Spanish speakers: Group is held weekly on a virtual zoom platform. Parenting class occurs every Wednesday from 5 – 6 pm. Group is facilitated throughout the year, with a brief pause in the summer between internship cohorts, and for facilitator to take time away for holidays and personal obligations if need be. Bilingual Clinical Psychologist II provides letters to confirm attendance and information about the class, as requested by need-to-know parties.
    - Summaries from the websites of each of the Evidence Based Practices (EBPs) utilized in group. Each module is a culturally and linguistically adapted EBP of Parenting:
        - **Triple P:** The Triple P – Positive Parenting Program is one of the most effective evidence-based parenting programs in the world, backed up by more than 35 years of ongoing research. Triple P gives parents simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behavior and prevent problems developing. Triple P is used in more 30 countries and has been shown to work across cultures, socio-economic groups and in many different kinds of family structures.
        - **STEP (Systematic Training for Effective Parenting):** The **STEP** parenting program is an effective, seven-session planned training curriculum that focuses on topics important to parents today. This course provides valuable tools which improve communication among family members and lessens conflict. Easy to understand and apply, **STEP** presents effective skills that can be used immediately. Dynamic video vignettes let parents see how easy it is to put **STEP** to work in the home everyday! For parents of school-age children - ages 6 through 12.
        - **Catch them being Good:** an extremely valuable parenting tool. Dr. Kussin has created a sound, practical program that provides parents of children ages 2-18 with the confidence to learn common sense, simple tools that really work. The true effectiveness of this program is based on the unique emphasis of strengthening the parent-child bond. Dr. Kussin's years of experience, wisdom, insight and authority in the area of parenting are clear. Quite simply, this book is an essential gift for any and all parenting needs
        - **Abriendo Puertas**: Each of the 10 sessions uses a "dicho," or popular saying, and incorporates culturally familiar activities and data. Available in both Spanish and English, the 10 sessions promote school readiness, family well-being, and advocacy by addressing best practices in brain development, key aspects of early childhood development (cognitive, language, physical, and social/emotional), early literacy, bilingualism, early math, positive use of technology, attendance, civic engagement, parent leadership, goal setting, and planning for family success.
        - **Adelante con nuestros niños**: developed with and for Latino Parents from Marin County.
    - Lessons on effective communication, positive disciplinary practices, stress and anger management, child abuse prevention, enhancement of health and self – concept, and accessing community resources are continuously presented, discussed and practiced as appropriate and based on community needs and occurrences. Classes are taught in Spanish and focus on parenting in the USA in the 21st century.
- 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).

CHANGES FOR FY24/25: Pause community health advocates program expansion by not releasing planned new RFPs for the Canal area of San Rafael and for the creation of a new Community Ambassador program.

HOMELESS-FOCUSED SUPPORT AND OUTREACH: SDOE 16

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 may 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 to engage them in services.
4) Provide coordinated supportive services to clients who are homeless or at-risk of homelessness to assist in achieving 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 serves 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 FY24/25: 240

NUMBERS SERVED IN FY22/23: 275

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 95 formerly homeless clients housed, with at least 96% 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

FY22/23 OUTCOMES:

- **Outcome 1: 77** individuals were unhoused at the time of an Access assessment in FY22/23. Additionally, there was an increase in the percent of individuals who were assessed that were unhoused at the time of assessment (up to 19% in FY22/23 from 15.1% in FY21/22).
- **Outcome 2:** The percent of unhoused individuals who identified as having psychiatric or emotional conditions increased slightly between the Point-in-Time Count conducted in 2019 to the Point-in-Time Count conducted in 2022. One major change during this time was the COVID pandemic as well as significant focus and de-stigmatization of mental health. In 2019, 42% (n=360) of survey participants reported having psychiatric or emotional conditions. This number increased slightly in 2022 - 45% (n=340) of survey participants reported having psychiatric or emotional conditions.
- **Outcome 3: 95** formerly homeless clients were housed through the Shelter+Care program with **96%** of participants remained housed at least 2 years.

CHANGES FOR FY24/25: Community Alternative Response and Engagement Team contract to be shifted to other County funding sources with no reduction in services.

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CalAIM) TRANSITION SUPPORT: SDOE 17

NOTE: *This is a NEW Program in the FY24-26 Three Year Plan, with funding earmarked in just year one of the plan.*

PROGRAM DESCRIPTION: This General System Development program is aiming to improve the county behavioral health service delivery system for all clients and their families by providing support for contracted partners in the payment reform transition for CalAIM.

FY23/24 is a major transition year for many Behavioral Health contractors including many that are shifting to a *Fee For Service* model. The *Fee For Service* model incentivizes face-to-face time with clients shifting the way contractors are paid so that they get a paid strictly based on time spent with clients. In order to help smooth the transition, incentive payments will be provided for "Contract Modernization" providing a bit of a cushion for the first year of operation under a *Fee For Service* system. Specialty Mental Health Contractors that are shifting from a Cost Reimbursement to *Fee For Service* payment structure will be eligible for this incentive.

Secondly, in order to implement many of the changes under CalAIM in July 2023 BHRS will be transitioning to a new Electronic Health Record (EHR) system (see the *Capital Facilities and Technology Needs* section for more details). In order to best provide coordinated care for Behavioral Health clients incentive payments will be provided to contractors to help ensure as much clinical documentation will take place in the new EHR (aka *SmartCare*) as possible so that contractors and county programs providing services to a client can coordinate within the system. Contracted agencies using *SmartCare* as their EHR for Marin County Beneficiaries and have their rendering providers/clinicians document into *SmartCare* in accordance with the Documentation Standards would be eligible for this incentive. Contracted agencies that have their administrative staff only enter the service level billing and state reporting data will not qualify for this incentive.

PROVIDER: These incentive payments would be provided to Medi-Cal billing Specialty Mental Health contracted providers

EXPECTED NUMBERS TO BE SERVED FOR FY24/25: 0. Services for approximately 600 individuals through contracted partners were impacted by this General System Development program in FY23/24. This was one-time funding but will have a lasting impact on how contracts are set up, improving the system for years to come.

OUTCOMES:

- Outcome 1: Increase the amount of face-to-time clients have with their Mental Health provider
- Outcome 2: Increase care coordination by increasing the number of providers who their clinical documentation into the BHRS *SmartCare* Electronic Health Record System

MEASUREMENT TOOL:

- Outcome 1: Comparing the Medi-Cal claims from FY22/23 with FY23/24 for Face-to-Face time with clients for the contracted agencies that shift from Cost Reimbursement to *Fee For Service*
- Outcome 2: This will be based on the number of providers who make the transition to include their clinical documentation in the new EHR in FY23/24.

MHSA GENERAL STANDARDS ALIGNMENT: Incentivizing contractors to utilize one electronic health record system will increase the ***integrated service experience*** for clients by enhancing the ability for providers to coordinate care. Incentivizing face-to-face time with clients also makes services more ***client-centered***.

FY22/23 OUTCOMES: No outcomes to report for FY22/23 as this program launches for FY23/24 only and outcomes will be reported in the FY25/26 Annual Update.

CARE OUTREACH AND TREATMENT: SDOE 18

NOTE: *This is a NEW Program in the FY24-26 Three Year Plan, with funding earmarked in years two and three of the plan.*

PROGRAM DESCRIPTION: The CARE Act establishes a new civil court program, CARE Court, focused on aiding individuals with schizophrenia or other psychotic disorders, who have previously been resistant to or unaware of available treatment options. The court process is collaborative and provides individuals a CARE plan with a clinically appropriate, community-based set of services and supports. Participants will receive behavioral health services through a county-operated Full Service Partnership program.

PROVIDER: County-operated

TARGET POPULATION: CARE Act is for individuals with untreated schizophrenia spectrum or other psychotic disorders. To qualify for the program individuals must be over 18 and meet the definition of these disorders per the latest Diagnostic and Statistical Manual of Mental disorders. The second criteria is that it must be determined that their judgement is so impaired from symptoms of mental illness that they are not able to "make informed or rational decisions about their medically necessary treatment." Many of the individuals in the target population are anticipated to be unhoused but it is not a requirement of CARE Act.

EXPECTED NUMBERS TO BE SERVED FOR FY24/25: 45

OUTCOMES:

- Outcome 1: The CARE Act team will attempt to establish contact and conduct at least five outreach and engagement efforts with all Respondents during the Petition/Investigation phase of CARE Court.
- Outcome 2: 80% of all Respondents who are deemed eligible will attend at least one CARE Court.
- Outcome 3: For those entering into a CARE Agreement or CARE Plan, the CARE Act team will hold a treatment conference with the Full-Service Partnership treatment team as part of the transition, inviting the Respondent to attend.

MEASUREMENT TOOL:

- Outcome 1: Tracking of all outreach and engagement efforts and contacts in the Petition/Investigation phase of CARE Court
- Outcome 2: Number of Respondents who attend CARE Court
- Outcome 3: Tracking transitions of care case conferences into a Full-Service Partnership

FY22/23 OUTCOMES: No outcome data for FY22/23 (program starting in FY23/24).

CHANGES FOR FY24/25: In the three-year plan this was a placeholder category which has now been allocated to fund 1.75FTE to provide outreach, engagement, assessment, and treatment planning as well as a set-aside for of flexible funding for to support access to housing (such as vouchers or rental assistance) for CARE Act participants in Full Service Partnership programs.

KERNER PROJECT-BASED HOUSING PROGRAM CAPITALIZED OPERATING SUBSIDY RESERVE (COSR): SDOE 19

NOTE: *This is a NEW Program in the FY24-26 Three Year Plan, with one-time funding earmarked in just year one of the plan.*

PROGRAM DESCRIPTION: This General System Development Project-Based Housing program establishes a Capitalized Operating Subsidy Reserve (COSR) for the Permanent Supportive Housing project at 3301 Kerner Blvd in San Rafael. Funds for the Capitalized Operating Subsidy Reserve will be deposited into a County-administered account in FY23/24, prior to occupancy.

Kerner Canal, LLP (an affiliate of Eden Housing, Inc.) will have to fulfill their duties as delineated in an Operating Agreement which outlines the operational requirements for the site and the requirements to receive yearly operating subsidies. This agreement is based upon activities and outcomes from the original Homekey application and includes the basic expectations for site operation and compliance with HHS Division of Homelessness & Whole Person Care operations standards. Kerner Canal, LLP (an affiliate of Eden Housing, Inc.) will be responsible for maintaining and managing the property, leasing units to the target population, and providing resident services.

PROPERTY DESCRIPTION: Marin County received a Project Homekey award from the State of California to purchase the office building at 3301 Kerner Boulevard in San Rafael. Project Homekey is a State program using Federal CARES Act funding to purchase existing properties – intended in large part to target hotels, but it also allows for creative re-use of other property types, including office buildings as proposed for 3301 Kerner. In addition, Marin County applied for and was awarded No Place Like Home (NPLH) funds to support 14 of the units.

DESIGN: The redesign within the current building includes 32 studios and 8 one-bedroom units, plus a two-bedroom manager's unit, storage spaces, a courtyard, community room, conference room, and offices for case managers and an on-site property manager. The residential floors include a laundry facility on the second floor and access to trash chutes on every floor. The redesign also includes utility upgrades and site improvements including accessible parking, paths of travel, localized grading, and drainage as deemed necessary. The patio courtyard will be redeveloped and a portion of the landscape will be replaced, or new planting will be designed and coordinated with existing irrigation. A portion of the top level parking garage will be designed as an outdoor open space and gardening area.

BUDGET NARRATIVE: After approval of this Three-year Plan, $7,649,740.00 will be deposited into a County-Operated account for this COSR. The amount deposited into the reserve account is based on the difference between the anticipated tenant portion of the rent minus revenue lost from anticipated vacancies and the estimated annual operating expenses of the Project-Based Housing after subtracting the other available funding sources. This comes out to an average of approximately $800/month for 40 tenants for 20 years.

PROVIDER: Kerner Canal, LLP (an affiliate of Eden Housing, Inc.)

TARGET POPULATION: All 40 individuals will be eligible for Specialty Mental Health Services who are either unhoused or at risk of homelessness.

This is an adaptive reuse project that is focused on providing permanent supportive housing and services for homeless or formerly homeless individuals with mental illness.

EXPECTED NUMBERS TO BE SERVED FOR FY24/25: The program is anticipated to begin serving people in the Fall of 2024 and is expected to serve 30 individuals in FY24/25. This program is expected to serve 40 individuals per year for the next 20 years.

OUTCOMES AND MEASURMENT TOOLS: To ensure the funding for this Project-Based Housing program is being used for the program as described in this work plan, the following measures will be reported on annually:

1) Number of Unduplicated Residents from the target population served annually (a cumulative count)
2) Occupancy rate (goal of 90%)

In addition, we will aim to include a report on:

3) A list of programs for the prior year put on by the Resident Services Coordinator and attendance count

ALIGNMENT WITH COMMUNITY PRIORITIES AND IDENTIFIED ISSUES: This program is in alignment with the first identified issue during the MHSA Community Planning Process, (issue #1) *homelessness* by providing a Capitalized Operating Subsidy Reserve supporting 40 units of permanent supportive housing.

MHSA GENERAL STANDARDS ALIGNMENT: This program is in alignment with the wellness, recovery, and resilience focus of the Mental Health Services Act by supporting Permanent Supportive Housing and a Housing First model.

FY22/23 OUTCOMES: No outcome data for FY22/23 (new program in the Three-Year plan for program implementation in FY23/24).

MHSA HOUSING PROGRAM: MHSA HP

PROGRAM HISTROY AND OVERVIEW: In August 2007, the guidelines for the Mental Health Services Act (MHSA) Housing Program (MHSAHP), a collaborative program administered by the California Housing Finance Agency and the State Department of Mental Health, were released. MHSAHP 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. MHSAHP housing must be permanent supportive housing. Counties are required to provide ongoing community-based support services designed to assist residents to maintain their housing and to support their ability to live independently. MHSAHP funds must be used for housing adults with serious mental illness or children with severe emotional disorders and their families. In order to qualify for MHSAHP housing, an individual/family/household must also be homeless or at risk of becoming homeless, as defined by MHSAHP regulations. The household must be able to pay rent, and the household income must be less than a specified maximum amount.

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 MHSAHP funds to leverage a set-aside of five (5) furnished housing units (studio and one-bedroom) for seniors in the Fireside Apartments. Fireside Apartments are a 50-unit affordable housing development for low-income families and seniors located in Tamalpias Valley in unincorporated Marin. The MHSAHP housing at the Fireside Apartments serves older adults (62 years and older) who, at the time of assessment for housing services, receive or qualify for Full-Service Partnership (FSP) services and are either homeless or at-risk of homelessness. These are individuals with serious mental illness who have been identified as traditionally unserved or underserved by the mental health system. Many of whom have a co-occurring substance use disorder, as well as complex and often untreated physical health disorders. Individuals may have negative background information and poor tenant histories as a result of their disability and lack of access to services. Occupancy is limited to those whose income corresponds to the level of support that individuals can expect to receive from Supplemental Security Income or from the State Supplemental Program. Intensive community treatment and housing support services are provided by the HOPE FSP Program. The tenants of the MHSAHP-funded units are eligible to participate in community activities offered at the Fireside Apartments by Homeward Bound of Marin. Homeward Bound of Marin is a community-based non-profit organization that is the main provider of shelter and support services for families and individuals who are homeless or at-risk of homelessness in Marin County.

Construction of the Fireside Apartments was completed in FY09/10 and opened on December 3, 2009, when community members began the application process for the MHSAHP-funded units. The first MHSAHP-funded unit was occupied on January 25, 2010 and all five (5) units were occupied as of June 6, 2010. These units remained filled for FY21/22.

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 MHSAHP 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 place 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. These units were occupied in FY22/23.

COMMUNITY SERVICES AND SUPPORTS COMPONENT BUDGET

Program	FY23/24	FY24/25	FY25/26	Total
FSP-01 Youth Empowerment Services (YES)	$1,155,338	$914,059	$822,780	$2,892,177
FSP-02 Transitional Age Youth (TAY) Program	$695,991	$888,955	$878,195	$2,463,141
FSP-03 Support and Treatment After Release (STAR)	$777,897	$755,215	$837,658	$2,370,770
FSP-04 Helping Older People Excel (HOPE)	$848,510	$877,138	$941,203	$2,666,851
FSP-05 Odyssey	$935,957	$904,707	$873,457	$2,714,122
FSP-07 IMPACT South	$881,994	$1,059,494	$1,059,494	$3,000,983
FSP-06 IMPACT North	$1,045,661	$1,045,661	$1,045,661	$3,136,983
SDOE-01 Enterprise Resource Center (ERC)	$633,257	$600,729	$568,200	$1,802,186
SDOE-09 Crisis Continuum of Care	$2,669,334	$2,621,696	$2,946,696	$8,237,725
SDOE-10 First Episode Psychosis (FEP)	$159,763	$159,763	$159,763	$479,289
SDOE-11 Consumer Operated Wellness Center (Empowerment Clubhouse)	$379,314	$379,314	$379,314	$1,137,941
SDOE-13 Recovery-Oriented System Development	$1,360,136	$911,446	$542,756	$2,814,339
SDOE-14 Stepping Up	$493,219	$305,865	$305,865	$1,104,949
SDOE-15 Community Outreach and Engagement	$1,378,895	$1,008,420	$1,008,420	$3,395,736
SDOE-16 Homeless Support and Outreach	$1,511,145	$1,308,295	$1,308,295	$4,127,734
SDOE-17 CalAIM System Development	$425,000	$0	$0	$425,000
SDOE-18 CARE Outreach and Treatment	$0	$341,155	$404,155	$745,310
SDOE-19 Kerner Project-Based Housing	$7,649,740	$0	$0	$7,649,740
Subtotal	**$23,001,150**	**$14,081,912**	**$14,081,912**	**$51,164,975**
MHSA Coordination and Evaluation	$374,263	$404,633	$404,633	$1,183,528
Community Planning	$100,000	$100,000	$100,000	$300,000
Administration and Indirect	$2,595,325	$2,187,982	$2,187,982	$6,971,289
Total	**$26,070,738**	**$16,774,527**	**$16,774,527**	**$59,619,792**

Transfer to Workforce Education & Training	$956,295	$172,691	$172,691	$1,301,677
Transfer to Capital Facilities & Technological Needs	$1,805,116	$805,116	$805,116	$3,415,348
Total Transfers out of CSS	**$2,761,411**	**$977,807**	**$977,807**	**$4,717,025**

PROJECTED COST PER CLIENT, TARGET NUMBERS BY AGE GROUP, FSP PROJECTIONS BY AGE GROUP

Program	Target Number By Age Group					Total	FY24/25 Projected Cost Per Person
	0-5	6-15	16-25	26-59	60+		
FSP-01 Youth Empowerment Services (YES)	3	52	40			95	$ 9,622
FSP-02 Transitional Age Youth (TAY) Program			45			45	$ 19,755
FSP-03 Support and Treatment After Release (STAR)			8	54	8	70	$ 10,789
FSP-04 Helping Older People Excel (HOPE)				2	70	72	$ 12,182
FSP-05 Odyssey			7	53	5	65	$ 13,919
FSP-06 IMPACT North			8	52	5	65	$ 16,087
FSP-07 IMPACT South			8	52	5	65	$ 16,300
FSP Totals	**3**	**52**	**111**	**208**	**93**	**467**	**$ 13,801**
SDOE-01 Enterprise Resource Center (ERC)			10	200	50	260	$ 2,310
SDOE-09 Crisis Continuum of Care		125	200	600	220	1145	$ 2,290
SDOE-10 First Episode Psychosis (FEP)		2	21	2		25	$ 6,391
SDOE-11 Consumer Operated Wellness Center (Empowerment Clubhouse)			5	63	17	85	$ 4,463
SDOE-13 Recovery-Oriented System Development		35	90	460	165	750	$ 1,215
SDOE-14 Stepping Up			25	100	25	150	$ 2,039
SDOE-15 Community Outreach and Engagement	5	235	460	1700	625	3025	$ 333
SDOE-16 Homeless Support and Outreach			30	140	70	240	$ 5,451
SDOE-18 CARE Outreach and Treatment			5	25	15	45	$ 7,581

SDOE-19 Kerner Project-Based Housing Capitalized Operating Subsidy Reserve			5	25	10	40	$500/month per client for 20 years

	Target Number By Age Group					**Total**
	0-5	6-15	16-25	26-59	60+	
Total	5	397	846	3305	1197	**5755**
FSP Totals	3	52	111	208	93	**467**

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

PREVENTION AND EARLY INTERVENTION (PEI)

COMPONENT OVERVIEW

MHSA Prevention and Early Intervention (PEI) funds serve the purpose of preventing mental illnesses from escalating into severe and disabling conditions. This involves early intervention at the onset of symptoms, minimizing risks associated with mental illness, enhancing awareness of mental health signs, diminishing stigma and discrimination, preventing suicide, and facilitating connections to suitable services. A minimum of 51% of PEI funds must be allocated to support youth and transition age youth (0-25 years old).

PEI places a strong emphasis on enhancing timely access to services for underserved populations and incorporates robust data collection methods to gauge the quality and outcomes of services. Programs within PEI are designed to implement strategies that mitigate the negative consequences of untreated mental illness, such as suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and the 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 un- and underserved populations. Some of the strategies employed are:

- **Improve Timely Access:** Increase the accessibility of mental health services for underserved populations by being culturally appropriate, logistically 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 initiatives aimed at diminishing disparities in service delivery, aligning with the Marin County Health and Human Services Equity and Operational Plan. This involves enhancing the accessibility and cultural responsiveness of services and integrating service delivery to better support clients.

PREVENTION AND EARLY INTERVENTION (PEI) PRIORITIES FOR FY23/24 THROUGH FY25/26

Throughout the MHSA Community Planning Process (CPP) conducted from November 2022 to February 2023, community members, providers, and county staff collaboratively identified a spectrum of priorities for the Prevention and Early Intervention (PEI) program. The themes derived from discussions and collected surveys now serve as the guiding framework for our PEI program and service priorities over the next three years. These five priorities include:

Priority One: Expanding Early Intervention Services for Older Adults through the Senior Peer Counseling program

Priority Two: Increasing resources for the Latine community by supporting trusted community partners

Priority Three: Enhancing Early Intervention and Prevention Supports to Transition Aged Youth (TAY) in Marin City and for Latine youth

Priority Four: Investing additional funding in Early Childhood Mental Health through the Public Health home visiting program and First 5

Priority Five: Expanding school-based programs in West Marin and implementing psycho-educational substance use curricula in Middle Schools

RATIONALE FOR KEY PRIORITY AREAS

Priority One: Expanding Early Intervention Services for Older Adults through the Senior Peer Counseling program:

During the MHSA planning process, stakeholders emphasized the need for expanded mental health supports for older adults to address depression, isolation, and loneliness. Many older adults live alone or have mobility issues and other factors that limit their interaction with others and may lead to feelings of disconnect and isolation. Inadequate mental health treatment and support can exacerbate these feelings and increase the risk for mental health concerns and suicide.

BHRS' Senior Peer Counseling program trains volunteers to support adults 60 and over that are experiencing mild to moderate mental health symptoms and would benefit from additional support. Building on this program's successful model, PEI funding will expand this program's reach by providing stipends to retired licensed providers to support Marin older adults experiencing mental health symptoms due to grief/loss, issues of aging, health concerns and other precipitating factors. Expansion of early intervention groups and other supportive activities will be provided with a focus on those that are experiencing isolation and are disconnected from other resources.

<u>Priority Two</u>: Increasing resources for the Latine community by supporting trusted community partners:

The PEI Latino Community Connection (LCC) program provides funding to trusted community-based organizations to address mild to moderate mental health concerns in the Latine community. The program serves primarily immigrant and monolingual Spanish speaking adults and youth through brief individual, group, and family counseling. While data suggests that this program has had a positive impact on the clients they serve, the community need is greater than current provider capacity. Expansion of the LCC program under this current plan will help to secure funding for an additional bilingual, bicultural therapist and build capacity to provide groups and other early intervention services to clients.

<u>Priority Three</u>: Enhancing Early Intervention and Prevention Supports to Transition Aged Youth (TAY) in Marin City and for Latine youth:

A critical gap identified during the MHSA community planning process was the insufficient number of resources and supports for TAY across the county. Stakeholders emphasized the need for addressing the stigma that often prevents young people, particularly young men, from accessing resources, and the importance of helping youth build the skills, knowledge, and relational trust to seek help when needed. Additional culturally responsive services that address the needs of youth and reflect an understanding of how mental health presents in the Latine and African American communities was a key priority of stakeholders.

To address the need for high quality culturally responsive TAY early intervention and prevention services, additional funding will:

- support expanded programming for Latine TAY in the Novato area by augmenting the contract with North Marin Community Services
- through an RFP process, support a community-based organization in Marin City to implement or expand an existing program. This program will focus on breaking down stigma and increasing access to community and county resources for TAY in Marin City.

<u>Priority Four:</u> Investing additional funding in Early Childhood Mental Health in partnership with the Public Health home visiting program and First 5, and expanding community education around Domestic Violence and resilience:

Addressing early childhood mental health was one of the top priorities that emerged from both focus groups and surveys. Stakeholders identified the need for additional supports for families of young children, particularly for families with those with limited means and access to resources. Providing early intervention to families of young children to build skills and resiliency in caregivers can play a critical role in promoting the long-term health and wellbeing of their children. This plan will add funding for ECMH in two areas:

- Increase funding for JFCS to expand its capacity to serve children and families throughout the county. The contract expansion will support a .5 FTE position that will be dedicated to supporting the county's home visiting program, ensuring that families and their newborn children have the information they need to access mental health services and other resources as indicated

- Funding will be provided to First 5 for outreach and marketing to support its efforts to promote and advocate for the physical and mental health of children across the county

<u>Priority Five:</u> Expanding school-based programs in West Marin and implementing psycho-educational substance use curricula in Middle Schools:

The last 3-year plan included a significant expansion of school-based early intervention and prevention services. Funding focused on improving access to short-term counseling to address issues such as depression and anxiety, improving coordination of services on school sites between staff and providers, and enhancing school climate efforts. Based on community feedback, two primary areas of focus will be integrated into the FY23/26 plan to fill other identified gaps in school-aged services:

- Through an RFP process, additional funding will be granted to an organization to provide services in Shoreline Unified. The increased funding will enhance the selected Provider's ability to recruit and retain a bilingual clinician to fill gaps in services for Spanish speaking students and families.
- Stakeholders identified the need for substance use services in schools to address the growing epidemic of youth opioid and other substance use problems. While previous PEI school-aged funding has focused on building systems to support access and linkage to resources, including substance use services, this current expanded funding will directly address substance use through the development and implementation of a psycho-educational curriculum in identified middle schools.

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. These priorities were included in the FY20-23 MHSA plan and are included in this current FY23-26 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 PRIORITITY CATEGORES:	**Percentage of Funding Allocated to Priority FY 24/25:**
1: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs	53%
2: Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan	54%
3: Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs	57%
4: Culturally competent and linguistically appropriate prevention and intervention	96%
5: Strategies targeting the mental health needs of older adults	29%
6: Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	82%

INTRODUCTION TO PEI PROGRAMS FOR FY23/24 THROUGH FY25/26

Several current PEI programs have demonstrated success in reaching underserved communities and accomplishing mental health-related objectives, as outlined in the FY21/22 Annual Update. Consequently, these successful programs will be sustained in the upcoming Three-Year Plan. In line with stakeholder feedback, evaluations of existing PEI initiatives, and the identification of gaps, select programs will be expanded in FY23/24. Requests for Proposals (RFP) were issued in the Fall/Winter of 2023 to solicit providers interested in supporting these expansion endeavors.

Required Service Category	Programs	SB 1004 Priority Categorization(s)	Marin PEI New Priority Strategy Area(s)
Prevention and Early Intervention	PEI-04 Transition-aged youth individual and group mental health services, including targeted counseling for LGBTQ youth	#1, #3, #4, #6	Transition-aged Youth Services and Supports
	PEI-18 School-based individual and group mental health services, school climate and service coordination	#1, #2, #3, #4, #6	School-based Mental Health and Psychoeducation
	PEI-07 Older Adult Prevention and Early Intervention • Early Intervention mental health services	#2, #4, #5, #6	Older Adult Supports and Connections
Prevention	PEI-01 Early Childhood Mental Health • Training and Consultation • Screening and Linkage • Home Visiting PEI-05 Latino Community Connection: • Cuerpo, Corazon, Communidad Radio	#1, #4, #6	Early Childhood Mental Health and Latine Prevention Supports
Early Intervention	PEI-05 Latino Community Connection: • Community based individual and group mental health services for Spanish Speaking adults and youth	#4, #6	Latine Early Intervention Supports
Stigma Reduction	PEI-12 Community Training and Supports • Mental Health Consultation in schools • Community trainings in West Marin • Mental Health First Aid	#2, #4, #5, #6	Transition-aged Youth Services and Supports School-based Mental Health and Psychoeducation
	PEI-20 Statewide PEI	#2	
	PEI-24 Storytelling Programs	#2, #4, #5	
Suicide Prevention	PEI-21 Suicide Prevention: • Suicide Prevention Coordinator • Community and targeted suicide prevention trainings	#2, #3, #4, #5	School-based Mental Health and Psychoeducation Older Adult Supports and Connections
Access and Linkage	PEI-23 Newcomers Coordination and Support • School-aged Newcomers Assessment and Linkage • Newcomers school-based groups	#1, #3, #4, #6	School-based Mental Health and Psychoeducation Latine Early Intervention
Outreach	PEI-19 Veteran's Community Connection	#2, #5, #6	Older Adult Supports and Connections

OVERVIEW OF FY 22/23 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
- **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**

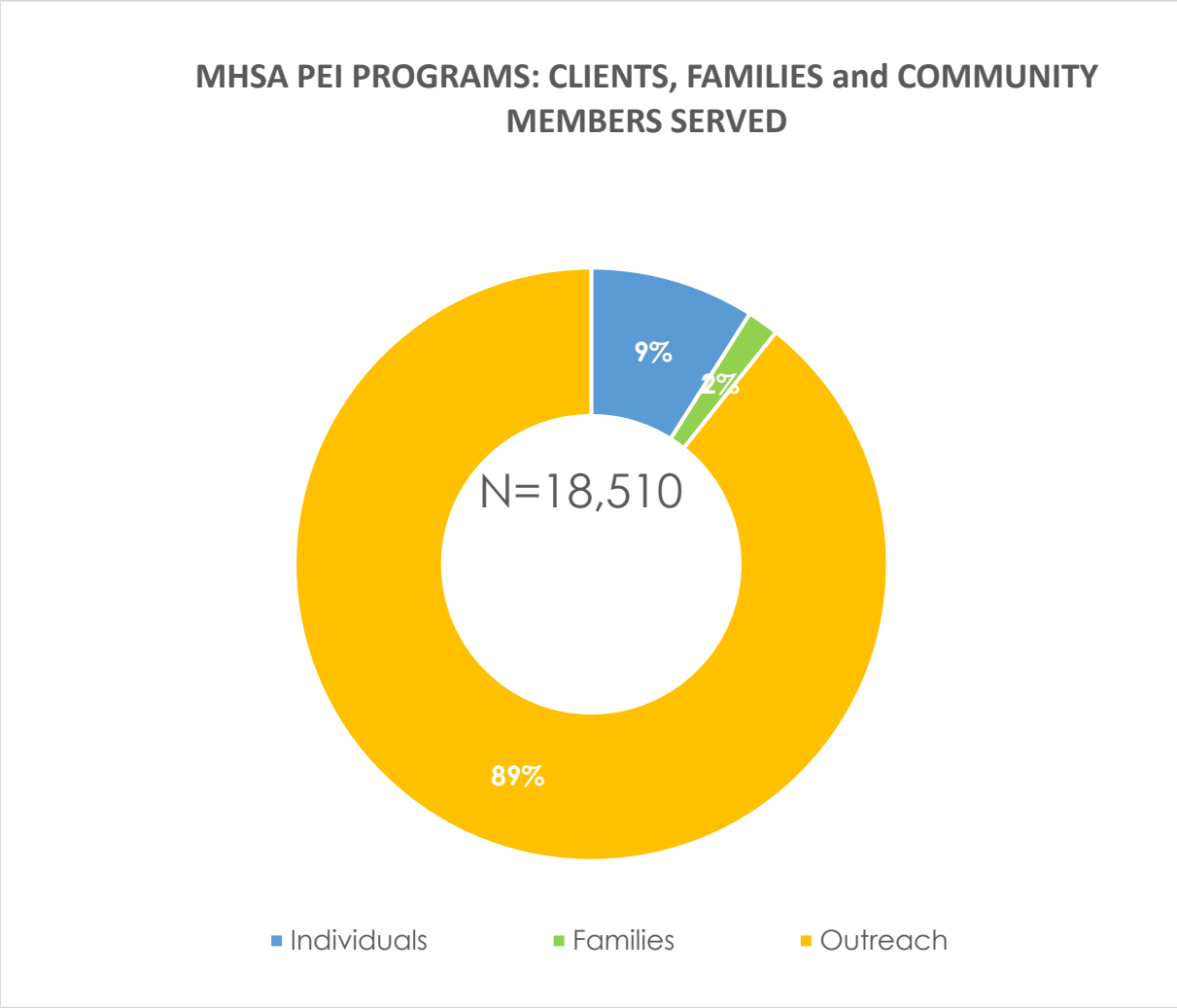
A focus of PEI is to reach un- and underserved populations. Some of the strategies employed are:

- Improve Timely Access: Increase the accessibility of mental health services for underserved populations by being culturally appropriate, logistically 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

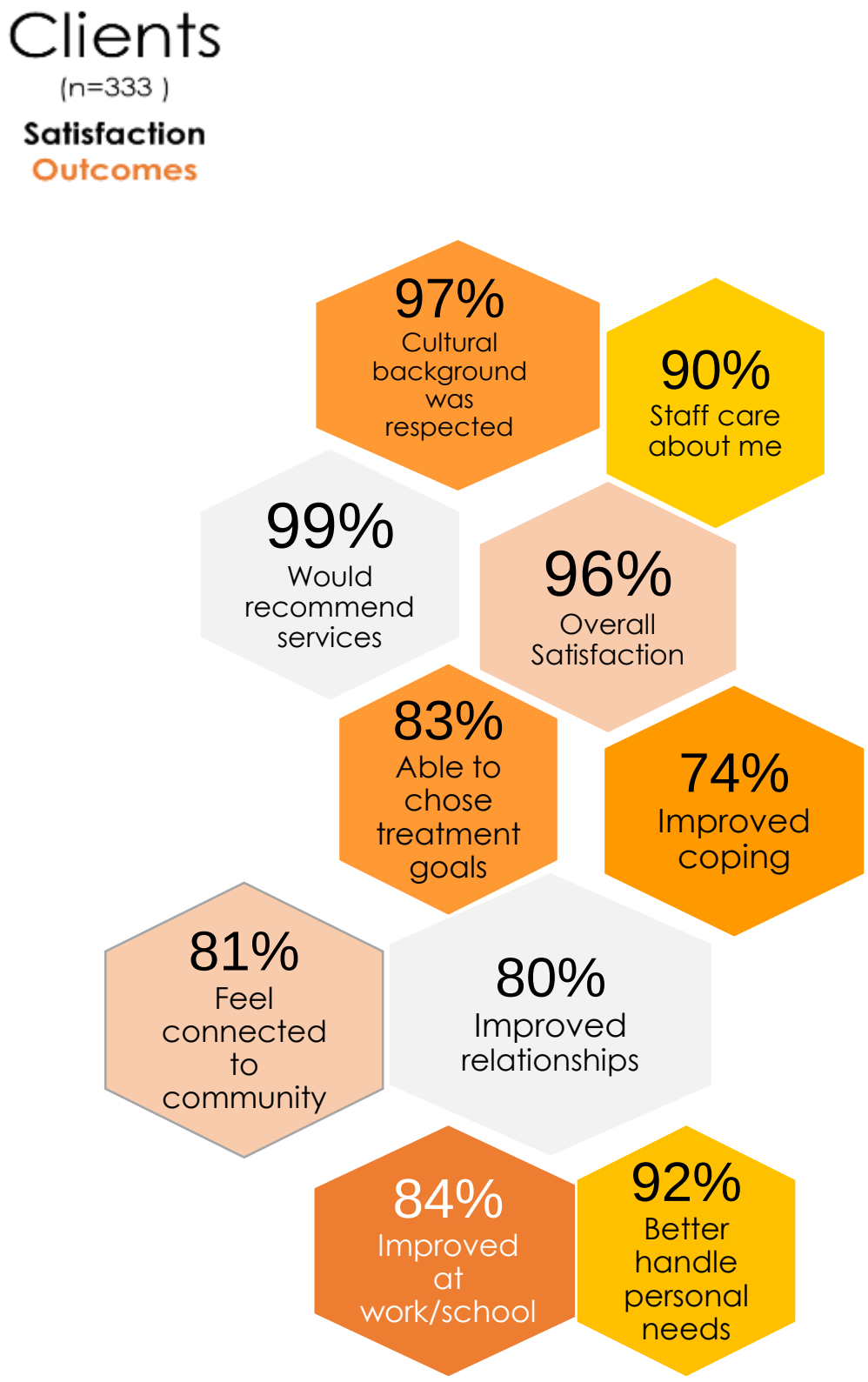
A minimum of 51% of PEI funds are required to be dedicated to youth and transition age youth (0-25 years old). In FY22/23, 64% of direct service funding was budgeted for youth—which is 53% of the total PEI budget. Acknowledging that enhanced funding and services alone are insufficient to achieve PEI goals, the PEI Program Supervisor organizes quarterly meetings with PEI Providers, conducts three annual site visits, participates in various PEI provider events and trainings, and as needed, assembles short-term targeted work groups to strategize on prevention efforts for specific populations.

CLIENTS SERVED

Throughout the delivery of Prevention & Early Intervention (PEI) services, program adjustments have been made to enhance their effectiveness in reaching underserved populations. For instance, the Behavioral Health Community Health Advocates/Promotores program has expanded its outreach to individuals from the Latino and Vietnamese communities, providing prevention, outreach, and educational services. The establishment of programs in Marin City and West Marin has improved access for African Americans and geographically isolated communities. To ensure inclusivity, programs are offered across the lifespan, catering to individuals from early childhood to older adults. PEI services are accessible to residents of all ages, addressing barriers such as language, stigma, cost, and others that previously hindered mental health support. The success of these efforts is reflected in satisfaction surveys completed by clients, further supported by program narratives featuring descriptions, outcomes, and client stories.



CLIENT SATISFACTION OUTCOMES



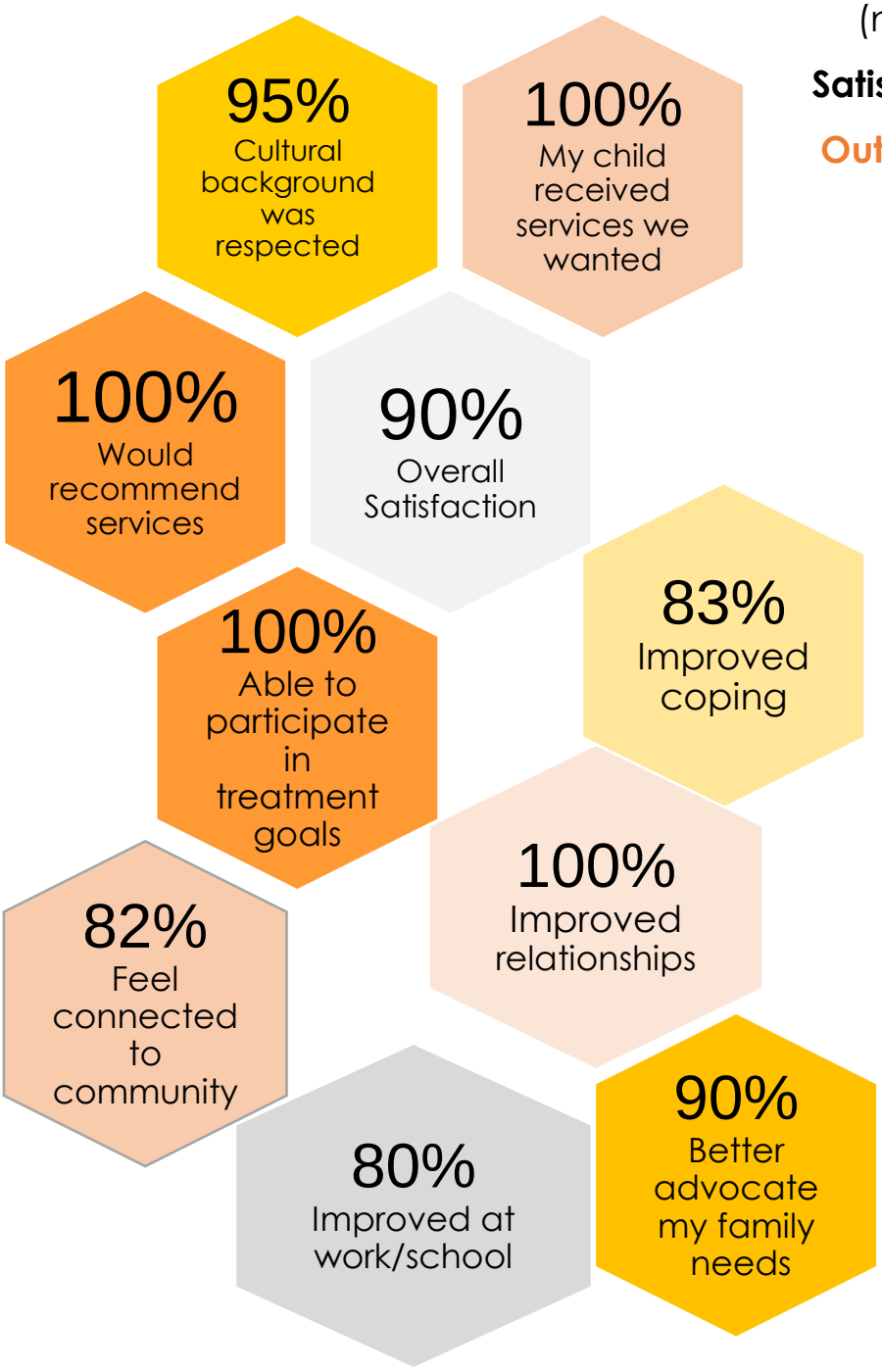
CAREGIVER SATISFACTION OUTCOMES

Caregiver

(n=31)

Satisfaction

Outcomes



COMPLIANCE WITH REGULATIONS

BACKGROUND

New PEI Regulations were adopted effective July 1, 2018.

COMPLIANCE PLAN

Marin was already compliant with various aspects of the regulations before the adoption of prior regulations effective October 6, 2015. These areas of compliance include:

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

Additionally, the following areas were implemented in FY 17/18 to comply with new July 2018 regulations and have since been further strengthened:

DEMOGRAPHICS

The demographics collection process has been enhanced with new elements, including a separation of race and ethnicity, types of disability, sexual orientation, gender assigned at birth, and current gender identity. Since July 1, 2017, all Early Intervention programs have been collecting this data. Furthermore, starting July 1, 2018, all PEI funded programs were mandated to gather expanded demographics when appropriate. The determination of appropriateness is made in collaboration with the PEI program supervisor, considering factors such as the duration and nature of the activity. For instance, data collection may be deemed suitable at the end of a lengthy workshop or series, but not necessarily at a brief presentation or outreach activity.

To enhance cultural sensitivity, new demographic forms were developed for the 20/21 fiscal year based on provider input. These forms remain in compliance with MHSA PEI regulations for demographic data collection.

OUTREACH SETTINGS AND TYPES OF RESPONDERS

Under the new regulations, programs focused on instructing individuals to identify and respond to early signs of potentially severe mental illness are required to provide reports on the settings where trainees might apply these skills (e.g., their workplace) and specify the type of responder they are (e.g., their job role). Starting July 1, 2018, these programs initiated the collection of information on the setting, type of responder, and demographics when deemed appropriate.

For Mental Health First Aid, we gather information on the type of participant and demographics during the registration process, which is conducted online.

ACCESS AND LINKAGE TO TREATMENT

Since July 1, 2016, PEI providers have been actively collecting information on referrals to the County of Marin Access Line. Subsequently, starting July 1, 2018, all PEI providers are mandated to collect and furnish data to the County, including:

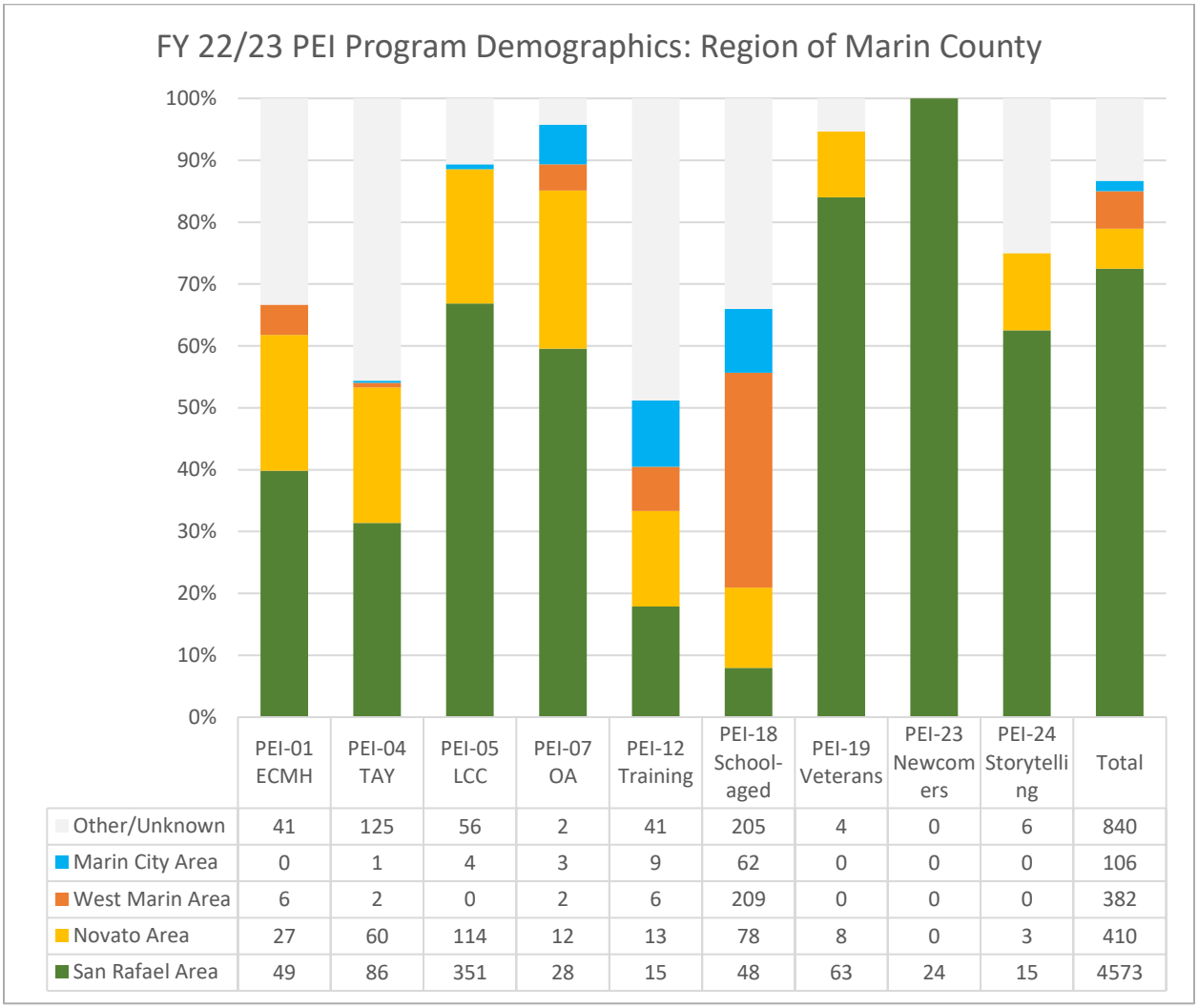
- The number of referrals to ACCESS (or other county mental health providers like a school-based EPSDT clinician)
- The percentage of total referrals successfully connected to services
- The average time elapsed between referral and connection
- The duration of untreated mental illness, as stipulated by PEI regulations.

IMPROVE TIMELY ACCESS

Commencing July 1, 2018, PEI providers initiated the collection of data on referrals to other PEI programs. Through discussions with PEI providers, it has been observed that written referrals to other PEI programs are infrequent, resulting in limited data for reporting in this aspect. The strategies employed to promote timely access to services are detailed in the narrative section of the Annual Update.

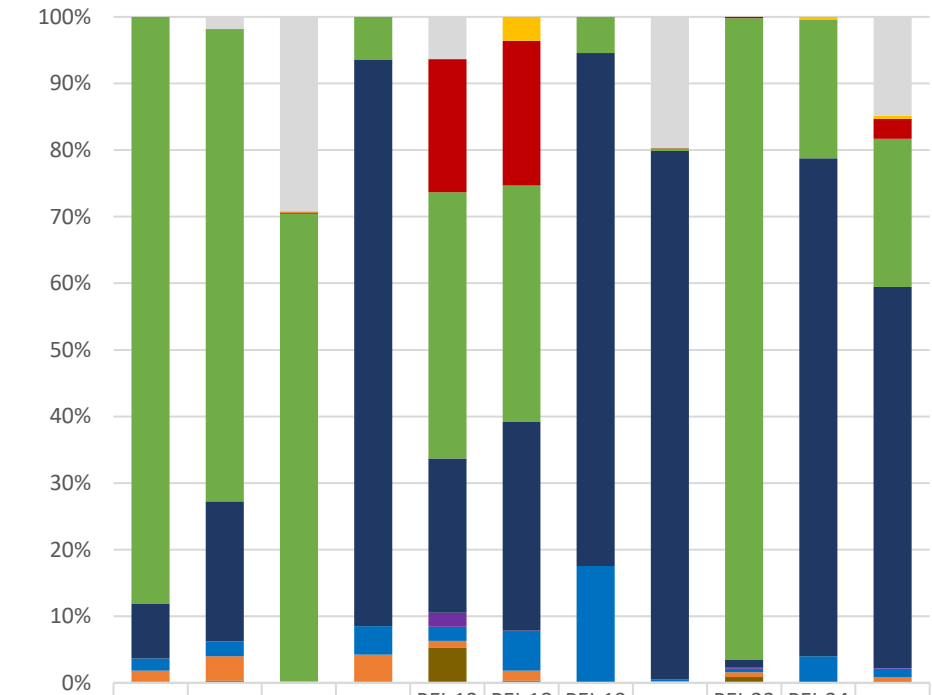
FY22/23 DEMOGRAPHICS

Below is a breakdown of the populations served by the PEI program in FY 22/23. Demographics are gathered for Prevention and Early Intervention programs encompassing services like support groups, counseling, skill building, training, and service navigation and advocacy. It's important to note that demographics were not collected for all clients.



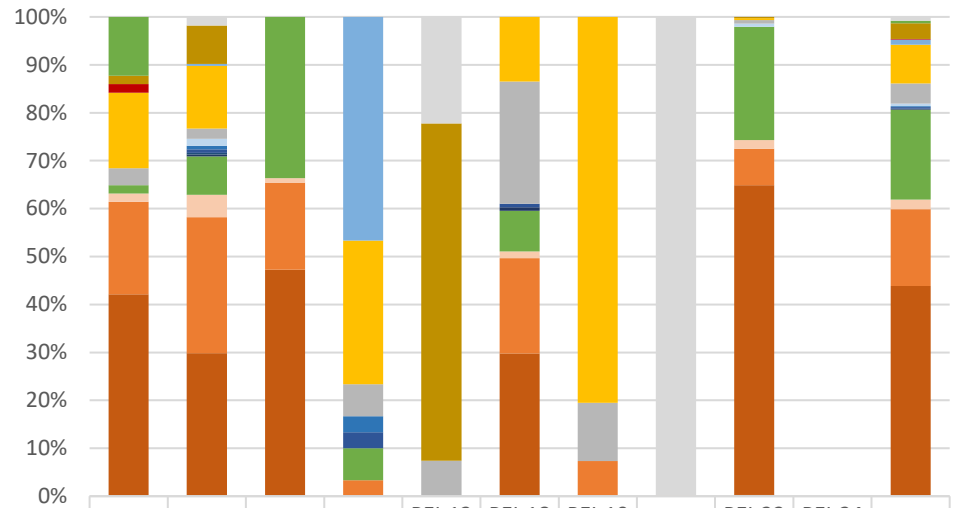
	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-23 Newcomers	PEI-24 Storytelling	Total
Other/Unknown	41	125	56	2	41	205	4	0	6	840
Marin City Area	0	1	4	3	9	62	0	0	0	106
West Marin Area	6	2	0	2	6	209	0	0	0	382
Novato Area	27	60	114	12	13	78	8	0	3	410
San Rafael Area	49	86	351	28	15	48	63	24	15	4573

The data on PEI demographics across different regions of Marin County reveals varying levels of representation within each area. The San Rafael Area stands out with the highest counts across multiple categories, particularly in PEI-05 LCC and PEI-19 Veterans, indicating a significant presence of individuals accessing services in these domains. The Novato Area shows moderate representation across several categories, while the West Marin Area notably demonstrates a higher concentration in PEI-18 School-aged. Marin City Area exhibits relatively lower counts compared to other regions. Additionally, there are notable counts of respondents categorized as Other/Unknown, indicating a portion of data with unspecified demographics.



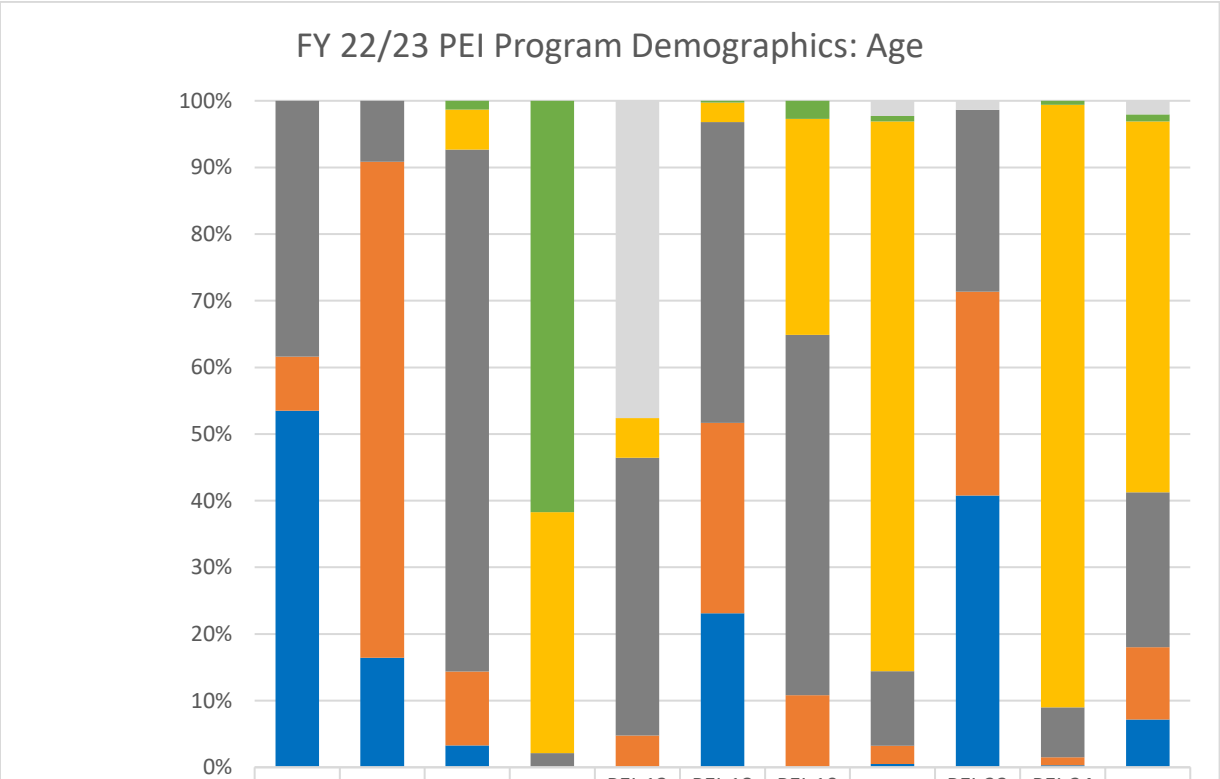
	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Missing or declined to answer	0	5	150	0	6	0	0	888	0	0	1049
More than one race	0	0	1	0	0	31	0	0	0	3	32
Other	0	0	1	0	19	188	0	2	1	0	211
Hispanic or Latino	96	195	361	3	38	307	4	16	551	173	1571
White (Non-Hispanic)	9	58	0	40	22	271	57	3575	7	619	4039
Native Hawaiian or other Pacific Islander	0	0	0	0	2	2	0	0	1	0	5
Black or African American	2	6	0	2	2	50	13	14	3	32	92
Asian	2	10	1	2	1	13	0	9	4	1	42
American Indian or Alaska Native	0	1	0	0	5	3	0	2	5	0	16

The data on race highlights several notable trends across different categories. White (Non-Hispanic) individuals comprise the largest demographic in several categories, particularly in PEI-18 School-aged and PEI-19 Veterans, where their counts are significantly high. Hispanic or Latino respondents show substantial representation across various categories, with particularly high counts in PEI-05 LCC and PEI-23 Newcomers. Black or African American individuals are notably represented in PEI-18 School-aged and PEI-24 Storytelling categories. Additionally, a considerable number of respondents chose not to disclose their race or declined to answer, indicating a significant proportion of missing data in some categories.



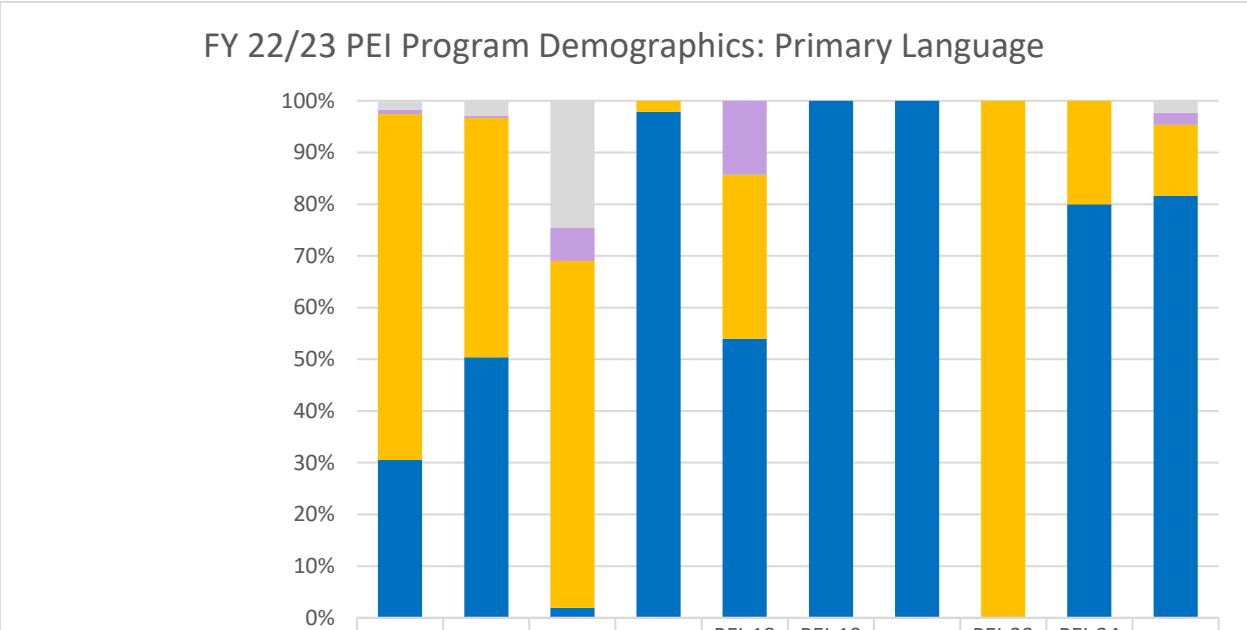
	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Missing or decline to answer	0	5	0	0	6	0	0	888	0	0	11
More than one ethnicity	7	0	0	0	0	0	0	0	0	0	7
Other	1	22	0	0	19	0	0	1	1	0	44
Middle Eastern	1	0	0	0	0	0	0	0	0	0	1
Eastern European	0	1	0	14	0	0	0	0	0	0	15
European	9	36	0	9	0	19	33	0	2	0	108
African American	2	6	0	2	2	36	5	0	3	0	56
African	0	0	0	0	0	0	0	0	0	0	0
Vietnamese	0	4	0	0	0	0	0	0	3	0	7
Korean	0	0	0	0	0	0	0	0	0	0	0
Japanese	0	0	0	0	0	0	0	0	0	0	0
Filipino	0	2	0	1	0	0	0	0	0	0	3
Chinese	0	2	0	1	0	1	0	0	0	0	4
Cambodian	0	1	0	0	0	0	0	0	0	0	1
Asian Indian/South Asian	0	1	0	0	0	1	0	0	0	0	2
Other Latino not listed	1	22	111	2	0	12	0	0	103	0	251
South American	1	13	3	0	0	2	0	0	8	0	27
Puerto Rican	0	0	0	0	0	0	0	0	0	0	0
Mexican/Mexican American	11	78	60	1	0	28	3	0	33	0	214
Central American	24	82	156	0	0	42	0	0	282	0	586
Caribbean	0	0	0	0	0	0	0	0	1	0	1

The data graph illustrates the distribution of respondents across various ethnicities in different categories. Central American, Mexican/Mexican American, and Other Latino not listed show the highest counts. African American respondents are notable in PEI-18 School-aged categories, while European ethnicity stands out in PEI-07 Older Adults and PEI-19 Veterans categories. Additionally, a few respondents have more than one ethnicity or have declined to answer.



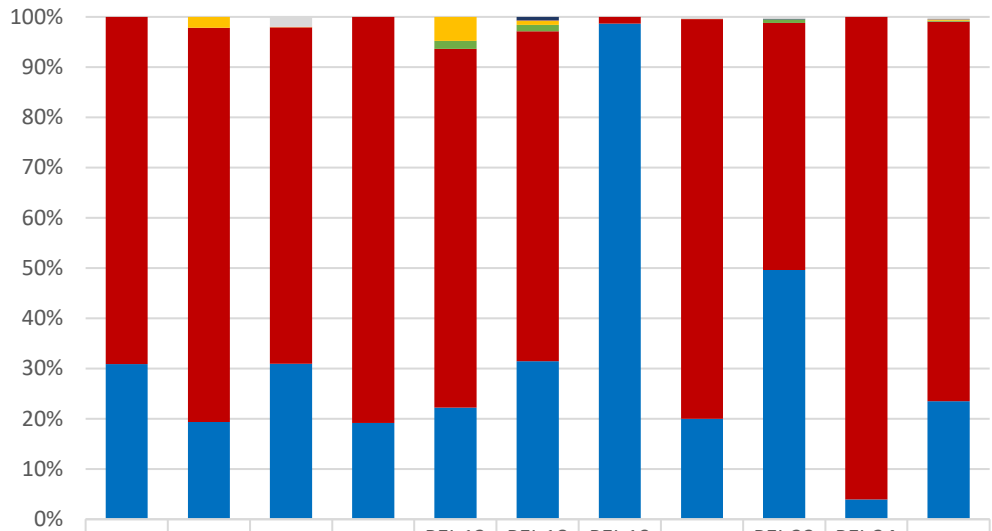
	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Decline to answer	0	0	0	0	40	0	0	103	8	0	151
75+	0	0	10	29	0	2	2	37	0	2	82
60-74	0	0	46	17	5	20	24	3739	0	302	4153
26-59	33	25	599	1	35	313	40	507	157	25	1735
16-25	7	204	85	0	4	198	8	123	176	4	809
0-15	46	45	25	0	0	160	0	23	235	1	535

The data on PEI age groups in Marin County provides insight into the distribution of respondents across different age brackets. Individuals aged 26-59 demonstrate the highest representation across various categories, particularly in PEI-05 LCC and PEI-19 Veterans, highlighting the prevalence of this demographic in accessing services. The 0-15 age group also shows considerable representation, particularly in PEI-18 School-aged and PEI-01 ECMH, indicating a focus on providing services for children and adolescents. Respondents aged 60-74 exhibit significant counts in PEI-19 Veterans, while those aged 75 and above are notably represented in PEI-19 Veterans and PEI-24 Storytelling. Additionally, there are respondents who have declined to answer, contributing to a portion of missing data within the age demographic.



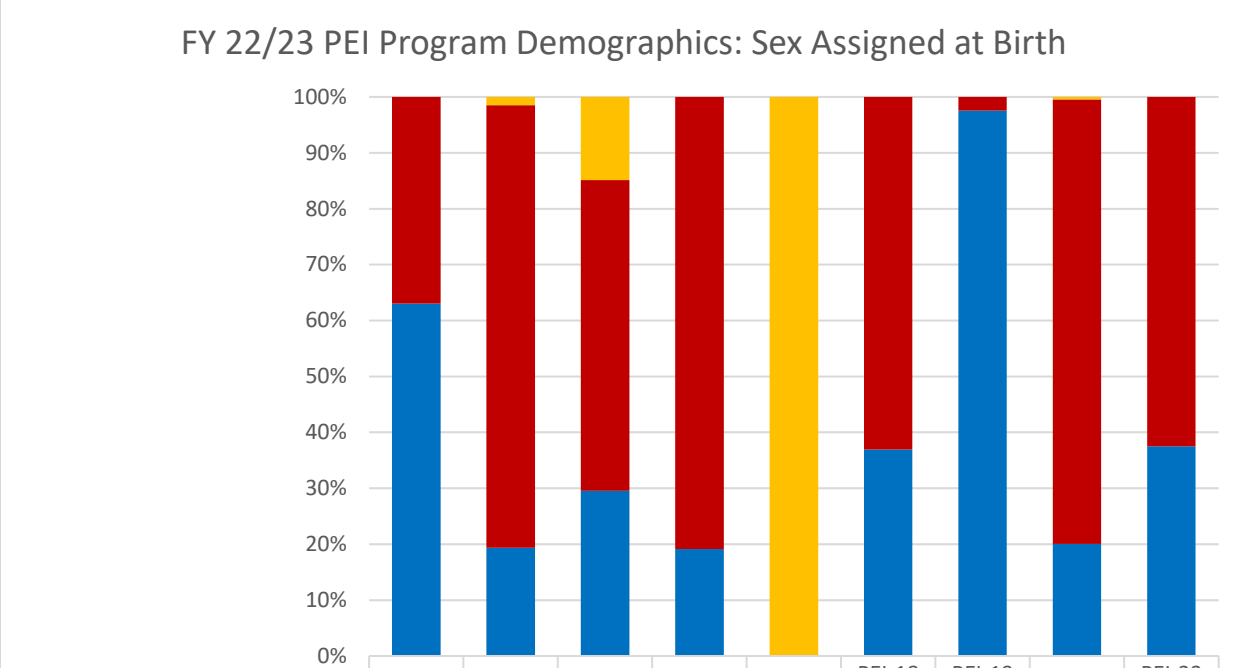
	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Decline to answer	2	8	139	0	0	0	0	0	0	149
Other Non-English Language	1	1	36	0	113	0	0	0	0	151
Filipino Dialect	0	0	0	0	0	0	0	0	0	0
Chinese Dialect	0	0	0	0	0	0	0	0	0	0
Korean	0	0	0	0	0	0	0	0	0	0
Vietnamese	0	0	0	0	1	0	0	0	0	1
Farsi	0	0	0	0	0	0	0	0	0	0
Arabic	0	0	0	0	0	0	0	0	0	0
Mandarin	0	0	0	0	0	0	0	0	0	0
Spanish	79	127	379	1	250	0	0	24	164	890
English	36	138	11	46	427	74	4507	0	654	5293

The data on PEI primary languages in Marin County reveals patterns of linguistic diversity among respondents accessing services. English emerges as the predominant language across various categories, particularly in PEI-19 Veterans and PEI-24 Storytelling, indicating widespread proficiency and usage. Spanish speakers also demonstrate significant representation, notably in PEI-05 LCC, PEI-01 ECMH and PEI-04 TAY, underscoring the importance of bilingual services to cater to this demographic. Additionally, there are respondents who speak other non-English languages, albeit in smaller numbers, highlighting the need for language-specific support services. Some respondents have declined to answer, contributing to a portion of missing data within the primary language demographic.



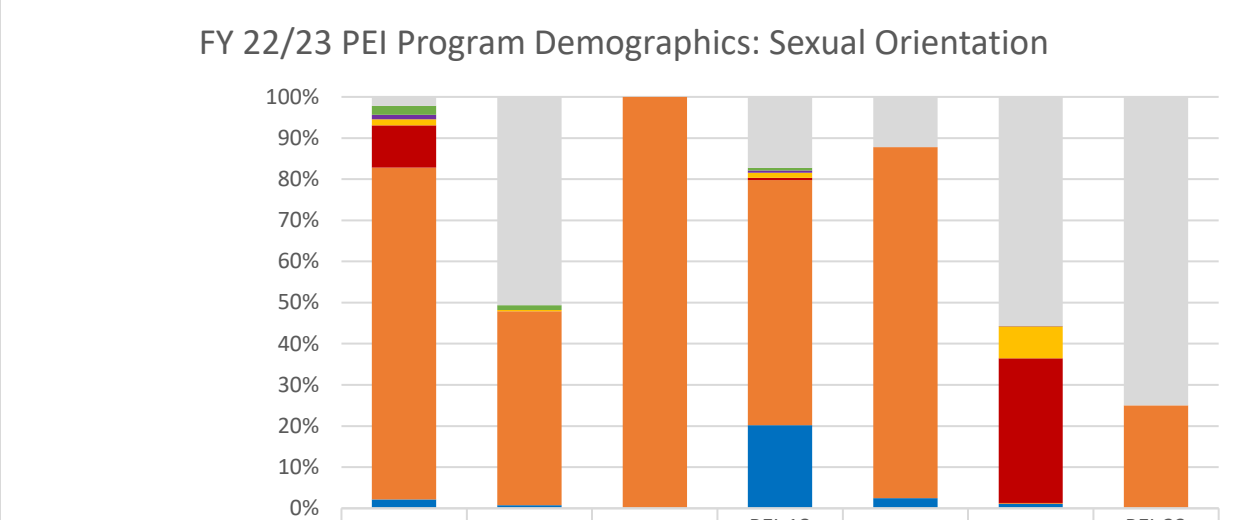
	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Decline to answer	0	0	15	0	0	0	0	17	2	0	34
Another gender identity	0	0	0	0	0	5	0	0	1	0	6
Questioning or unsure	0	0	1	0	0	1	0	3	0	0	5
Genderqueer	0	6	0	0	3	5	0	0	0	0	14
Transgender	0	0	0	0	1	9	0	0	4	0	14
Female	85	215	513	38	45	464	1	3587	278	773	5999
Male	38	53	237	9	14	222	73	903	281	32	1862

The data on PEI gender identity in Marin County sheds light on the diverse gender identities of respondents accessing services. Female respondents constitute the largest demographic across multiple categories, particularly in PEI-04 TAY and PEI-21 Suicide Prevention, indicating significant representation within these domains. Male respondents also show considerable presence, especially in PEI-19 Veterans and PEI-23 Newcomer categories. Additionally, there are respondents identifying as transgender, genderqueer, and questioning or unsure, as well as those identifying with another gender identity. A portion of respondents has declined to answer, contributing to a segment of missing data within the gender identity demographic.



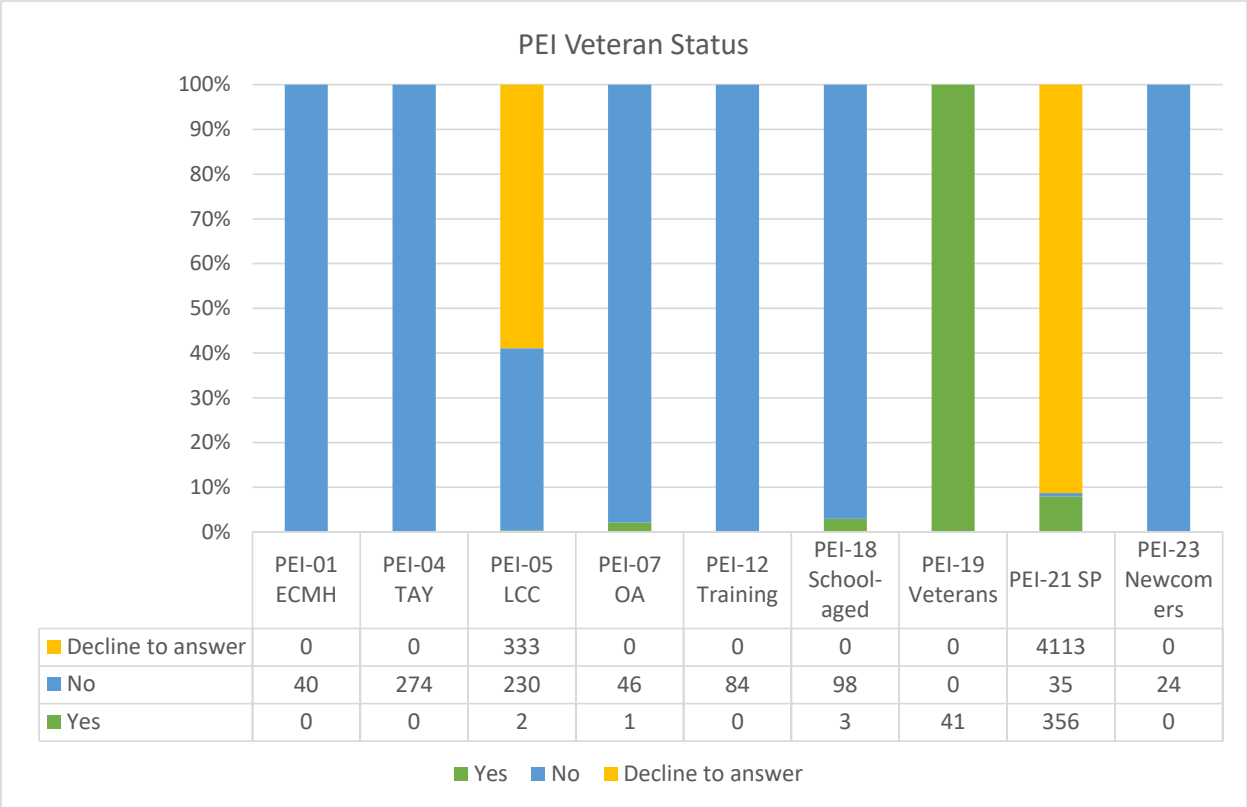
	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers
Decline to answer	0	4	68	0	84	0	0	20	0
Other sex not listed (intersex)	0	0	0	0	0	0	0	0	0
Female	17	217	254	38	0	87	1	3584	15
Male	29	53	135	9	0	51	40	902	9

The data on PEI sex assigned at birth in Marin County provides insight into the gender identities of respondents based on their birth assignments. Male respondents constitute a significant portion across various categories, particularly in PEI-19 Veterans and PEI-01 ECMH, indicating notable representation within these domains. Female respondents also show considerable presence, especially in PEI-05 LCC, PEI-04 TAY and PEI-07 Older Adult categories. Additionally, there are no respondents identified as having another sex assigned at birth (intersex). Notably, there are respondents who have declined to answer, contributing to a segment of missing data within the sex assigned at birth demographic.



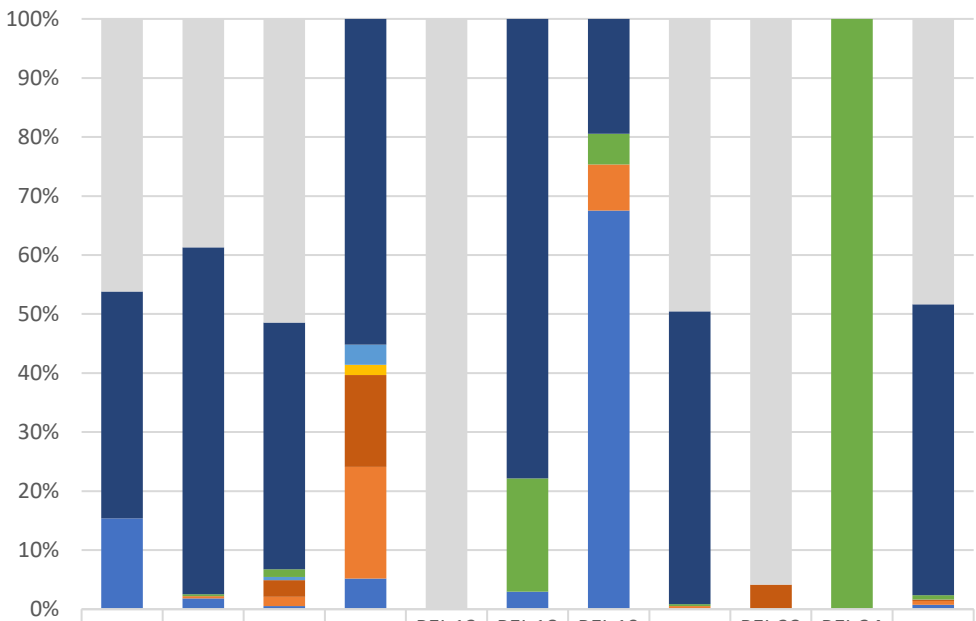
	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers
Decline to answer	6	207	0	29	5	2510	18
Another sexual orientation	6	5	0	1	0	0	0
Queer	3	0	0	1	0	2	0
Questioning/Unsure	4	1	0	2	0	352	0
Bisexual	28	0	0	1	0	1585	0
Heterosexual/Straight	221	193	47	100	35	10	6
Gay or Lesbian	6	3	0	34	1	48	0

The data on PEI sexual orientation in Marin County presents a diverse range of sexual identities among respondents accessing services. Heterosexual or straight individuals represent the largest demographic across various categories, particularly in PEI-18 School-aged and PEI-19 Veterans, indicating significant representation within these groups. Respondents who identified as bisexual, gay or lesbian, questioning or unsure, queer, and with another sexual orientation, underscore the importance of inclusive support services. A portion of respondents declined to answer, contributing to a segment of missing data within the sexual orientation demographic.



	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers
Decline to answer	0	0	333	0	0	0	0	4113	0
No	40	274	230	46	84	98	0	35	24
Yes	0	0	2	1	0	3	41	356	0

The data on PEI veteran status in Marin County provides insight into the military service backgrounds of respondents accessing services. The majority of respondents indicate that they are not veterans. However, there is a significant proportion of respondents who declined to answer, contributing to a segment of missing data within the veteran status demographic. Additionally, there are respondents who affirm their veteran status, particularly in PEI-19 Veterans and PEI-21 Suicide Prevention, albeit in smaller numbers.



	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Decline to State	6	106	198	0	84	0	0	4416	23	0	4833
No Disability	5	161	161	32	0	130	15	4416	0	0	4920
Another type of disability	0	1	5	0	0	32	4	31	0	5	73
Difficulty Seeing	0	0	2	2	0	0	0	0	0	0	4
Difficulty Hearing	0	0	0	1	0	0	0	0	0	0	1
Chronic Health Condition	0	0	11	9	0	0	0	0	1	0	21
Physical	0	1	6	11	0	0	6	42	0	0	66
Mental	2	5	2	3	0	5	52	5	0	0	74

The data on PEI disability status in Marin County highlights the prevalence and diversity of disabilities among respondents accessing services. A significant portion of respondents reports having no disability, with notable representation across various categories. Mental disabilities are also prevalent among respondents. Physical disabilities and chronic health conditions are reported by a smaller proportion of respondents. Additionally, there are individuals who have declined to state their disability status, contributing to a segment of missing data within the disability demographic.

EARLY CHILDHOOD MENTAL HEALTH (ECMH): PEI 01

SERVICE CATEGORY: PREVENTION

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

MARIN PEI PRIORITY STRATEGY AREA: Early Childhood Mental Health

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: The program aims to foster healthy social-emotional development and promote the mental health of young children by increasing the skills of teachers and parents to observe, understand and respond to children's emotional and developmental needs. This is done through training, coaching, screening, and linkage to appropriate supports. The program works to strengthen the capacity of staff, families, programs, and systems to promote positive social and emotional development as well as prevent, identify, and reduce the impact of mental health problems among children from birth to age 5.

Increased funding will expand JFCS' capacity to serve families throughout the county by funding an additional .5FTE that will work in partnership with Marin County's Public Health home visiting program. Funding will also support First 5's outreach and advocacy efforts focused on promoting early childhood mental and physical health.

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

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	46	88	116	250

KEY OUTCOMES:

- Reduced likelihood of behavioral problems and school failure in pre-school;
- Earlier identification of students with behavioral problems that may indicate mental/emotional difficulties;
- Increased timely access to medically necessary services;
- Increased capacity of staff to recognize and respond to early signs of significant risk for emotional disturbance;
- Reduced Prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): PEI client, caregiver, provider and staff satisfaction surveys, Ages and Stages Questionnaires (ASQ-3) screening tool, workshop/training surveys, demographics and numbers reached through outreach activities.

FY 2022-23 OUTCOMES:

Outcomes: Jewish Family & Children Services	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Children receiving prevention services through staff consultation	535	472	535	635	535	656
Percent from un/underserved cultural populations	70%	93%	70%	93%	70%	93%
Children/families identified for enhanced intervention by providers that received ECMH consultation	65%	114%	65%	78%	85%	96.15%
Children in childcare settings served by ECMH Consultants retained in current program or transitioned to an appropriate setting	95%	100%	95%	100%	95%	100%
Parents/primary caregivers reporting increased understanding	85%	97%	N/A	N/A	N/A	N/A
Caregivers reporting satisfaction with PEI services in two or more areas of satisfaction surveys	75%	92%	75%	75%	50%	100%
Total referrals to County Behavioral Health (BHRS)	N/A	11	N/A	6	N/A	5
Number of individuals successfully referred and linked to a Marin County mental health treatment program	N/A	5	N/A	0	N/A	0
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	6	N/A	6	N/A	6
Total referrals to other PEI providers	N/A	2	N/A	1	N/A	4
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	2	N/A	0	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	2	N/A	1.5

Outcomes: Jewish Family & Children Services	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Total referrals to other mental health services or to resources for basic needs	N/A	14	N/A	22	N/A	32

Early Childhood Education:

Outcomes: Jewish Family & Children Services	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Staff receiving ECMH Consultation ability to identify, intervene, and support children	85%	88%	85%	88%	85%	96.15%
Satisfaction with ECMH Consultation services among staff	75%	96%	75%	75%	50%	100%

CHANGES FOR FY 2024-25: Anticipated for FY 24-25 are several favorable developments in the delivery of Early Childhood Mental Health services. Service expansion has been implemented county-wide, including outreach to Marin City, specifically at the Horizon Community (Pre) School — an area previously lacking such services. The funding from First 5 (Help Me Grow) will additionally bolster service provisions and referrals for the Marin City community.

PROGRAM STORY

Evan*, a four-year-old student, faced severe separation anxiety at his preschool, causing disruptions and distress for both himself and those around him. His behavior escalated to the point where he had to leave his previous preschool. Upon enrolling at a site with an Early Childhood Mental Health (ECMH) Consultant, immediate intervention was initiated.

The ECMH consultant prioritized building a strong rapport with Evan's parents, offering culturally relevant support in their primary language (Spanish) and providing psychoeducation. Collaborative efforts between parents and preschool staff were made to understand the root causes of Evan's behavior and develop a tailored action plan.

Assessment for trauma and mental health issues was conducted, alongside the creation of a "social story" to aid Evan in managing his emotions. Consistent transition plans were established, aligning with the family's values and the site's protocols.

With these interventions, Evan's behavior significantly improved. The ECMH consultant facilitated workshops to equip staff with skills to address anxiety and supported parents in understanding Evan's social-emotional needs, connecting them with additional services as needed.

The consultant's non-judgmental and compassionate approach fostered an environment where both preschool staff and Evan's family felt supported. The site director credited the consultant with preventing Evan's potential expulsion, highlighting the invaluable impact of the ECMH service.

*Real names are not used, and any identifying information has been altered to protect the confidentiality of individuals' health information.

TRANSITION AGE YOUTH (TAY): PEI 04

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #1, #2, #3, #4, #6

MARIN PEI PRIORITY STRATEGY AREA: Transition-Aged Youth (TAY) Services and Supports

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: TAY PEI provides screening and brief intervention for behavioral health concerns in teen clinics and group and individual services in 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 Transitional-Aged Youth, as well as trainings for educators on supporting LGBTQ youth.

During this reporting period, there have been expansions in TAY support in two key areas.

One area of expansion involved an increase in funding for North Marin Community Services to enhance English and Spanish language capacity at the Novato Teen Clinic (NTC), aimed at better serving the needs of the youth population at NTC.

Additionally, TAY support in Marin City was granted to the Marin County Cooperation Team's "Vision Project," with program implementation commencing in January 2024. The Vision Project entails mentorship from non-parental adults who play pivotal roles in fostering healthy development among Marin City youth within a strengths-based, advocacy framework. The objective of this mentoring initiative is to provide youth with positive adult interactions and consequently mitigate risk factors such as early antisocial behavior and alienation, while enhancing protective factors such as healthy beliefs and opportunities for involvement, along with social and material reinforcement for behavior change.

TARGET POPULATION: The target population is 16–25-year-olds—and some younger youth ages 12 to 15—from underserved populations such as LGBTQ+, Latine, and African American youth; school staff and providers who receive training and consultation.

NUMBERS SERVED:

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	684	59	3,748	4,491

KEY OUTCOMES:

- Reduced likelihood of school failure and/or unemployment;
- Early identification of youth with behavioral problems that may indicate mental/emotional difficulties; and increased timely access to early intervention or treatment services;
- Increased capacity of teachers and providers to support LGBTQ youth;
- Reduced Prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): Patient Health Questionnaire (PHQ), Generalized Anxiety Disorder scale (GAD), Partners for Change Outcome Management System (PCOMS), Global Appraiser of Individual

Needs (GAIN-I) and Rapid Assessment for Adolescent Preventive Services (RAAPS) screening tools, PEI client satisfaction surveys, workshop/training evaluations.

FY 2022-23 OUTCOMES:

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 FY19/20	Actual FY19/20	Goal FY20/21	Actual FY20/21	Goal FY22/23	Actual FY22/23
TAY screened for behavioral health concerns	350	261	165	170	165	117
TAY participating in individual and/or family counseling in school or clinic settings	200	714	100	133	100	223
Family members participating in TAY counseling in support of the client	50	364	50	63	N/A	N/A
⅓ of families will engage in Early Intervention services in support of the TAY client	N/A	N/A	N/A	N/A	1/3 of families	5.4% of clients had family interaction
TAY participating in at least 3 sessions of counseling showing statistically significant improvement in client well-being* (PCOMS: Outcome Rating Scale)	60%	78% N=68	75%	100% N=41	N/A	N/A
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)	75%	97% N=68	75%	100% N=41	75%	71%
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	N/A	93% N=70	75%	98% N=41	75%	99.04% N=126
Total referrals to County Behavioral Health (BHRS)	N/A	23	N/A	30	N/A	3
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	15	N/A	30	N/A	2
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other PEI providers	N/A	49	N/A	30	N/A	14

Outcomes: Huckleberry Youth Programs	Goal FY19/20	Actual FY19/20	Goal FY20/21	Actual FY20/21	Goal FY22/23	Actual FY22/23
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	45	N/A	Not reported	N/A	14
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	Not reported	N/A	N/A	N/A	2
Total referrals to other mental health services or to resources for basic needs	N/A	159	N/A	40	N/A	7

North Marin Community Services (NMCS) Screening and brief intervention services for behavioral health and reproductive health issues at the Novato Teen Clinic (NTC), within schools, and across the community. Moreover, NMCS facilitates direct connections to mental health counseling, substance use counseling, case management, school-based groups, individual and/or family counseling. Additionally, specialized support is provided for immigrant and LGBTQ+ students. Peer health promoters (PHP) play a crucial role in promoting behavioral health education. They actively participate in Teen Clinic days, engage in community outreach efforts, and contribute to the development of social media content. Their involvement helps normalize the concept of accessing these vital services among their peers.

Outcomes: North Marin Community Services	Goal FY19/20	Actual FY19/20	Goal FY20/21	Actual FY20/21	Goal FY22/23	Actual FY22/23
Peer Health Promoters (PHP) will serve annually as ambassadors to the NTC.	N/A	N/A	7	8	7	6
PHP's will agree or strongly agree that the training and experience they have received have been valuable in preparing for their future.	N/A	N/A	N/A	N/A	85%	100%
TAY screened for behavioral health concerns	350	261	200	164	200	209
Youth will receive education and outreach annually	N/A	N/A	500	541	500	1,219
Youth will be reached through NTC's social media presence	N/A	N/A	3,500	3,500	3,500	30,000
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)	60%	65% N=49	N/A	N/A	N/A	N/A
TAY participating in individual and/or counseling in school or clinic settings	200	714	75	47	75	104

Outcomes: North Marin Community Services	Goal FY19/20	Actual FY19/20	Goal FY20/21	Actual FY20/21	Goal FY22/23	Actual FY22/23
Family members participating in TAY counseling in support of the client	50	364	N/A	N/A	N/A	N/A
Youth participating in follow-up visits with the mental health clinician will demonstrate improvement in well-being, as measured by PHQ and GAD scores	60%	78% N=68	60%	70% N=33	70%	57%
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	N/A	93% N=70	75%	N/A	75%	100%
Total referrals to County Behavioral Health (BHRS)	N/A	23	N/A	6	N/A	2
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	15	N/A	3	N/A	0
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Not reported	N/A	Not reported	N/A	52-136 weeks
Total referrals to other PEI providers	N/A	49	N/A	3	N/A	4
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	45	N/A	3	N/A	0
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	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other mental health services or to resources for basic needs	N/A	159	N/A	24	N/A	45

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

Outcomes: Spahr Center	Goal FY19/20	Actual FY19/20	Goal FY20/21	Actual FY20/21	Goal FY22/23	Actual FY22/23
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	272	200	200	500 hours 20 youth	558 hours 20 youth
Provide Training for educators in a minimum of 5 middle and high schools	5	5	5	5	5	Not reported

Outcomes: Spahr Center	Goal FY19/20	Actual FY19/20	Goal FY20/21	Actual FY20/21	Goal FY22/23	Actual FY22/23
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	75%	100%	75%	100%
Increase self-knowledge and self-confidence for LGBTQ+ youth seen for at least 24 sessions	N/A	N/A	85% LGBTQ+ youth	100%	85%	100% LGBTQ+
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	N/A	92% N=15	75%	100% N=10	75% N=20	100%
Total referrals to County Behavioral Health (BHRS)	N/A	1	N/A	3	N/A	0
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	1	N/A	0	N/A	0
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other PEI providers	N/A	2	N/A	4	N/A	0
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	0	N/A	4	N/A	0
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	1	N/A	Not reported
Total referrals to other mental health services or to resources for basic needs	N/A	1	N/A	17	N/A	7

CHANGES FOR FY 2024-25: Effective as of February 16, 2024, The Spahr Center announced the indefinite suspension of all programs due to ongoing financial challenges. Consequently, The Spahr Center will cease to provide LGBTQ+ TAY services under PEI.

PROGRAM STORIES

Huckleberry

Esteban*, a 17-year-old high school student, was referred to Huckleberry counseling services by his school due to frequent absences, declining grades, and signs of depression. After multiple sessions, Esteban and his Huckleberry therapist built a strong bond, allowing him to open up about his struggles. Esteban revealed feeling isolated at school and unsupported at home, admitting to using methamphetamines to cope with loneliness and grief.

Working together, Esteban and his therapist set goals for counseling, focusing on improving his academic performance and addressing substance use. Huckleberry also involved Esteban's parents in his healing journey. Following brief intervention, Esteban was referred to another agency for long-term substance abuse treatment.

Upon completing therapy, Esteban expressed newfound hope for his future. Thanks to Huckleberry's support, his grades improved dramatically, enabling him to graduate high school. Engaging in recreational sports helped him connect with others and manage his depression.

Huckleberry's mental health services empower and support youth like Esteban by meeting them where they are and providing essential resources to help them thrive.

North Marin Community Services

This year has marked a period of transition for Novato Teen Clinic (NTC) and Marin Community Clinic, characterized by staffing changes and the return to fully in-person operations as the pandemic situation improves. Word-of-mouth has traditionally been a key driver of NTC participation, but this has presented challenges as many youth aged out of services during the pandemic, and educating younger youth requires time.

In response to lower attendance rates at the Teen Clinic and increase behavioral health education efforts changes have been made to expand outreach through social media platforms. Peer Health Promoters and NTC staff created a new TikTok account, complementing existing outreach strategies. This initiative has contributed to ensuring that NTC reaches capacity most Wednesdays. As we conclude our year-end outcome reporting, we are pleased to report that our NTC TikTok account has over 30,000 views, indicating promising momentum moving forward.

Spahr

Cam* was referred to Spahr Center TAY services by a friend who had previously benefited from individual therapy services. At the time of the referral, the youth was 17 years old and in the process of coming out as transgender. They were experiencing gender dysphoria and facing challenges with family members who lacked support for their gender and sexuality. The LGBTQ+ transition age youth services at Spahr Center provided Cam with access to LGBTQ+ affirming therapy under minor consent, as they were unable to afford the standard cost of individual therapy as a full-time student. Throughout their participation in therapeutic services, the client engaged in an in-depth exploration of their gender

identity and sexuality, improved coping skills, and reported a decrease in symptoms of anxiety and gender dysphoria.

Upon turning 18, Spahr center therapist supported them in connecting with the Kaiser Gender Clinic to undergo assessment and access hormone replacement therapy (HRT) to address persistent and severe symptoms of gender dysphoria. Since beginning HRT, Cam has reported a decrease in symptoms related to gender dysphoria and an increase in self-esteem, satisfaction, and overall well-being.

*Real names are not used, and any identifying information has been altered to protect the confidentiality of individuals' health information.

LATINO COMMUNITY CONNECTION (LCC): PEI 05

SERVICE CATEGORY: EARLY INTERVENTION, PREVENTION

SB 1004 PRIORITY CATEGORIZATION: #4, #6

MARIN PEI PRIORITY STRATEGY AREA(S): Latine Early Intervention

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: The *Latino Community Connection* program aims to address mental health concerns within the Latine community by enhancing the identification of individuals struggling with mental illness and bolstering protective factors for those at heightened risk due to trauma. Bilingual behavioral health providers offer brief interventions to individuals, couples, and families, which include psychoeducation, coping skills training, communication techniques, and appropriate referrals to behavioral health services. Clients may also access group sessions focused on trauma, stress management, depression, and anxiety, aimed at developing effective coping and stress reduction strategies. Furthermore, the program includes the local Spanish-language radio show "Cuerpo Corazon Comunidad" to disseminate outreach and prevention information on various health topics, including mental health and substance use.

The LCC program expanded with increased funding allocated to Canal Alliance, enabling the addition of another behavioral health clinician. This expansion aimed to broaden services for Spanish-speaking residents, particularly immigrants, in the Canal Area of Marin.

TARGET POPULATION: The focus group comprises Latine individuals across the County, with particular attention to recent immigrants encountering numerous stressors and obstacles when attempting to access services. This demographic confronts various significant risk factors associated with mental illness, including but not limited to severe trauma, persistent stress, economic hardship, familial discord or domestic abuse, racial discrimination, social disparity, and traumatic loss.

NUMBERS SERVED	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	**527**	**135**	**291 + 12,500 number of radio show streams**	**13,453**

KEY OUTCOMES:

- Reduced likelihood of school failure and unemployment due to mental health challenges;
- Earlier identification of mental/emotional difficulties and increased timely access to medically necessary services;
- Increased community awareness of mental health and community resources;
- Reduced stigma around mental health and help seeking within the Latino Community;
- Reduced Prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): In assessing the mental health status and wellbeing of the target population, a variety of measurement tools have been employed. These tools include the GAD-7 (Generalized Anxiety Disorder 7), BDI (Beck Depression Inventory), CES-D (Center for Epidemiologic Studies Depression Scale), PSI-4 (Personality Assessment Inventory-4), PHQ-9 (Patient Health Questionnaire), and PHQ-9A (Patient Health Questionnaire for Adolescents). Additionally, PEI caregiver and client satisfaction surveys have been utilized. Furthermore, radio program efforts have been assessed through quarterly and end-of-year listener surveys.

FY 2022-23 OUTCOMES:

Outcomes: Canal Alliance	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Individuals participating in support groups or individual/family sessions	150	121	150	171	N/A	N/A
Family members participating in support of the client	30	9	30	9	N/A	N/A
Individuals and their family will participate in individual/family sessions.	N/A	N/A	N/A	N/A	70 individuals & 15% of family members	475 individuals & 25% of family members
Individual/family session participants completing at least 3 sessions will report a reduction in symptoms by one category measured on the GAD-7, BDI, CES-D, or PSI-4.	50%	100%	50%	100%	50%	100%
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	75%	84%	75%	100%	75%	100%
Individuals being served will achieve two or more of the following outcomes: Improved performance in academic or social aspects of school or work. Strengthened relationships with family, friends, teachers, or other individuals. Enhanced coping skills for managing adversity. Increased sense of connection to the community. Improved ability to advocate for personal needs.	75%	100%	75%	100%	75%	100%
Conduct staff trainings on identifying mental health issues across different stages of life and on utilizing trauma-informed strategies and tools.	N/A	N/A	N/A	N/A	10 trainings of 20 staff	17 trainings with 20+ staff
Total referrals to County Behavioral Health (BHRS)	N/A	55	N/A	6	N/A	70
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	11	N/A	2	N/A	15

Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	8	N/A	12	N/A	32 weeks
Total referrals to other PEI providers	N/A	19	N/A	14	N/A	55
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	19	N/A	7	N/A	25
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	Not reported	N/A	Not reported	N/A	12 weeks
Total referrals to other mental health services or resources for basic needs	N/A	574	N/A	83	N/A	150

Outcomes: North Marin Community Services	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21	Goal FY 22/23	Actual FY 22/23
Individuals receiving health information and support from Promotores or Family Resource Advocates	900	999	See CSS Section	See CSS Section	See CSS Section	See CSS Section
Individuals participating in support groups or individual/family sessions	150	171	70	90	60	52
Family members participating in support of the client	30	40	30	9	15	15
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	N/A	84% (N=128)	N/A	Data unavailable	75%	100%
Clients/Caregivers surveyed will indicate feeling more accomplished related to two or more areas on the county survey.	N/A	N/A	N/A	N/A	75%	100%
Facilitate a group intervention session as part of the "*charla*" newcomers programing	N/A	N/A	N/A	N/A	12 students	6 students
Total referrals to County Behavioral Health (BHRS)	N/A	55	N/A	16	N/A	3
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	11	N/A	Not reported	N/A	Not reported

Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	8	N/A	52	N/A	52
Total referrals to other PEI providers	N/A	19	N/A	11	N/A	6
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	19	N/A	11	N/A	Not reported
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	Not reported	N/A	Not reported	N/A	Not reported

Outcomes: Multicultural Center of Marin Cuerpo Corazon Communidad	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21	Goal FY 22/23	Actual FY 22/23
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	51	52	52
Radio Show Listener Survey Responses:						
"I have a better understanding of resources in my community"	N/A	95% (N=18)	N/A	90% (N=59)	N/A	Not reported
"I learned something about mental health (emotional wellbeing) that I didn't know before"	N/A	89% (N=18)	N/A	80% (N=59)	N/A	Not reported
"I would recommend this radio show to a friend or family member"	N/A	95% (N=18)	N/A	97% (N=59)	N/A	Not reported

Top 5 Cuerpo Corazon Communidad Radio Shows	English Translation	Number of Streams	Airdate
Inversiones y Mercado de Capitales	Investments and Capital Markets	475	11/16/22
Especial con Dolores Huerta	Special with Dolores Huerta	434	6/21/23
Cómo comprar una casa por primera vez	How to Buy a House for the First Time	415	11/30/22
Abogando por las necesidades en nuestra comunidad	Advocating for the Needs in Our Community	386	1/4/23

Top 5 Cuerpo Corazon Communidad Radio Shows	English Translation	Number of Streams	Airdate
La conexión entre redes sociales y nuestra imagen	The Connection Between Social Media and Our Image	352	4/29/23

CHANGES FOR FY 2024-25: There are no changes to report for FY 24-25.

PROGRAM STORIES

North Marin Community Services:

"Cuándo yo empecé con mi terapista no podía ni hablar ni una sola palabra, sólo llorar hacía y mi terapista respetó mi dolor y me hizo sentir en confianza, al término de mis sesiones yo ya era otra persona, ya podía sonreír y ver la vida desde otra perspectiva, gracias mil gracias, por tan valiosa ayuda, le estaré eternamente agradecida, saludos cordiales."

"When I started with my therapist, I couldn't even speak a single word, I only cried and my therapist respected my pain and made me feel confident. At the end of my sessions I was already another person, I could smile and see life from a different perspective. another perspective, thank you very much, for such valuable help, I will be eternally grateful, best regards."

Canal Alliance

A 44-year-old male client from El Salvador sought behavioral health treatment following a traumatic experience where he was attacked at knifepoint outside his home. Upon beginning treatment, the client exhibited symptoms consistent with post-traumatic stress disorder (PTSD), including persistent fear and anxiety, intrusive thoughts and nightmares, extreme guilt, shame, avoidance of triggers, and social withdrawal from loved ones. He expressed that he only felt comfortable going to work and returning home, which strained his relationship with his wife and children.

The client responded positively to psychoeducation about trauma and actively participated in mindfulness and somatic exercises to manage his anxiety and fears. Initially, he felt ashamed and embarrassed about his symptoms, viewing himself as weak for not being able to overcome the trauma. However, after normalizing his experiences and learning about PTSD, he experienced a significant reduction in feelings of shame and was able to communicate with his wife about his struggles, allowing her to provide support.

After four months of treatment, the client reported no longer experiencing nightmares and enjoyed spending quality time outdoors with his family and attending church. Feeling confident in his ability to utilize the coping skills learned in therapy and the support of his wife and community, he chose to conclude treatment at the four-month mark, believing he could continue to progress independently.

*Real names are not used, and any identifying information has been altered to protect the confidentiality of individuals' health information.

OLDER ADULT: PEI 07

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #2, #4, #5, #6

MARIN PEI PRIORITY STRATEGY AREA: Older Adult Supports and Connections

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: Older adults continue to represent a growing percentage of the population of Marin and face many risks for mental illness.

The Older Adult PEI programs aim to address this by offering training and education for both the community and healthcare providers on mental health concerns specific to older adults. This includes support for LGBTQ+ older adults and training in suicide prevention tailored to their needs.

For those experiencing depression and anxiety, especially in connection with medical issues, loss, or life transitions, early intervention services are available. Clinicians provide support through home visits and maintain collaboration with family members and other healthcare providers.

The Hope Program's Senior Peer Counseling (SPC) volunteer program assists older adults in navigating the challenges of aging, such as loss of independence and isolation. SPC volunteers, supervised by mental health professionals, offer emotional support and practical advice to help clients cope with change and maintain independence.

PEI funding aims to expand the reach of the SPC program in by working with an older adult consultant to train staff and develop Early Intervention groups. Additional activities will target isolated individuals lacking access to resources. Future plans include providing stipends to volunteer SPCs to support older adults in Marin dealing with mental health issues related to grief, aging, health concerns, and other factors.

TARGET POPULATION: The target population is older adults (60+ years old), including individuals from underserved populations such as Latine, Asian, African American, LGBTQ+, low-income, and geographically isolated.

NUMBERS SERVED	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	**142**	**10**	**906**	**1,058**

KEY OUTCOMES:

- Earlier identification of mental/emotional difficulties and increased timely access to medically necessary services;
- Increased provider awareness of the mental health needs of older adults and linkage to appropriate community resources;
- Reduced stigma around mental health and help seeking within the older adult LGBTQ community;
- Reduced Prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): PHQ-9 (Patient Health Questionnaire-9), GDS (Geriatric Depression Scale) & GAD-7 (Generalized Anxiety Disorder 7). PEI client satisfaction surveys for groups and individual support

services. Provider workshop surveys to assess satisfaction, skill development and awareness of community resources.

FY 2022-23 OUTCOMES:

Outcomes: JFCS BOOST	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21	Goal FY 22/23	Actual FY 22/23
Individuals receiving education regarding behavioral health signs and symptoms in older adults	100	240	100	557	100	423
Seniors at Home clients screened for behavioral health concerns *PHQ9, substance use	150	150	150	156	150	150
Low income clients receiving brief intervention services	50	49	50	109	50	51
Low income clients receiving brief intervention services who are from underserved populations	20%	24% (N=12)	20%	21% (N=10)	20%	4%
Clients completing a short-term treatment protocol for depression or anxiety	70%	85% (N=49)	70%	85% (N=40)	70%	88%
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%	100% (N=49)	60%	78% (N=46)	60%	77%
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	75%	100% (N=27)	75%	96% (N=45)	75%	100% (N=25)
Total referrals to County Behavioral Health (BHRS)	N/A	2	N/A	4	N/A	5
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	0	N/A	2	N/A	2
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	17 days	N/A	19 days	N/A	Not reported
Total referrals to other PEI providers	N/A	5	N/A	2	N/A	Not reported

Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	2	N/A	2	N/A	Not reported
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	2	N/A	Not reported
Total referrals to other of mental health services or resources for basic needs	N/A	114	N/A	110	N/A	18

Outcomes: JFCS Healthcare Provider Education	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21	Goal FY 22/23	Actual FY 22/23
Provide trainings on older adult mental health topics to healthcare providers (MD's, Nurses, Caregivers, healthcare support staff etc.)	N/A	N/A	4 trainings 80 participants	4 trainings 67 participants	4 trainings 80 participants	6 trainings 91 participants
Training participants will report an increase in their knowledge of mental health in older adults and their ability to detect symptoms	N/A	N/A	80%	71%	80%	100%
Training participants will increase ability to differentiate dementia and depression	N/A	N/A	80%	92%	80%	100%
Training participants will report increased understanding of impact of racism on older adult mental health, ethnic and cultural differences, and racial disparities that might impede appropriate diagnosis and treatment	N/A	N/A	80%	85%	80%	100%
Training participants will report increased knowledge of community resources and services that treat older adults with mental illnesses	N/A	N/A	80%	78%	80%	100%
Training participants will become familiar with mental health screening tool and will be knowledgeable in its appropriate usage	N/A	N/A	100%	92%	80%	100%

Outcomes: Spahr Center	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21	Goal FY 22/23	Actual FY 22/23
LGBTQ+ older adult cultural competency trainings and or technical assistance to older adult service providers	N/A	N/A	2	1	8	8 (5 trainings/3 technical assistance)
Training participants will better understand LGBTQ+ identities, feel more equipped to support LGBTQ+ older adults, know the resources available for LGBTQ+ older adults	N/A	N/A	N/A	N/A	75%	97.6%
Establish an annual speaker's bureau comprised of LGBTQ+ older adults who will collaborate with trainer to share their personal experiences and articulate the needs of LGBTQ+ seniors.	N/A	N/A	10	8	N/A	N/A
Conduct train the trainer to deliver LGBTQ+ older adult cultural competency and allyship training to healthcare and community service providers	N/A	N/A	2 trainings 3 participants	1 training 2 participants	N/A	N/A
Conduct cultural competency and allyship trainings annually for healthcare and community service providers	N/A	N/A	4 trainings 60 employees	1 training 25 employees	N/A	N/A

CHANGES FOR FY 2024-25: Effective as of February 16, 2024, The Spahr Center announced the indefinite suspension of all programs due to ongoing financial challenges. Consequently, The Spahr Center will cease to provide LGBTQ+ Older Adult trainings under PEI.

The changes to the JFCS Healthcare Provider Education contract for FY 24/25 involve the addition of Suicide Prevention training for Older Adults which already includes the training, Detecting, Differentiating, and Addressing Depression and Dementia in Older Adults. These additional offerings aim to support healthcare providers and caregivers who work with older adults.

For FY 24/25, Helping Older People Excel (HOPE) Senior Peer Counseling program will undergo changes as two BHRS staff members have departed, and a new supervisor will assume responsibility for senior peer counseling, maintaining one-on-one support and exploring group options to expand services for the older adult community.

PROGRAM STORIES

JFCS BOOST

Rob*, a 79-year-old man residing alone in San Rafael, reached out to the JFCS BOOST program on his own initiative. He was grappling with a blend of depression and anxiety, compounded by feelings of social isolation. Rob articulated concerns about aging and the impact it had on his activities of daily living, coupled with apprehension about an uncertain future. Through consistent, personalized therapy sessions conducted in his home on a weekly basis, Rob effectively engaged with BOOST therapy. This facilitated his journey towards identifying and embracing positive activities, enhancing self-assurance, and fostering a sense of social belonging. With the guidance of his BOOST clinician, Rob recognized and addressed limiting beliefs that hindered his capacity for deeper interpersonal connections. After several months of dedicated work, Rob's transformation became evident as he transitioned into a more active and socially engaged lifestyle. He now volunteers weekly at a local animal agency, has participated in two 5K runs, joined recreational activities such as ping pong and chess at another local organization, enrolled in a community class, and forged new friendships along the way. Expressing his newfound joy, Rob recently conveyed to his clinician, "I'm experiencing so much fulfillment in my life now, thanks to your support!"

JFCS PROVIDER Education

In February 2023, we delivered an adapted version of the presentation titled "Detecting, Differentiating, and Addressing Depression and Dementia in Older Adults." This presentation was tailored for family caregivers participating in the JFCS Family Caregiver Support Group, many of whom have been providing care for their loved ones for many years. The group actively engaged with the material, posing numerous practical questions regarding behaviors, cognitive testing, home-screening tools, medication options, and more. In response to the audience's interest, we recorded the presentation, receiving multiple requests for access to the recording. One individual, who had missed the initial presentation, visited our office five months later to view the recording due to difficulties accessing it at home. Encouraged by the positive feedback, the group invited us to conduct another presentation focused on addressing challenging behaviors, expressing gratitude for the valuable insights provided. Recognizing the significant demand for information among family caregivers, particularly regarding topics typically addressed by neurologists, we realized the importance of broadening our audience reach. This presentation served as an opportunity for caregivers to have their practical questions addressed, filling a gap in their access to specialized knowledge and support.

*Real names are not used, and any identifying information has been altered to protect the confidentiality of individuals' health information.

COMMUNITY TRAINING AND SUPPORTS: PEI 12

SERVICE CATEGORY: STIGMA REDUCTION, PREVENTION

SB 1004 PRIORITY CATEGORIZATION: #2, #4, #5, #6

MARIN PEI PRIORITY STRATEGY AREA(S): Transition-aged Youth Services and Supports; School-based Mental Health and Psychoeducation.

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: Marin County has allocated funds to support the goals of Prevention and Early Intervention (MHSA PEI), which include enhancing awareness of mental illness, reducing stigma and discrimination, and implementing effective practices. A significant aspect of this initiative involves outreach, training, and education.

An element of these efforts is the provision of Mental Health First Aid (MHFA) training sessions, which are conducted regularly throughout the community. Approximately four to six MHFA trainings are held each year, for both Adults and those that support Youth, with sessions available in both English and Spanish. These trainings are conducted across various communities within the county.

Furthermore, the allocated funds are utilized for various other strategies, including suicide prevention training and outreach efforts targeting individuals capable of recognizing and responding to mental illness, including both affected individuals and their families. These initiatives are conducted in English with Spanish translation support available. Additionally, there are some targeted activities specifically offered in only in Spanish or Vietnamese. Additionally, funds support sending professionals, consumers, families, and other stakeholders to relevant conferences, such as those pertaining to Mental Health and Suicide Prevention Awareness Month activities. Moreover, funding is directed towards community-wide initiatives promoting equity and inclusion, with a specific focus on reducing stigma.

The focus of the expansion in community training and prevention resources is on domestic violence prevention and outreach, with a primary emphasis on youth and families of young individuals who have encountered domestic violence. A request for proposals (RFP) was issued on November 1, 2023, seeking proposals for domestic violence prevention and outreach services. The RFP committee has chosen Canal Alliance as the awardee. The Behavioral Health program at Canal Alliance will serve the low-income, Latine community in Marin County through bilingual, trauma-informed, and culturally appropriate services for domestic violence prevention and education.

TARGET POPULATION: The target population for this program is:

- Individuals within the community who are capable of *identifying and addressing early signs of mental illness*, including but not limited to school staff, frontline workers in health and human service agencies, community health advocates/Promotores, family members, first responders, probation staff, librarians, teachers, counselors and others.
- Individuals within the community who are capable of executing activities aimed at *reducing stigma and discrimination*. This encompasses community leaders, peer providers, relevant county staff, and other stakeholders.

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	**-**	**-**	**2,400**	**2,400**

KEY OUTCOMES:

- Enhanced comprehension of mental health, suicide prevention, and substance use disorders.
- Heightened awareness of indicators and symptoms associated with conditions like depression, anxiety, psychosis, and substance abuse.
- Diminished negative attitudes and misconceptions regarding individuals experiencing symptoms of mental health disorders.
- Improved capabilities for effectively responding to individuals displaying signs of mental illness and facilitating their connection to appropriate services.
- Expanded knowledge of accessible resources within the community.

MEASUREMENT TOOL(S): For community trainings; California Institute for Behavioral Health Solutions (CIBHS), Measurements, Outcomes, and Quality Assessment (MOQA) participant questionnaire. For Mental Health First Aid (MHFA), pre and post surveys to assess change in knowledge. PEI Client and caregiver satisfaction surveys will be administered for domestic violence programming.

FY 2022-23 OUTCOMES:

Outcomes: Mental Health First Aid	FY 20/21	FY 21/22	FY 22/23
Number of Marin County community members that participated in MHFA	46	104	84
Participants reporting increased knowledge about mental illness signs/symptoms (0-5 scale)	4.56	4.27	3.66 (1-4 scale)
Participants recognize and correct misconceptions about mental health and mental illness as they encounter them (0-5 scale)	4.5	4.48	4.53
Participants are aware of their feelings and views about mental health problems and disorders (0-5 scale)	4.4	4.31	4.47
Participants reporting ability to assist somebody experiencing a mental health problem or crisis to connect with community, peer or personal support (0-5 scale)	4.3	4.22	4.45
Participants reporting feeling able to offer a distressed person basic "first aid" information and reassurance about mental health (0-5 scale)	4.32	4.27	3.66 (1-4 scale)
Participants reporting ability to assist somebody experiencing a mental health problem or crisis to seek appropriate professional help (0-5 scale)	4.36	4.25	4.27

Settings where participants might use Mental Health First Aid	FY 20/21	FY 21/22	FY 22/23
Community Members	11	38	43
Family Member of Person with Serious Mental Illness	5	6	5

Settings where participants might use Mental Health First Aid	FY 20/21	FY 21/22	FY 22/23
Providers			
County Behavioral Health and Recovery Services	6	9	0
Community-based Mental Health and/or Substance Use Provider	15	20	21
Education (including High School Students)	1	12	1
Law Enforcement	0	0	0
Primary Health Care	1	3	0
Senior Centers/Services	1	2	1
Social Services (County and Community)	2	5	10
Veterans	0	0	0
Faith-based	1	1	1
Shelters/Homeless Services/Public Housing	1	0	0
Libraries	0	0	0
Public Transit	0	0	0
Employment	0	0	0
Other – List: DV, BOS, Parks Svcs, PH	1	3	0
Security, Emergency Svcs	0	0	0
Unknown	1	5	2

SUICIDE PREVENTION COLLABORATIVE ACTIVITIES

The Marin County Suicide Prevention Collaborative continues to adopt a comprehensive socio-ecological framework to systematically implement prevention, intervention, and postvention strategies across individual, community, and institutional levels. Over the past three years, Community Action Teams have made significant progress in advancing the strategic plan. By 2023, these teams encompassed vital areas such as Postvention, Data Analysis, Lethal Means Reduction, Youth Outreach, School Initiatives, Training/Education, and Support for Men and Boys. Furthermore, in May 2023, efforts were underway to broaden partnerships with law enforcement, fire services, emergency medical services, and healthcare providers.

Bi-monthly public meetings, typically attended by 50-60 participants, serve as a platform for engagement and collaboration. The Collaborative actively involves all residents of Marin County, including vulnerable groups such as veterans, middle-aged and older adults, LGBTQ+ individuals, and community-based organizations, school districts, and county partners.

Key partnerships have been established to advance strategic goals. For instance, the Marin County Schools Wellness Collaborative focuses on enhancing policies and programs to support student mental health, aligning with Strategy 6 of the suicide prevention plan. Similarly, the Lethal Means Action Team collaborates with various organizations to address Strategy 7.

A summary of accomplishments for FY 22/23 and future steps for each strategy is provided:

Strategy 1: Establish Leadership and Oversight
Accomplishments include maintaining leadership structures, collecting and analyzing local data, and fostering partnerships with key organizations. Next steps involve compiling and presenting year three data, launching a suicide data dashboard, and expanding the Lethal Means Action Team.

Strategy 2: Develop Coordinated Care Systems
Accomplishments encompass implementing support programs, increasing volunteer recruitment, and providing crisis response training. Future plans include launching additional training programs and campaigns to enhance suicide prevention efforts.

Strategy 3: Implement Public Awareness Campaigns
Accomplishments include launching wellness campaigns and raising awareness through community events and presentations. The next phase involves expanding campaign implementations and hosting targeted events.

Strategy 4: Provide Evidence-Based Training
Accomplishments involve hosting various community events and implementing training programs. Future efforts aim to expand training opportunities and distribute educational materials.

Strategy 5: Outreach and Support
Accomplishments include partnering in wellness festivals and delivering support services to affected individuals. Future plans include launching digital resources and hosting outreach events.

Strategy 6: Foster Safe School Environments
Accomplishments include implementing mental health initiatives and crisis response protocols. Next steps involve supporting evidence-based screening programs and hosting suicide prevention training for school staff.

Strategy 7: Reduce Access to Lethal Means
Accomplishments include conducting awareness campaigns and collaborating with community organizations. Future initiatives include hosting training sessions and integrating lethal means safety messaging into broader campaigns.

Overall, the Marin County Suicide Prevention Collaborative remains dedicated to its mission of reducing suicide rates and providing support to individuals and communities affected by suicidal behaviors.

SUICIDE PREVENTION MONTH ACTIVITIES 2022

- Marin County Suicide Prevention Collaborative Meeting: LGBTQ+ Allyship Training September 2022
- Suicide Prevention and Recovery Month Resolution: September 13, 2022
- Collaborative Event with American Foundation for Suicide Prevention and Marin County Office of Education: September 14, 2022.
- Meeting on Grief and Hope with Marin Schools Wellness Collaborative: September 15, 2022
- Film Screening and Discussion: "Marin Women in Recovery": September 15, 2022
- From Compassion to Action: A Community Guide for Suicide Prevention & Support in Marin County: Series of Five Conversation Circles
- Wellness Carnival for Suicide Prevention: Week of September 19, 2022. Supported by the Marin County Suicide Prevention Collaborative
- Information Session on Local Outreach to Survivors of Suicide (LOSS) Team: September 20, 2022
- Helen Vine Recovery Center Recovery Month Celebration: September 22, 2022
- Hike for Hope: Thursday, September 22, 2022
- Hike for Veterans and Men/Boys Action Team: Sunday, September 25, 2022
- Shine! A Community Event for Teen Mental Health and Suicide Prevention: September 25, 2022
- Pressing Play: A Creative Journey into Wellness Through Storytelling with Edward Gunawan: Thursday, September 29, 2022. Hosted by the National Alliance for Mental Illness-Marin
- Multi-County Suicide Prevention Summit: September 30, 2022

MAY MENTAL HEALTH MONTH ACTIVITIES 2023

- Marin County Suicide Prevention Collaborative presents a Resolution for May Mental Health Month at the Board of Supervisor Meeting on May 2, 2023.
- Virtual event hosted by Marin County Suicide Prevention Collaborative for May Mental Health Month on May 3, 2023.
- Let's Talk Community Discussion on Mental Health and Underage Substance Youth on May 3, 2023.
- Peer Coffee Talk: A Hybrid Event on May 4, 2023.
- A Youth Wellness Festival hosted by the Marin County Youth Commission and partners including Marin 9 to 25, the Marin County Suicide Prevention Collaborative, on May 6, 2023.
- Real Talk Matters: Fighting Fentanyl and Its Impact on Mental Health hosted by OD Free Marin during National Fentanyl Awareness Day on May 9, 2023.
- Mental Health First Aid Adult Training on May 10, 2023 at Mt. Tam Room, 20 North San Pedro Rd., San Rafael.
- Let's Talk about Suicide Prevention hosted by North Marin Community Services on May 11, 2023. Presented in Spanish.
- Buckelew Programs Bike for Mental Health on May 13, 2023 at Miwok Meadows, China Camp, Marin County.
- American Foundation for Suicide Prevention (AFSP) Talk Saves Lives: LGBTQ+ hosted with the Marin County Office of Education on May 16, 2023.

- Mental Health First Aid Training by Marin County-BHRS for adults on May 17, 2023.
- Mental Health First Aid Training presented in Spanish for adults on May 20, 2023.
- Mental Health First Aid Training presented in Spanish for youth on May 20, 2023. In-person.
- The Power of Storytelling on Mental Health hosted by NAMI-Marin and Opening the World on May 22, 2023.
- Peer Support: Introduction to the Practice and Model on May 23, 2023.

OTHER OUTREACH AND TRAINING ACTIVITIES FOR FY 2022-23:

- Youth Leadership Institute and Youth Mental Health Festival. This event included support and engagement with the Youth Art and Film Showcase through art, music, poetry.

- College of Marin Equity in Mental Health Symposium. This event hosted over 200 people to discuss equity, justice and culture.

- Caring Card Initiative. This initiative distributed over 2,000 caring cards that provide messages of hope and connection to resources and discharged from psychiatric units, treatment centers, support groups, etc.

- Suicide Attempt Survivor Facilitator Training. This training provided by Didi Hirsh support the facilitation skills to lead attempt survivors.

CHANGES FOR FY 2024-25: The Mental Health First Aid (MHFA) program will no longer be offered through the Community Training and Supports services PEI program. This decision comes as community members and providers faced various access barriers to the training. These barriers include the lengthy 8-hour commitment required, lack of childcare options, digital literacy challenges related to internet registration and web based pre-course work to participate in the trainings. These factors resulted in low participation rates and a high number of no-shows from registered participants.

Additionally, the MHFA training program has strict guidelines regarding participant age, participant-to-instructor ratios, and proprietary instruction materials, making it challenging to manage both participants and contracted instructors effectively.

Despite these challenges, MHFA training remains available for those interested in taking the course. Interested individuals can access the course through the MHFA national website, where both Adult and Youth courses are offered in both virtual and in-person formats.

PEI programming is exploring alternatives to deliver mental health and recovery education sessions that prioritize accessibility and embrace flexible delivery approaches. The goal is to minimize barriers within the community, fostering open and adaptable mental health and recovery education through targeted language sessions and community conversations.

SCHOOL-AGED PEI: PEI 18

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

SB 1004 PRIORITY CATEGORIZATION: #1, #2, #3, #4, #6

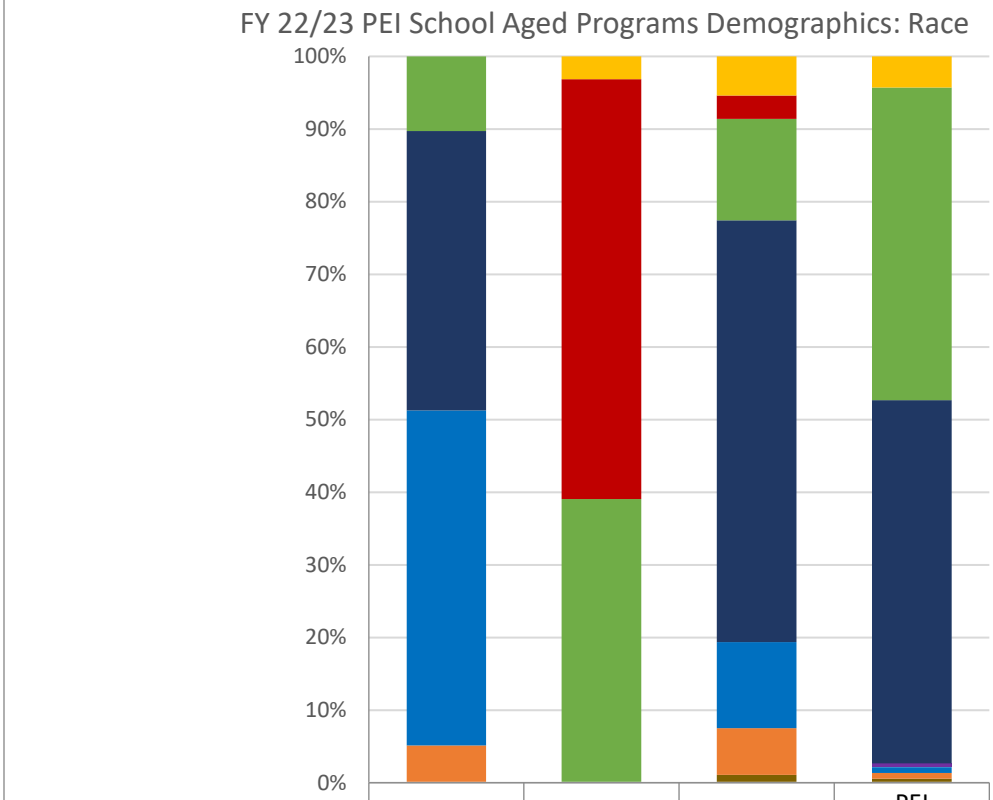
MARIN PEI PRIORITY STRATEGY AREA: School-based Mental Health and Psycho-education

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: 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** 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 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.

Additional funding will be granted to an organization to provide services in Shoreline Unified through an RFP process with a focus on services for Spanish speaking students and families. Additional expanded funding will support the development and implantation of substance use prevention psychoeducation to be used in middle schools across the county.

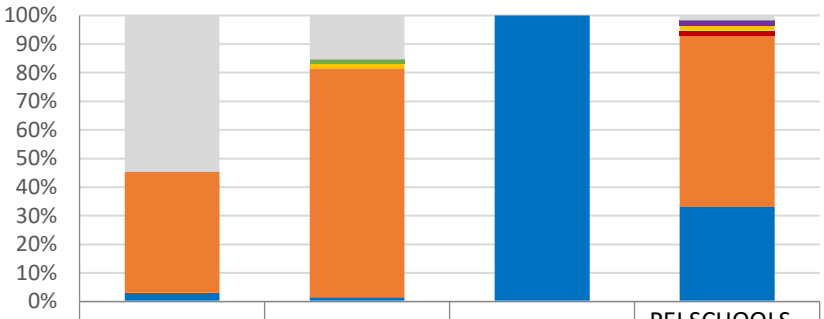
TARGET POPULATION: The target demographic includes students from kindergarten through twelfth grade, ranging in age from 5 to 18. These students may be facing emotional disturbances or are at a significantly higher risk due to various factors such as adverse childhood experiences, severe trauma, poverty, family conflict, domestic violence, racism, social inequality, or other related issues. Additionally, middle school students are also targeted for substance use prevention and psychoeducation.



	PEI Schools -SMCSD	PEI Schools - NMCS	PEI Schools -Spahr	PEI SCHOOLS - Petaluma Health Center
Missing or declined to answer	0	0	0	0
More than one race	0	10	5	16
Another race not listed	0	185	3	0
Hispanic or Latino	8	125	13	161
White (Non-Hispanic)	30	0	54	187
Native Hawaiian or other Pacific Islander	0	0	0	2
Black or African American	36	0	11	3
Asian	4	0	6	3
American Indian or Alaska Native	0	0	1	2

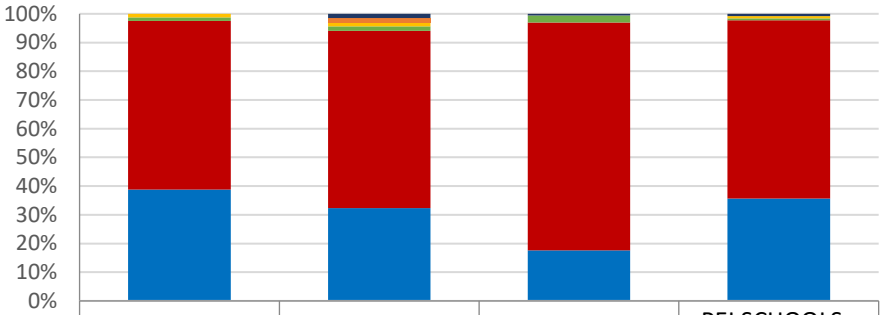
While most respondents provided demographic information, it's important to acknowledge that some responses were missing or declined.

FY 22/23 PEI School Aged Programs Demographics: Sexual Orientation



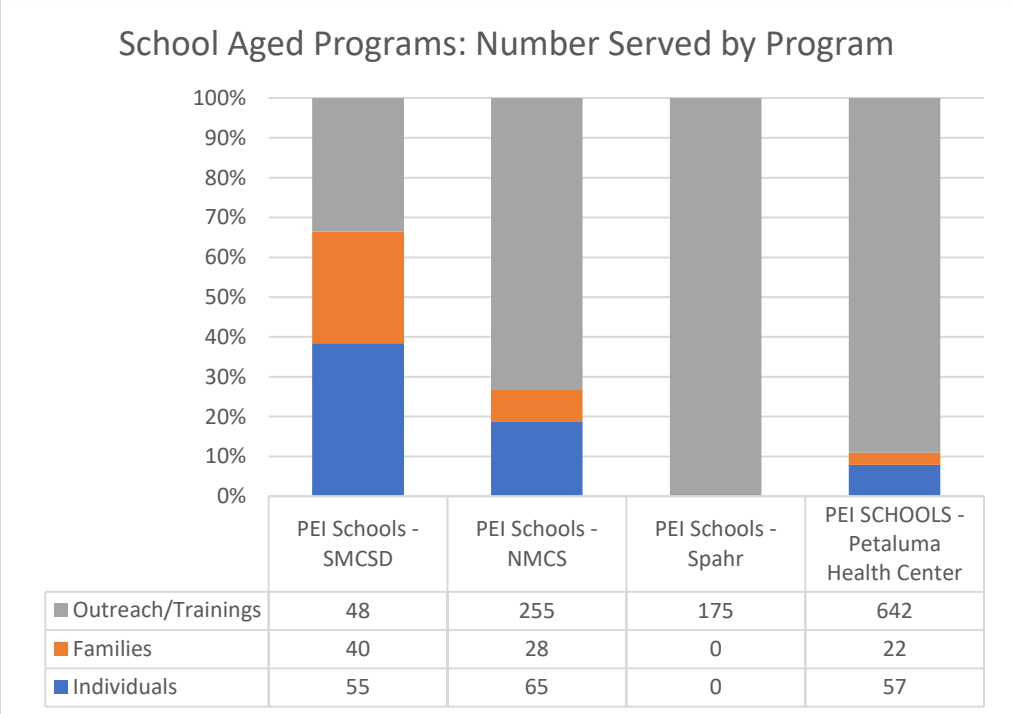
	PEI Schools - SMCSD	PEI Schools - NMCS	PEI Schools - Spahr	PEI SCHOOLS - Petaluma Health Center
Decline to answer/unknown	18	10	0	1
Another sexual orientation	0	1	0	0
Queer	0	0	0	1
Questioning/Unsure	0	1	0	1
Bisexual	0	0	0	1
Heterosexual/Straight	14	52	0	34
Gay or Lesbian	1	1	13	19

FY 22/23 PEI School Aged Programs Demographics: Current Gender Identity



	PEI Schools - SMCSD	PEI Schools - NMCS	PEI Schools - Spahr	PEI SCHOOLS - Petaluma Health Center
Decline to answer	0	0	0	0
Another gender identity	0	1	1	3
Questioning or unsure	0	1	0	0
Genderqueer	1	1	0	3
Transgender	1	1	4	3
Female	47	42	131	244
Male	31	22	29	140

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	177	90	1,120	1,387



KEY OUTCOMES:

- Reduced likelihood of behavioral problems and school failure;
- Improved academic performance and readiness to learn;
- Improved school connectedness;
- Early identification of students with behavioral problems that may indicate mental/emotional difficulties and increased timely access to early intervention or treatment services;
- Improved school culture and destigmatizing of mental health;
- Increased capacity of teachers to support students with challenges and understand the impact of trauma on learning;
- Increased service integration and more effective/equitable distribution of resources;
- Reduce Prolonged Suffering by increasing protective factors and reducing risk factors.

MEASUREMENT TOOL(S): PEI caregiver and client satisfaction surveys, workshop/training surveys, and demographic surveys will be utilized to ensure effective reach and quality of services. COST Rubric to measure quality of Coordination of Services Team and support the development of team goals will also be used.

FY 2022-23 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.

Outcomes: Petaluma Health Center	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
School staff participating in trainings reporting awareness of risks, signs, and symptoms of children experiencing emotional disturbances and/or risk of abuse (Post-survey)	75%	75%	75%	75%+	75%	Not reported
Students participating in Social Emotional Learning curriculum	185	185	185	Not Reported	185	Not reported
Students with mild to moderate mental health concerns receiving at least 3 sessions of individual or group counseling	25	28	25	64	25	34
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%	66% N=18	65%	40% N=15	65%	Not Reported
Students completing at least 3 sessions showing improved attendance or improved school performance (PEI Survey)	65%	66% N=18	65%	33% N=15	65%	Not Reported
Parents completing at least 3 sessions family counseling	10	2	10	5	10	22
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%	73%	65%	Not Reported	65%	100%
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)	75%	83%	75%	Not collected	75%	Not reported
Total referrals to County Behavioral Health (BHRS)	N/A	2	N/A	6	N/A	6
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	1	N/A	4	N/A	6
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	1	N/A	1	N/A	2

Outcomes: Petaluma Health Center	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
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	N/A	N/A	N/A	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	2	N/A	0	N/A	0

Spahr Center: The Spahr Center's School-based program plays a role in empowering middle and high school students through leadership programs focused on addressing LGBTQ+ inequities within their educational institutions. This initiative aims to cultivate leadership skills and provide valuable professional experiences for students. Additionally, the program fosters collaboration with schools to offer professional development opportunities for staff members. It also actively addresses infrastructural issues, ensuring a more comprehensive and inclusive approach to meeting the needs of LGBTQ+ students.

SPAHR Center Goals	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Youth will participate in advocacy projects	10	11	10	10	10	10
Spahr will provide at least 5 hours of leadership development training for 10 youth	5 hours	5 hours	5 hours	5 hours	5 hours	5 hours
Spahr will hold youth meeting time	60 hours	60 hours	40 hours	40 hours	40 hours	40 hours
Youth engaged in program will report that they have learned new skills, feel empowered, and that their voices are heard.	85% of youth	100%	85%	Not reported	85%	Not reported
Provide capacity building to schools	5 schools	5 schools	3 schools	3 schools	3 schools	5 schools
75% of staff participating in program will report that they: Understand LGBTQ+ identities, feel equipped to support LGBTQ+ students, and know the LGBTQ+ resources available	75%	No trainings provided	75%	75%	75%	98%
Technical assistance/cultural competency trainings for at least 15 schools	N/A	N/A	N/A	N/A	15	19
4 LGBTQ+ student panels	N/A	N/A	N/A	N/A	4	4 panels 12 panelists

North Marin Community Services: The NMCS school-based PEI program offers extensive clinical support to Spanish-speaking Latine students and families at Novato High School. A part-time bilingual clinician with a master's degree collaborates closely with NMCS Latine Youth Wellness Coordinator, the NUSD's Newcomer Counselor, school administrators, counselors, and other staff. Their goal is to engage Spanish-speaking students in mental health services and connect them, along with their families, to suitable school and community-based resources. These resources include NMCS Case Management services and the Novato Teen Clinic.

Outcomes: North Marin Community Services	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Students will receive school-based mental health services (screening, brief interventions, individual/group therapy, referrals)	35 students	33 students	30 students	74 students	50-75 students	65 students
Students will participate in group therapy	8 students	8 students	8 students	6 students	8 students	8 students
Students' overall depression and anxiety will decrease from initial visit to final visit, as measured by the average overall score using the PHQ-A and/or GAD-7.	N/A	N/A	N/A	N/A	65%	50%
Students will complete at least 3 sessions demonstrating improvement in school performance	65% of students (N=22)	67%	65% of students	68% of students	65% of students	Not reported
Spanish-speaking parents/guardians will be provided psychoeducation about risk and protective factors related to mental health and substance use.	N/A	N/A	12 parents	14 parents	12 parents	28 parents
Newcomer students at Novato High's Camp N will participate in social-emotional learning activities focused on strengthening family/peer connections, self advocacy, community building, and improved communication skills.	N/A	N/A	N/A	N/A	15	14
Newcomer students and U.S. allies in Novato High's Dreamer's Club will participate in weekly meetings, as well as contribute to community projects and social events.	N/A	N/A	N/A	N/A	15	70
Total referrals to County Behavioral Health (BHRS)	N/A	1	N/A	3	N/A	3
Number of individuals successfully referred and linked to a Marin County mental health treatment program	N/A	1	N/A	3	N/A	12
Average duration in weeks of signs of untreated mental illness	N/A	8	N/A	6-12 months	N/A	-
Total referrals to other PEI providers	N/A	5	N/A	6	N/A	6

Sausalito Marin City School District: School-based clinicians offer both individual and group emotional support as well as social skills development. They coordinate services within classrooms, including socio-emotional learning classes, and provide support and training to staff members. These services are available to children (K-8) in the district and their families.

Outcomes: Sausalito Marin City School District Goals	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Students with mild to moderate mental health concerns will receive at least 3 sessions of individual or group counseling	30 Students	28 students	30 students	146 students	30 students	143 students
Families with mild to moderate mental health concerns will receive at least 2 sessions of family counseling	10 Families	7 families	10 families	36 families	10 families	48 families
Individuals served will accomplish two or more of the following outcomes: 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	65% of students (CANS not implemented)	N/A	75% of students	100% of students	75% of students	Not reported
Caregivers of individuals served with at least 3 or more counseling sessions will report overall satisfaction of services their child received	75% N=9	100% N=9	75%	100%	75%	Not reported
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 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	75% N=9	100% N=6	75%	100%	75%	Not reported
Parents/teachers of students (under age 11) receiving at least 3 sessions	65% of students	N/A	65% of students	85% of students	65% of students	Not reported

Outcomes: Sausalito Marin City School District Goals	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
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)	(CANS not implemented)					
Conduct home visits for students/caregivers identified through COST or administration	10	8	10	15	10	10+
Total referrals to County Behavioral Health (BHRS)	N/A	8	N/A	10	N/A	7
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	4	N/A	-	N/A	1
Total referrals to other mental health services or resources for basic needs	N/A	3	N/A	10	N/A	0

CHANGES FOR FY 2024-25: During the Fiscal Year 24-25, School-Based services will proceed as scheduled. However, it Is important to note that as of FY23/24 Petaluma Health Center no longer is contracted to provide services in the Shoreline Unified School District (West Marin). In FY22/23 a RFP was issued and awarded to North Marin Community Services. This shift aims to enhance the assessment and response to mental health needs within the district's school population, with a particular focus on Newcomer students.

With the exception of The Spahr Center, all other contracts and associated services will remain unchanged and proceed as originally planned. Effective as of February 16, 2024, The Spahr Center has announced the indefinite suspension of all programs due to ongoing financial challenges. Consequently, The Spahr Center will cease to provide School-Based services under PEI.

PROGRAM STORIES

Spahr Program Story:

In January 2023, we provided training to a local elementary school, and our reception was incredibly warm. Following the training, several staff members expressed their appreciation for the valuable insights we shared regarding legal responsibilities, addressing parent and family concerns, utilizing Spahr resources, and more.

Since our training session, the school has taken proactive steps towards creating an elementary school version of a GSA (gender-sexuality alliance). Additionally, they successfully organized their inaugural Pride Week, during which they invited us to conduct read-alouds and participate in their parade. Furthermore, the school's principal has expressed interest in arranging a follow-up training session for the next academic year.

Moreover, the principal actively participated in an educator panel that we co-hosted with the Marin County Office of Education, where they candidly shared their learning journey regarding LGBTQ+ student support. As a result of their commitment, the principal also requested LGBTQ+ inclusive books for the school library and classrooms. Thanks to separate funding, we were able to provide them with over 80 LGBTQ+ inclusive books.

NMCS – Novato High School Program Story:

A huge program success this year is the addition of the Dreamer's Club, which was added in an effort to ensure that newcomer, immigrant and Spanish speaking youth feel safe, welcome and connected on campus. Our Navigator/Specialty Youth Case Manager and has helped create this unique club. While we anticipated only 15 unduplicated NHS students may participate, this target was exceeded by 367% with 70 students attending! The group met weekly, participated in a variety of campus activities that newcomer/immigrant youth are typically not as engaged in as the student population, as a whole (such as homecoming, Wellness events, dances and other activities). They even partnered with the LINK Crew (a campus leadership group) to co-host a Friendsgiving event at Thanksgiving! This was designed to bring together Spanish and English-speaking youth in a way that had not previously occurred. Finally, the Dreamers Club raised funds to go on field trips and visit local parks.

Petaluma Health Center – A Community Response

Tragically, a student at Tomales high school died in a tragic car accident at the end of the school year. The school community was greatly impacted by this loss and in need of immediate support for students, staff, and families. The district was already lacking mental health support staff and having a difficult time meeting the need prior to the accident. The Wellness Coordinator, funded through county PEI funding, acted quickly, reaching out to all networks. By the time students returned to school, therapy dogs and grief support staff provided by MCOE, PHC, HHS, and SAY were scheduled for the remainder of the year. By the Bay Health provided a parent support night about grief. The community came together to support one another, and the therapy dogs provided much needed comfort and company during the most challenging time of the school year.

VETERANS COMMUNITY CONNECTION: PEI 19

SERVICE CATEGORY: OUTREACH

SB 1004 PRIORITY CATEGORIZATION: #2, #4, #6

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: Veterans experience mental health disorders, substance use disorders, post-traumatic stress, and traumatic brain injury at disproportionate rates compared to their civilian counterparts. While there are federal initiatives aimed at addressing this issue, there's also potential for impactful interventions at the local level to alleviate prolonged suffering and meet the demand for more intensive services. Beginning in FY2014-15, MHSA PEI initiated funding for the Marin County Veterans' Service Office, operating within the Department of Health and Human Services. This program offers supportive services for veterans dealing with mental illness through a part-time case manager. Its ongoing efforts involve outreach across the county, especially targeting unhoused veterans and those involved in the criminal justice system, to connect them with behavioral health and recovery services.

TARGET POPULATION: The target population is Marin County veterans who are unhoused or involved in the criminal justice system.

NUMBERS SERVED	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	**116**	**1**	**39**	**156**

KEY OUTCOMES:

- Linkage to appropriate services within the county, community, and the Department of Veteran's Affairs (VA)
- Increased number of veterans permanently housed
- Reduced prolonged suffering by increasing protective factors and reducing risk factors

MEASUREMENT TOOL(S): PEI client satisfaction survey, housing and referral data, and outreach logs.

FY 2022-23 OUTCOMES:

Outcomes: Marin County Veterans' Service Office	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Veterans will be permanently housed	N/A	N/A	N/A	14	N/A	17
Number of veterans that received support services to increase likelihood of completing the veteran's mental health treatment plan. (Average number of services: 8)	100	82	100	117	100	116
Number of family members that received services to increase their capacity to support the client	20	6	20	3	20	1

75% of veterans receiving support achieved at least one goal towards stability and recovery	75%	75%	75%	75%	75%	77%
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	91%	N/A	89%	N/A	77%
Total referrals to County Behavioral Health (BHRS)	N/A	0	N/A	2	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	2	N/A	0
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other PEI providers	N/A	0	N/A	3	N/A	1
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	Not reported	N/A	3	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	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other mental health services or resources for basic needs	N/A	80	N/A	77	N/A	92

CHANGES FOR FY 2024-25: In the upcoming fiscal year alternative funding will be explored to enhance support for veterans engaged in our Veterans Treatment Court. The strategy involves the addition of one full-time equivalent (FTE) staff member to facilitate case management, attend court hearings, and offer referrals to better serve participating veterans.

PROGRAM STORIES

Sarah*, a 74-year-old veteran with 24 years of service in the U.S. Army, was struggling with untreated schizophrenia. Adult protective services intervened, seeking assistance from veterans' services to facilitate her placement and connection to VA healthcare services, as well as a secure facility placement, given her severe disability. Our program played a pivotal role as part of the care coordination team, enabling her transfer from Marin General to the VA in Palo Alto for additional observation and treatment.

Rick*, an 81-year-old Vietnam veteran with an honorable discharge, was living homeless in his car in San Rafael. Through our case management program, we successfully registered him for VA healthcare services. Additionally, we facilitated the process of obtaining disability benefits for him. Ultimately, our efforts resulted in securing placement for Rick at the Veterans Home in Redding, California.

*Real names are not used, and any identifying information has been altered to protect the confidentiality of individuals' health information.

PEI STATEWIDE: PEI 20

SERVICE CATEGORY: STIGMA REDUCTION

SB 1004 PRIORITY CATEGORIZATION: #2

FY23-26 THREE-YEAR PLAN 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 Latine community, rural populations, and youth.

MEASUREMENT TOOL(S): CalMHSA-Each Mind Matters California and Marin County Impact Statements

OUTCOMES:

- Reduced Mental Illness Stigma and Increased Confidence to Intervene;
- Increased Knowledge and Improved Attitudes Toward Mental Illness;
- Increased capacity within counties to develop and implement comprehensive suicide prevention strategies.

FY 2022-23 ACTIVITIES:

In 23-23, funding to the PEI Project supported activities and programs such as:

- Expanding public awareness and education campaigns
- Creating new outreach materials for diverse audiences
- Providing technical assistance and outreach to county agencies, schools, and community-based organizations, including ongoing County liaison calls
- Providing mental health/stigma reduction/suicide prevention trainings to diverse audiences
- Engaging youth through Directing Change (September and May activities) and promotional content
- Building the capacities of schools to address mental health, stigma reduction, and suicide prevention
- Disseminating Take Action for Mental Health suite Toolkit, including May/Sept Toolkits and KTS Toolkits. Refer general public to Take Action and put the links on front facing communications
- Print outs and "swag" from the online store with bulk order discount
- Statewide Webinars (recordings provided)
- All communications are evaluated for best practices, effectiveness, equity and relatability
- Increased amount of in-print materials
- Support for one special project
- Building the capacities of schools to address mental health, stigma reduction, and suicide prevention. 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

In addition, CalMHSA highlighted Marin County Behavioral Health and Recovery Services (BHRS):

- Through participation in the state-wide Collaborative, BHRS staff members received support in the early efforts of suicide prevention 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.
- The Each Mind Matters (EMM) / Striving for Zero technical assistance (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 continues to provide as needed support and feedback regarding prevention, intervention or postvention supports, such as the development of the LOSS Team or evaluation.

LEARNING COLLABORATIVES AND TECHNICAL ASSISTANCE:

Each Mind Matters/Striving for Zero Learning Collaboratives: The Learning Collaborative utilizes a public health approach to suicide prevention and has supported more than 20 county teams (including Marin) in creating strategic plans for suicide prevention using national models aligning with the California Strategic Plan for Suicide Prevention. Support has been provided through a combination of online learning modules and individual technical assistance.

CalMHSA 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 **22/23**, the TA team provided five+ modules for Collaborative members across the state.

The BHRS Prevention Team has also presented to the state-wide Collaborative on the development of the Men and Boys Action Team and the Redefining Strength campaign, as well as the Caring Card Initiative which promotes connection to resources as part of a follow up process after discharge from treatment and recovery programs or psychiatric settings.

In addition, in **FY 22/23**, local schools (San Marin High, SR Terra Linda, Novato High School, Sinaloa, San Jose Middle School) 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. Ongoing partnership with Marin County Office of Education and local CBO's allow the county to created shared language and understanding by utilizing materials from the Learning Collaborative, and developing activities that are coordinated and aligned for the school and broader community.

CHANGES FOR FY 2024-25:

Marin has decided to discontinue its involvement in PEI statewide initiatives with CalMHSA due to diminished interest from school partners. Additionally, the complexity of administering and accessing funds has hindered the efficient implementation of PEI projects within the community. While the initiatives "swag" produced is incredible, the costs were very high for the products.

SUICIDE PREVENTION: PEI 21

SERVICE CATEGORY: SUICIDE PREVENTION

SB 1004 PRIORITY CATEGORIZATION: #2, #3, #4, #5

MARIN PEI PRIORITY STRATEGY AREA: School-based Mental Health and Psychoeducation; Older Adult Supports and Connections

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: In January of 2020, Marin County released its Suicide Prevention Strategic Plan. BHRS hired a full-time Suicide Prevention Coordinator to coordinate all aspects of the strategic plan implementation.

Funding under Suicide Prevention will continue to fund Buckelew's North Bay Suicide Prevention Program which provides the 988 Suicide and Crisis Lifeline 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 for those at disproportionate risk of suicides as well as support groups (attempt survivors).

The postvention strategy supports the implementation of a suicide loss survivor outreach model (e.g. LOSS Team) and access to support groups for youth and adult loss survivors.

Expansion for the Suicide Prevention program will include additional funding for current suicide community partners including 988 to support Lifeline services and for Felton/LOSS team to support outreach efforts and implementation of support groups.

TARGET POPULATION: All residents of Marin County including veterans, middle-aged and older adults, LGBTQ+ and other residents at disproportionate risk for suicide; community-based organizations, school districts and county partners.

NUMBERS SERVED	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	437+38	112	931	1,480

KEY OUTCOMES:

- Reduce suicide attempts and deaths in Marin County by:
  - Improving timely access to supports and services for individuals at risk of suicide, with targeted efforts for groups that are disproportionately affected by suicide;
  - Strengthening protective factors including building community connection and reducing stigma around discussing or seeking help for thoughts of suicide, mental health, or substance use issues;
  - Preparing individuals, communities, and organizations to recognize warning signs for suicide and confidence to intervene when someone is at risk.

MEASUREMENT TOOL(S): For community trainings, we will use the CIBHS Measurements, Outcomes, and Quality Assessment (MOQA) participant questionnaire. Additional tools to be developed in support of comprehensive evaluation in FY23/24.

FY 2022-23 OUTCOMES:

Buckelew: Buckelew's North Bay Suicide Prevention Program provides the 988 Suicide & Crisis Lifeline for Marin, Sonoma, Mendocino and Lake Counties. The Lifeline 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. In addition, Buckelew hosts twice/monthly Allies of Hope Support Group for loss survivors and provides community outreach, education and training to community partners and schools.

Outcomes: Buckelew	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21	Goal FY 22/23	Actual FY 22/23
Calls to hotline originating in Marin County	6,000	5,361	5,000	3,807	5,000	4,535
Callers who express a reduction in level of suicidal risk by 1 level or maintain Low (Low, Medium, High)	80%	82% (N=428)	N/A	Not reported	N/A	Not reported
Offer **SOS** groups to at least 20 unduplicated individuals	6 groups	21 groups	12 groups	24 groups	12 groups 20 individuals	17 groups 36 individuals
Agencies receiving suicide prevention campaign materials	50	37	50	20+	50	109
Provide training and education in the community	30	15	8	6	5	8
Community members receiving training that report they can describe suicide warning signs (agree/strongly agree)	50%	100% (N=229)	50%	N/A	50%	Not reported
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%	93% (N=229)	50%	N/A	50%	Not reported
Community members receiving training that can describe the work of Buckelew Suicide Prevention Hotline and Program (agree/strongly agree)	50%	93% (N=229)	50%	N/A	50%	Not reported
Training participants that would recommend the training to a friend or loved one (agree/strongly agree)	50%	96% (N=229)	50%	N/A	50%	Not reported
Total referrals to County Behavioral Health (BHRS)	N/A	68	N/A	17	N/A	40

Total referrals to other PEI providers	N/A	2	N/A	15	N/A	2
Total referrals to other mental health services or resources for basic needs	N/A	19	N/A	63	N/A	10

Felton Institute (LOSS): Felton Local Outreach for Survivors of Suicide (LOSS) Team offers a vital postvention service for those who have lost someone to suicide with immediate assistance. The LOSS Team is comprised of other survivors of suicide who serve as a guidepost for the newly bereaved in their process of grief and recovery and provides resources, support, connection, and understanding immediately after a suicide loss. In addition to the LOSS Team, Felton provides support groups for youth and young adults and attempt survivors.

Outcomes: Felton Institute	Goal FY 19/20	Actual FY 19/20	Goal FY 20/21	Actual FY 20/21	Goal FY 22/23	Actual FY 22/23
Maintain volunteers with lived experience as a loss survivor span the spectrums of race, religion, age, gender, ethnicity, race, socio-economic and cultural backgrounds, etc.	N/A	N/A	20-25	7	20-25	17
Volunteers will report satisfaction of training as good or very good. Volunteers must demonstrate increased knowledge and confidence in family visits before active outreach with bereaved.	N/A	N/A	80%	86%	80%	80%
Distribute electronic/paper outreach materials that reflect the cultural/linguistic needs of the community to at least 20	N/A	N/A	20	20	20 organizations	50 organizations

organizations who work with or offer any services to attempt survivors and/or loss survivors across Marin County						
At least one After Care kit will be provided to families bereaved by suicide to increase family/individual awareness of supports and resources	N/A	N/A	100%	1	100%	112
Families or individuals will be outreached by phone in days following aftermath within 48 hours of notification	N/A	N/A	100% contacted 85% reached	1 family was contacted	100% contacted 85% reached	100% of 34 families served were contacted by phone in
Provide youth loss survivors support group. Engage 20 unduplicated participants.	N/A	N/A	90%	0	20	0
Provide adult attempt survivor group. Engage 20 unduplicated participants.	N/A	N/A	20	0	20 unduplicated participants	2 participants currently engaged for groups starting 8/2023

CHANGES FOR FY 2024-25: There are no changes to report.

PROGRAM STORIES

Buckelew

Anna* called our hotline feeling lonely and expressing suicidal thoughts and feelings. She rated her intent to harm herself as level 3. Throughout the conversation, Anna revealed that she had contemplated a plan for suicide but did not have immediate access to the means. The hotline counselor was able to establish a connection with Anna and helped her identify aspects of her life that she values. Together, they worked on developing a safety plan. By the end of the call, Anna had lowered her self-rated intent from a 3 to a 2.

Felton

Our team met with a woman who experienced the sudden loss of her husband. Despite being in shock, she displayed high levels of functioning. She and her son resided in the same house where the death occurred. We provided her with our aftercare guide and spent some time visiting her at home. A few days later, she reached out by phone to inform us that she had utilized one of the resources included in the Aftercare guide to help her articulate her husband's loss to her clients and friends, which proved to be beneficial. She also expressed her intention to explore the Allies of Hope Survivors group. Following up with the program coordinator, we confirmed that she indeed attended a meeting. This aligns with the goals of our program, aiming to alleviate some of the anxiety, pain, and suffering associated with suicide by offering practical resources and fostering connections with other survivors.

*Real names are not used, and any identifying information has been altered to protect the confidentiality of individuals' health information.

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): School-based Mental Health and Psychoeducation; Latine Early Intervention

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: This program is aimed at newly arrived immigrant youth, primarily attending middle and high schools in San Rafael, Novato, and West Marin. Following a multi-tiered systems of support (MTSS) framework, the program is structured to assist these young individuals in navigating school and community resources, while also accessing academic, legal, and mental health assistance. The interventions are geared towards leveraging their strengths and resilience to foster success in both their academic endeavors and beyond.

Newcomer coordinators are tasked with conducting assessments, linking students to resources, and providing short-term case management at San Rafael middle and secondary schools as well as Novato Schools. Additionally, these coordinators offer training sessions for school staff to help them understand the unique needs of this population and to support their academic and social-emotional development effectively. The program addresses various issues such as grief, loss, acculturation, and the establishment of resources and support systems.

There is a particular focus on community outreach at a specific San Rafael middle school. This involves organizing parent workshops and holiday gatherings, which serve to involve other non-PEI community organizations, thereby enriching the available resources for both youth and their families.

Additional funding for newcomers expands and strengthens coordination efforts among school, county, and community-based organization partners. This, in turn, enhances the accessibility of services for immigrant youth and their families.

TARGET POPULATION: Recently arrived immigrant youth in Marin County schools.

NUMBERS SERVED:

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	**340**	**91**	**1036**	**1467**

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;
- Increased service integration, more effective linkage to/engagement with school and community resources for newcomers.

MEASUREMENT TOOL(S): Baseline data on attendance, discipline and school connectedness will be collected and analyzed to evaluate impact overtime. PEI caregiver and client satisfaction surveys, workshop/training surveys will also be utilized. Staff interviews/surveys regarding Newcomers Toolkit implementation.

FY 2022-23 OUTCOMES:

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	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
EL Level 1 and 2 students will receive information about the Newcomer Workshops (via attendance at classes, ELAC and newcomer parent meetings, etc.)	100%	100%	100%	100%	100%	100%
Students will participate in Newcomer Workshops at Novato High Schools.	50-60 Students	58	75	114	100	106
Individuals served will report overall satisfaction with received.	75%	93% N=39	75%	100% N=60	75%	Not reported
Total referrals to County Behavioral Health (BHRS)	N/A	9	N/A	6	N/A	5
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	3
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other PEI providers	N/A	10	N/A	7	N/A	12
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	7	N/A	6	N/A	9
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	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other mental health services or resources for basic needs	N/A	12	N/A	10	N/A	7

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	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Students at San Rafael and Terra Linda High Schools will engage in one of 8 groups that are offered throughout the school year	75 students 8 groups	31 students 8 groups	65 students 8 groups	107 students 8 groups	115 students 8 groups	115 students 13 groups
Individuals served will report overall satisfaction with services received	75%	72%	75%	100%	75%	90.1%
Youth trained through "Nuestra Salud" initiative	15	15	15	23	15	18
Youth served through outreach events	N/A	100	N/A	0	N/A	Not reported
Total referrals to County Behavioral Health (BHRS)	N/A	0	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	Not reported	N/A	Not reported	N/A	Not reported
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other PEI providers	N/A	15	N/A	0	N/A	0
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	15	N/A	0	N/A	Not reported
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	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other mental health services or resources for basic needs	N/A	2	N/A	0	N/A	0

Canal Alliance PEI Newcomers contract provides annual reunification group, *Lazos Familiares,* 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	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
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	N/A	N/A	N/A	N/A
Serve approximately 6 to 8 families with 2-8 members per family.	N/A	N/A	6-8 Families & 2-8 family members	14 families with 2-5 family members	6-8 Families & 2-8 family members	10 families with 2-8 family members
Total referrals to County Behavioral Health (BHRS)	N/A	0	N/A	5	N/A	0
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	Not reported	N/A	Not reported	N/A	Not reported
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Not reported	N/A	26-52 weeks	N/A	13-26 weeks
Total referrals to other PEI providers	N/A	0	N/A	6	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 program and the individual's first in-person appointment with the PEI funded provider	N/A	151	N/A	Not reported	N/A	2 weeks
Total referrals to other mental health services or resources for basic needs	N/A	12	N/A	6	N/A	4

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	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
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	N/A	N/A	N/A	N/A
By the end of the school year the newcomer youth and their families will have completed 2 sessions to learn about how to cope with stress, recognize signs of substance abuse and the health and legal consequences of using substances	50%	48%	50%	50%	50%	100%
By the end of the school year, newcomer students will participate in cultural circles with former newcomer students	50%	20%	75%	82%	75%	74%
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%	64%	60%	75%	60%	67%
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%	33%	50%	70%	50%	72%
By the end of the school year **teachers** working with Newcomers will have completed at least 2 of the training offerings	75%	75%	75%	0%	75%	100%
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%	75%	75%	84%	75%	100%
Total referrals to County Behavioral Health (BHRS)	N/A	23	N/A	20	N/A	5
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	0	N/A	2	N/A	1
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other PEI providers	N/A	2	N/A	2	N/A	0

Outcomes: Bay Area Community Resources	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	2	N/A	1	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	Not reported	N/A	1	N/A	Not reported
Total referrals to other mental health services or resources for basic needs	N/A	154	N /A	78	N/A	227

CHANGES FOR FY 2024-25: There are no changes to report.

PROGRAM STORIES

North Marin Community Services

This is the story of a 17-year-old Latine student who attended our Newcomer workshops. After completing the 8-week workshop, we conducted one-on-one assessments with participants. During the assessment with this student, our Youth Wellness Coordinator noticed areas of concern and connected them with NMCS case management services and a school-based mental health clinician. Our Newcomers staff facilitated a smooth transition to these services. The youth wellness coordinator stayed involved, coordinating care with other providers. With the support of wraparound services, the student found hope and began their senior year successfully. Our Newcomers program conducts needs assessments and referrals for students, ensuring ongoing support through routine check-ins.

Huckleberry Youth Programs

*Sara, a rising Junior at a local high school, was actively involved in both ACE Academy and the Nuestra Salud newcomers program. Despite initially being reserved and quiet, she emerged as a strong facilitator and peer health educator during her second year in Nuestra Salud. Sara consistently contributed valuable insights and demonstrated critical thinking skills during program sessions, showcasing significant growth overall.

Bay Area Community Resources

At our school, we encounter newcomer students with very low Spanish literacy skills. This year, our Newcomer Family Services Specialist (NFS) advocated for a Spanish literacy class to address this need. In March 2023, we began sessions 2 to 3 times a week, serving 19 newcomer students referred by their English Language Development teachers. NFS played a crucial role in coordinating the program, including identifying a facilitator, obtaining principal approval, coordinating assessment placement, securing session space, and facilitating communication between ELD teachers, facilitators, and administrators. With grant funding, we provided incentives to keep students engaged. This collaborative effort involved administrators, staff, and ELD teachers working together to lay a literacy foundation for these students, enhancing their opportunities upon entering the ELD program. As a result, participants developed basic

literacy skills, showed improved attendance, improved self-confidence, and were excited to make progress academically. Moving forward, the school principal plans to assign a permanent teacher for the Spanish literacy class in the upcoming school year.

*Real names are not used, and any identifying information has been altered to protect the confidentiality of individuals' health information.

STORYTELLING PROGRAMS: PEI 24

SERVICE CATEGORY: STIGMA REDUCTION

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

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: Marin County Storytelling Program is designed to raise awareness of mental health, suicidality and substance use, create safe and healthy environments for sharing and increase knowledge of community resources. In May of 2019, The National Alliance on Mental Illness (NAMI)-Marin was awarded a contract to expand their "In Our Own Voices" storytelling series. This series includes the training of speakers with lived experience to share their own story and experience in a welcome and accepting environment. The structure of the program allows for audience and participants to follow life journeys in which storytellers come to have insight about their illness and environment, sought help, and were on the road to recovery. The storytellers also share their coping strategies, care networks, and grounding techniques. NAMI storytellers range in age, gender, race, occupation, and health challenge. The program is designed to create healthy environments of compassion, kindness, respect, non-judgment, and support.

TARGET POPULATION: Community members and those with lived mental health, suicidality, and/or substance use experiences.

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 22/23	-	-	522	522

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.

MEASUREMENT TOOL(S): For community trainings, we will use the CIBHS Measurements, Outcomes, and Quality Assessment (MOQA) participant questionnaire, speakers' evaluations to measure skill development and satisfaction with training component of program.

FY 2022-23 OUTCOMES:

NAMI-Marin

The "In Our Own Voices" (IOOV) program, part of the National Alliance on Mental Illness (NAMI)-Marin, is a storytelling series aimed at fostering environments of compassion, kindness, respect, non-judgment, and support. This unique public education initiative features trained speakers sharing their personal journeys of living with mental illness and finding pathways to recovery. IOOV presentations are

delivered to diverse audiences, including students, law enforcement officials, hospitals, educators, healthcare providers, members of faith communities, and other interested civic groups.

Outcomes: NAMI-Marin	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Recruit speakers through outreach and engagement	8	8	8	9	10	15
Train speakers in the Speaker Training "In Our Own Voice". Improve skills and comfort level amongst speakers in public speaking and sharing their stories	5	5	5	9	10	15
Complete a minimum of 4 hours of training annually to stay abreast of new learning regarding cultural humility, racial equity and trauma-informed practices	4 hours	4 hours	4 hours	6 hours	4 hours	6 hours

Opening the World

The Opening the World (OTW) program works with marginalized transitional age youth (ages 16 to 26) from diverse cultural backgrounds who have encountered various challenges such as trauma, conflicts in relationships, loss, substance abuse, homelessness, educational obstacles, and poverty. Through OTW, these young adults are paired with peers who have faced similar hardships but have overcome them, allowing them to share stories of struggle, hope, growth, and success.

Participants in the program also receive training in film techniques, enabling them to create short film clips (ranging from one to four minutes) that raise awareness about mental health issues and their impact on the community. Each video is accompanied by relevant resources and a survey for feedback. The completed videos are accessible on the Opening the World website.

Outcomes: Opening the World	Goal FY 20/21	Actual FY 20/21	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23
Instruct two youth interns to develop short film clips on mental health	2	2	2	2	2	2
Develop 6-8 short film clips	6	6	6	6	6	6
By the end of the year, recruit speakers through outreach and engagement	8	8	6	6	6	6
Complete a minimum of 4 hours of training annually to stay abreast of new learning regarding cultural humility, racial equity and trauma-informed practices	4	4	4	4	4	4

CHANGES FOR FY 2024-25

No changes to report for upcoming FY 2024-25

PROGRAM STORY

A Storytelling Workshop participant with lived experience expressed how helpful this program has been in feeling more confident and empowered talking openly about their experiences with mental illness. This participant expressed excitement at being part of our Speaker's Bureau, and at the opportunity to discuss not only what was helpful for them during their recovery, but also the juxtaposition of their experience with those that might face even more barriers through intersectionality. This participant noted that the accessibility of this program was particularly valuable, stating that the free access to this resource was "one of the single most additionally healing aspects" as much of their life has been dictated by access or lack thereof to mental health resources. In a response to a feedback survey the participant expressed that the workshop changed their life for the better, allowing them to embrace who they are and feel a renewed sense of importance to share their experiences with others.

PEI COMPONENT BUDGET

Program	FY2023-24	FY2024-25	FY2025-26	% of budget for youth	FY24-25 Budget to be spent on youth 25 and under	Total
PEI-01 Early Childhood Mental Health Consultation ECMH	$453,000	$453,000	$453,000	100%	$453,000	$1,359,000
PEI-04 Transition Age Youth (TAY) PEI	$470,500	$397,000	$397,000	100%	$397,000	$1,264,500
PEI-05 Latino Community Connection	$642,170	$642,170	$642,170	11%	$70,639	$1,926,511
PEI-07 Older Adult PEI	$320,050	$292,000	$292,000	0%	$0	$904,050
PEI-12 Community Training and Supports	$127,700	$109,000	$109,000	46%	$50,140	$345,700
PEI-18 School Age PEI	$934,622	$879,952	$879,952	100%	$879,952	$2,694,527
PEI-19 Veteran's Community Connection	$76,650	$56,650	$56,650	8%	$4,532	$189,950
PEI-20 Statewide PEI	$81,000	$0	$0	58%	$0	$81,000
PEI-21 Suicide Prevention	$594,151	$583,141	$583,141	40%	$233,256	$1,760,433
PEI-23 Newcomer Supports	$319,438	$316,146	$316,146	100%	$316,146	$951,729
PEI-24 Storytelling programs	$63,000	$63,000	$63,000	40%	$25,200	$189,000
Subtotal Direct Services	**$4,082,281**	**$3,792,059**	**$3,792,059**	**59.5%**	**$2,429,865**	**$11,666,400**
PEI Coordination, Evaluation, and Community Engagement	$127,100	$154,100	$154,100			$435,300
Administration and Indirect	$631,404	$591,924	$591,924			$1,815,252
Total	**$4,840,786**	**$4,538,083**	**$4,538,083**	**50.2%**		**$13,916,952**

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, ended December 2023 and FY22/23 outcomes 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

PROGRAM OVERVIEW

PROJECT DATES: January 1, 2019- December 31, 2023

PROJECT BUDGET: $1,580,000 over 5 years. Project concluded in the middle of FY 23/24.

PROJECT APPROVAL: The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the original project in September of 2018.

PROJECT DESCRIPTION: 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. 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 was 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:

- 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 primarily language spoken is Spanish

ESTIMATED NUMBERS TO BE SERVED: 200

LEARNING GOALS:

- What changes do older adults report in their sense of social connectedness due to participation in this program?
- What changes do older adults report in their sense of health and well-being due to participation in this program?
- Are there changes in the attitudes towards digital health tools/technology after digital literacy training?
- What are the most effective strategies for recruitment of older adults within the county?
- What is the motivation to participate in the pilot and the program?

UPCOMING PROJECT CHANGES:

The Help@Hand project in Marin is winding down in the first half of the FY 23/24. For the remainder of the project, Marin County is shifting its focus from the initial application focused collaborative initiative to a grants program that will give time-limited to local organizations through a Request for Proposal (RFP) process. The purpose of these grants will be for organizations to incorporate a digital component to increase access to wellness supports, program, and or community event with an emphasis on supporting digital literacy and promoting access for older adults in the community who may not otherwise have access.

FY22/23 OUTCOMES:

A Request for Proposal (RFP) was issued in May 2023 and seven grantees were selected. The selected organizations were chosen because they collaborate closely with their respective communities, employ a multifaceted approach to building digital literacy among older adults. Workshops, individual sessions, informative videos, and digital literacy websites collectively serve to empower older adults with essential technological skills. Learning opportunities delivered through both in-person and virtual sessions, ensure accessibility and inclusivity for all.

Marin's Peer facilitated English and Spanish digital literacy workshops and individual technology sessions for older adults in the community. The sessions were recovery-oriented, culturally appropriate services that promote engagement, socialization, self-sufficiency, and self-advocacy through trauma informed support. The Peer designed and planned 13 digital literacy workshops. She worked directly on site with two community partners, Marin City Community Development Corporation and Enterprise Resource Center.

Both the Peer and the subgrants made significant strides in promoting mental health wellness among English and Spanish-speaking adults aged 65 and over. These individuals were offered increased access to mental health services through improved digital literacy. The result is that many older adults have experienced increased feelings of connection with family and their community and discovered new opportunities to continue growing as individuals. These successes will continue to spread through the effort of our subgrantees.

- Older adults were served nearly 1,500 times (duplicated count)
- Over 700 sessions were offered
- Over 1,000 hours of services

Participants experienced a significant increase in their comfort with technology after the digital literacy sessions. Grantees reported a 160% increase in the percent of people who said they were somewhat or very comfortable in their use of technology. Before the sessions 41-60% of participants felt somewhat or very comfortable with technology. After services, that percentage rose a full quintile to 61-80%.

Participants are more capable of accessing telehealth, addressing health concerns, receiving aid for depression, loneliness, anxiety, or boredom, reading the news, articles, blogs, or books, and even discovering employment opportunities.

Overall, the participants appreciated the services with nearly 100% being willing to recommend the program.

One participant shared how much the program meant "So so helpful, like life-saving help, when drowning in ignorance and going down deeper in complicated technology. I want to learn so much and have. Thank you so much from my heart."

CHANGES FOR FY 2024-25: This program ended December 2023.

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

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

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

EXPANDED PROJECT BUDGET TOTAL: $2,355,300 (No changes in project dates). The extension adds $560,300 of additional funding (average of $140,075 per year for the final 4 years of the project)

PROJECT APPROVAL: The Mental Health Services Oversight and Accountability Commission (MHSOAC) approved the original project on May 27, 2021. The Marin County Board of Supervisors approved this project on June 8, 2021. The project expansion was approved by the Marin County Board of Supervisors on March 28, 2023.

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 promotes 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 includes 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 is 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 is 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 begin prior to residency at the house—as part of their re-entry planning, the trauma therapist works 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 focuses on actively resisting re-traumatization and supporting the women to remain engaged with the trauma healing after they move on from living in the house. Women do not graduate from this supportive housing environment without housing and ongoing support in place. When women do leave, they can 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 is 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 is managed in a Trauma Informed way and she is not 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 are utilized. The woman

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 is a holistic approach, including strong coordination with other service providers throughout Health and Human Services and the community including substance use treatment. Nutrition is 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.

With the project expansion, there are no changes to the target population.

ESTIMATED NUMBERS TO BE SERVED: It is estimated that there would be 8 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, 16 women would be served, year three 24 women would be served, year four there would be 32 women served, and year five there would be 40 women served. In addition, by year 5, another 100 individuals would be offered somatic or alternative therapy programs that that the women in the house and alumni recommend. In all, approximately 140 individuals would be served, with a projected 40 women having resided in the house. Since its opening in 2022, the Carmelita House has served a total of 13 residents and is currently housing seven women, including the peer support specialist. Over the past year, two beds were added, increasing Carmelita's capacity to eight beds. Of the 13 residents served, six were women of color: two identified as Black, African American or African, three as multiracial, and one as Guatemalan. Six additional women identified as non-Hispanic White, and one as White Hispanic/Latina. Two women identified as Bisexual, and two as queer.

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?
- How can we spread the learnings throughout the Behavioral Health and homelessness systems of care? (New with Project Expansion)
- Is the *Housing to Healing* approach Cost effective as compared to expected costs without this intervention?

UPCOMING PROJECT CHANGES: While the essence and structure of this project has not changed since its inception, based on initial learnings, a few changes were made in 2023 to strengthen the program for existing clients and expand the program's overall reach. In March 2023, additional funding was granted to expand the number of women served and enhance the learning around how to best spread what is being learned through this project throughout our systems of care. The reasons for implementing this expansion in 2023 were twofold: First, the community that was being built at "Carmelita House" (the name for the Housing to Healing residence) in the first 9 months of the project far exceed expectations but was also leaving many of the women feeling trepidation about their transition to long-term housing. In addition, many other women in the community were still cycling through homelessness and incarceration and eager to partake in this project. Second, which is very closely tied to the first reason, is that we are hoping to speed up the additional focus on the stated learning goal around how to spread the key learnings from this innovation project throughout our behavioral health and homelessness systems of care. This expansion will help reshape the systems into places these women—and everyone else—can get that desire for connection addressed, allowing them to feel confident in leaving Carmelita House to their next step.

The expanded funding will be used in the following ways for the duration of the project:

- **Expanding the number of women served in the house** (increasing from 6 to 8 residents at a time): The organization we selected to operate the housing component of the From *Housing to Healing* project has the capacity for additional bedrooms to accommodate other women in the community ready for this healing centered intervention.

- **Increasing the support for women to transition out of the house and retain that critical sense of community** (by adding a stipended alumnae peer position): Currently we have a stipended peer resident ($750 per month in addition to housing). Through this expansion, we will establish a second stipended peer position ($750/month) for a former resident to focus on supporting Carmelita alumnae in bringing them back for weekly dinners, events, and groups and building that support network for women who have transitioned to their next place of residence, helping alleviate the fear many women are expressing in leaving Carmelita House. These alumnae will also help share their success stories with the current residents helping them see opportunities for connection and community after leaving the house as well.

- **Expanding learnings more widely throughout the behavioral health and homelessness systems of care** (*Seeds of Hope—1.0 FTE* peer specialist position): The third portion of funding for the expansion will be focused on expanding the learning throughout the systems of care through what we are calling "Seeds of Hope". This will involve funding one full-time or two-part time peer leader positions who would help build the pipeline of peer leaders/staff by reaching out to peers interested in giving back and mentoring them in peer leadership and potentially peer certification to help build and spread community building. In addition, the peer leaders will identify, publicize, and create opportunities for social connection based on the desires of this community. One of the focuses of these peers will be for building this social fabric and workforce pipeline to those in our recently established and upcoming supportive housing programs (where many of the Carmelita residents may eventually move), those living on the streets, those at Carmelita House, and those who have been homeless but are now housed independently Local data has shown that the first six months of independent housing for many individuals who have been chronically homeless can be the most vulnerable due to a loss of that sense of community that can be found in places like an encampment or Carmelita house.

- **Expanding the Evaluation Scope:** We have increased the evaluation budget by $20,000 to evaluate the more expansive focus on spreading the learnings throughout the system of care through "Seeds of Hope."

CHANGES FOR FY 24/25: None.

FY 22/23 EVALUATION: The following pages are from a report prepared by the independent Evaluation consultant, Impact Justice, contracted to evaluate this Innovation project.

Evaluation Contractor: IMPACT JUSTICE

Impact Justice is a national innovation and resource center committed to reducing the number of people involved in US criminal justice systems, improving conditions for those who remain incarcerated, providing meaningful opportunities for successful re-entry, and attending to crime victims' needs. Home to some of the foremost leaders in juvenile justice, violence prevention, research and evaluation, restorative justice, and youth development, Impact Justice provides an array of technical assistance to criminal justice and community stakeholders. For more information, please visit www.ImpactJustice.org

THE RESEARCH AND ACTION CENTER

This report falls under the purview of the Research and Action Center. As a Center of Impact Justice, our research catalyzes community efforts to eliminate disparities and propel system change. We focus especially on the populations most impacted by disparities, including youth and adults of color, as well as members of the LGBQ/GNCT communities. That's why we partner with community service providers, government agencies, and key stakeholders across the country to research, evaluate, and support implementation of the most effective and innovative practices.

Kiara Sample
Senior Research Analyst, Research & Action Center

Findings from Year 2 of Implementation

DATA COLLECTION METHODOLOGY

To document and assess program outcomes, the evaluation team utilized administrative data collected by Carmelita House staff, surveys, and in-depth interviews. Surveys administered in January of 2024 by Carmelita staff were designed to assess self-efficacy using the Self-Efficacy for Personal Recovery Scale (SEPRS)1 and Coping Self-Efficacy Scale (CSE)2, sense of safety using the Neuroception of Psychological Safety Scale (NPSS)3, as well as belonging and social inclusion using the Social and Community Opportunities Profile (SCOPE).4 We received completed surveys from 4 of the 6 current residents (66%) and conducted interviews with all 6 residents, the peer support specialist resident, the full-time onsite therapist, house manager, and MSW intern. Survey data was entered into Excel workbooks for analysis and interviews were coded for themes. In person interviews were conducted with all six residents, the peer support specialist, and Carmelita House staff in February of 2024. Interview questions focused on evaluating the experience of living in Carmelita house, and the impact of the somatic-centered therapeutic practices.

We received feedback on the surveys indicating that residents found some questions confusing to answer, and consistent distribution every six months was challenging. Moving forward, Impact Justice will collaborate with the house manager and therapist to refine data collection tools that better align with Carmelita House's holistic healing approach and can be seamlessly integrated into daily routines and programming. For this report, the interviews and qualitative analysis offer an overview of Carmelita House's structure, programming, and impact.

DEMOGRAPHICS AND CARMELITA HOUSE CAPACITY

Since its opening in 2022, the Carmelita House has served a total of 13 residents and is currently housing seven women, including the peer support specialist. Over the past year, two beds were added, increasing Carmelita's capacity to eight beds. Of the 13 residents served, six were women of color: two identified as Black, African American or African, three as multiracial, and one as Guatemalan. Six additional women identified as non-Hispanic White, and one as White Hispanic/Latina. Two women identified as Bisexual, and two as queer.

All the residents have extensive histories of struggles with mental health, substance use, and trauma which means Carmelita House is effectively serving their target population: women at the highest risk of ongoing mental and behavioral health struggles, and who are also at high risk for homelessness.

Entrances and Exits

Since its opening, Carmelita House has seen a total of 10 individuals enter and exit the program. For those who exited the program, the length of stay ranged from one month to one and a half years, with 6 months being the average length of stay for those who exited the program. Reasons for leaving Carmelita House vary, including substance use, voluntary departure, and arrest. One resident successfully graduated out of the program and transitioned into stable housing. Unfortunately, one resident tragically committed suicide during the process of transitioning to stable housing after receiving a voucher.

Table 1. Exits and Entrances of Carmelita Residents 2022-2024

Enrollment Status	# of Residents
Exited	7
Exited and returned	3

Table 2. Current Resident Length of Stay

Length of Stay	# of residents
Less than 6 months	1
6 months	2
1 year or more	3

COMMON THEMES FROM SURVEYS & INTERVIEWS

Why Carmelita House

Residents were drawn to Carmelita House for various reasons, including the trauma-centered approach, onsite counseling, group activities, gym membership, location, and need for housing. Initially, some residents were apprehensive but became excited after seeing the welcoming environment.

After moving in, residents found Carmelita House exceeded their expectations. They appreciated the supportive environment and the caring staff. Over time, they became more comfortable and engaged with the program. Through activities like tours, family-style dinners, and introductions, most residents felt welcomed by staff and other residents. Challenges during the initial days included the distance to stores and the probationary period requiring a buddy for outings.

Residents suggested having direct welcome groups to facilitate introductions and encourage interaction among new residents. They also proposed encouraging new residents to bring friends or family for additional support during tours to establish Carmelita as also connected to their support system outside the house.

Daily Routine and Therapeutic Programming

Residents described their typical days at Carmelita House as structured yet flexible. They engage in various activities such as group sessions, walks, cooking classes, and outings to the store. Meals are often communal, and evenings may include movie nights or engaging in personal hobbies like reading or watching TV. They follow a structured daily routine with morning groups, therapy sessions, walks and evening activities such as cooking classes, sewing, yoga, and AA meetings. Activities are announced in morning groups. The daily schedule is written on a whiteboard in a common space, and residents are given planners.

Residents participate in a wide range of activities, including yoga, creative writing, acupuncture, and cooking classes. Their top-rated activities include massage therapy, cooking, and NADA acupuncture. Some expressed excitement about future excursions like visiting the farmer's market and suggested group trips to the gym. However, certain activities, like breathwork exercises, are avoided by some due to personal limitations. The flexibility of the programming allows residents to exercise autonomy and decline activities that don't resonate with them.

Somatic-centered therapeutic programming is a key focus of Carmelita House programming. The onsite therapist has incorporated acupuncture into the therapeutic programming at Carmelita House, and it has been a form of healing widely embraced by residents. The sessions are facilitated by the onsite therapist who has over a decade of experience offering acupuncture in group contexts. The acupuncture

protocol implemented draws from the NADA (National Acupuncture Detoxification Association) technique, involving the insertion of five small needles into specific points in the outer ear.

"…one of their favorite interventions, and I think a lot of that is because it doesn't involve them having to, it's very passive….they just have to receive it...The lives the women live here is very busy, always taking appointments, and acupuncture is the main activity where they don't have to do any work." - Staff

Even those who entered with hesitation frequently found themselves becoming "more open" as sessions unfolded. With 90% of residents eagerly partaking, residents reported the experience evoked a sense of "strength and silence," allowing them to enter a state of stillness and inward focus aided by soft music or reading materials during the session. The sessions represented a chance to simply receive and allow themselves to wholly relax without any additional effort required. The physiological and psychological impacts described by residents highlighted acupuncture's capacity for inducing a calm, focused state. Many articulated feelings of relaxation, both mental and physical, with observed benefits like reduced cravings and anger. For some, the sessions facilitate a profound inward journey, cultivating greater self-compassion, peace and ability to inhabit safer emotional zones. Residents widely characterized the experience as soothing and grounding.

While generally positive, a few residents mentioned adverse effects like dizziness, discomfort, or an overwhelming sense of sleepiness that could linger for an extended period after the session. However, these responses were outnumbered by depictions of acupuncture as "very relaxing" and even "life-changing" in gaining a sense of self-control and guidance. This aligns with Carmelita House's trauma-informed approach, providing a safe space for residents to mindfully inhabit their bodies through guided somatic experiences within a supportive community.

"I feel calm. 'cause sometimes, ever since getting sober, I find myself a little angry because I actually have to confront my feelings now…but I just feel calm and I think that maybe they help with my cravings a little bit.."- Resident

BENEFITS OF HUMAN CENTERED PRACTICES

Open-door Policy

Carmelita House sets itself apart from similar programs with its open-door policy and flexible timeline. This means that if a resident must leave due to substance use or breaking an "immediate denial of service" rule, they are given multiple opportunities to return to the house after taking the necessary steps to stabilize themselves. Typically, this involves going through a substance use treatment program or working with their recovery coach. The current system of accountability is a 30-day period three-strikes rule. If a resident receives three written warnings within a 30-day period, the fourth warning results in an immediate denial of service. However, warnings are only kept on record for 30 days.

The impact of this policy is evident in the supportive community it fosters. The open-door policy reflects the belief that healing isn't always straightforward. Staff understand that residents may stumble, relapse, or break rules, and this policy provides space for them to navigate these challenges without losing their main source of support and stable housing. It allows residents to fully engage in their healing journey, with staff providing continuous support through ups and downs.

Moreover, the open-door policy allows for "aftercare." Even after graduating from the program, residents can still attend therapy sessions, join group activities, and come back for family-style dinners. This reinforces the sense of safety cultivated during their time at Carmelita and acknowledges the potential distress a sudden cut-off of support causes for those with a history of trauma. The Carmelita house ethic is they will never exit someone to homelessness or an unstable situation. Overall, Carmelita House is committed to never leaving someone without support or housing, even if they continue to struggle with rule violations or substance abuse. Staff will ensure residents have access to support and housing, even if they can't stay at Carmelita House.

Open-ended timeline - "However long recovery takes"

The open-ended timeline at the program means there's no fixed graduation date for residents. The positive impact of this policy has been seen mostly on community building and the healing process. This open timeline provides residents with ample space and time to foster a close-knit community, where everyone cares for, respects, and supports each other. Staff actively encourages residents to discuss with other residents their challenges with sobriety, finding housing, and healing from trauma. This approach also influences conflict resolution and mediation. Knowing they can stay long-term motivates residents to invest in building a strong community. Staff can schedule processing groups and ensure everyone's voices are heard. They understand the need to resolve tensions and coexist harmoniously. Residents are given time to understand each other, identify triggers, and learn coping mechanisms. If resolving issues takes time, they're supported in building lasting relationships.

"I haven't participated in other SLES [programs] before. But I often hear about like, there's fighting and there's this, and there's drama and there's so and so doesn't like so and so, and don't get me wrong, right. It a hundred percent happens here. Mm-Hmm. It is the way that we manage those…occurrences or problems in the home that I think is significantly different….I would say in general because the open door policy, we have a really strong bond. And so the goal is always like, we are a family and we all care for each other. We respect each other. Everybody looks out for each other." – Staff

The open-ended timeline at Carmelita also accommodates the time needed to navigate the system. Since the women have stable housing, they're not prioritized for housing vouchers. This means that if their main goal is to secure a job and a housing voucher, they must work within both their own timeline and the county's schedule. Moreover, there are many smaller steps involved in achieving these goals, such as managing finances, building credit to be applicable for housing, and learning essential life skills like cooking and grocery shopping in order to maintain healthy independent living. Carmelita's flexible timeline acknowledges and addresses the typical challenges associated with BHRS case management.

The flexibility in their timeline allows residents to relax and focus on healing without constantly worrying about their next steps. They can settle into the house and prioritize trauma recovery rather than being in survival mode. However, this flexibility may also lead to minor anxiety about transitioning out of the house. Residents appreciate the support structures at Carmelita but may feel nervous about what comes next when they do not have those structures in place. Additionally, the level of flexibility compared to other programs can cause some confusion. Overall, the open-ended timeline provides space for residents to relax, heal, and build meaningful relationships.

Individualized Care and Attention to Personal Growth

Carmelita House customizes goals and support levels for each resident based on their individual needs, which is crucial for a trauma-informed approach. A key strength of the program is their approach to teaching through "modeling," which means they are aware that residents are looking to the people around them to also learn how to live and take care of themselves.

This modeling approach is a critical part of Carmelita's success in teaching residents essential life skills. Success at Carmelita is measured not just by housing, but also by residents' personal development and acquisition of life skills such as budgeting, scheduling, and technology use.

CARMELITA HOUSE STAFFING

Relationships with Staff

Residents at Carmelita expressed positive relationships with staff, feeling comfortable approaching them. They described the staff as upbeat, approachable, and like a little family. Staff members prioritize fostering open communication and relationships with residents. Residents appreciate the respectful communication and open-door policy, feeling at ease discussing various issues with staff.

Residents appreciate staff availability, and they value informal communication opportunities with staff during downtime, meals, and activities. Staff strive to bridge the gap between residents' experiences at Carmelita House and their relationships outside, ensuring holistic support. Residents value staff members' respectful and attentive communication style, which allows space for negative emotions and regular check-ins. Having staff onsite and their willingness to engage fosters strong relationships over time.

Full-time Trauma Therapist

Residents expressed significant benefits from the accessibility and proximity of having an onsite therapist. The full-time trauma therapist plays a crucial role in delivering trauma-centered group and individual therapy sessions. They are responsible for providing talk and EMDR therapy, as well as coordinating somatic-centered therapeutic programming. The presence of an onsite therapist and trauma centered healing activities were some of the most often named reasons that made residents want to stay at Carmelita. Eliminating the need to travel for therapy sessions reduces barriers and frustrations, particularly for those grappling with depression. Residents appreciate being able to express themselves freely to the therapist, who offers empathy and support, sometimes even doing walking therapy sessions.

"I could come in and express myself to her and she'll go for a walk with me or we'll talk. And it's just, it's really helpful to just express myself and get everything out. Off my shoulders. And she made me feel better when I talked to her about things as well." – Resident

"I suffer from depression. So the faster that I act on…getting help, the better. And it's just really easy to…have somebody on site. Because sometimes having to travel to an office, I've turned around and gone home. Because I'm like, I don't want to do this. I don't want to take all this time and do all this stuff. But, knowing that at minimum I have one day a week where I can talk to somebody." Resident

While Carmelita House offers a rich array of therapeutic programs, there are limitations to its 50-minute weekly therapy sessions guaranteed for each resident. Some residents want more frequent therapy sessions or an extra therapist to discuss daily issues that come up during the week. They propose having additional shorter check-in sessions throughout the week to better address their needs.

Full-time Peer Support Specialist

The peer support specialist role is designed for an individual with lived experience in recovery to serve as a positive role model and support the other residents in their healing journeys. The person in this role receives training, mentoring, and a monthly stipend in addition to free rent and utilities. Living full-time

at Carmelita House alongside other residents, the peer support specialist actively engages in talk therapy with the onsite therapist and participates in various house activities.

Affectionately deemed the "house mother," the current peer support specialist has emerged as an integral figure within the communal fabric of Carmelita House. In interviews, residents consistently highlighted the “house mother” as one of the most helpful and important people in their experience. Her main responsibilities encompass providing daily support to residents through informal mental health support (open availability to talk), teaching essential life skills like cooking and laundry, managing the house during weekends, mediating conflicts among residents, and ensuring the overall smooth operation of the household. Additionally, she started a daily spiritual grounding group in the mornings which has become an additional space for fostering a deeper sense of community.

“she stays here, so she's always there to talk and she really just made me feel better. I even told her like, she makes me happy, she makes me feel better. She listens and. And she don't put people down or anything.” - Resident

Residents express overwhelmingly positive feedback about the house mother, praising her open-door policy and non-judgmental presence. They appreciate her ability to listen without criticism, offer practical advice on establishing routines, and engage in meaningful discussions about sobriety and life experiences. The house mother's role is essential to creating the warm, welcoming atmosphere at Carmelita House. As someone living in the home with her own recovery experience, she embodies the program’s principles and serves as a model for others. Through her consistent presence, especially during weekends, and compassionate mentorship, she contributes significantly to the communal bonds that make Carmelita House feel like a supportive environment for healing.

Part-time House Manager – Catholic Charities employee

The part-time house manager, equipped with specialized training in trauma despite not being a clinical therapist, plays a multifaceted role in overseeing the daily operations and community dynamics at Carmelita House. As the Senior Program Director for Catholic Charities supervising multiple programs, their responsibilities at Carmelita include managing the physical property, enforcing house rules and guidelines, conducting intake for new residents, collaborating with the therapist on programming, leading off-site excursions, and documenting incidents.

The current house manager's impact extends beyond these logistical and maintenance duties. Residents frequently referred to her as an important and supportive presence. She engages with residents as peers and community members while also maintaining authority to establish boundaries and uphold rules. She fosters a sense of autonomy by approaching Carmelita House not merely as a sober living environment but as the residents' home, empowering them to shape their living space to meet their needs to feel the most comfortable and safe.

Residents expressed appreciation for the house manager's respectful demeanor, dependability in getting things done, and willingness to advocate on their behalf, such as writing letters to probation officers. Her role in assisting with essential tasks like grocery shopping, which can be challenging given Carmelita's remote location, further positions her as a compassionate friend rather than merely the house manager to residents.

The house manager walks a delicate balance of showing care and warmth towards residents, while also being the authority figure who must uphold rules at times. She has an open-door policy and regularly makes time for casual check-ins about residents' daily lives, frustrations, and victories. This nurturing yet structured approach has established her as another supportive "house mother" figure. Through this blended approach of compassionate leadership and logistical support, the house manager reinforces the program's trauma-informed, community-oriented culture.

Part-time MSW Intern

The part-time MSW intern, who began in August 2023 and will conclude her internship in May 2024, works under the supervision of the onsite therapist. She conducts therapy sessions with individual clients, leads therapy groups, and engages in outreach and recruitment activities. Additionally, she assists in connecting women to various resources and occasionally provides support in case management, such as helping a resident navigate anxiety related to court appearances and communicating with their case manager.

Despite being in a learning phase as an intern, her proficiency in Spanish is a valuable asset at Carmelita House. As one resident's first language is Spanish, the intern also offers translation services and conducts therapy sessions in Spanish for this resident. Her presence underscores the need for improved language accessibility at Carmelita House, a role that will need to be addressed once her internship concludes.

Conclusions & Recommendations

Overall, the surveys and interviews conducted at Carmelita House revealed several common themes that underscore the program's effectiveness in providing trauma-centered support and fostering a supportive community environment. Firstly, the presence of dedicated staff members, including a full-time trauma therapist, a peer resident support specialist, a part-time house manager trained in trauma, and a part-time MSW intern, play a crucial role in meeting residents' diverse needs. The accessibility of on-site therapy sessions and the supportive presence of staff members contribute significantly to residents' sense of safety and well-being. The division of labor between therapy and operational roles is identified as a key strength, allowing for a balanced approach to care while maintaining confidentiality and accountability.

The welcoming experience at Carmelita House, characterized by inclusive activities and a supportive atmosphere, sets the stage for residents to engage in their healing journey comfortably. The open-door policy and flexible timeline further reinforce the program's commitment to providing continuous support and housing stability, even amidst setbacks or relapses. Additionally, the emphasis on individualized care and personal growth, coupled with the modeling approach adopted by staff, fosters a supportive learning environment where residents can acquire essential life skills and build meaningful relationships.

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

PROJECT DATES: March 1, 2022-August 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 skills[2] 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

[2] 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, Latine, 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?

FY 22/23 OUTCOMES: Data was limited because SWAP Y1 2022/2023 focused on building and launching the program, including: establishing relationships between MCOE and the school SWA sites; setting up the SWA program; developing and implementing orientations and trainings for SWA site coordinators and SWAs; developing and implementing the evaluation data collection tools.

Four SWAP trainings/meetings for all cohort 1 sites during 2022-2023:

- 98% reported (n=54) they had been able to connect with people in a meaningful way
- Majority expressed knowledgeable and confidence in using information or skills gained from training/meeting in SWAP role
- 100% of SWA training participants (n=55) reported:
    - Everyone was encouraged to participate
    - Training/meeting materials were engaging
    - Trainer/facilitator was well prepared
    - Training/meeting went well
    - Glad I attended the training/meeting

Participants (n=12) expressed willingness to:

- Take action to prevent discrimination against people with mental health conditions: 91%
- Hang out with someone who had a mental health condition: 83%
- Actively and compassionately listen to someone in distress: 83%
- Seek support from a mental health professional if I thought I needed it: 67%
- Talk to a friend or family member if I thought I was experiencing emotional distress: 59%

CHANGES FOR FY 2024-25: There are no anticipated project changes.

INNOVATION COMPONENT BUDGET

Note: For Innovation Projects the budget is flexible between the years of the project but cannot exceed the total amount approved for that project by the MHSOAC either through the original approval or a subsequent addendum.

Program	FY23/24	FY24/25	FY25/26	Total	
Older Adult Focused Innovation Project: Help@Hand	$404,630			$404,630	
From Housing to Healing, Re-Entry Community for Women	$478,117	$499,145	$510,093	$1,487,355	note: project total is $2,355,300 including prior and future fiscal years
Student Wellness Ambassador Program (SWAP): A County-Wide Equity-Focused Approach	*$466,500*	$499,350	$91,750	$1,057,600	note: project total is $1,648,000 including past fiscal years
Admin/Indirect for INN is included in each Project Budget					
Total	**$1,349,247**	**$998,495**	**$601,843**	**$2,949,585**	

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 culturally and linguistically competent providers, as well as peer and family providers. In Marin this includes Spanish speaking, Latino, African American and Black, 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
rebecca.stein@marincounty.gov

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 evidence-based culturally humble and responsive 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.

FY22/23 ACTIVITIES: Training, technical assistance, consultation, and curriculum development. Some of these trainings included:

- Mandatory Culturally Responsive Clinical Supervision Intensive Training for all BHRS clinical and administrative supervisors by Dr Kenneth V. Hardy, which included a comprehensive related organizational assessment of our system's strengths and deficits in providing culturally sensitive and responsive services to the community
- Contracted with PESI to provide an online and on demand training portal for all Marin County PMHS clinicians and staff that offers 13 clinical and cultural humility trainings and up to a total of 88.5 CEUs
- Cultural-Humility Cohort Training and Consultation with Indigenous Vision
- Working Respectfully with Limited English Proficiency Clients and Language Professionals in a BHRS Setting Training and Consultation
- Disordered Eating Training and Consultation
- Workshop series for BHRS All-Staff with Yejin Lee of Jeong Coaching and Consulting focusing on addressing harm and understanding elements power and oppression in the workplace

- Senior Management Team Anti-Oppressive Practices Coaching with Yejin Lee of Jeong Coaching and Consultation
- Trauma-Informed LGBTQ+ Training and Consultation, including Gender Inclusive Language *En Español*
- Training series for BHRS leadership and for workforce on working with, and supporting work with, behavioral health clients through an anti-racism and trauma informed lens
- Law and Ethics Trainings
- Clinical Supervision for unlicensed staff and contractors

CHANGES FOR FY24/25: No changes.

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.

FY22/23 ACTIVITES:

- 4 individuals with lived experience were placed into Peer Specialist Internships
- The Scholarship program was able to award 27 applicants with scholarships to pursue vocational education in the field of Peer Support and Co-Occurring Substance Use Counseling.
- The Scholarship program had 4 cycles FY22/23

CHANGES FOR FY24/25: Discontinue WET funded scholarship, continue participation in CalMHSA Medi-Cal Peer Support Specialist Certification program.

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 FY22/23: The Greater Bay Area Regional Partnership Loan Repayment Program was launched by CalMHSA in FY21/22. In Marin:

- Marin contributed an additional $4,843 in MHSA FY 2022-2023 funding 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.
- No loan repayment awards were offered in FY 2022-2023
- Post Residency Fellow was hired and supported group programming as well as the psychology internship training program by assisting in training predoctoral interns providing services to the PMHS

CHANGES FOR FY24/25: Discontinue WET Post Doctoral position. In FY23/24 an RFP was released for the Internship Consortium proposed in the Three-Year Plan however there were no responses to the RFP so this program will not be continuing in FY24/25.

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,
- preforming 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: Salaries, benefits, and operating costs directly associated with the WET Coordinator and Administrative Services Technician-Bilingual.

CHANGES FOR FY24/25: None.

WORKFORCE EDUCATION AND TRAINING COMPONENT BUDGET

PROGRAM NAME	FY23/24	FY24/25	FY25/26	Total
Training and Technical Assistance	$242,243	$242,243	$242,243	$726,729
Mental Health Career Pathways	$135,000	$33,172	$33,172	$201,344
Financial Incentive Programs	$286,404	$40,000	$40,000	$366,404
Workforce Staffing Support	$292,648	$292,648	$292,648	$877,944
Admin/Indirect (15%)	-	-	-	-
TOTAL	**$956,295**	**$608,063**	**$608,063**	**$2,172,421**

FY24/25 transfer	$172,691
Existing fund balance	$435,372

CAPITAL FACILITIES AND TECHNOLOGY NEEDS (CFTN)

ELECTRONIC HEALTH RECORD AND PRACTICE MANAGEMENT SYSTEM ENCHANCEMENTS

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

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 OUTCOMES: Senior Business System Analyst hired to assist with the transition to the new EHR platform, SmartCare, which launched in July 2023.

COORDINATED CASE MANAGEMENT SYSTEM

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.

TELE-HEALTH IMPROVEMENTS

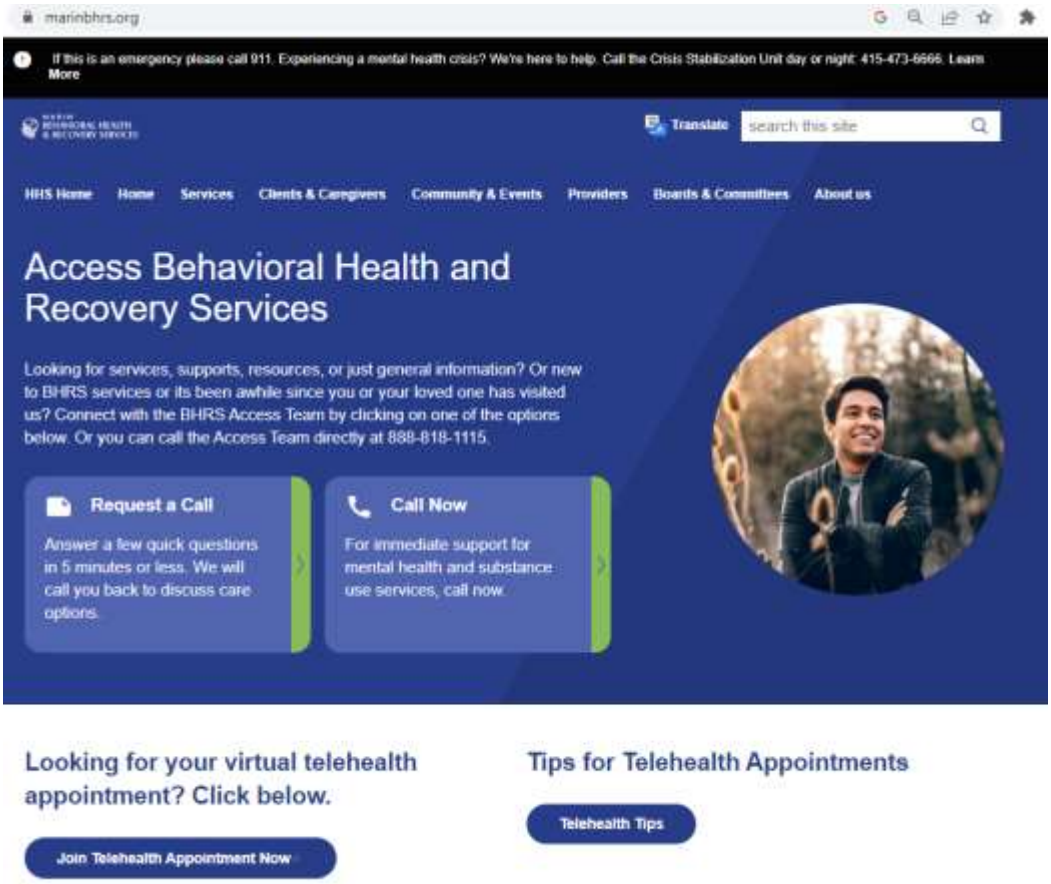
PROGRAM DESCRIPTION: In response to the COVID-19 pandemic, which has quickly changed the way behavioral health services are offered, BHRS is dedicating resources to strengthening telehealth options, including the ability to provide group services via telehealth. This funding would be used for software 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

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.

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 which was build out to make accessing services easier (including a clear step by step process guide for accessing services). See screen shots of the following pages.



This program ended in the new three year plan so this is the final report for the Website Enhancement effort.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS COMPONENT BUDGET

PROGRAM NAME	FY23/24	FY24/25	FY25/26	Total
Electronic Health Record and Practice Management System Enhancements	$1,575,101	$1,282,927	$1,282,927	$4,140,955
Coordinated Case Management system	$55,000	$55,000	$55,000	$165,000
Telehealth Expansions	$70,000	$70,000	$70,000	$210,000
Admin/Indirect	$255,015	$211,189	$211,189	$677,393
TOTAL	**$1,955,116**	**$1,619,116**	**$1,619,116**	**$5,193,348**

FY24/25 transfer	$805,116
Existing fund balance	$814,000

TOTAL BUDGET

	FY23/24	FY24/25	FY25/26	Total
Community Services and Supports (CSS)	$26,070,738	$16,774,527	$16,774,527	$59,619,792
Prevention and Early Intervention (PEI)	$4,840,786	$4,538,083	$4,538,083	$13,916,952
Capital Facilities and Technology Needs (CFTN)	$1,955,116	$1,619,116	$1,619,116	$5,193,348
Workforce Education and Training (WET)	$956,295	$608,063	$608,063	$2,172,421
Innovation (INN)	$1,349,247	$998,495	$601,843	$2,949,585
TOTAL	$35,172,181	$24,538,284	$24,141,632	$83,852,097

APPENDIX 1: MHSA COUNTY COMPLIANCE CERTIFICATION

To be added.

APPENDIX 2: MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

To be added.

APPENDIX 3: BOARD OF SUPERVISORS APPROVAL

To be added.