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

MENTAL HEALTH SERVICES ACT (MHSA)
FY2025/2026
ANNUAL UPDATE
&
AMENDMENT TO THE
FY2024/2025
ANNUAL UPDATE

COUNTY OF MARIN

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FISCAL YEAR 2024/25 AMENDMENT

This document serves as an Amendment to the approved MHSA Annual Update for Fiscal Year 2024-2025 to increase the funding transfer by $2,300,000 from Community Services and Supports (CSS) to Capital Facilities and Technology Needs (CFTN) to support ongoing Health Information Technology System needs and to provide match funding for a Bond Behavioral Health Continuum Infrastructure Program (BHCIP).

Background: Passed by California voters in November 2004, Proposition 63, also known as the Mental Health Services Act (MHSA), created a dedicated 1% increase in income taxes on personal income over $1 million to be used for community behavioral health services. There are five MHSA components; Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN). CSS, PEI, and INN components receive an ongoing percentage of funds while the CFTN and WET components were funded with a one-time allocation. The California Code of Regulations allows for the transfer of up to 20% of the average of the prior 5 years' total MHSA allocation out of the Community Services and Supports (CSS) account into either the Prudent Reserve, the CFTN account, and/or the WET account.

The ability to reallocate funds is critical to the sustainability of Capital Facilities and Technological Needs (CFTN) to support both ongoing Health Information Technology System needs and to provide match funding for a Bond Behavioral Health Continuum Infrastructure Program (BHCIP).

Fiscal Year	Total MHSA Allocation for Marin
FY 2019-20	$10,875,510.84
FY 2020-21	$16,568,640.65
FY 2021-22	$18,928,297.86
FY 2022-23	$12,459,586.92
FY 2023-24	$23,284,467.52

Average Allocation from prior 5 years (FY20/21-FY24/25)	$16,423,300.76
20% of average allocation:	$3,284,660.15
Amount transferred from CSS in Approved FY24/25 AU	$977,807

Amount remaining eligible for transfer from CSS:	$2,306,853.15

Approved Plan: In the approved MHSA FY 2024/25 MHSA Annual Update a total of $977,807 was approved to be transferred out of CSS including $805,116 approved as a transfer from CSS to CFTN. This Amendment authorizes an additional $2,300,000 in transfers from CSS to CFTN for a total of $3,105,116 transferring into CFTN.

Rationale: CFTN funds are available for 10 years, so this increased transfer in FY24/25 will allow for the funding to be spread across the next decade to address a portion of the capital facility and technology needs of the department.

The Health Information Technology System has allowed for improved data tracking and transparency around service utilization and disparities in system access. This improved ability to track information allows the Department and the community to make informed decisions on how to address disparities. Given the upcoming increased reporting requirements mandated by the Behavioral Health Service Act, tracking this data will be central to meeting the requirements.

BHCIP requires entities receiving awards to provide matching funds or real property as specified in Welfare and Institutions Code 5960.15. Specifically, local governments are required to match 10% of funds and only funds that can be used for capital development expenses can be pledged. Funding for a BHCIP bond match will expand the capacity of behavioral health care facilities and address gaps in the care continuum for individuals with behavioral health conditions through the establishment of these inclusive, accessible, and supportive environments. This transfer to CFTN along with a similar transfer planned in the FY 2025/26 Annual Update will allow for the County to have enough available match funds for this project and to fund potential office space renovations as part of a larger treatment facility project.

Stakeholder Process: This priority was discussed during the FY25/26 MHSA Community Planning meetings. BHRS held a total of sixteen community-wide Community Planning meetings (both virtual and in-person) including community planning meetings focused on those with lived experience, older adults, family members, LGBTQ+, BHRS staff, and to the MHSA Advisory Committee.

This Amendment will be posted for public comment from April 11-May 13, 2025, with a public hearing hosted by the Behavioral Health Board on May 13, 2025.

Amendment to page 123 of the approved FY2024-25 MHSA Annual Update:

COMMUNITY SERVICES AND SUPPORTS (CSS)
COMPONENT BUDGET

Transfer to Workforce Education & Training	$172,691	No Changes
Transfer to Capital Facilities & Technological Needs	~~$805,116~~	$3,105,116
Total Transfers out of CSS	**~~$977,807~~**	**$3,277,807**

EXECUTIVE SUMMARY

OVERVIEW

The Fiscal Year (FY) 25/26 Annual Update is an opportunity to make changes to the Mental Health Services Act (MHSA) FY23/24-25/26 Three Year Plan in addition to report on the outcomes and activities from FY23/24 (Fiscal Year from July 1, 2023-June 30, 2024). FY23/24 was the first year of implementation of the MHSA Three-Year Program and Expenditure Plan for FY23/24 through FY25/26. All MHSA related Annual Updates and the MHSA Three-Year Plan can be found here - MarinBHRS.org/MHSA.

FY25/26 is the final fiscal year under MHSA regulations. Beginning July 2026, the current funding allocations under MHSA will be revised under the Behavioral Health Services Act (BHSA). Funding categories will be significantly restructured into three main components: housing (30%), full-service partnerships (35%), and behavioral health services and supports (35%). With the passage of Proposition 1 in March 2024, BHSA will prioritize services for individuals with the most significant behavioral health needs. Under BHSA, counties will no longer receive prevention and workforce training funding, the innovation component will be eliminated, and the state will increase their own allocation from 5% to 10%. Additionally, there will be new reporting requirements under BHSA for all behavioral health programs across all funding sources which necessitate a substantial administrative effort to achieve.

KEY CHANGES IN THE FY25/26 ANNUAL UPDATE

Changes for the FY25/26 Annual Update are rooted in planning for Behavioral Health Transformation which goes into effect at the end of the Fiscal Year. Most things remain the same for the final year of the last MHSA Three-Year Plan, however the changes implemented in this Annual Update are to best prepare the County and our providers for the changes that go into effect in FY26/27 and to best take advantage of the Bond money for housing and treatment facilities.

Similar to the FY24/25 annual update, these changes were informed by Stakeholder feedback on community and system of care needs and rooted in a fiscally responsible approach. 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 **evaluating** all potential reduction or allocation scenarios
- Where not in line with BHSA 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

Priorities highlighted during the Community Planning process focused on addressing the upcoming changes that will occur with BHSA; offering culturally responsive services; increasing peer support services; and increasing housing options.

Changes for the FY25/26 Annual Update:

I. Community Services and Supports Budget
   i) Funding for CalAIM System Development to support additional contractors to prepare for Behavioral Health transformation and the requirements for Medi-Cal billing as well as to increase the number of Certified Peer Providers employed by contracted providers who provide Medi-Cal billable services
   ii) Funding to support outreach and engagement with individuals experiencing homelessness
   iii) Funding for a Project-Based Housing Program to support construction/acquisitions/rehabilitation of a property as either the HomeKey+ match or similar project

II. Prevention and Early Intervention Budget
   i) Funding for LGBTQ+ culturally responsive services
   ii) Funding to support West Marin school-based services
   iii) In preparation for behavioral Health transformation, shifting the Suicide Prevention Senior Program Coordinator to the Public Health Department

III. Innovation Budget
   i) Funding for Student Wellness Ambassadors Program extension through FY25/26

IV. Workforce Education and Training (WET) Budget
   i) Increased transfer to Workforce Education and Training to support ongoing training needs associated with BHSA mandated evidence-based practices. WET funds are available for 10 years, so this transfer in FY25/26 allows for the funding to be spread throughout the next decade for training needs.

V. Capital Facilities and Technology Needs (CFTN) Budget
   i) Increased transfer to Capital Facilities and Technology Needs to support ongoing Health Information Technology System needs and to make funding available for the Behavioral Health Continuum Infrastructure Program (BHCIP) bond match. CFTN funds are available for 10 years, so this transfer in FY25/26 allows for the funding to be spread across the next decade to address a portion of the capital facility and technology needs of the department.

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 Behavioral Health Services Oversight and Accountability Commission (BHSOAC) within thirty (30) days after Board of Supervisor adoption.

MARIN COUNTY CHARACTERISTICS

Marin County is a mid-sized county (as defined by the State as between 200,000 and 749,000 residents) situated in the northwestern part of the San Francisco Bay Area with a **population of 262,321** 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, **about 70% of Marin's workforce commute 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 2023 ACS 1-Year Survey found:

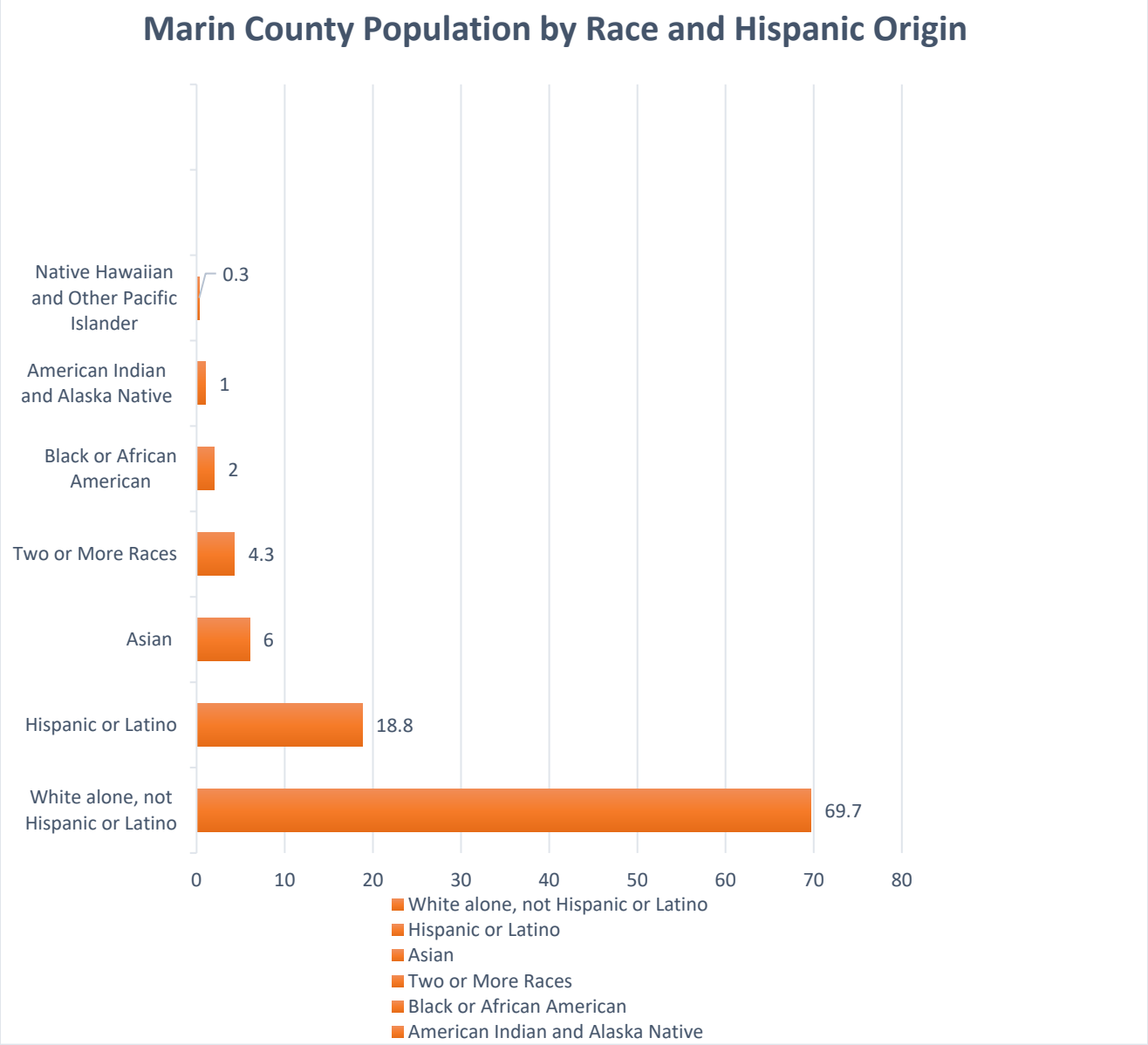
- 74.6% of residents in Marin speak only English,
- 15.1% speak Spanish (42.5% of whom speak English less than "very well"),
- 6.6% speak another Indo-European language (20.2% of whom speak English less than "very well")
- 3.1% speak an Asian or Pacific Island language (37.3% of whom speak English less than "very well")
- .6% speak other languages (53.8% of whom speak English less than "very well")

According to the Marin County Health Rankings and Roadmaps released in March 2024, Marin ranked as one of 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. According to the US Census, almost a quarter of Marin County residents were 65 years and older. **The median household income in Marin county was $142,785 in 2023 with 8.7% of individuals living in poverty.**

Marin County was ranked as the **14th highest racially disparate county in California** by the Advancement Project RaceCounts. Marin County's high racial disparities in safety and justice, economic opportunity, 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 followed by Latinx residents.

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.

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. 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.



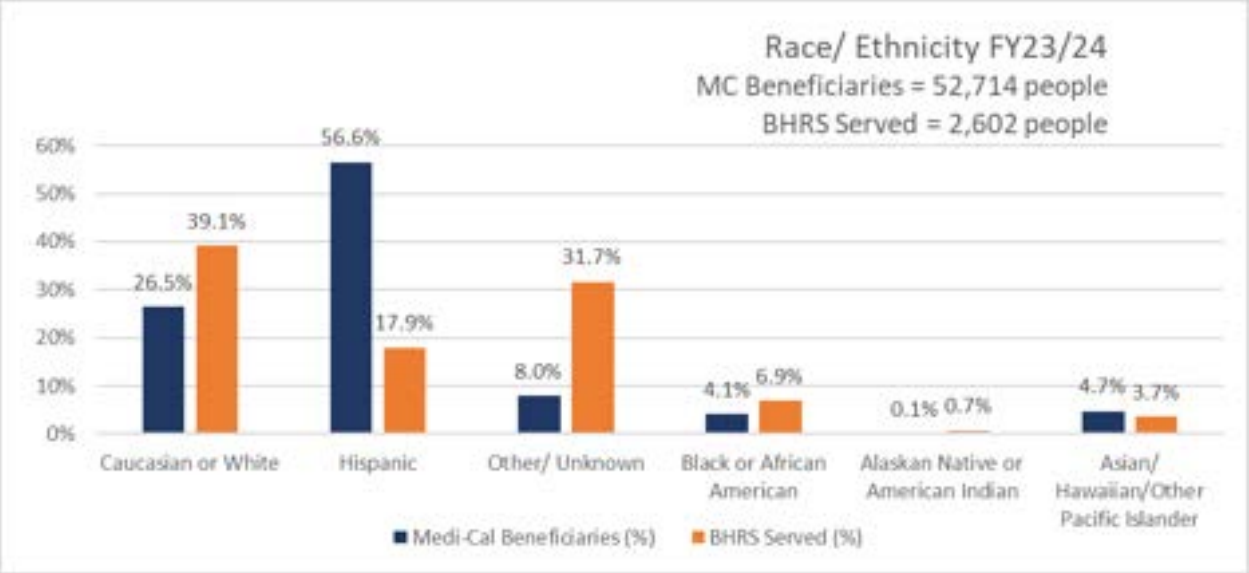
RACIAL/ETHNIC DISPARITIES IN SERVICE UTILIZATION

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.

When analyzing the FY23/24 utilization data, the Asian/Hawaiian/Other Pacific Islander population was served at a lower rate in Marin than the Medi-Cal population (3.7% served vs 4.7% of the Medi-Cal population). Marin continues to focus on this population.

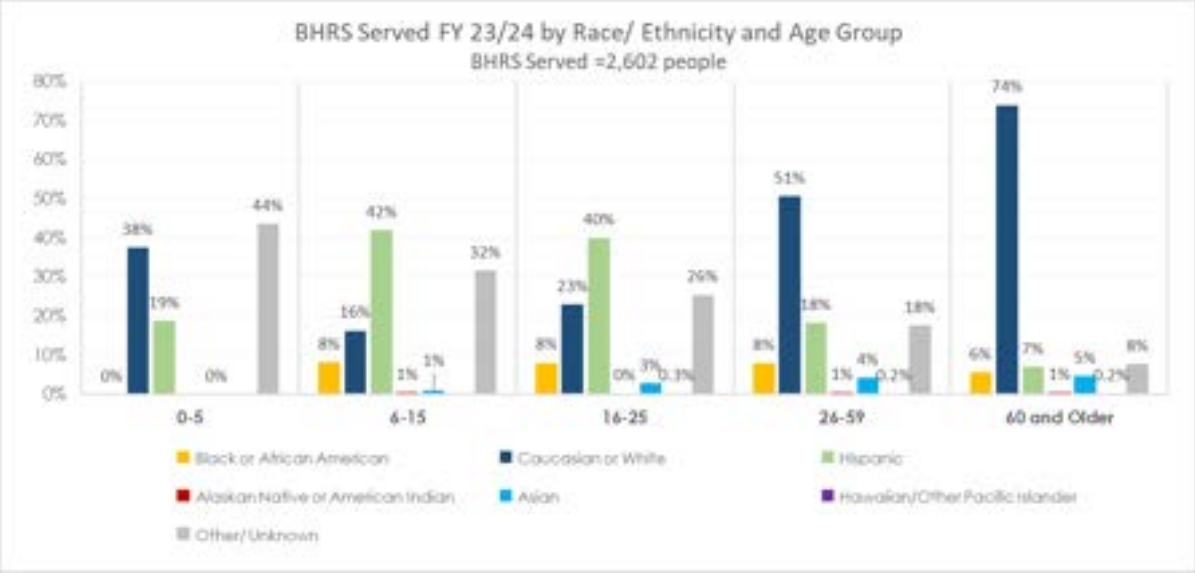
Designation of un/underserved populations is based on the distribution of Marin residents who are eligible for County mental health services. This is represented in the following charts by the comparison of "Medi-Cal Beneficiaries" to the distribution of those receiving county mental health treatment 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 FY23/24 broken down by age group, the trend of the Latine population receiving a significantly higher proportion of services as youth than adults remained the same as the prior year. This trend is consistent with prior data analyses of BHRS clients served by race/ethnicity and age group.

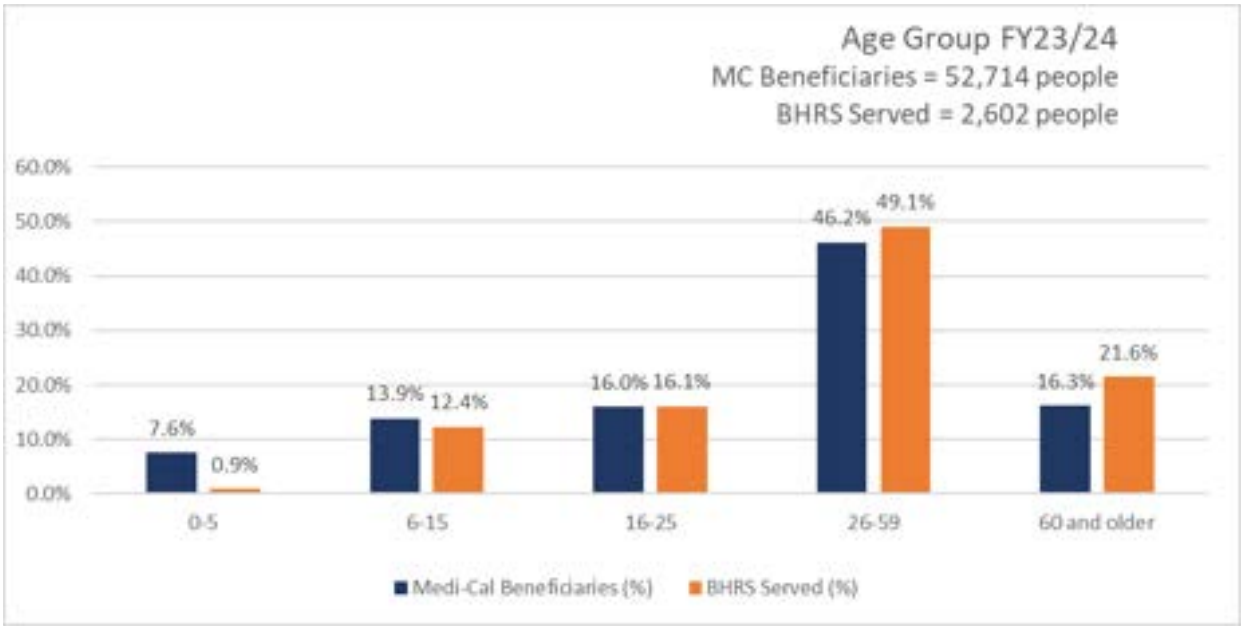
RACIAL/ETHNIC DISTRIBUTION OF THOSE SERVED BY BHRS BY AGE GROUP



AGE DISPARITIES IN SERVICE UTILIZATION

Very young children (0-5) 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. Children (6-15) were also served at a lower rate, representing 13.9% of Medi-Cal population with 12.4% served by BHRS. Older adults make up 16.3% of the Medi-Cal population and 21.6% were served by BHRS.

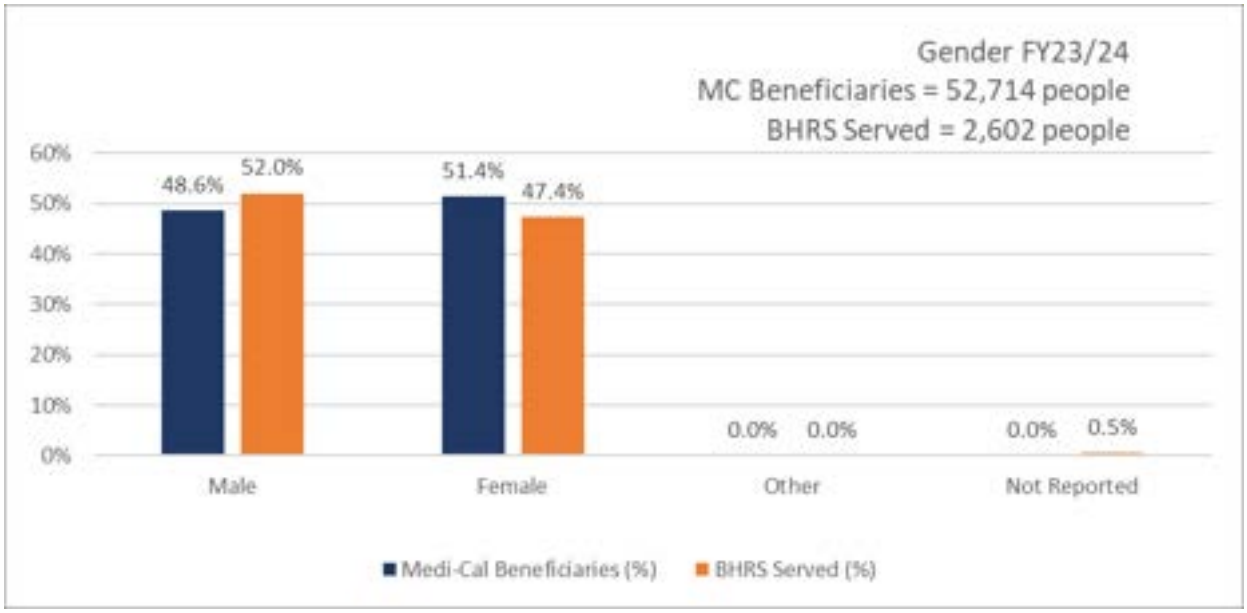
AGE GROUP DISTRIBUTION OF MARIN MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS



GENDER DISPARITIES IN SERVICE UTILIZATION

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

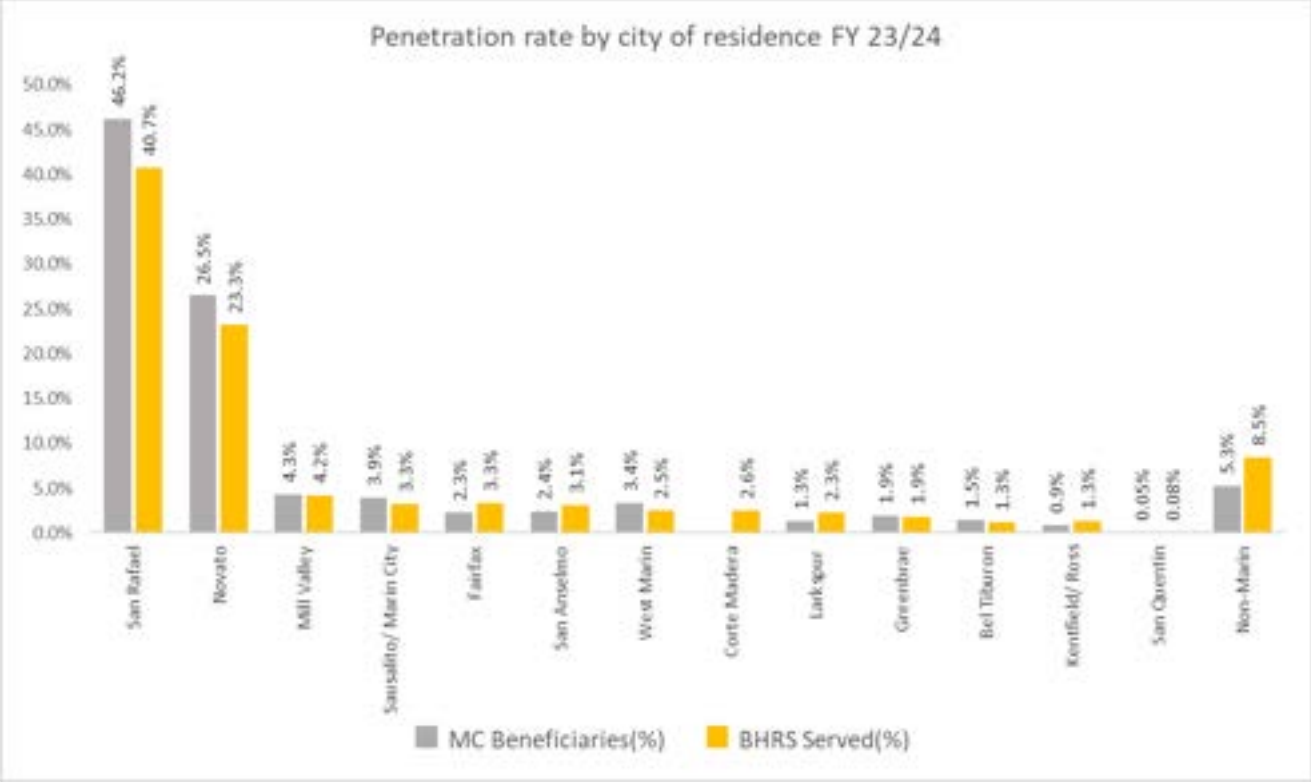
GENDER DISTRIBUTION OF MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS



GEOGRAPHIC DISPARITIES IN SERVICE UTILIZATION

Of Marin Medi-Cal beneficiaries, 72.7% live in either San Rafael or Novato which is reflected in the percentage served by BHRS in those geographic areas. Novato was slightly underserved in FY23/24 with 26.5% of the Medi-Cal population and 23.3% of the beneficiaries served by BHRS. 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 the physical location opens.

PERCENT OF MARIN MEDI-CAL BENEFICIARIES VS THOSE SERVED BY BHRS BY CITY OF RESIDENCE: FY23/24



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: https://prevention.marinbhrs.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, 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 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.

<u>Community Planning Survey</u>

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*

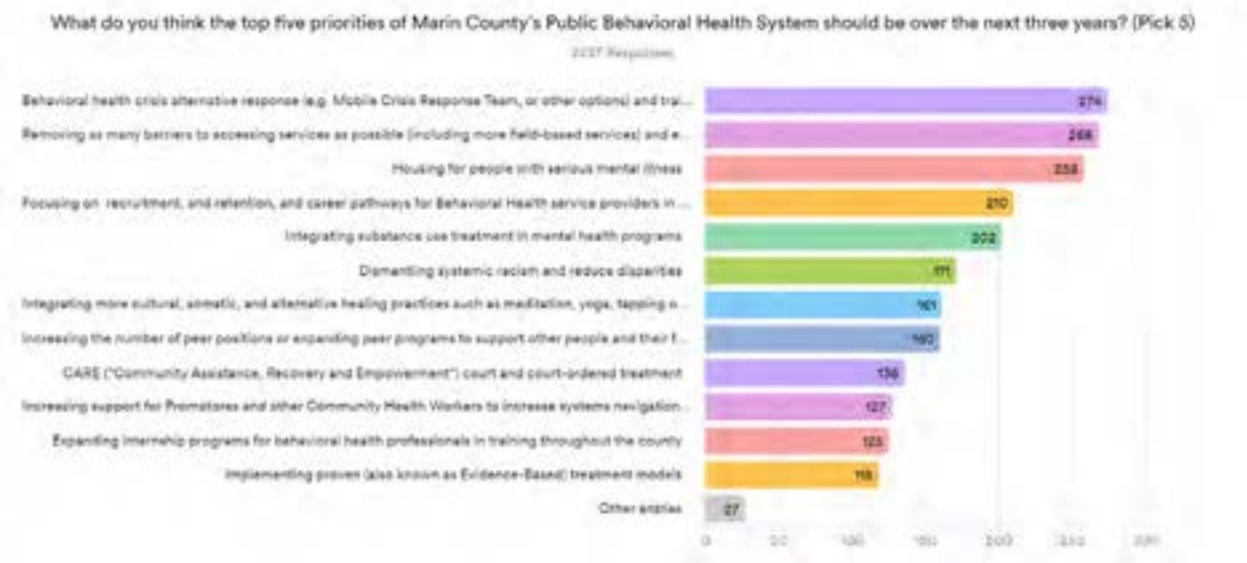
2. *Removing as many barriers to accessing services as possible (including more field-based services) and expanding outreach and engagement efforts*

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.



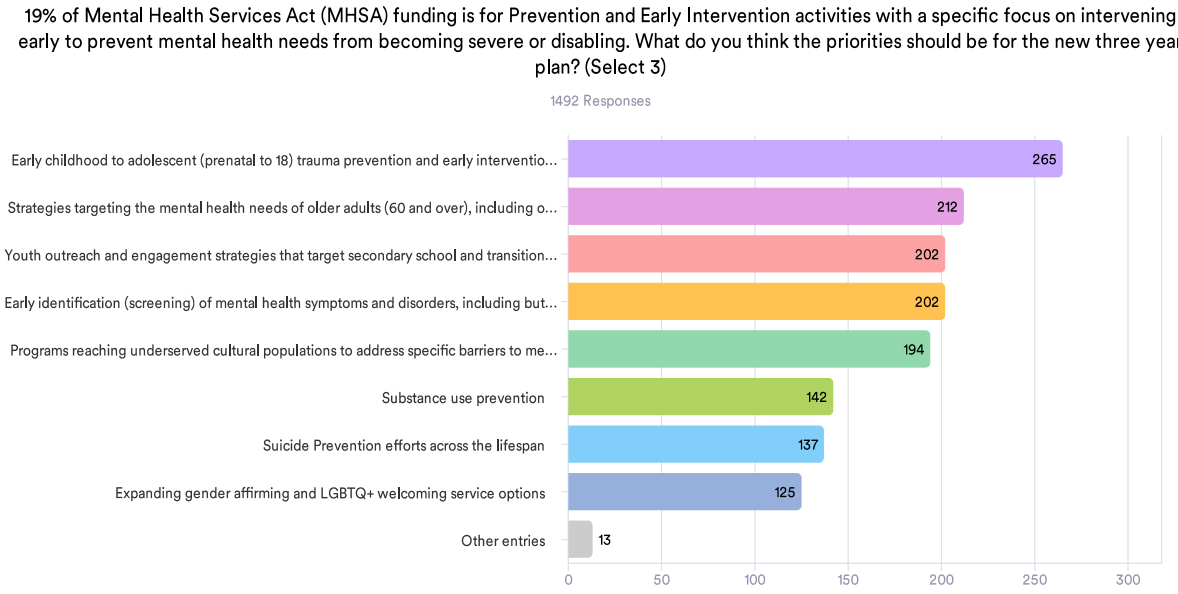
The top 3 priorities for Prevention and Early Intervention funding were:

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



Peer-Led Interviews:

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:

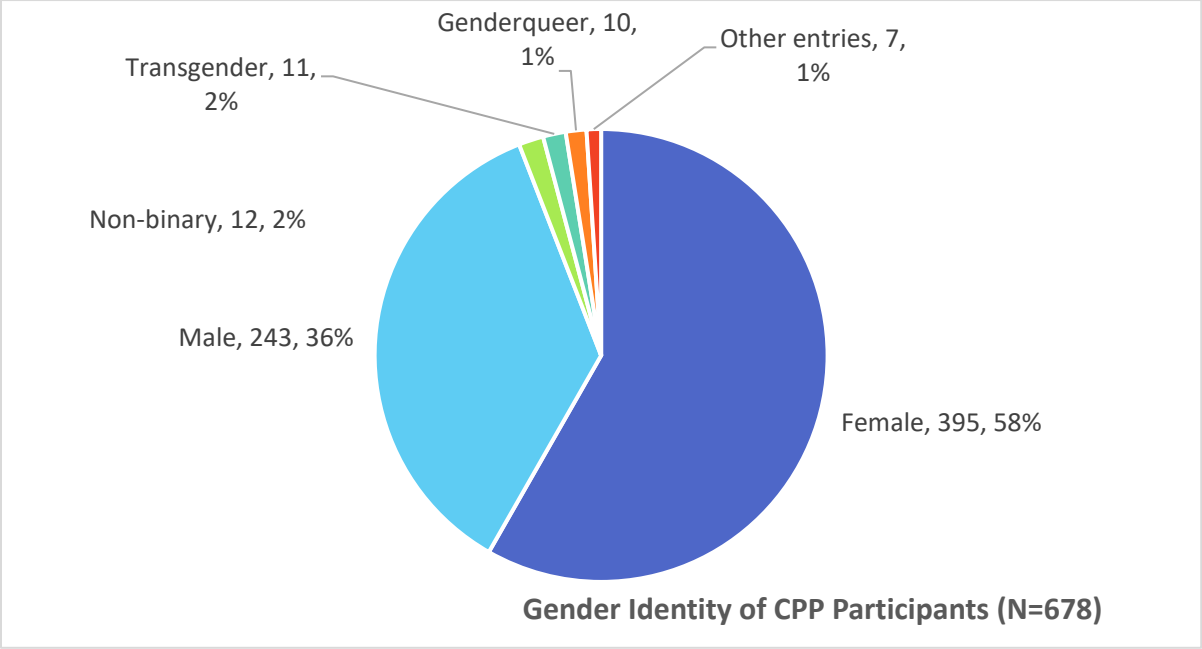
- Mental Health Board
- Advisory Board on Alcohol and Other Drugs
- Behavioral Health and Recovery Services Senior Management Team
- Community Partners (including San Rafael Police Department, Canal Alliance, NAMI Staff, and Marin Community Foundation, Marin Community Clinics Pediatrician)
- Mental Health 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.

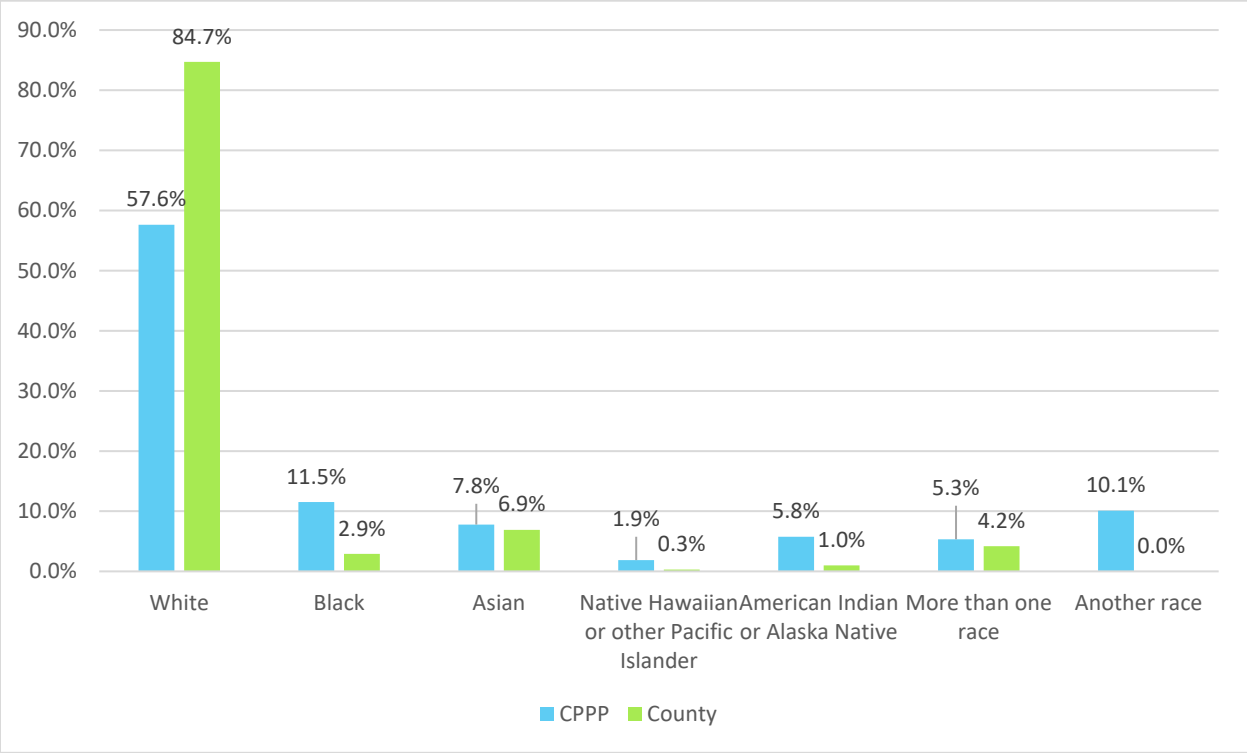
As with previous Community Planning processes, females were slightly over-represented in the community planning process however there was significantly **more engagement with individuals who identified as male, non-binary, transgender, genderqueer, and other gender identities than previous planning cycles.**



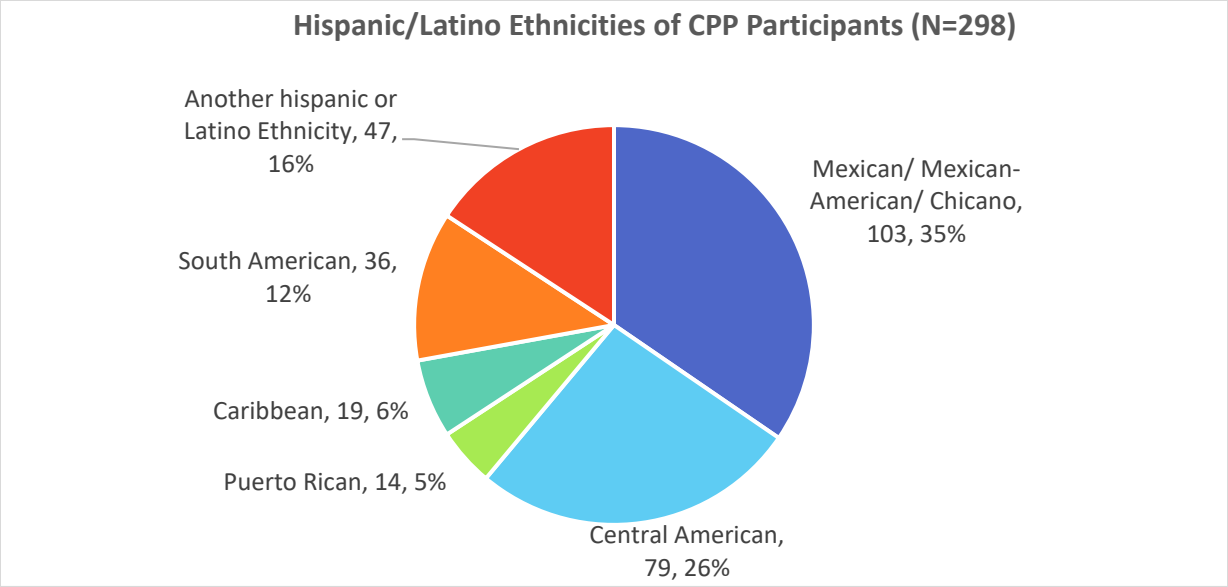
The unserved and underserved racial/ethnic populations in Marin participated in the community program planning process at a higher rate than their white counterparts, for instance, **Black or African Americans represented 11.5% of CPPP participants, but only 2.9% of the county population**.

RACIAL DISTRIBUTION OF THE COUNTY VS

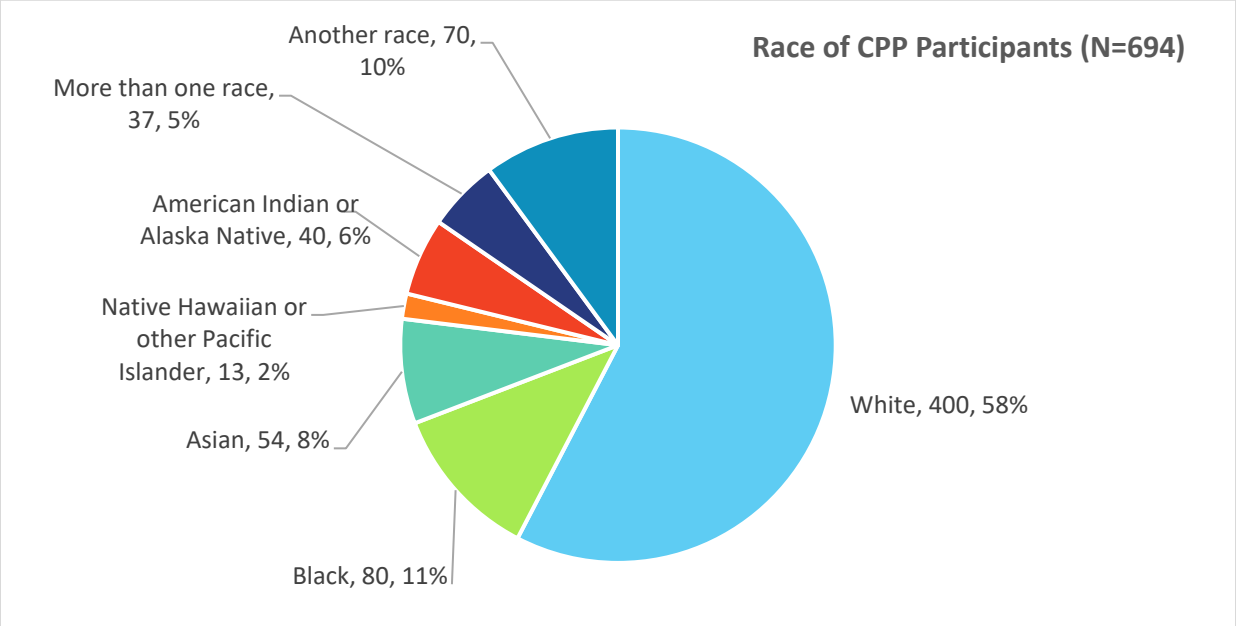
TOTAL 3YR PLANNING COMMUNITY PROGRAM PLANNING PARTICIPANTS (CPPP)



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.**

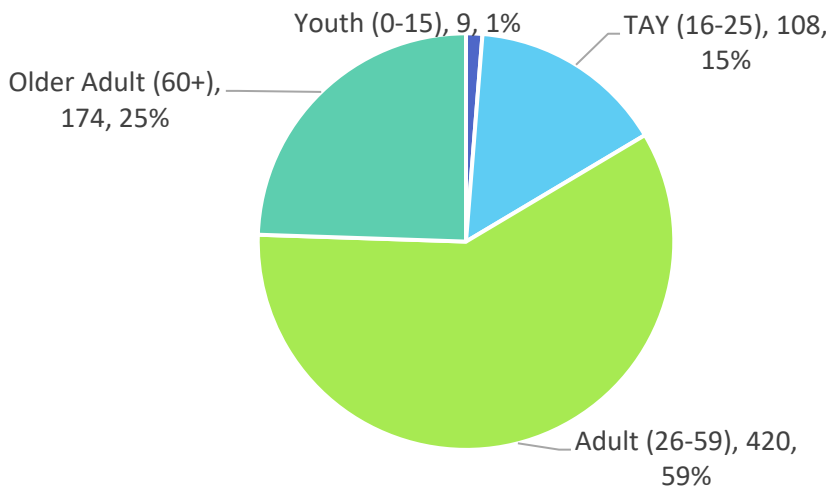


Here is another view of the demographic breakdown of the CPPP by Race:

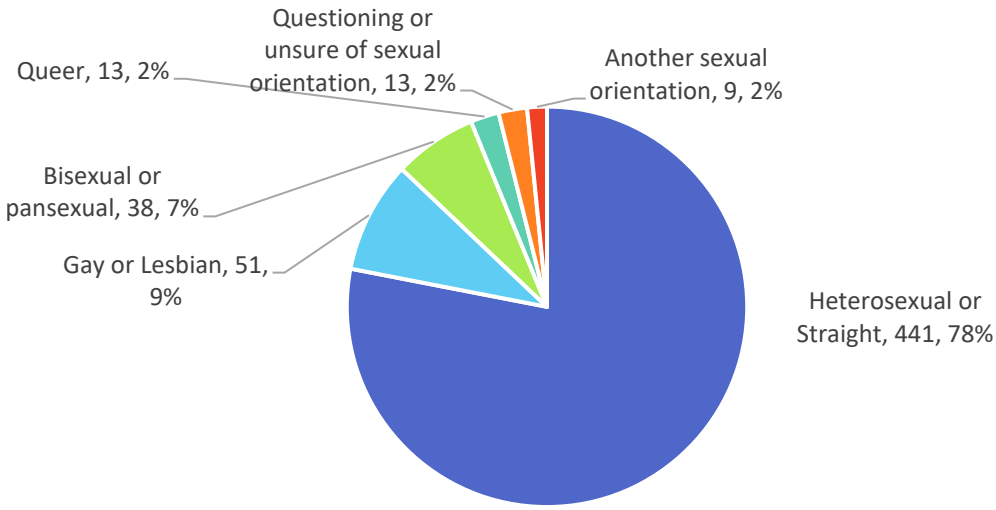


Youth under 16 represented 1% of the participants who completed demographic forms and **TAY made up 15%** of CPPP participants. Adults between the ages of **26-59 made up 59%** of participants in those meetings, and older adults between **60 and up made up 25%.** Given that Marin County is the oldest 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.

FY25/26 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. These meetings included information on BHSA and sought community input on both the FY25/26 MHSA Annual Update and the FY26/27 – FY28/29 BHSA Integrated Plan:

- Thursday November 14, 2024 from 12 – 1:30pm **Community Planning** meeting at 2330 Marinship Way, #100, Sausalito
- Monday November 18, 2024 from 12 – 1:30pm **Community Planning** meeting afternoon meeting via Zoom
- Wednesday November 20, 2024 from 1:30 – 3pm **Community Planning presentation to MHSA Advisory Committee** via Zoom
- Wednesday November 20, 2024 from 6 – 7:30pm **Community Planning** meeting evening meeting via Zoom
- Friday November 22, 2024 from 12 – 1:30pm **Lived Experience focused Community Planning** meeting at Enterprise Resource Center, 3270 Kerner Blvd., San Rafael
- Thursday December 5, 2024 from 6 – 7:30pm **Family Member focused Community Planning** meeting at 20 N. San Pedro Road, San Rafael
- Monday December 9, 2024 from 12 – 1:30pm **Provider focused Community Planning** via Zoom
- Thursday December 12, 2024 from 9:30 – 11am **Provider focused Community Planning** via Zoom
- Thursday January 9, 2025 **Provider focused Community Planning** via Zoom
- Wednesday January 15, 2025 **Provider focused Community Planning** via Zoom
- Wednesday January 15, 2025 from 2 – 3:30pm **Older Adult focused Community Planning** via Zoom
- Wednesday, January 29, 2025, 3 - 4:30PM **Early Childhood Behavioral Health Provider focused Community Planning** at 3240 Kerner Blvd., Rooms 109/110, San Rafael
- Wednesday, February 5, 2025, 6 - 7:30PM **LGBTQ+ focused Community Planning** via Zoom

- Thursday, February 6, 2025, 1 - 2:30PM **Novato Community Planning** at Margaret Todd Senior Center, 1560 Hill Road, Novato

- Wednesday, February 19, 2025, 1 - 2:30 **West Marin Community Planning** at West Marin Health & Human Services Multi Services Center, 1 Sixth Street, Point Reyes Station

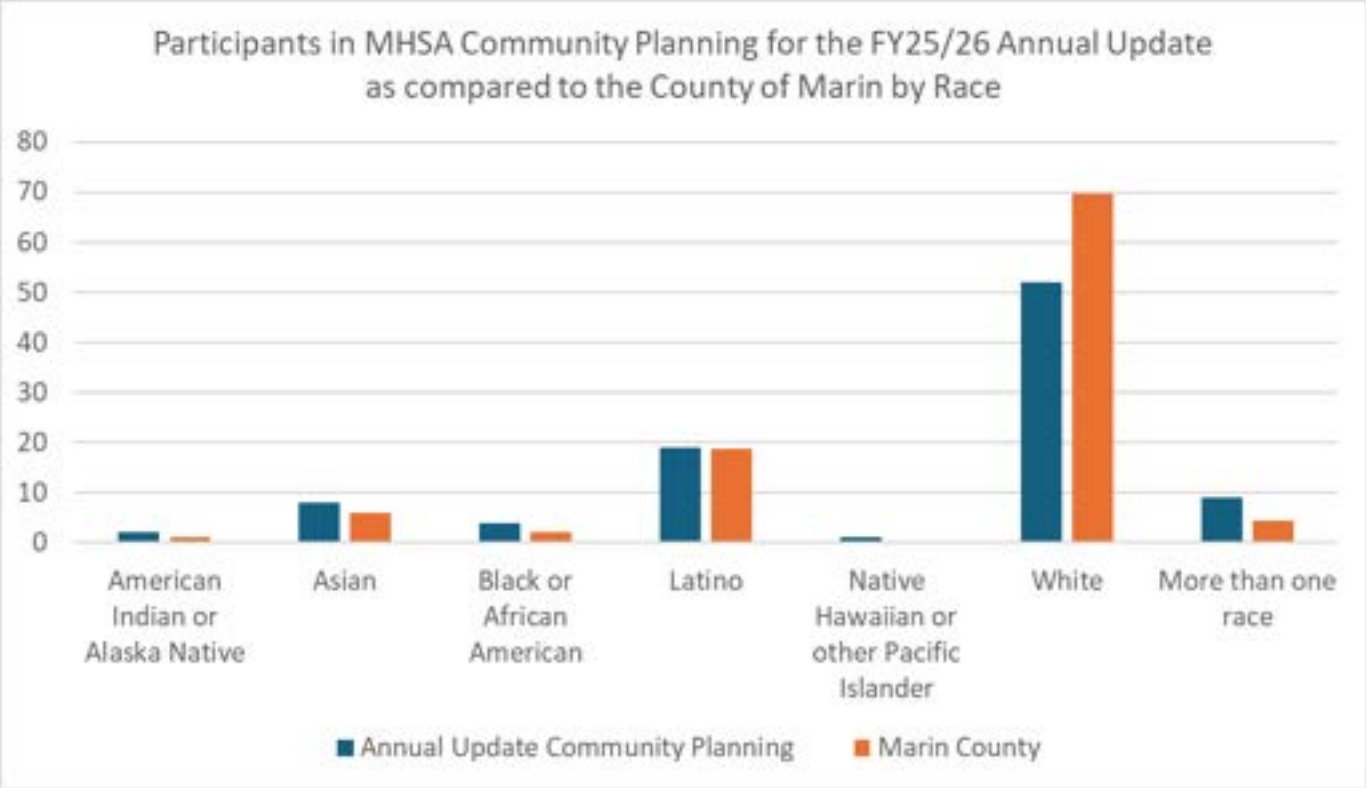
- Tuesday, February 25, 2025, 6 - 7:30 **Novato Community Planning in Spanish** at North Marin Community Services, 1907 Novato Blvd, Novato

DEMOGRAPHICS OF FY25/26 MHSA ANNUAL UPDATE COMMUNITY PLANNING:

Over 137 people participated in these meetings including 91 who completed the demographic survey.

57% (52 individuals) of those who participated in the community planning for the FY25/26 MHSA Annual Update have lived experience as a **family member** of someone with mental health challenges

43% (39 individuals) identified as having **personal lived experience** with serious mental illness



73% of individuals speak English as a primary language**, 21%** speak Spanish as a primary language, **1%** Cantonese, **1%** Russian, and **1%** another language

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

FY25/26 MHSA ANNUAL UPDATE PLAN PUBLIC REVIEW PROCESS

The MHSA Annual Update and Expenditure Plan for FY25/26 will be posted for **30-day Public Comment** beginning on **April 11, 2025 through May 13, 2025**. The MHSA FY25/26 Annual Update and prior Three-Year Plans and Annual Updates are posted on Marin County's website at: https://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 post 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 X account.

On **Tuesday May 13, 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 general standards 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:

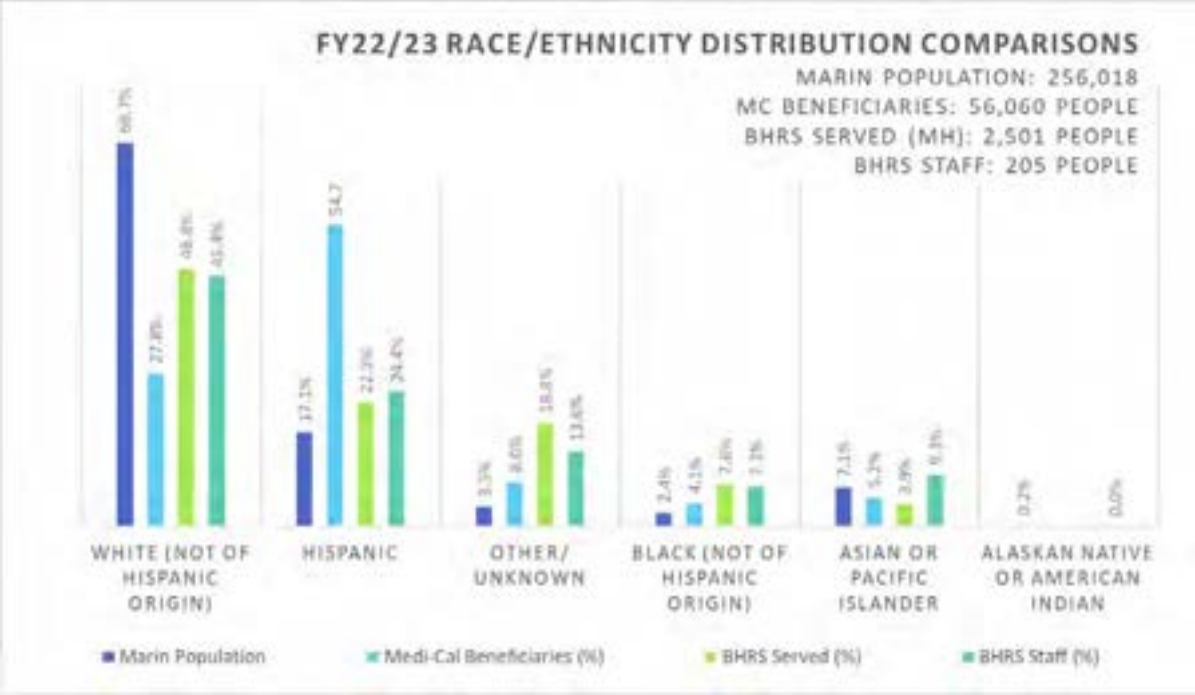
- Percentages of diverse cultural, racial/ethnic, and linguistic groups represented among direct service providers, as compared to percentage of the total population needing services and the total population being served and evaluation of bilingual proficiency in threshold languages; and
- Challenges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

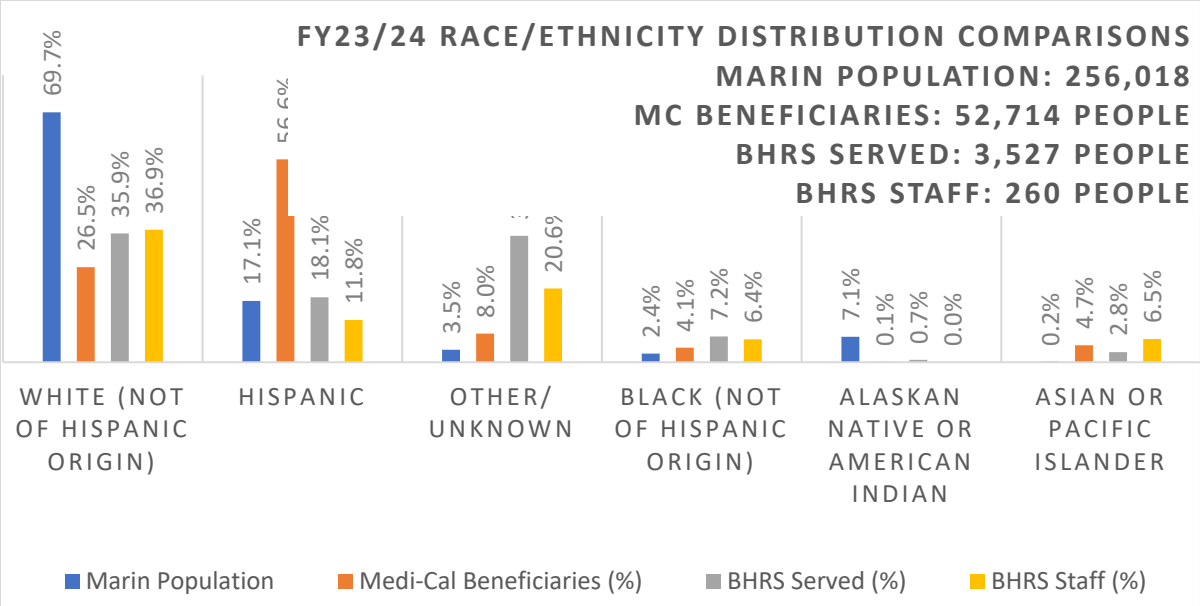
PERCENTAGES OF DIVERSE CULTURAL, RACIAL/ETHNIC, AND LINGUISTIC GROUPS

Please reference our most up to date data on Behavioral Health and Recovery Services (BHRS) via our Cultural Humility and Responsivity Three Year Plan for FY 23/24 – 25/26. The annual update for FY23/24 was released in January 2025.

The most notable changes in percentages of diverse cultural, racial/ethnic, and linguistic groups between FY 22-23 to FY 23/24 include:

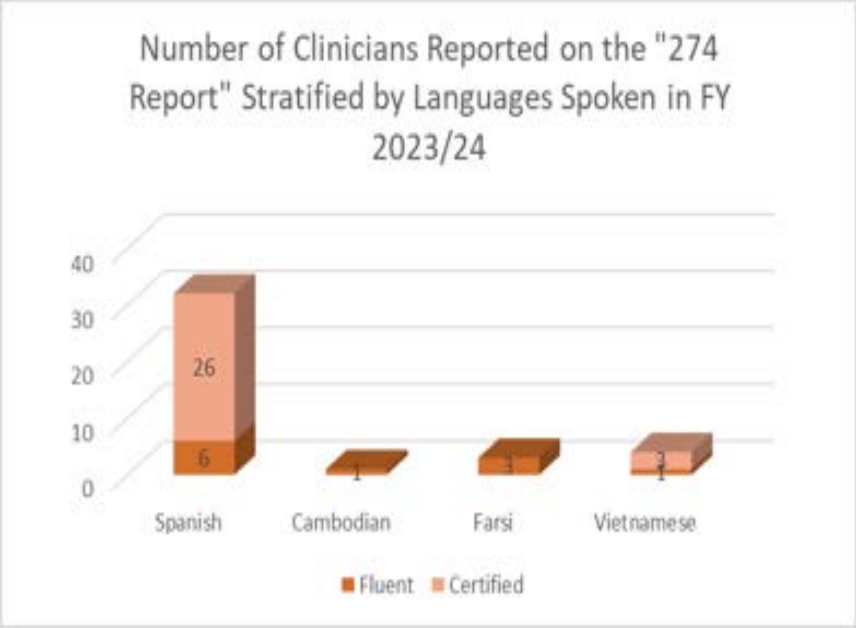
- A reduction in Medi-Cal beneficiaries; and
- An inclusion of SUD services in the total BHRS served count; and
- An increase in the number of BHRS staff; and
- A growing percentage of BHRS served in the "other/unknown" category; and
- An increase in the percentage of BHRS staff in the "other/unknown" category.





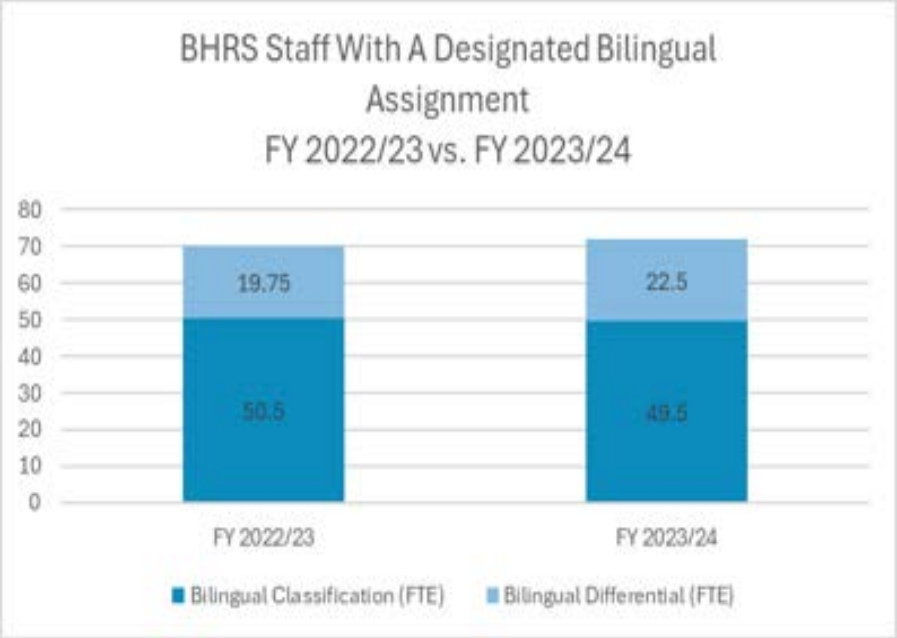
Spanish is the only threshold language in Marin however official documents are often also translated into Vietnamese as that is our second largest population.

The 40 County Clinicians self-reported language data on the 274 Report shows a significant portion of the bilingual clinicians are Spanish speaking. During the reporting time of the 274, BHRS had 32 clinicians that speaks Spanish, 4 that speaks Vietnamese, 1 that speaks Cambodian, and 3 that speaks Farsi.

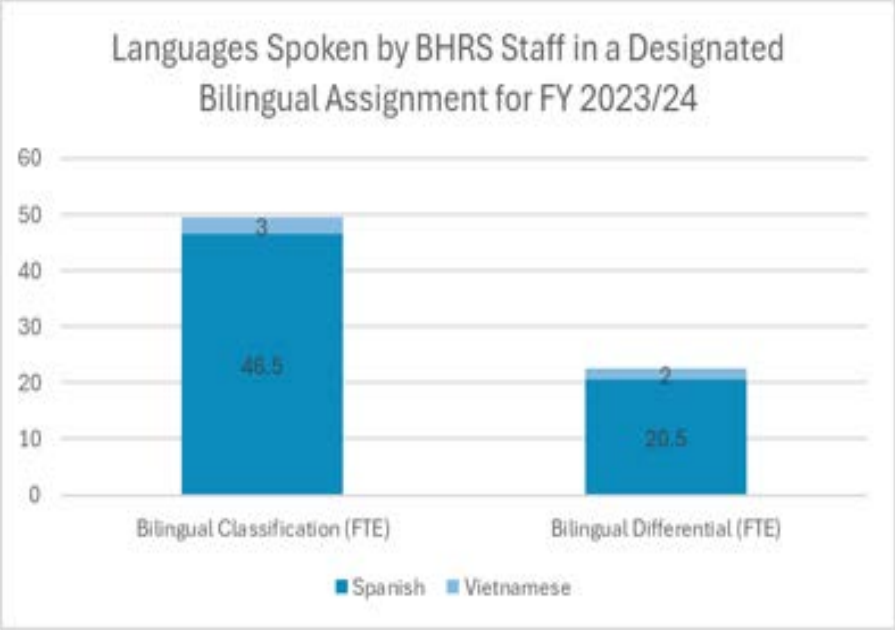


*Notes: Fluent is not an indication if a clinician is in a Bilingual Classification or receiving a Bilingual Differential. Clinicians who speak multiple additional languages would be represented multiple times in the graph.

In FY 2023/24, BHRS employed 72 bilingual staff across the Division. Of those staff members, 49.5 Full-Time Employee (FTE)s were in a bilingual classification and 22.5 FTEs received a bilingual differential. Below is a graph that demonstrates the number of occupied bilingual positions within BHRS from FY 22/23 to FY 23/24. There was a slight increase of occupied bilingual positions, including bilingual classification and bilingual differential, between FY 22/23 and FY 23/24.



Further analysis of the employee data shows there were 67 FTEs that spoke Spanish (46.5 in a Bilingual Classification and 20.5 receiving a Bilingual Differential) and 5 that spoke Vietnamese (3 in a Bilingual Classification and 2 receiving a Bilingual Differential).



*FTE totals represented in the above graphs are inclusive of full-time and part-time staff that provide bilingual services.

CHALLENGES and CONSIDERATIONS:

Data Collection:

- New Electronic Health Record (EHR) SmartCare:

  Over the years, BHRS has faced several ongoing challenges with collecting and documenting client demographic information. This past year has been no exception. Just in the past year, BHRS has implemented a new electronic health record (EHR), implemented new clinical documentation requirements, shifted clinician and administration staff roles and responsibilities, and actively updating client entry point procedures to be in alignment with CalAIM initiatives. These changes have only made it more challenging for BHRS staff to accurately collect and document client demographics in the EHR. Some of the high-level gaps identified include:

  - unique admission forms for each access point with different levels of data collection questions
  - missing or erroneous client demographics from the HER
  - missing or erroneous client Race, Ethnicity, and Language (REAL) and Sexual Orientation and Gender Identity (SOGI) information in the HER
  - confusion on the location to document client REAL and SOGI information in the EHR
  - different data dictionaries across platforms.

  The EHR is responsible for tracking three (3) different State reporting mandates, each reporting mandate requires its own information tracking page and follow different data dictionaries. In addition, new features and fields are being continuously developed in the EHR, including adding new flags/warnings for missing demographic data, new fields that document a clients' primary or preferred language, a field to document if a translator or interpreter is needed, and tracking what language was used in a clients' individual services. As these new features are made available, BHRS staff must develop and administer new trainings to an already overloaded staff who are still just trying to get the basics down of an ever-changing EHR.

- Health Information Exchange (HIE):

  In September 2023, BHRS signed the California Data Exchange Framework (DxF), the first division within Marin County HHS to do so. Since then, BHRS has been working with their new Electronic Health Record (EHR) vendor CalMHSA to develop and implement interoperability technology with local healthcare organizations, develop new Policies, Procedures, and a BHRS Privacy Policy Document, and execute a joint data sharing agreement between Marin County Public Health and BHRS with a Qualified Health Information Organization (QHIO), SacValley Medshare. Through this agreement, BHRS clinicians will have the capability to electronically provide and access bi-directional client health information with other healthcare organizations across the State of California. Data elements to be shared, at a minimum, will follow the United States Core Data for

Interoperability (USCDI) guidelines and will provide current and historical pertinent client health information to the clinician to improve client care and care coordination.

- Sources of Data Collection:

  Outside of BHRS' EHR and the data provided by BHRS Quality Management, BHRS is reliant upon several externally operated systems for data collection, including Marin County Human Resources (HR), data from the External Quality Review Organization (EQRO), and Marin County Communications. This is a challenge, as these teams have different policies, procedures, approaches, and limitations with data collection. For example, BHRS is reliant on staff demographics from County HR, who only collect staff demographic information at the point of hire. This means our staff demographic information is oftentimes outdated and/or incomplete. Though each year BHRS advocates for HR to find new approaches to collecting staff demographic information, there has been delayed progress in this area. BHRS is hopeful that with the Health and Human Services (HHS) Strategic Plan and HHS Race Equity Roadmap, there might be a pathway forward with increased advocacy and partnership. BHRS is also starting a Quality Improvement Project (QIP) in partnership with the HHS Race Equity RBA framework to improve demographic data collection of our clients within the EHR.

<u>System Navigation:</u>

- Lengthy assessments causing slower turn-around of completed assessments; and
- Inability to contract manage language line vendors at the BHRS level; and
- System navigation challenges, including clients navigating complicated processes, requirements, and criteria (i.e., share of cost).

<u>Outreach and Engagement:</u>

- Lack of alternative healing practices that are culturally and affirming to specific groups; and
- Lack of engagement of Latine, Hispanic, Undocumented, and/or Spanish Speaking groups and linguistically and culturally affirming services; and
- Lack of engagement in client perception surveys.

<u>Workforce:</u>

- 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
- 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 24/25 STRATEGIES TO OVERCOME CHALLENGES:

Goal Area 1: Language Access	
Description	**FY 24/25 Update**
BHRS will develop a process to implement the community-translation stipend.	Update: BHRS has advocated for HHS to explore this as a program for the broader HHS community. It is a formal suggestion that will also be brought to the County's upcoming Language Access Workgroup. **Updated goal**: BHRS will no longer be pursuing this goal due to lack of path forward for funding. In the meantime, the BHRS Latine Steering Committee (LSC) is having all translated documents reviewed by a contracted community member who has behavioral health experience, lived-experience, and is a certified interpreter/translator. BHRS will continue to utilize this as an option while advocating for HHS to identify review process of translated documents in the new County-wide Language Access Workgroup.
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**: The BHRS Program Manager of Equity and Inclusion (PMEI) will liaise regularly with the Director of Countywide Communications, who is the new contract manager for all language contracts. PMEI will provide feedback, as needed, on any challenges relating to contract management, interpretation/translation vendor reliability, etc. Update: The County of Marin is starting a Language Access Workgroup to address the ongoing challenges throughout the County with language access. The hope is to address this as a full system instead of as independent departments. This workgroup is expected to begin in 2025. **Updated goal**: BHRS PMEI will participate in the Language Access Workgroup to elevate any BHRS specific concerns, challenges, or proposals at the County-wide level.
Update BHRS' internal policy on use of bilingual staff and working with interpreters.	Update: PMEI organized a group of HHS department representatives to develop a report-out on commonly experienced issues. This was presented to HHS Equity Team, who is now intending to develop a department-wide policy. Once this policy is developed and finalized, BHRS will develop and implement any specific procedure that is unique to BHRS.
Pull bilingual staff data from 274 in 2024 to evaluate distribution of bilingual staff and language capacity across BHRS.	Update: This goal is now represented in the Workforce section, as it applies to workforce capacity. However, BHRS is one step closer to achieving a greater understanding of our internal language capacity, as HR is now able to report-on which languages are spoken by bilingual staff. This data will be shared below in the Workforce section of updates.

Continue to increase the number of trainings provided in commonly spoken languages (i.e., Spanish and Vietnamese).	Update: In September 2024 for Suicide Prevention Month a suicide prevention training was hosted in Spanish and in Vietnamese. Update: In January 2025, BHRS will launch a Latine Learning Academy for bilingual providers who work primarily with Spanish-speakers. Update: Once the Latine Steering Committee has finalized new materials for distribution, the BHRS bilingual Outreach and Engagement Senior Program Coordinator will provide trainings in the community on use of materials, including presentations on the *Cuerpo Corazon Communidad* Radio Show. Update: BHRS outreach and engagement team will begin a pilot to outreach to Vietnamese speakers in the community who need behavioral health services. This will include BHRS Vietnamese speaking staff providing training to Vietnamese speaking volunteers who will serve as a bridge between the Vietnamese speaking community and BHRS services.

Goal Area 2: Disparities in Latine Service Utilization	
Description	**FY 24/25 Update**
BHRS Latine Steering Committee (LSC) will formally document and steward BHRS' Quality Improvement Project (QIP) of 5 strategies to create system navigation tools.	Update: The QIP is an internal document that is being utilized by the LSC to guide their work and deadlines. **Updated goal:** The Outreach and Engagement Senior Program Coordinator will be able to present on the QIP during any site-visits or external quality review processes.
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	Update: The BHRS LSC is currently pursuing a contract with a Spanish-speaking videographer to create a video series featuring Spanish-speakers navigating the BHRS system of care. The goal is to produce 4 videos by June 2025. Update: The LSC is on track to print a navigation booklet translated into Spanish that explains financial responsibility, insurance eligibility, and parts of the BHRS assessment process by January 2025. Update: The LSC is on track to have some of our brochures updated and translated into Spanish by early January 2025. **Updated goal:** The Outreach and Engagement Senior Program Coordinator will lead efforts to develop system navigation tools in partnership with Access and

targeted to address disparities within the Latine and Spanish speaking communities of Marin, and will develop a cultural ambassador program.	the LSC and will monitor the QIP targeted to address disparities within the Latine and Spanish speaking communities of Marin.
Outreach and Engagement Senior Program Coordinator will work with BHRS Program Managers to create an outreach strategy utilizing bilingual mental health practitioners.	Update: For FY 24/25, the Outreach and Engagement program is piloting an internal strategy for reaching out to Vietnamese speakers in Marin County who need behavioral health services. Set to begin in January 2025, the outreach and engagement team will collaborate with BHRS' Bridge Kerner team and a Vietnamese speaking Psychologist to build a bridge between Vietnamese speakers who need to be connected to behavioral health services and an existing clinical support group conducted in Vietnamese. The pilot will focus on recruiting Vietnamese speakers from the community to promote behavioral health services to those in need. An evaluation of this pilot and internal strategy will be prepared in July 2025 to determine broader applicability to other cultural groups.
Present policy on case management and therapy integrative model to supervisors and engage in formal review with the Medical Director, ACCESS Supervisor, staff, and members of CSOC, Forensics, Residential Team, and Crisis Team.	Update: BHRS Adult System of Care (ASOC) has not finalized this policy. However, since last update, BHRS has operationalized several FSP teams providing psychotherapy for their own clients and reduced reliance on intern program and network providers. In addition, it is better for BHRS clients to have coordinated services within their treatment team, which allows for more collaboration between providers. **Updated goal:** The path forward is the Access reorganization. It sets up the foundation for therapy to be provided at the team level because all services will be coordinated by the team. BHRS will re-evaluate the specifics of this goal once the Access re-organization is finalized.

Goal Area 3: Cultural Humility, Anti-Racism, and Trauma-Informed Frameworks	
Description	**FY 24/25 Updates**
Develop and implement a DEIB plan within BHRS and work cross departmentally to advocate for an HHS	Update: BHRS is on track to have a finalized Diversity, Equity, Inclusion, and Belonging (DEIB) Council Launch Plan by 12/31/2024.

holding of this work within the upcoming HHS Equity Plan.	**Updated goal:** The BHRS DEIB Council will be formed by July 2025 and will begin to support BHRS workforce equity initiatives, in addition to partnering with HHS on alignment with HHS Equity Roadmap.
Re-launch DEIB supervision space for supervisors to maintain space for culturally responsive supervision.	Update: The DEI Consultation / Coaching Series for Expanded Leadership began in September 2024 and will continue through June 2025. The purpose of this space is to create a supportive and proactive space for managers, supervisors, and directors to address inclusivity, equity, justice, and diversity issues within the workplace. This consultation series aims to minimize microaggressions, enhance the ability to respond to ruptures, and promote a culturally responsive environment in co-worker dynamics, organizational practices, and clinical work. The consultation will seamlessly blend discussions related to personnel and clinical spaces, recognizing the interconnectedness of individual experiences with organizational and clinical dynamics. Incorporating a supervisor's supervision model, the sessions will provide an additional layer of support for those in managerial roles, ensuring a holistic approach to addressing challenges. The sessions will serve as a designated space for open dialogue, constructive discussions, and collaborative problem-solving. **Updated goal:** Evaluate the DEI Consultation / Coaching Series for Expanded Leadership with input and feedback both from participants in the series and the people whose supervision is impacted.

Goal Area 4: Workforce and Training	
Description	**FY 24/25 Updates**
Complete a Workforce, Education, and Training (WET) Plan that integrates both MHSA community planning and organizational assessment input.	Update: Trainings are currently being implemented, with offerings that include a LGBTQ+ service delivery series, working with interpreters/translators for both administrative and direct service staff series, a DEI consultation / coaching series for leadership, a cultural humility and trauma-informed training series for all staff, a learning academy to improve service delivery for Latine / Spanish-speaking clients, and additional trainings added to the online PESI training platform.
Simplify and streamline current cultural humility training policy and tracking system via feedback from listening sessions completed in 2023.	Update: The WET team and Program Manager of Equity and Inclusion (PMEI) are beginning the testing phase for hosting trainings on the current Marin County TalentQuest platform. One training has been posted to TalentQuest, and the team is considering how analytics and tracking will work. A soft launch of this option for taking trainings on demand and tracking through a new system is set for the beginning of FY 25/26.

Add additional training to PESI platform that satisfies cultural humility and LGBTQ+ training requirements.	Update: This goal is ongoing, as courses are added to PESI based on the needs of the system. Current cultural humility and/or LGBTQ+ trainings available on the PESI platform include: Culturally Responsive Clinical Supervision: Ethical and Trauma-Informed Multicultural Supervision Strategies and Cultural Competency and Trauma-Informed Care for Working with Trans and Trans BIPOC Clients: Create a Welcoming and Gender-Affirming Safe and Trusting Environment. **Updated goal:** Collaborate with MHSA WET team on trainings to be included for FY 25/26 on PESI platform.
Identify and implement recruitment and retention strategies of bilingual staff, working cross departmentally to advocate for an HHS holding of this work within the upcoming HHS Equity Roadmap.	Update: The BHRS Latine Learning Academy is set to begin in January 2025, which is an effort to promote the retention of bilingual providers who are working with Spanish-speaking populations. This is a free Academy offering with a give-back component, which includes pre-committing to ongoing participation in DEI efforts across the county of Marin. Update: BHRS is currently waiting for the new HHS Equity Roadmap, in addition to the start of a new County-wide Language Access Workgroup. **Updated goal**: BHRS will participate in the new County-wide Language Access Workgroup and will advocate for a Language Access plan that is inclusive of strategies to address recruitment / retention of bilingual staff. **Updated goal:** Explore possibility of equity / administrative carve-out for bilingual providers performing bilingual services outside the scope of their position. **Updated goal:** The upcoming BHRS Diversity, Equity, Inclusion, and Belonging (DEIB) Council will identify pathways for a staff-held bilingual support group.
Implement a Latine Learning Academy for BHRS staff and contracted providers to support focused learning with Spanish speaking and Latine clients.	Update: Application and selection process has been finalized with a confirmed 20 participants to begin the Academy in January 2025.
Use 274 in 2024 to track the number of bilingual staff, the team they are on, and what	Update: The 274 Report is a mandated monthly report sent to Department of Health Care Services (DHCS) that includes information on behavioral health clinicians rendering services to Medi-Cal beneficiaries. This does not include non-clinicians and non-required programs (i.e. Mental Health Residential Programs). For better accuracy and tracking of this strategy, moving forward, BHRS will split the goal into two, more distinct goals below.

language(s) they are bilingual in.	**Updated goal 1:** Use the 274 Report to annually track the number of reported clinicians rendering services in languages other than English to Medi-Cal Beneficiaries, what programs they work in, and what other languages they speak. **Updated goal 2:** Collaborate with Health and Human Services (HHS) – Human Resources (HR) to annually track the number of BHRS staff that speak a language other than English with BHRS clients, what programs they work in, and what other languages they speak.
Use new Electronic Health Record (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.	Update: The new EHR is unable to track how long it takes clients to receive a service in a language other than English once they have made a request. The EHR can only provide what the clients' preferred language is and what language individual services were provided in. For better accuracy and tracking of this strategy, moving forward, BHRS will split this into two, more distinct goals. **Updated goal 1:** BHRS will utilize the EHR to identify the number of clients who have indicated a primary/preferred language other than English and compare to the language services were rendered in. BHRS is currently developing a training for staff on documenting a clients' preferred language and how to document a service that was provided in a language other than English and implementing an EHR flag to be added to a client's profile if this information is missing. **Updated goal 2:** BHRS will continue to monitor any feedback from Limited English Proficiency (LEP) clients who are waiting longer for services due to the need for services in a language other than English.
Implement Workforce Equity Survey to track demographics at the leadership level.	Update: The Marin County - Office of County Executive launched an anonymous County-wide Employee Engagement Survey in October 2024. The County expects to provide the results to each of the Departments and their Divisions by the end of Calendar Year (CY) 2024 or beginning of CY 2025. Included in the survey, employee demographic data was an optional question and if completed, will be used to breakdown the results. Update: HHS is in the process of finalizing a 3-year departmental strategic plan. Within this plan are five focus areas including Advance Racial Equity, Improve Community Conditions, Foster Community Partnerships, Optimize Workforce, and Boost Data Collection, Within the Optimize Workforce focus area, a planned activity includes conducting an HHS employee survey by December 2025 focusing on topics such as employee engagement and professional development needs and will include an optional section to collect staff demographics.
Implement new Cultural Competency Plan	Update: Waiting for DHCS to indicate when Counties are required to implement.

Requirements (CCPR) guidelines for language capacity tracking.	

Goal Area 5: Engagement with Underserved or Inappropriately Served Communities	
Description	**FY 24/25 Updates**
BHRS Outreach and Engagement Senior Program Coordinator will identify new opportunities for partnership with impacted groups in Marin by developing and implementing the cultural ambassadors program.	Update: With the passing of Proposition 1, the cultural ambassador program is no longer a planned project. **Updated goal:** The BHRS Outreach and Engagement Senior Program Coordinator will identify new opportunities for partnership with impacted groups in Marin post the implementation of Proposition 1.
Resource and/or support alternative healing practice efforts in the community.	Update: BHRS is instituting the Latine Learning Academy, where alternative healing practice topics will be covered, and local healers will be brought in to share their knowledge and expertise. Update: The Marin County Office of Equity has included in their Race Equity Action Plan (REAP) plan a mental health goal on piloting a healing arts program for youth in Marin City and the Canal Area to address mental health needs.
BHRS will identify how to track the new health indicators that are required in the new Department of Health Care Services (DHCS) Cultural Competency Plan Requirements (CCPR) guidelines.	Update: Waiting for DHCS to release new CCPR guidelines.
BHRS will identify how their new Electronic Health	Update: This goal is still in progress. BHRS' EHR ("SmartCare") was implemented in July of 2023. The implementation of the new software was fraught with challenges across various aspects of the system, including that of

Record (EHR) system can be equipped to effectively measure outcomes.	data collection/entry and the ability of the EHR to produce meaningful reports. Over the past year, the EHR vendor has been heavily focused on meeting the needs of the County as it relates to functionality of templates and modules related to state reporting. Not all these functions are tied to outcomes, especially as they relate to demographic data. The mechanisms for demographic data collection are present within the EHR, albeit with more limited demographic categories than BHRS would hope to collect, and with different collection templates that use nonidentical data dictionaries dependent upon the system of care. Efforts are currently being directed toward increasing staff knowledge and understanding of the different areas within the EHR where demographic data needs to be collected and entered. A quality improvement project has been initiated to provide the aforementioned knowledge, and to carry out the goal of developing technical trainings, along with client-focused, and trauma-informed trainings regarding the collection of sensitive personal information. This project also aims to shift the culture surrounding the collection of demographic data, fostering an environment that encourages thoughtful, respectful, and inclusive approaches to gathering this information. Getting accurate data correctly entered into the EHR is the first step toward being able to extract meaningful data from the system. As IT and analytic staff have been able to learn more about the EHR over the past year, they have worked to hone their skills around writing queries to extract data from the EHR and are working to develop their knowledge of new analytic software. These skills and resources, along with the efforts toward meaningful and accurate data entry will allow BHRS to stratify data by Race, Ethnicity and Language (REAL) and Sexual Orientation and Gender Identity (SOGI) demographic categories and effectively measure outcomes of important behavioral health indicators in the near future. **Updated goal:** Develop and implement the Quality Improvement Project (QIP), with additional partnership from the Health and Human Services (HHS) Measurement, Learning, and Evaluation (MLE) team and results-based accountability (RBA) framework, designed to improve demographic data entry into the EHR "SmartCare."
The BHRS Equity Data Workgroup will lead conversations around Sexual Orientation and Gender Identity (SOGI) and Race, Ethnicity, Age, and Language (REAL) to identify inclusive	Update: Over the past fiscal year, clinicians' primary focus has been on implementation of the basic clinical functions of the EHR and less focus on non-essential client data, i.e. SOGI and REAL. With minimal progress from previous interventions, BHRS is planning to develop a formal Quality Improvement Project (QIP). The QIP will focus on developing policies and procedures to ensure clinicians and administrative staff collect client SOGI and REAL data and input into SmartCare. This will include an annual policy to update client information, including demographic information.

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.	
Identify process for Crisis Stabilization Unit (CSU) to follow-up with clients with "not reported / unknown" race/ethnicity in client profile.	Update: The CSU will be included in the planned SOGI and REAL Quality Improvement Project (detailed more below) and potentially partially solved through the revised client profile update annual policy.
Identify engagement strategies to close the disparate gap in race/ethnicity after 15 services.	Update: This goal will be contingent upon the success of the SOGI and REAL QIP so that BHRS can pull a more updated report on engagement in services past 15 days.
Improve contract monitoring outcomes including developing and monitoring better equity outcomes and tracking cultural humility training efforts.	Update: BHRS has agreed to participate in the early adoption of the Integrated Behavioral Health State Contract. This changes the monitoring requirements to allow annual desk audits with on-site audits every three (3) years. BHRS will continue to work on identifying resources, monitoring tools, and audit schedules through the next year. Update: HHS Contracts Team has developed a workgroup that is taking on this goal more broadly for the system of care.
Develop strategies to increase participation in Performance Outcomes and Quality Improvement (POQI) and Treatment	Update: The BHRS Equity and Community Partnerships Committee (ECPC) hosted a meeting in partnership with the BHRS Quality Management (QM) Director and shared ideas on how to increase participation in POQI and TPS. ECPC suggested that Peers are utilized in supporting clients to fill out the surveys each year.

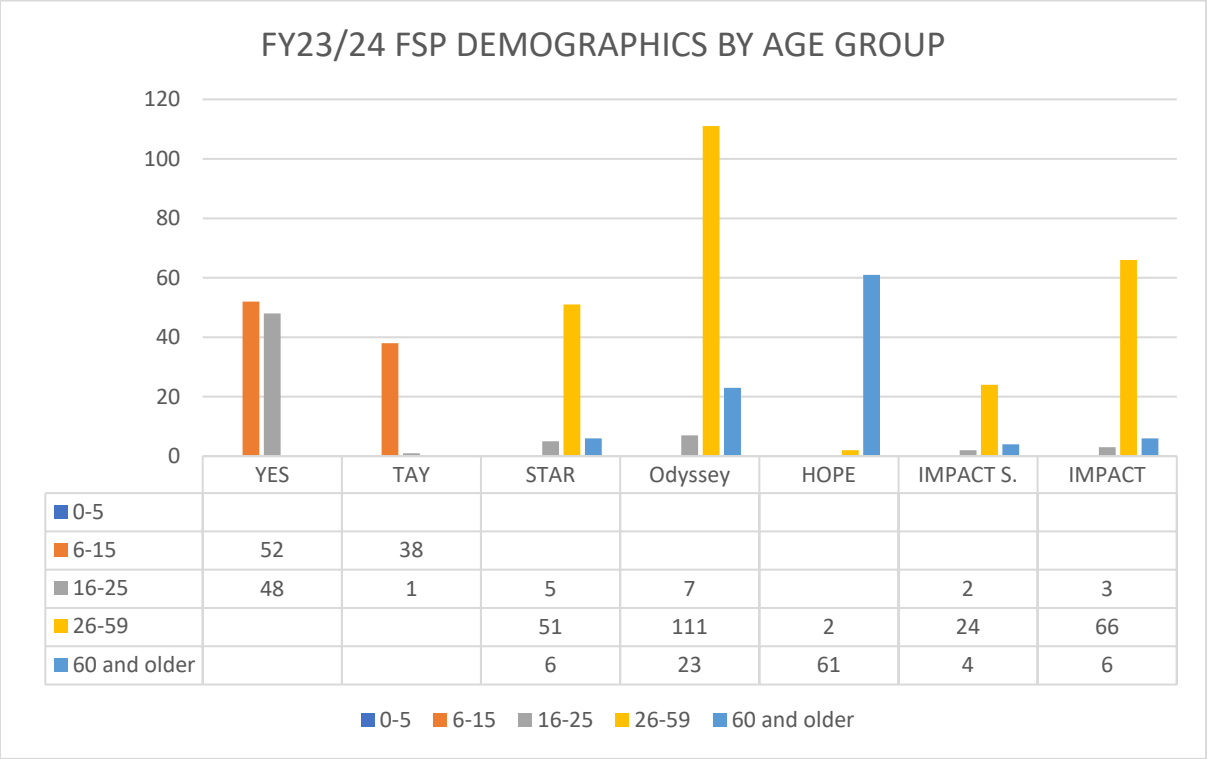
Perception Survey (TPS) surveys.	

Other Strategies to Address Disparities:

- DEIB Council Launch Plan for BHRS Workforce: BHRS is looking forward to the finalization and implementation of our Diversity, Equity, Inclusion, and Belonging (DEIB) Council Launch Plan, which is the result of years of work, consultation, feedback sessions, survey assessments, and system evaluation. This is unique as it focuses on providing progress updates on what is possible to achieve within BHRS and outlines where additional support is needed to tackle broader system issues. It integrates feedback from BHRS staff and leadership, in addition to the recommendations from professional Diversity, Equity, and Inclusion (DEI) consultants. The DEIB Council Launch Plan recognizes that any Plan should be a living document, with room to adjust as our understanding of the problems and solutions evolve. The DEIB Council is expected to hold BHRS Senior Leadership accountable, support workforce equity initiatives, and partner with other county-led equity groups. The Council will also encourage the voices and participation of those who are less frequently heard. The DEIB Council Launch Plan is expected to be released in January 2025.
- Cultural Celebrations for BHRS Clients: BHRS received feedback during the last MHSA 3-Year Planning and CHRP 3-Year Planning cycle around the importance of culturally affirming events for clients. As a result, BHRS has been able to implement two culturally affirming events since the start of the 3-Year Planning cycle. So far, this fiscal year, BHRS has hosted an event for *Dia de los Muertos*, which included a community circle discussion, building an altar, decorating sugar skulls, making marigolds, and hosting a raffle. The event is still under evaluation and will be reported on more broadly in the next plan. Coming up, BHRS plans to host a culturally affirming event during Lunar New Year and Juneteenth, as well.

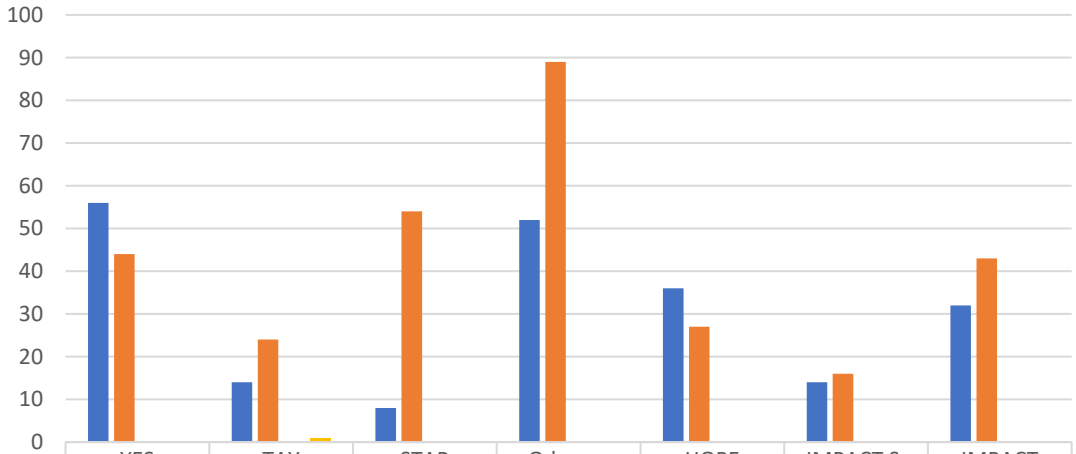
FULL-SERVICE PARTNERSHIP DEMOGRAPHICS

In an effort to show a 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 S.	IMPACT
0-5							
6-15	52	38					
16-25	48	1	5	7		2	3
26-59			51	111	2	24	66
60 and older			6	23	61	4	6

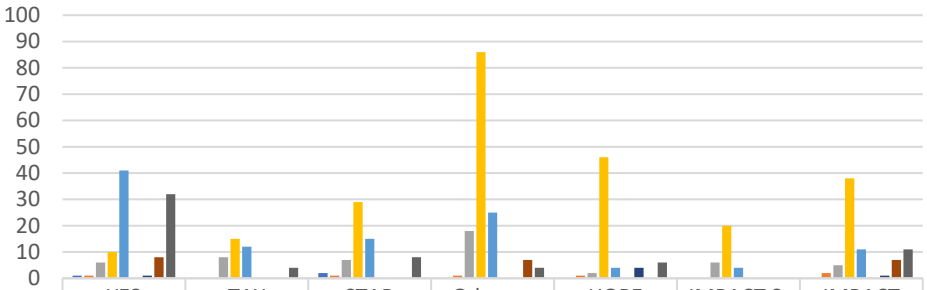
FY23/24 FSP DEMOGRAPHICS BY GENDER IDENTITY



	YES	TAY	STAR	Odyssey	HOPE	IMPACT S.	IMPACT
Female	56	14	8	52	36	14	32
Male	44	24	54	89	27	16	43
Other							
Not Reported		1					

Female Male Other Not Reported

FY23/24 FSP DEMOGRAPHICS BY RACE/ETHNICITY



	YES	TAY	STAR	Odyssey	HOPE	IMPACT S.	IMPACT
American Indian/Alaskan Native	1		2				
Asian	1		1	1	1		2
Black or African American	6	8	7	18	2	6	5
Caucasian or White	10	15	29	86	46	20	38
Hispanic	41	12	15	25	4	4	11
Hawiian/ Pacific Islander							
Vietnamese	1				4		1
Other/ Mixed Race	8			7			7
Unknown / Not Reported	32	4	8	4	6		11

American Indian/Alaskan Native Asian Black or African American
Caucasian or White Hispanic Hawiian/ Pacific Islander
Vietnamese Other/ Mixed Race Unknown / Not Reported

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 was 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 108 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.

FY23/24 OUTCOMES:

In FY23/24 there were 100 children and youth served by the YES program, including 52 youth (between the ages of 6 and 15) and 48 Transitional Age Youth (between the ages of 16 and 25). 72 of these partners were in the program for one year or longer at the end of FY23/24.

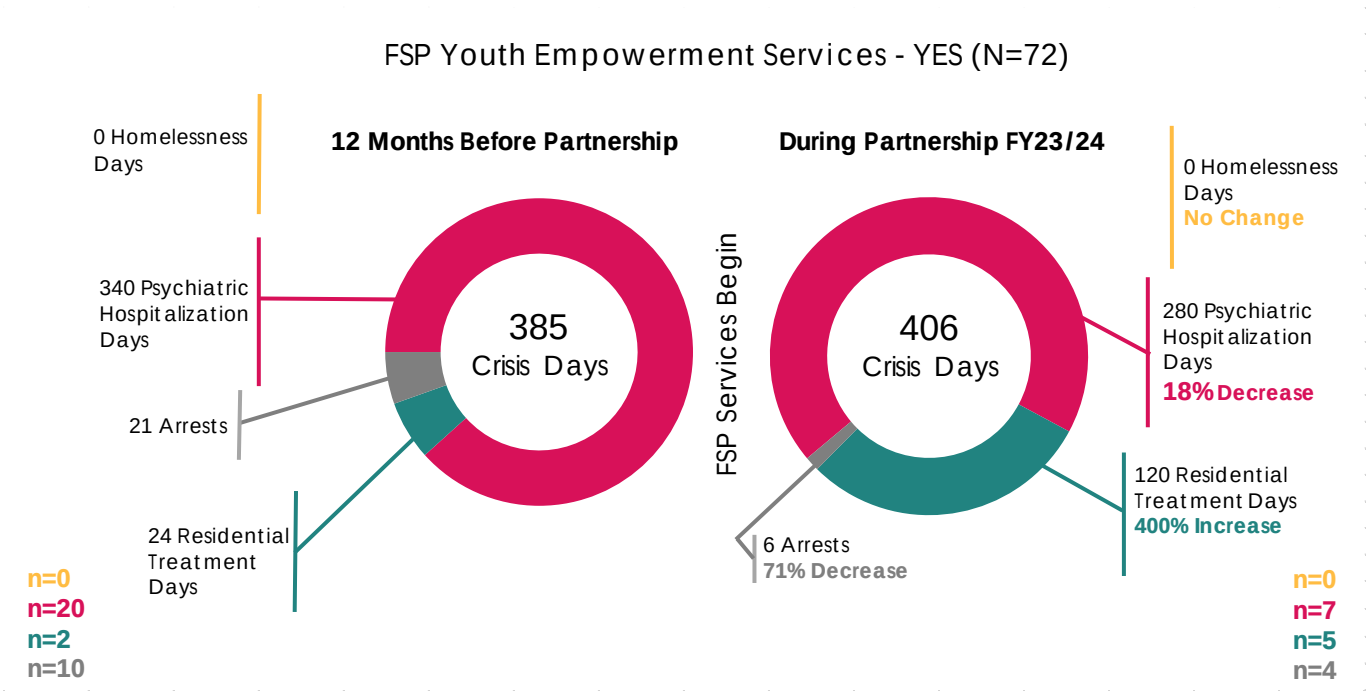
1. In FY23/24, there was an 18**% decrease in total psychiatric hospitalization days**: Of the clients who had been enrolled in YES for at least one year, 20 had experienced at least one psychiatric hospitalization in the year prior to enrollment, for a collective 340 hospitalization days. In In FY23/24, 7 of the YES clients experienced a psychiatric hospitalization for a total of 280 hospitalization days (an 18% decrease).

2. **Zero days Homeless:** In the twelve months prior to entry into the FSP, none of the partners experienced homelessness in the year before services. In In FY23/24 there were no days homeless.

3. In the twelve months prior to entry into the FSP, 2 partners were in residential treatment for 24 days. In In FY23/24, there were 5 partners who spent at least one night in residential treatment for a total of 120 days—a **400% increase in residential treatment days** from the baseline year.

4. **71% Decrease in number of Arrests:** Of the 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 21 arrests. In In FY23/24, 4 (60% decrease in number of partners) for a total of 6 arrests - a 71% decrease from the baseline year.

PROGRAM CHANGES FOR FY25/26: None.



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

PROGRAM OVERVIEW AND HISTORY: Marin County's Transition Age Youth (TAY) services, provided by 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 training, employment services, housing supports, and comprehensive, culturally appropriate, integrated mental health and substance abuse services. There is also a well-attended "drop-in" program for youth who can take advantage of the group activities and ongoing social support.

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. Research has shown there are significant benefits from early intervention with these high-risk populations. The TAY FSP also partners with the county's First Episode Psychosis program, when TAY youth are presenting with a first episode of psychosis (within the past two years).

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, 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 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.

In FY23/24 in alignment with the new CalAIM changes the TAY FSP contract was converted to a fee-for-service contract, emphasizing face-to-face time with clients. We also clarified how to capture service time for services provided to clients stepping down from psychiatric facilities or juvenile hall. Because FSP clients generally have higher acuity of symptomology, escalation in symptoms sometimes results in psychiatric hospitalization or incarceration, which the program is seeking to mitigate. In FY23/24 the TAY program increased 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. This has meant being more fluid with service delivery and ensuring that FSP services are not duplicative of institution-based services. This increase in focus on these acute situations has shown positive results in reducing the number of youth discharged with no plan or safety net.

EXPECTED NUMBERS TO BE SERVED: Anticipate that approximate 45 Transitional Age Youth will be served throughout the year with approximately ~50 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.

FY23/24 OUTCOMES:

In FY23/24 there were 39 partners served in TAY (between the ages of 16 and 25), 38 of whom had been in the program for one year or longer and were served during FY23/24.

1. **25% Decrease in Psychiatric Hospitalization days:** Of the 39 partners who had been enrolled in TAY for at least one year, 4 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 88 hospitalization days. In FY23/24, 3 of the partners experienced a psychiatric hospitalization, for a collective total of 66 hospitalization days—a 25% decrease from the baseline year.

2. **10% Decrease in days homelessness:** In the twelve months prior to entry into the FSP, 1 partner experienced homelessness for a collective total of 10 days in the year before services. In FY23/24, there was 1 partner who experienced homelessness for a collective total of 9 days—a

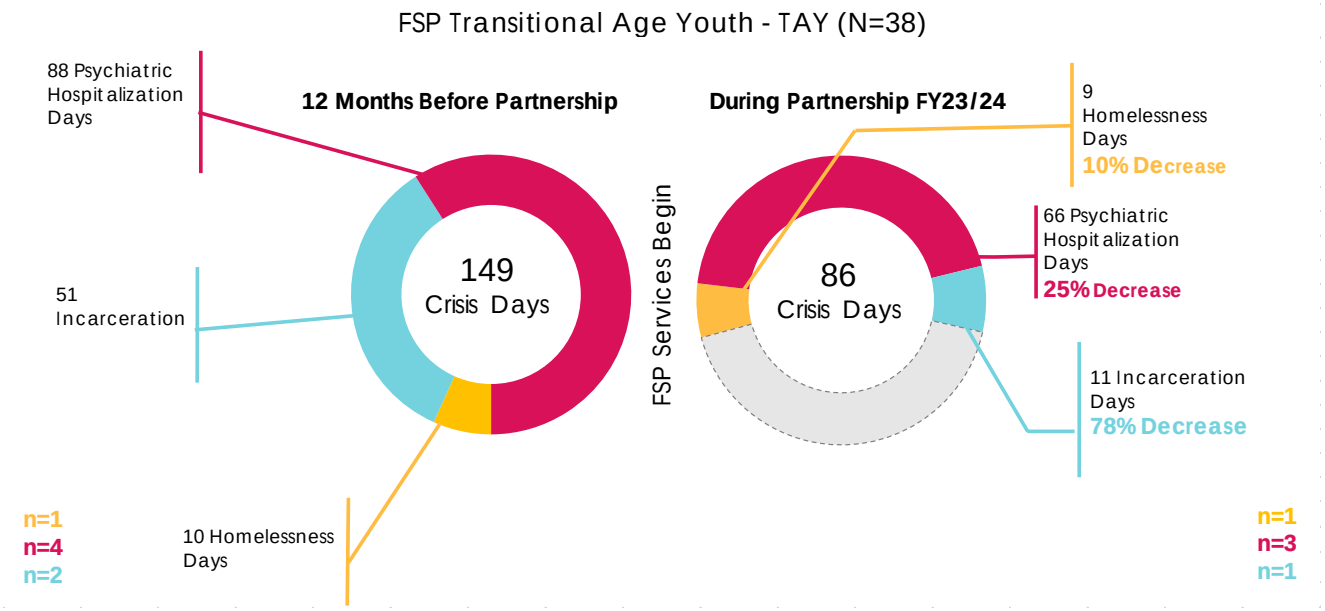
10% decrease in days homeless.

3. **78% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 2 partners were incarcerated for a total of 51 days. In FY23/24, 1 partners spent at least one day in jail for a collective 11 days, a decrease of 78% in incarceration days.

4. 74% of TAY partners were engaged with either school or work (or both) during FY23/24.

5. 100% 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 the first year since the COVID pandemic that the center operated without having to close the office or drop-in center due to health concerns. 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 FY25/26: None.



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

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. The STAR FSP also 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. However, in practice there was no substantial difference between how clients were served and the process ended in FY24/25. 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 was 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. In FY24/25 added a Peer Support Counselor and MHSA-funded Behavioral Health Practitioner position to provide services to existing clients and CARE Act clients. In addition, the Psychologist position shifted to provide more assessments on the front end and support the CARE Court process. It is expected there will be an increase in the number of clients served in FY24/25 with the implementation of CARE Act in December 2024.

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.

FY23/24 OUTCOMES:

In FY23/24 there were 62 partners served in STAR, including 5 Transitional Age Youth (between 16-25), 51 adults (between 26-59), and 6 older adults (60+). 56 of these partners had been in the program for one year or longer by the end of FY23/24.

1. **88% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 25 partners experienced homelessness for a collective 4,425 days homeless in the year before services. In FY23/24, 7 partners who had been enrolled in STAR for over one-year experienced homelessness at any point during FY23/24 for a collective 518 days homeless, an 88% decrease.

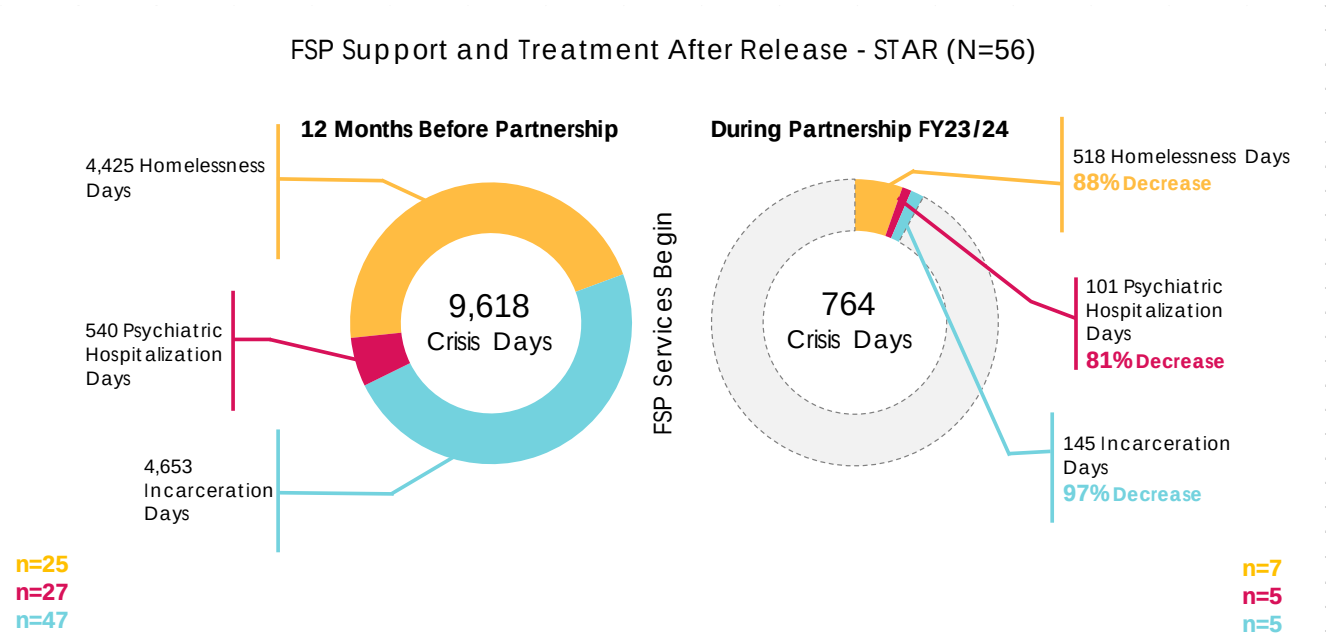
2. **65% decrease in arrests:** In the twelve months prior to entry, 45 partners had at least one arrest

for a collective total of 72 arrests. In FY23/24, there were 11 partners who had been enrolled in STAR for one year or more had at least one arrest for a total of 25 arrests, a 65% decrease in arrests.

3. **97% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 47 partners had experienced incarceration for a collective 4,653 days in custody in the year before services. In FY23/24, 5 partners spent a collective 145 days in custody, for a 97% decrease in incarceration days.

4. **81% decrease in psychiatric hospitalization:** Of the 56 partners who had been enrolled in STAR for at least one year, 27 experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 540 hospitalization days in their year before entering STAR. In FY23/24, there were 5 partners who had been enrolled in STAR for one year or more who experienced a psychiatric hospitalization for a total of 101 hospitalization days, an 81% decrease.

PROGRAM CHANGES FOR FY25/26: None.



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 were 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 on 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.

FY23/24 OUTCOMES:

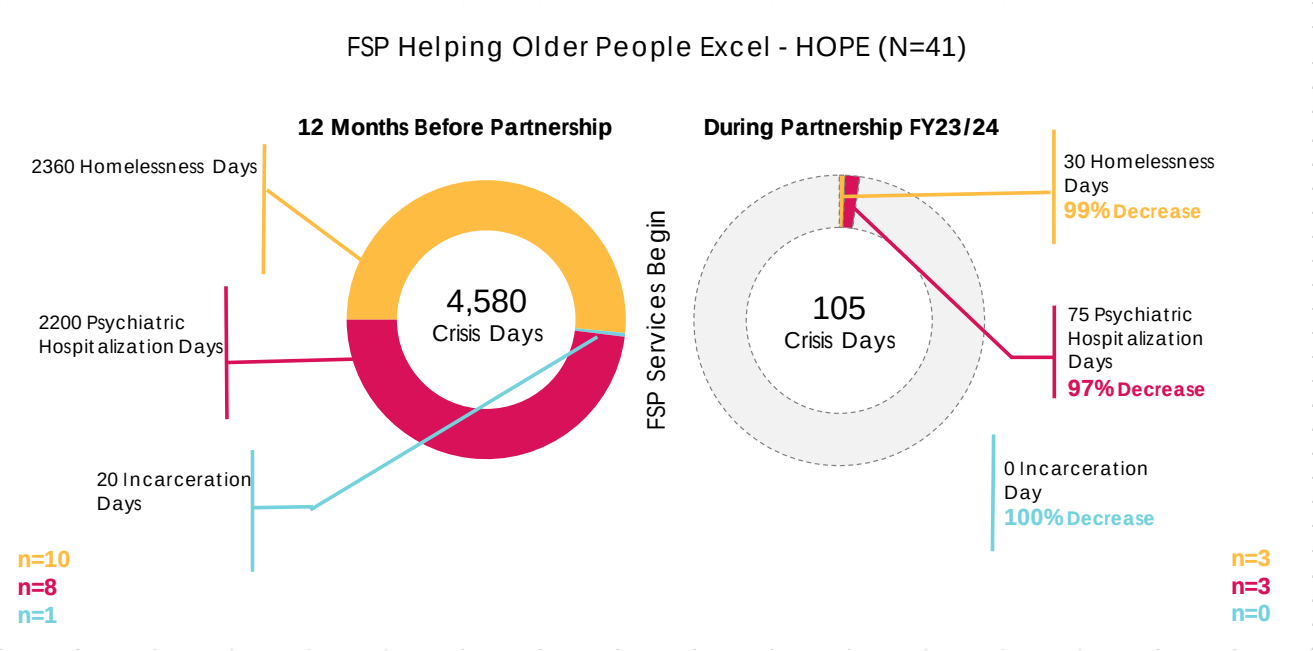
In FY23/24 there were 63 partners served in HOPE, 41 who had been in the program for one year or longer at the end of FY23/24.

1. **97% Decrease in Psychiatric Hospitalization:** Of the 41 partners who had been enrolled in HOPE for at least one year, 8 experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 2,200 hospitalization days. In FY23/24, there were 3 partners who had been enrolled in HOPE for one year or more who experienced a psychiatric hospitalization in FY23/24, for a total of 75 hospitalization days, a 97% decrease.

2. **100% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 1 partner experienced incarceration for a collective 20 days in custody in the year before services. In FY23/24, 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 FY23/24.

3. **99% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 10 partners experienced homelessness for a collective 2,360 days homeless in the year before services. In FY23/24, there was a 99% decrease in days homeless with 3 FSP partners who had been enrolled in HOPE for over one-year experienced homelessness for a collective 30 days homeless in FY23/24.

PROGRAM CHANGES FOR FY25/26: None.



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 of 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 was 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 115 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.

FY23/24 OUTCOMES:

In FY23/24 there were 141 partners served in Odyssey, including 7 Transitional Age Youth (16-25 years old), 111 adults (26-59 years old), and 23 older adults (60+). 138 of these partners had been in the program for one year or longer by the end of FY23/24.

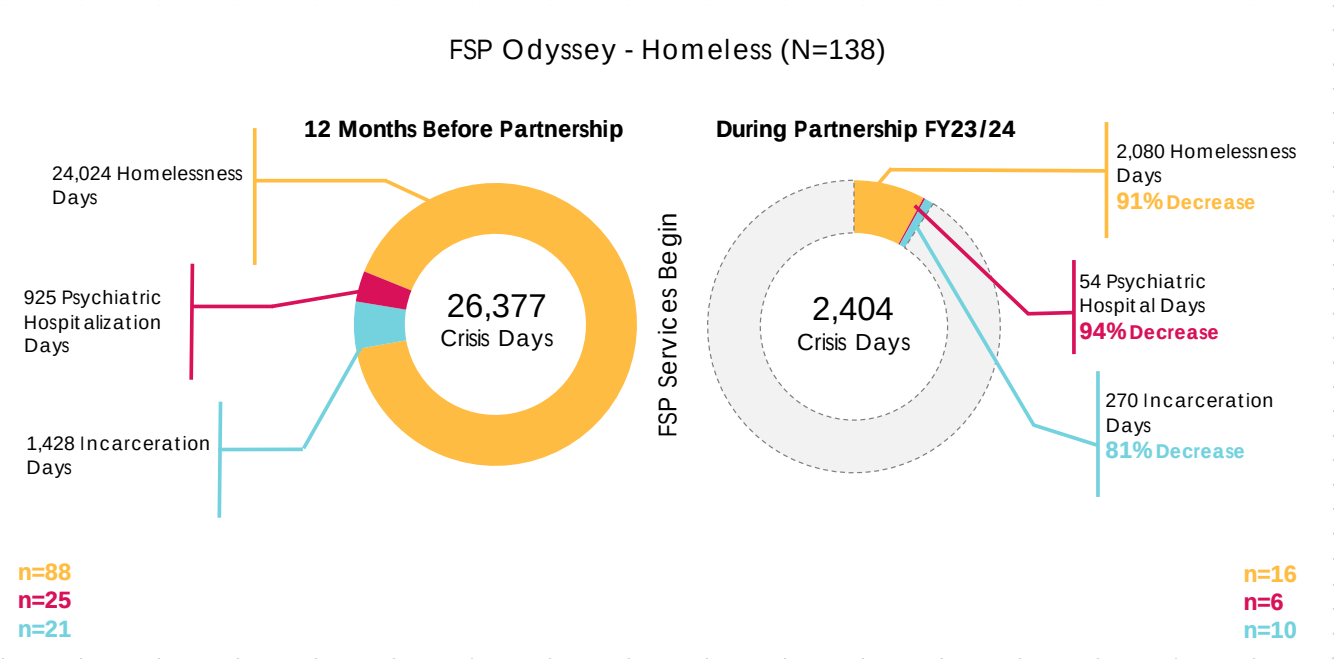
1. **94% decrease in Psychiatric Hospitalization:** Of the 138 partners who were enrolled in Odyssey for at least one year, 25 experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 925 psychiatric hospitalization days. In FY23/24, 6 partners experienced a psychiatric hospitalization in FY23/24, for a total of 54 psychiatric hospitalization days—a 94% decrease.

2. **81% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 21 partners experienced incarceration for a collective 1,428 days in custody in the year before

services. In FY23/24, 10 partners spent 270 days collectively in custody—a 81% decrease in incarceration days.

3. **91% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 88 partners experienced homelessness for a collective 24,024 days homeless in the year before services (averaging 273 days homeless in the year before services). In FY23/24, there were 16 partners who experienced one day or more of homelessness, for a collective 2,080 days—an 91% decrease ***resulting in 21,944 fewer collective days homeless in FY23/24 as compared to the baseline year***.

PROGRAM CHANGES FOR FY25/26: None.



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 82 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.

FY23/24 OUTCOMES:

The outcomes for Impact North and South are combined for FY23/24. At the point in time the data was captured, the programs had not been separated in the electronic health record. The programs have been separated for FY24/25.

In FY23/24 there were 75 partners served in IMPACT, including 3 Transitional Age Youth (16-25 year olds), 66 adults (26-59), and 6 older adults (60+). In FY23/24 there were 30 partners served in IMPACT South, including 2 Transitional Age Youth (16-25 year olds), 24 adults (26-59), and 4 older adults (60+). 46 of partners had been in either the Impact North or South program for one year or longer by the end of FY23/24.

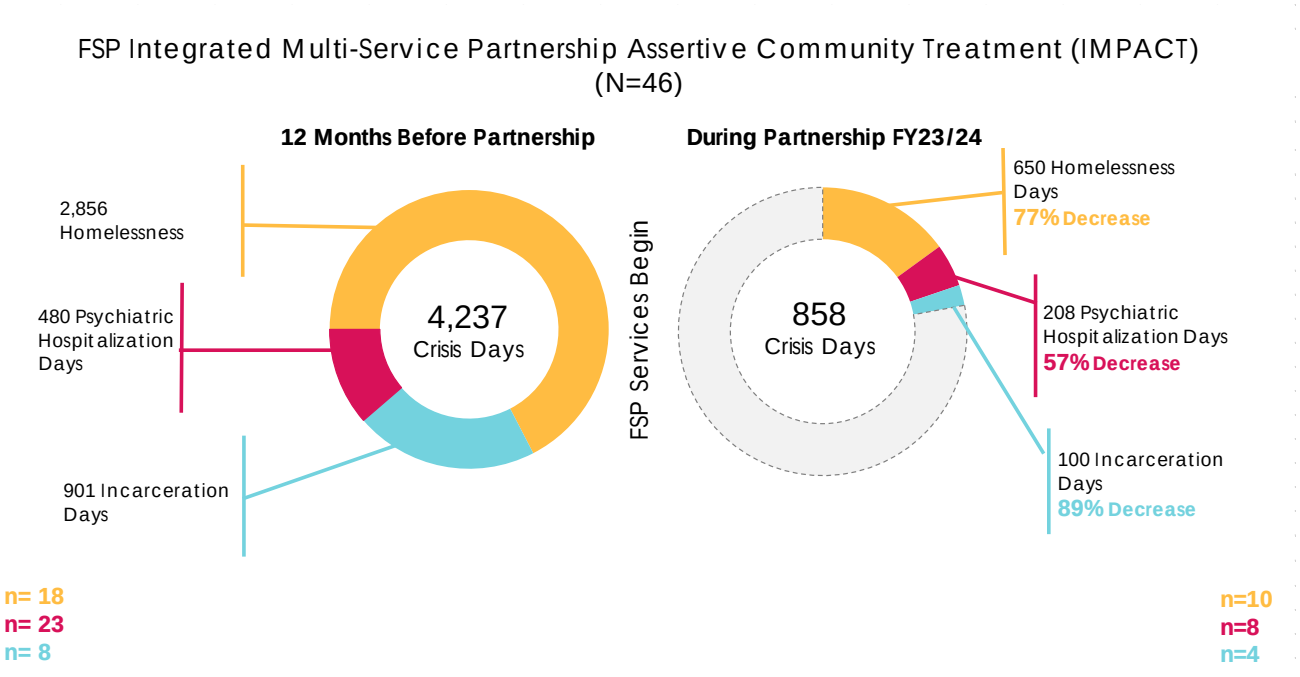
1. **57% decrease in Psychiatric Hospitalization:** Of the partners who were enrolled for at least one year, 23 had experienced at least one psychiatric hospitalization in the year prior to enrollment for a collective 480 psychiatric hospitalization days. In FY23/24, there were 8 partners who experienced a psychiatric hospitalization for a total of 208 psychiatric hospitalization days—a 57% decrease in hospitalization days and a 65% decrease in the number of people needing hospitalization.

2. **89% decrease in incarceration days:** In the twelve months prior to entry into the FSP, 8 of the partners experienced incarceration for a collective 901 days in custody in the year before services. In FY23/24, there were 4 partners who spent 100 days collectively in custody—an 89% decrease in incarceration days.

3. **77% decrease in days homelessness:** In the twelve months prior to entry into the FSP, 18 partners experienced homelessness for a collective 2,856 days homeless in the year before

services. In FY23/24, there were 10 partners who experienced one day or more of homelessness, for a collective 650 days—a 77% decrease.

PROGRAM CHANGES FOR FY25/26: 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 82 TAY, Adults, and Older Adults.

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.

FY23/24 OUTCOMES: In FY23/24 there were 30 partners served in IMPACT South, including 2 Transitional Age Youth (16-25 year olds), 24 adults (26-59), and 4 older adults (60+). The outcomes for Impact North and South are combined for FY23/24. At the point in time the data was captured, the programs had not been separated in the electronic health record. The programs have been separated for FY24/25. Please refer to the previous section *IMPACT North* for outcome data.

PROGRAM CHANGES FOR FY25/26: In FY25/26 IMPACT South anticipates providing office based services in Marin City, one of the justifications for creating a Southern Marin County FSP team. BHRS will utilize space in the forthcoming Health and Human Services Hub in Marin City with dedicated 1:1 space for clients to meet with clinical staff and for medication services.

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.

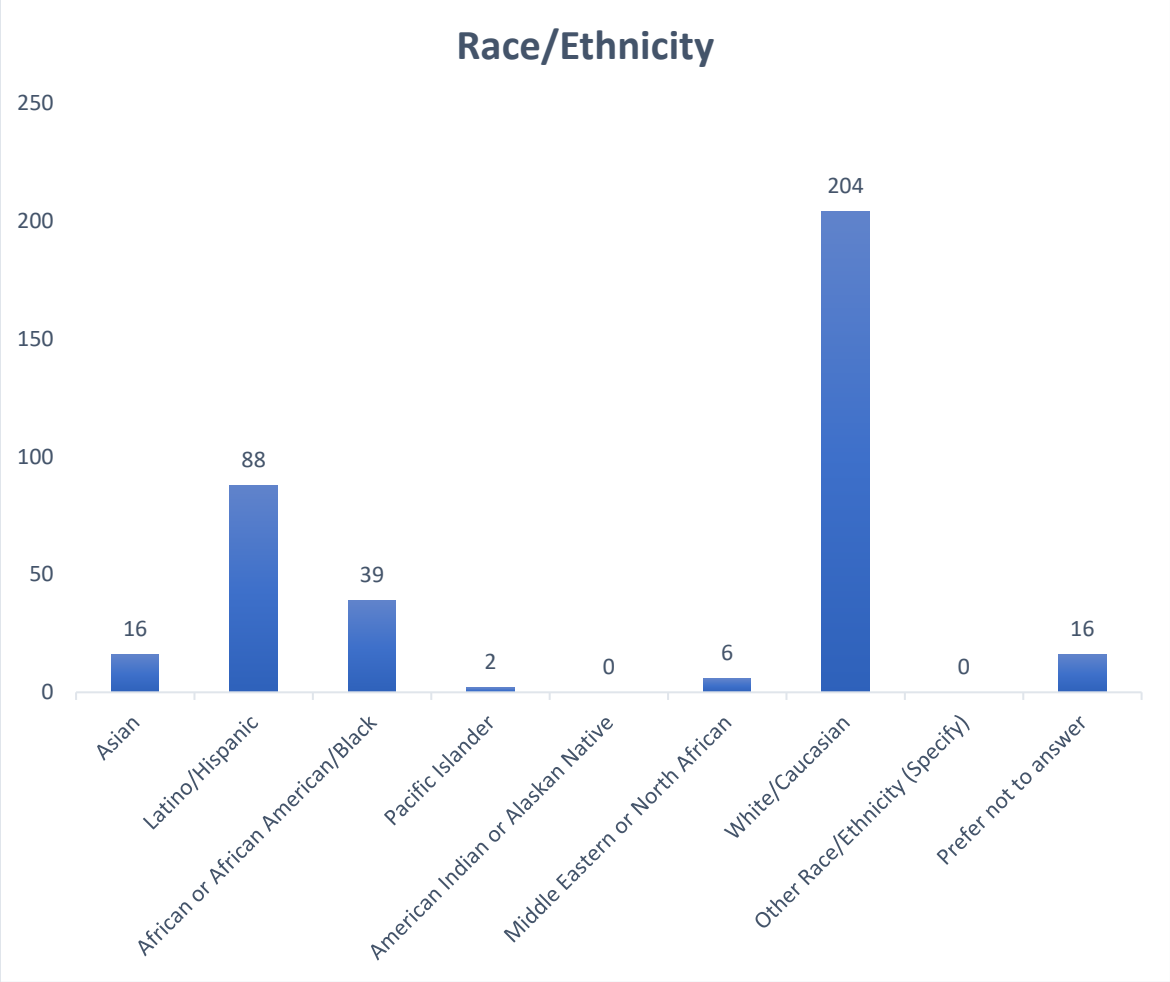
In FY20/21 BHRS released a Request for Proposals (RFP) for Peer-run services to ensure that county contracts allow for competition. The RFP process solicited bids for Peer-Run, Recovery-Oriented programs with a focus on ensuring equity along racial/ethnic and geographic lines. Peer-run programs must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

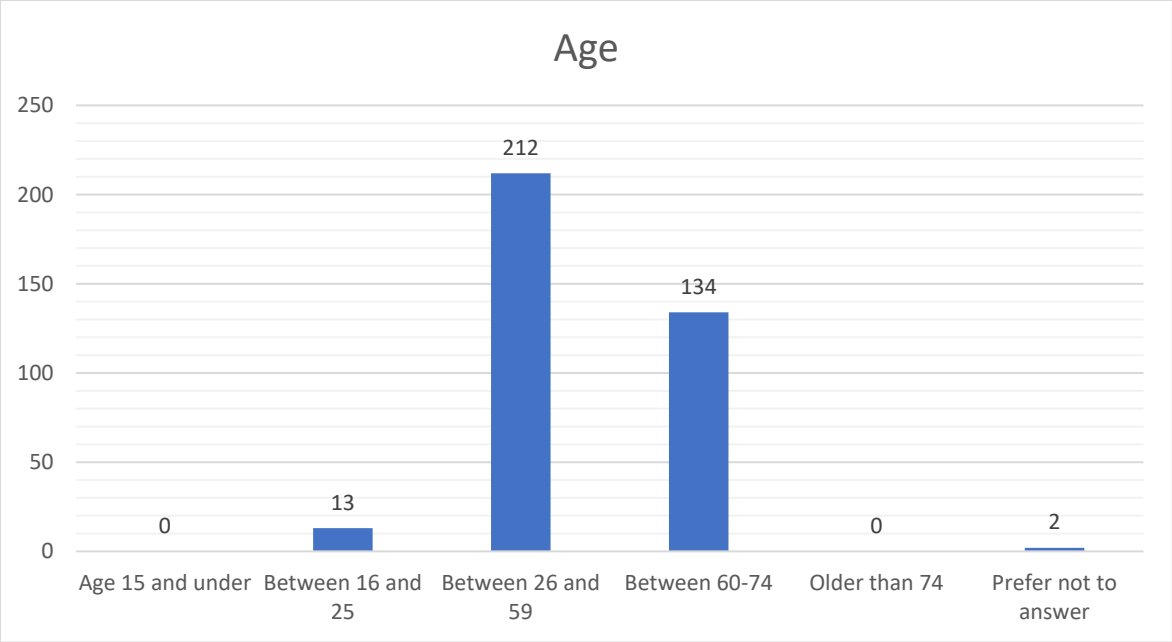
PROVIDER: Mental Health Advocates of Marin through the fiscal sponsorship of MarinLInk.

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 ERC made changes to the Matt Tasley program in FY23/24. Most of the participants who attended the Matt Tasley program came from Board and Care facilities. These facilities created their own programs similar to the Matt Tasley program which negatively impacted attendance in the Matt Tasley program. ERC's outreach to increase numbers were unsuccessful, with only one participant regularly attending. ERC altered the program and began offering the activities originally offered in the Matt Tasley program to all participants at the ERC. Participants go on regular walks to the garden and assist with gardening tasks. The change has been well received and many people are participating in the activities.

FY23/24 NUMBERS SERVED: 16,493 participant visits (duplicated) and 6,378 Warm Line calls. 2,331 unduplicated individuals signed in.

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200
150
100
50
0
0
13
212
134
0
2
Age 15 and under
Between 16 and 25
Between 26 and 59
Between 60-74
Older than 74
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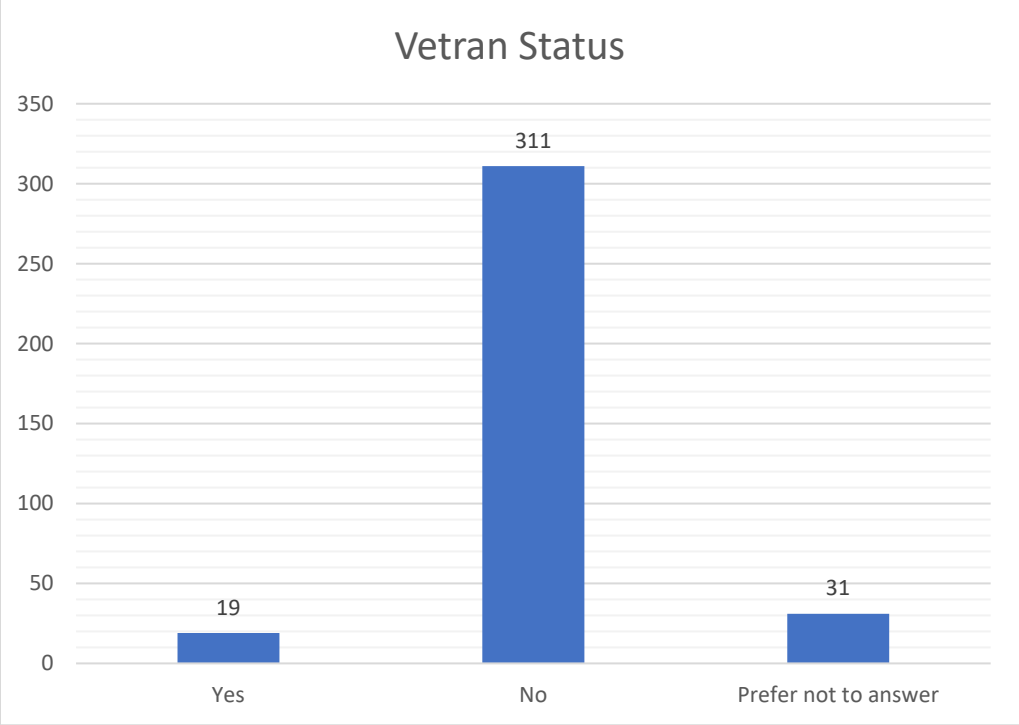
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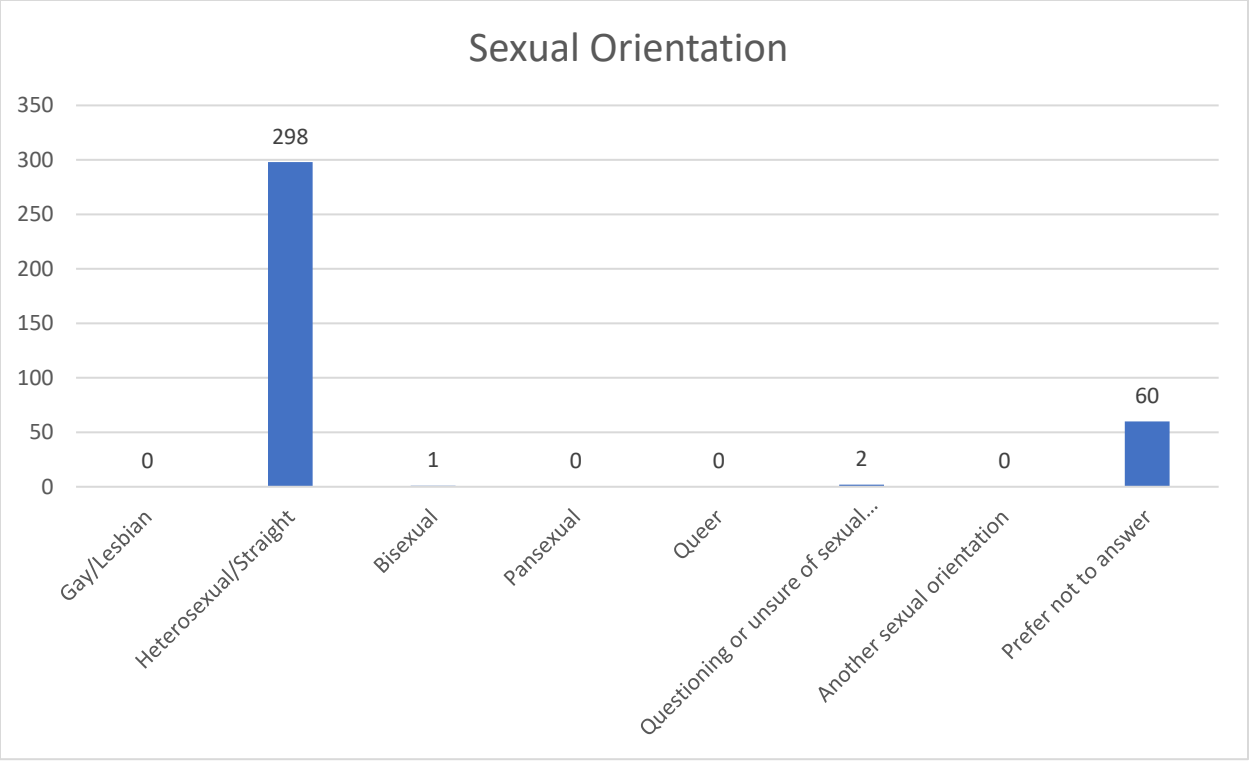
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200
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2
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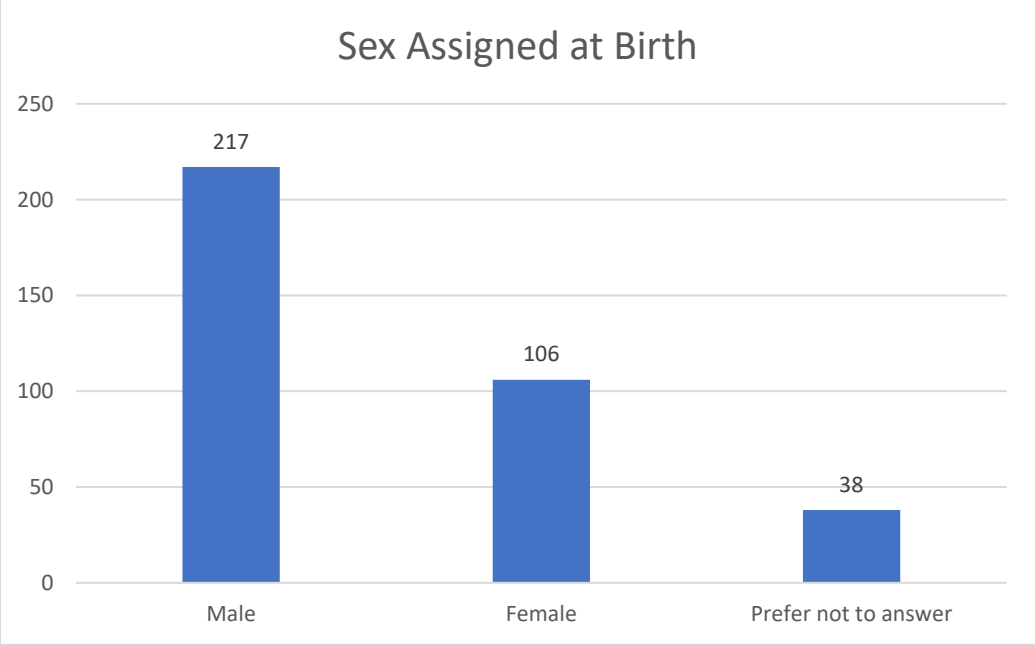
Heterosexual/Straight
Bisexual
Pansexual
Queer
Questioning or unsure of sexual...
Another sexual orientation
Prefer not to answer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Female
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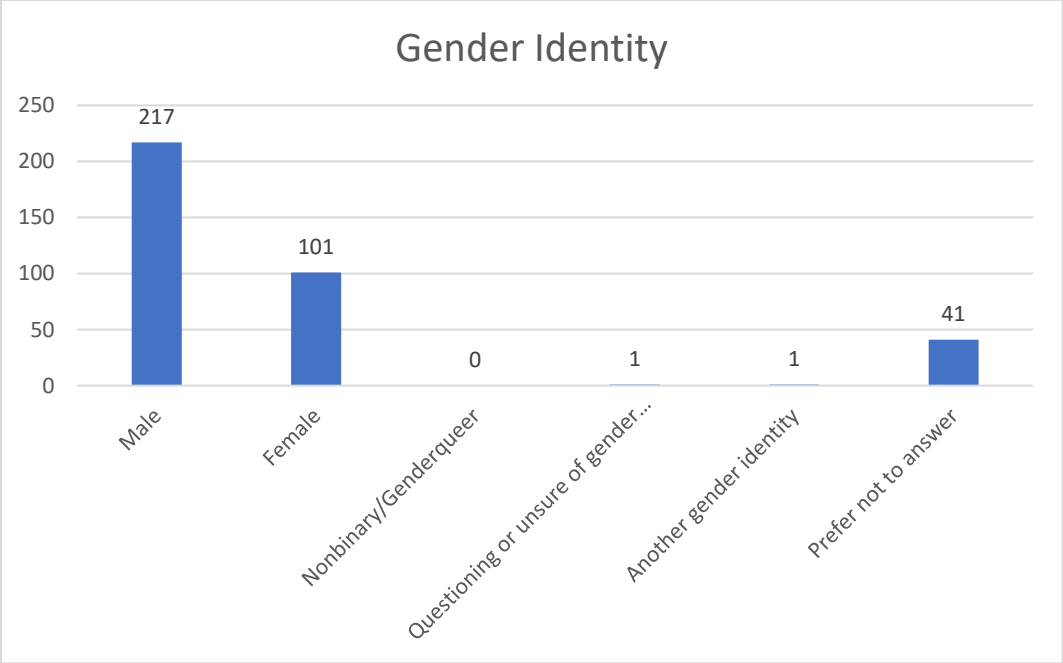


OUTCOMES: In FY23/24, the Enterprise Resource Center conducted four evidence-based groups weekly and an average of eleven evidence-informed groups per week. In addition, they offered daily board games, a morning walk, ping-pong, and movies in the afternoon. Scheduled activities included:

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

FY23/24 GROUP SCHEDULE:

MONDAY	
10AM-11AM	MH SUPPORT FOR PEOPLE OF COLOR
10:30-11am	½ HOUR MEDITATION
11AM-12PM	ANXIETY SUPPORT GROUP
12PM-1PM	ERC ADVOCACY TEAM
1PM-2PM	LIFE SKILLS GROUP
2PM-3PM	TED TALKS GROUP
2:30PM-3PM	½ HOUR WALKING GROUP
5PM-6PM	SPANISH SUPPORT GROUP (GRUPO DE APOYO ESPANOL)
TUESDAY	
10AM-11AM	WOMEN'S SUPPORT GROUP
10:30-11am	½ HOUR MEDITATION
11AM-11:30AM	PALABRA CHECK IN

11AM-12PM	HOARDING BEHAVIORS
12:30PM-1PM	½ HOUR WALKING GROUP
1PM-2PM	MEN'S SUPPORT GROUP
2PM-3:30PM	SMART RECOVERY GROUP
4PM-5:30PM	PEER EDUCATION *SIGN UP REQUIRED
6:30PM-7:30PM	RECOVERY DHARMA
WEDNESDAY	
10:30AM-11am	½ HOUR MEDITATION
11AM-12:30PM	HEARING VOICES & NEGATIVE THOUGHTS
1PM-2PM	DEPRESSION SUPPORT GROUP
2PM-3PM	HOUSING RETENTION WORKSHOPS
2:15PM-2:45PM	½ HOUR WALKING GROUP
THURSDAY	
10:30-11PM	½ HOUR MEDITATION
11AM-12PM	BIPOLAR SUPPORT GROUP
12PM-1PM	PEER COMPANION GROUP
3PM-3:30PM	½ HOUR WALKING GROUP
4PM-5:30PM	PEER EDUCATION *SIGN UP REQUIRED
7PM-8:30PM	SPANISH-SPEAKING NA SUPPORT GROUP
FRIDAY	
10:30AM-11AM	½ HOUR MEDITATION
10:30AM-12:30PM	MASSAGE GROUP (once a month call ahead)
12PM-1PM	TRAUMA PROCESS GROUP
1PM-2PM	MAKING FRIENDS GROUP
2PM-2:30PM	½ HOUR WALKING GROUP
3PM-5PM	WRAP *DATES VARY CALL FOR DETAILS
SATURDAY	
12PM-1PM	PEER TO PEER SUPPORT GROUP
1PM-4PM	ART GROUP
2PM-4PM	MOVIES IN THE GROUP ROOM
SUNDAY	
1PM-2PM	PEER TO PEER SUPPORT GROUP
2PM-4PM	MOVIES IN THE GROUP ROOM

PARTICIPANT STORY FROM FY23/24:

A participant attended our Women's Support Group. Let's call her Jane. After the group ended, the group leader came to me and expressed concern about Jane saying that in the group she had spoken about not wanting to live anymore. The supervisor and group leader went to Jane and asked her to come speak to them in a private room. "Am I in trouble?" asked Jane. We both assured her she was not. We asked her how she was holding up. Jane expressed that she was feeling like she didn't want to live anymore. That she had gone to the pharmacy earlier that day looking at what she could take to end her life. She told us that it is comforting thought, knowing that the people at the ERC truly understand. But today, Jane felt an overwhelming sense of isolation.

We told her we were concerned and suggested calling the Mobile Crisis Team and she said no. That she didn't want us to call them. We didn't push and respected her wishes. We asked how we could help. The question hit her hard and she began to cry.

Jane had been coming to the ERC regularly. She said it was a place she had come to rely on over the past few months and called it a sanctuary. She asked us if she could stay all day because it was the "only place she feels safe". We told her of course and that she could come every day if she needed to. She said that today she had tried to distract herself by chatting with some of the others and participating in a group, but thoughts she had been battling for weeks now were louder than ever, drowning out everything else.

We thanked her for telling us and that we know it's not easy to open up about how she's feeling. But she's not alone in this. We can get through it together and that she didn't have to carry this burden alone. She seemed relieved and stopped crying. She promised that she wouldn't try to kill herself.

We kept an eye on her throughout the day. Checking in often. She came back every day for the next week and by the end she was smiling and laughing and thanked us many times.

Her family found her a place to live that was supportive housing and provided crisis care. On her last day she said she came to say goodbye to everyone and thanked the ERC and everyone here. She said she felt we had saved her life.

PROGRAM CHANGES FOR FY25/26: None.

CRISIS CONTINUUM OF CARE: SDOE 09

NOTE: The Transition Outreach Team was renamed the Crisis Aftercare Team in FY24/25. The Forensic and Mobile Crisis Division was renamed the Crisis and Justice Involved Services Division in FY24/25. The Crisis Stabilization Unit moved from the Adult System of Care to the Crisis and Justice Involved Services Division in FY24/25.

OVERVIEW OF MHSA PROGRAMS WITHIN CRISIS CONTINUUM:

- **Mobile Teams** (Mobile Crisis Response Team [MCRT] and Crisis Aftercare Team [CAT])
- **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 Crisis Aftercare Team [CAT]):

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. We can also transport an individual to the Crisis Stabilization Unit when it is safe to do so. 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 24/7/365 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 **Crisis Aftercare Team (CAT)** provides short-term intensive support and linkage to any individual who 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 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. In these cases, if eligible, the team could submit a CARE Court petition for additional outreach and engagement support.

The team provides transitional services 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 and Peer Specialists. 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, CAT 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 CAT 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 MCRT. CAT services are available to qualifying individuals enrolled in Marin County Medi-cal.

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 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 symptomatic 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)

The CSU was enhanced with MHSA funds to provide Family Partner and Peer support. The Family Partner role ended with the reduction of the MHASF contract in the second half of FY24/25. Peer support continues to be available to engage and support clients in the CSU.

Target Population: All ages with a separate section for youth

OUTCOMES:

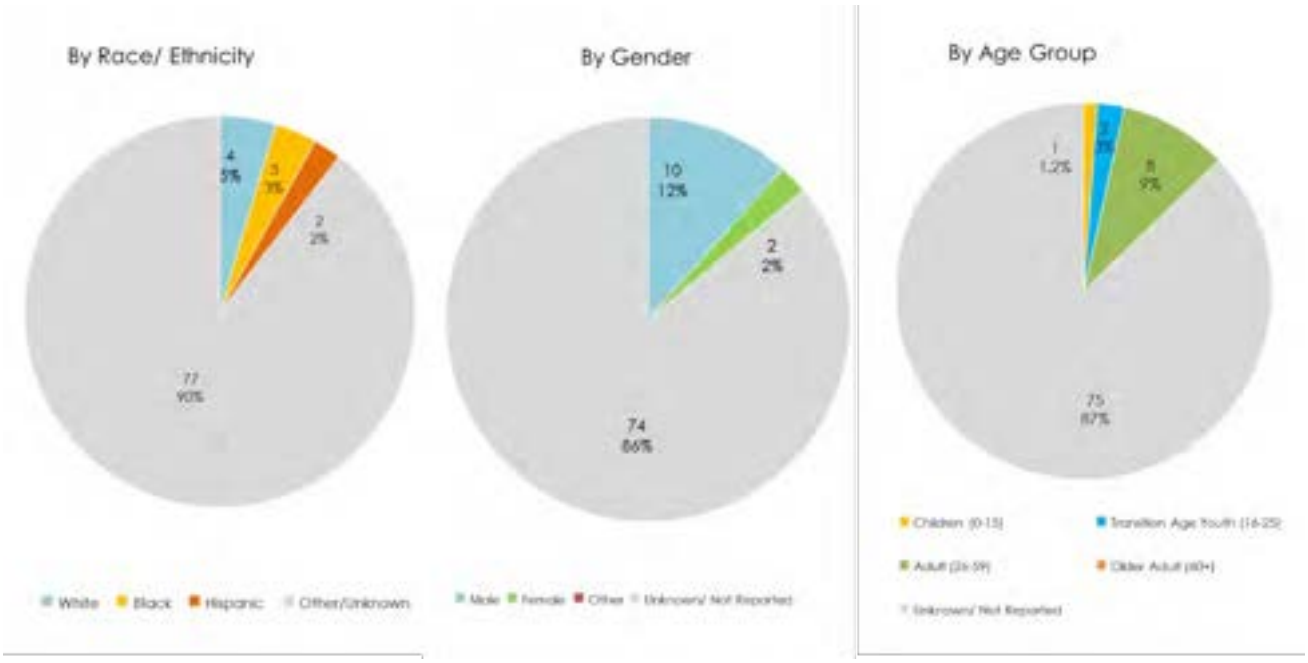
1) After a visit with the Mobile Crisis Response Team (MCRT) people experience decreased distress and increased reports that they would engage in services/support in the future should they need it.
2) Increase in feelings of hopefulness after an experience with the Mobile Crisis Response Team (MCRT)
3) Decrease in need for crisis services after being served by the Crisis Aftercare Team (CAT)
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 (this has been discontinued for FY24/25 forward)

MEASURMENT TOOLS:

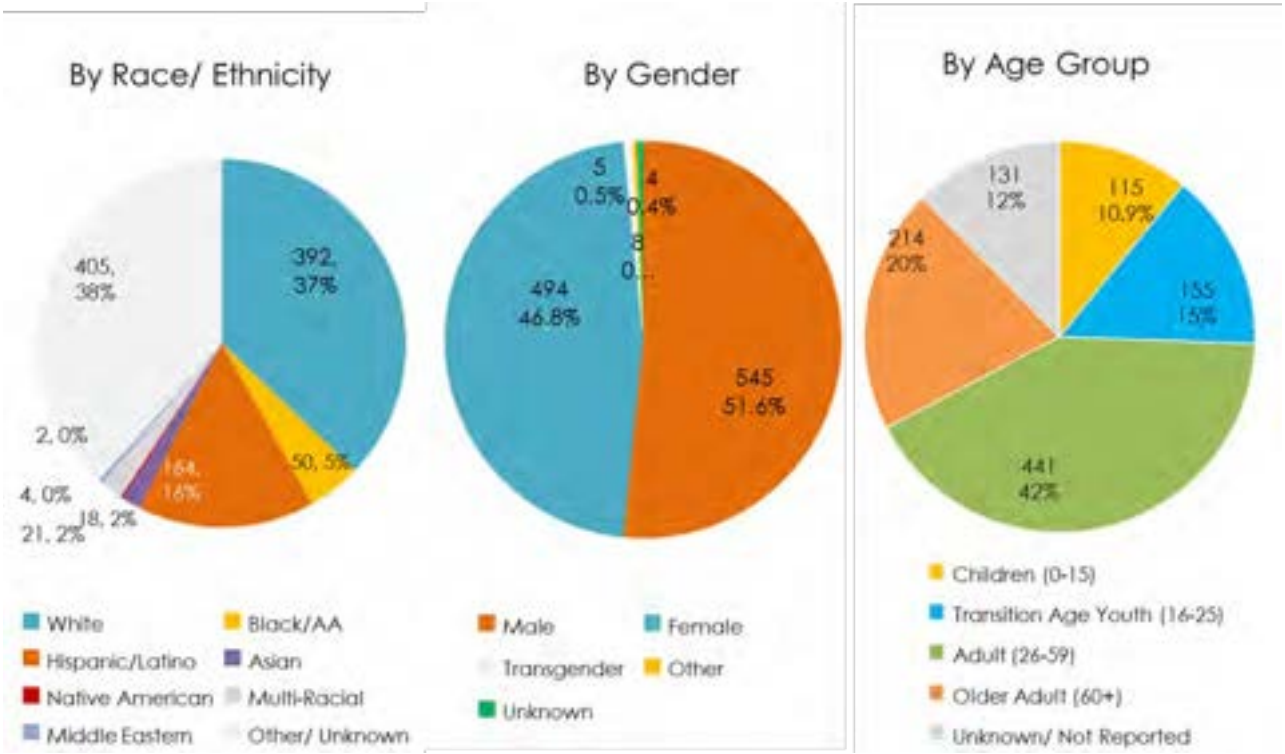
- Outcomes 1-2 will be tracked using data from the Marin Crisis Continuum Customer Satisfaction Survey. The data will be pulled from the two outcomes questions:
    - "As a result of my services I feel less distress and more likely to engage in services/support in the future should I need it."
    - "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 Crisis Aftercare 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.

FY23/24 DEMOGRAPHICS:

In FY23/24 the Crisis Aftercare Team (CAT) **served 86 community members** with 831 total contacts. The demographics of those served by CAT were as follows:



In FY23/24 the Mobile Crisis Response Team (MCRT) served **1056 unique community members** (up 8% from FY22/23). The demographics of those served by MCRT were as follows:



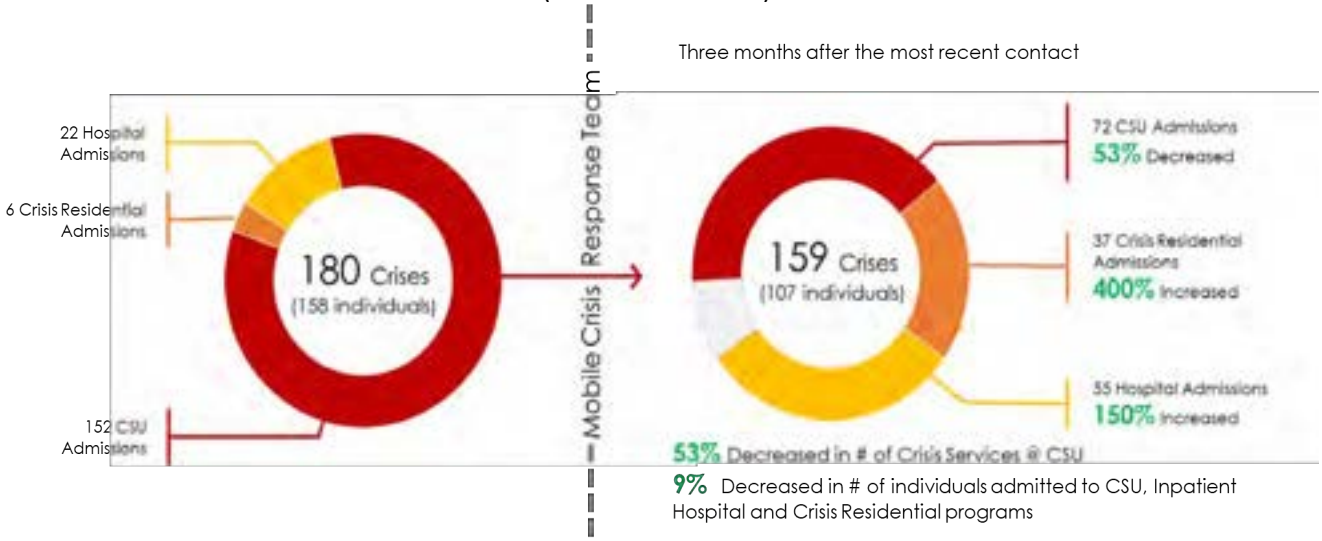
Overall, demographics across age, race, and gender were relatively consistent from FY22/23 to FY23/24. In FY23/24 there was a 64% increase in Hispanic/Latino individuals served, a 26.6% increase in the number of older adults served, a 23.7% increase in number of children served, and a 19.8% increase in the number of adults served.

There was a **53% decrease** in the number of crisis services at the CSU by individuals in the three months after their last contact with the Mobile Crisis Response Team (MCRT) as compared to the three months prior (from 152 down to 72). There was an **8% decrease** in the number of individuals admitted to the CSU, Inpatient hospital, and Crisis Residential Programs.

Contact date between 7/1/2023-6/30/2024

FY23/24 MOBILE CRISIS RESPONSE TEAM OUTCOMES

(N=818 individuals)



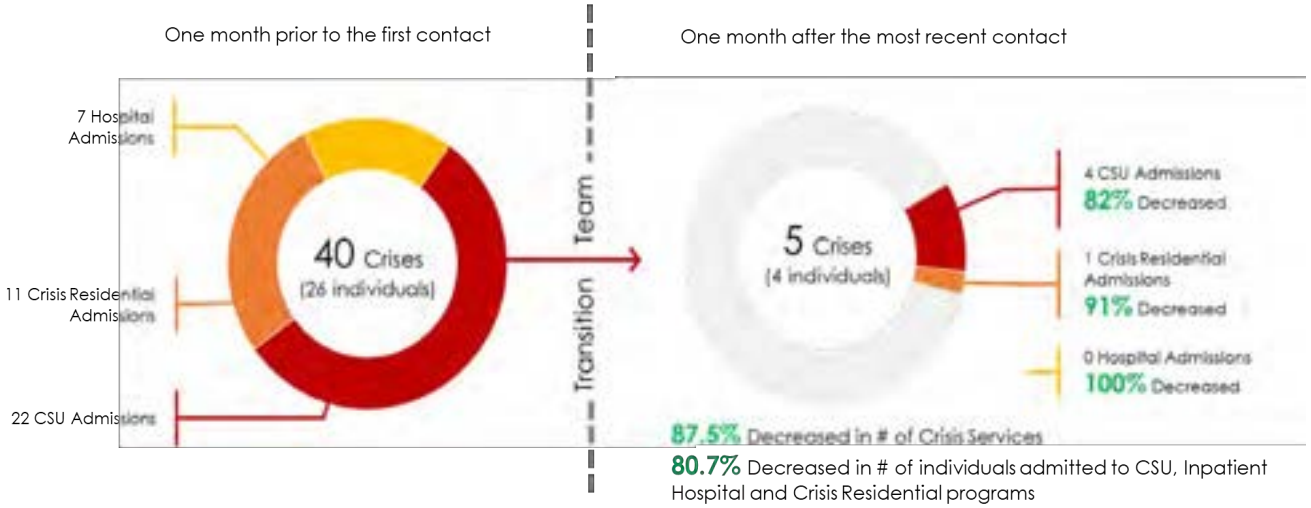
In FY23/24, the MCRT had **3,042 contacts with community members.**

FY23/24 OUTCOMES:

1) Outcomes 1 and 2: No surveys were collected for FY23/24.

2) Outcome 3: There was an **87.5% decrease** in the number of crisis services used by individuals in the three months after their last contact with the Crisis Aftercare Team as compared to the three months prior (from 40 crises down to 5). In addition, there was an **80.7% decrease in the number of individuals** admitted to the CSU, Inpatient hospital, and Crisis Residential Programs.

Contact date between 7/1/2023-6/30/2024
FY23/24 CRISIS AFTERCARE TEAM OUTCOMES
(N=83 individuals)



3) Outcome 4: **90% of the 185 individuals served** left *Casa René* with full discharge plans in place including identified referrals, community services, and scheduled appointments as identified on their treatment plan such as ACCESS, employment, housing, and case management benefits. In FY23/24 *Edgewood* served <10 clients*. 100% of clients were linked to outpatient services at the time of discharge from *Edgewood*.

4) Outcome 5: **87% of the 185 individuals served** were discharged to a lower level of care when discharged from *Casa René.* 50% of clients were discharged to a lower level of care at the time of discharge from *Edgewood*.

5) Outcome 6: The provider survey was not collected during FY23/24.

PROGRAM CHANGES FOR FY25/26: None

*Fewer than 10 clients served is represented as "<10" to protect the privacy of clients

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.

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.

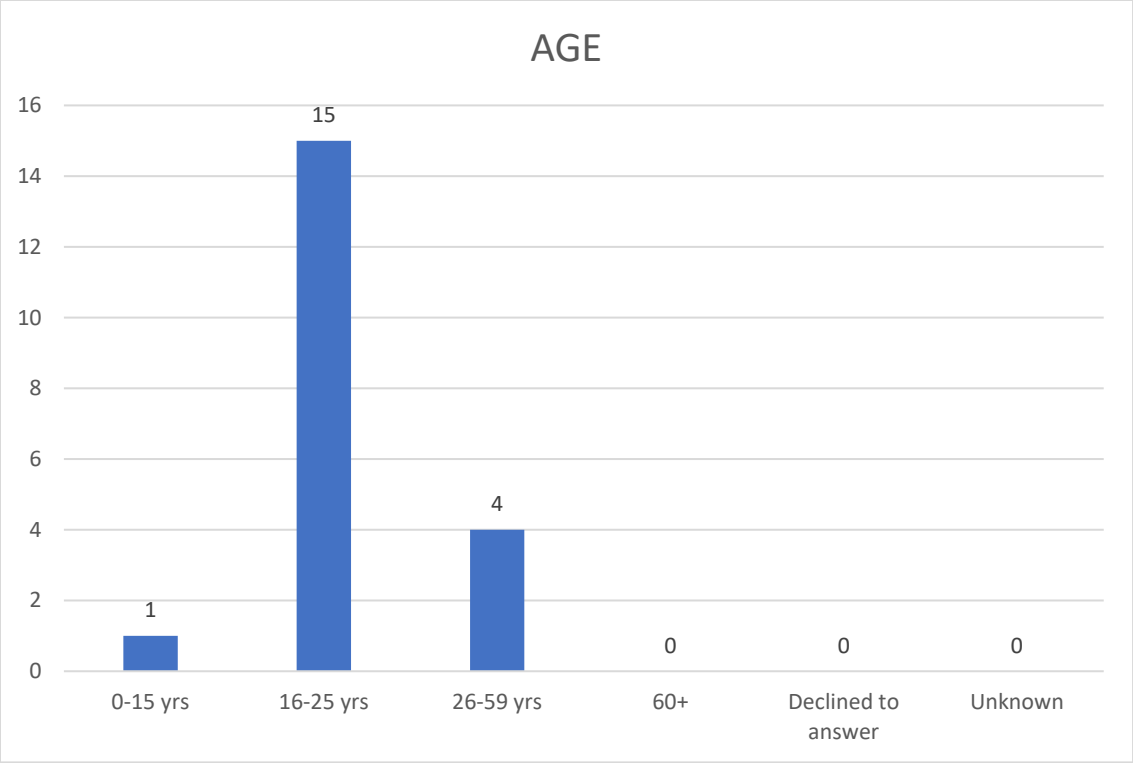
Clients are offered all modalities of individual and family services, based on their individual needs and willingness to participate. Services are offered intensively, often weekly with client centered treatment plans which are reviewed during the course of treatment and measured against an array of 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.

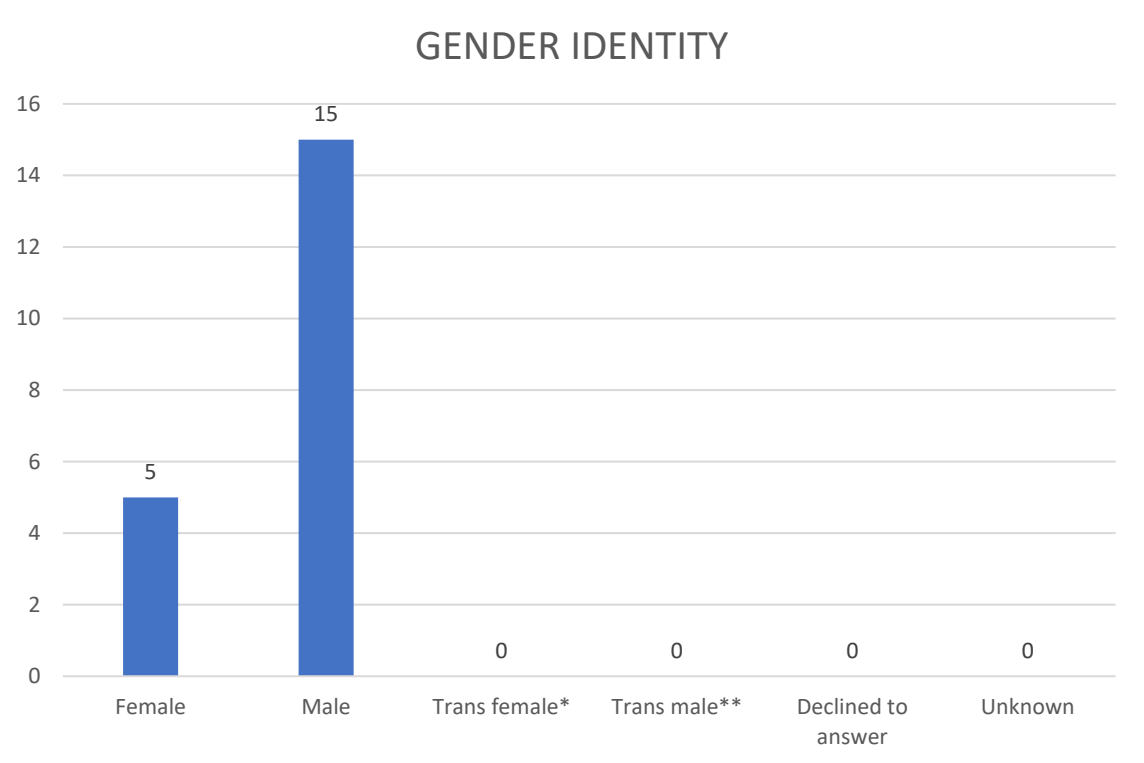
Services will be delivered by direct service team formed by:

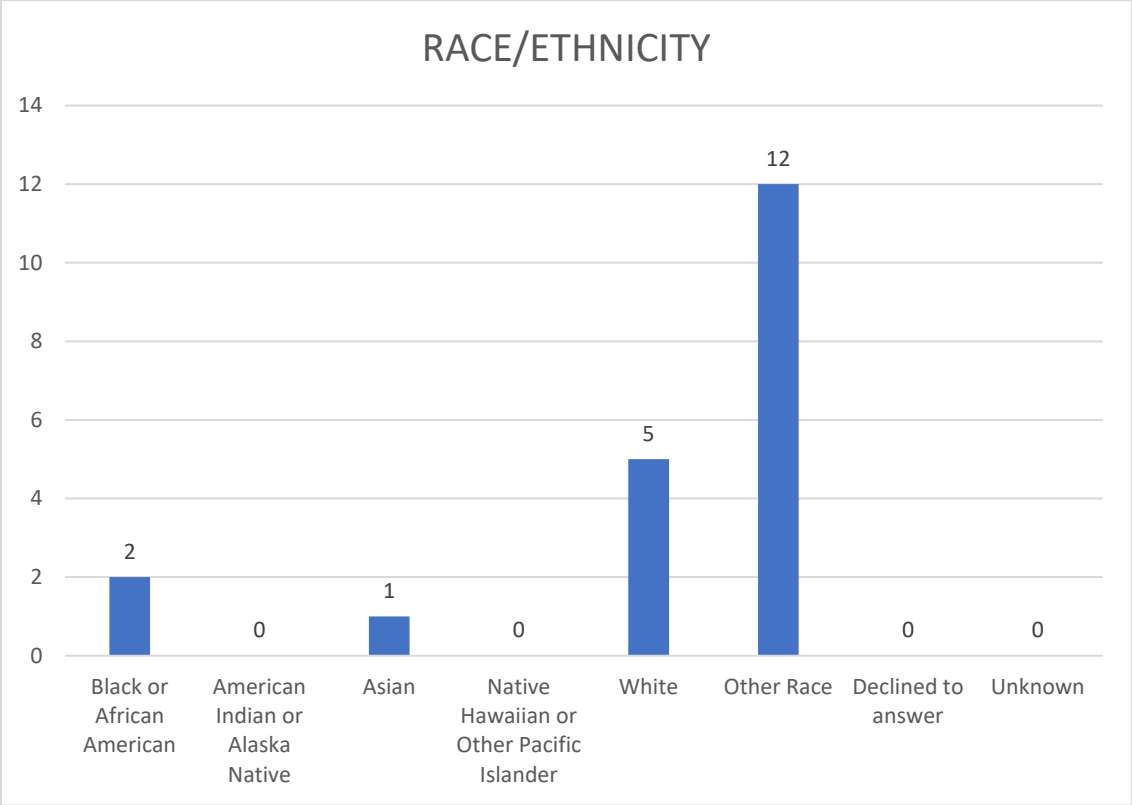
- Clinical Supervisor/Team Leader (1.0) FTE
- Clinical Care Manager (1.0) FTE
- Psychiatric Nurse Practitioner (0.12 FTE) with weekly supervision provided by licensed psychiatrist
- Employment and Education Specialist (0.6)
- Office Manager /Admin Support (0.2 FTE)

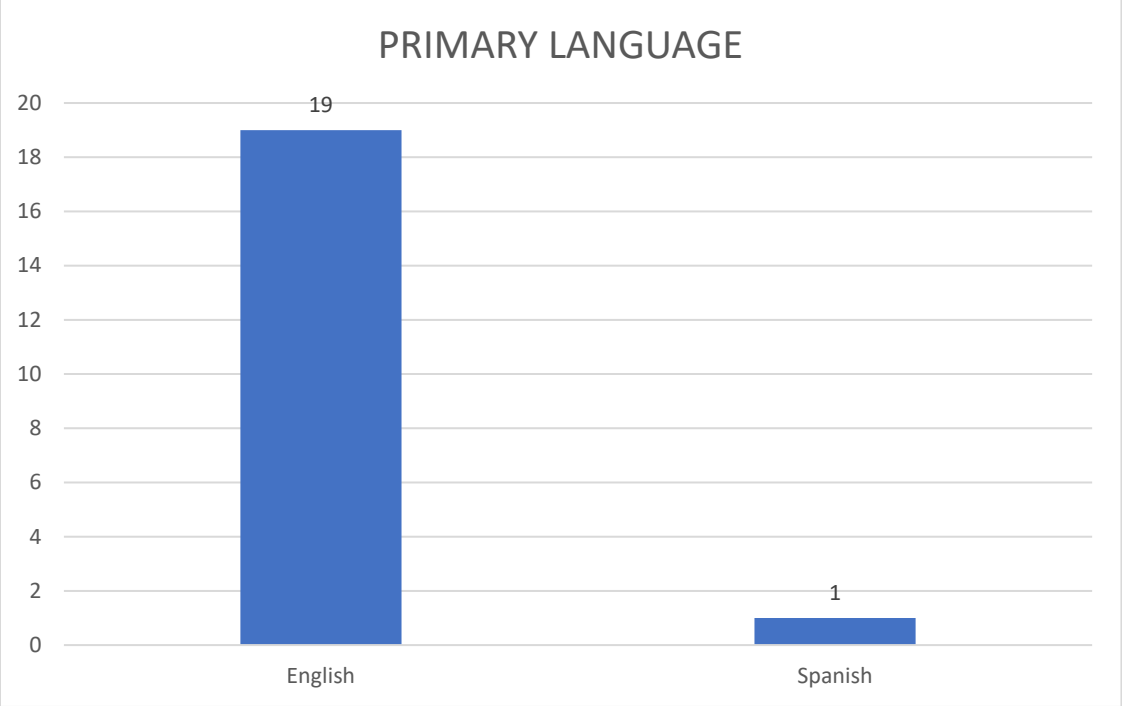
EXPECTED NUMBER TO BE SERVED: 25

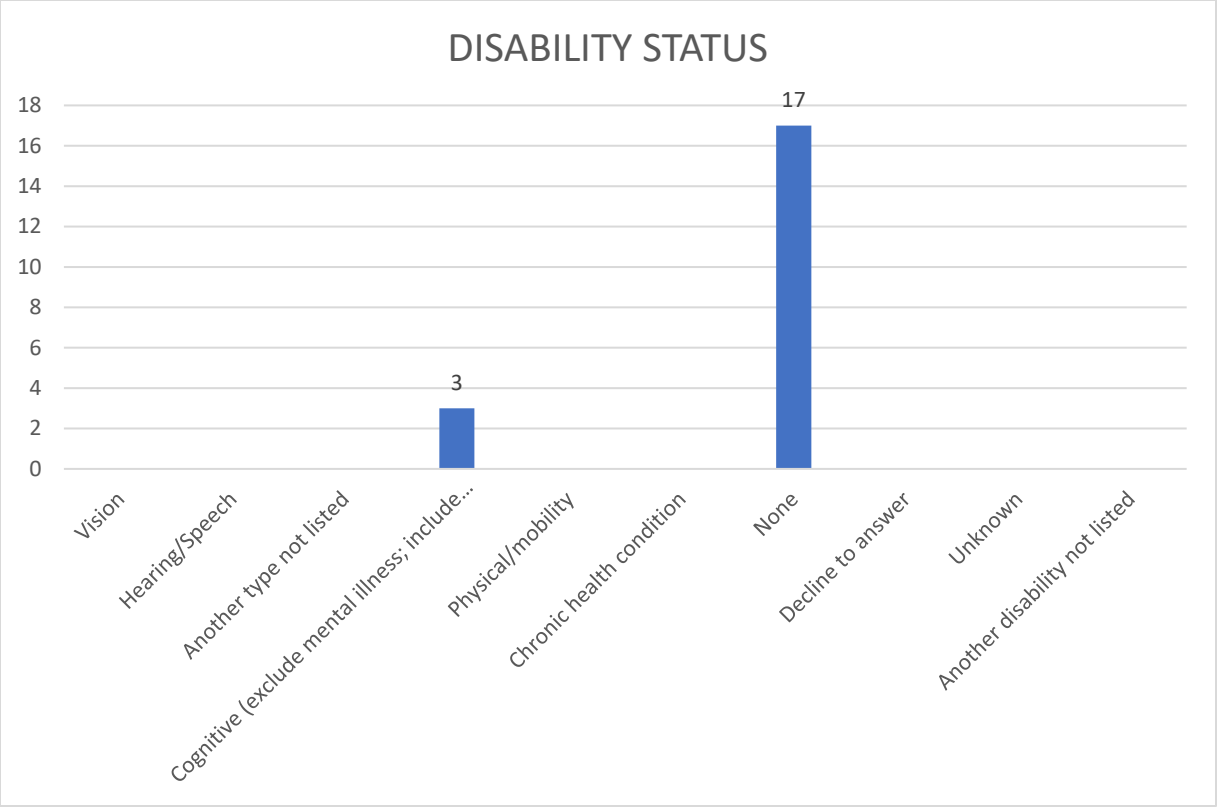
ACTUAL NUMBER SERVED IN FY 23/24: In in FY22/23, the census was 18; In FY 23/24 the program admitted an additional 2 clients. While this is less than the goal of 25 unduplicated clients, it represents continued progress in building the program's census. The program continues to work toward increased engagement with Marin residents living in the rural region of West Marin as a primary focus for future growth.


AGE
16
14
12
10
8
6
4
2
0
15
1
4
0
0
0
0-15 yrs
16-25 yrs
26-59 yrs
60+
Declined to answer
Unknown


GENDER IDENTITY
16
14
12
10
8
6
4
2
0
15
5
0
0
0
0
Female
Male
Trans female*
Trans male**
Declined to answer
Unknown


RACE/ETHNICITY
14
12
10
8
6
4
2
0
2
0
1
0
5
12
0
0
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
White
Other Race
Declined to answer
Unknown


PRIMARY LANGUAGE
20
18
16
14
12
10
8
6
4
2
0
19
1
English
Spanish



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 FY23/24:

1. Of the 20 clients served during this reporting period, 13 were served for six months or longer. Of these 13 clients, 8 had acute inpatient setting episodes in the year prior to services. 6 of the 8 (75%) 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®.

2. Of the 20 clients served during this reporting period, 13 were served for six months or longer. Of these 13 clients, 9 clients (69.2%) have been ongoingly involved in school, employment and training opportunities or are making the transition from training to employment.

FY23/24 Client Story:

This is the story of a 27-year-old cis gender, heterosexual individual of Indian and Latino descent. They have been working with the program since 2022, making use of individual psychotherapy, medication support, family support, employment and education support, and case management. Upon starting services with the program, they were struggling with symptoms of psychosis and significant social disruptions. Since engaging in services, they have not only learned to manage their stressors and symptoms, but also joined a soccer team at the local community college and initiated contact with romantic interests without internalizing rejection as they have done in the past. Currently, they are working with the team to transition out of the program and are actively identifying and advocating for the level of care that they feel is necessary. They have shown improvement in their confidence, self-esteem, and rejection sensitivity and represent how early intervention for psychosis works and can lead program participants to a full and happy life regardless of their mental health challenges.

PROGRAM CHANGES FOR FY25/26: 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: 155 members including TAY, Adults, and Older Adults

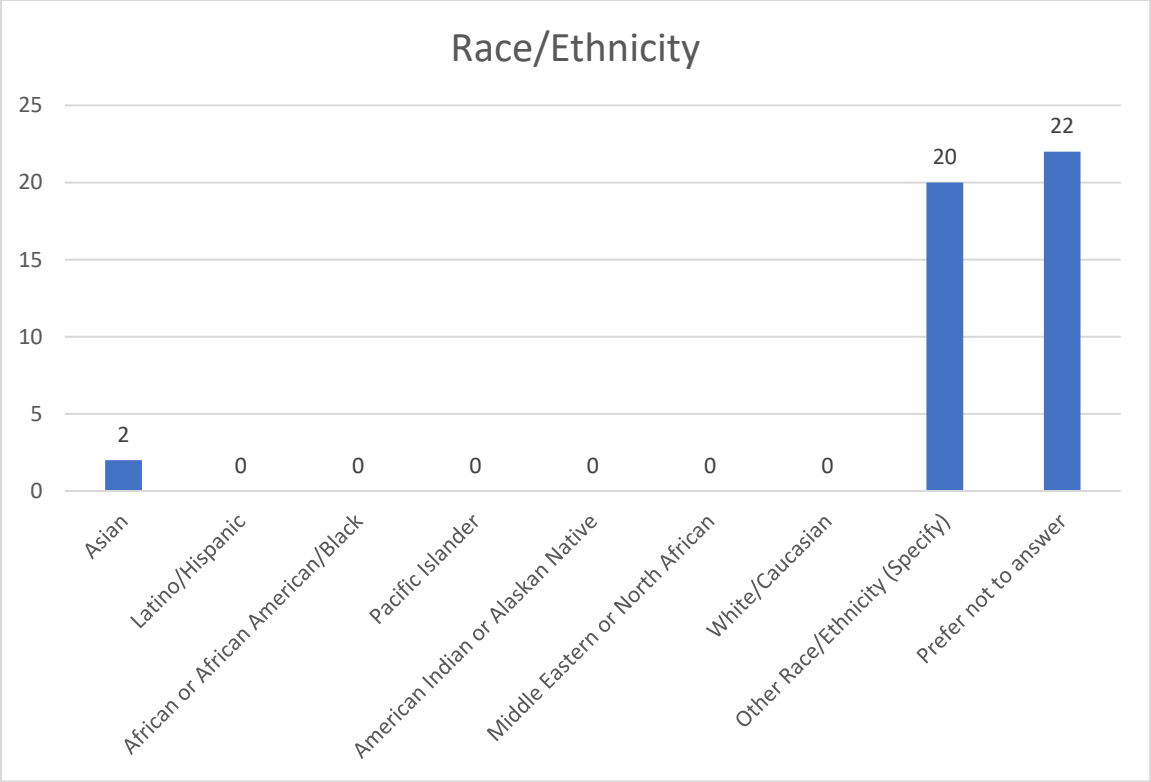
EXPECTED OUTCOMES:

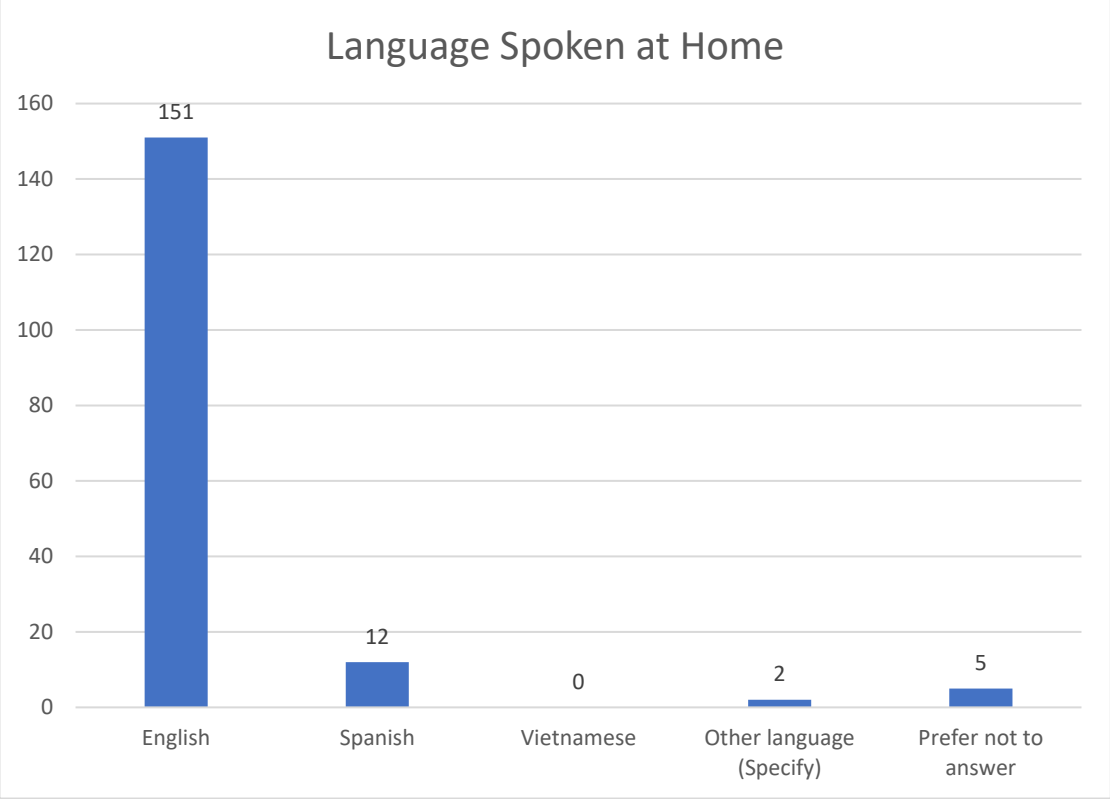
- Program average daily attendance (ADA) of at least 12
- Clubhouse members are expected to show an **increase in wellness and recovery**, such as:
    - Increased access to resources
    - Increased resiliency factors, such as feeling of belonging to a supportive community
- ***Member Defined Goals***: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

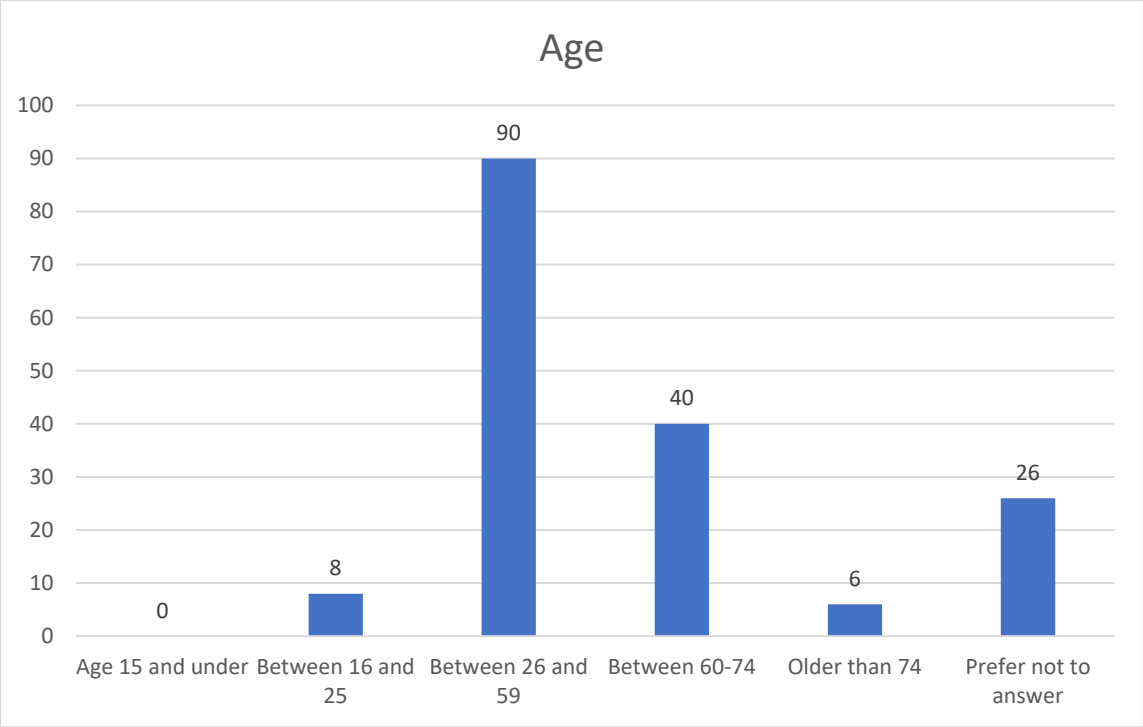
FY23/24 ACTIVITES AND IMPACT: The Empowerment Clubhouse (EC) greatly enhanced and structured member outreach , community events, and business outreach to their weekly activities. This exciting and collaborative engagement contributed to supporting individuals with mental health. As a result, the EC experienced exponential growth in FY23/24. At the end of FY23/24, the EC had 170 Members.

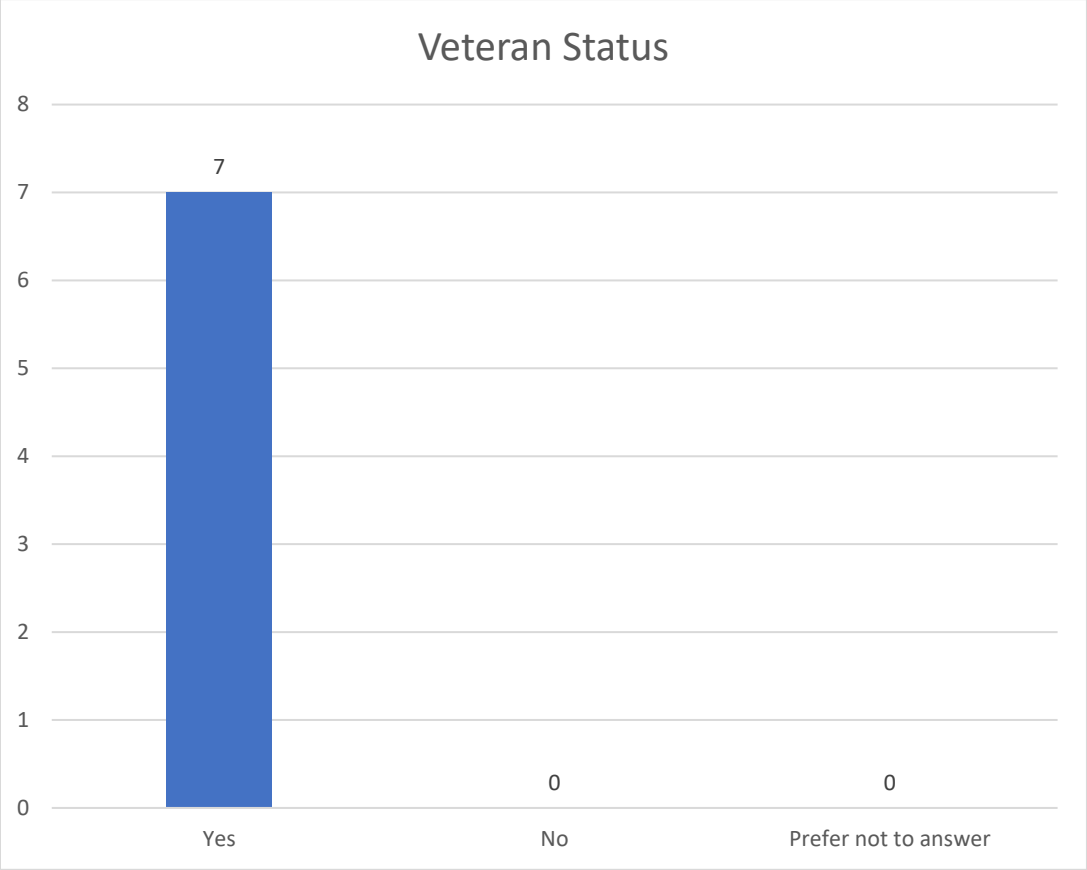
FY23/24 outcomes include:

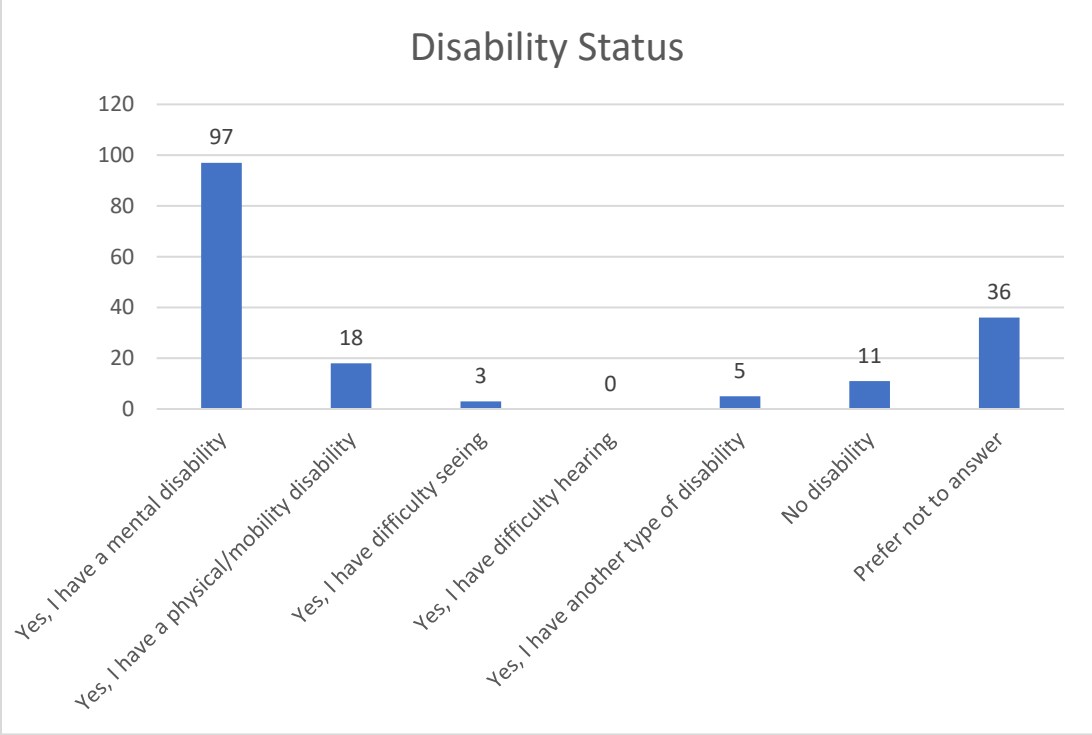
- Expanded their support to individuals in the Construction Trades Industry,
- Young Adult Program launched along with adding two young EC Advisory Committee Members to help with strategic planning
- Increased number of new members
- Assisted 15 Members getting hired, 10 are New/Pending, 15 Completed Transitional Employment

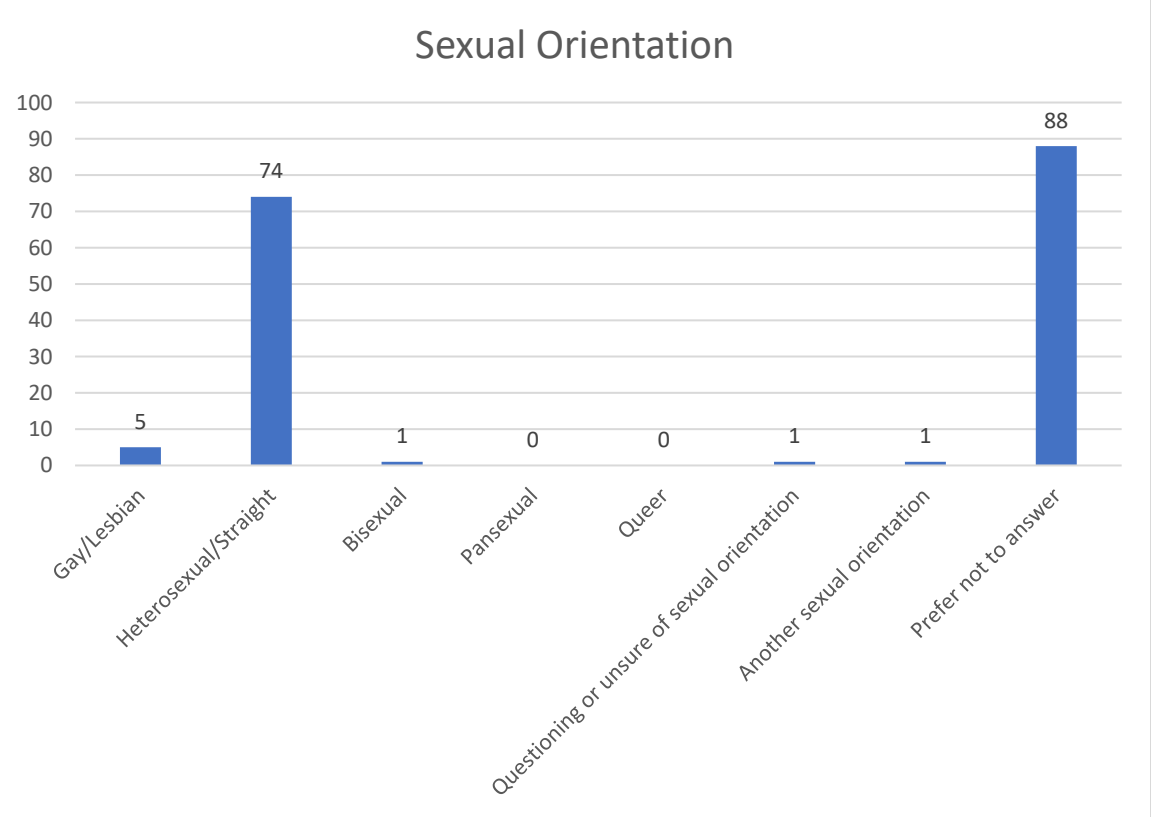

Race/Ethnicity
25
20
15
10
5
0
2
0
0
0
0
0
0
20
22
Asian
Latino/Hispanic
African or African American/Black
Pacific Islander
American Indian or Alaskan Native
Middle Eastern or North African
White/Caucasian
Other Race/Ethnicity (Specify)
Prefer not to answer

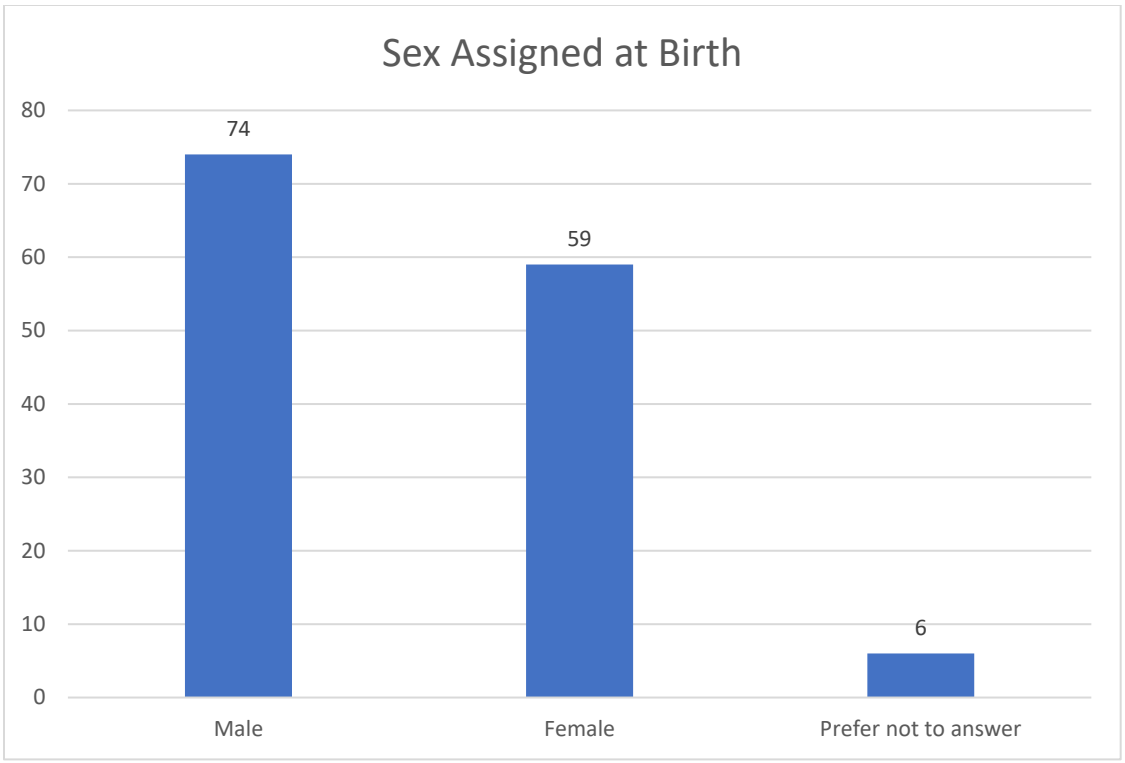

Language Spoken at Home
160
140
120
100
80
60
40
20
0
151
12
0
2
5
English
Spanish
Vietnamese
Other language (Specify)
Prefer not to answer

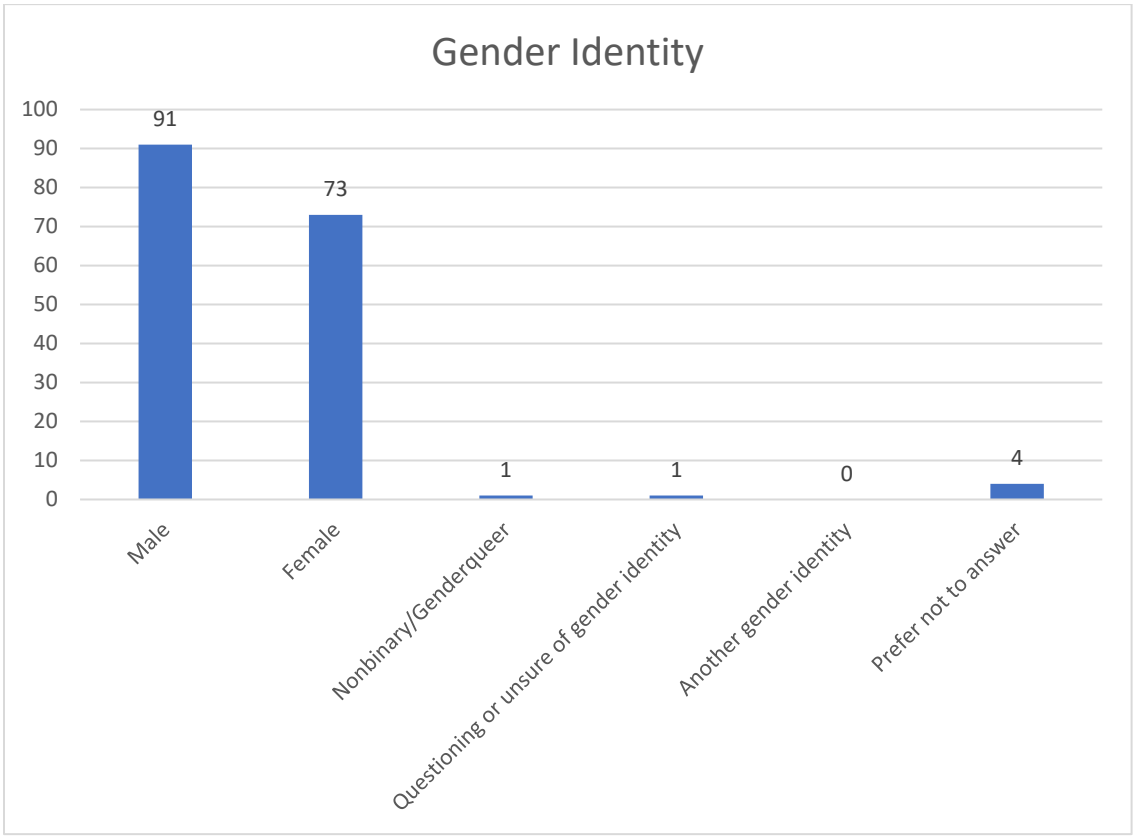

Age
100
90
80
70
60
50
40
30
20
10
0
0
8
90
40
6
26
Age 15 and under
Between 16 and 25
Between 26 and 59
Between 60-74
Older than 74
Prefer not to answer


Veteran Status
8
7
6
5
4
3
2
1
0
7
0
0
Yes
No
Prefer not to answer


Disability Status
120
100
80
60
40
20
0
97
18
3
0
5
11
36
Yes, I have a mental disability
Yes, I have a physical/mobility disability
Yes, I have difficulty seeing
Yes, I have difficulty hearing
Yes, I have another type of disability
No disability
Prefer not to answer


Sexual Orientation
100
90
80
70
60
50
40
30
20
10
0
5
74
1
0
0
1
1
88
Gay/Lesbian
Heterosexual/Straight
Bisexual
Pansexual
Queer
Questioning or unsure of sexual orientation
Another sexual orientation
Prefer not to answer

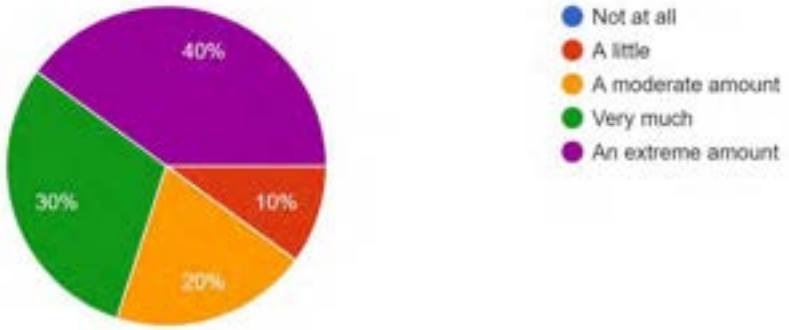

Sex Assigned at Birth
80
70
60
50
40
30
20
10
0
74
59
6
Male
Female
Prefer not to answer


Gender Identity
100
90
80
70
60
50
40
30
20
10
0
91
73
1
1
0
4
Male
Female
Nonbinary/Genderqueer
Questioning or unsure of gender identity
Another gender identity
Prefer not to answer

I hav
33 res

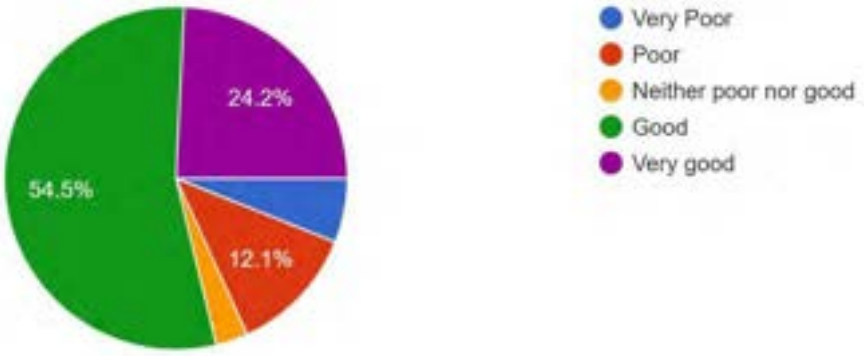
To what extent do you feel your life to be meaningful?

30 responses



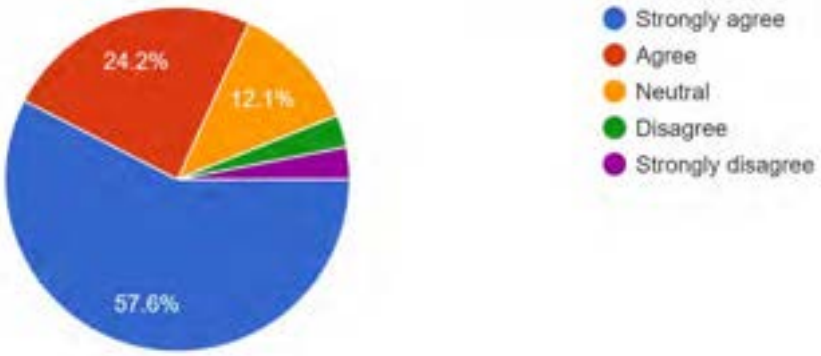
How would you rate your overall quality of life over the past year?

33 responses



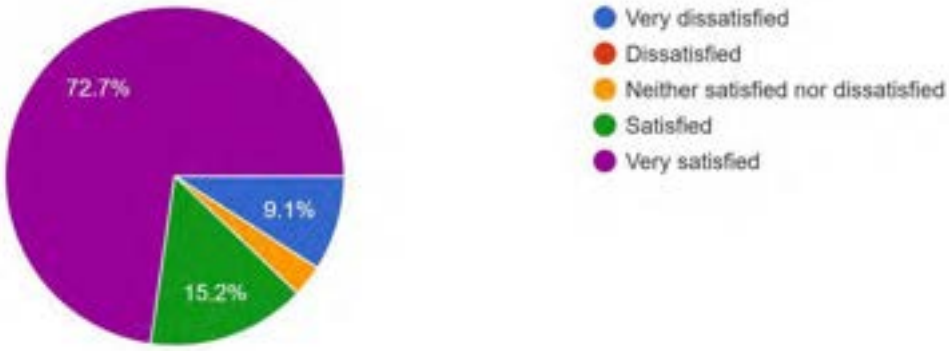
The Clubhouse assisted me with obtaining educational opportunities (for example: schooling, training, etc...) when I needed them.

33 responses



How satisfied are you with our Empowerment Clubhouse program overall?

33 responses



PROGRAM CHANGES FOR FY25/26: 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:

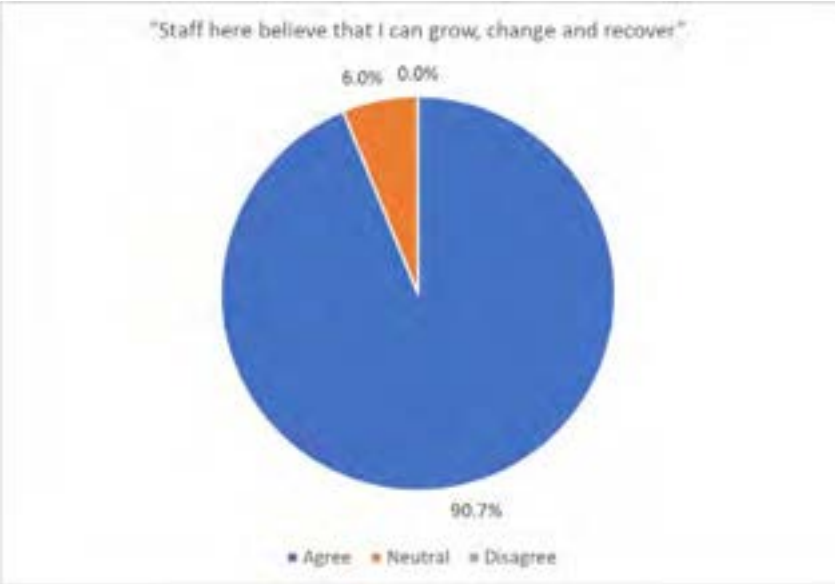
1) At least 70% of clients will report feeling that staff believe that they can grow, change, and recover
2) At least 70% of clients will report that staff helped them obtain the information they needed so that they could take charge of managing their illness
3) At least 70% of clients will identify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

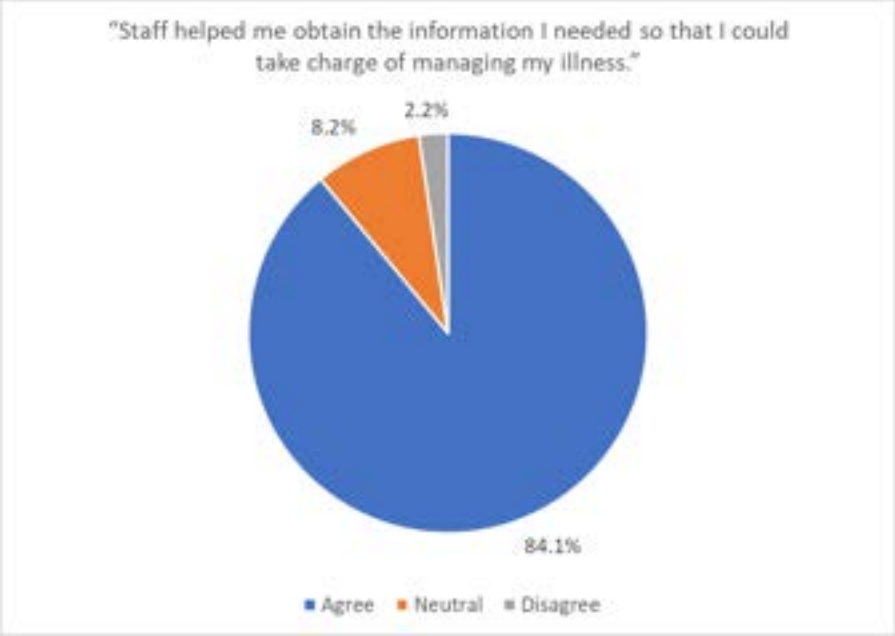
1) Outcomes 1-3 will be measured using the Performance Outcomes and Quality Improvement (POQI) MHSIP Consumer Perception Survey, which was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services. "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 FY23/24:

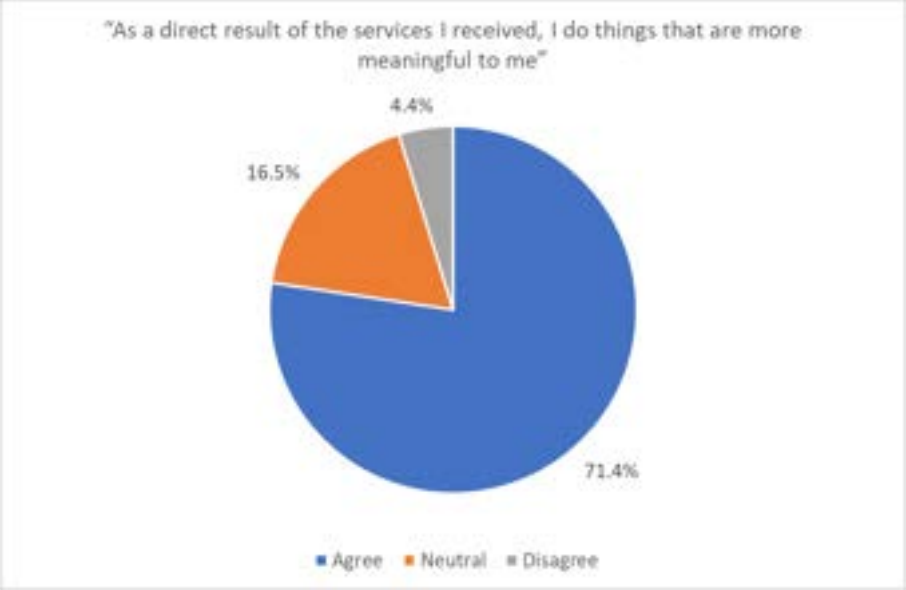
1) In FY23/24, **90.7%** of clients reported feeling that **staff believe that they can grow, change, and recover**:



2) **84.1%** of clients reported in FY23/24 that staff helped them obtain the information they needed so that they could **take charge** of managing their illness:



3) In FY23/24, **71.4%** of clients reported that as a direct result of the services they received, they are better able to **do things that are meaningful** to them:



PROGRAM CHANGES FOR FY25/26: None.

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 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 FY23/24:

Jail Re-Entry Support

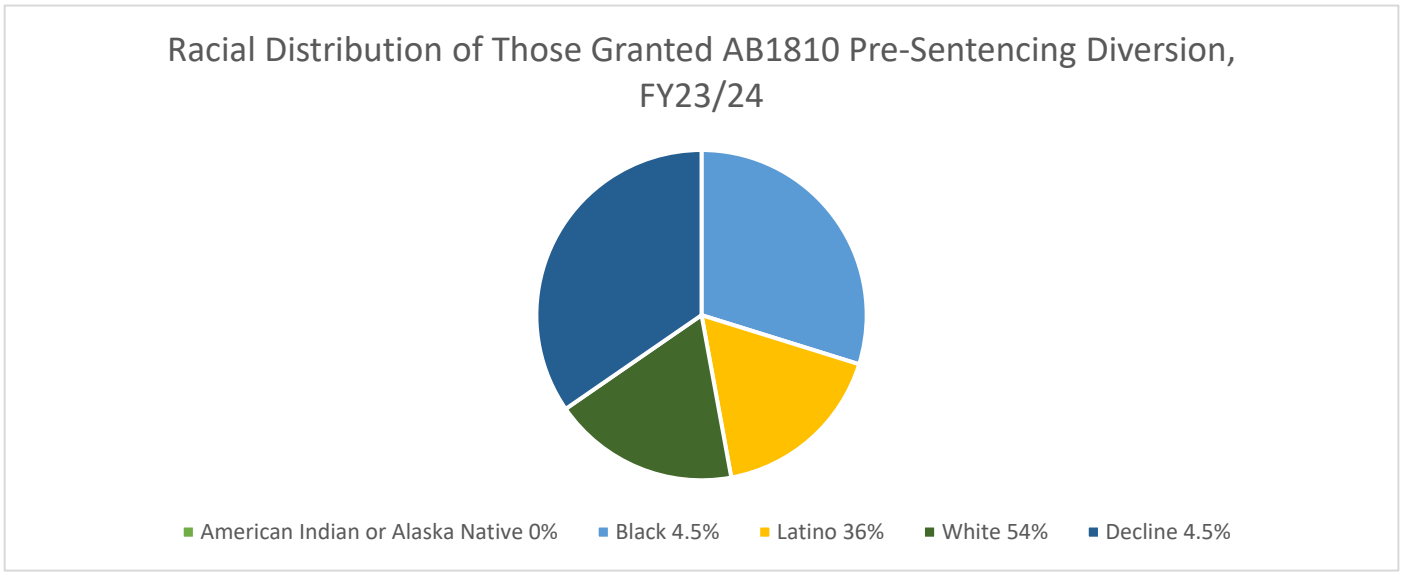
- **Outcome 1:** The Jail Re-Entry support portion of the Stepping Up initiative served 72 individuals in FY23/24, and recidivism was measured.
    - Of the 72 individuals, 27 were re-arrested after 6 months – 37.5%.
    - Of the 72 individuals, 7 were re-arrested after 1 year – 9.7%
    - Of the 72 individuals, 1 was re-arrested after 2 years – 1.3%
    - Of the 72 individuals, 4 were re-arrested after 6 months and 1 year – 5.5%
    - Of the 72 individuals, 1 individual was arrested after 6 months, 1 year, and 2 years – 1.3%

- **Outcome 2:** The Jail Re-Entry support portion of the Stepping Up initiative served 72 individuals in FY23/24, and access to care and engagement in services after release was measured:
    - Of the 72 individuals, 63 received access to care – 87.5%
    - Of the 72 individuals, 35 were still engaged in services after release – 48.6%

AB1810 Diversion Program

- **Outcome 3**: Of the **22 individuals** who were granted AB1810 diversion, **71%** 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, 76% of those who applied for AB1810 Diversion met the basic screening criteria. 31% of those who met the screening criteria ended up being granted diversion. This included 4.5% (1/22) of the Black applicants, 36% (8/22) of the Latino applicants, 0% (0/22) of the American Indian or Alaska Native, 54% (12/22)of the White applicants, and 4.5% (1/22) 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 FY23/24 approximately **68.5%** of officers and deputies in Marin have completed the CIT training. This includes:

    - Marin Sheriff – 42%
    - National Park Service/U.S Park Police – 75%
    - San Rafael PD – 77%
    - Novato PD – 79%
    - California Highway Patrol – 10%
    - Mill Valley PD – 100%
    - Fairfax PD – 60%
    - Central Marin PD – no response
    - Belvedere PD – no response
    - Tiburon RD – 75%
    - College of Marin PD – 100%
    - Sausalito PD – 66%

PROGRAM CHANGES FOR FY25/26: None.

COMMUNITY OUTREACH AND ENGAGEMENT: SDOE 15

PROGRAM DESCRIPTION: This program focuses on supporting underserved communities and identifying unserved individuals 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 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) Coordinating 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.

PROVIDERS: Combination of county-operated and contracted.

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 TOOLS:

- Program End of Year Reports

OUTCOMES FROM FY23/24:

- **<u>Canal Alliance Health Navigator:</u>**
    - Provider description: The Canal Alliance behavioral health program bilingual team is comprised of three Behavioral Health Clinicians, a Behavioral Health Navigator, trauma-informed case manager, all of whom work together to conduct interventions, assess risks, and collaborate with individuals, family members, teachers, and medical providers to mitigate the negative outcomes of behavioral health disorders.

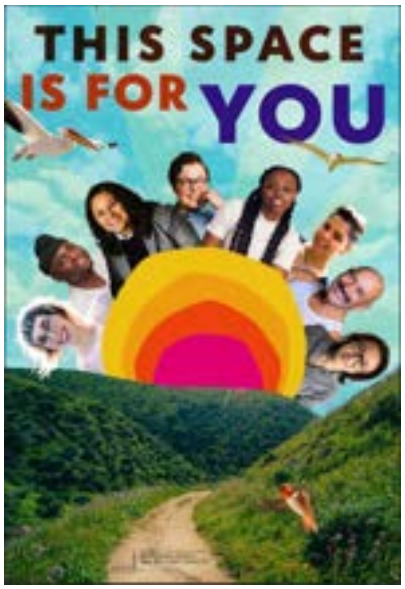
    - Service description: The behavioral health navigator provides outreach and engagement and system navigation that supports individuals and families getting connected to

mental health and recovery services. The navigator education and learning in this role is supported by ongoing trainings in areas or trauma informed and mental health issues across the lifespan.

Outcomes: Canal Alliance	Goal FY23/24	Actual FY23/24
Behavioral Health Navigator will support the increased number of clients successfully connected to mental health and or support services.	35 individuals	55 individuals
The Behavioral Health Navigator will participate in trainings on identifying mental health issues across all ages and implementing trauma-informed strategies	5 trainings	5 trainings

- **<u>Enhancing Services for LGBTQ+ Clients and Families:</u>**

  - Welcoming Posters: In FY 23/24, BHRS developed a series of posters geared toward reaching out to LGBTQ+ clients and families. Posters were then translated into Spanish and Vietnamese and are now displayed in areas throughout BHRS locations.



- PRIDE Event: In FY 23/24, BHRS co-hosted a PRIDE event with College of Marin (COM) to outreach to LGBTQ+ clients and families and to have a planning session to address the mental health and substance use service delivery needs for this community.
  - The event featured 14 tables and resources from community partners, a drag performance inspired by their own behavioral health journey, prizes for participants that were donated from local organizations, and a facilitated community planning session with over 106 community members.
  - The outcome from the community planning session is still under review. Preliminarily, the community has reported several barriers and desired outcomes. This will result in recommendations for our BHRS Behavioral Health System (as a whole) and our Outreach and Engagement Team, the HHS Equity Team, and Marin County Office of Equity. Recently, the BHRS Equity and Community Partnerships Committee (ECPC) was given the opportunity to review the report-out and commit to a concrete action that addresses a barrier named in the report. The ECPC will continue to focus on this in the coming year. The BHRS LGBTQ+ Workgroup will also continue to utilize the results of this report-out to guide their work and focus.

- **Cultural Ambassadors Program:** Funding was reserved in the 3-Year Plan for a new Cultural Ambassadors program, however due to budget constraints and upcoming changes to MHSA with the passage of Prop 1, this program did not have a viable path forward and was therefore cut.

- **CBO-Access Partnership Days Program:** Funding was reserved in the 3-Year Plan for a partnership between BHRS Access and strategically located Community Based Organizations (CBOs), however due to budget constraints and upcoming changes to MHSA with the passage of Prop 1, this program did not have a viable path forward and was therefore cut.

- **System Navigation Materials:** In FY 23/24, BHRS committed to developing materials to support system navigation, including details on how to navigate the various complexities of our system and who we serve.
    - New Non-Discrimination Poster: The following poster was developed in English and translated into English and Spanish and is on display at various BHRS locations.

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

Authenticity, inclusion, and belonging are guiding principles at Marin County Behavioral Health and Recovery Services (BHRS)

We do not unlawfully discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, gender expression, sexual orientation or any other basis protected by State or federal civil rights laws.

Our staff does not unlawfully exclude people or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, gender expression, sexual orientation or any other basis protected by State or federal civil rights laws.

BHRS endeavors to treat every individual with respect. We want to know how BHRS honors your identities. We want to know if you have experienced discrimination at BHRS. We are accountable for the services we provide, and your feedback is important.

Please contact us at BHRSfeedback@marincounty.org for complaints, compliments, and suggestions.

Requests for disability accommodations may be made by phoning (415) 473-4381 (Voice), CA Relay 711 or by e-mail at: disabilityaccess@marincounty.org. Copies of documents are available in alternative formats, upon request.

- Latine Steering Committee and the Quality Improvement Project to Develop System Navigation Tools for Spanish Speakers: In FY 23/24, BHRS developed a Latine Steering Committee that is focused on developing a Quality Improvement Plan to Develop System Navigation Tools for Spanish Speakers.
    - The group's first tool (sneak peek below) is expected for release in January 2025. This group will focus on the development of brochures, pamphlets, infographics, videos, and social media campaigns that are culturally and linguistically affirming and relevant for Spanish Speakers.

- **<u>Community Health Advocates (CHA) Programs</u>:** 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.

    - New Canal-Based CHA Program: Funding was reserved in the 3-Year Plan for issuing an RFP to host a new CHA program in the Canal neighborhood, however due to budget constraints and upcoming changes to MHSA with the passage of Prop 1, this program did not have a viable path forward and was therefore cut.

    - 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.

North Marin Community Services	Goal FY 23/24	Actual FY 23/24
13 *Promotores* from Novato, San Rafael and West Marin will participate in at least **20** hours of training.	**13/20**	**13/22**
As a result of the trainings provided by NMCS, at least **85%** of *Promotores* will agree or strongly agree that they: a. Experienced growth as community leaders due to participating in the *Promotores* Program; b. Know at least 2 places in Marin where they can refer clients for bilingual mental health services; c. Are better able to recognize the signs that someone may be dealing with a mental health problem or crisis; and d. Are better able to reach out to someone who may be dealing with a mental health problem or crisis.	**85%**	a) **100%** experienced growth as community leaders. b) **100%** know at least 2 places in Marin where they can refer clients for bilingual mental health services. c) **98%** of *Promotores* are better able to recognize the signs that someone may be dealing with a mental health problem or crisis d) **100%** of *Promotores* are able to reach out to someone who may be dealing with a mental health problem or crisis.
Promotores will reach **905** Latine community members via face to face, phone, and text outreach, workshops and 1:1 emotional support.	**905**	**3848**
Promotores will: • Reach **600** Latine community members via face to face, phone, text and video contacts in Novato, San Rafael and West Marin; • Facilitate at least **12** *talleres* (workshops) on mental health stigma, stress management or suicide prevention in local groups (ELAC's, church groups, etc.) reaching an estimated 140 individuals with emphasis on increasing outreach to West Marin; and • Provide informal counseling, screening, and referrals (1:1 emotional support) to **165** Latine individuals and family members.		Facilitated **19** *talleres* (workshops) on mental health stigma, stress management or suicide prevention in local groups (ELAC's, church groups, etc.) reaching **337** individuals with emphasis on increasing outreach to West Marin; and • Provided informal counseling, screening, and referrals (1:1 emotional support) to **178** Latine

		individuals and family members.
NMCS staff will complete a minimum of **2** hours training annually to stay abreast of new learning regarding cultural humility, racial equity, and trauma-informed practices.	**2**	**2**
NMCS will attend at least **75%** of MHSA Committee meetings and relevant sub-committee meetings.	**75%**	**100%**
Latine Program Assistant will participate in at least **4** collaborative meetings at the local and/or state level.	**4**	Latine Program Assistant participated in the HHS CHW Collaborative, *Vision y Compromiso* - CHW Collaborative, Novato Community Coalition for Substance Prevention, and CHW/P/R Coalition.

NMCS *Promotora* quotes:

- "My name is Ana del Carmen, since I became a *Promotora* last year, my life has changed. When I was a little girl, I always thought that I was not intelligent and that I was not able to do anything right. However, I met a *Promotora* and she told me that I was already doing the work of a *Promotora*, so she encouraged me to join the group. During the time I have been part of this program I feel I can help and support my community, because of the training I have received, I have learned to listen, be empathic, and have work ethic with participants. I have learned the importance of confidentiality. I feel that I can help and give better emotional support in a more educated and proper way. I have also learned not to judge people based on how they look or how they feel. I am excited about our (*Promotores*) meetings once a month to see the team and share with the group the experiences and lessons. I am incredibly happy and grateful to be part of this group of *Promotores* and continue to be helping the community."
- "The *Promotores* program has helped my personal growth and thanks to the trainings I received I am able to support my community in many ways. I feel very happy to be able to help others."
- "This year I supported a community member that has been a gardener for more than 10 years and is a very responsible person. Unfortunately, he was diagnosed with cancer in his blood and was feeling very scared because he didn't know where to ask for help. I guided him, helped him get his Medi-Cal and found other resources for him. I feel very proud of the work I do as a Promotor."

Quote from participant receiving emotional support from a *Promotora*:

- "I am 20 years old newly arrived immigrant and sadly, I had to leave my four-year-old boy in my country Guatemala. I do not have any family in this country. The journey to get here was exceedingly

difficult. I went through painful situations, but I thank God that I found people like you (*Promotores* Program Coordinator) and the *Promotores* that have helped me and guided me toward resources. They have been keeping an eye on me and protecting me. They have not abandoned me. I am a shy person and thanks to you my self-esteem is better, and I feel more confident in myself. Thank you so much for your help. I am blessed for having found you."

- 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 23/24	Actual FY 23/24
9 Community Health Advocates from Marin City will Participate in at least **4** trainings each by June 30, 2024	**9/4**	**9/4**
Each FMBC staff and CHA will complete a minimum of **2 hours** annually to stay abreast of new learning regarding cultural humility, racial equity, and trauma-informed practices by June 30, 2023.	**2 hours by each CHA**	**2 hours were met by each CHA**
CHAs will serve as a bridge between Marin City community members and supportive	**800**	**898**

services and reach **800** Marin City residents by June 30, 2023.		
An FMBC representative will attend at least **75%** of MHSA Advisory Committee meetings, meetings with the BHRS Outreach and Engagement Coordinator, and the Equity and Community Partnerships (ECPC) by June 30, 2023	**75%**	**40%**
CHAs to support **2** conversations between Sheriff's Dept and Marin City residents to build trust and understanding on the role of law enforcement and how mental health shows up for residents in this community by June 30, 2023.	**2**	**1** event with Sheriff's Office that lasted for a duration of 90 mins, including a crisis panel discussion, a presentation from BHRS Mobile Crisis Response Team (MCRT), and a presentation from Marin County Sheriff Dept on their protocols in responding to mental health crisis. The community had the opportunity to address their concerns about how mental health crisis are handled in Marin City.
Develop partnership with MCRT to better support clients in Marin City by June 30, 2023.		FMBC met with the BHRS Division Director of Forensics to negotiate dates that MCRT could come to the community to discuss their protocols, hear feedback, and establish relationships with the community members of Marin County. There was a Mobile Crisis Panel

		Discussion held with MCRT and MCCT.

First Missionary Baptist Church (FMBC) Highlighted Case Studies:

- One of the FMBC CHAs worked with a family of 4, 3 kids being raised by their grandmother. The eldest, who is now in his early 20's, was diagnosed with bipolar disorder and Schizophrenia. Before working with this family, he served jail time and was at risk of going back to jail for probation violations. The CHA started working with the family and sent referrals to BHRS to seek therapy and Empowerment clubhouse. He utilized both resources.
- One of the FMBC CHAs works with a young lady in her mid – late 20s. She has been going through a difficult time. At times she struggled with suicidal Ideations and other struggles. The CHA worked with her and took a long time to build trust to get her to open up so that she could recommend the proper resources. After a few consultations, trust was developed, and the young lady began to open up more to the CHA. She was pointed in the direction of BHRS to seek therapy options and utilized Helen Vine. The young lady made notable progress. She moved out of her parent's house, found a good job, and began to laugh and smile more.

Multicultural Center of Marin (MCM) and Marin Asian Advocacy Project (MAAP)	**Goal FY 23/24**	**Actual FY 23/24**
CHA Supervisor and other CHAs will take **1** annual training on NARCAN, which will cover how to administer NARCAN to the Vietnamese-speaking community.	**1**	**2**
CHAs will distribute NARCAN to **150 – 200** individuals by June 30, 2024.	**150 - 200**	**Unknown**
MAAP will hold **1** social connectedness, physical health, and/or wellness group **1x/month**, targeting at least **25** Vietnamese-speaking community members.	**12/25**	**12/Unknown**
MAAP will participate in the Marin County Voluntary Organizations Active in Disaster (VOAD) **monthly**.	**12**	**12**
MAAP will have at least **4** CHAs by March 1, 2024.	**4**	**4**
Each CHA will complete a **monthly** training after recruited to understand the role of a CHA and how to recognize signs of mental health/substance use.	**12**	**3**
Each CHA will refer 5 Vietnamese-speaking community members in need of behavioral health support to BHRS by June 30, 2024 for a total of **20** referrals.	**20**	**2**
MAAP will hold **1** behavioral health group **1x/month**, targeting at least 25 Vietnamese-speaking community members.	**12**	**0**

Each CHA, including CHA Coordinator/Supervisor will complete a minimum of **2** hours annually to stay abreast of new learning regarding cultural humility, racial equity, and trauma-informed practices.	**2**	**0**

- Multicultural Center of Marin (MCM) and Marin Asian Advocacy Project (MAAP): MCM is the fiscal sponsor for MAAP, who 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.

- **<u>BHRS Spanish Language Groups:</u>**
  - 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 than 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 co-parenting, 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 United States in the 21st century.
- A total of 6 parents came to the groups throughout FY 23/24, including a set of co-parents, which was a new achievement due to added curriculum focusing on co-parenting.

- **<u>Mental Health First Aid (MHFA) Training for Spanish Speakers:</u>**
  Mental Health First Aid is a course that teaches the skills needed to recognize and respond to signs and symptoms of mental health and substance use challenges, as well as how to provide someone with initial support until they are connected with appropriate professional help.

  - Topics covered in FY 23/24 included: Mental Health First Aid for Adults & Mental Health First aid for supporting Youth

- Number of MHFA trainings in Spanish held in FY 23/24: Four (4)
  MHFA para Adultos – San Rafael 6/1/24
  MHFA para Adultos – Point Reyes 4/20/24
  MHFA para Jovenes – San Rafael 1/20/24
  MHFA para Adultos – Novato 12/9/23

- Number of Spanish speaking people reached in FY 23/24: Forty (40)

CHANGES FOR FY24/25:

- **System Navigation Materials:**
  - New materials (including updated brochures, booklets, social media campaigns, and infographics) to support the navigation of our complex system will be released in this fiscal year.
- **Changes to Community Health Advocate (CHA) Programs:**
  - BHRS is no longer contracting with Multicultural Center of Marin (MCM) for the Vietnamese speaking CHA program. BHRS is planning to pilot a Vietnamese Outreach Program using internal supports, community volunteers, and support groups as a means of reaching this population.
- **Outreach Events for Clients:**
  - Cultural events for clients and potential clients are planned for this fiscal year, including a *Dia de Los Muertos* event, a Lunar New Year event, a Juneteenth event, and a PRIDE event.

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 FY25/26: 300

NUMBERS SERVED IN FY23/24: 376

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

FY23/24 OUTCOMES:

- **Outcome 1: 48** individuals were unhoused at the time of an Access assessment in FY23/24. Additionally, there was a decrease in the percent of individuals who were assessed that were unhoused at the time of assessment (down to 10% from 19% in FY22/23).
- **Outcome 2:** The percent of unhoused individuals who identified as having psychiatric or emotional conditions remained the same between the Point-in-Time Count conducted in 2022 to the Point-in-Time Count conducted in 2024. Although the percentage remained the same the overall number slightly increased. In 2022, 45% (N=359, 153 individuals) of survey participants reported having psychiatric or emotional conditions. In 2024, 45% (N=378, 170 individuals) of survey participants reported having psychiatric or emotional conditions.
- **Outcome 3: 92** formerly homeless clients were housed through the Shelter+Care program with **90%** of participants remained housed at least 2 years.

CHANGES FOR FY25/26: Funding to support outreach and engagement with individuals experiencing homelessness.

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

NOTE: *This was a NEW Program in the FY24-26 Three Year Plan, with funding originally earmarked in just year one of the plan. This has now been updated to also include funding for year three of the plan (FY25-26).*

PROGRAM DESCRIPTION: This General System Development program aimed 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 was a major transition year for many Behavioral Health contractors including many that shifted to a *Fee For Service* model. The *Fee For Service* model incentivizes face-to-face time with clients shifting the way contractors were paid so that they get a paid strictly based on time spent with clients. In order to help smooth the transition, incentive payments were 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 shifting from a Cost Reimbursement to *Fee For Service* payment structure were eligible for this incentive.

Secondly, in order to implement many of the changes under CalAIM in July 2023 BHRS transitioned to a new Electronic Health Record (EHR) system. In order to best provide coordinated care for Behavioral Health clients, incentive payments were provided to contractors to help ensure as much clinical documentation occurred in the new EHR (aka *SmartCare*) as possible so contractors and county programs providing services to a client could 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 were eligible for this incentive. Contracted agencies that have their administrative staff only enter the service level billing and state reporting data did not qualify for this incentive.

FY25/26 marks the final year of MHSA. These incentive payments proved to be a valuable tool in helping contractors shift to new mandates and requirements. BHRS plans to utilize incentive payments in FY25/26 to help prepare providers for the Behavioral Health Transition in alignment with the CalAIM changes. These incentives will be in alignment with increasing coordination of services through the Electronic Health Record System, easing transition to Fee For Service models, and incentivizing utilizing additional provider types such as Certified Peer Support Specialists.

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

EXPECTED NUMBERS TO BE SERVED FOR FY25/26: 300.

NUMBERS SERVED IN FY23/24: 824 clients were served through contracts that received CalAIM incentive payments in FY23/24 (exceeding the projection of 600 clients by 37%). This included:

Contractor	Contract	Clients Served in FY23/24
Buckelew Programs	MAIL/RSS Outpatient MH	148
Marin Housing Authority	Shelter + Care	92
Mental Health Association of S.F.	Peer and Family Partner Outpatient	131
Side By Side Services	TBS/IHBS	23

Side By Side Services	Transitional Age Youth Full Service Partnership	39
Seneca Center San Rafael	Wraparound	18
Seneca Family of Agencies	My Home MH and Case Management	61
Buckelew Programs	Casa Rene (Crisis Residential Program)	151
Progress Foundation	Transitional Adult Residential Treatment	25
Network Providers	Various	134

OUTCOMES:

- Outcome 1: Increase the amount of face-to-face time clients have with their Mental Health provider
- Outcome 2: Increase care coordination by increasing the number of providers who enter their clinical documentation into the BHRS *SmartCare* Electronic Health Record System
- Outcome 3: *NEW for FY25/26* Increase the number of Certified Peer Providers providing Medi-Cal Billable services who are employed by contracted providers.

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.
- Outcome 3: *NEW for FY25/26* Compare the number of certified peer providers who provided 5 or more units of Medi-Cal billable services in the first six months of FY24/25 with the number of Certified Peer Providers who provided 5 or more units of Medi-Cal billable services in the last 6 months of FY25/26.

FY23/24 OUTCOMES:

- **Outcome 1:** Overall **126% increase** in documented face-to-face time clients had with their Mental Health providers through contractors who received the Contract Modernization incentives. The three contracted providers who received Contract Modernization incentives for successfully preparing and switching from Cost Reimbursement to Fee-For-Service all showed significant increases in documented Face:Face time with clients.
    - For Marin Housing Authority, there was a 76% increase in the amount of documented Face:Face time with clients as compared to FY22/23 when the agreement was cost reimbursed rather than paid as Fee For Service.
    - For Side By Side TAY FSP, there was a 36% increase in documented direct face:face services with clients as compared with FY22/23 with the agreement was cost reimbursed.
    - Specialty Mental Health Services provided by Buckelew programs at their mental health housing programs (Residential Support Services and MAIL levels) had the biggest increase: clients had 246% more documented face to face time with mental health providers through that contract agreement as compared with the prior year under cost reimbursement.

- **Outcome 2:** 11 of the 13 (85%) eligible Mental Health contracted providers made the conversation to adopting the new BHRS Electronic Health Record (EHR) system utilizing the EHR incentive to cover necessary staff training time and other needed system shifts. This expanded the ability for care coordination through the EHR by 85%.

CHANGES FOR FY25/26: For FY25/26 BHRS will utilize additional CalAIM Transition Support incentive funds allocated in this Annual Update to help contracted providers prepare for Behavioral Health Transformation which is in alignment with the CalAIM transition. This can involve incentives for providers who will newly be billing Medi-Cal or newly adopting our Electronic Health Record System, as well as for providers to expand provider types offered such as adding the Certified Peer Support Specialist provider type. Part of this transition support funds may also be utilized to support contract managers and providers selected through the Request for Proposal process in the Spring of 2026 for FY26/27-28/29 services in alignment with the first BHSA 3-Year Plan in order to be ready for the changes under BHSA including billing Medi-Cal and potentially Other Health Coverage.

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***.

CARE OUTREACH AND TREATMENT: SDOE 18

NOTE: *This was 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: 150

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

FY23/24 OUTCOMES: No outcome data for FY23/24 (program started FY24/25).

CHANGES FOR FY25/26: None.

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

NOTE: *This was a NEW Program in the FY23/24-25/26 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 established 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 were deposited into a County-administered account in FY23/24, prior to occupancy.

Kerner Canal, LLP (an affiliate of Eden Housing, Inc.) will fulfill their duties as delineated in an Operating Agreement which outlined the operational requirements for the site and the requirements to receive yearly operating subsidies. This agreement was based upon activities and outcomes from the original Homekey application and included 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.) is responsible for maintaining and managing the property, leasing units to the target population, and providing resident services.

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.

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

BUDGET NARRATIVE: In FY23/24, $7,649,740.00 was deposited into a County-Operated account for this COSR. The amount deposited into the reserve account was 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.

EXPECTED NUMBERS TO BE SERVED FOR FY25/26: 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

FY23/24 OUTCOMES: The COSR was successfully established in FY23/24 with $7,649,740 deposited into the county-operated reserve account in accordance with the MHSA regulations for setting up the COSR. Clients are scheduled to move into 3301 Kerner in April 2025. No client-facing services were provided in FY23/24.

CHANGES FOR FY25/26: No changes for FY25/26. This was a one-year disbursement with the full allocation expended into the reserve account in FY23/24.

PROJECT-BASED HOUSING PROGRAM: SDOE 20

NOTE: *This is a NEW Program in the FY25/26 Annual Update, with one-time funding earmarked for FY25/26.*

PROGRAM DESCRIPTION: In alignment with Proposition 1 and local community input, this Annual Update is prioritizing making funding available for housing, as housing stability is vital to mental health wellness. Expanding on the success of the HomeKey Program, Proposition 1 allocated bond funds to the State to administer an application process to help support the development of permanent supportive housing (PSH) for veterans and individuals at risk of or experiencing homelessness and with mental health or substance use challenges under the new name "HomeKey+." In this Annual Update, this new General System Development "Project-Based Housing Program" allows for the County to provide either match funding for Round 1 or 2 of HomeKey+ or to be used for a similar PSH project approved by the Board of Supervisors.

Under the Mental Health Services Act, Project-Based Housing program funding must meet the following criteria:

- The units shall be used for the purpose of providing housing as specified in the County's approved in this annual update, for a minimum of 20 years. In this case, PSH for individuals at risk of or experiencing homelessness and with behavioral health challenges.

- Housing units owned by a non-government agency shall have a regulatory agreement, covenant, or deed restriction that requires the Project-Based Housing to be used for the program as described in this annual update for a minimum of 20 years.

The County may use General System Development funds for costs associated with Project-Based Housing for purchasing, renovating, and constructing Project-Based Housing.

BUDGET NARRATIVE: Cost containment efforts will restrict the use of MHSA funds to no more than an average of $450,000 per unit of PSH at a site. If used for HomeKey+ matching requirements this would be $150,000 in MHSA funds and $300,000 in State Bond funding.

PROVIDER: TBD

TARGET POPULATION: Individuals at risk of or experiencing homelessness and with behavioral health challenges.

EXPECTED NUMBERS TO BE SERVED FOR FY25/26: This program is expected to open after FY 2025/26 and serve clients for twenty to fifty-five 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:

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

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 given 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 FY22/23.

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 placed through Coordinated Entry and had been chronically homeless for years prior to residency in these apartments and are supported by the Full-Service Partnership teams. These units were occupied in FY23/24.

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	$1,511,145	$4,330,584
SDOE-17 CalAIM System Development	$425,000	$0	$500,000	$925,000
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
SDOE-20 PSH Project-Based Housing	$0	$0	$3,750,000	$3,750,000
Subtotal	**$23,001,150**	**$14,081,912**	**$18,534,762**	**$51,867,825**
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	$472,691	$1,601,677
Transfer to Capital Facilities & Technological Needs	$1,805,116	$3,105,116	$3,176,949	$8,087,181
Total Transfers out of CSS	**$2,761,411**	**$3,277,807**	**$3,649,640**	**$9,688,858**

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

Program	Target Number By Age Group					Total	FY25/26 Projected Cost Per Person
	0-5	6-15	16-25	26-59	60+		
FSP-01 Youth Empowerment Services (YES)	3	55	50			108	$7,618
FSP-02 Transitional Age Youth (TAY) Program		45	5			50	$17,564
FSP-03 Support and Treatment After Release (STAR)			8	54	8	70	$11,967
FSP-04 Helping Older People Excel (HOPE)				2	70	72	$13,072
FSP-05 Odyssey			10	90	15	115	$7,595
FSP-06 IMPACT North			5	70	7	82	$12,752
FSP-07 IMPACT South			5	70	7	82	$12,921
FSP Totals	**3**	**100**	**83**	**286**	**107**	**579**	**$11,154**
SDOE-01 Enterprise Resource Center (ERC)			15	220	150	385	$1,476
SDOE-09 Crisis Continuum of Care		125	200	500	230	1055	$2,793
SDOE-10 First Episode Psychosis (FEP)		2	21	2		25	$6,391
SDOE-11 Consumer Operated Wellness Center (Empowerment Clubhouse)			10	95	50	155	$2,447
SDOE-13 Recovery-Oriented System Development		35	90	460	165	750	$724
SDOE-14 Stepping Up			30	150	30	210	$1,457
SDOE-15 Community Outreach and Engagement	50	300	1500	2150	1000	5000	$202
SDOE-16 Homeless Support and Outreach			50	150	100	300	$5,037
SDOE-17 CalAIM System Development		40	70	455	125	690	$725

SDOE-18 CARE Outreach and Treatment			25	100	25	150	$2,694
SDOE-20 PSH Project-Based Housing	This housing site is expected to open after FY25/26						Up to $450,000 per PSH unit

	Target Number By Age Group					**Total**
	0-5	6-15	16-25	26-59	60+	
Total	50	462	1946	3852	1760	**8070**
FSP Totals	3	100	83	286	107	**579**

FSP = Full-Service Partnership
SD OE = 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 Latino community by supporting trusted community partners

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

Priority Four: Investing additional funding in Early Childhood Mental Health

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

RATIONALE FOR KEY PRIORITY AREAS

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

During the MHSA planning process, stakeholders emphasized the need for expanded early intervention mental health supports for older adults to address depression, anxiety, 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 early intervention mental health 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 early intervention groups and other supportive activities will be provided with a focus on older adults that are experiencing early emergence of psychological distress, need support and are disconnected from other resources.

<u>Priority Two</u>: Increasing resources for the Latino 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 Latino 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 providers 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 Latino 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 Latino 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:

- Expanded programming for Latino TAY in the Novato area by augmenting the contract with North Marin Community Services.
- Marin County Cooperation Team Vision Project TAY youth program in southern Marin was awarded PEI funds via RFP process and focuses on early intervention support for TAY youth through a mentor/mentee model.

<u>Priority Four:</u> Investing additional funding in Early Childhood Mental Health and expanding community education on Domestic Violence Prevention and Outreach:

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 areas:

- Fund were allocated to expand early childhood consultation at the Marin City/Horizons childcare center.
- Domestic Violence Prevention and Outreach contract was awarded to Canal Alliance and complete program information can be found in PEI 12 Community Training and Supports.

<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 was granted to NMCS 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 23/24:**
1: Childhood trauma prevention and early intervention to deal with the early origins of mental health needs	74%
2: Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan	68%

3: Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs	54%
4: Culturally competent and linguistically appropriate prevention and intervention	96%
5: Strategies targeting the mental health needs of older adults	39%
6: Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	83%

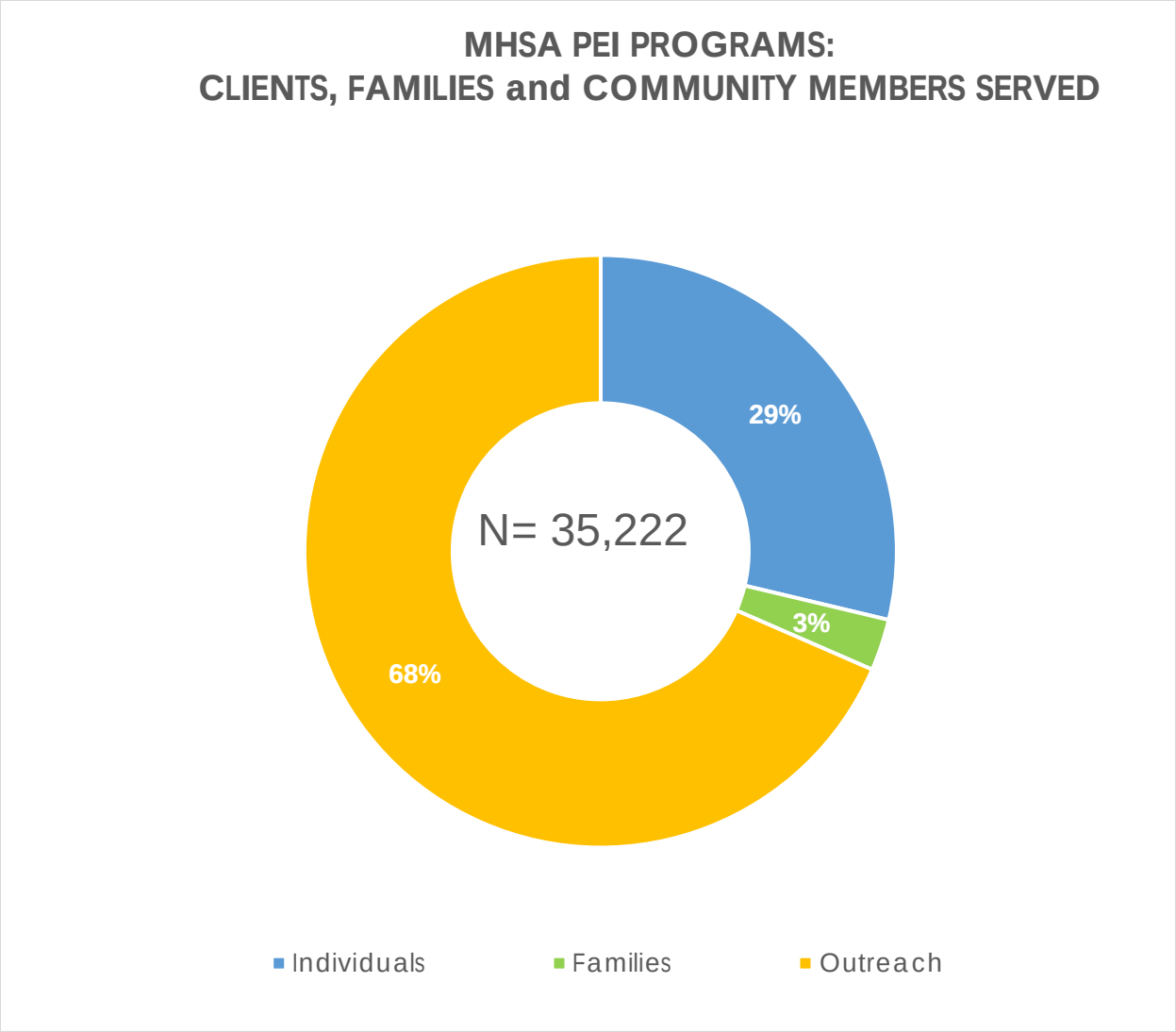
OVERVIEW TO PEI PROGRAMS FOR FY23/24 THROUGH FY25/26

Required Service Category	Programs	SB 1004 Priority Categorization(s)	Marin Priority Strategy Area(s)
Prevention and Early Intervention	PEI-04 Transition-aged youth individual and group mental health/case management services	#1, #3, #4, #6	Enhancing Early Intervention and Prevention Supports to Transition Aged Youth
	PEI-18 School Based prevention and early intervention	#1, #2, #3, #4, #6	School-based Mental Health and Substance Use Psychoeducation
	PEI-07 Older Adult Prevention and Early Intervention	#2, #4, #5, #6	Expanding Early Intervention Services for Older Adults
	PEI-01 Early Childhood Mental Health	#1, #4, #6	Investing additional funding in Early Childhood Mental Health
Prevention	PEI-01 Early Childhood Mental Health PEI-05 Latino Community Connection PEI-12 Community Training and Supports	#1, #2, #4, #5 #6	Increasing resources for the Latino community by supporting trusted community partners
Early Intervention	PEI-05 Latino Community Connection	#4, #6	Increasing resources for the Latino community by supporting trusted community partners
Stigma Reduction	PEI-12 Community Training and Supports	#2, #4, #5, #6	Increasing resources for the Latino community by supporting trusted community partners
	PEI-24 Storytelling Program	#2, #4, #5	-
Suicide Prevention	PEI-21 Suicide Prevention PEI-07 Older Adult Prevention and Early Intervention PEI-05 Latino Community Connection	#2, #3, #4, #5	-
Access and Linkage	PEI-23 Newcomers Coordination and Support	#1, #3, #4, #6	Increasing resources for the Latino community

			by supporting trusted community partners
Outreach	PEI-19 Veteran's Community Connection	#2, #5, #6	-

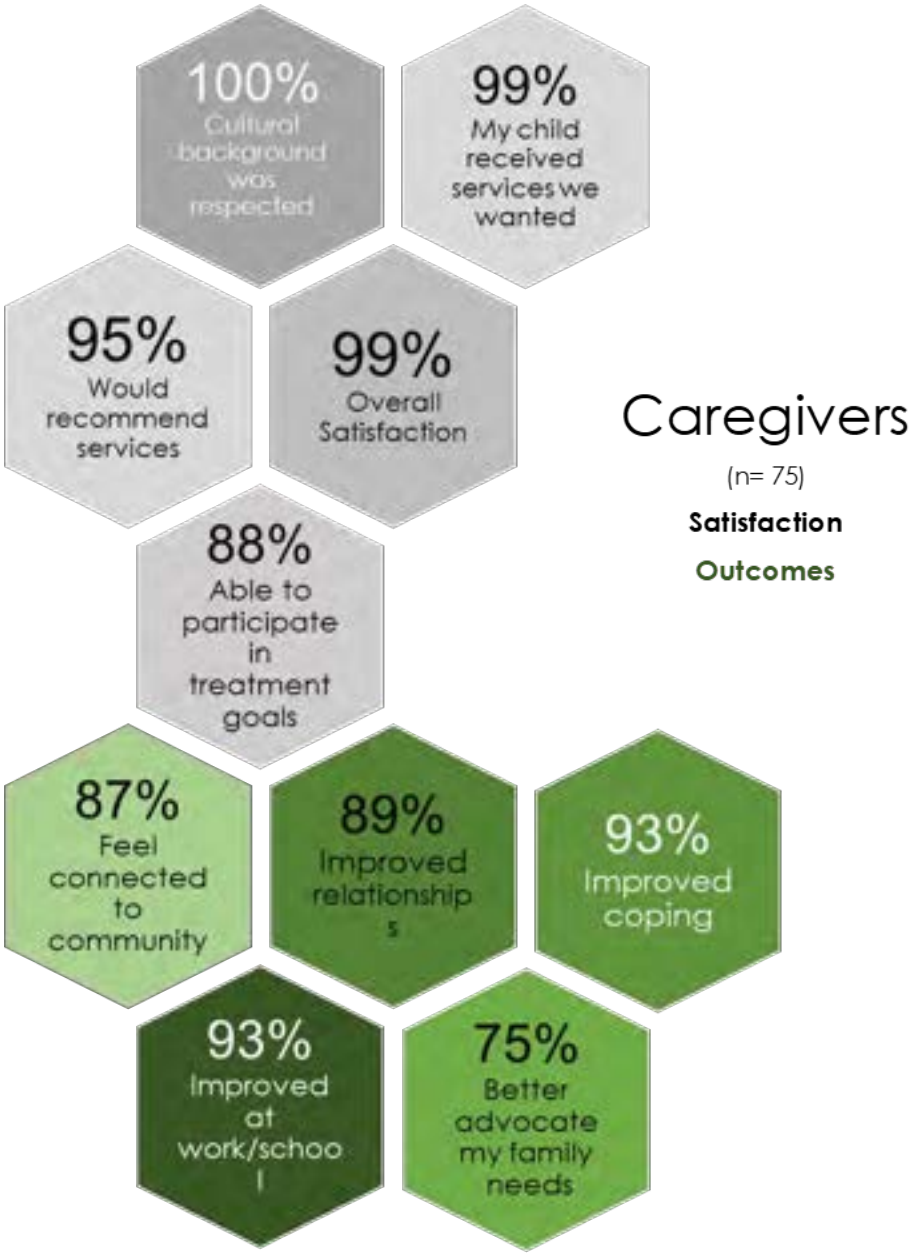
COMMUNITY REACH AND IMPACT

Throughout the delivery of Prevention & Early Intervention (PEI) services, efforts have been made to better reach underserved populations. Establishing programs in Southern and West Marin has increased access for geographically isolated and underserved communities. This year, PEI programs engaged 35,222 individuals, families, and community members—an expanded reach compared to last year's 18,510. This growth reflects successful outreach, which includes community training, workshops, events, and support initiatives such as the Suicide Prevention Collaborative. Participants may attend multiple events or workshops and thus may be counted more than once, alongside unique services provided to individuals and families. Programs are offered across the lifespan, supporting people from early childhood through older adulthood, and addressing barriers such as language, stigma, discrimination, and service access that can limit mental health and recovery support. Key collaborations with community-based organizations have been instrumental in enhancing inclusive engagement and service delivery. Client and caregiver satisfaction surveys, along with program narratives—including descriptions, outcomes, and personal stories—further demonstrate the impact of these initiatives.


MHSA PEI PROGRAMS:
CLIENTS, FAMILIES and COMMUNITY MEMBERS SERVED
N= 35,222
29%
3%
68%
Individuals
Families
Outreach

CLIENT SATISFACTION OUTCOMES

CAREGIVER 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.

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:

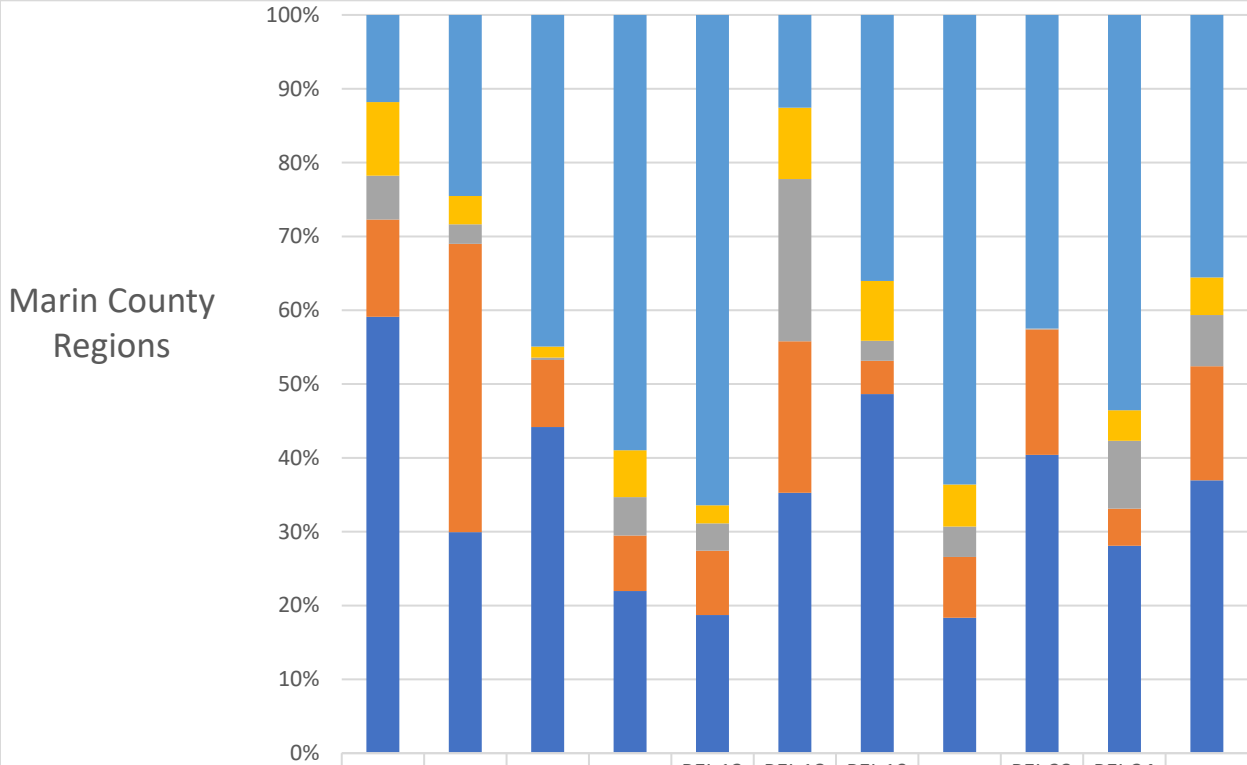
- The number of referrals to ACCESS (or other county mental health providers like a school-based EPSDT clinician)
- The percentage of total referrals successfully connected to services
- The average time elapsed between referral and connection
- The duration of untreated mental illness, as stipulated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

IMPROVE TIMELY ACCESS

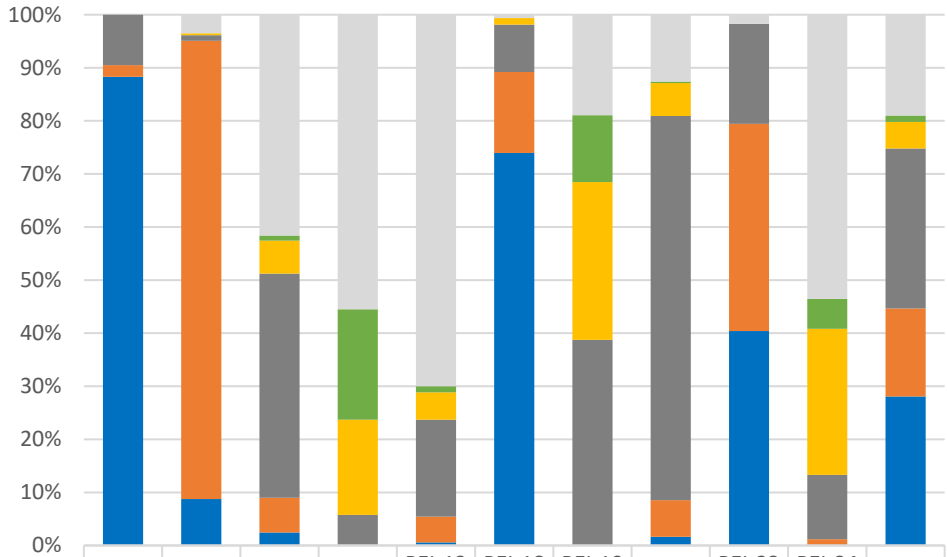
Commencing July 1, 2018, PEI providers initiated the collection of data on referrals to other PEI programs. Through discussions with PEI providers, it has been observed that written referrals to other PEI programs are infrequent, resulting in limited data for reporting in this aspect. The strategies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

FY23/24 DEMOGRAPHICS

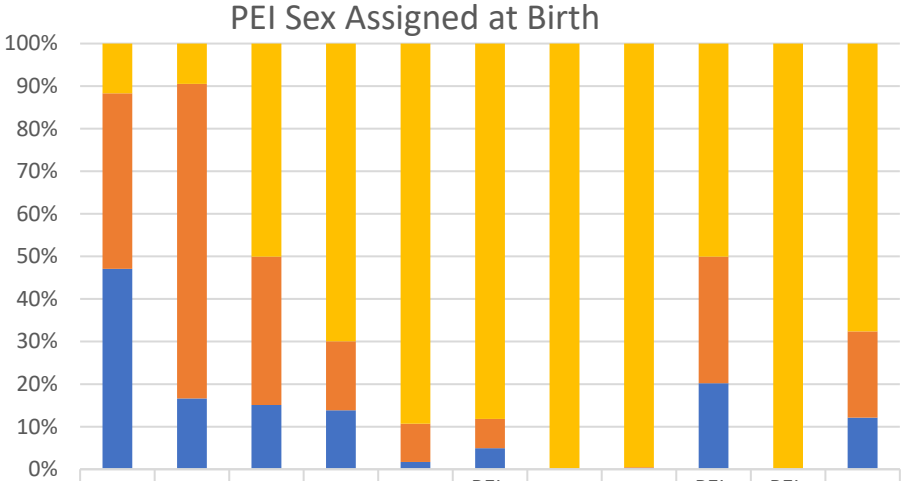
Below is a breakdown of the populations served by the PEI program in FY23/24. Demographics are gathered for Prevention and Early Intervention programs encompassing services like support groups, counseling, skill building, training, and service navigation and advocacy. It's important to note that demographics 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-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Decline to answer/unknown	103	140	420	102	465	155	40 *	201	370	181	2177
Southern Marin	87	22	14	11	17	119	9	18	0	14	311
West Marin	52	15	3	9	26	271	3	13	1	31	424
North Marin	115	223	85	13	61	253	5	26	148	17	946
Central Marin	516	171	413	38	131	435	54	58	352	95	2263



	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/Unknown	0	20	389	96	490	8	21	230	15	181	1450
75+	0	0	9	36	8	0	14	5	0	19	91
60-74	0	2	58	31	36	15	33	113	0	93	381
26-59	83	6	395	10	128	110	43	1321	164	41	2301
16-25	19	493	61	0	34	188	0	126	340	4	1265
0-15	771	50	23	0	4	912	0	30	352	0	2142



	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/unknown	102	54	468	121	625	1087	111	1816	436	338	5158
Female	360	422	326	28	63	85	0	4	259	0	1547
Male	411	95	141	24	12	61	0	5	176	0	925

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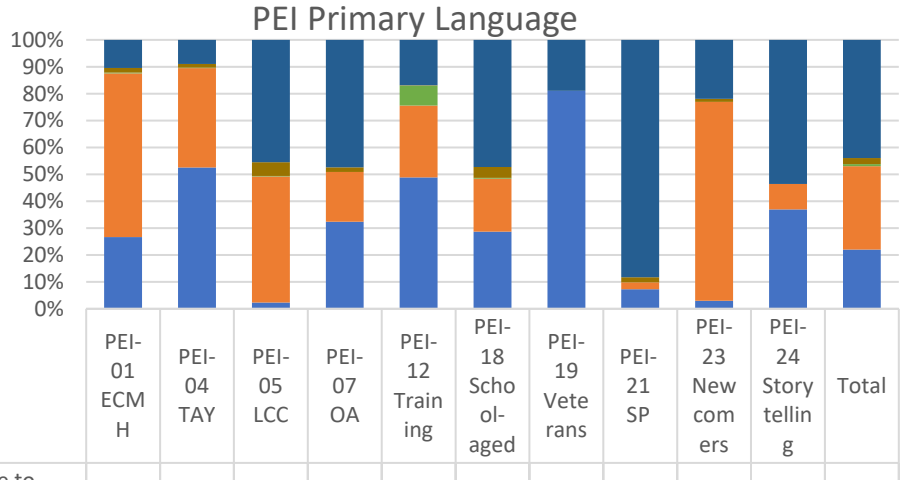
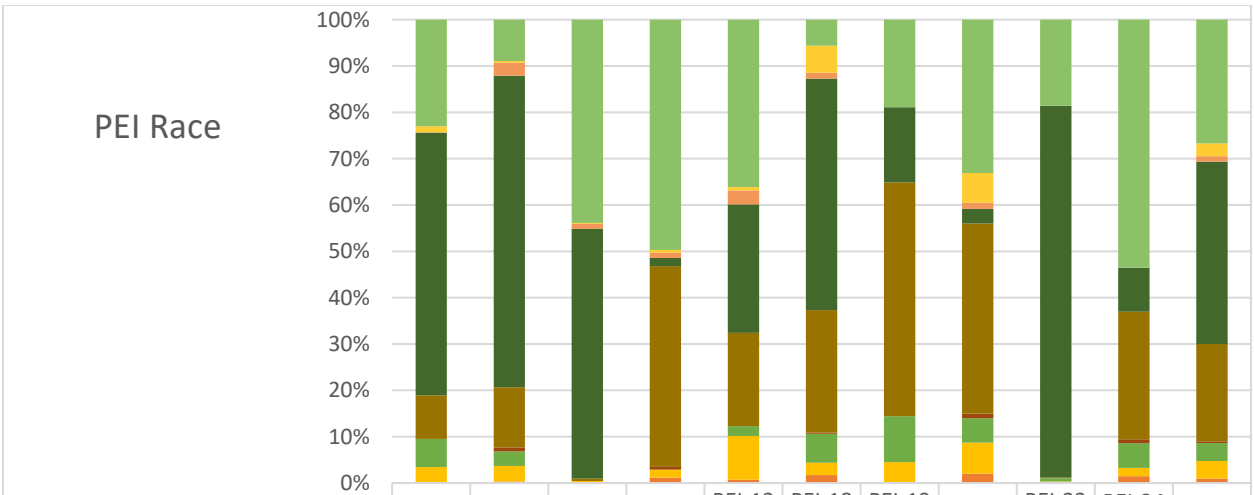
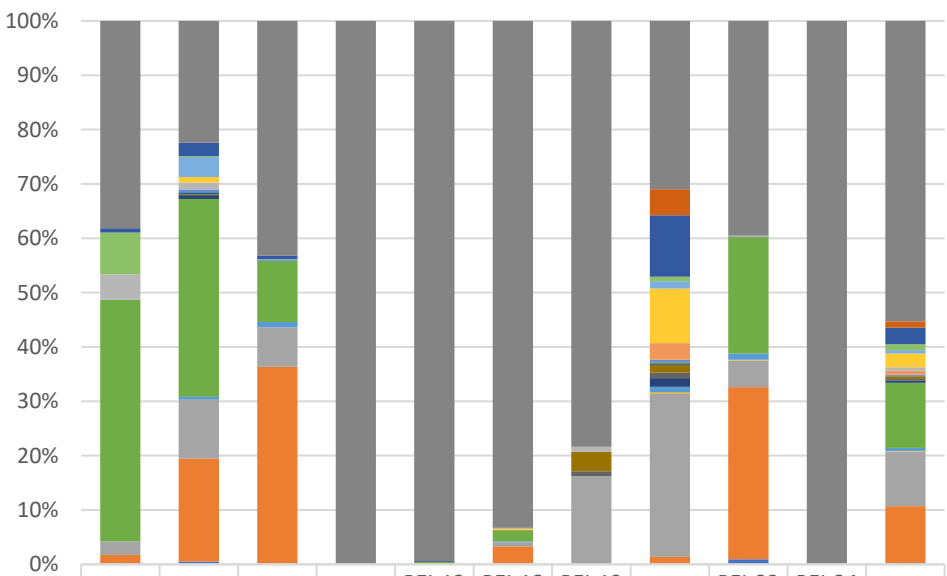


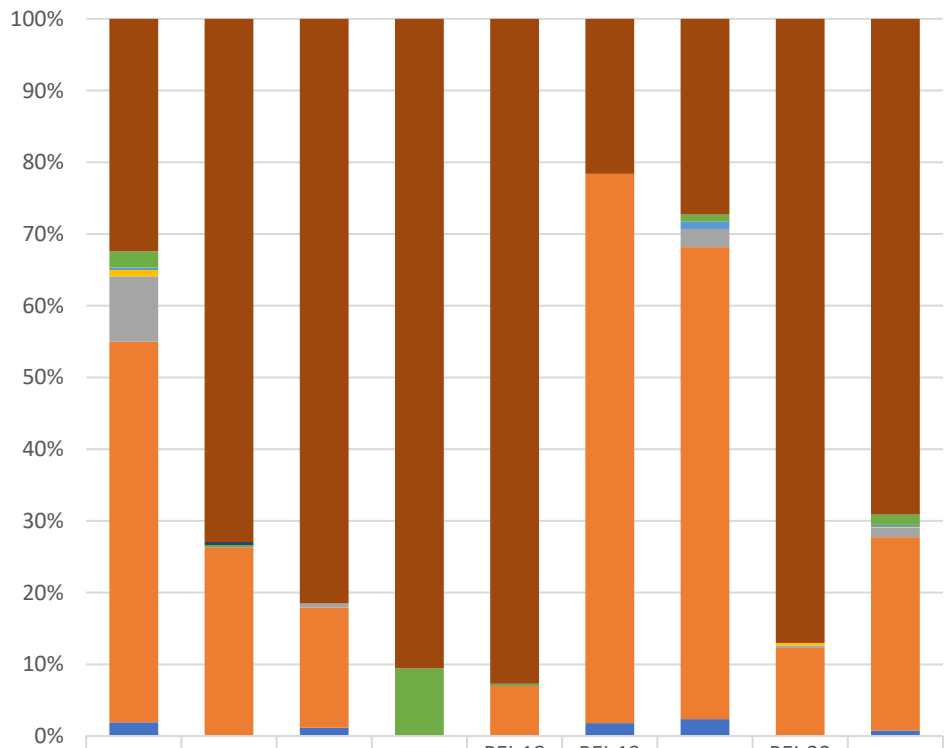
	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Decline to answer/unknown	91	51	425	82	118	583	21	1611	191	181	3354
Other Non-English Language	15	8	48	3	1	50	0	34	10	0	169
Vietnamese	3	1	2	0	52	3	0	0	0	0	61
Spanish	531	211	438	32	187	243	0	47	644	32	2365
English	233	300	22	56	342	354	90	133	26	125	1681



	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/unknown	201	51	410	86	253	69	21	604	162	181	2038
More than one race	11	2	2	1	5	72	0	117	0	0	210
Other	1	16	10	2	21	16	0	24	0	0	90
Hispanic or Latino	495	384	504	3	194	616	18	58	699	32	3003
White (Non-Hispanic)	82	74	5	75	141	326	56	749	1	93	1602
Native Hawaiian or other Pacific Islander	0	5	0	1	0	3	0	18	0	3	30
Black or African American	53	18	0	0	15	77	11	96	6	18	294
Asian	30	19	4	3	66	33	5	122	1	6	289
American Indian or Alaska Native	0	2	0	2	5	21	0	37	2	5	74

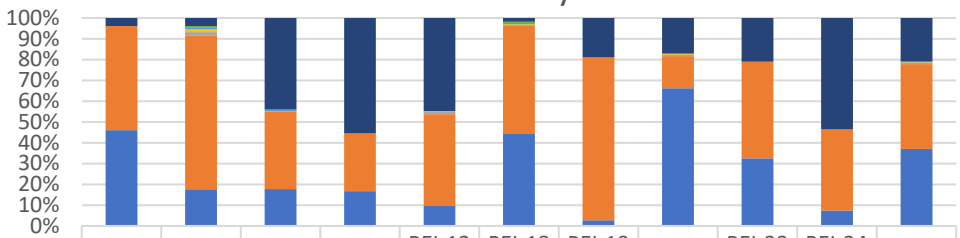


	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Decline to answer/unknown	333	128	404	173	696	1150	87	565	344	338	4218
More than one ethnicity	0	0	0	0	0	0	0	88	0	0	88
Other	7	14	6	0	0	1	0	206	0	0	234
Middle Eastern	67	1	0	0	0	0	0	15	0	0	83
Eastern European	0	21	1	0	0	0	0	25	1	0	48
European	0	6	0	0	0	3	0	183	0	0	192
African American	41	7	0	0	0	1	1	0	0	0	50
African	0	0	0	0	0	0	0	56	0	0	56
Vietnamese	0	3	2	0	0	0	0	9	1	0	15
Korean	0	0	0	0	0	0	0	4	0	0	4
Japanese	0	2	0	0	0	0	0	4	0	0	6
Filipino	0	1	0	0	0	1	4	26	1	0	33
Chinese	0	0	0	0	0	0	1	18	0	0	19
Cambodian	0	0	0	0	0	0	0	1	0	0	1
Asian Indian/South Asian	0	4	0	0	1	0	0	29	0	0	34
Other Latino not listed	388	208	105	0	3	25	0	0	186	0	915
South American	0	3	9	0	0	2	0	19	10	0	43
Puerto Rican	0	0	0	0	0	0	0	5	1	0	6
Mexican/Mexican American	22	62	68	0	0	9	18	547	43	0	769
Central American	15	108	339	0	0	39	0	22	276	0	799
Caribbean	0	3	1	0	0	2	0	3	8	0	17



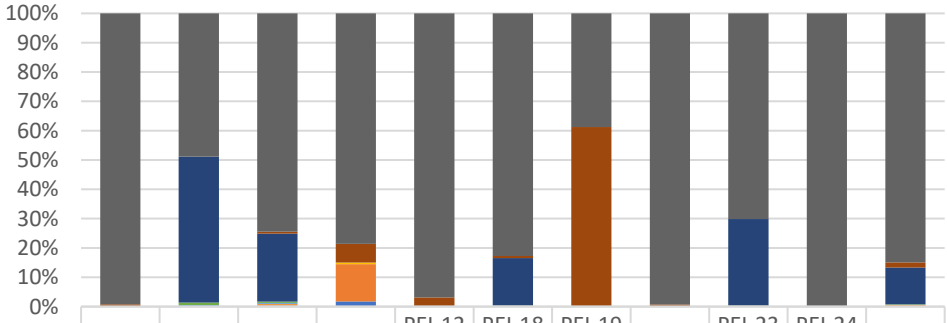
	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	Total
Decline to answer/unknown	185	682	141	634	1143	24	498	758	5272
Another sexual orientation	0	4	0	0	1	0	0	0	5
Undisclosed/Nonspecific Sexual orientation	13	3	0	66	3	0	18	0	107
Queer	2	0	0	0	0	0	19	0	21
Questioning/Unsure	5	0	0	0	0	0	0	3	8
Bisexual	52	0	1	0	0	0	46	3	102
Heterosexual/Straight	303	245	29	0	86	85	1201	106	2055
Gay or Lesbian	11	1	2	0	0	2	43	1	60

PEI Current Gender Identity

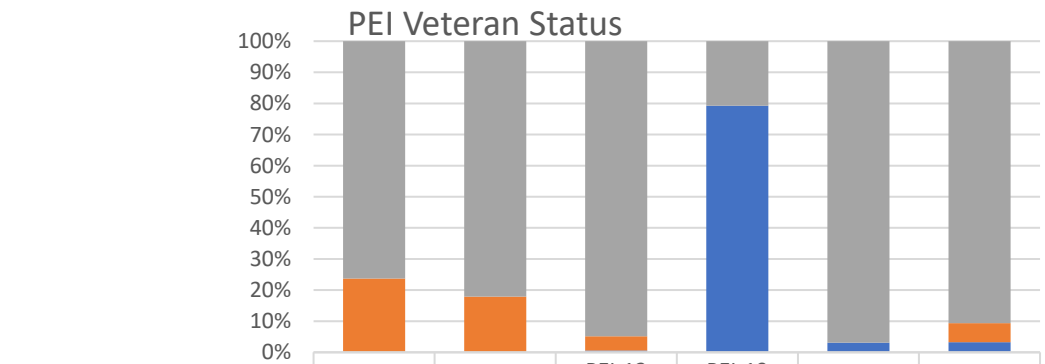


	PEI-01 ECMH	PEI-04 TAY	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-18 School-aged	PEI-19 Veterans	PEI-21 SP	PEI-23 Newcomers	PEI-24 Storytelling	Total
Decline to answer/unknown	34	22	412	96	313	22	21	312	183	181	1596
Another gender identity	0	5	1	0	0	16	0	5	0	0	27
Questioning or unsure	0	4	7	0	1	0	0	0	0	0	12
Genderqueer/Non-Binary	0	8	0	0	0	3	0	8	0	0	19
Transgender	0	10	1	0	10	6	0	9	1	0	37
Female	437	421	348	48	309	641	87	283	404	132	3110
Male	402	101	166	29	67	545	3	1208	283	25	2829

PEI Disability Status



	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/unknown	866	279	696	136	678	1020	43	1812	611	338	6479
Undisclosed Disability (YES)	7	0	6	11	22	9	68	12	0	0	135
No Disability (NO)	0	284	217	0	0	200	0	0	257	0	958
Another type of disability	0	5	4	0	0	1	0	0	1	0	11
Difficulty Seeing	0	2	3	0	0	0	0	0	0	0	5
Difficulty Hearing	0	0	1	1	0	1	0	0	0	0	3
Chronic Health Condition	0	0	0	0	0	0	0	0	0	0	0
Physical	0	0	5	22	0	1	0	0	1	0	29
Mental	0	1	3	3	0	1	0	1	1	0	10



	PEI-05 LCC	PEI-07 OA	PEI-12 Training	PEI-19 Veterans	PEI-21 SP	Total
Decline to answer/unknown	713	142	664	23	1768	4217
No	221	31	32	0	0	284
Yes	1	0	4	88	57	152

EARLY CHILDHOOD MENTAL HEALTH (ECMH) (PEI 01)

SERVICE CATEGORY: PREVENTION & EARLY INTERVENTION

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

MARIN PEI PRIORITY STRATEGY AREA: Early Childhood Mental Health

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 programs work 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.

Changes made for FY 24/25 included increased funding to support expanded capacity for serving families in the Marin City/Sausalito community with a focus on outreach, advocacy, and linkages to essential mental and physical health services.

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

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 23/24	**916**	**500**	**1,702**	**3,118**

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, ASQ-2E) screening tool, PEARLS (Pediatric ACES and Related Life Events Screener), workshop/training surveys, demographics and numbers reached through outreach activities.

FY 2023-24 OUTCOMES:

Jewish Family & Children's Services (JFCS) provides Early Childhood Mental Health (ECMH) services to children 0 to 5 years of age and their primary caregivers. This consultation, offered to childcare staff and parents, helps identify developmental concerns, make appropriate referrals, and generally support caregivers in responding to early childhood mental health needs. During fiscal year 2023-24, JFCS offered clinical support and training to Marin County's Health Families Marin program and in fiscal year 2024-25 JFCS' scope of work focuses on expanded services in Marin City, meeting a significant community need.

Outcomes: Jewish Family & Children Services	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Childcare providers receiving ECMH consultation services	N/A	N/A	N/A	N/A	120	138
Children/families identified for enhanced intervention by providers that received ECMH consultation	N/A	N/A	N/A	N/A	65	61
Parents/primary caregivers reporting improved skills and knowledge	N/A	N/A	N/A	N/A	75%	89%
Children receiving prevention services through staff consultation	535	635	535	656	N/A	N/A
Percent from un/underserved cultural populations	70%	93%	70%	93%	N/A	N/A
Children/families identified for enhanced intervention by providers that received ECMH consultation	65%	78%	85%	96.15%	N/A	N/A
Children in childcare settings served by ECMH Consultants retained in current program or transitioned to an appropriate setting	95%	100%	95%	100%	N/A	N/A
Parents/primary caregivers reporting increased understanding	N/A	Not Reported	N/A	Not Reported	N/A	N/A
Caregivers reporting satisfaction with PEI services in two or more areas of satisfaction surveys	75%	75%	50%	100%	N/A	N/A
Total referrals to County Behavioral Health (BHRS)	N/A	6	N/A	5	N/A	2
Number of individuals successfully referred and linked to a Marin County mental health treatment program	N/A	0	N/A	0	N/A	0

Outcomes: Jewish Family & Children Services	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	6	N/A	6	N/A	Not Reported
Total referrals to other PEI providers	N/A	1	N/A	4	N/A	4
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	0	N/A	2	N/A	1
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	2	N/A	1.5	N/A	1
Total referrals to other mental health services or to resources for basic needs	N/A	22	N/A	32	N/A	66

First 5 Marin's Help Me Grow program supports families in navigating complex systems and making appropriate referrals by using screening tools to identify developmental needs and strengths in young children, as well as to build parent and provider skills to foster healthy child development. PEI funding supports Help Me Grow Marin to develop partnerships in the Marin City/Sausalito area.

Outcomes: First 5 Marin | Help Me Grow	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Increased referrals to Help Me Grow Marin in the Sausalito/Marin City area	N/A	N/A	N/A	N/A	50%	100%
Increase the number of children and families from the Sausalito/Marin City area served by the Help Me Grow Marin program	N/A	N/A	N/A	N/A	N/A	2
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	N/A	N/A	0

Outcomes: First 5 Marin | Help Me Grow	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Number of individuals successfully referred and linked to a Marin County mental health treatment program	N/A	N/A	N/A	N/A	N/A	Not Reported
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	N/A	N/A	N/A	N/A	Not Reported
Total referrals to other PEI providers	N/A	N/A	N/A	N/A	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	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	N/A	N/A	Not Reported
Total referrals to other mental health services or to resources for basic needs	N/A	N/A	N/A	N/A	N/A	4

CHANGES FOR FY 2025-26:

For FY 25-26 we expect a number of positive changes in the provision of Early Childhood Mental Health services. Services and relationships will continue to expand across the county with a targeted focus in Marin City, a previously underserved community within Marin County in terms of Early Childhood Mental Health services. For instance, with the support of the Help Me Grow program, during the Fall of 2024, Horizon's Preschool is launching universal developmental screening. Additionally, ECMH consultation will be more available to both childcare centers, as well as family-based childcare programs through JFCS. With increased screening, as well as strengthened relationships between service providers, schools, community-based organizations and the County of Marin, we would expect an increase in referrals for both physical and mental health care with an improved continuum of care for children ages 0-5 and their families.

Program Stories

Jewish Family & Children's Services (JFCS)

Kai* is a 4-year-old African-American boy newly enrolled at in a childcare program in San Rafael wherein 97% of the children are Latino. Kai presented as defiant and aggressive – hitting, spitting at teachers, and throwing toys. One teacher, after being hit with a stapler, threatened to quit if Kai's behaviors were

not addressed. The teachers were frustrated with his mother's apparent lack of discipline and interest in addressing his behaviors, noting that she was often looking at her phone and seemed to avoid talking to them when she was at the site.

The ECMH consultant astutely realized that her role not only involved intervening with regard to Kai's behaviors, but she must also support the parents and the school to develop a trusting relationship with one another. Through building rapport with Kai's mother and using a trauma-focused approach to care, the ECMH consultant began meeting weekly with her outside of the childcare setting. She learned that Kai had been expelled from numerous preschools and that CPS had been called in the past, which contributed to Kai's mother's avoidance and mistrust of the staff at the site. It became apparent that Kai's mother was actually eager for support, and she reported feeling often alone and isolated in her role as a parent.

While the consultant engaged in regular meetings with Kai's mother, she simultaneously worked with the teaching staff, offering tools to support Kai and address his behaviors, providing psychoeducation on trauma and childhood adversity, developing and conducting workshops for staff on supporting children through the use of co-regulation strategies, and assisting them to reflect on their own implicit racial biases. The ECMH consultant was eventually able to bring the staff and the mother together for meetings that focused on how they could collaborate to support Kai. The site director later stated, "that was the moment I realized the need for an enduring connection with this family, as it wasn't going to be a quick fix. I'm thankful to [the ECMH consultant] for getting that ball rolling. The support we received to care for this family has been invaluable."

First 5 Marin Help Me Grow

Help Me Grow (HMG) received a referral for Troy*, a 5-year-old child who began exhibiting disruptive behaviors shortly after starting Kindergarten in a charter school setting, which jeopardized his ability to stay in school. HMG staff conducted observations of the child at school and home, consulted with both the parents and school administrators, and administered key assessment tools, including the PEARLS (Pediatric ACES and Related Life Events Screener), the ASQ-SE2, and the ASQ-3 (Ages and Stages Questionnaires). The child scored 5 on the PEARLS, indicating high risk for toxic stress and the ASQ-SE2 showed behavioral concerns that required a referral for services. However, Troy screened as "developmentally on schedule" with no identified concerns using the ASQ-3. Additionally, during observations, HMG staff noted that Troy had a pattern of acting out when in the care of adults with whom he did not have a previously established relationship while he behaved in a more cooperative manner and displayed a calm, delightful mood more often when interacting with adults he knew well.

This feedback was provided to Troy's parents and school administrators; through this consultation, the family decided to move him to the traditional public-school setting where there were staff and children that looked like him and he encountered friends from his preschool. Upon transfer, HMG staff continued to work with the child, family and the new school to ensure a successful transition. Most of the behaviors went away, and Troy freely participated in all academic work. HMG staff continues to maintain communication with the family to provide regular follow up support, as needed.

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

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

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION

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

MARIN PEI PRIORITY STRATEGY AREA: Enhancing Early Intervention and Prevention Supports to Transition Aged Youth

FY23-26 THREE-YEAR PLAN PROGRAM DESCRIPTION: TAY programming provides screening and brief interventions for behavioral health concerns in teen clinics, as well as group and individual services in high schools for at-risk students. Providers conduct psychosocial screenings at health access points, offering direct linkage to mental health counseling, substance use counseling, case management, school-based groups, individual and/or family counseling, and targeted supports for immigrant youth

Additionally, TAY programming in southern Marin includes mentorship from non-parental adults who play pivotal roles in fostering healthy youth development within a strengths-based, advocacy framework. The objective of this mentoring initiative is to provide youth with positive adult interactions, which helps mitigate risk factors such as behavioral health issues, substance use, and alienation, while enhancing protective factors like healthy beliefs, opportunities for involvement, and social and material reinforcement for positive outcomes.

TARGET POPULATION: The target population is 16–25-year-olds—and some younger youth ages 12 to 15—from underserved populations such as Latino, African American youth and LGBTQ+

NUMBERS SERVED:

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 23/24	747	41	1627	2415

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;
- 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 2023-24 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 FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY23/24	Actual FY23/24
TAY screened for behavioral health concerns	165	170	165	117	170	170
TAY participating in individual and/or family counseling in school or clinic settings	100	133	100	223	100	264
Family members participating in TAY counseling in support of the client	50	63	50	0	30	9
⅓ of families will engage in Early Intervention services in support of the TAY client	1/3 of families	6% of clients had family interaction	1/3 of families	5.4% of clients had family interaction	N/A	N/A
TAY participating in at least 3 sessions of counseling showing improvement in doing better in school, stronger relationships with family, better coping skills, Connection to community* (PEI: Outcome survey)	N/A	Not Reported	N/A	Not Reported	75%	100%
TAY participating in at least 3 sessions of counseling showing statistically significant improvement in client well-being* (PCOMS: Outcome Rating Scale)	75%	100%	N/A	N/A	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%	100%	75%	71%	75%	87.5%

Outcomes: Huckleberry Youth Programs	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY23/24	Actual FY23/24
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	75%	98%	75%	99.04%	75	100%
Total referrals to County Behavioral Health (BHRS)	N/A	30	N/A	3	N/A	7
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	30	N/A	2	N/A	7
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	30	N/A	14	N/A	5
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	Not Reported	N/A	14	N/A	5
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	2 weeks	N/A	1 week
Total referrals to other mental health services or to resources for basic needs	N/A	Not reported	N/A	Not reported	N/A	22

Marin County Cooperation Team (MCCT) Vision Project

MCCT - Vision Project entails TAY mentorship from non-parental adults who play pivotal roles in fostering healthy youth development within a strengths-based, advocacy framework. The objective of this

mentoring initiative is to provide youth with positive adult interactions, which helps mitigate risk factors such as behavioral and mental health issues, substance use, and alienation, while enhancing protective factors like healthy beliefs, opportunities for involvement, and social and material reinforcement for positive outcomes.

Outcomes: MCCT Vision Project	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
MCCT's mentors will provide mentorship to youth and will complete needs assessment(s) and development and implementation of individual development plan (IDP).	N/A	N/A	N/A	N/A	10 Mentors to mentor 10 Youth 1.5+ contact hours each week	6 Mentors 6 Youth 1.5± contact hours each week
Youth participants will report positive changes in their knowledge, skills, and/or attitudes related to mental health, recovery, education, employment, housing, social skills, and financial literacy.	N/A	N/A	N/A	N/A	50%	100%
Youth participants will have completed an IDP and achieved at least 1 goal within it	N/A	N/A	N/A	N/A	50%	83.33%
Youth, Mentors partners, and staff will attend bi-monthly **community-building** events.	N/A	N/A	N/A	N/A	50%	100% staff 70.83% mentors; 55.55% for youth
Youth, Mentors, partners, staff, and guest speakers will attend bi-monthly **skill-building** events.	N/A	N/A	N/A	N/A	50%	100% staff 70.83% mentors; 55.55% for youth
Youth participants will report feeling comfortable asking questions/asking for help during the program	N/A	N/A	N/A	N/A	50%	100%
Youth participants will report a positive overall	N/A	N/A	N/A	N/A	50%	100%

Outcomes: MCCT Vision Project	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
experience with their mentor						
Youth participants will report increased self-esteem	N/A	N/A	N/A	N/A	50%	100%
Youth participants will recommend the program	N/A	N/A	N/A	N/A	50%	80%
Youth participants of 2023-2024 participants will want to return to the program in 2024-2025	N/A	N/A	N/A	N/A	50%	80%
Total referrals to County Behavioral Health (BHRS)	N/A	N/A	N/A	N/A	N/A	Not Reported
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	N/A	N/A	N/A	N/A	Not Reported
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	N/A	N/A	N/A	N/A	Not Reported
Total referrals to other PEI providers	N/A	N/A	N/A	N/A	N/A	1
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	N/A	N/A	N/A	N/A	1
Average time in weeks between when a referral was given to individual by your program and the individual's first in-person appointment with the PEI-funded provider	N/A	N/A	N/A	N/A	N/A	Not Reported
Total referrals to other mental health services or to resources for basic needs	N/A	N/A	N/A	N/A	N/A	Not Reported

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 FY21/22	Actual FY21/22	Goal FY22/23	Actual FY22/23	Goal FY23/24	Actual FY23/24
Peer Health Promoters (PHP) will serve annually as ambassadors to the Novato Teen Clinic.	7	8	7	6	7	4
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	85%	100%	85%	100%
Youth will undergo screening using the Rapid Adolescent Prevention Screening (RAAPS) tool and will be referred for services or further assessment/treatment as clinically indicated	200	164	200	209	200	275
Youth will receive education and outreach through mental health education workshops held in schools and within the local community.	500	541	500	1,219	500	886
Novato Teen Clinic's social media presence, managed by the NTC staff and PHPs, will engage with youth by promoting messages concerning prevention, early intervention, resources, and access to care across various social media platforms.	3,500	3,500	3,500	30,000	3,500	~10,000
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)	N/A	N/A	N/A	N/A	N/A	N/A
Youth will participate in brief interventions at NTC and receive referrals for treatment or case management as needed.	75	47	75	104		

Outcomes: North Marin Community Services	Goal FY21/22	Actual FY21/22	Goal FY22/23	Actual FY22/23	Goal FY23/24	Actual FY23/24
TAY participating in individual and/or counseling in school or clinic settings					75	72
Family members participating in TAY counseling in support of the client	N/A	N/A	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%	70% N=33	70%	57%	70%	95%
Youth receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) PEI Satisfaction survey	75%	N/A	75%	100%	75%	78%
Youth who complete satisfaction surveys will report making changes in their personal self-care practices and skills to improve their mental health and wellness. *PEI Outcome survey	65%	Not Reported	65%	80%	65%	70%
Total referrals to County Behavioral Health (BHRS)	N/A	6	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	3	N/A	0	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	52-136 weeks	N/A	50 weeks
Total referrals to other PEI providers	N/A	3	N/A	4	N/A	4
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	3	N/A	0	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: North Marin Community Services	Goal FY21/22	Actual FY21/22	Goal FY22/23	Actual FY22/23	Goal FY23/24	Actual FY23/24
Total referrals to other mental health services or to resources for basic needs	N/A	24	N/A	45	N/A	14

The Spahr Center provided clinic-based individual therapy to LGBTQ+ youth throughout Marin County. Effective as of February 16, 2024, The Spahr Center has announced the indefinite suspension of all programs due to ongoing financial challenges.

Outcomes: Spahr Center	Goal FY21/22	Actual FY21/22	Goal FY22/23	Actual FY22/23	Goal FY23/24	Actual FY23/24
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	200 hours 10 youth	402 hours 10 youth	500 hours 20 youth	558 hours 20 youth	500 hours 20 Youth	252 hours 32 youth
Provide Training for educators in a minimum of 5 middle and high schools	5	5	5	Not reported	5	Not Reported
PEI clients completing more than 3 sessions of therapy will indicate a positive therapeutic alliance, a significant predictor of clinical outcomes.	75%	100%	75%	100%	75%	Not Reported
Increase self-knowledge and self-confidence for LGBTQ+ youth seen for at least 24 sessions	85%	100%	85%	100%	85%	Not Reported
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	75%	100%	75%	100%	75%	Not Reported
Total referrals to County Behavioral Health (BHRS)	N/A	3	N/A	0	N/A	Not Reported

Outcomes: Spahr Center	Goal FY21/22	Actual FY21/22	Goal FY22/23	Actual FY22/23	Goal FY23/24	Actual FY23/24
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	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	4	N/A	0	N/A	Not Reported
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	4	N/A	0	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	1	N/A	Not reported	N/A	Not Reported
Total referrals to other mental health services or to resources for basic needs	N/A	17	N/A	7	N/A	Not Reported

CHANGES FOR FY 2025-26:

The MCCT-Vision Project is working to implement effective, evidence-based tool(s) to enhance early intervention efforts for TAY youth. These tools will help inform individual development plans and facilitate referrals to BHRS mental health and recovery services as needed. As mentors work with youth, the Vision Project aims to adapt these tools to be more culturally relevant and less stigmatizing within the mentee community, reducing barriers and ensuring timely access to services when appropriate.

Effective February 16, 2024, The Spahr Center announced the indefinite suspension of all programs due to ongoing financial challenges. Consequently, The Spahr Center will no longer provide LGBTQ+ TAY services under PEI.

Program Stories

Huckleberry Youth Programs

Huckleberry Youth Teen Clinic received a referral from a school counselor for a youth who initially struggled to open up and seemed hesitant to engage. After connecting with a bilingual Wellness Intervention Specialist (WIS) and spending several weeks building trust, the youth gradually began to share their needs.

At first, they requested basic necessities like food, clothing, and blankets. However, during further screening, the youth disclosed experiencing suicidal ideation and expressed a desire to leave the space shortly after sharing their situation. Staff responded with empathy and care, guiding them through the steps of contacting the mobile crisis team while continuing to provide reassurance and acting as interpreters when the crisis team arrived.

As we continued to work with the youth, it became clear they were navigating an extremely unstable period in their life. Their living situation was precarious, they had sustained a work-related injury, and they were coping with an emotionally volatile family member.

Thanks to Huckleberry's support and youth-centered approach, we were able to address their immediate needs by providing bedding, food, housewares, and shoes. Over time, the youth's connection with our team deepened as they continued engaging in case management and eventually became open to meeting with a therapist again.

This story reflects a common experience in our work—building trust and rapport is often the first and most critical step in helping young people access the support they need. Huckleberry's Mental Health team provides youth-centered, comprehensive support through case management and therapy. These resources are vital in addressing the diverse and pressing needs of the youth we serve.

North Marin Community Services: Youth Participant Story #1

A young adult came to the NMCS Teen Clinic after a friend recommended they seek mental health support. The friend had noticed them becoming increasingly isolated and recognized they were in an unhealthy relationship.

Through counseling, the client realized they had been normalizing their partner's abusive behaviors, including imposed isolation, physical harm, and threats against their life. Therapy gave them the courage to report their partner's actions to the police, leading to an immediate arrest.

As they continued counseling, the client built self-confidence and learned they could not change others but could change themselves by setting boundaries. They began to identify as a survivor rather than a victim.

A quote from the client:

"Mental health therapy has positively affected every aspect of my life and may even have saved my life. I want others to know how important having the Teen Clinic is in our community."

North Marin Community Services: Caregiver Story #1

The teen clinic program and services at NMCS are a true lifesaver! My family and I are so grateful for the opportunity to take our teenager to therapy at the Novato Teen Clinic. The therapist was incredibly professional, knowledgeable, and compassionate. She helped my teen overcome several challenges that were contributing to their depression, build confidence, and develop healthier habits, including eating better.

Now, I see my child as a more mature teenager who speaks up for themselves and is, overall, a much happier individual. They respect the technology boundaries we've set, and we, in turn, have learned to respect their privacy. We've built a relationship of trust, which has made a huge difference for our family.

I highly recommend the counseling services at NMCS to any family struggling to support their child or teen.

MCCT – Mentor and Mentee Stories from the Vision Project Program

Mentor/Mentee Pair 1

With the support of his mentor, Mentee 1 achieved two significant milestones: graduating from high school and securing employment. These accomplishments were especially important to him as a young father. Together, he and his mentor had in-depth discussions about fatherhood and the vital role it plays.

The mentor shared how much he valued working with his mentee, praising the mentee's willingness to listen and his genuine appreciation for the guidance provided. Reflecting on the program, the mentor expressed how refreshing it was to have an organization like MCCT focused on building a brighter future for children in the community.

Mentor/Mentee Pair 2

Although Mentee 2 faced behavioral challenges in school, conversations with his mentor about the importance of education and planning for his future set him on the path to high school graduation. The pair discovered they both had similar medical conditions, which created a strong bond and a shared foundation for mutual support. They often talked about the importance of physical and mental health and spent time together over meals.

The mentor also helped Mentee 2 explore realistic goals. While the mentee aspired to become a professional heavyweight boxer, they discussed potential limitations due to his medical condition. Together, they created a backup plan: starting a business specializing in boxing gear, similar to a sports shop storefront. In the meantime, the mentee has joined a boxing team and continues to pursue his passion.

The mentor shared how much he enjoyed building a positive rapport with his mentee and spending quality time with him each week.

Mentor/Mentee Pair 3

Mentee 3 worked with his mentor to set short- and long-term goals related to education, employment, and life skills. They focused on creating realistic plans for the future, discussing the importance of having a Plan B if Plan A didn't work out.

The mentee noted how inspiring it was to see professionals in leadership roles who reflected his own culture. He shared how the VP program was instrumental in developing young community leaders. His mentor, reflecting on his experience, said, "As a Black man myself, I appreciate the coming together of the Black community to support our youth. This program was a great experience, and I am thankful to have been a part of it."

Mentor/Mentee Pair 4

Mentee 4 had the support of a Marin County government leader as his mentor. Together, they navigated and achieved key goals in housing, child custody, life skills, and employment. The mentee successfully enrolled in the Fire Foundry program with his mentor's guidance.

Additionally, the mentor supported the mentee in navigating the complexities of being a male domestic violence survivor. The mentee described his mentor as "a constant positive force," while the mentor highlighted how rewarding it was to have "a positive effect in my mentee's life."

Mentor/Mentee Pair 5

Mentee 5 achieved their goals of earning a high school diploma and gaining employment. Along the way, the mentor and mentee had meaningful discussions about ethics and worked together on resume development. The mentee credited their mentor's guidance as instrumental in their ability to graduate.

Reflecting on the program, the mentor emphasized the importance of patience and empathy, stating: "Most fatherless kids are emotionally wounded, so tender loving care is necessary to support them."

Vision Project | First Missionary Baptist Church TAY Center: A Community Resource

As part of the VP program, the Spring of 2024 was dedicated to building and planning the opening of a TAY Center at First Missionary Baptist Church, a faith-based organization in Marin City. The TAY Center plans to open starting September 2024 for FY 24/25 seven hours a day, five days a week, providing a safe and welcoming space for VP participants and other transitional-age youth.

The center offers essential supplies such as food and toiletries, along with a TV/computer lab, games, lounge areas, technology charging stations, and more. This vital resource ensures that youth in the community have access to the support and tools they need to thrive.

*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): Increasing resources for the Latino community by supporting trusted community partners

PROGRAM DESCRIPTION: The *Latino Community Connection* program aims to address mental health concerns within the Latino community by enhancing the identification of individuals struggling with mental illness and bolstering protective factors. 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 & recovery services. Clients may also access group sessions focused on trauma, stress management, depression, and anxiety, aimed at developing effective coping and stress reduction strategies.

LCC programming also includes the local Spanish-language radio show "Cuerpo Corazón Comunidad" with Marin Multicultural Center offering resources, information, and solutions on health and safety.

TARGET POPULATION: The focus group comprises Latino 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 23/24	570	110	2560	3240

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 2023-24 OUTCOMES:

Outcomes: Canal Alliance	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Individuals and their family will participate in individual/family and group sessions.	N/A	N/A	70 individuals & 15% of family members	475 individuals & 25% of family members	140 individuals & 15% of family members	531 individuals & 20% of family members
Individual/family/group session participants completing at least 2-3 sessions will report a reduction in symptoms by one category measured on the GAD-7, BDI, CES-D, PCL-C or PSI-4.	50%	100%	50%	100%	50%	100%
Behavioral Health Navigator will support the increased number of clients successfully connected to mental health and or support services.	N/A	N/A	N/A	N/A	35 individuals	55 individuals
The Behavioral Health Navigator will participate in trainings on identifying mental health issues across all ages and implementing trauma-informed strategies	N/A	N/A	N/A	N/A	5 trainings	5 trainings
Behavioral Health Clinicians will provide behavioral health information by: ▪ Facilitating at least 5 Canal Alliance staff trainings to 20+ employees on Mental Health identification across the lifespan and trauma-informed strategies and tools	N/A	N/A	Facilitate 10 staff trainings to at least 20 staff	17 trainings with 20+ staff	Facilitate 5 staff training to at least 20+ AND participate/ attend in 8 community partner panels	5 trainings with 20+ staff and participated in 10 community partner panels

▪ Participating in 8 community partner panels or workshops on behavioral health in Marin County #4						
Clients receiving brief intervention reporting *satisfaction* (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	75%	100%	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%
Individuals participating in support groups or individual/family sessions	150	171	N/A	N/A	N/A	N/A
Family members participating in support of the client	30	9	N/A	N/A	N/A	N/A
Total referrals to County Behavioral Health (BHRS)	N/A	6	N/A	70	N/A	19
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	2	N/A	15	N/A	2
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	12	N/A	32 weeks	N/A	12 weeks

Total referrals to other PEI providers	N/A	14	N/A	55	N/A	79
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	7	N/A	25	N/A	36
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	12 weeks	N/A	4 weeks
Total referrals to other mental health services or resources for basic needs	N/A	83	N/A	150	N/A	140

Outcomes: North Marin Community Services	**Goal FY 21/22**	**Actual FY 21/22**	**Goal FY 22/23**	**Actual FY 22/23**	**Goal FY 23/24**	**Actual FY 23/24**
Spanish-speaking community members will undergo screening, receive brief interventions, and be referred for higher levels of care, and if appropriate have the option to participate in individual, family, and or group therapy sessions.	60	52	60	52	50	39
Provide group intervention or "*charla*"	12 clients	14 clients	12 clients	6 clients	N/A	N/A
Spanish-speaking participants in individual or family sessions who complete a minimum of three sessions will show a decrease in mental health distress and symptoms, as assessed by the PHQ-9 and/or GAD-7 scales.	70%	68%	70%	57%	70%	82%
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	75%	100%	75%	100%	75%	100%
Clients surveyed will indicate feeling more accomplished related to two or more areas on the county survey. *PEI Outcomes survey	75%	100%	75%	100%	75%	100%
Total referrals to County Behavioral Health (BHRS)	N/A	16	N/A	3	N/A	2

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	52 weeks	N/A	52 weeks	N/A	52 weeks
Total referrals to other PEI providers	N/A	11	N/A	6	N/A	0
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	11	N/A	Not Reported	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: Cuerpo Corazón Comunidad Listener Feedback Responses	**Goal FY 21/22**	**Actual FY 21/22**	**Goal FY 22/23**	**Goal FY 22/23**	**Goal FY 23/24**	**Goal FY 23/24**
"I have a better understanding of resources in my community"	N/A	2 report agree/ 1 report strongly agree n=3	N/A	Not Reported	N/A	Not Reported
"I learned something about mental health (emotional wellbeing) that I didn't know before"	N/A	2 report agree/ 1 report strongly agree n=3	N/A	Not Reported	N/A	Not Reported
"I would recommend this radio show to a friend or family member"	N/A	2 report agree/ 1 report strongly agree n=3	N/A	Not Reported	N/A	Not Reported

Top 5 Cuerpo Corazón Comunidad Radio Shows FY 23/24	**English Translation**	**Number of Streams**	**Airdate**
Programas y Recursos para First 5 Marin	Programs and Resources for First 5 Marin	2,745*	1/10/24
La Muerte y el Duelo	Death and Grieving	2,698*	8/9/23
Medicina del Alma	Soul Medicine	2,538*	3/6/24
Amistades y Relaciones Sanas	Friendships and Healthy Relationships	2,518*	7/6/23
Torogoz con Voz: Academia de Música y Artes	Torogoz con Voz: Academy of Music and Arts	2,396*	1/24/24

*Reported streaming numbers across Spotify, Facebook, and YouTube for radio show broadcasts include duplicated streams and listens. These figures do not represent unique listeners but rather cumulative views across multiple platforms.

CHANGES FOR FY 2025-26:

There are no changes to report for FY 25-26.

Program Stories

Canal Alliance: Sylvia's Story

Sylvia* is a 28-year-old mother of three. Born in Mexico, she came to the U.S. as a baby and is undocumented, without DACA status.

Sylvia is a survivor of childhood trauma and sought therapy to address how her past experiences were affecting her present life, including symptoms of anxiety. During her early sessions, Sylvia shared that she believed she was "born under a bad star," a phrase she used to describe feelings of being unlucky and a deep sense of shame. This belief created a strong desire for perfection and shaped how she viewed herself and her life.

In therapy, Sylvia and her clinician worked to explore the roots of this negative self-narrative and to identify positive moments that challenged it. Through this process, Sylvia is learning to replace harmful thoughts with healthier, more self-compassionate ones. In one session, she shared, "You know, sometimes I feel proud of myself." Recognizing how significant this shift was, her clinician encouraged her to focus on and embrace the feeling. Sylvia reflected that while the feeling of pride "comes and goes," she enjoys it and hopes to experience it more often and for longer periods of time.

Beyond addressing her internal struggles, Sylvia's clinician also supports her with external stressors, such as accompanying her to court hearings. Sylvia explained that when she is stressed or anxious, she has difficulty retaining the information discussed in court, which can lead to further misunderstandings and challenges. By attending hearings with her, the clinician helps reduce Sylvia's anxiety, ensuring she can better understand and follow the court's requirements.

During court proceedings, Sylvia's clinician models calming techniques like deep breathing and guides her through grounding exercises when possible. These strategies help Sylvia manage her anxiety in the moment and feel more in control of the situation.

Thanks to the support of her clinician, Sylvia is beginning to rewrite her personal narrative, recognizing moments of pride and resilience, and developing tools to manage her stress and anxiety.

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

Canal Alliance: Gloria's Story

Gloria* is a 50 yo, female client from Yucatan, Mexico, is a monolingual Spanish speaker and a mother of three. Gloria began treatment to address symptoms of anxiety and find support in overcoming a recent trauma which, in addition to be highly distressing, triggered historical traumas.

At the onset of treatment, Gloria expressed often feeling anxious, constantly worried and feeling like something bad is going to happen. As treatment began Gloria shared that she has battled with anxiety

for a long time and believes it is tied to several instances of sexual harassment which resulted in significant emotional and psychological harm.

At the onset of treatment Gloria scored a 16 on the GAD-7 indicating severe anxiety. Gloria's anxiety was largely focused on the wellbeing of her daughters. Gloria recognized that she was overly focused on her daughters but reported not being able to stop herself from worrying excessively about them. To tend to Gloria's most pressing concern, initially treatment focused on providing psychoeducation about developmentally appropriate milestones/behaviors for her daughters and exploring healthy boundaries with them, as well as teaching her coping mechanisms to manage her anxiety. Gloria and her clinician discussed cultural differences in child-rearing and how difficult it is at times to raise children in a country that isn't your own. They discussed the importance of her and her husband being on the same page when it comes to rules and limit setting to avoid triangulation and normalized some of her daughters' behaviors while focusing her concerns on her daughters' wellbeing and safety.

At the 3-month mark of treatment, the clinician readministered the GAD-7, and Gloria's score had decreased from 16 to 10. Gloria reported that the support around understanding developmental milestones and normative adolescent behavior, in addition to understanding and having tools to manage her own anxiety were what she attributed to the decrease in her symptoms. At the 3-month check in Gloria stated she was ready to shift the focus from her daughters and onto herself and her own personal and professional development.

The following three months focused on continuing to support Gloria in finding and practicing tools to manage her anxiety, accompanying her in taking steps to open her own daycare through clinical case management and planning/accountability during sessions. One major milestone which Gloria reached during treatment, was sharing her story of working to overcome the impacts of sexual abuse at an event coordinated by a different local agency, which was attended by other families with children who had been sexually abused. Leading up to this event, the clinician supported Gloria in preparing and revising her speech, reminded her of tools to manage her nerves, and encouraging her in taking this step. Following the event, Gloria reported feeling proud of herself, encouraged to continue to use her experience to support others, and noted that she could retell her/her family's experience without being triggered.

At the end of treatment Gloria reported feeling very hopeful and excited about her future and having the tools she needs to manage future stressors. At the close of treatment, Gloria's score on the GAD-7 had decreased to a 3, indicating minimal anxiety.

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

North Marin Community Services: Isabella's Story

Isabella, a 50-year-old mother of one, found out about the LCC program through an outreach event by NMCS. She shared that she had moved to the area four years ago after separating from her husband. Shortly after, she and her child became homeless for about two months.

Isabella was struggling with depression and anxiety. She felt like she had failed as a parent and believed her family was judging her. Through therapy sessions, Isabella started to understand herself better, face her fears, and learn ways to manage feelings of overwhelm, shame, guilt, and sadness.

With support from her therapist, Isabella found a temporary but stable place to live and began feeling more confident. The NMCS clinician helped her see her strengths and successes and gave her tools to build her confidence.

As her therapy sessions were ending, Isabella shared her thoughts through a satisfaction survey:

“You have no idea how much this program helps and how much it changes people’s lives. The changes are HUGE. Without these services, people like me would spend years trying to figure things out. Here, you can talk to someone, share your problems, and find the resources you need.

This kind of help makes a world of difference. Without it, we would stay stuck emotionally, and every day would feel like a struggle. These services have helped me mentally and financially. I want others to know about this program so they don’t feel alone anymore. It has helped me lead a more dignified life for myself and my child, and I am so grateful.”

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

North Marin Community Services: Juanita’s Story

Juanita, a 30-year-old woman, came to the LCC program after being referred by her case manager. She shared that she often felt scared, isolated, and unable to focus at work. She was dealing with anxiety, depression, and thoughts of suicide.

During therapy, Juanita's therapist diagnosed her with PTSD after learning about her traumatic experiences. Juanita had come to the U.S. from Mexico at the age of 20, completely on her own. She had to find housing and work by herself. She explained that she found a job, but when she tried to leave, her employer kidnapped her and held her against her will for several days.

In therapy, Juanita also opened up about being sexually abused as a child, something she had never told anyone before.

Juanita now meets with her therapist weekly, where they work on her trauma using CBT (Cognitive Behavioral Therapy) and DBT (Dialectical Behavioral Therapy). Thanks to the LCC program, she has access to worksheets and books in Spanish, which help her better understand how her trauma has affected her.

Recently, Juanita shared that she feels more confident in herself and has fewer thoughts of self-harm. She has found a job she enjoys and is now connected to helpful resources, such as the Center for Domestic Peace and NMCS case management.

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

OLDER ADULT PREVENTION AND EARLY INTERVENTION (PEI 07)

SERVICE CATEGORY: PREVENTION AND EARLY INTERVENTION; SUICIDE PREVENTION

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 risks factors for mental illness.

Jewish Family and Children's Services (JFCS) address this need by providing training and education to both the community and healthcare providers on mental health concerns specific to older adults. This includes specialized support and training in suicide prevention tailored to their unique needs. JFCS also offers BOOST brief therapy for older adults experiencing depression and anxiety, particularly in connection with medical issues, loss, or life transitions. Additionally, early intervention services are available. Clinicians provide support through home visits and collaborate closely with family members and other healthcare providers to ensure comprehensive care.

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 groups. Additional activities will target isolated individuals lacking access to resources.

Marin Asian Advocacy Project (MAAP) major goals are to cultivate community leadership, promote physical and mental health wellbeing, help and educate the communities to become self-sufficient. MAAP's older adult monolingual Vietnamese group provides outreach and engagement and education training on topics related to suicide prevention, culturally defined evidenced based practices around meditation and mindfulness. MAAP mental health events are guided by local Vietnamese psychologist and a resident Buddhist monk.

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

NUMBERS SERVED	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 23/24	**146**	**1**	**720**	**867**

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 2023-24 OUTCOMES:

Outcomes: JFCS BOOST	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Individuals receiving education regarding behavioral health signs and symptoms in older adults	100	557	100	423	100	693
Seniors at Home clients screened for behavioral health concerns *PHQ9, substance use	150	156	150	150	150	150
Low income clients receiving brief intervention services	50	109	50	51	50	52
Low income clients receiving brief intervention services who are from under/unserved populations (race, ethnicity, language, geographical area and LGBTQ+ identity).	20%	21% (N=10)	20%	4%	20%	23% (n=10)
Clients completing a short-term treatment protocol for depression or anxiety	70%	85% (N=40)	70%	88%	70%	92%
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%	78% (N=46)	60%	77%	60%	60%
Clients receiving brief intervention reporting satisfaction (strongly agree or agree) with services (would use again, recommend) *PEI Satisfaction survey	75%	96% (N=45)	75%	100% (N=25)	75%	100%

Total referrals to County Behavioral Health (BHRS)	N/A	4	N/A	5	N/A	6
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	2	N/A	2	N/A	2
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	19 days	N/A	Not reported	N/A	52 weeks
Total referrals to other PEI providers	N/A	2	N/A	Not reported	N/A	Not reported
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	2	N/A	Not reported	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	2	N/A	Not reported	N/A	Not reported
Total referrals to other of mental health services or resources for basic needs	N/A	110	N/A	18	N/A	120

Outcomes: JFCS Healthcare Provider Education	**Goal FY 21/22**	**Actual FY 21/22**	**Goal FY 22/23**	**Actual FY 22/23**	**Goal FY 23/24**	**Actual FY 23/24**
Provide trainings on older adult mental health topics to healthcare providers (MD's, Nurses, Caregivers, healthcare support staff etc.)	4 trainings 80 participants	4 trainings 67 participants	4 trainings 80 participants	6 trainings 91 participants	6 trainings 80 participants	8 trainings 100 participants
Training participants will report an increase in their knowledge of mental health in older	80%	71%	80%	100%		

adults and their ability to detect symptoms					80%	85%
Training participants will report an increase in their knowledge of signs, symptoms and risk factors on the topic presented	N/A	N/A	N/A	N/A	80%	85%
Training participants will increase ability to differentiate dementia and depression	80%	92%	80%	100%	N/A	N/A
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	80%	85%	80%	100%	80%	81%
Training participants will report increased knowledge of community resources and services that treat older adults with mental illnesses	80%	78%	80%	100%	80%	81%
Training participants will become familiar with mental health screening tool and will be knowledgeable in its appropriate usage	100%	92%	80%	100%	80%	81%

Outcomes: Spahr Center	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
LGBTQ+ older adult cultural competency trainings and or technical assistance to older adult service providers	2 trainings	1 trainings	8 trainings	8 trainings	8 trainings	4 trainings*
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	75%	97.6%	75%	78.1%*
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.	10	8	N/A	N/A	N/A	Not Reported*
Conduct train the trainer to deliver LGBTQ+ older adult cultural competency and allyship training to healthcare and community service providers	2 trainings 3 participants	1 training 2 participants	N/A	N/A	N/A	Not Reported*
Conduct cultural competency and allyship trainings annually for healthcare and community service providers	4 trainings 60 employees	1 training 25 employees	N/A	N/A	N/A	N/A

***NOTE:** SPAHR FY 23/24 older adult outcomes are from 23/24 mid-year reporting.

CHANGES FOR FY 2025-26:

No changes for FY 25/26.

Program Stories

BHRS HOPE: Senior Peer Counseling Program

Wanda, an 87-year-old widow, lives alone in the rural community of West Marin, in the home her husband built for their family in 1955. She was referred to the Senior Peer Counseling (SPC) program in 2016, back when she was still able to drive and participate in community activities, including group lunches at her local community center.

At the time, Wanda struggled with moderate depression. She often withdrew from others, slept and ate excessively, and faced difficulties managing her type II diabetes and arthritis. As the years passed, her limited mobility and the steep stairs outside her home made it increasingly difficult to stay connected with others, leading to greater isolation.

When her trusted In-Home Support Services (IHSS) caregiver retired, Wanda faced significant challenges finding a replacement due to a shortage of caregivers in her area. With inconsistent support from her children, she became increasingly anxious about how she would manage her daily needs. This was when her Senior Peer Counselor stepped in. Over the past eight years, the counselor has provided regular home visits, becoming a consistent and trusted companion. In a community where resources are scarce, this ongoing support has been invaluable.

Through their sessions, Wanda's counselor has helped her stay on track with medical appointments, sort through personal documents, letters, and photos as part of a "life review," and navigate the emotional challenges of aging and loss. With encouragement and support, Wanda has remained engaged with her surroundings and has found the motivation to tackle daily tasks despite her physical limitations.

Over the years, gaps in her care led to two Adult Protective Services (APS) cases related to difficulty managing her insulin, increased needs for personal care, and struggles with household tasks such as cleaning and cooking. With her counselor's guidance, Wanda was able to bring together a mix of formal and informal support, including care managers, family members, and friends, to ensure her needs were met.

Today, Wanda is on hospice care but is managing well without IHSS services, thanks to the strong support network she has built with her counselor's help. She continues to live independently in her family home, where she feels safe, supported, and at peace. Thanks to the SPC program, Wanda is facing the end of her life with dignity, comfort, and connection in the place she loves most.

Jewish Family & Children Services: BOOST Program

Boris* is an 86-year-old Russian man and a monolingual Russian speaker. Therapy was conducted in Russian. He immigrated to the U.S. 35 years ago with his family and settled in Marin County. Currently, he receives case management services at JFCS and was referred to therapy through this department.

Boris sought therapy due to anxiety related to the war in Ukraine, prolonged grief following the loss of his wife to COVID-19 in 2021, and a growing sense of cultural and emotional disconnect from his daughter, who serves as his primary caregiver. His grief felt isolating, and he struggled to find meaning in his life after his wife's passing.

Therapy followed a Narrative Theoretical Orientation, with a focus on Meaning-Making and Storytelling. Through this approach, Boris was encouraged to reinterpret his life story, understand his grief as a personal and evolving process, and foster a renewed sense of identity beyond his late wife. He also explored ways to strengthen social connections and develop coping strategies to manage long-term anxiety and grief.

As therapy progressed, Boris realized he had been caught in a cycle of negative thoughts that he had never actively challenged. Engaging in storytelling allowed him to reflect on his immigration journey, career, challenges, and achievements. To integrate his past, present, and future aspirations, he recorded his life story and shared it with his daughter as a legacy for future generations.

In time, Boris found the courage to express his grief with his family, despite his initial fear of burdening them. Opening up to his daughter strengthened their relationship and reduced his sense of isolation. He

also gained a deeper acceptance of his wife's passing and established new daily habits, such as walking and practicing breathing exercises, to manage his anxiety more effectively.

By the end of treatment, Boris had developed a stronger connection with his daughter, a greater sense of self, and new ways to navigate grief, ensuring that he could move forward with greater resilience and hope.

Jewish Family & Children Services: BOOST Program

Helen* is a 69-year-old married woman with no children who sought therapy through the BOOST program in February 2024. She reached out preemptively, recognizing the need to return to therapy after years of managing panic disorder. With her husband planning extended travel without her due to her extensive medical and mental health challenges, Helen anticipated heightened anxiety and wanted to prepare for the transition. Although she denied struggling with crippling depression or anxiety, she experienced her first panic attack in her 30s and was paralyzed by its impact for over a decade while actively seeking treatment and relief.

Helen's early life was deeply shaped by trauma. Both of her parents were Holocaust survivors, and as a result, she and her family endured severe intergenerational trauma that has persisted from childhood into the present day. In therapy, her clinician utilized an intergenerational family trauma model combined with Cognitive Behavioral Therapy, Psychodynamic approaches, and Strengths-Based interventions to help her build resilience and coping strategies.

During treatment, Helen faced her first real test when her husband left for an extended trip. She feared she might "die" or "end up in the hospital" due to her overwhelming anxiety and lack of confidence in her ability to care for herself. However, with the support of her BOOST therapist, Helen successfully navigated this period without experiencing a single panic attack or requiring medical intervention. She relied on self-soothing and healing tools daily, demonstrating her capacity for self-regulation and emotional resilience.

Although Helen continues to experience physical pain related to her back, hip, and knees, and still struggles with anxiety, she has made significant progress. Her responsiveness to therapy and commitment to healing remain strong. Recognizing the benefits of continued support, she has chosen to extend her treatment beyond BOOST through her Medicare benefit, actively engaging in her ongoing care.

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

COMMUNITY TRAININGS AND SUPPORT (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.

PROGRAM DESCRIPTION: Marin County has allocated funds to support the goals of Prevention and Early Intervention (PEI) which include enhancing awareness of mental illness, reducing stigma and discrimination, and implementing effective practices.

Funds are utilized for community trainings and support significantly involves community workshops, events and outreach. Our efforts targets individuals capable of recognizing and responding to mental illness, including community members and their families. These initiatives can offer disability and language accommodations when requested. Additionally, there are some targeted community activities specifically offered in only Spanish or Vietnamese.

Funds may support sending professionals, consumers, families, and other stakeholders to relevant conferences and or trainings, such as those pertaining to Mental Health & Recovery and Suicide Prevention Awareness Month activities. Funding may support community-wide initiatives promoting diversity, equity and inclusion, with targeted themes on mental health and recovery as it relates to enhancing awareness of mental illness, reducing stigma and discrimination, and implementing effective practices.

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 23/24	**6**	**10**	**2054**	**2070**

TARGET POPULATION: Potential Responders

- 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 members, civic leaders, peer providers, relevant county staff, and others.

Potential Responders identified through PEI training/outreach activities as capable of recognizing early signs of severe mental illness, providing support, referring individuals to treatment, and or executing activities to reduce stigma and discrimination.	FY 21/22	FY 22/23	FY 23/24
Community Members	38	43	47
Family Member of Person with Serious Mental Illness	6	5	3

Potential Responders identified through PEI training/outreach activities as capable of recognizing early signs of severe mental illness, providing support, referring individuals to treatment, and or executing activities to reduce stigma and discrimination.	**FY 21/22**	**FY 22/23**	**FY 23/24**
Providers			
Peer Provider	0	0	0
Community Health Advocate/Promotores	0	0	0
Marin County BHRS	9	0	5
Community-based Mental Health and/or Substance Use	20	21	8
Education	12	1	6
Employer	0	0	0
Law Enforcement	0	0	1
Primary Health Care	3	0	1
Emergency Services	0	0	0
Older Adult Centers/Services	2	1	2
LGBTQ+ Services	0	0	0
Transition Age Youth	0	0	0
Native American/Indigenous Community	0	0	0
Social Services (County and Community)	5	10	24
Veterans	0	0	0
Law Practitioners (lawyers, paralegals, mediators)	0	0	0
Faith-Based Organization	1	1	3
Shelters/Homeless	0	0	6
Services/Public Housing	0	0	0
Unknown	5	2	1

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 Mental Health First Aid (MHFA), pre and post surveys to assess change in knowledge. County client and caregiver feedback and satisfaction surveys.

FY 2023-24 OUTCOMES:

Canal Alliance | Domestic Violence Prevention & Outreach

The Behavioral Health program at Canal Alliance supports the low-income, Spanish-speaking community in Marin County by providing bilingual, trauma-informed, and culturally responsive services focused on domestic violence prevention and education. This program follows a train-the-trainer model, equipping Community Health Workers (CHWs) with the knowledge and skills to educate the community on topics such as: what domestic violence is and how it functions, recovery, the intersection between mental health and domestic violence, the impact of domestic violence on families/children, mindfulness skills, characteristics of healthy/non-violent relationships, and available support services. Additionally, the program provides case management support for youth and adults who have experienced domestic violence. By training CHWs and expanding peer support programs, Canal Alliance strengthens community resources and improves access to critical support services.

Outcomes: Canal Alliance | Domestic Violence Prevention & Outreach	Goal FY 23/24	Actual FY 23/24
Develop a domestic violence (DV) curriculum within the first six months of program implementation to train Community Health Workers (CHWs) to educate community members. Collaborate with an established DV agency to review and refine the curriculum for effectiveness.	One DV curriculum	Curriculum completed. Curriculum review with Center 4 Domestic Peace completed.
Provide a 30-hour domestic violence (DV) prevention and education training to Community Health Workers (CHWs) to prepare them for outreach and co-facilitation of community cohorts. The training will cover DV awareness, its intersections with mental health, coping strategies, and available community resources.	Train 6 CHW's	6 CHW's completed training
Introduce mindfulness or stress management basic theory and technique in each CHW training session to enhance coping skills for managing anxiety, depression, and general stress. These techniques will also equip CHWs to support and educate community members in stress management.	1 skill per training	4 skills taught over 4 training sessions to CHW's
Program staff/CHW's/Community members report feeling supported in a safe and confidential environment.	75%	100% n=6

MAY MENTAL HEALTH MONTH ACTIVITIES 2024

Marin County Behavioral Health & Recovery Services (BHRS) is spreading awareness for better mental health and well-being during May Mental Health Month 2024. Together, we can create an inclusive and accepting community that is free of mental health stigma. One way we can do that is by sharing stories,

creating conversations, and finding connections, both to resources and treatment. One of our goals at BHRS is to support your mental health and those you care about, not just this month but throughout the year. There are over 10 different events hosted by BHRS and community-based partners around Marin County

- Marin County Suicide Prevention Collaborative meeting. The focus of this meeting is an update of strategy 6 of the strategic plan that addresses suicide prevention, intervention and postvention in school based settings.
- Let's Talk: Mental Health and Underage Substance Use - Hosted by Marin Healthy Youth Partnership.
- Suicide Prevention Safety Planning Training for the Vietnamese Community. Learn ways to keep a person safe who may be struggling through 6 steps.
- Mental Health First Aid for Adults in Spanish HHS San Rafael
- Drew Robinson: A Survivor's Story of Mental Health, Hope and Recovery. Hosted by BHRS, Marin County Office of Education, Buckelew Programs, Equip, College of Marin and Rotary Club Novato.
- Mental Health First Aid for Adults at Empowerment Clubhouse Marin City
- Youth Wellness Festival. Hosted by the Marin County Youth Commission and partners: Marin 9 to 25, the Marin County Suicide Prevention Collaborative.
- Buckelew Programs Bike/Hike for Mental Health hosted by Buckelew Miwok Meadows
- Suicide Prevention Training for the Spanish-speaking Community virtual
- Team, OD Free, BHRS, and Suicide Prevention Collaborative.
- Honoring Stories, Transforming Minds with Living Arts Playback Theater Homeward Bound Novato

OTHER OUTREACH AND TRAINING ACTIVITIES FOR FY 2023-24:

- College of Marin Equity in Mental Health Symposium. This event hosted over 200 people to discuss equity, justice and culture. August 2023
- MarinLink and Nami Marin "Healing: Our Path from Mental Illness to Mental Health" Dr. Insel speaking on insights and perspectives on the journey from mental illness to mental health. October 2023
- Suicide Prevention and Safety Planning trainings provided in English, Spanish and Vietnamese across Marin County.
- Mental Health First Aid trainings (Youth and Adult) offered in English and Spanish across Marin County.

- Latin Heritage Month: Mental Health & Recovery panel with North Marin Community Services Promotores October 2023
- BHRS LGBTQ+ Pride community discussion on addressing the MH & substance use service needs of the Marin LGBTQ+ community: June 2024
- 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 2025-26:

The Mental Health First Aid (MHFA) training will conclude its final year in 25/26 and 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 have 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 Substance Use Psychoeducation

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 interventions 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.

PEI funding ensures an intentional focus on providing services for underserved students and families, including Spanish speaking youth, newcomer students, rural communities, as well as expanded efforts to provide substance use prevention psychoeducation within 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.

Numbers Served	Individuals	Families	Reached Through Outreach/Training	Total
Fiscal Year 23/24	216	92	2,161	2,469

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, clinical assessment measures (i.e.. SDQ, PHQ-A, GAD-7, among others), workshop/training surveys, and demographic surveys will be utilized to ensure effective reach and quality of services.

FY 2023-24 OUTCOMES:

North Marin Community Services (NMCS) – Shoreline Unified School District (SUSD)/West Marin

NMCS provides School-Based mental health services within the Shoreline Unified School District (PreK-12) via systems coordination, program development, direct individual and group counseling to support students with mild to moderate mental health needs. NMCS also facilitates community collaboration and outreach, as well as provides student, staff, and parent mental health education and training to reduce stigma and foster resilience. All services are provided with equity and inclusion in mind and support an overall positive school climate and culture.

Outcomes: North Marin Community Services (SUSD)	Goal FY 23/24	Actual FY 23/24
Students will receive school based mental health services and referrals, as clinically indicated	30	72
Students completing at least 3 sessions will demonstrate a reduction in mental health distress, as measured by PHQ-A and/or GAD-7	65%	85%
Parents/guardians will receive psychoeducation and/or collateral interventions about risk and protective factors related to mental health and substance use	8-12	21
Students surveyed will report satisfaction with services	75%	100%
Parents/guardians surveyed will report satisfaction with services	75%	80%
Groups will be held for Newcomers, informed by the FUERTE curriculum	2-3	2
SUSD staff surveyed will report that they agree or strongly agree that when they have a student who needs extra support, they know the process for seeking that support and that the response is timely	90%	100%

Outcomes: North Marin Community Services (SUSD)	Goal FY 23/24	Actual FY 23/24
SUSD staff participating in trainings regarding topics such as: mental health, inclusion, suicide prevention, etc. would recommend the training and felt it would help them better support the learning and wellness needs of students	75%	99%
Total referrals to County Behavioral Health (BHRS)	N/A	6
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	3
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	4
Total referrals to other PEI providers	N/A	20
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	14
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
Total referrals to other mental health services or resources for basic needs	N/A	17

North Marin Community Services (NMCS) – Novato High School (NHS)

The NMCS school-based PEI program offers extensive clinical support to Spanish-speaking Latine students and families at Novato High School. Bilingual mental health providers work onsite at NHS, collaborating closely with NMCS' Latine Youth Wellness Coordinator, NUSD Wellness staff, Counselors, school administrators, and other community partners serving NHS students. 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 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Newcomer students at Novato High's Camp N will participate in social-emotional learning activities	N/A	N/A	15	14	12	13
Newcomer and other immigrant students will engage in activities that advance wellness, equity and justice to	N/A	N/A	15	70		

Outcomes: North Marin Community Services	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
increase a greater sense of school and community connectedness					15	95
Students will receive school-based mental health services (screening, brief interventions, individual/group therapy, referrals)	30 students	74 students	50 students	65 students	50 students	93 students
Students will participate in group therapy	8 students	6 students	8 students	8 students	8 students	16 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	65%	50%	65%	76%
Students will complete at least 3 sessions demonstrating improvement in school performance	65% of students	68% of students	65% of students	Not reported	65%	76% of students
Spanish-speaking parents/guardians will be provided psychoeducation about risk and protective factors related to mental health and substance use.	12 parents	14 parents	12 parents	28 parents	12 Parents	12 parents
Students surveyed will report satisfaction with services received	75%	100%	75%	100%	75%	100%
Students surveyed will report they are better able to cope when things went wrong, to advocate for themselves, experience greater success at school or work, and are more able to make connections to family, friends, and the community	75%	100%	75%	95%	75%	90%
Total referrals to County Behavioral Health (BHRS)	N/A	3	N/A	3	N/A	2
Number of individuals successfully referred and linked to a Marin County mental health treatment program	N/A	3	N/A	12	N/A	Not Reported
Average duration in weeks of signs of untreated mental illness	N/A	6-12 months	N/A	Not reported	N/A	52-153 weeks
Total referrals to other PEI providers	N/A	6	N/A	6	N/A	5
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	6	N/A	Not reported	N/A	Not reported

Outcomes: North Marin Community Services	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
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	8	N/A	18	N/A	3

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 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Students per site served through individual, family, or group counseling individual or group counseling	N/A	N/A	N/A	N/A	40 students	40 students
Students identifying as needing services through the COST will receive referrals and/or linkages to those services	N/A	N/A	N/A	N/A	100%	100% at elementary level; 80% at middle school level
Trainings provided for school staff to increase trauma and developmentally informed care in the schools	N/A	N/A	N/A	N/A	3-4	2
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%	75% N=9
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	N/A	N/A

Outcomes: Sausalito Marin City School District Goals	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
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	N/A
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	N/A (CANS not implemented)	75% of students	100% of students	75% students	N/A
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%	N/A	N/A

Outcomes: Sausalito Marin City School District Goals	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Parents/teachers of students (under age 11) receiving at least 3 sessions will report a reduction in children's/student's difficulties in one or more of the following areas: emotional problems, conduct problems, hyperactivity problems, peer problems, and/or socialization (CANS assessment)	65% of students	N/A (CANS not implemented)	65% of students	85% of students	N/A	N/A
Conduct home visits for students/caregivers identified through COST or administration	10	8	10	15	N/A	N/A
Total referrals to County Behavioral Health (BHRS)	N/A	8	N/A	10	N/A	0
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	4	N/A	Not Reported		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	Not Reported	N/A	Not Reported	N/A	Not Reported
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	Not Reported	N/A	Not Reported	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

Outcomes: Sausalito Marin City School District Goals	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Total referrals to other mental health services or resources for basic needs	N/A	3	N/A	10	N/A	3

Marin County Office of Education – Substance Use Prevention

MCOE partners with We Lead Ours (WELO) to provide education and honest and informed dialogue with Marin seventh graders as to the effects, risks, and alternatives to drug and alcohol use, utilizing a harm-reduction, psychoeducation model. The program effectively covers tobacco and vaping, alcohol, marijuana, and other drug use.

Outcomes: MCOE	Goal FY 23/24	Actual FY 23/24
Reach at-risk, impressionable youth by increasing drug education and reduce later substance use	500	571
Students reporting increased knowledge and understanding of particular drugs and alcohol, effects, and alternatives	75%	75%

Spahr Center: The Spahr Center's school-based program played a key role in empowering middle and high school students through training and leadership programs focused on addressing LGBTQ+ inequities within their educational institutions. Unfortunately, the organization closed operations, effective 2/16/24. A full reporting of activities and outcomes is not available. Data reported here is based on the PEI FY 23-24 Mid-Year Report.

SPAHR Center Goals	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 22/23	Actual FY 22/23
Youth will participate in advocacy projects	10	10	10	10	10	Not Reported
Spahr will provide at least 5 hours of leadership development training for 10 youth	5 hours	5 hours	5 hours	5 hours	5 hours	Not Reported
Spahr will hold youth meeting time	40 hours	40 hours	40 hours	40 hours	40 hours	Not Reported
Youth engaged in program will report that they have learned new skills, feel	85%	Not reported	85%	Not reported	85%	Not Reported

SPAHR Center Goals	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 22/23	Actual FY 22/23
empowered, and that their voices are heard.						
Provide capacity building to schools	3 schools	3 schools	3 schools	5 schools	15 Schools	12 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%	75%	75%	98%	75%	59.4% strongly agreed, and 37.7% agreed that they have a greater understanding of LGBTQ+ identities; 55.1% strongly agreed, and 44.9% agreed that they felt more equipped to support LGBTQ+ youth
Technical assistance/cultural competency trainings for at least 15 schools	N/A	N/A	15	19	15	Not Reported
Youth led panel discussions highlighting LGBTQ+ student concerns and supports	N/A	N/A	4	4 panels 12 panelists	4 panels	1 panel

CHANGES FOR FY 2025-26:

NMCS-Shoreline Unified School District is working on program improvements including strengthening referral systems and processes to ensure clients are connected with the appropriate services in a timely manner, data collection and documentation improvements, as well as other small program changes. Examples include providing incentives for survey participation, focusing on parent education efforts, increasing social media outreach, and collaborating more with peer wellness youth leadership students.

NMCS-Novato High School is providing additional supports through group-based interventions to newcomer students and collaborating more closely with case management services to help families address social determinants of health. Regarding substance use education prevention, MCOE anticipates obtaining funding to sustain this critical work when prevention funding will cease through MHSA/BHSA and intends to expanding to 7 school sites, up from 3 school sites in 23/24, as well as reaching into 8th grade classrooms. We Lead Our Own (WELO) will also be utilizing and facilitating Stanford REACH Lab's drug education curricula, which is evidence based.

Lastly, a request for proposal (RFP) for early intervention services for LGBTQ+ youth will be released in Spring 2025. This RFP will focus on school-based outreach, support, and linkage services for FY 2025-26.

Program Stories

North Marin Community Services (NMCS) – Shoreline Unified School District (SUSD)/West Marin

Following the initial Fuerte newcomer group session, Jose* experienced an emotional week filled with happiness and a newfound sense of support from the school. He expressed later that it was the first time they felt truly seen and heard on campus, no longer relegated to the shadows. This sentiment was echoed by fellow group members. While there continues a need to build additional newcomer student services, the launch of the Fuerte group has helped to create a sense of "home" and community which is so critical to the healing process.

North Marin Community Services (NMCS) – Novato High School

"Lo que pienso es de que ellos son buena gente para hablarle sobre problemas que temenos" (What I think is that they [the NMCS counselors] are good people to talk to about problems that we have.) This student is a 16 yr old female who identified as a newcomer from Honduras. She met with a female NMCS clinician due to experiencing fear and anxiety about being in an American high school for the first time and the desire to not disappoint her family. She reported not having made many friends yet and wasn't sure who to talk to about her experiences. Her mother worked 3 different jobs so was often not available and it was her responsibility to help out with her younger siblings. Fitting in homework assignments and navigating school was extremely anxiety provoking. She had difficulty sleeping and often felt tired. The NMCS clinician provided a safe space for her to explain what she was feeling, taught her progressive relaxation skills, and mindfulness. Each session began with some type of grounding exercise and lots of encouragement to the client. After meeting with the client for approximately 12 weeks, the client reported she felt more able to talk to her mother about the stressors she was feeling and felt encouraged to be at school. She learned how to practice her own self-soothing and her anxiety reduced. Her family was also connected to other community resources, such as low-cost after-school programs for her siblings.

Sausalito Marin City School District

Marcus (name changed to protect confidentiality) is a 13-year-old Black male referred to the PEI funded clinician through COST. He struggled with previous homelessness, low self-worth and peer conflicts. At first, this student was unwilling to attend sessions but as treatment went on he was more willing to participate and was receptive to learning new skills. The PEI funded clinician played basketball with the student when others were in class to discuss his challenges and coping skills in a more progressive way. Student reported that he felt close to clinician and that he could rely on her during crisis. Over the course of the year student went from getting into fights with peers almost every week to barely even once a month. Fights also moved away from being physical and student was willing to continue therapy over the summer. Another success in this case was working with the parents to help them feel more comfortable with the idea of therapy as they had been previously skeptical due to CFS involvement.

Marin County Office of Education – Substance Use Prevention
The following information that was gathered from WELO post workshop surveys:

- Approximately 7% of post-survey respondents (7th graders) indicated that they had used vapes/e-cigs, alcohol, cannabis, hookah, or cigarettes.

- 25% indicated that they may be / are interested in getting more information about substances.
- 63% of youth indicated that having counseling sessions when a student is caught using substances is the best way to decrease harmful substance use.

Based on observations of an adult facilitator, the majority of youth began the workshops with the understanding that substances such as nicotine, cannabis, alcohol, tobacco, etc. are inherently bad for one's health. However, many could not necessarily explain why or in what specific ways. By the end of the workshop, when asked to share something new that they learned, many students expressed a deepened understanding of specific effects that substances can have on your health and wellbeing. Here are just a few excerpts from the post-survey:

- I learned that when you smoke, tar gets trapped in your lungs making it harder to breath.
- I learned that when you drink alcohol, you throw up because your body rejects the alcohol out of your body.
- I learned a ton of new stuff about how drugs can affect your body.
- Que las drogas a veces danan los pulmones de una persona.
- Your emotions can change if you do drugs.
- I learned how alcohol and drugs affects your body.
- Some drugs can make you feel relaxed and sleepy. Others can make you feel like you're seeing things.
- Something that I learned is how drugs can affect your brain development.
- Aprendi que la droga y el alcohol afecta la salud del cuerpo.
- I learned that drugs are bad for your body, mind, and lungs.

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

VETERANS COMMUNITY CONNECTION (PEI 19)

SERVICE CATEGORY: OUTREACH

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

PROGRAM DESCRIPTION: Veterans experience mental health disorders, substance use disorders, post-traumatic stress, and traumatic brain injuries at disproportionately higher rates than their civilian counterparts. While federal initiatives exist to address these challenges, local interventions can play a critical role in reducing prolonged suffering.

Since FY 2014-15, MHSA PEI has provided funding for the Marin County Veterans' Service Office, which operates within the Department of Health and Human Services. This program offers supportive services through a part-time Licensed Clinical Social Worker (LCSW) who assists veterans living with mental illness. Its ongoing efforts focus on outreach to unhoused veterans and those involved in the Veteran's treatment court connecting them with behavioral health care, recovery services, and other essential support.

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 23/24	**111**	**2**	**-**	**113**

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 2023-24 OUTCOMES:

Outcomes: Marin County Veterans' Service Office	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Veterans will be permanently housed	N/A	14	N/A	17	N/A	24
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	117	100	116	100	111
Number of family members that received services to increase their capacity to support the client	20	3	20	1	20	2

75% of veterans receiving support achieved at least one goal towards stability and recovery	75%	75%	75%	77%	75%	75%
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	89%	N/A	77%	N/A	84%
Total referrals to County Behavioral Health (BHRS)	N/A	2	N/A	1	N/A	0
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	2	N/A	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	3	N/A	1	N/A	0
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	3	N/A	0	N/A	N/A
Average time in weeks between when a referral was given to individual by program and the individual's first in person appointment with the PEI funded provider	N/A	Not reported	N/A	Not reported	N/A	Not reported
Total referrals to other mental health services or resources for basic needs	N/A	77	N/A	92	N/A	161

CHANGES FOR FY 2025-26:

Veterans Services will continue working with a student intern who has an interest in working with veterans to support programming, particularly within the Veterans Treatment Court. No additional changes are anticipated for FY 2025-26.

Program Stories

Story #1

Gerardo* is a 64-year-old veteran who served 12 years in the Army. For the past 12 years, he had experienced homelessness. He was divorced and had two children but was estranged from them.

The Veterans Office began by identifying financial resources to support him, starting with Social Security benefits. Staff assisted Gerardo in applying for Social Security. Within a month, he was awarded $1,300 per month in benefits. However, a week later, his payments were frozen due to unpaid child support in the state of Washington. Gerardo was discouraged but remarked that his "luck had always been bad."

After two to three weeks, a letter arrived from the state of Washington notifying him that his Social Security payments would be released, as his children were now in their 30s. Two weeks later, he

received an unexpected check for $17,000 from the Washington State Child Support Office. This amount was due to years of overpayments from paycheck garnishments related to his child support obligations.

Gerardo is now housed at New Beginnings and is set to move into permanent housing within a few weeks. Additionally, he has been granted a service-connected disability status for injuries sustained during his military service, further securing his financial stability.

Story #2

Sammy* is a 90-year-old Navy veteran who was living in his car when he was first connected with support services. Efforts began to collect the necessary documents to secure him placement in a transitional housing facility in Petaluma at Nations Finest Hearn House. Initially, the agency expressed concerns about his ability to function independently due to his advanced age. To address these concerns, a face-to-face meeting was arranged, during which Sammy's charm and determination convinced the facility to accept him.

However, on the day he was set to be admitted, he fell from his vehicle and suffered a severe head injury. He was taken to Marin General Hospital, where he was diagnosed with a brain bleed. After a week of hospitalization, he was discharged to a skilled nursing facility. Unfortunately, during his stay, his wallet was stolen.

Since then, staff have assisted him in obtaining a new state ID card and bank card. He receives weekly visits, during which he is encouraged to participate in physical therapy. Despite the challenges he faces, Sammy remains hopeful about his eventual discharge. He continues to share captivating stories of his time sailing around the world, making each visit a rewarding experience.

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

PEI STATEWIDE (PEI 20)

FY23-26 PROGRAM DESCRIPTION: In alignment with the 2023-24 annual update, Marin has discontinued its involvement in PEI statewide initiatives with CalMHSA for FY 2024-25 and FY 2025-26 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 promotional materials produced through these initiatives were impressive, their costs were disproportionately high.

SUICIDE PREVENTION (PEI 21)

SERVICE CATEGORY: SUICIDE PREVENTION

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

PROGRAM DESCRIPTION: In January 2020, Marin County released its Suicide Prevention Strategic Plan and hired a full-time Suicide Prevention Coordinator to oversee its implementation.

Marin County's suicide prevention community partners include Buckelew's North Bay Suicide Prevention Program, which operates the 988 Suicide & Crisis Lifeline, and The Felton Institute.

A key component of Marin County's efforts is the Marin County Suicide Prevention Collaborative, a comprehensive framework that integrates prevention, intervention, and postvention strategies at individual, community, and institutional levels.

Each September, Marin County collaborates with diverse community members and local nonprofits to host Suicide Prevention Month events across the county. These events honor lives lost to suicide, support those affected, raise awareness about prevention, and share messages of hope.

Additionally, Prevention and Early Intervention (PEI) suicide prevention funds support community-based and targeted suicide prevention trainings in English, Spanish, and Vietnamese for populations at disproportionate risk of suicide.

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 23/24	6789	-	8672	15,461

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.

FY 2023-24 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 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Calls to hotline originating in Marin County	5,000	3,807	5,000	4,535	5,000	6,571
Callers who express a reduction in level of suicidal risk by 1 level or maintain Low (Low, Medium, High)	N/A	Not reported	N/A	Not reported	N/A	Not reported
Offer 12 **SOS** groups to at least 20 unduplicated individuals	12 groups	24 groups	12 groups 20 individuals	17 groups 36 individuals	12 groups 20 individuals	24 groups 12 individuals
Agencies receiving suicide prevention campaign materials	50	20+	50	109	50	50
Provide training and education in the community	8	6	5	8	8	26
Community members receiving training that report they can describe suicide warning signs (agree/strongly agree)	50%	N/A	50%	Not reported	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%	N/A	50%	Not reported	50%	Not reported
Community members receiving training that can describe the work of Buckelew Suicide Prevention Hotline and Program (agree/strongly agree)	50%	N/A	50%	Not reported	50%	Not reported
Training participants that would recommend the training to a friend or loved one (agree/strongly agree)	50%	N/A	50%	Not reported	50%	Not reported
Total referrals to County Behavioral Health (BHRS)	N/A	17	N/A	40	N/A	61
Total referrals to other PEI providers	N/A	15	N/A	2	N/A	2
Total referrals to other mental health services or resources for basic needs	N/A	63	N/A	10	N/A	25

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 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
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.	20 volunteers	7 volunteers	20 volunteers	17 volunteers	20 volunteers	12 volunteers
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.	80%	86%	80%	80%	80%	100%
Distribute electronic/paper outreach materials that reflect the cultural/linguistic needs of the community to at least 20 organizations who work with or offer any services	20 orgs	20 orgs	20 orgs	50 orgs	20 orgs	26 orgs

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	100%	1	100%	112	100%	218
Families or individuals will be outreached by phone in days following aftermath within 48 hours of notification	100% contacted 85% reached	1 family was contacted	100% contacted 85% reached	100% contacted	100% contacted 85% reached	100% Contacted 99% reached
Provide *youth* **loss survivors support group.** Engage 20 unduplicated participants.	20 youth participants	0 youth participants	20 youth participants	0 youth participants	20 youth participants	5 youth participants
Provide *adult* **attempt survivor group**. Engage 20 unduplicated participants.	20 adult participants	0 adult participants	20 adult participants	0 adult participants	20 adult participants	5 adult participants
Total referrals to County Behavioral Health (BHRS)	N/A	Not Reported	N/A	Not Reported	N/A	Not Reported
Total referrals to other PEI providers	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	Not Reported	N/A	Not Reported	N/A	1

SUICIDE PREVENTION COLLABORATIVE

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, emergency medical services, and healthcare providers.

Bi-monthly public meetings 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.

The following summary provides a snapshot of accomplishments for FY 23/24 and future steps for each strategy. Complete Suicide Prevention (SP) information can be found in the Suicide Prevention Annual Report for 23/24.

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 the suicide and overdose fatality review process, 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 examining recommendations for system care and 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 developing educational resources to support families and health providers in collaboration with community partners and the Lethal Means Action Team. 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 2023

September Suicide Prevention and Recovery Month is celebrated each September to create awareness of this important health issue. During this month, Marin County BHRS and community-based partners come together to host virtual and in-person events for allies, providers, educators, students, loss survivors and populations disproportionately impacted by suicide. During September 2023, over 15 events were held reaching 1500 people. As part of our efforts, we also partner with regional Counties, co-hosting the third Multi-County Summit for Suicide Prevention addressing men's well-being, counseling for lethal means, and more.

- Suicide Prevention Training for Vietnamese Populations
- Marin County Suicide Prevention Collaborative Meeting
- Gun Violence Restraining Order Training virtual training
- Mental Health First Aid. Adult-Spanish. In-person. North Marin Community Services.
- American Foundation for Suicide Prevention. Talk Saves Lives, Older Adults. Virtual.
- The Mask You Live In
- Mental Health First Aid. Youth/English. In-person. Pt. Reyes Station
- A Forum on Children's Mental Health and Well-Being. First Five and Families Commission
- A Community Conversation on 988. Virtual.
- Growing Older in Marin: The Connection Between Ageism and Well-Being. Virtual.
- Mental Health First Aid. Adult/English. in-person: San Geronimo
- American Foundation for Suicide Prevention (AFSP) Walk in Sonoma. Join the Buckelew Programs or Felton Institute Teams!

- Mental Health First Aid. Youth/Spanish. in person: Canal Alliance
- NAMI-Marin “Storytelling H.O.P.E Panel." Virtual. Register here.
- Resilient Even Now: Finding Hope and Liberation After Exploitation. Special guest: Brielle Decker, Resilient Even Now. Dominican University
- Suicide Prevention Training for Spanish-Speaking Populations. North Marin Community Services. Virtual.
- Regional Multi-County Suicide Prevention Summit. Virtual.

CHANGES FOR FY 2025-26:

As the Mental Health Services Act (MHSA) transitions to the Behavioral Health Services Act (BHSA) under Proposition 1, the California Department of Health Care Services (DHCS) has directed that prevention programs and activities will shift to the California Department of Public Health.

As part of this transition, the Suicide Prevention Senior Program Coordinator role will move into the Marin County Public Health division. This shift will strengthen suicide prevention efforts by aligning with BHSA’s direction and serving as a bridge between Public Health and Behavioral Health. The position will continue to support suicide prevention activities in alignment with the strategic plan and goals, working collaboratively with Behavioral Health and Recovery Services (BHRS) and Public Health.

This transition will not change services or funding within suicide prevention programming. The move will take effect at the end of FY 2024-25 and continue into FY 2025-26.

Program Stories

Buckelew

Program Story #1

We received a call from an individual who stated he was angry, felt the world was bullying him, and expressed feeling depressed and hopeless. Our hotline counselor provided empathy, active listening, and encouraged the caller to take deep breaths to help clarify his experience, which worked well. The caller indicated that he was upset about his roommate and job situation. The counselor engaged the caller in safety planning and encouraged him to go for a walk, take deep breaths, and/or contact a friend or family member when upset. The caller agreed to use the safety plan and would contact the hotline as needed. The caller thanked the counselor for listening and stated that he felt much better after talking. He also shared that he would tell others how helpful the hotline was.

Program Story #2

A goal of ours for many years included developing a closer relationship with community members in the Canal neighborhood in Marin County. This year, through our outreach coordinators, the team held 4-5

meetings with the Canal Alliance and other local organizations to foster connections and coordinate efforts to support the needs of the community. As a result, our outreach team provided multiple trainings in April with the Canal Alliance, resulting in a request for additional trainings in the future. Our outreach efforts demonstrated the success of establishing and maintaining relationships in a community in need of services and support. Through these efforts, we are looking forward to ways we can collaborate more in the future.

The Felton Institute

Program Story #1

The LOSS Team received a phone call from a middle-aged man from Marin County seeking support because his longtime partner had recently died by suicide outside of the County. He indicated that his partner had struggled for years with severe depression/bipolar disorder and had made a previous suicide attempt. We offered the After Care Kit to him. During our conversation, we identified the support he has currently has, discussed the healthy self-care tools he's using, and encouraged him attend the local Allies of Hope: SOS group to connect to a survivor community. I later learned that he attended the support group. He shared how touched he was that some of his fellow survivors from the group attended his musical performance and how grateful he was to be a part of the group. A response we received from him after sending a card to him underscored the importance of our work. He wrote:

"I received a card from you wishing me peace and hope as it will soon be a year since my beloved partner passed away. I cried from the thought of your gesture…I am putting the card of her on her shrine."

Program Story #2

In one of our Survivor of Suicide Attempt (SOSA) support groups, an individual experienced a crisis that we discovered using our protocol to "check-in" after the first session. The group member reported that their suicidal thoughts had increased, they did not feel safe, and would be going to the hospital. The group member indicated that their feelings had been building. I connected them with our licensed clinical supervisor for an assessment. After their experience at the hospital, the member returned to the SOSA group and shared their experience with the other survivors about the importance of asking for help. The member also shared that they are hopeful to gain skills in dealing with their suicidal ideation in therapy, medications, and group experience. This group member wanted to have people in their life who can validate their experience even though others may not "understand" suicidal thoughts. In short, they wanted to feel "seen." Although the suicidal crisis was challenging, our team relied on the protocols in place to help us navigate the situation and respond with calm, clear and compassionate communication and support. Ultimately, the SOSA participant made the best decisions to reach out for support!

*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): Increasing resources for the Latino community by supporting trusted community partners

PROGRAM DESCRIPTION: This program targets newly arrived immigrant youth primarily in middle and high schools in San Rafael and Novato.

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 screenings/assessments, linking students to resources, and providing short-term case management in a school-based setting. Additionally, these coordinators implement groups, such as *Fuerte* groups, for newcomer students and offer training sessions for school staff to help them understand the unique needs of this population. *Fuerte* is a school-based curriculum developed by the University of California, San Francisco for newcomer immigrant youth at risk for traumatic stress. The program addresses various issues such as grief, loss, acculturation, and the establishment of resources and support systems.

There is also a particular focus on community outreach and family reunification in San Rafael. Overall, this program expands and strengthens coordination efforts among school, county, and community-based organization partners, thereby enhancing 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 23/24	622	267	5065	5954

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 2023-24 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 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Newcomer students in grades 9-12 participating in Novato High School's (NHS's) summer-based Camp N program will connect with Newcomer Program staff	N/A	N/A	N/A	N/A	90%	90%
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.	75 students	114 students	100 students	106 students	100 students	150 students
Newcomer students will be screened for behavioral health and safety net service needs	N/A	N/A	N/A	N/A	75%	60%
Participants surveyed will report satisfaction with services in two or more areas of the program	75%	100% N=60	75%	Not reported	75%	77%
Total referrals to County Behavioral Health (BHRS)	N/A	6	N/A	5	N/A	4
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	0	N/A	3	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	7	N/A	12	N/A	3
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	6	N/A	9	N/A	2

Outcomes: North Marin Community Services	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
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	1
Total referrals to other mental health services or resources for basic needs	N/A	10	N/A	7	N/A	2

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 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Students at San Rafael, Terra Linda, and Madrone High Schools will engage in one of 12 series of groups that are offered throughout the school year	-	-	-	-	115 Students	268 Students
Students at San Rafael and Terra Linda High Schools will engage in one of 8 groups that are offered throughout the school year	65 students 8 groups	107 students 8 groups	115 students 8 groups	115 students 13 groups	N/A	N/A
Participants surveyed will report satisfaction with services in two or more areas of the program	75%	100%	75%	90.1%	75%	100%
Individuals served will accomplish two or more of the following: doing better in school (i.e. academically, socially) and /or work; stronger relationships with family/friends/teachers or others; better able to cope when things go wrong; more connected to community; better able to advocate for needs	-	-	-	-	75%	100%
Participants who engage in three or more sessions will indicate an improvement in wellbeing	-	-	-	-	60%	69.4%
Participants who engage in three or more sessions will indicate a positive therapeutic alliance with the facilitators	-	-	-	-	75%	87.5%
High school and TAY Spanish-speaking youth from Marin County will engage	-	-	-	-	30	15

Outcomes: Huckleberry Youth Programs	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
one of two bilingual Peer Health Educator cohorts					youth	youth
Youth trained through "Nuestra Salud" initiative	15	23	15	18	N/A	N/A
Youth served through outreach events	N/A	0	N/A	Not reported	N/A	Not reported
Total referrals to County Behavioral Health (BHRS)	N/A	0	N/A	0	N/A	Not reported
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	0	N/A	0	N/A	15
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	0	N/A	Not reported	N/A	15
Average time in weeks between when a referral was given to individual by program and the individual's first in-person appointment with the PEI funded provider	N/A	Not reported	N/A	Not reported	N/A	1
Total referrals to other mental health services or resources for basic needs	N/A	0	N/A	0	N/A	5

Canal Alliance provides reunification groups, *Lazos Familiares*, for newly arrived immigrant youth and their families primarily in the San Rafael area focused on building newcomers' resilience and promoting their healthy adjustment to a new school and country.

Outcomes: Canal Alliance	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Serve approximately 6 to 8 Newcomer students and their families through multi-family groups	-	-	-	-	6-8 Students	5 Students
Serve approximately 6 to 8 families with 2-8 members per family.	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	N/A	N/A

Outcomes: Canal Alliance	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
At least 75% of families served will report satisfaction with group services	-	-	-	-	75%	100%
Total referrals to County Behavioral Health (BHRS)	N/A	5	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	0
Average duration in weeks of signs of untreated mental illness (per client or caregiver report)	N/A	26-52 weeks	N/A	13-26 weeks	N/A	Not reported
Total referrals to other PEI providers	N/A	6	N/A	2	N/A	2
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	2	N/A	2	N/A	1
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	2 weeks	N/A	4
Total referrals to other mental health services or resources for basic needs	N/A	6	N/A	4	N/A	3

Bay Area Community Resources (BACR) serves newcomer students at Davidson Middle School through assessment of needs, referrals, outreach, mentoring, direct services, and parent engagement. BACR's Newcomer Specialist, in partnership with San Rafael City Schools (SRCS), organizes and facilitates internal and external resources, as well as brings together community partners to offer a range of support and opportunities to the newcomer youth and families during and out of school time.

Outcomes: Bay Area Community Resources	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
NFC will run groups in Year 1 with an average of 10 family members per group for 2-4 weeks each	N/A	N/A	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%	50%	50%	100%	N/A	N/A
By the end of the school year, newcomer students will participate in cultural circles with former newcomer students	75%	82%	75%	74%	N/A	N/A
The Newcomer Services Specialist will guide newcomer families on the school enrollment process	-	-	-	-	50%	100%
Newcomer youth and at least one caregiver will have completed 2 sessions to learn healing and self-care strategies	-	-	-	-	50%	100%
Newcomer family members will attend at least one parent workshop	-	-	-	-	50%	67%
Newcomer students transitioning to high school will participate in a leadership academy summer program	-	-	-	-	N/A	30
Newcomer students will participate in out of school time activities	-	-	-	-	60%	73%
Newcomer students in 6th to 8th grade will have a mentor (population focused on those enrolled in afterschool program)	-	-	-	-	50%	56%
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%	75%	60%	67%	N/A	N/A
Newcomer students will attend at least one tutoring session per week	-	-	-	-	50%	62%
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%	70%	50%	72%	N/A	N/A

Outcomes: Bay Area Community Resources	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
By the end of the school year **teachers** working with Newcomers will have completed at least 2 of the training offerings	75%	0%	75%	100%	N/A	N/A
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%	84%	75%	100%	N/A	N /A
Total referrals to County Behavioral Health (BHRS)	N/A	20	N/A	5	N/A	24
Number of individuals who were successfully referred and linked to a Marin County mental health treatment program	N/A	2	N/A	1	N/A	12
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	1-4 weeks
Total referrals to other PEI providers	N/A	2	N/A	0	N/A	14
Number of individuals followed through on referral & engaged in a PEI-funded program	N/A	1	N/A	N/A	N/A	5
Average time in weeks between when a referral was given to individual by program and the individual's first in-person appointment with the PEI funded provider	N/A	1 week	N/A	Not reported	N/A	1-2 weeks
Total referrals to other mental health services or resources for basic needs	N /A	78	N/A	227	N/A	332

CHANGES FOR FY 2025-26:

Upcoming changes to the Huckleberry Youth Program's *Nuestra Salud* will include a greater focus on mental health subjects through project-based activities, such as creating a mental health focused magazine and/or developing poster campaigns for schools. It will also include strengthened capacity to serve youth with co-occurring substance use disorders through the addition of new bilingual therapists/trainees and continued offering of the expanded middle school *Charlas* sessions.

Bay Area Community Resources will be engaging a facilitator who is a bilingual psychologist to provide presentations for newcomers that focus on developing self-awareness, self-confidence, effective communication, motivation, self-efficacy, resilience, and critical thinking. Mentorship will be provided to newcomer students registered to the afterschool program and parenting classes will continue to be offered to support families in navigating the school system, learning about bilingual education, and incorporating an in-person healing class, in partnership with a non-profit Raices del Canal.

No changes mentioned for North Marin Community Services or Canal Alliance.

Program Stories

North Marin Community Services (NMCS)

A teen's family of 6 had been renting one room in a house, tensions between family members were high due to the cramped living environment. The teen moved out of the family's room that they were renting and left to stay with a friend. Meanwhile, NMCS case managers were able to work with the family to secure stable housing, collaborating with community partners and other sources to obtain the initial deposit needed to rent a house which could accommodate the large family. The teen was then able to return to her family and feel secure in their new home. Another older teen, an 18yo newcomer who graduated high school, shared how the newcomer groups helped him establish healthier communication with his mom; he was grateful for the program and the skills he now possesses for his future.

Huckleberry Youth Programs (HYP)

Trust building and establishing rapport is essential for youth to engage in necessary next steps required to obtain much needed support and feel safe in sharing their story. The HYP newcomer program often encounters youth who present as if all is fine, and with time staff are able to uncover and address the underlying life changing issues. An example of many is a young person who was referred to HYP by a school counselor. The youth was hesitant to share at first, but the HYP provider addressed basic needs as an entry point and soon realized serious mental health issues were also impacting this young person's life. His living situation was not emotionally safe, as he had suffered a work-related injury and was not able to rely on family for appropriate support. The HYP newcomer provider offered basic needs support to address living conditions AND a connection to the Mobile Crisis Response Team when a crisis arose.

Canal Alliance

Lazos Familiares is a program that brings newcomer families together. They help prepare and share a meal together, as well as stories of arrival one chapter at a time over the course of 10 weeks. Some families share more openly than others, some establish a foundation of understanding and communication within their families, and some listen and take the sharing and knowledge of tools in and integrate it in their family's life. All report gaining a skill, a better understanding, a feeling a connectedness and part of something. One example is a family of 5 from Mexico. The family fled Mexico after their father/grandfather was assaulted and they were under threat of further harm. The family has 3 daughters- 11 (primary child client), 13 and 19 years old. The family made the journey to the US together; unfortunately, the eldest daughter was separated from the family and placed in a detention center for approximately 4 weeks longer than mom and the other two children. At the time of intake, the family had been in the US for approximately 2 months. Mom shared how difficult it is for her to recall and retell her trauma story and feels that immigration trauma has deeply impacted her daughters' capacity to express and share their feelings. Mom struggles regulating her emotions when trying to support her daughters, which has caused some distance between them. Through participation in *Lazos* sessions, mom and daughters engaged in each of the interventions and created their narrative story book together. Mom was able to share her portion aloud to the group and, although she became emotional while reading, she was also able to support her daughters as they read their stories aloud.

The mom became a role model and thus provided the opportunity for daughters to openly share and begin their healing process. Since the group, this mom and children have requested further opportunity to process their trauma and were referred for mental health treatment. Mom has been able to reflect on the message she had previously sent to her daughters around being strong and guarding feelings and not opening up and sharing. She now states that she would like to teach them a different lesson: that being strong includes expressing feelings and asking for help, at times.

Bay Area Community Resources

An 8th grade newcomer student at Davidson Middle School in San Rafael arrived in the U.S. near the end of the previous school year. He struggled in relationships with peers, had low attendance, was not interested in afterschool activities, and was generally isolated. The opportunity to offer a support group during school hours arose and he was the first one invited. He attended all 7 sessions of the group and actively participated. Due to this positive experience, he was open to receiving more services and soon began participating in individual weekly check-in sessions with the community liaison, meeting with a case manager, and was linked with virtual individual counseling. This student also requested to be signed up to BACR's summer camp, "to be out of trouble", he said. Once he successfully graduated middle school and registered for high school, he sent the BACR Newcomer Coordinator the following email, "gracias le agradezco mucho por todo el tiempo que me ayudó" ("thanks, I am very grateful for all the times you helped me"). The coordinator recognized the kind words but more importantly was thrilled to see him sending emails, a skill he learned in the program and will utilize on his academic and personal journey.

*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

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.

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 23/24	-	-	**338**	**338**

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 2023-24 OUTCOMES:

NAMI-Marin

The In Our Own Voices (IOOV) storytelling series, part of the National Alliance on Mental Illness (NAMI)-Marin, is a public education initiative that fosters understanding and reduces stigma around mental illness. The program trains individuals with lived experience to share their personal journeys in a supportive and accepting environment, highlighting their insights, challenges, recovery pathways, and coping strategies. NAMI storytellers reflect a diverse range of ages, genders, races, occupations, and health challenges, offering varied perspectives on mental health. IOOV presentations reach a wide audience, including students, law enforcement, healthcare providers, educators, and faith communities, promoting compassion, respect, and support.

Outcomes: NAMI-Marin	Goal FY 21/22	Actual FY 21/22	Goal FY 22/23	Actual FY 22/23	Goal FY 23/24	Actual FY 23/24
Recruit speakers through outreach and engagement	8	9	10	15	8	8
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	9	10	15	8	8
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	6 hours	4 hours	6 hours	6 hours	7 hours

CHANGES FOR FY 2024-25

No changes to report for upcoming FY 2025-26

Program Stories

The Power of Sharing

Every week I'd sit in therapy knowing what I wanted to share, but feeling too ashamed to share it. I'd share all other details of my life and work through deep emotions, but this secret was too scary to let out. It felt safer to keep it inside. I tried to hide the memories of my past, of the sexual abuse I had experienced as a child, but they kept coming back stronger. Until finally I could no longer keep them to myself.

One day, I opened up to a loved one about my experience, and about the depression I was feeling. As I shared, my loved one shared that they too had been treated the same way–that we shared this traumatic experience from our childhoods. We were both survivors, but now we were no longer alone. I realized that opening up about these memories, and other experiences that affect my mental health would allow me to grow, and even help others.

I found a support group, knowing it would be helpful to continue talking to others. Especially others who have gone through similar experiences. In the group, I feel safe and accepted. I've learned how to support my loved ones and how to manage my current relationships with my family. Every week, I actually look forward to sharing, and to being a source of support for others. I love knowing that everyone in the group has a shared understanding of the importance of receiving help around mental health and the confidentiality, support, compassion, and empathy the group provides. The group has made me feel like I belong.

El poder de compartir nuestra historia

Todas las semanas yo asistía a terapia sabiendo lo que quería compartir, sin embargo siempre me sentía avergonzada e incómoda al expresarme. Compartia todos los detalles sobre mi vida y sobre mi trabajo, pero menos aquello que más me llenaba de inseguridad. Ese secreto era demasiado aterrador para revelarlo. Me sentía más segura manteniéndolo en lo más profundo de mi ser. Intenté por muchos años y con todas mis fuerzas de reprimir los recuerdos de mi pasado, aquel abuso sexual que había sufrido yo cuando era tan solo una niña . De nada servía, cada vez los recuerdos volvían con más fuerza, me ahogaban. Finalmente se desbordó el vaso, y ya no pude más.

Recuerdo aquel día, cuando por fin me abrí y le conté a un ser querido mi experiencia y la depresión profunda por la que llevaba yo pasando por años. ¿cuál fue mi sorpresa al oír que mi ser querido había pasado por la misma experiencia y también había sido victims de abuso sexual. Aquí estábamos, compartiendo esta experiencia traumática de nuestra infancia. Ambos éramos sobrevivientes , la gran diferencia es que ahora ya no estábamos solos. Me di cuenta entonces de que compartir estos recuerdos tan pesados disminuyeron su fuerza y descubrí que al departir las experiencias que afectan mi salud mental me permitiría crecer, sanar e incluso ayudar a los demás.

Muy pronto encontré un grupo de apoyo, sabiendo que sería útil seguir hablando y compartiendo con otras personas; específicamente con otros que han pasado por experiencias similares. En el grupo me siento escuchada y aceptada. Además, aprendí cómo apoyar an mis seres queridos y cómo manejar y mejorar mis relaciones actuales con mi familia. Cada semana, espero compartir y ser una fuente de apoyo para los demás. Me encanta saber que todos en el grupo tienen una vivencias compartidas y entender la importancia de recibir ayuda en cuanto a la salud mental. Todo esto en un espacio de confidencialidad, lleno de apoyo, donde se brinda compasión y reina la empatía de grupo. El grupo me ha hecho sentir que existe un lugar donde pertenezco.

A Mother's Journey

One day, I faced a mother's nightmare: I found my son unconscious. For years, he'd struggled with bad friendships, poor decisions, substance use, and suicidal thoughts. In that time, I often felt desperate and anxious about his well-being when I wasn't with him. Worried about the decisions he was making, about his substance use, about his wellbeing.

When I found him, I contacted emergency services and he was hospitalized. This marked the beginning of his journey to recovery, including multiple hospitalizations. Throughout his journey, we sought help from groups and support organizations like AA. What truly helped him were the therapies he received during his crises. That hospitalization changed his life.

I faced difficulty finding a space where I could connect with others and receive support for myself. Being part of support groups has helped me realize that there are others going through similar situations. It has enabled me to express myself and relate to those facing similar challenges. I can share my experiences and offer support, ensuring others don't feel isolated, like I had as a single mother facing these challenges. Support groups are safe spaces for us to share our experiences, problems, and difficulties with loved ones who have mental health issues or are going through a tough time. I want to help more people and ensure the community has a space to talk and receive help with the situations they are going through.

I always prayed to God for my son's well-being, and thankfully, he is now doing well. Though the fear of relapse lingers, our bond has strengthened, and he has become a responsible, hardworking, and loving son. Being sober, he regrets his past decisions and has future goals. Expressing love to him every day has been crucial in his recovery journey. Letting our loved ones know that we care is something I think is important to let them know every day.

Los retos que enfrenta una madre

Un día me enfrenté a la pesadilla a la que más teme una madre: me encontré a mi hijo inconsciente. Durante años, había andado rodeado de malas amistades, tomado malas decisiones, batallado con el consumo de sustancias y abatido por pensamientos suicidas. En aquel entonces me sentía a menudo muy desesperada y ansiosa por su bienestar cuando no estaba con él. Inmensamente preocupada por las decisiones que estaba tomando, por su consumo de sustancias dañinas, por su seguridad y por su bienestar.

Cuando lo encontré inconsciente, contacté a los servicios de emergencia y lo hospitalizaron. Esto marcó el inicio de su trayectoria camino a su recuperación, misma que incluyó múltiples hospitalizaciones. A lo largo de su viaje, buscamos ayuda de grupos y organizaciones de apoyo como Alcoholicos Anónimos . Una de las cosas que realmente lo ayudaron fueron las terapias que recibió durante sus múltiples crisis. Pero sin lugar a dudas, esa primera hospitalización, cambió su vida.

Por un tiempo, tuve gran dificultad para encontrar un espacio donde yo pudiera conectarme con otras personas y recibir apoyo. Sin embargo finalmente encontré un grupo para familias.Ser parte de grupos de apoyo me ha ayudado a darme cuenta de que hay otras personas que están pasando por situaciones similares. Esto me ha permitido expresarme y relacionarme con quienes enfrentan desafíos similares a los míos. Ahora puedo compartir mis experiencias y ofrecer apoyo, asegurándome de que otros no se sientan aislados, como me sentí yo cuando era madre soltera al enfrentar estos desafíos. Los grupos de apoyo son espacios muy seguros para que compartamos nuestras experiencias, problemas y dificultades con seres queridos que tienen problemas de salud mental o que están pasando por momentos difíciles. Ahora quiero ayudar a más personas y lograr que la comunidad tenga un espacio dedicado para hablar y recibir ayuda con las situaciones por las que están pasando.

Siempre le pedí a Dios por el bienestar de mi hijo y, afortunadamente, ahora se encuentra estable. Aunque el temor a una recaída siempre persiste, nuestro vínculo se ha fortalecido y él se ha convertido en un hijo responsable, trabajador y amoroso. Al estar sobrio, lamenta sus decisiones pasadas y me llena de felicidad ver que tiene metas futuras. El yo expresarle amor todos los días ha sido crucial en su camino a la recuperación. Hacerles saber a nuestros seres queridos que nos preocupamos por ellos es algo que creo que es esencial hacerles saber todos los días.

PEI COMPONENT BUDGET

Program	FY2023-24	FY2024-25	FY2025-26	% of budget for youth	FY25-26 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	$1,154,952	100%	$1,154,952	$2,969,527
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	$508,141	40%	$203,256	$1,685,433
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**	**$3,992,059**	**65.5%**	**$2,674,865**	**$11,866,400**
PEI Coordination, Evaluation, and Community Engagement	$127,100	$154,100	$154,100			$435,300
Administration and Indirect	$631,404	$591,924	$621,924			$1,845,252
Total	**$4,840,786**	**$4,538,083**	**$4,768,083**	**55.3%**		**$14,146,952**

INNOVATION COMPONENT

OVERVIEW

The Behavioral Health Services Oversight and Accountability Commission (BHSOAC, previously named the *Mental Health Services Oversight and Accountability Commission*) 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 FY23/24 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. In FY24-25 community planning led to the extension of the Student Wellness Ambassador Program (SWAP) for an additional year.

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

PROJECT FINAL OUTCOMES:

Marin County is proud to have participated in and celebrated the innovative work with CalMHSA and the 14 cities and counties involved in the Help@Hand program, which ran from March 2019 to June 2024. The final statewide evaluation of Help@Hand can be found HERE.

This Mental Health Services Act (MHSA) Innovation project aimed to integrate a suite of mental health technologies into the public mental health system. Counties and cities joined in two cohorts beginning in 2017, with teams participating for up to five years and implementation concluding in 2024. MHSA Innovation projects prioritize learning and sustainability, providing a platform for mental health plans to test and refine novel strategies to support their communities. Help@Hand identified five overall learning objectives:

1. Detect and acknowledge mental health symptoms sooner;
2. Reduce stigma associated with mental illness by promoting mental wellness;
3. Increase access to the appropriate level of support and care;
4. Increase purpose, belonging, and social connectedness of individuals served; and
5. Analyze and collect data to improve mental health needs assessment and service delivery.

What We Did
Participating counties and cities engaged with technologies in a variety of ways during Help@Hand. Two counties used Help@Hand funds to develop custom technologies – *Wellscreen* Monterey in Monterey County and *Take my Hand* in Riverside County. Thirteen counties and cities chose to explore existing technologies to see if they met their local needs. They investigated 53 different technologies, with features ranging from peer chat to chatbot to meditation and sleep guidance to digital phenotyping.

When a county or city identified a technology that matched their community's needs, they could choose to pilot that technology with a designated population and/or proceed to a full implementation. Seven counties conducted pilot implementations of eight distinct technologies, and 10 counties fully implemented nine different technologies. The most commonly implemented technologies during Help@Hand were Headspace, *Mindstrong*, *myStrength, and 7 Cups.*

Digital Mental Health: More Than Just Apps
Help@Hand participants quickly learned that implementing mental health technologies required a great deal of effort beyond simply selecting an app and making it available in their community. Three counties conducted detailed needs assessments during Help@Hand to engage their communities and determine how the community felt mental health technologies could benefit them. Counties worked to address two common barriers to implementing mental health apps – lack of access to high-speed internet or suitable devices and the need for support to build digital mental health literacy. Eight counties and cities distributed devices as part of Help@Hand and one county deployed kiosks that could be used to access mental health technologies. Nine counties and cities hosted digital literacy trainings to help community members develop the skills necessary to use mental health technologies. Help@Hand participants also worked to build awareness about mental health and mental health technologies in their communities. Three counties launched mental health awareness initiatives and six counties published app guides or brochures to educate the community on mental health technologies available. These activities, in combination with exploring and implementing specific technologies, yielded a great deal of learning about the practicalities of integrating digital mental health into the public mental health system.

What We Learned:
Cross-County Collaboration and Implementation Infrastructure
Help@Hand was the first of its kind – a project where multiple county and city mental health plans came together to accomplish a common goal while prioritizing local needs. As such, participants learned a lot during the project, about both how to coordinate a project like this and how to build the infrastructure to support implementing mental health technologies. CalMHSA served as the overall project manager, providing administrative support for contracting, invoicing, and project management. The project quickly discovered they needed to balance flexibility with structure in project management, leveraging standardized processes and templates as much as possible. The collaborative structure allowed for sharing across mental health plans. Participants shared best practices and lessons learned and even were able to share experiences with vendors and consider pooling resources to access technologies that would otherwise be cost-prohibited.

Implementing mental health technologies requires significant infrastructure and collaboration within each county or city as well. Many participants felt they initially underestimated staffing needs to support the project and needed to engage contractors for additional time and expertise. They also emphasized the importance of identifying technology champions and internal expertise. Successful implementation required collaboration with county or city Information Technology, Compliance, and Legal teams, and partnering with CBOs and integrating technologies into existing systems facilitated success.

Additionally, Help@Hand provided many lessons about selecting and customizing technology and partnering with technology vendors. When selecting an app, participants needed to evaluate app functionality and user experience, consider support available from the

vendor or develop a support strategy, establish a sustainable payment model, and identify the need for and cost of customization. Many apps available on the marketplace required customization to improve accessibility and cultural sensitivity and meet county or city requirements for security and resource availability. However, customization often required significant time and money, and not all technologies supported all of the desired customizations.

Engaging Community Members, Peers, and Potential Users
Mental health technologies are only valuable if they are used by the people that participating organizations serve. In addition to addressing digital barriers, Help@Hand participants needed to address privacy concerns and mental health stigma. App usage was also promoted by proactively seeking community perspectives and conducting outreach and marketing early and often during implementation. Apps with simple, intuitive interfaces were most appealing in Help@Hand counties and cities, and transition aged youth (ages 18-25) and adults and teens experiencing high levels of psychological distress were most likely to use mental health apps.

Peers – individuals with lived experiences of mental health challenges and recovery – provided extremely valuable support when engaging the community and potential users. They contributed to community outreach, digital literacy training, and technology planning and implementation. Peers also helped to develop language-appropriate and culturally responsive support for people using mental health technologies. While Peers were an integral part of Help@Hand, future efforts should create a structure for managing Peer hiring, retention, and workload. Moreover, counties and cities should intentionally engage Peers in all project phases.

Promising Outcomes
Data from the California Health Interview Survey (CHIS) showed that more adults reported psychological distress from 2019 to 2022 and high levels of both adults and teens reported unmet mental health needs during the same time period. This emphasizes the importance of innovative approaches to reaching people with mental health needs and providing services that meet them where they are. UC Irvine conducted a meta-analysis from implementations of Headspace, iPrevail, Mindstrong, and myStrength in seven participating Help@Hand counties and cities. 47% of app users who responded to Help@Hand surveys reported reduced mental health symptoms. Approximately one-quarter of respondents reported reduced mental health stigma, and nearly one-third reported decreased loneliness. These results show great potential for benefits of mental health technologies in the public mental health system.

What's Next
Help@Hand demonstrated the challenges and the promises of implementing mental health technologies in the public mental health system. As California continues to respond to the increasing need for mental health support, mental health plans should engage with CalMHSA and Help@Hand participants to leverage the tools and learnings developed through the

project. The final statewide evaluation of Help@Hand can be found HERE.

CHANGES FOR FY25/26: This program ended in 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.

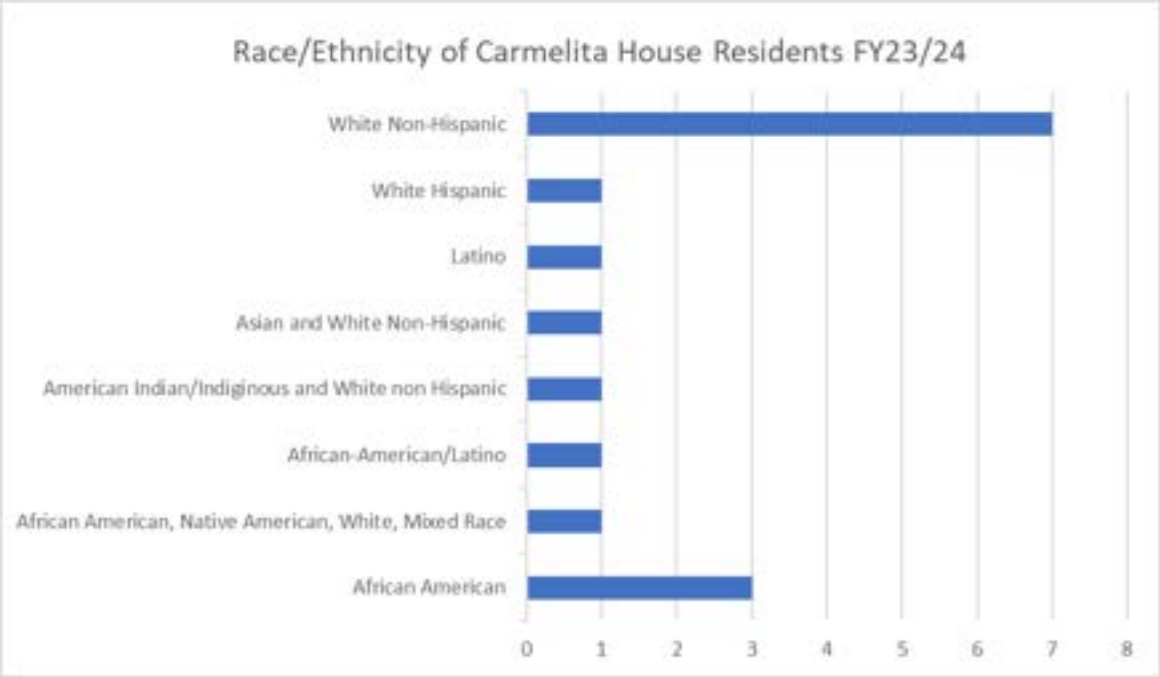
This program focuses on actively resisting re-traumatization and supporting the women to remain engaged with the trauma healing after they move on from living in the house. Women do not graduate from this supportive housing environment without housing and ongoing support in place. When women do leave, 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 18 residents and is currently housing seven women, including the peer support specialist. Carmelita's capacity is eight beds. Sixteen women were served in FY23/24.



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?

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 was very closely tied to the first reason, was that we were 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 25/26: None.

FY 23/24 EVALUATION: The following pages are from a report prepared by the independent Evaluation consultant, Impact Justice, contracted to evaluate this Innovation project.

About Us

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.

Antoinette Davis
Vice President and Director

Lallen Johnson, PhD
Associate Director

Research and Action Center, Impact Justice | February 2025

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Introduction

This report will serve as the third annual summary update for the Carmelita House project. Throughout the project's implementation, the evaluation team has collected and analyzed administrative data from Carmelita House staff, along with survey responses. The team also conducted site visits and in-depth interviews with residents and staff in March 2023 and January 2024, focusing on residents' experiences and the impact of somatic-centered therapeutic practices.

This update will examine programmatic changes, successes, and challenges while highlighting residents' progress. Future reporting will seek to assess legal system outcomes, specifically whether participants have reduced contact with the criminal legal system and engaged in court-ordered services.

These outcomes align with the core objectives of the Carmelita program, which is to provide critical support and services to women with histories of substance use, trauma, and severe mental health disorders. By offering a comprehensive system of care, the program aims to help residents stabilize, fulfill court requirements, and achieve long-term housing stability.

Carmelita House

Background

“I envisioned a home that offers compassionate support, meets women where they are, allows for setbacks without punitive consequences, and provides the flexibility for women to leave and return after a relapse. [These are] necessary components of successful reentry for this population but not normally afforded.”

Carmelita House Founder

In partnership with Catholic Charities CYO of San Francisco, Marin County launched the Carmelita House in 2022, with funding from the California Mental Health Services Act Innovations Grant. Carmelita House is an innovative project designed to support women with histories of incarceration and co-occurring mental health and substance use disorders. Now in its third year, the program remains rooted in trauma-informed care as the foundation for treatment. It serves women with serious mental illness and substance use disorders who have experienced incarceration or confinement in locked facilities, many of whom have Adverse Childhood Experiences (ACEs).

As a trauma-centered sober living residence, Carmelita’s services and system of care are flexible and tailored to address the behavioral challenges that have prevented their clients from participating in other treatment programs. One of Carmelita House’s founders emphasized the importance of reaching women who have historically lacked access to comprehensive, trauma-informed, and non-punitive services—particularly those with histories of incarceration, mental health challenges, and substance addiction. With Carmelita, she envisioned a home that offers compassionate support, meets women where they are, allows for setbacks without punishment, and offers the flexibility to leave and return after a relapse—resources rarely available to this population.

As part of this commitment, women have the option to reenter the program after relapse, ensuring they continue to receive the support they need. Additionally, graduation from the supportive housing environment is contingent on securing stable housing and ongoing support, reinforcing long-term success. To further promote continuity of care, participants may also choose to continue therapy with Carmelita’s trauma therapist and attend community and holiday events, ensuring that treatment and connection do not abruptly end as they transition into independent housing.

Why Carmelita House

Trauma is prevalent in female offenders and often intertwined with mental health and substance abuse disorders.[1] Women facing these challenges encounter unique risk factors and systemic barriers that complicate their ability to seek and receive effective care. A major issue is that traditional reentry programs for women with mental health and substance use disorders often rely on punitive measures and standardized approaches that fail to address their distinct and multifaceted needs -- particularly trauma.

The prevalence of co-occurring mental health and substance use disorders among incarcerated women is significant. Studies indicate that up to 72% of jailed women are diagnosed with a substance use disorder, and approximately 22% have co-occurring mental health, substance use, and other complex needs requiring attention.[3, 4] This is concerning, as individuals with mental health disorders experience recidivism rates between 50% and 230% higher than those without such conditions.[5]

Despite this reality, most reentry programs fail to incorporate trauma-informed care, gender-specific services, or integrated mental health and substance use treatment. Further barriers—such as inadequate childcare, inconsistent access to healthcare and treatment, housing instability, and limited employment opportunities—are frequently overlooked, making successful reintegration difficult. The lack of holistic, individualized support contributes to high recidivism rates and poor long-term outcomes.[6] In contrast, research strongly links integrated mental health and substance use treatment with higher rates of successful reintegration and reduced recidivism.[7]

A 2017 Department of Justice report found female jail inmates were more likely to have a history of mental health issues (66% of females and 35% of males), as well as more likely to have serious psychological stress.[2]

[1] Green, B. L., Dass-Brailsford, P., Hurtado de Mendoza, A., et al. (2016). Trauma experiences and mental health among incarcerated women. *Psychological Trauma: Theory, Research, Practice, and Policy, 8*(4), 455–463. https://doi.org/10.1037/tra0000113

[2] Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011-12. *Bureau of Justice Statistics.*)

[3] Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). *Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009* (NCJ 250546). Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf

[4] Robertson, A.G., Easter, M.M., Lin, H., Khoury, D. Pierce, J., Swanson, J., & Swartz, M. (2020). Gender-specific participation and outcomes among jail diversion clients with co-occurring substance use and mental health disorders. *Journal of Substance Abuse Treatment*, *115*

[5] Baillargeon, J., Binswanger, I. A., Penn, J. V., Williams, B. A., & Murray, O. J. (2009). Psychiatric disorders and repeat incarcerations: The revolving prison door. *American Journal of Psychiatry, 166*(1), 103–109. https://doi.org/10.1176/appi.ajp.2008.08030416

[6] Fazel, S., Hayes, A. J., Bartellas, K., Clerici, M., & Trestman, R. (2016). *Mental health of prisoners: Prevalence, adverse outcomes, and interventions*. *The Lancet Psychiatry, 3*(9), 871–881. https://doi.org/10.1016/S2215-0366(16)30142-0

[7] Substance Abuse and Mental Health Services Administration. (2009). *Integrated treatment for co-occurring disorders: Building your program* (DHHS Publication No. SMA-08-4366). Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Program Overview

Eligibility criteria for Carmelita House require participants to be at least 18 years old, identify as women (trans-inclusive), reside in Marin County, have a history of cycling through behavioral health systems and locked facilities, and qualify for Medi-Cal or county services.

The program operates on a sober living model, providing residents with case management services and access to a trauma therapist to support their recovery and wellness journey. Carmelita offers a wide range of tailored services, with staff and Catholic Charities continuously adapting clinical programming and activities based on available resources, participant requests, and somatic and cognitive interventions.[8]

Therapeutic and Skill-Building Groups

Carmelita maintains a structured, yet flexible schedule of therapeutic and skill-building groups designed to support residents' recovery and personal growth.

Morning groups take place daily at 10 AM, with sessions led by either peer-residents, the Catholic Charities program manager or the house clinician. These are typically

meditation groups aimed at setting intentions for the day

Afternoon groups are held Monday through Thursday at 3 PM, with Mondays, Tuesdays, and Thursdays facilitated by either the house clinician or outside providers. These sessions balance cognitive, somatic, creative, and life skills activities, ensuring both active and passive engagement based on residents' needs

Wednesday afternoon groups, led by the house peers or external providers, offer additional opportunities for engagement and support. Sessions include self-care activities such as spa days, reviewing lessons from prior clinician-led groups (e.g., DBT homework, EFT, and self-acupressure), walking meditation, and outdoor activities like walks and hiking.

Together, these groups create a comprehensive and adaptable program to meet the diverse needs of the residents.

Group Topics and Activities

Therapeutic groups and activities at Carmelita House are coordinated and planned by the Catholic Charities program manager and house clinician, in collaboration with the peer resident and resident feedback. They cover a diverse range of topics, many of which are part of an ongoing series and are periodically repeated.

Clinical and Wellness-Based Groups:

Dialectical Behavioral Therapy (DBT)

Narrative storytelling

Emotional Freedom Technique (EFT or "tapping")

[8] Please see the previous reports for in-depth description of program structure and services.

Overdose prevention and Narcan training

Mobile crisis intervention

Creative and Expressive Therapy:

Cooking and nutrition classes

Crafting projects, including a decorative house quilt

Visual arts: painting, drawing, and collaging

Gardening

Somatic and Mindfulness-Based Interventions:

Yoga, self-massage, and acupressure

Stretching, sound baths, hiking, and walking meditation

Equine therapy

Life Skills and Practical Support:

Boundaries workshops and processing groups

Financial education: budgeting, banking, saving, and money management

Technology education: email, internet, and phone skills

Skill-building trips to farmers' markets and grocery stores focused on food and nutrition

Planning and organizing, and time management workshops

Update to Services

Since its inception, Carmelita House has implemented several significant changes in its programs, services, and structure which include the following:

Introduction of a Clinical Phase Program:

A clinical phase program was introduced to provide residents with a structured framework for understanding and tracking their trauma recovery. This program aligns with Judith Herman's Tri-Phasic Model of Trauma Recovery, focusing on:

Self-reflection and strength-building

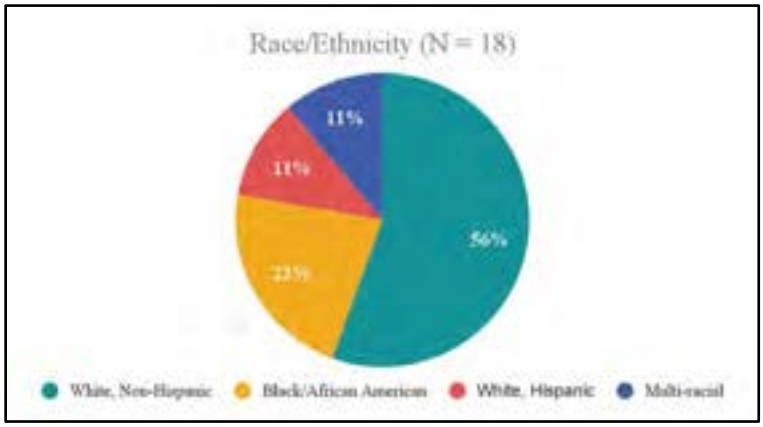
Self-care and developing trust

Navigating conflict and increasing community involvement

Each phase incorporates therapy, skill-building, case management, and community engagement goals, helping residents establish internal and external support systems while maintaining a structured daily and weekly routine as they transition out of the house.[9] This work is completed as a collaboration between the house clinician and the Catholic Charities program manager.

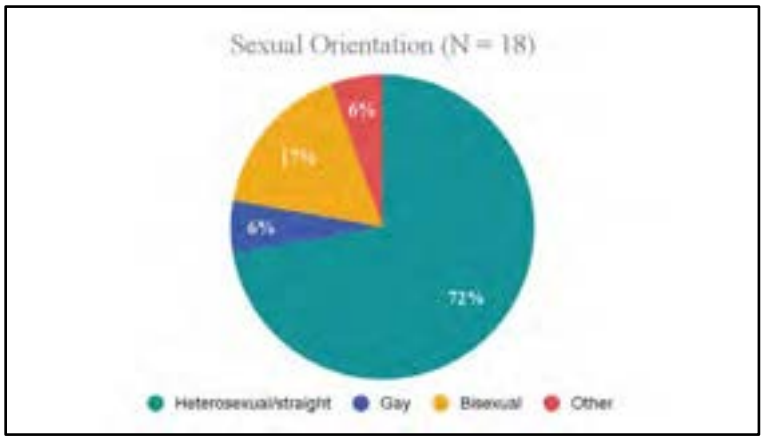
Enhanced Housing Support

To address limited housing options and the lack of case management services for individuals exiting the program, a new collaboration was established between the clinician and the housing placement team. This partnership has already secured permanent supportive housing for several residents transitioning out of Carmelita House.



Expanded Therapy Services

Recognizing the needs of individuals who may not be able to reside at Carmelita due to the nature or severity of their charges, the clinician expanded therapy services to support these clients off-site. This year, one such client successfully received treatment through this extended service model.



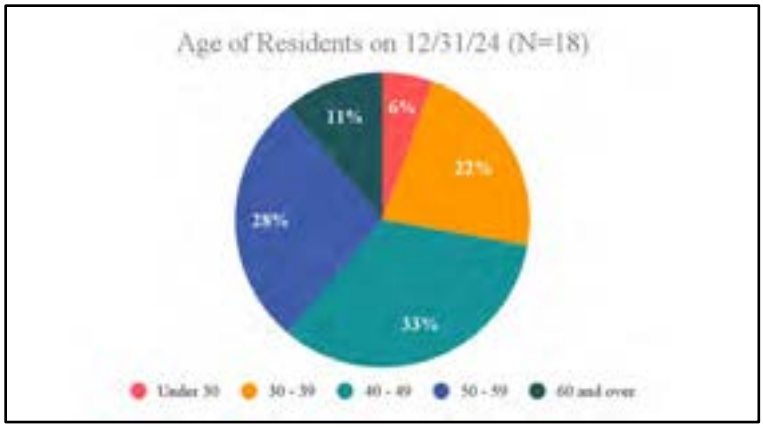
Residents' Demographic Characteristics

All residents of Carmelita House have extensive histories of mental health struggles, substance use, trauma, and homelessness, reflecting the program's success in reaching its target population.

Since its opening in 2022, Carmelita House has served a total of 18 residents. It currently houses eight women, including a peer support specialist. While it is a small, targeted program, its residents come from diverse backgrounds, further reinforcing its commitment to serving women with complex needs who may struggle to access traditional support systems.

[9] Herman, J. L. (1992). *Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror*. Basic Books

Eight of the 18 residents identify as members of racial or ethnic minority groups. As shown below, four participants identified as Black or African American (22%), two as White Hispanic, and two as Multiracial (11%). The remaining 10 identified as non-Hispanic White (56%).



The majority of residents-- 9 of 18-- identified as heterosexual (72%), while three identified as bisexual (17%) and one as "other" (6%).

A significant portion of the residents— 8 of 17—have children (47%), including four who are non-custodial parents to minor children.[10]

The ages of the women in the program vary: four clients are aged 30–39 years (22%), six aged 40–49 years (33%), and five aged 50–59 years (28%). Additionally, one client is under 30, and two are over 60 years.

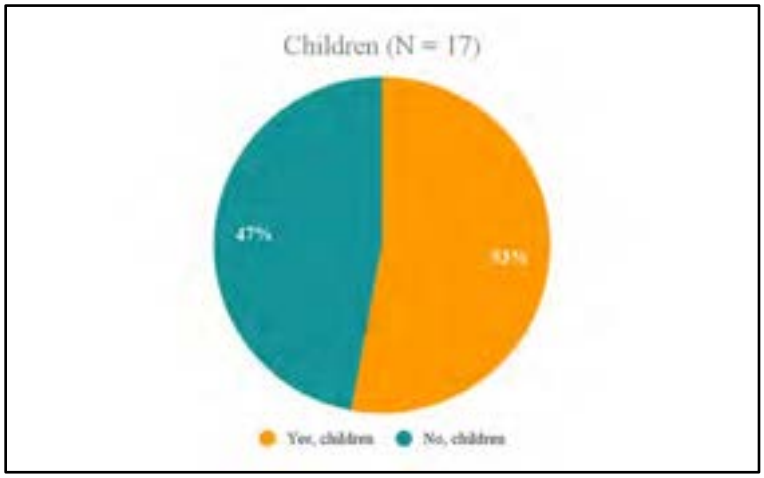
Impact on Residents

Case Studies

Interviews with staff and residents underscore the program's significant impact in supporting trauma recovery, emotional regulation, and life skills development. The following case studies offer a closer look at the challenges residents face and the progress they make, reflecting the program's commitment to addressing the complex needs of the women it serves.

Resident A

Resident A entered Carmelita with a history of presenting factors in Table 1. Among these include severe mental health challenges, placements in locked facilities, poor emotional regulation skills, unemployment, and homelessness. She also spent over 10 years on probation. Despite these significant barriers, she is now transitioning into permanent supportive housing, with housing retention supported by a Carmelita Aftercare peer.



This transition is a critical milestone, as stable housing provides a foundation for long-term recovery, personal growth, and independence. Access to permanent supportive housing can significantly reduce the risk of re-hospitalization,

[10] Data reported for 17 out of 18 participants; status of one participant is unknown.

incarceration, and further homelessness, offering her the stability needed to continue addressing her mental health and emotional regulation challenges.

Additionally, she will continue therapy with a Carmelita clinician until she is either linked to another county therapist or decides to conclude therapy. Ongoing access to mental health support is essential in helping her build coping skills, maintain emotional stability, and prevent relapsing into past patterns of crisis and instability.

She will also be encouraged to stay engaged with the Carmelita House community through on-site and alumni activities, including holiday celebrations, dinners, select in-house groups, and off-site events. This continued connection fosters a sense of belonging, reinforces her support network, and provides a positive social structure that can help sustain her progress.

These achievements mark a transformative shift in Resident A's life, moving her from a cycle of institutionalization and instability toward a future of stability, self-sufficiency, and community connection.

Table 1: Resident A

	Presenting Factors	Outcomes
Legal	• Probation 10+ years • History of placement in locked facilities • Enrollment in STAR Collaborative Court	• Completed and released from probation supervision • Graduated STAR collaborative court with all requirements completed
Health	• Severe mental health diagnosis with psychosis and low insight • Low medication compliance	• Improved medication adherence • Consistently maintained all benefits • Engaged regularly in creative pursuits, traveling with family
Housing	• 8 – 10 years of chronic homelessness	• Accepted into permanent supportive housing
Family/ Social Functioning	• Poor/low emotional regulation skills • Socially isolated and guarded • Lack of engagement core functioning activities	• Increased emotional regulation skills • Participated in somatic groups – sound baths, acupuncture, and walking meditation • Engaged in prosocial and functioning activities • Completed a vocational gardening program • Engaged and traveled with family
Life Skills	• Unemployed • Disengaged in self-care • Limited ability to shop for groceries and cook • Poor personal hygiene	• Obtained clearance for driver's license • Obtained identification documents • Developed ability to grocery shop and cook for herself • Improved personal hygiene

Resident B

Resident B has a history of cycling in and out of jail systems and locked facilities, poor emotional regulation skills, difficulties with physical health and self-care, unemployment, and over 10 years of homelessness. She is also a non-custodial parent and had no contact with her children.

Despite these significant challenges, she has successfully retained permanent independent housing and achieved notable personal and professional milestones (see Table 2). She completed a vocational gardening program and remains engaged with vocational services as she works toward her employment goals. Additionally, she graduated from the Mental Health Diversion Collaborative Court program, completed probation, and transitioned from therapy with her Carmelita clinician to regular sessions with a community therapist. She now maintains strong family relationships, has sustained sobriety, and engages consistently with case management and healthcare providers.

These accomplishments are particularly significant given her history of instability and lack of support. Maintaining permanent housing, securing vocational training, and engaging in long-term therapy demonstrate her ability to build a stable, self-sufficient future. Her reconnection with family and commitment to sobriety not only improve her personal well-being but also increase her chances of sustained independence. Additionally, her continued involvement in the Carmelita House community—participating in on-site and alumni activities such as holiday celebrations, dinners, in-house groups, and off-site events—reflects her sense of belonging and reinforces the support system that contributes to her success.

Her progress highlights the impact of comprehensive, trauma-informed, and non-punitive support services in helping individuals overcome deep-rooted barriers and build meaningful, sustainable lives.

Table 2: Resident B

	Presenting Factors	Outcomes
Legal	• Presented with multiple criminal charges • Probation 12+ years • History of cycling in and out of jail and other locked facilities	• Enrolled and completed Mental Health Diversion program – all charges dismissed • Completed and released from probation supervision
Health	• Chronic/severe substance use • Mental health diagnosis – PTSD, anxiety, and depression • Unmaintained chronic health conditions	• Maintained continuous sobriety from substances o Completed intensive outpatient program for substance use • Engaged in medical treatment and wellness activities for chronic conditions • Maintained benefit enrollments
Housing	• 10+ Years of chronic homelessness	• Moved into and maintaining permanent supportive housing
Family/Social	• Poor/low emotional regulation skills	• Participated in somatic groups – sound baths, acupuncture, and walking meditation • Completed a vocational gardening program

Functioning	• Non-custodial parent with no contact with children	• Engaged in prosocial and functioning activities • Reconnected and maintaining relationships with children and family
Life Skills	• Unemployed with limited skills and workforce training • Disengaged in self-care	• Obtained identification documents • Completed 2 vocational training programs and paid job placements • Improved personal hygiene

Strengths and Challenges

Carmelita House's approach to supporting its residents is built on adaptability, an intimate setting, and a strong emphasis on continuity of care. Flexible funding has allowed the program to implement a diverse range of therapeutic services tailored to the unique needs of residents, ensuring a holistic and individualized approach. The program's small-scale structure, with a capacity of just eight residents, fosters a close-knit, supportive environment where staff can provide personalized attention. Additionally, pre-release engagement plays a crucial role in establishing trust, preparing residents for their transition, and maintaining long-term stability through continued aftercare.

However, providing consistent, comprehensive, wraparound care presents ongoing challenges. Carmelita requires clients to actively participate in county case management services as a condition of residency while also working with the Catholic Charities program manager and clinician to ensure continuity of care. Staffing shortages and capacity limitations within Marin County frequently result in gaps in services for clients.

Conclusion

The Carmelita House serves a vital and innovative response to the complex needs of women with histories of incarceration, severe mental health disorders, substance use, and trauma. By integrating trauma-informed care, gender-responsive services, and a flexible, non-punitive approach, the program fills critical gaps left by traditional reentry models. Unlike many reentry programs that rely on standardized or punitive frameworks, The program prioritizes individualized support, allowing women to stabilize, navigate recovery, and build the necessary skills for long-term success.

The program's impact is evident in the success stories of its residents. Through stable housing, continued therapy, vocational training, and social reintegration, women at Carmelita break cycles of institutionalization and homelessness while reclaiming agency over their lives. The program's commitment to allowing reentry after relapse ensures that setbacks do not result in permanent exclusion, fostering a recovery-oriented environment where women can receive the continued care they need.

However, there are challenges —particularly in securing consistent case management services and addressing systemic barriers such as housing shortages and employment limitations. Staffing shortages in county services have led to service gaps, making it difficult to sustain comprehensive wraparound care. Despite these obstacles, Carmelita House's strengths—including its small resident capacity, flexible funding, and pre-release engagement—allow for deeply personalized care that is rarely afforded to this population.

As research continues to highlight the intersection of trauma, mental illness, and substance use among incarcerated women, programs like Carmelita House provide a model for addressing these challenges through comprehensive, holistic, and trauma-centered interventions.

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[11] 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

[11] 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?

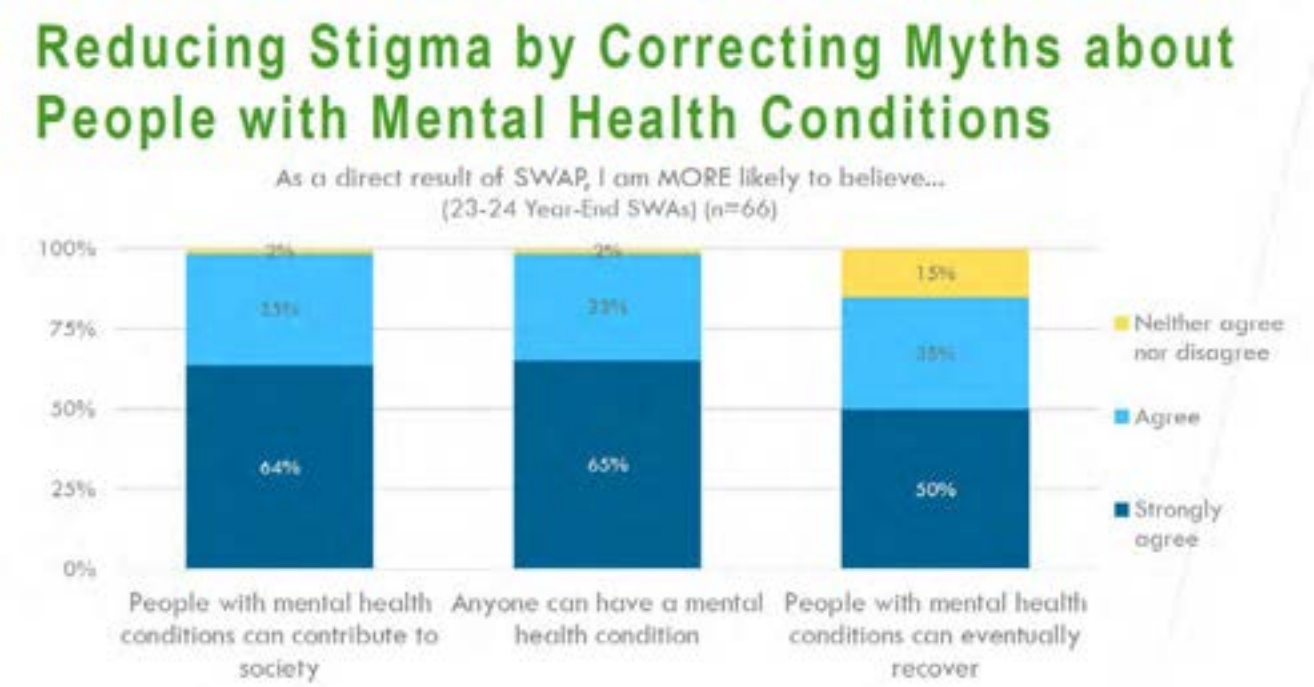
FY 23/24 OUTCOMES: The response rates for both baseline and year-end SWA surveys has been low in both 2022-23 and 2023-24. In 2023-24, the SWA survey response rate increased to 50%, up from 30% in 2022-23, for both the baseline survey and year-end survey. In In 2023-24 a total of 8 school districts were active in SWAP up from 4 in 2022-23. Most secondary students are now in SWAP districts, and 73% of Black, indigenous, and people of color (BIPOC) students attend districts that are now participating in SWAP.

In FY23/24 there were 8 trainings/events for SWAs and 2 site coordinator orientations.

- 99% of event participants (n=158) reported 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

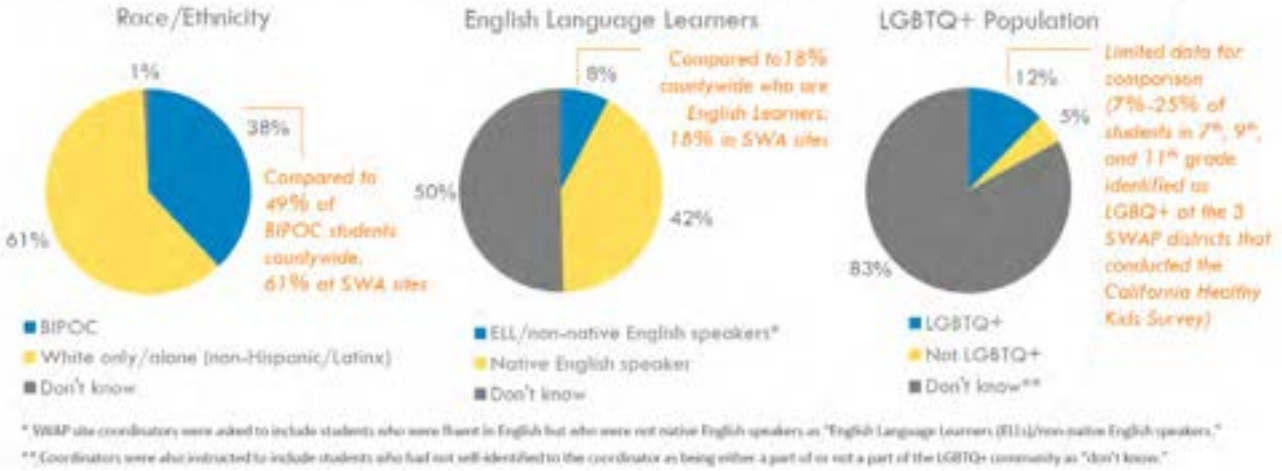
In 2023-24, site coordinators reported that 129 students participated as SWAs. The 66 SWAs who completed surveys expressed willingness to:

- Take action to prevent discrimination against people with mental health conditions: 91%
- Hang out with someone who had a mental health condition: 88%
- Actively and compassionately listen to someone in distress: 97%
- Seek support from a mental health professional if I thought I needed it: 71%
- Talk to a friend or family member if I thought I was experiencing emotional distress: 73%



SWA Demographics (reported by Site Coordinators)

In 2023-2024, 129 students (from 8 districts) participated as SWAs.

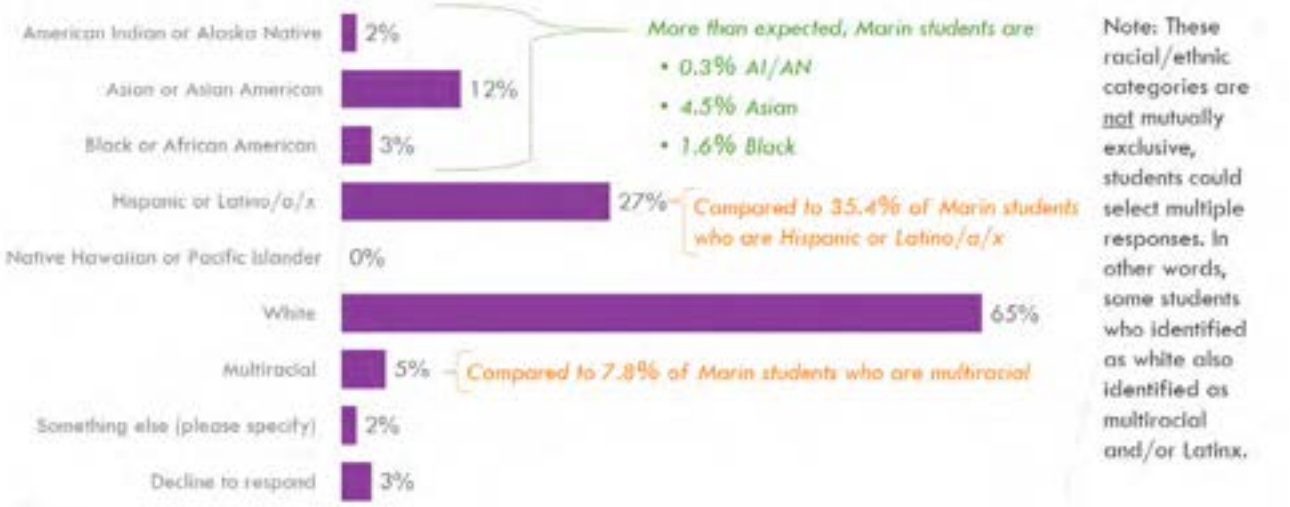


* SWAP site coordinators were asked to include students who were fluent in English but who were not native English speakers as "English Language Learners (ELLs)/non-native English speakers."

** Coordinators were also instructed to include students who had not self-identified to the coordinator as being either a part of or not a part of the LGBTQ+ community as "don't know."

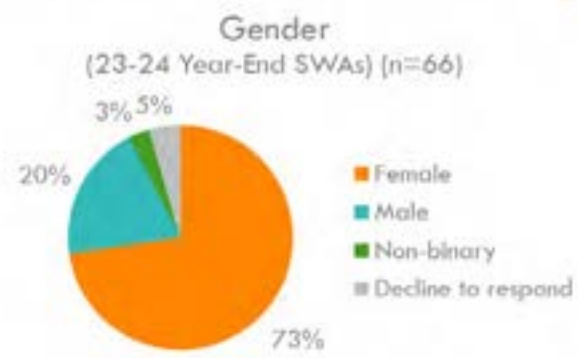
Race/Ethnicity of SWA Survey Participants

(23-24 Year-End SWAs) (n=66)

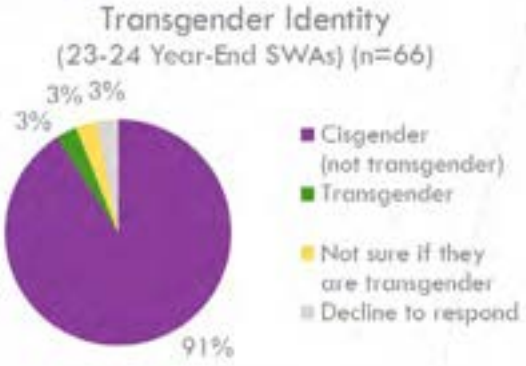


Note: These racial/ethnic categories are not mutually exclusive, students could select multiple responses. In other words, some students who identified as white also identified as multiracial and/or Latinx.

Gender of SWA Survey Participants

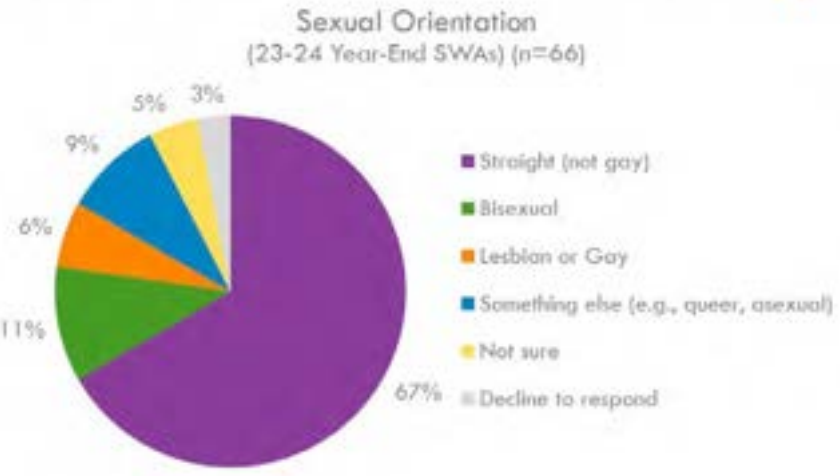


The California Department of Education reports annual enrollment data in the four gender categories listed above. In 2023-2024, 0.33% of 6th-12th grade students in Marin County (all districts, including charter and non-charter schools) identified in non-binary.



Marin school districts that participated in the 2022-23 California Healthy Kids Survey (CHKS) each had 94-100% of surveyed students identify as cisgender, 0-3% identify as transgender, 0-3% identify as not sure, and 0-5% decline to respond.

Sexual Orientation of SWA Survey Participants



For comparison, SWAP school districts that participated in the 2022-23 California Healthy Kids Survey (CHKS) had students in surveyed grades (7th, 9th, 11th, and non-traditional students) report the following demographics:

- 73-100% straight
- 0-14% bisexual
- 0-6% lesbian or gay
- 0-6% something else
- 0-9% not sure
- 0-5% decline to respond

CHANGES FOR FY25/26: Extend program through August 2026.

SWAP INNOVATIVE PROJECT EXTENSION PLAN

County Name: **Marin**
Project Title: **Student Wellness Ambassador Program (SWAP): A County-Wide Equity-Focused Approach** Public Hearing: **March 11, 2025**

Original Plan
Date of Original Approval: **9/23/2021 MHSOAC approval; 11/2/2021 BOS approval**
Project Start Date: **3/1/2022**
Project End Date: **6/30/2025**
Duration of Approved project: **3.5 years**
Original Approved budget: **$1,648,000**

Extension Plan
Request for additional funding: **$870,000**
New total budget: **$2,518,000**
Request for additional time: **Extend to 6/30/2026, will not exceed 5-year limitation**
Date of Extension Approval:

LEARNING OBJECTIVES

Has the primary purpose changed? **No**

What is the added value in learning with the extension?

The first year of the Student Wellness Ambassador Program (SWAP) focused on the creation and launch of the program while the two subsequent years focused on expansion. Evaluation data has shown improved awareness of behavioral health resources and enhanced meaningful connections with others among Student Wellness Ambassador participants. SWAP has been implemented in 8 of Marin's 16 school districts. This expansion will provide additional learning on how the program **builds upon its initial success, incorporates additional school sites and districts to achieve the goal of equitable county-wide student peer support, and implements the sustainability plan.** The extension will increase our understanding of advancing equity, capacity, and sustainability of student peer support in Marin schools and develop a model for other counties to replicate.

Learning Objectives:

1. Can a county-wide centralized coordination and training structure enhance the effectiveness and sustainability of student peer wellness support across Marin County schools?

2. Does centralizing student peer wellness support county-wide increased equity in who accesses peer support?

3. 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?

4. **How can we build upon the initial success, incorporate additional school sites and districts to achieve the goal of equitable county-wide student peer support, and implement the sustainability plan?**

Has the target population changed? **No**

OVERVIEW OF REQUESTS FOR ADDITIONAL FUNDING

What is the reason for the additional funds?

In the three years since SWAP began, SWA programs have been implemented at 11 school sites in 8 school districts across Marin. Evaluation of the program found improved awareness of behavioral health resources and increased meaningful connections with other students among participants. Initial learnings revealed SWAP has been received and supported differently across school sites and districts. The extension will aid expansion efforts to incorporate additional school sites and districts and strengthen sustainability efforts to integrate SWAP into existing school structures.

The extension will increase access to peer support services for all students, with a focus on expanding access for Black, indigenous, and people of color (BIPOC) students. At present, SWAs do not fully represent the diversity of the school communities they support. This additional year will allow for expanding BIPOC representation with the support of local stakeholders and CBOs with cultural and linguistic expert.

This extension will further our knowledge with regard to how the program builds upon its initial success, incorporate additional school sites and districts to achieve the goal of equitable county-wide student peer support, and implements the sustainability plan. The extension will deepen our understanding of advancing the equity, capacity, and sustainability of equitable student peer support in Marin schools and develop a model for other counties to replicate.

How will the county be utilizing the new funding?

- **Expand the number of students participating in SWAP through the inclusion of additional of school sites and districts**
- **Increase access for BIPOC students and ensure student peer support aligns with school and district demographics**
- **Implement a sustainability plan through integration with pre-existing school structures** (*Marin County Office of Education-1.0 FTE* SWAP Coordinator)

Additional funding will support the increasing the number of participating school sites and districts to achieve the goal of an equitable county-wide student peer support program. The expansion of SWAP to additional school settings will increase access to peer support programs for all Marin County students.

This expansion will ensure student peer support aligns with school and district demographics. This will be done through targeted recruitment of BIPOC SWAs, with additional support from local stakeholders and CBOs with specific cultural and linguistic expertise.

Funding will support the implementation of sustainability efforts led by the Marin County Office of Education SWA Coordinator position. The expansion will enable SWA programs to be incorporated into pre-existing school structures (e.g., wellness programming, school clubs, other peer led initiatives). Making the SWA program a school elective course is another potential sustainability strategy that will be pursued.

Has the evaluation budget changed?

An additional $35,000 is allocated to continue the evaluation project for one more year.

COMMUNITY PLANNING PROCESS

Public Comment Period: **November 14, 2024 – March 11, 2025**
Public Hearing: **March 11, 2025**

The proposal to extend SWAP for an additional year has been presented at several community planning meetings. Response from the public has been overwhelmingly in support of extending SWAP. One individual noted a request for more evaluation data, specifically from students who received peer support from a Student Wellness Ambassador.

A targeted meeting was held with Marin County students, Marin County school staff, and community-based organizations who all expressed their enthusiastic and unanimous support of extending SWAP for an additional year. Only comments of support were received such as, *"It is so cool to see how this program has grown and developed over the last few years! And I'm super grateful that I've gotten to be a part of it"* and *"we're so thankful to partner with SWAP and be able to work with and hear from youth directly on the kind of support they need in their schools, whether that's trainings for staff on building LGBTQ+ inclusive schools, student presentations, etc. It allows us to ensure that we're providing youth-led, culturally responsive support."*

Public Comments Received

Only comments of support were received during the Public Comment period and at the Public Hearing. One inquiry received from the Behavioral Health Services Oversight and Accountability Commission's Innovation inbox during the Public Comment period commended SWAP for, *"this initiative to support youth in their wellness journey."* A letter of support received from Marin 9 to 5 during the Public Comment period is attached to this proposal. Universal support was expressed at the Public Hearing. Individuals noted the importance of SWAP with regard to addressing stigma and its innovative use of student peer support to address the behavioral health needs of Marin County students. The Behavioral Health Board voted unanimously in favor of supporting the expansion of this innovation project.

OTHER

- How did the county originally plan on sustaining a successful INN plan in the original proposal? *If shown to be successful and cost-effective we would demonstrate the cost-effectiveness to the Marin County Office of Education to sustain funding. Since mentors are recruited from within the student population, fewer resources are needed over the long-term once the infrastructure has been established. There is an existing resource pool that can be tapped into for recruitment of new peers. In addition, peers can help train new cohorts of peer mentors to ensure sustainability. Funding to maintain SWAP when Innovation funding ends will be less than the annual costs of each Innovation project year.*

- If the county is saying the original INN plan is going well, and requesting for an extension, the county will need to explain the additional value added to their successful program by seeking an extension. *The first year of SWAP focused on the creation and launch of the program while the two subsequent years focused on expansion. Initial learnings revealed SWAP has been received and supported differently across school sites and districts. The extension will aid expansion efforts to incorporate additional school sites and districts and sustainability efforts to integrate SWAP into existing school structures. The extension would expand the number of students served, including a focus on expanding the number of BIPOC students served. The extension will deepen our understanding of advancing equity, capacity, and sustainability of student peer support in Marin schools.*

OTHER – BHSA ALIGNMENT AND SUSTAINABILITY

- Does it provide housing interventions for persons who are chronically homeless or experiencing homelessness or are at risk of homelessness? *No.*

- Does it support early intervention programs or approaches in order to prevent mental illnesses and substance abuse disorders from becoming severe and disabling? *The program supports a community based, youth-driven peer approach to reduce stigma, engage in mental health awareness and advocacy campaigns. Student Wellness Ambassadors engage in peer conversations, participate in wellness centered activities and meetings which build skills and efficacy, and offer peer support for students in need.*

- Does it support Full-Service Partnership efforts and services for individuals living with serious mental illness? *No.*

- How will the County continue the project, or components of the project, after its completion without the ability to utilize certain components of MHSA funding for sustainability? *The extension will allow for additional time to demonstrate the cost-effectiveness, for Marin County Office of Education to identify sustainable resources, and for SWAP to be integrated into existing school structures. Fewer resources are needed over the long-term once the infrastructure has been established.*

BUDGET

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*		
EXPENDITURES		
PERSONNEL COSTS (salaries, wages, benefits)		**FY 25/26**
1	Salaries	$0
	Benefits	$0
2	Direct Costs	$0
3	Indirect Costs	$0
4	Total Personnel Costs	$0
OPERATING COSTS		**FY 25/26**
5	Marin County Office of Education Expenses	$ 274,500.00
6	Sub-contracts with Community Based Organizations	$ 255,000.00
7	Sub-contracts with Trainers	$ 152,058.00
6	Indirect Costs	$ 102,233.70
7	Total Operating Costs	**$ 783,791.70**
NON RECURRING COSTS (equipment, technology)		**FY 25/26**
8	Non Recurring Costs	$ -
9	Total Non-recurring costs	$ -
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		**FY 25/26**
10	Evaluation Costs	$ 46,703.00
11	Indirect Costs	$ 7,005.30
12	Total Consultant Costs	**$ 53,708.30**

OTHER EXPENDITURES (please explain in budget narrative)		**FY 25/26**
13	Stipends for SWAs and stakeholder representatives	$ 28,260.87
14	Indirect Costs	$ 4,239.13
15	Total Other Expenditures	**$ 32,500.00**
EXPANSION PROPOSAL TOTAL		**FY 25/26**
Personnel (line 1)		$ -
Direct Costs (add lines 2, 5, 6, 7, and 10 from above)		$ 728,261.00
Indirect Costs (add lines 3, 6 and 11 from above)		$ 113,478.13
Non-recurring costs (line 9)		$ -
Other Expenditures (line 15)		$ 28,260.87
TOTAL BUDGET		**$ 870,000.00**

* For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

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	$961,750	$1,927,600	note: project total is $2,518,000 including past fiscal years
Admin/Indirect for INN is included in each Project Budget					
Total	**$1,349,247**	**$998,495**	**$1,471,843**	**$3,819,585**	

WORKFORCE EDUCATION AND TRAINING (WET)

MHSA ALLOCATION FY25/26: $472,691 transfer to Workforce Education and Training to support ongoing training needs associated with BHSA mandated evidence-based practices. WET funds are available for 10 years, so this transfer in FY25/26 allows for the funding to be spread throughout the next decade for training needs.

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 FY2023-24 through 2025-26 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.

The County of Marin's WET Coordinator is:

Rebecca Stein, PsyD
BHRS Unit Supervisor
WET (Workforce, Education, and Training) Program
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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.

FY23/24 ACTIVITIES: Training, technical assistance, consultation, and curriculum development. Some of these trainings included:

- The County of Marin online, on demand PESI clinical training portal for all Marin County PMHS clinicians and staff offering 19 courses and up to a total of 93 Continuing Education Units.
- Behavioral Health Interpreters Trainings offered through National Latino Behavioral Health Association
- Trauma-informed LGBTQ + clinical training series provided by Natasha Ellerin and associates, including topics such as Eating Disorders, Body Image, and Domestic Violence in the LGBTQ+ community
- Understanding Black Male Grief training provided by Dr Allen Lipscomb
- Culturally Responsive Trauma Responsiveness training provided by Dr Bryan Rojas-Araúz
- Equity Plan consultation with Jeong Coaching and Consultation
- Consultation and preparation for the FY 24/25 Latine Learning Academy with Crossing Edge Consulting

- Clinical Supervision for unlicensed staff and contractors through Wayfinder

CHANGES FOR FY25/26: None.

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.

FY23/24 ACTIVITES:

- The Scholarship program had 4 limited cycles in FY 23/24
- Peer Internships were funded through Community Partner Agencies such as the Enterprise Resource Center, the Multi-Cultural Center of Marin, and Marin City Community Development Clubhouse
- Peer Certification Training, Testing, and Certification through CalMHSA was funded for staff and PMHS peers

CHANGES FOR FY25/26: None.

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 FY22/23 BHRS added 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.

OUTCOMES FOR FY23/24: The Greater Bay Area Regional Partnership Loan Repayment Program was launched by CalMHSA in FY21/22. In Marin:

- Post Residency Fellow was funded for the duration of her training year, supporting group programming and therapy services for Behavioral Health and Recovery Services
- No loan repayment awards were offered in FY23/24
- Stipends were provided to Maters Level Interns training in Behavioral Health and Recovery Services
- Stipends for field-based expenditures were provided to Behavioral Health and Recovery Program Psychology Interns
- Stipends were provided to Peer interns working in the PMHS

CHANGES FOR FY25/26: None.

WORKFORCE STAFFING SUPPORT

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

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

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

FUNDING CATEGORY: Workforce Staffing Support

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

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

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

CHANGES FOR FY25/26: 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**

FY25/26 transfer	$472,691
Existing fund balance	$135,372

CAPITAL FACILITIES AND TECHNOLOGY NEEDS (CFTN)

MHSA ALLOCATION FY25/26: $2,000,000 transfer to Capital Facilities and Technology Needs to support ongoing Health Information Technology System needs and to make funding available for the Behavioral Health Continuum Infrastructure Program (BHCIP) bond match. CFTN funds are available for 10 years, so this transfer in FY25/26 allows for the funding to be spread across the next decade to address a portion of the capital facility and technology needs of the department.

ELECTRONIC HEALTH RECORD AND PRACTICE MANAGEMENT SYSTEM ENHANCEMENTS

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).

FY23/24 OUTCOMES: New EHR platform, SmartCare, launched in July 2023 has allowed for data tracking, information exchange, and transparency around service utilization and disparities.

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 are not 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 quickly changed the way behavioral health services are offered, BHRS dedicated resources to strengthen telehealth options, including the ability to provide group services via telehealth. This funding allowed 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.

The telehealth platform allows clients to log into virtual appointments remotely and the lobby administrator places clients into virtual meeting rooms to meet with their treatment provider. These services are provided between 8:00 a.m. and 8:00 p.m. Monday through Friday, (with an option of Saturdays as needed), excluding County holidays.

The virtual telehealth clinic platform and lobby administration provides a secure platform for those seeking mental health and substance use services. BHRS strives to have safe and widely accessible service options for our clients, and telehealth has been vital in delivering quality care and treatment to clients who have limited transportation or means to get to a clinic location. A virtual environment for telehealth allows for services to clients who may not otherwise seek treatment due to community stigma, organizational difficulties, transportation barriers, and time constraints.

The virtual clinic is available to all clients of BHRS without regard to race, ethnicity, religion, socio-economic status, sex, sexual orientation, gender expression, age, national origin, disability or other State and Federal protected classes. Lobby administration is provided in a linguistically and culturally appropriate manner, and the lobby attendants can communicate in English and Spanish as needed. Should the client require services in another language, an appropriate interpreter will be scheduled to participate.

BHRS is looking to install virtual clinic Kiosk locations in areas of the county that are being underserved. Potential sites include community spaces and satellite sites.

CAPITAL FACILITY PROJECT

PROGRAM DESCRIPTION: In alignment with Proposition 1 and local community input, funding transferred into CFTN will be available for a Behavioral Health Continuum Infrastructure Program (BHCIP) bond match. The availability of a BHCIP bond match will support expanding the capacity of behavioral health care facilities for those in need. BHCIP requires entities receiving awards to provide matching funds or real property as specified in Welfare and Institutions Code 5960.15. Specifically, local governments are required to match 10% of funds and only funds that can be used for capital development expenses can be pledged.

The stated goals of BHCIP are advancing both racial and geographic equity through the investment in behavioral health infrastructure. Additionally, BHCIP seeks to address gaps in the care continuum for individuals with behavioral health conditions through the establishment of inclusive, accessible, and supportive environments.

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
Capital Facility Project			$2,000,000	$2,000,000
Admin/Indirect	$255,015	$211,189	$241,713	$707,917
TOTAL	**$1,955,116**	**$1,619,116**	**$3,649,640**	**$7,223,872**

FY25/26 transfer	$3,176,949
Existing fund balance	$472,691

TOTAL BUDGET

	FY23/24	FY24/25	FY25/26	Total
Community Services and Supports (CSS)	$26,070,738	$16,774,527	$21,227,377	$64,072,642
Prevention and Early Intervention (PEI)	$4,840,786	$4,538,083	$4,768,083	$14,146,952
Capital Facilities and Technology Needs (CFTN)	$1,955,116	$1,619,116	$3,649,640	$7,223,872
Workforce Education and Training (WET)	$956,295	$608,063	$608,063	$2,172,421
Innovation (INN)	$1,349,247	$998,495	$1,471,843	$3,819,585
TOTAL	$35,172,181	$24,538,284	$31,725,006	$91,435,471

APPENDIX 1: ANNUAL PREVENTION AND EARLY INTERVENTION (PEI) REPORT

To be added.

APPENDIX 2: ANNUAL INNOVATION (INN) REPORT

To be added.

APPENDIX 3: MHSA COUNTY COMPLIANCE CERTIFICATION

To be added.

APPENDIX 4: MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

To be added.

APPENDIX 5: BOARD OF SUPERVISORS APPROVAL

To be added.