2026 - 2029 Integrated Plan
Marin County

The Behavioral Health Services Act (BHSA) requires counties to submit three-year Integrated Plans (IPs) for Behavioral Health Services and Outcomes. For related policy information, refer to 3.A. Purpose of the Integrated Plan .

General Information

County, City, Joint Powers, or Joint Submission
County

Entity Name
Marin County

Behavioral Health Agency Name
Marin County Department of Health & Human Services, Division of Behavioral Health & Recovery Services

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Quality Assurance or Quality Improvement (QA/QI) lead

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Medical Director

Name	Email address
Amit Rajparia, MD	Amit.Rajparia@MarinCounty.gov

County Behavioral Health System Overview

Please provide the city/county behavioral health system (inclusive of mental health and substance use disorder) information listed throughout this section. The purpose of this section is to provide a high-level overview of the city/county behavioral health system's populations served, technological infrastructure, and services provided. This information is intended to support city/county planning and transparency for stakeholders. The Department of Health Care Services recognizes that some information provided in this section is subject to change over the course of the Integrated Plan (IP) period. All data should be based on FY preceding the year plan development begins (i.e., for 2026-2029 IP, data from FY 2023-2024 should be used).

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 3.E.2 General Requirements .

Populations Served by County Behavioral Health System

Includes individuals that have been served through the county Medi-Cal Behavioral Health Delivery System and individuals served through other county behavioral health programs. Population-level behavioral health measures, including for untreated behavioral health conditions, are covered in the Statewide Behavioral Health Goals section and County Population-Level Behavioral Health Measure Workbook. For related policy information, refer to 2.B.3 Eligible Populations and 3.A.2 Contents of the Integrated Plan .

Children and Youth

In the table below, please report the number of children and youth (under 21) served by the county behavioral health system who meet the criteria listed in each row. Counts may be duplicated as individuals may be included in more than one category.

Criteria	Number of Children and Youth Under Age 21
Received Medi-Cal Specialty Mental Health Services (SMHS)	97%
Received at least one substance use disorder (SUD) individual-level prevention and/or early intervention service	571
Received Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) services	5%
Received mental health (MH) and SUD services from the mental health plan (MHP) and DMC county or DMC-ODS plan	1%
Accessed the Early Psychosis Intervention Plus Program, pursuant to Welfare and Institutions Code Part 3.4 (commencing with section 5835), Coordinated Specialty Care, or other similar evidence-based practices and community-defined evidence practices for early psychosis and mood disorder detection and intervention programs	20

Criteria	Number of Children and Youth Under Age 21
Were chronically homeless or experiencing homelessness or at risk of homelessness	9
Were in the juvenile justice system	21
Have reentered the community from a youth correctional facility	2
Were served by the Mental Health Plan and had an open child welfare case	1%
Were served by the DMC County or DMC-ODS plan and had an open child welfare case	1%
Have received acute psychiatric care	52

Adults and Older Adults

In the table below, please report the number of adults and older adults (21 and older) served by the county behavioral health system who meet the criteria listed in each row. Counts may be duplicated as individuals may be included in more than one category.

Criteria	Number of Adults and Older Adults
Were dual-eligible Medicare and Medicaid members	654

Criteria	Number of Adults and Older Adults
Received Medi-Cal SMHS	70%
Received DMC or DMC-ODS services	54%
Received MH and SUD services from the MHP and DMC county or DMC-ODS plan	12%
Were chronically homeless, or experiencing homelessness, or at risk of homelessness	540
Experienced unsheltered homelessness	000
Moved from unsheltered homelessness to being sheltered (emergency shelter, transitional housing, or permanent housing)	000
Of the total number of those who moved from unsheltered homelessness to being sheltered, how many transitioned into permanent housing	000
Were in the justice system (on parole or probation and not currently incarcerated)	55
Were incarcerated (including state prison and jail)	146

Criteria	Number of Adults and Older Adults
Reentered the community from state prison or county jail	55
Received acute psychiatric services	228

Input the number of persons in designated and approved facilities who were

Admitted or detained for 72-hour evaluation and treatment rate
77%

Admitted for 14-day and 30-day periods of intensive treatment
23%

Admitted for 180-day post certification intensive treatment
0%

Please report the total population enrolled in Department of State Hospital (DSH) Lanterman-Petris-Short (LPS) Act programs
1382

Please report the total population enrolled in DSH community solution projects (e.g., community-based restoration and diversion programs)
1

Of the data reported in this section, are there any areas where the county would like to provide additional context for DHCS's understanding?
Yes

Please explain
There are certain data points that are being requested that the county is currently unable to provide. For example, questions around homelessness cannot be answered as our Electronic Health Record does have some of the categories requested above and we cannot differentiate between such categories as Experienced unsheltered homelessness, Moved from unsheltered homelessness to being sheltered, Moved from unsheltered homelessness to being sheltered, etc. Marin is examining solutions to address how this data is captured in the EHR. Data regarding clients who were part of the justice system is not comprehensive.

Please describe the local data used during the planning process
FY23/24 data used

If desired, provide documentation on the local data used during the planning process (optional)

County Behavioral Health Technical Infrastructure

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Does the county behavioral health system use an Electronic Health Record (EHR)?
Yes

Please select which of the following EHRs the county uses
SmartCare

County participates in a Qualified Health Information Organization (QHIO)?
Yes

Please select which QHIO the county participates in
Connex
SacValley MedShare

Application Programming Interface Information

Counties are required to implement Application Programming Interfaces (API) in accordance with Behavioral Health Information Notice (BHIN) 22-068 and federal law.

Please provide the link to the county's API endpoint on the county behavioral health plan's website
https://www.marinbhrs.org/clients-caregivers/api-application-programming-interface

Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

Counties are required to meet admission, discharge, and transfer data sharing requirements as outlined in the attachments to BHINs 23-056 , 23-057 , and 24-016 . Does the county wish to disclose any implementation challenges or concerns with these requirements?
No

County Behavioral Health System Service Delivery Landscape

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to 6.C.1 Promoting Access to Care Through Efficient Use of State and County Resources Introduction .

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH) Grant

Will the county participate in SAMHSA's PATH Grant during the Integrated Plan period?
No

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Community Mental Health Services Block Grant (MHBG)

Will the county behavioral health system participate in any MHBG set-asides during the Integrated Plan period?
Yes

Please select all set asides that the county behavioral health system plans to participate in under the MHBG
Children's System of Care Set-Aside
Discretionary/Base Allocation
First Episode Psychosis Set-Aside

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)

Will the county behavioral health system participate in any SUBG set asides during the Integrated Plan period?
Yes

Please select all set-asides that the county behavioral health system participates in under SUBG

Adolescent/Youth Set-Aside
Discretionary
Perinatal Set-Aside
Primary Prevention Set-Aside

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Opioid Settlement Funds (OSF)

Will the county behavioral health system have planned expenditures for OSF during the Integrated Plan period?
Yes

Please check all set asides the county behavioral health system participates in under OSF Exhibit E
Connect People Who Need Help to The Help They Need (Connections to Care)
First Responders
Leadership, Planning, and Coordination
Prevent Misuse of Opioids
Prevent Overdose Deaths and Other Harms (Harm Reduction)
Support People in Treatment and Recovery
Treat Opioid Use Disorder (OUD)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Bronzan-McCorquodale Act

The county behavioral health system is mandated to provide the following community mental health services as described in the Bronzan-McCorquodale Act (BMA).

a. Case Management
b. Comprehensive Evaluation and Assessment
c. Group Services
d. Individual Service Plan
e. Medication Education and Management
f. Pre-crisis and Crisis Services
g. Rehabilitation and Support Services
h. Residential Services
i. Services for Homeless Persons
j. Twenty-four-hour Treatment Services
k. Vocational Rehabilitation

In addition, BMA funds may be used for the specific services identified in the list below. Select all services that are funded with BMA funds:
N/A

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Public Safety Realignment (2011 Realignment)

The county behavioral health system is required to provide the following services which may be funded under the Public Safety Realignment (2011 Realignment)

a. Drug Courts
b. Medi-Cal Specialty Mental Health Services, including Early Periodic Screening Diagnostic Treatment (EPSDT)
c. Regular and Perinatal Drug Medi-Cal Services
d. Regular and Perinatal DMC Organized Delivery System Services, including EPSDT
e. Regular and Perinatal Non-Drug Medi-Cal Services

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Medi-Cal Specialty Mental Health Services (SMHS)

The county behavioral health system is mandated to provide the following services under SMHS authority (no action required).

a. Adult Residential Treatment Services
b. Crisis Intervention
c. Crisis Residential Treatment Services
d. Crisis Stabilization
e. Day Rehabilitation
f. Day Treatment Intensive
g. Mental Health Services
h. Medication Support Services
i. Mobile Crisis Services
j. Psychiatric Health Facility Services
k. Psychiatric Inpatient Hospital Services
l. Targeted Case Management
m. Functional Family Therapy for individuals under the age of 21
n. High Fidelity Wraparound for individuals under the age of 21
o. Intensive Care Coordination for individuals under the age of 21
p. Intensive Home-based Services for individuals under the age of 21
q. Multisystemic Therapy for individuals under the age of 21
r. Parent-Child Interaction Therapy for individuals under the age of 21
s. Therapeutic Behavioral Services for individuals under the age of 21

t. Therapeutic Foster Care for individuals under the age of 21
u. All Other Medically Necessary SMHS for individuals under the age of 21

Has the county behavioral health system opted to provide the specific Medi-Cal SMHS identified in the list below as of June 30, 2026?
Clubhouse Services
CSC for FEP
IPS Supported Employment

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Drug Medi-Cal (DMC)/Drug Medi-Cal Organized Delivery System (DMC-ODS)

Select which of the following services the county behavioral health system participates in
DMC-ODS **Program**

Drug Medi-Cal Organized Delivery System (DMC-ODS)
The county behavioral health system is mandated to provide the following services as a part of the DMC-ODS Program (DHCS currently follows the guidance set forth in the American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition). (no action required)
a. Care Coordination Services
b. Clinician Consultation
c. Outpatient Treatment Services (ASAM Level 1)
d. Intensive Outpatient Treatment Services (ASAM Level 2.1)
e. Medications for Addiction Treatment (MAT), Including Narcotics Treatment Program (NTP) Services
f. Mobile Crisis Services
g. Recovery Services
h. Residential Treatment services (ASAM Levels 3.1, 3.3., 3.5)
i. Traditional Healers and Natural Helpers
j. Withdrawal Management Services
k. All Other Medically Necessary Services for individuals under age 21 for individuals under age 21
l. Early Intervention for individuals under age 21

Has the county behavioral health system opted to provide the specific Medi-Cal SUD services identified in the list below as of June 30, 2026?
Peer Support Services
Recovery Incentives Program (Contingency Management)

Does the county wish to disclose any implementation challenges or concerns with the requirements under this program?
No

Other Programs and Services

Please list any other programs and services the county behavioral health system provides through other federal grants or other county mental health and SUD programs

Program or service
N/A

Care Transitions

Has the county implemented the state-mandated Transition of Care Tool for Medi-Cal Mental Health Services **(Adult and Youth)?**
Yes

Does the county's Memorandum of Understanding include a description of the system used to transition a member's care between the member's mental health plan and their managed care plan based upon the member's health condition?
Yes

Statewide Behavioral Health Goals

All fields must be completed unless marked as optional. You don't need to finish everything at once-your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to, please see 3.E.6 Statewide behavioral health goals

Population-Level Behavioral Health Measures

The statewide behavioral health goals and associated population-level behavioral health measures must be used in the county Behavioral Health Services Act (BHSA) planning process and should inform resource planning and implementation of targeted interventions to improve outcomes for the fiscal year(s) being addressed in the IP. For more information on the statewide behavioral health goals, please see the Policy Manual Chapter 2, Section C .

Please review your county's status on each population-level behavioral health measure, including the primary measures and supplemental measures for each of the 14 goals. All measures are publicly available, and counties are able to review their status by accessing the measures via DHCS-provided instructions and the County Population-Level Behavioral Health Measure Workbook.

As part of this review, counties are required to evaluate disparities related to the six priority statewide behavioral health goals. Counties are encouraged to use their existing tools, methods, and systems to support this analysis and may also incorporate local data sources to strengthen their evaluation.

Please note that several Phase 1 measures include demographic stratifications – such as race, sex, age, and spoken language – which are included in the prompts below. Counties may also use local data to conduct additional analyses beyond these demographic categories.

For related policy information, refer to E.6.1 Population-level Behavioral Health Measures .

Mark page as complete

Priority statewide behavioral health goals for improvement

Counties are required to address the six priority statewide behavioral health goals in this section. Cities should utilize data that corresponds to the county they are located within. As such, the City of Berkeley should use data from Alameda County and Tri-City should use data from Los Angeles County. For related policy information, refer to E.6.2 Primary and Supplemental Measures .

Access to care: Primary measures

Specialty Mental Health Services (SMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity

Non-Specialty Mental Health Services (NSMHS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Above

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity

Drug Medi-Cal (DMC) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
N/A

For children/youth
N/A

What disparities did you identify across demographic groups or special populations?
N/A

Drug Medi-Cal Organized Delivery System (DMC-ODS) Penetration Rates for Adults and Children & Youth (DHCS), FY 2022 - 2023

How does your county status compare to the statewide rate?

For adults/older adults
Above

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Access to care: Supplemental Measures

Initiation of Substance Use Disorder Treatment (IET-INI) (DHCS), FY 2023

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Access to care: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Marin was below the county-level rates among Asian American/Pacific Islander, Latino, and American Indian/Alaska Native adults and adults ages 21-44 with regard to Specialty Mental Health Services (SMHS) penetration rates. The

Marin County Non-Specialty Mental Health Service (NSMHS) penetration rate was below the county-level rates among Asian American/Pacific Islander adults. Initiation of Substance Use Disorder Treatment indicated Marin was below the Statewide rate. Marin DMC-ODS Penetration Rates showed the penetration rates among Latino and Asian/Pacific Islander groups fell below county-level rates.

With regard to Access to Care for children and youth, Marin County was below the Statewide rate with regard to SMHS Penetration Rates for Children and Youth. Additionally, SMHS rates for Marin were below county-level rates for males, American Indian/Alaska Native, Asian American/Pacific Islander, and Latino children and youth and for ages 0-11. NSMHS rates for Marin were below the county-level rates among males, Black/African American and Asian American/Pacific Islander children and youth, and for ages 6-11. DMC-ODS penetration rate for children and youth indicated Marin County was below the Statewide rate.

Access to care: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

- Strengthen outreach and engagement efforts that move beyond awareness-building to ensure identified individuals are directly connected to SMHS treatment through warm hand-offs and closed-loop referral systems.
- Expand place-based services in West and South Marin to increase access to treatment
- Capitalize on new Assertive Field-Based Substance Use Disorder services to meet clients where they are to provide on-the-spot assessments and immediate linkage to care
- Partner with MCPs to develop pathways for MCPs to identify and refer members needing specialty mental health or SUD treatment
- Housing interventions outreach and engagement to utilize transitional housing, shelters, and supportive housing as touchpoints for behavioral health screening and treatment linkage
- Partner with CBOs to expand behavioral health outreach, screenings, treatment, and support closed-loop referrals
- Strengthen outreach and engagement efforts that move beyond awareness-building to ensure identified individuals are directly connected to SMHS treatment through warm hand-offs and closed-loop referral systems.
- Strengthen adolescent SUD treatment services through new Assertive Field-Based Substance Use Disorder services to meet clients where they are to provide on-the-spot assessments and immediate linkage to care
- Partner with MCPs to develop pathways for MCPs to identify and refer

members needing specialty mental health or SUD treatment
- Partner with CBOs to expand early intervention outreach, screenings, treatment, and support closed-loop referrals

Please identify the category or categories of funding that the county is using to address the access to care goal
BHSA Behavioral Health Services and Supports (BHSS)
2011 Realignment
Federal Financial Participation (SMHS, Drug Medi-Cal/Drug Medi-Cal Organized Delivery System (DMC/DMC-ODS)

Homelessness: Primary measures

People Experiencing Homelessness Point-in-Time Count (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Below

What disparities did you identify across demographic groups or special populations?
Age
Sex
Race or Ethnicity

Homeless Student Enrollment by Dwelling Type, California Department of Education (CDE), 2023 - 2024

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Homelessness: Supplemental Measures

PIT Count Rate of People Experience Homelessness with Severe Mental Illness, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

PIT Count Rate of People Experience Homelessness with Chronic Substance Abuse, (Rate per 10,000 people by Continuum of Care Region) (HUD), 2024

How does your county status compare to the PIT Count Rate out of every 10,000 people by Continuum of Care region?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

People Experiencing Homelessness Who Accessed Services from a Continuum of Care (CoC) Rate (BCSH), 2023 (This measure will increase as people access services.)

How does your local CoC's rate compare to the average rate across all CoCs?
Below

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity

Homelessness: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Adults ages 18-44, males, and Native Hawaiian/Pacific Islander, Black/African American, Latino, and American Indian/Alaska Native groups were overrepresented in the Point-In-Time Count Rate of People Experiencing Homelessness. According to the CA Department of Education Housing Status of K-12 students, Latino students in Marin were overrepresented in the number of students experiencing homelessness with the majority identified as having a housing status as "temporarily doubled up." Males, individuals under the age of 18, ages 25-44, and Black/African American, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Latino groups were more likely to access CoC services.

Homelessness: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of homelessness in the population experiencing

severe mental illness, severe SUD, or co-occurring conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

- Housing interventions outreach and engagement to utilize transitional housing, shelters, and supportive housing as touchpoints for behavioral health screening and treatment linkage
- Partner with MCPs to connect unhoused or housing-unstable clients to ECM and housing-related Community Supports
- Partner with Community Resiliency Teams to increase successful navigation of access points to behavioral health and housing services
- Partner with Homelessness and Coordinated Care to both strengthen outreach and engagement and to identify and prioritize clients with unmet behavioral health needs
- Strengthen Behavioral Health Bridge Housing services with the goal of improving permanent housing, recovery, and behavioral health outcomes
- Pair bilingual/bicultural peers with homeless outreach teams in high-volume service areas (shelters, encampments, food distribution sites) to provide on-the-spot screening, harm reduction services, and referrals

Please identify the category or categories of funding that the county is using to address the homelessness goal

BHSA FSP
BHSA Housing Interventions
1991 Realignment
MHBG

Institutionalization

Per 42 CFR 435.1010, an institution is "an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor." Institutional settings are intended for individuals with conditions including, but not limited to, behavioral health conditions.

Care provided in inpatient and residential (i.e., institutional) settings can be clinically appropriate and is part of the care continuum. Here, institutionalization refers to individuals residing in these settings longer than clinically appropriate. Therefore, the goal is not to reduce stays in institutional settings to zero. The focus of this goal is on reducing stays in institutional settings that provide a Level of Care that is not – or is no longer – the least restrictive environment. (no action)

Institutionalization: Primary Measures

Inpatient administrative days (DHCS) rate, FY 2023 How does your county status compare to the statewide rate/average?

For adults/older adults
Data Unavailable

For children/youth
Data Unavailable

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Institutionalization: Supplemental Measures

Involuntary Detention Rates, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

14-day involuntary detention rates per 10,000
Below

30-day involuntary detention rates per 10,000
Above

180-day post-certification involuntary detention rates per 10,000
Same

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Conservatorships, FY 2021 - 2022

How does your county status compare to the statewide rate/average?

Temporary Conservatorships
Same

Permanent Conservatorships
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

SMHS Crisis Service Utilization (Crisis Intervention, Crisis Residential Treatment Services, and Crisis Stabilization) (DHCS), FY 2023
Increasing access to crisis services may reduce or prevent unnecessary admissions to institutional facilities

How does your county status compare to the statewide rate/average?

Crisis Intervention

For adults/older adults
Below

For children/youth
Below

Crisis Residential Treatment Services

For adults/older adults
Below

For children/youth
Data Unavailable

Crisis Stabilization

For adults/older adults
Above

For children/youth
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Institutionalization: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Marin County was higher than Statewide SMHS Crisis Stabilization and 30-Day Involuntary Detention rates. When compared to county-level rates, Marin had higher Crisis Intervention rates among adults ages 45-56, 69+ and White individuals. Crisis Stabilization youth rates were higher among males, ages 18-20, and Black and Latino groups. Compared to county-level rates, Marin had higher Crisis Stabilization rates among adults ages 69+.

Institutionalization: Cross-Measure Questions

What additional local data do you have on the current status of institutionalization in your county? (Example: utilization of Mental Health Rehabilitation Center or Skilled Nursing Facility-Special Treatment Programs)
N/A

File Upload (optional)

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's rate of institutionalization. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., enhancing crisis response services targeting a sub-population in which data demonstrates they have poorer outcomes)

- Early intervention to support individuals experiencing a behavioral health crisis (e.g., warm lines, support groups, drop-in centers, Community Resiliency Teams)
- Strengthen Mobile Crisis Response Team and Crisis Aftercare Team to reduce need for stabilization and/or residential
- Develop voluntary, short-term, peer respite option for individuals in crisis. Ensure respite centers are connected to warm lines, MCRT, and outpatient behavioral health programs.

File Upload (optional)

Please identify the category or categories of funding that the county is using to address the institutionalization goal
BHSA BHSS
BHSA FSP
BHSA Housing Interventions
1991 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Justice-Involvement: Primary Measures

Arrests: Adult and Juvenile Rates (Department of Justice), Statistical Year 2023

How does your county status compare to the statewide rate/average?

For adults/older adults
Below

For juveniles
Above

What disparities did you identify across demographic groups or special populations?
Race or Ethnicity
Sex
Age

Justice-Involvement: Supplemental Measures

Adult Recidivism Conviction Rate (California Department of Corrections and Rehabilitation (CDCR)), FY 2019 - 2020

How does your county status compare to the statewide rate/average?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Incompetent to Stand Trial (IST) Count (Department of State Hospitals(DSH)), FY 2023 Note: The IST count includes all programs funded by DSH, including, state hospital, Jail Based Competency Treatment (JBCT), waitlist, community inpatient facilities, conditional release, community-based restoration and diversion programs. However, this count excludes county-funded programs. As such, individuals with Felony IST designations who are court-ordered to county-funded programs are not included in this count.

How does your county status compare to the statewide rate/average?
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Justice-Involvement: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Adults ages 20-39, Black/African American, Latino, and males were overrepresented in both felony and misdemeanor arrests in Marin County. Similarly, Black/African American, Latino, and male juveniles were overrepresented in felony and misdemeanor arrests in Marin County.

Justice-Involvement: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of justice-involvement for those living with significant behavioral health needs. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

- Utilize CalAIM funding streams to provide Enhanced Care Management (ECM), Community Supports, and case management for individuals leaving jail or prison.
- Ensure justice-involved individuals are connected to specialty mental health and SUD treatment immediately upon release.
- Create partnerships with probation, MCPs, and CBOs to expand behavioral health screenings and support closed-loop referrals
- New expansion of Crisis Intervention Training with emphasis on implicit bias
- Partner with Community Resiliency Teams to increase successful navigation of access points to behavioral health and housing services
- Strengthen early intervention services for youth and young adults (ages 16–25) at risk of arrest, including behavioral health supports
- Improve language access in reentry and jail-based services. Ensure all screening, treatment, and case management services in jail are linguistically and culturally appropriate. Translate reentry planning materials/packets, peer navigation resources, and community referrals.

Please identify the category or categories of funding that the county is using to address the justice-involvement goal

BHSA BHSS
BHSA FSP
2011 Realignment
Federal Financial Participation (SMHS, DMC/DMC-ODS)

Removal Of Children from Home: Primary Measures

Children in Foster Care (Child Welfare Indicators Project (CWIP)), as of January 2025

How does your county status compare to the statewide rate?

Below

What disparities did you identify across demographic groups or special populations?

Race or Ethnicity

Removal Of Children from Home: Supplemental Measures

Open Child Welfare Cases SMHS Penetration Rates (DHCS), 2022

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
Age
Race or Ethnicity
Sex

Child Maltreatment Substantiations (CWIP), 2022

How does your county status compare to the statewide rate?
Below

What disparities did you identify across demographic groups or special populations?
None Identified

Removal Of Children from Home: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Open Child Welfare Case SMHS Penetration Rates revealed lower rates for Marin County in comparison to Statewide rates and county-level rates with regard to White, Latino, female, and youth ages 0-5 and 18-20. Moreover, Latino children were overrepresented in the Point in Time/In Care Counts of children in foster care.

Removal Of Children from Home: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may increase your county's level of access to care. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships, or initiatives the county is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes

- Strengthen referral pathway between Marin Children and Family Services Family Preservation and BHRS to provide behavioral health supports to prevent a

case from being opened
- Formalize referral pathways so that Marin Child and Family Services (CFS) consistently refers families with open child welfare cases to BHRS
- Enroll eligible children and families in ECM to improve care coordination between CFS, BHRS, and MCPs. Leverage CalAIM housing and family stabilization supports for child welfare–involved families at risk of homelessness.
- Strengthen trauma-informed, culturally responsive, and linguistically appropriate parenting groups. Incorporate lived-experience family partners who can support parents navigating both CFS and BHRS.
- Ensure early childhood early intervention programs assess for neglect and maltreatment. Strengthen closed-loop referral systems.

File Upload (optional)

Please identify the category or categories of funding that the county is using to address the removal of children from home goal
BHSA BHSS
BHSA FSP
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)
MHBG

Untreated Behavioral Health Conditions: Primary Measures

Follow-Up After Emergency Department Visits for Substance Use (FUA-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Follow-Up After Emergency Department Visits for Mental Illness (FUM-30), 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Untreated Behavioral Health Conditions: Supplemental Measures

Adults that needed help for emotional/mental health problems or use of alcohol/drugs who had no visits for mental/drug/alcohol issues in past year (CHIS), 2023

How does your county status compare to the statewide rate?

For the full population measure
Below

What disparities did you identify across demographic groups or special populations?
No Disparities Data Available

Untreated Behavioral Health Conditions: Disparities Analysis

For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
N/A

Untreated Behavioral Health Conditions: Cross-Measure Questions

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may reduce your county's level of untreated behavioral health conditions. In your response, please describe how you plan to address measures where your status is below the statewide average or median, within the context of local needs. Additionally, please refer to any data that was used to inform new programs, services, partnerships or initiatives the count is implementing (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)

- Strengthen outreach and engagement efforts that move beyond awareness-building to ensure identified individuals are directly connected to SMHS treatment through warm hand-offs and closed-loop referral systems.
- Capitalize on new Assertive Field-Based Substance Use Disorder services to meet clients where they are to provide on-the-spot assessments and immediate linkage to care
- Partner with CBOs to expand early intervention outreach, screenings, treatment, and support closed-loop referrals

Please identify the category or categories of funding that the county is using to address the untreated behavioral health conditions goal
BHSA BHSS
BHSA FSP

Additional statewide behavioral health goals for improvement

Please review your county's status on the remaining eight statewide behavioral health goals using the primary measure(s) to compare your county to the statewide status and review the supplemental measure(s) for additional insights in the County Performance Workbook. These measures should inform the overall strategy and where relevant, be incorporated into the planning around the six priority goals.

In the next section, the county will select AT LEAST one goal from below for which your county is performing below the statewide rate/average on the primary measure(s) to improve on as a priority for the county.

For related policy information, refer to E.6.2 Primary and Supplemental Measures.

Care Experience: Primary Measures

Perception of Cultural Appropriateness/Quality Domain Score (Consumer Perception Survey (CPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Same

For children/youth
Above

Quality Domain Score (Treatment Perception Survey (TPS)), 2024

How does your county status compare to the statewide rate/average?

For adults/older adults
Above

For children/youth
Above

Engagement In School: Primary Measures

Twelfth Graders who Graduated High School on Time (Kids Count), 2022

How does your county status compare to the statewide rate/average?
Above

Engagement In School: Supplemental Measures

Meaningful Participation at School (California Health Kids Survey (CHKS)), 2023

How does your county status compare to the statewide rate/average?
Above

Student Chronic Absenteeism Rate (Data Quest), 2022

How does your county status compare to the statewide rate/average?
Below

Engagement In Work: Primary Measures

Unemployment Rate (California Employment Development Department (CA EDD)), 2023

How does your county status compare to the statewide rate/average?
Below

Engagement In Work: Supplemental Measures

Unable to Work Due to Mental Problems (California Health Interview Survey (CHIS)), 2023

How does your county status compare to the statewide rate/average?
Below

Overdoses: Primary Measures

All Drug-Related Overdose Deaths (California Department of Public Health (CDPH)), 2022

How does your county status compare to the statewide rate/average?

For the full population measure
Below

For adults/older adults
Above

For children/youth
Below

Overdoses: Supplemental Measures

All-Drug Related Overdose Emergency Department Visits (CDPH), 2022

How does your county status compare to the statewide rate/average?

For the full population measure
Above

For adults/older adults
Above

For children/youth
Above

Prevention And Treatment of Co-Occurring Physical Health Conditions: Primary Measures

Adults' Access to Preventive/Ambulatory Health Service & Child and Adolescent Well-Care Visits (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults (specific to Adults' Access to Preventive/Ambulatory Health Service)
Above

For children/youth (specific to Child and Adolescent Well-Care Visits)
Above

Prevention And Treatment of Co-Occurring Physical Health Conditions: Supplemental Measures

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications & Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing (DHCS), 2022

How does your county status compare to the statewide rate/average?

For adults/older adults (specific to Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications)
Below

For children/youth (specific to Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing)
Below

Quality Of Life: Primary Measures

Perception of Functioning Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Same

For adults/older adults
Same

For children/youth
Same

Quality Of Life: Supplemental Measures

Poor Mental Health Days Reported (Behavioral Risk Factor Surveillance System (BRFSS)), 2024

How does your county status compare to the statewide rate/average?

For the full population measure
Below

Social Connection: Primary Measures

Perception of Social Connectedness Domain Score (CPS), 2024

How does your county status compare to the statewide rate/average?

For the full population measured
Same

For adults/older adults
Same

For children/youth
Same

Social Connection: Supplemental Measures

Caring Adult Relationships at School (CHKS), 2023

How does your county status compare to the statewide rate/average?
Above

Suicides: Primary Measures

Suicide Deaths, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Above

Suicides: Supplemental Measures

Non-Fatal Emergency Department Visits Due to Self-Harm, 2022

How does your county status compare to the statewide rate/average?

For the full population measured
Below

For adults/older adults
Above

For children/youth
Above

County-selected statewide population behavioral health goals

For related policy information, refer to 3.E.6 Statewide Behavioral Health Goals.

Based on your county's performance or inequities identified, select at least one additional goal to improve on as a priority for the county for which your county is performing below the statewide rate/average on the primary measure(s). For each county-selected goal, provide the information requested below.
Overdoses
Suicides

Overdoses

Please describe why this goal was selected
This goal was selected given the growing importance of reducing overdoses in Marin County. Overdoses, and substance use services in general, were identified as priorities in community planning feedback and in the most recent Marin County Community Health Assessment.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Marin County had a higher All Drug-Related Overdose ED Visits rate compared to the State. Compared to county-level rates, Marin had higher All Drug-Related Overdose ED Visits rates for males; ages < 5, 10-29, 30-39; and for White, Latino, and Black/African American individuals. Marin also had higher All Drug-Related Overdose Deaths for males; ages 30-44, 50-74; and for White and Black/African American individuals.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Overdoses and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
- Capitalize on new Assertive Field-Based Substance Use Disorder services to connect TAY and older adults with on-the-spot assessments, mobile MAT initiation, naloxone distribution, and low-barrier treatment entry to care
- Strengthen partnerships with Marin County Aging and Adult Services and trusted, culturally responsive CBOs to engage impacted populations. Coordinate overdose prevention, surveillance, and harm reduction strategies with LHJ.
- Strengthen partnership with OD Free Marin, the countywide collaborative focused on reducing overdoses, to improve rates of ED visits for all drug-related overdoses. Specific strategies include supporting efforts to increase MAT prescriber capacity, promoting the availability of substance use prevention, harm reduction and treatment services, and address stigma related to substance use and MAT access.
- Suicide Overdose Fatality Review process allows County behavioral health and public health departments and local mental health, substance use/addiction, and medical providers to track near real-time trends, determine which populations in Marin are most at risk, and consider systemic changes that could potentially prevent future suicides and overdose related deaths

Please identify the category or categories of funding that the county is using to address this goal
BHSA BHSS
BHSA FSP
2011 Realignment
State General Fund
Federal Financial Participation (SMHS, DMC/DMC-ODS)

SUBG
Other

Please describe other
Opioid Settlement Funds

Suicides

Please describe why this goal was selected
Suicide reduction has long been a goal of Marin County. Reducing suicides was identified as priorities in community planning feedback and in the most recent Marin County Community Health Assessment.

What disparities did you identify across demographic groups or priority populations among the Additional Statewide Behavioral Health Goals? For any disparities observed, please provide a written summary of your findings, including the measures and population groups experiencing disparities and a description of the data that supported your analysis
Marin County had a higher death by suicide rate compared to the Statewide rate. Compared the county-level rate, Marin had a higher death by suicide rate for males. Marin County higher non-fatal self-harm injury ED visit rates among individuals aged 10-44, females, and Black/African American and Latino individuals in comparison to the county-level rate. Additional analysis of EpiCenter California Injury Data Online Dashboard data found that Marin had higher non-fatal self-harm injury ED visit rates due to drug poisoning for individuals ages 10-25 when compared to the county-level rate.

Please describe what programs, services, partnerships, or initiatives the county is planning to strengthen or implement beginning July 1, 2026 that may improve your county's level of Suicides and refer to any data that was used to make this decision (e.g., developing an intervention targeting a sub-population in which data demonstrates they have poorer outcomes)
- Early identification and linkage of individuals experiencing initial signs of suicidality or related behavioral health concerns
- Groups for individuals with suicidal ideation and/or prior attempt
- Strengthen Crisis Aftercare Team to offer outreach to people discharged from the ED following self-harm
- Target intentional and nonintentional drug overdoses through strategies that may include new Assertive Field-Based Substance Use Disorder services for youth and TAYs
- Increase access to and awareness of MAT for the youth and TAY population through partnership with OD Free Marin
- Partner with schools to expand school-based substance use prevention education
- Suicide Overdose Fatality Review process allows County behavioral health and public health departments and local mental health, substance use/addiction, and medical providers to track near real-time trends, determine which populations in Marin are most at risk, and consider systemic changes that could potentially prevent future suicides and overdose related deaths

Please identify the category or categories of funding that the county is using to address this goal
BHSA BHSS
BHSA FSP
Federal Financial Participation (SMHS, DMC/DMC-ODS)
Other

Please describe other
Opioid Settlement Funds

Community Planning Process

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.B Community Planning Process .

Stakeholder Engagement

For related policy information, refer to 3.B.1 Stakeholder involvement

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Please indicate the type of engagement used to obtain input on the planning process

County outreach through social media
County outreach through townhall meetings
County outreach through traditional media (e.g., television, radio, newspaper)
Meeting(s) with county
Public e-mail inbox submission
Survey participation
Training, education, and outreach related to community planning
Workgroups and committee meetings

Include date(s) of stakeholder engagement for each type of engagement

Type of engagement
County outreach through social media

Date
1/9/2025

Type of engagement
County outreach through townhall meetings

Date
11/14/2024

Type of engagement
County outreach through traditional media (e.g., television, radio, newspaper)

Date
5/11/2025

Type of engagement
Training, education, and outreach related to community planning

Date
10/24/2024

Type of engagement
Survey participation

Date
11/14/2024

Type of engagement
Meeting(s) with county

Date
3/26/2024

Type of engagement
Public e-mail inbox submission

Date
10/24/2024

Type of engagement
Workgroups and committee meetings

Date
5/15/2024

Please list specific stakeholder organizations that were engaged in the planning process. Please do not include specific names of individuals
Aging Action Initiative, Bay Area Community Resources, Buckelew, Canal Alliance, Children and Family Services, Coastal Miwok Tribal Council of Marin, College of Marin, Commission on Aging, Empowerment Clubhouse, Enterprise Resource Center, Felton Institute, First 5, Golden Gate Regional Center, Healthy Marin Partnership, Huckleberry, Jewish Family Services, Kaiser, Marin 9 to 5, Marin Community Clinics, Marin County Aging and Adult Services, Marin County Alcohol and Drug Advisory Board, Marin County Behavioral Health Board, Marin County Cooperation Team, Marin County Homelessness and Coordinated Care, Marin County labor organizations (MAPE, MCMEA), Marin County Office of Education, Marin County Probation, Marin County Public Health, Marin County Sheriff's Office, Marin County Social Services, Marin County Veterans Services, Marin Multicultural Center, MHSA Advisory Committee, NAMI, North Marin Community Services, OD Free Marin, Partnership Health Plan, San Rafael Police Department, Sutter Health, West Marin Multi-Services Center

What are the five most populous cities in counties with a population greater than 200,000 (Cities submitting IP independently are not required to collaborate with other cities) (Population and Housing Estimates for Cities, Counties, and the State)

	City name
1	San Rafael
2	Novato
3	Mill Valley
4	San Anselmo
5	Larkspur

Were you able to engage all required stakeholders/groups i**n the planning process?**
Yes

Please describe and provide documentation (such as meeting minutes) to support how diverse stakeholder viewpoints were incorporated into the development of the Integrated Plan, including any community-identified strengths, needs, and priorities
Marin County employed a comprehensive and inclusive approach to community engagement in the development of the BHSA Integrated Plan. Broad, ongoing input from diverse community stakeholders served as a foundation for shaping the plan. In addition, Marin County convened multiple community planning meetings, with feedback documented and organized in an Excel database for review. ChatGPT was utilized to explore qualitative feedback collected from the planning meetings, as well as from continuous stakeholder engagement efforts and a dedicated Opioid Settlement Fund Listening Session with youth participants. Furthermore, Marin County collected and incorporated data from a BHSA Survey, offered in English, Spanish, and Vietnamese, which provided community-ranked behavioral health priorities and detailed feedback on barriers to service. By combining qualitative insights with quantitative survey results, Marin conducted a thorough analysis to ensure that identified behavioral health priorities truly reflect the voices, experiences, and needs of the community.

Upload File (optional)
BHSA Community Planning Process Demographics and Feedback.pdf

Local Health Jurisdiction (LHJ)

Cities submitting their Integrated Plan independently from their counties do not have to complete this section. For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Did the county work with its LHJ on the development of the LHJ's recent Community Health Assessment (CHA) and/or Community Health Improvement Plan (CHIP)? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3.
Yes

Please describe how the county engaged with LHJs, along with Medi-Cal managed care plans (MCPs), across these three areas in developing the CHA and/or CHIP: collaboration, data-sharing, and stakeholder activities
Collaborative engagement occurs through bi-weekly Healthy Marin Partnership CHA/CHIP subcommittee meetings. Behavioral Health Goal data was shared to inform the development of the CHIP. Collaborative stakeholder activities occurs through identification of shared stakeholders; co-hosting community events; coordinating messaging on the development of the IP, CHA, and CHIP; and sharing BHSA community stakeholder engagement feedback to inform the development of the CHIP.

Did the county utilize the County-LHJ-MCP Collaboration Tool provided via technical assistance?
No

Collaboration

Please select how the county collaborated with the LHJ
Attended key CHA and CHIP meetings as requested.
Served on CHA and CHIP governance structures and/or subcommittees as requested.

Data-Sharing

Data-Sharing to Support the CHA/CHIP

Select Statewide Behavioral Health Goals that were identified for data-sharing to support behavioral health-related focus areas of the CHA and CHIP
Access to Care
Overdoses
Suicides

Was data shared?
Yes

Data-Sharing from MCPS and LHJs to Support IP development

Select Statewide Behavioral Health Goals that were identified for data-sharing to inform IP development
Access to Care
Overdoses
Suicides

Was data shared?
Yes

Stakeholder Activities

Select which stakeholder activities the county has coordinated for IP development with the LHJ engagement on the CHA/CHIP. Please note that although counties must coordinate stakeholder activities with LHJ CHA/CHIP processes (where feasible), the options below are for illustrative purposes only and are not required forms of stakeholder activity coordination (e.g., counties do not need to conduct each of these activities)
Collaborated with LHJ to identify shared stakeholders that are key for both the IP and CHA/CHIP process.
Co-hosted community sessions, listening tours, and/or other community events that can be used to strengthen stakeholder engagement for both the IP and CHA/CHIP.
Coordinated messaging and stakeholder events calendars (e.g., governance meetings) around IP development and CHA/CHIP engagement.

Most Recent Community Health Assessment (CHA), Community Health Improvement Plan (CHIP) or Strategic Plan

Has the county considered either the LHJ's most recent CHA/CHIP or strategic plan in the development of its IP ? Additional information regarding engagement requirements with other local program planning processes can be found in Policy Manual Chapter 3, Section B.2.3
Yes

Provide a brief description of how the county has considered the LHJ's CHA/CHIP or strategic plan when preparing its IP
Access to mental health and substance use services were consistently identified as needs in the Marin County Community Health Assessment (CHA). The Key Indicators listed in the CHA align with the input received in community planning and statewide behavioral health goals and their associated measures. Overdose Prevention is the number one priority followed by Access to Care in the 2024 – 2026 Marin Community Health Improvement Plan.

Medi-Cal Managed Care Plan (MCP) Community Reinvestment

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Please list the Managed Care Plans (MCP) the county worked with to inform the MCPs' respective community reinvestment planning and decision-making processes
Kaiser and Partnership HealthPlan of California

Which activities in the MCP Community Reinvestment Plan submissions address needs identified through the Behavioral Health Services Act community planning process and collaboration between the county, MCP, and other stakeholders on the county's Integrated Plan?

Kaiser does not submit a Community Reinvestment Plan, however, makes alternative investments in the community. Marin will collaborate with Partnership HealthPlan on MCP Community Reinvestment activities that address identified behavioral health needs.

Comment Period and Public Hearing

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Comment Period and Public Hearing

For related policy information, refer to B.3 Public Comment and Updates to the Integrated Plan .

Date the draft Integrated Plan (IP) was released for stakeholder comment
10/3/2025

Date the stakeholder comment period closed
11/4/2025

Date of behavioral health board public hearing on draft IP
11/4/2025

Please provide proof of a public posting with information on the public hearing. Please select the county's preferred submission modality
Link

Please provide the link to the public posting
https://MarinBHRS.org/MHSA

If the county uses an existing landing page or other web-based location to publicly post IPs for comment, please provide a link to the landing page (optional)

File Upload (optional)

Please select the process by which the draft plan was circulated to stakeholders
Public posting

Please describe stakeholder input in the table below. Please add each stakeholder group into their own row in the table

Stakeholder group that provided feedback
To be added after the close of the Public Comment period.

Summarize the substantive revisions recommended this stakeholder during the comment period
To be added after the close of the Public Comment period.

Please describe any substantive recommendations made by the local behavioral health board that are not included in the final Integrated Plan or update. If no substantive revisions were recommended by stakeholders during the comment period, please input N/A.

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

County Behavioral Health Services Care Continuum

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress.

County Behavioral Health Services Care Continuum

The Behavioral Health Care Continuum is composed of two distinct frameworks for substance use disorder and mental health services. These frameworks are used for counties to demonstrate planned expenditures across key service categories in their service continuum. Questions on the Behavioral Health Care Continuum are in the Integrated Plan Budget Template.

Mark section as complete

County Provider Monitoring and Oversight

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For related policy information, refer to 6.C.2 Securing Medi-Cal Payment .

Medi-Cal Quality Improvement Plans

Cities submitting their Integrated Plan independently from their counties do not have to complete this section or Question 1 under All BHSA Provider Locations.

For Specialty Mental Health Services (SMHS) or for integrated SMHS/Drug Medi-Cal Organized Delivery System (DMC-ODS) contracts under Behavioral Health Administrative Integration, please upload a copy of the county's current Quality Improvement Plan (QIP) for State Fiscal Year (SFY) 2026-2027
2025.3.14 2024-25 integrated workplan Final .pdf

Does the county operate a standalone DMC-ODS program (i.e., a DMC-ODS program that is not under an integrated SMHS/DMC-ODS contract)?
No

Contracted BHSA Provider Locations

As of the date this report is submitted, please provide the total number of contracted Behavioral Health Services Act (BHSA) provider locations offering non-Housing services for SFY 2025-26. I.e., BHSA-funded locations that are (i) not owned or operated by the county, and (ii) offer BHSA services other than Housing Interventions services. (A provider location should be counted if it offers both Housing Interventions and mental health (MH) or substance use disorder services (SUD); provider location that contracts with the county to provide both mental health and substance use disorder services should be counted separately.)

Services Provided	**Number of contracted BHSA provider locations**
Mental Health (MH) services only	19
Substance Use Disorder (SUD) services only	0
Both MH and SUD services	3

Among the county's contracted BHSA provider locations, please identify the number of locations that also participate in the county's Medi-Cal Behavioral Health Delivery System (BHDS) (including SMHS and Drug MC/DMC-ODS) for SFY 2025-26

Services Provided	**Number of Contracted BHSA Provider Locations**
SMHS only	6
DMC/DMC-ODS only	0
Both SMHS and DMC/DMC-ODS systems	0

All BHSA Provider Locations

For related policy information, refer to B.2 Considerations of Other Local Program Planning Processes .

Among the county's BHSA funded SMHS provider locations (county-operated and contracted) that offer services/Levels of Care that may be covered by Medi-Cal MCPs as non-specialty mental health services (NSMHS), what percentage of BHSA funded SMHS providers contract with at least one MCP in the county for the delivery of NSMHS?
14%

Please describe the county's plans to enhance rates of MCP contracting starting July 1, 2027, and over the subsequent two years among the BHSA provider locations that are providing services that can/should be reimbursed by Medi-Cal MCPs
BHRS has been collaborating with Carelon and Partnership HealthPlan to support MCP contracting at provider locations. Additionally, in partnership with MCPs, BHRS will hold a MCP contracting summit with providers in October 2025.
To maximize resource efficiency, counties must, as of July 1, 2027, require their BHSA providers to (subject to certain exceptions)

a. **Check whether an individual seeking services eligible for BHSA funding is enrolled in Medi-Cal and/or a commercial health plan, and if uninsured, refer the individual for eligibility screening**
b. **Bill the Medi-Cal Behavioral Health Delivery System for covered services for which the provider receives BHSA funding; and**
c. **Make a good faith effort to seek reimbursement from Medi-Cal Managed Care Plans (MCPs) and commercial health plans for covered services for which the provider receives BHSA funding**

Does the county wish to describe implementation challenges or concerns with these requirements?
No

Counties must monitor BHSA-funded providers for compliance with applicable requirements under the Policy Manual, the county's BHSA contract with DHCS, and state law and regulations. Effective SFY 2027-2028, counties must (1) adopt a monitoring schedule that includes periodic site visits and (2) preserve monitoring records, including monitoring reports, county-approved provider Corrective Action Plans (CAPs), and confirmations of CAP resolutions. Counties shall supply these records at any time upon DHCS's request. DHCS encourages counties to adopt the same provider monitoring schedule as under Medi-Cal: annual monitoring with a site visit at least once every three years. For providers that participate in multiple counties' BHSA programs, a county may rely on monitoring performed by another county. Does the county intend to adopt this recommended monitoring schedule for BHSA-funded providers that:

Also participate in the county's Medi-Cal Behavioral Health Delivery System? (Reminder: Counties may simultaneously monitor for compliance with Medi-Cal and BHSA requirements)
Yes

Do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Behavioral Health Services Act/Fund Programs

Behavioral Health Services and Supports (BHSS)

For related policy information, refer to 7.A.1 Behavioral Health Services and Supports Expenditure Guidelines

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General

Please select the specific Behavioral Health Services and Supports (BHSS) that are included in your plan

Early Intervention Programs (EIP)
Adult and Older Adult System of Care (non-FSP)
Outreach and Engagement (O&E)
Workforce, Education and Training (WET)
Capital Facilities and Technological Needs (CFTN)

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program

Mental health services
Supportive services
Substance Use Disorder (SUD) treatment services

Please describe the specific services provided

Casa René is a 10-bed Crisis Residential Unit (CRU) administered by Buckelew Programs. The program is expected 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.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	188
FY 2027 – 2028	192
FY 2028 – 2029	196

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care
Average of FY22/23 and FY23/24 individuals served with 2% yearly growth

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program
Mental health services
Supportive services
Substance Use Disorder (SUD) treatment services

Please describe the specific services provided
Provide culturally responsive and recovery-oriented peer services. Improved support for family members. Enhancing services to underserved populations.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	2570
FY 2027 – 2028	2634
FY 2028 – 2029	2700

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care
FY23/24 individuals served with 2-3% yearly growth

Adult and Older Adult System of Care (Non-Full Service Partnership (FSP)) Program

For each program or service type that is part of the county's BHSS funded Adult and Older Adult System of Care (Non-FSP) program, provide the following information. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.2 Children's, Adult, and Older Adult Systems of Care

Please select the service types provided under Program
Supportive services

Please describe the specific services provided
Supportive services at Permanent Supportive Housing sites. 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.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	395
FY 2027 – 2028	415
FY 2028 – 2029	435

Please describe any data or assumptions the county used to project the number of individuals served through the Adult and Older Adult System of Care
FY22/23 and FY23/24 individuals served with 5% yearly growth based on anticipated increased number of individuals experiencing homelessness receiving services.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Early Childhood Behavioral Health

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues
Treatment Services and Supports: Other

Please specify "other" type of Treatment Services and Supports
Infant and Early Childhood Mental Health Consultation

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please describe intended outcomes of the program or service
- Earlier identification of infants and young children exposed to, or who are at risk of exposure to, adverse childhood experiences (ACEs) and traumatic childhood events, environmental trauma including community violence, generational trauma, institutional trauma, and prolonged toxic stress
- Earlier identification and referral to services for children at risk of removal from home
- Increased capacity of caregivers to promote healthy social and emotional development in children
- Increased timely access to culturally responsive and linguistically appropriate behavioral health services for children ages zero to five and their caregivers
- Reduced likelihood of behavioral health difficulties and school failure in pre-school and beyond
- Reduced severity and duration of early symptoms of depression, anxiety, trauma, and social isolation
- Reduced disparities in access to care for children

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1200
FY 2027 – 2028	1500
FY 2028 – 2029	1500

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
The county has been partnering with community-based providers to provide early childhood mental health PEI programming targeting the mental health needs of eligible children and youth who are zero to five years of age for many years. Over the past two years, the average number of individuals and family members served include 565, with an additional 1,400 people reached through outreach and training for an average total of 1,965. With a targeted focus on early intervention, the County estimates that for FY 2026 – 2027, the total number served will be 1,200 including early childhood mental health consultation, targeted outreach, screening, assessment, linkage to services and early intervention treatment. We anticipate this number to grow to 1,500 in subsequent years.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
School-Age Behavioral Health

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments

Access and Linkage: Referrals
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please provide the name of the EBPs and CDEPs that app (optional)

EBPs and CDEPs

Please describe intended outcomes of the program or service
- Reduced likelihood of behavioral health problems and school failure
- Improved academic performance and readiness to learn
- Improved school connectedness
- Early identification of students with behavioral health difficulties and increased timely access to culturally responsive and linguistically appropriate behavioral health services
- Early identification and engagement of students from underserved cultural communities showing early signs of behavioral health concerns
- Reduced disparities in access to care for youth
- Increased access to brief, culturally and linguistically responsive behavioral health services
- Improved linkage to short-term therapeutic and recovery-oriented services
- Reduced severity and duration of early symptoms of depression, anxiety, trauma, and social isolation

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program (optional)

Additional priority name	Description

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1800
FY 2027 – 2028	2000
FY 2028 – 2029	2000

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
The county has been partnering with community-based providers to provide behavioral health PEI programming targeting eligible school aged youth who have significantly higher risk factors due to variables such as adverse childhood experiences, severe trauma, poverty, family conflict, domestic violence, racism, social inequality, or other related issues. Additionally, the county and community partners have focused on providing services for underserved youth and families, including Spanish speaking youth, newcomer students, LGBTQIA+ youth, youth in rural communities, as well as expanded efforts to provide accessible services within schools and community settings. Over the past two years, the average number of individuals and family members served include 820, with an additional 5,000 people reached through outreach and training for an average total of 5,820. With a targeted focus on early intervention, the County estimates that for FY 2026 – 2027, the total number served will be 1,800 including targeted outreach, screening, assessment, linkage to services and early intervention treatment. We anticipate this number to grow to 2,000 in subsequent years.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Transition Age Youth (TAY)

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please provide the name of the EBPs and CDEPs that app (optional)

EBPs and CDEPs

Please describe intended outcomes of the program or service
- Reduced likelihood of school failure, unemployment, and/or justice-involvement
- Reduced likelihood of intentional and nonintentional drug overdoses
- Increased access to services and supports that prevent, respond, and treat a behavioral health crisis
- Early identification of youth with behavioral health problems and increased timely access to culturally responsive and linguistically appropriate behavioral health services
- Increased access to brief, culturally and linguistically responsive mental health services
- Improved linkage to short-term therapeutic and recovery-oriented services
- Reduced severity and duration of early symptoms of depression, anxiety, trauma, and social isolation

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program (optional)

Additional priority name	Description

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	3074
FY 2027 – 2028	3188
FY 2028 – 2029	3303

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections are based on past MHSA data for TAY and their families. A modest annual growth rate of 2% was applied to reflect service demand and continued outreach. Estimates remain consistent with program capacity and account for year-to-year fluctuations in participation.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Our Communities

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please provide the name of the EBPs and CDEPs that app (optional)

EBPs and CDEPs

Please describe intended outcomes of the program or service

- Early identification and engagement of individuals from underserved cultural and geographic communities showing early signs of behavioral health concerns.
- Increased access to culturally and linguistically responsive early intervention therapeutic and recovery-oriented services.
- Strengthened peer-led support to improve engagement and trust among high-barrier populations.
- Enhanced potential responder capacity to recognize and respond to early signs of mental health, suicidal and substance use issues
- Reduced severity and duration of early symptoms of depression, anxiety, trauma, and social isolation
- Decreased need for emergency or acute behavioral health interventions

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program (optional)

Additional priority name	Description

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	15450
FY 2027 – 2028	15908
FY 2028 – 2029	16388

Please describe any data or assumptions the county used to project the number of individuals served through EI programs

Projections are based on three-year averages of participation across previous MHSA direct service program areas including the Enterprise Resource Center peer drop-in services (3,596), Latino Community Connection (991), and Community Training and Supports (1,119). To reflect program expansion into West Marin and South Marin, an additional baseline estimate of 150 individuals per region (300 total) was included. This yielded a baseline of approximately 6,000 individuals, with 2% annual growth applied. To reflect the scope of early intervention work, projections also include targeted outreach at 1.5x the direct service baseline, resulting in total engagement of 15,450 individuals in FY26/27, scaling to more than 16,000 by FY28/29.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Compassion to Action

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals
Access and Linkage: Assessments
Treatment Services and Supports: Services that prevent, respond to, or treat a behavioral health crisis or decrease the impacts of suicide

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please provide the name of the EBPs and CDEPs that app (optional)

EBPs and CDEPs

Please describe intended outcomes of the program or service
- Early identification and engagement of individuals experiencing initial signs of suicidality or related behavioral health concerns.
- Timely access to short-duration, culturally responsive behavioral health services.
- Increased linkage to appropriate clinical and non-clinical supports.
- Reduction in the severity and frequency of suicidal ideation and behaviors.
- Decreased need for emergency or inpatient behavioral health services.
- Improved individual functioning, safety, and stabilization.
- Strengthened peer support through trained peer specialists who offer engagement, navigation, and emotional support
- Enhanced continuity of care and follow-up after suicidal behavior or crisis.

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program (optional)

Additional priority name	Description

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	15752
FY 2027 – 2028	16231
FY 2028 – 2029	16716

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections are based on the three-year average of 6,302 individuals reached through direct service programming, which includes crisis hotline support, survivor/attempt group services and crisis aftercare team support. We project early intervention targeted outreach at approximately 9,450 scaling gradually each year to over 10,030 by FY28/29.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Caring Connections

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Assessments
Access and Linkage: Referrals

Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please provide the name of the EBPs and CDEPs that app (optional)

EBPs and CDEPs

Please describe intended outcomes of the program or service

- Early identification and engagement of older adults showing initial signs of behavioral health concerns
- Strengthened peer support through trained older adult peer specialists who offer engagement, navigation, and emotional support
- Improved linkage to clinical, community-based, and social support services tailored to the needs of older adults
- Increased potential responders capacity to recognize behavioral health symptoms in older adults
- Reduction in severity and duration of depressive symptoms, anxiety, trauma-related stress, or social isolation
- Decreased risk of behavioral health crises and reduced use of emergency or inpatient services
- Improved overall well-being, daily functioning, and quality of life for participating older adults

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program (optional)

Additional priority name	Description

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	421
FY 2027 – 2028	436
FY 2028 – 2029	451

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Based on the MHSA Older Adult PEI three-year average of 167 individuals served annually (modest growth applied) we project targeted outreach at approximately 250 individuals per year, scaling gradually to 270 by FY28/29.

Early Intervention (EI) Programs

For each program or service type that is part of the county's overall EI program, provide the following information. County EI programs must include all required components outlined in Policy Manual Chapter 7, Section A.7.3 , but counties may develop multiple programs/interventions to meet all county EI requirements. If the county provides more than one program or service type, use the "Add" button. For related policy information, refer to 7.A.7 Early Intervention Programs .

Program or service name
Veterans

Please select which of the three EI components are included as part of the program or service
Outreach
Access and Linkage: Screenings
Access and Linkage: Referrals
Treatment Services and Supports: Services to address co-occurring mental health and substance use issues

Please indicate if the program or service includes evidence-based practices (EBPs) or community-defined evidence practices (CDEPs) from the biennial list for EI programs
Yes

Please provide the name of the EBPs and CDEPs that app (optional)

EBPs and CDEPs

Please describe intended outcomes of the program or service

- Early identification and engagement of veterans showing initial signs of behavioral health concerns.
- Improved linkage to clinical, community-based, and social support services tailored to the needs of veterans.
- Increased potential responders capacity to recognize behavioral health symptoms in veterans.
- Decreased risk of behavioral health crises and reduced use of emergency or inpatient services
- Improved overall well-being, daily functioning, and quality of life for participating veterans

Please indicate if the county identified additional priority uses of BHSS EI funds beyond those listed in the Policy Manual Chapter 7, Section A.7.2
No

Please describe for each additional priority why the county opted to include this priority and metrics to assess the effectiveness of the program (optional)

Additional priority name	Description

Please provide the total projected number of individuals served for EI during the plan period by fiscal year (FY)

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	120
FY 2027 – 2028	123
FY 2028 – 2029	126

Please describe any data or assumptions the county used to project the number of individuals served through EI programs
Projections are based on the three-year average reported in MHSA annual updates (117 individuals served), with modest growth of 2–3% applied annually to reflect recent upward trends and expanded outreach. Estimates remain consistent with program capacity to ensure they are achievable. Family participation is expected to remain stable at approximately 6–8 families per year.

Coordinated Specialty Care for First Episode Psychosis (CSC) program

For related policy information, refer to 7.A.7.5.1 Coordinated Specialty Care for First Episode Psychosis .

Please provide the following information on the county's Coordinated Specialty Care for First Episode Psychosis (CSC) program

CSC program name
Marin's Early Psychosis Program

CSC program description
Marin's Early Psychosis Program (EPP) will deliver comprehensive, coordinated treatment experiencing early signs and symptoms of a psychotic disorder, as well as providing families the tools to support their loved ones in their recovery process. The program will provide outreach and education to a variety of Marin County agencies, including schools and school districts, community-based agencies, Marin County programs and services and other interested parties. The program will engage unserved individuals in the community who may be experiencing symptoms of early psychosis to help them access services. The program will provide screening and assessment for clients to determine eligibility for coordinated specialty care services, short-term services to support clients during transition to other providers, and information/resources for clients not eligible for their direct services, as well as their families.

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for CSC. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population. These projections are not binding and are for planning purposes. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA CSC requirements

Please review the total estimated number of individuals who may be eligible for CSC (based on the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence Based Practice (EBP) Policy Guide and the Policy Manual Chapter 7, Section A.7.5). Please input the estimates provided to the county in the table below.

CSC Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	20
Number of Uninsured Individuals	1

CSC Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	5
Number of Teams Needed to Serve Total Eligible Population	1

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for BHSS, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide CSC over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	5	5	5
Total Number of Teams	1	1	1

Will the county's CSC program be supplemented with other (non-BHSA) funding source(s)?
Yes

Please list the other funding source(s)
Federal Mental Health Block Grant, Medi-Cal reimbursement

Outreach and Engagement (O&E) Program

For each program or activity that is part of the county's standalone O&E programs provide the following information. If the county provides more than one program or activity, use the "Add" button. For related policy information, refer to 7.A.3 Outreach and Engagement .

Program or activity name
Community Outreach and Engagement

Please describe the program or activity
Outreach and engagement to underserved individuals to successfully connect them to behavioral health services. This program will support regional equity and address disparities through culturally responsive and linguistically appropriate services, closed-loop referrals, field-based screenings and assessments.

Please provide the projected number of individuals served during the plan period by fiscal year (FY) in the table below

Plan Period by FY	Projected Number of Individuals Served
FY 2026 – 2027	1200
FY 2027 – 2028	1260
FY 2028 – 2029	1323

Please describe any data or assumptions the county used to project the number of individuals served through O&E programs
FY23/24 individuals served and expanded regional equity with 5% yearly growth

County Workforce, Education, and Training (WET) Program

As described in the Policy Manual, WET activities should supplement, but not duplicate, funding available through other state-administered workforce initiatives, including the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative administered by the Department of Health Care Access and Information (HCAI). Counties should prioritize available BH-CONNECT and other state-administered workforce programs whenever possible. Responses in this section should address the county's WET program. Other workforce efforts should be addressed in the Workforce Strategy section of the Integrated Plan (IP).
For each program or activity that is part of the county's overall WET program, provide the following information. If the county provides more than one program or activity type, use the "Add" button. For related policy information, refer to 7.A.4 Workforce Education and Training .

Program or activity name
Training and Technical Assistance

Please select which of the following categories the activity falls under
Continuing Education

Please describe efforts to address disparities in the Behavioral Health workforce. Additional information regarding diversity of the behavioral health workforce can found in Policy Manual Chapter 7, Section A.4.9

Marin will leverage state workforce initiatives, pursue local training partnerships, and strengthen retention strategies to develop and sustain a diverse and skilled workforce.

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Electronic Health Record And Practice Management System Enhancements

Please select the type of project
Technological needs project

Please describe the project
Improve 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 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.

If capital facilities project, please indicate which of the following categories the project falls under

If Technological Needs Project, please select the focus area(s) of the project
Electronic health record system

Capital Facilities and Technological Needs (CFTN) Program

For each project that is part of the county's CFTN project, provide the following information. If the county provides more than one project, use the "Add" button. Additional information on CFTN policies can be found in Policy Manual Chapter 7, Section A.5 .

Project name
Telehealth Improvements

Please select the type of project
Technological needs project

Please describe the project
Strengthen telehealth options, including the ability to provide group services via

telehealth. Investments in software and hardware for client use to allow them to access telehealth services in locations throughout the county (including kiosks or personal devices as needed). 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.

If capital facilities project, please indicate which of the following categories the project falls under

If Technological Needs Project, please select the focus area(s) of the project
Telemedicine

Full Service Partnership Program

DHCS will provide counties with information to complete the estimated fields for eligible population and practitioners/teams needed for each EBP. The estimated numbers of teams/practitioners reflect the numbers needed to reach the entire eligible population (i.e., achieve a 100 percent penetration rate), and DHCS recognizes that counties will generally not be able to reach the entire eligible population, in consideration of BHSA funding availability. These projections are not binding and are for planning purposes only. In future guidance, DHCS will provide more information on the number of teams counties must implement to demonstrate compliance with BHSA FSP requirements. For related policy information, refer to 7.B.3 Full Service Partnership Program Requirements and 7.B.4 Full Service Partnership Levels of Care

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Please review the total estimated number of individuals who may be eligible for each of the following Full Service Partnership (FSP) services (consistent with the Service Criteria in the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Evidence-Based Practice (EBP) Policy Guide , the Policy Manual Chapter 7, Section B , and forthcoming High Fidelity Wraparound (HFW) Medi-Cal Guidance): Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT), Full Service Partnership (FSP) Intensive Case Management (ICM), HFW and Individual Placement and Support (IPS) Model of Supported Employment). Please input the estimates provided to the county in the table below

Total Adult FSP Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	275
Number of Uninsured Individuals	34
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	42

Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) Eligible Population

Please input the estimates provided to the county in the table below

ACT and FACT Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	65
Number of Uninsured Individuals	8

ACT and FACT Eligible Population	Estimates
Number of Total FSP Eligible Individuals with Some Justice-System Involvement	23

ACT and FACT Eligible Population	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	7
Number of Teams Needed to Serve Total Eligible Population	1

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and Full-Time Equivalents (FTEs) (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide ACT and FACT over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and Technical Assistance (TA) to assist counties with completing these fields.

County Actuals	**FY 26-27**	**FY 27-28**	**FY 28-29**
Total Number of Practitioners	14	14	14
Total Number of Teams	1	1	1

Full Service Partnership (FSP) Intensive Case Management (ICM) Eligible Population

Please input the estimates provided to the county in the table below

FSP ICM Eligible Population	**Estimates**
Number of Medi-Cal Enrolled Individuals	210
Number of Uninsured Individuals	26

FSP ICM Practitioners and Teams Needed	**Estimates**
Number of Practitioners Needed to Serve Total Eligible Population	10
Number of Teams Needed to Serve Total Eligible Population	2

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTEs) to provide FSP ICM over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	27	27	27
Total Number of Teams	4	4	4

High Fidelity Wraparound (HFW) Eligible Population

Please input the estimates provided to the county in the table below

HFW Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	50
Number of Uninsured Individuals	0

HFW Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	11
Number of Teams Needed to Serve Total Eligible Population	4

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide HFW over this Integrated Plan period, by fiscal year. DHCS will provide further guidance and TA to assist counties with completing these fields.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	11	13	15
Total Number of Teams	4	5	6

Individual Placement and Support (IPS) Eligible Population

Please input the estimates provided to the county in the table below

IPS Eligible Population	Estimates
Number of Medi-Cal Enrolled Individuals	1324
Number of Uninsured Individuals	163

IPS Practitioners and Teams Needed	Estimates
Number of Practitioners Needed to Serve Total Eligible Population	7
Number of Teams Needed to Serve Total Eligible Population	3

Taking into account the total eligible population estimates, current and projected workforce capacity, and BHSA funding allocation for FSP, please provide the total number of teams and FTEs (county and non-county contracted providers) the county behavioral health system plans to utilize (i.e., current and new FTE) to provide IPS over this Integrated Plan period, by fiscal year.

County Actuals	FY 26-27	FY 27-28	FY 28-29
Total Number of Practitioners	7	9	9
Total Number of Teams	3	4	4

Full Service Partnership (FSP) Program Overview

Please provide the following information about the county's BHSA FSP program

Will any of the estimated number of practitioners the county plans to utilize (provided above) be responsible for providing more than one EBP?
Yes

Please describe how the estimated practitioners will provide more than one EBP
It is anticipated that some practitioners in the adult system of care will be trained in both ACT and FACT in order to ensure sufficient capacity and flexibility to meet any changes in needs and demands. For the children's system of care, High Fidelity Wrap will be utilized.

Please describe how the county is employing a whole-person, trauma-informed approach, in partnership with families or an individual's natural supports
Marin BHRS acknowledges that individuals are experts on their own life and that recovery involves working in partnership with individuals and their families or other natural supports. Strategies the county employs to support whole-person and trauma-informed approaches in partnership with families and other natural supports include:

- All of Marin County's Youth and Family Services behavioral health programs, including Wraparound services, are family focused and utilize Child and Family Team (CFTs) to elicit and support family voice and choice in the services they receive. Our clinical teams receive extensive training on the impact of individual and transgenerational trauma on behavior.
- FSPs engage families and/or other natural support networks in the client's treatment and recovery support processes. BHRS also provides support, education, and skill-building for family members including through family groups and embedding Family Partners in FSP programs.
- FSP programs are staffed with Peers, as well as utilize Recovery Coaches, who also engage and provide support to the client and their families and assist with referrals, linkages and other recovery supports.
- BHRS supports various workforce development initiatives, such as offering training on providing trauma-informed care, peer led services and modalities, and other pertinent topics that support capacity to effectively support whole-person approaches in partnership with families and other natural supports.

Please describe the county's efforts to reduce disparities among FSP participants
The county implements numerous strategies to provide culturally and linguistically responsive services in order to reduce disparities among FSP participants. Examples include implementing initiatives to increase bilingual staffing and services delivered in Spanish and Vietnamese, strengthening peer and family supports, and supporting workforce development efforts related to developing career pathways, providing culturally responsive services and

supervision, and competency development. In addition to providing field-based services, the county's behavioral health clinics and services are located throughout the County to support geographically equitable access to care.

In addition to operating under a robust Cultural Humility and Responsivity Plan, BHRS also leads and participates in numerous initiatives focused on reducing disparities, such as the Equity and Community Partnerships Committee, Language Access Workgroup, Latine Steering Committee, LGBTQ+ Collaborative, and Addressing Harm Workgroup, among others.

Select which goals the county is hoping to support based on the county's allocation of FSP funding
Homelessness
Institutionalization
Justice involvement
Removal of children from home
Untreated behavioral health conditions

Please describe what actions or activities the county behavioral health system is doing to provide ongoing engagement services to individuals receiving FSP ICM
Marin BHRS is providing ongoing engagement services to individuals receiving FSP ICM services using the following strategies:

a. Maintaining low staff to client ratios to support individualized care, frequent contact and ongoing engagement
b. Supporting a multi-disciplinary team-based approach, including practitioners with lived experience, to provide coordinated and integrated care
c. Maintaining regular communication and follow-up, including providing a minimum of one service per week, as clinically indicated
d. Supporting low barrier access to care through providing services in environments where they need services and offering a flexible service delivery approach
e. Promoting connection to community-based and recovery-oriented resources, such as the Enterprise Resource Center and Empowerment Clubhouse

Ongoing engagement services is a required component of ACT, FACT, IPS, and HFW.
Please describe any ongoing engagement services the county behavioral health system will provide beyond what is required of the EBP
N/A

Please describe how the county will comply with the required FSP levels of care (e.g., transition FSP ICM teams to ACT, stand up new ACT teams and/or stand up new FSP ICM teams, etc.)
Marin County BHRS will comply with the required FSP levels of care by implementing the following:

· Transition two (2) existing FSP teams to operate as one (1) full ACT team. Reconfiguring staffing, as needed, to support capacity development to effectively serve individuals with co-occurring SMI and substance use conditions. The team will participate in training provided by the Centers of Excellence, as well as in fidelity assessment activities.

- Transition three (3) existing FSP teams to operate as three (3) FSP ICM teams, including reconfiguring staffing, as needed, to support capacity development to effectively serve individuals with co-occurring SMI and substance use conditions.
- Update practices for identifying and facilitating clinically appropriate transitions between BHRS programs to the indicated FSP level of care, as applicable.

Please indicate whether the county FSP program will include any of the following optional and allowable services
N/A

Primary substance use disorder (SUD) FSPs
No

Outreach activities related to enrolling individuals living with significant behavioral health needs in an FSP (activities that fall under assertive field-based initiation of substance use disorder treatment services will be captured separately in the next section)
No

Other recovery-oriented services
No

If there are other services not described above that the county FSP program will include, please list them here. For team-based services, please include number of teams. If no additional FSP services, use "N/A"
N/A

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth in the development of the county's FSP program (e.g., review data, engage with stakeholders, analyze research, etc.) who are:

In, or at-risk of being in, the juvenile justice system
BHRS leadership continue to participate in the county's Executive Committee Juvenile Justice Workgroup, to best identify and respond to the community's changing Juvenile Justice needs.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Marin Youth and Family Services is a partner of the Marin LGBTQ+ Center as well as other local LGBTQ+ advocacy groups. Through these relationships our leadership team can hear about changes in the experience and needs of LGBTQ+ youth in Marin County. Additionally, a LGBTQ+ focused session was held during community planning.

In the child welfare system
Marin BHRS is a strong partner with our Child Welfare Division (Children and Family Services), who not only track data on affected children and youth, but also lead a quarterly multidisciplinary meeting (AB 2083) that reviews trends and

needs in the Child Welfare population.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's FSP (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults
The Helping Older People Excel (HOPE) Program has been a successful 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. This program will continue as a BHSA-funded program. Additionally, BHRS regularly engages with stakeholders who represent the unique needs of older adults.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
BHRS regularly partners with the Marin LGBTQ+ Center as well as other local LGBTQ+ advocacy groups. Additionally, a LGBTQ+ focused session was held during community planning.

In, or are at risk of being in, the justice system
The Marin County Support and Treatment After Release Program has been an MHSA-funded county-operated Full-Service Partnership serving adults with serious mental illness who are at risk of incarceration or re-incarceration since 2006. In addition to reviewing the data and engaging with stakeholders, BHRS receives ongoing input on behavioral health priorities from community-based agencies and advocates who serve individuals with justice system experience, public safety partners, and members of the judicial system.

Assertive Field-Based Substance Use Disorder (SUD) Questions

For related policy information, refer to 7.B.6 Assertive Field-Based Initiation for Substance Use Disorder Treatment Services

Please describe the county behavioral health system's approach and timeline(s) to support and implement assertive field-based initiation for SUD treatment services program requirements by listing the existing and new programs (as applicable) that the county will leverage to support the assertive field-based SUD program requirements and provide the current funding source, BHSA service expansion, and the expected timeline for meeting programmatic requirements to expand existing programs and/or stand up new initiatives before July 1, 2029.

Counties should include programs not funded directly or exclusively by BHSA dollars. Additional information regarding assertive field-based initiation for SUD treatment services can be found in the BHSA Policy Manual Chapter 7, Section B.6.

Existing Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

Existing programs
Suspected Non-Fatal Overdose Follow-Up; Ritter Center's Health and Wellness Outreach Team

Program descriptions
DMC-ODS Providers perform outreach to individuals that experienced a suspected non-fatal overdose. Individuals are identified through EMS records and/or ED data from Point Click Care.

The Outreach teams include a behavioral health van and Street Medicine team, staffed with a medical provider, patient navigator/ medical assistant, benefits specialist, and harm reduction outreach workers. The Teams provide both urgent primary medical care and preventive care, while connecting patients to wrap-around services that may include behavioral health support, shelter and housing resources, medical insurance registration, and access to food and income.

Current funding source
Suspected Non-Fatal Overdose Follow-Up: Opioid Settlement Fund; General Fund; SUBG

Ritter Center's Health and Wellness Outreach Team: Grant funding from HHS – Public Health and Anthem Blue Cross; Medi-Cal

BHSA changes to existing programs to meet BHSA requirements
Explore SMHS Providers also conducting outreach and consider alternate outreach strategies to support higher SUD engagement among individuals with a suspected non-fatal overdose. Explore outreach and engagement strategies to youth and TAY population.

Explore the feasibility of expanding outreach locations and direct MAT prescribing.

Expected timeline of operation
Suspected Non-Fatal Overdose Follow-Up: Limited outreach currently in operation

Ritter Center's Health and Wellness Outreach Team: Currently in operation

Mobile-field based programs

Existing programs
Ritter Center's Health and Wellness Outreach Team

Program descriptions
The Outreach teams include a behavioral health van and Street Medicine team, staffed with a medical provider, patient navigator/ medical assistant, benefits specialist, and harm reduction outreach workers. The Teams provide both urgent primary medical care and preventive care, while connecting patients to wrap-around services that may include behavioral health support, shelter and housing resources, medical insurance registration, and access to food and income.

Current funding source
Grant funding from HHS – Public Health and Anthem Blue Cross; Medi-Cal

BHSA changes to existing programs to meet BHSA requirements
Explore the feasibility of expanding outreach locations and direct MAT prescribing.

Expected timeline of operation
Limited outreach currently in operation

Open-access clinics

Existing programs
Marin Health Emergency Department; Ritter Center; Marin Treatment Center

Program descriptions
Marin Health Emergency Department, which is a CA Bridge Site, performs 24/7 MAT Inductions and referrals to outpatient clinics for ongoing MAT.

Ritter Center is a Federally Qualified Health Center (FQHC) offering low barrier access to MAT/SUD treatment.

Marin Treatment Center is the County's Opioid Treatment Program and offers MAT, including methadone.

Current funding source
Marin Health Emergency Department: Medi-Cal, Medicare, Commercial Insurance

Ritter Center: Medi-Cal; Other

Marin Treatment Center: DMC-ODS, BHSOAC Grant, Medicare, Commercial Insurance

BHSA changes to existing programs to meet BHSA requirements
Marin Health Emergency Department: N/A

Ritter Center: Exploring the feasibility of adding prescribers or offering drop-in hours to support rapid MAT access.

Marin Treatment Center: Expanding prescriber capacity to support rapid access to MAT.

Expected timeline of operation
All programs are currently in operation

New Programs for Assertive Field-Based SUD Treatment Services

Targeted outreach

New programs
CalAIM/Jail Behavioral Health Services; DMC-ODS Outpatient and Residential settings; Mobile Outreach (Provider TBD)

Program descriptions
CalAIM/Jail Behavioral Health Services: In-custody screening and assessment for MAT and timely linkage to in-custody and community-based MAT.

DMC-ODS Outpatient and Residential settings: DMC-ODS Outpatient and Residential provider sites to implement new or expand existing MAT Prescriber capacity.

Mobile Outreach (Provider TBD): Expand mobile outreach efforts to include additional locations, as applicable, and workflows/capacity to provide rapid access to SUD services, including MAT.

Planned funding
CalAIM/Jail Behavioral Health Services: Medi-Cal; County General Fund

DMC-ODS Outpatient and Residential settings: Drug/Medi-Cal; BHSOAC Grant

Mobile Outreach (Provider TBD): Medi-Cal; BHSA; TBD

Planned operations
CalAIM/Jail Behavioral Health Services: In partnership with the Sheriff, Probation and Detention Health, implement new workflows to identify and link individuals to MAT, as clinically indicated.

DMC-ODS Outpatient and Residential settings: Embed MAT Prescribers in at least four (4) DMC-ODS Outpatient and Residential provider sites and implement new workflows to identify and serve clients appropriate for MAT.

Mobile Outreach (Provider TBD): Issue an RFP, if applicable, to solicit a Provider to implement/ expand mobile outreach efforts that facilitate rapid access to SUD services.

Expected timeline of implementation
CalAIM/Jail Behavioral Health Services: October 2026

DMC-ODS Outpatient and Residential settings: July 2026

Mobile Outreach (Provider TBD): December 2026

Mobile-field based programs

New programs
Mobile Outreach (Provider TBD)

Program descriptions
Expand mobile outreach efforts to include additional locations, as applicable, and workflows/capacity to provide rapid access to MAT.

Planned funding
Medi-Cal; BHSA; TBD

Planned operations
Issue an RFP, if applicable, to solicit a Provider to implement/ expand mobile outreach efforts that facilitate rapid access to SUD services.

Expected timeline of implementation
December 2026

Open-access clinics

New programs
Ritter Center; Marin Treatment Center; Telehealth (Provider TBD)

Program descriptions
Ritter Center: Ritter Center is a Federally Qualified Health Center (FQHC) offering low barrier access to MAT/SUD Treatment.

Marin Treatment Center: Marin Treatment Center is the County's Opioid Treatment Program and offers MAT, including methadone.

Telehealth (Provider TBD): Contract with a telehealth provider(s) to offer rapid access to MAT.

Planned funding
Ritter Center: Medi-Cal; Other

Marin Treatment Center: Multiple: DMC-ODS, BHSOAC Grant, Medicare, Commercial Insurance

Telehealth (Provider TBD): Medi-Cal; Commercial Insurance

Planned operations
Ritter Center and Marin Treatment Center: Promote availability of Ritter Center's and Marin Treatment Center's MAT services, including ensuring targeted outreach providers, FSP staff and Mobile Field-Based Program have workflows to refer to these services, as appropriate.

Telehealth (Provider TBD): Issue an RFP; develop a referral arrangement and/or expand existing contracts to provide MAT via telehealth.

Expected timeline of implementation
December 2026 all programs

Medications for Addiction Treatment (MAT) Details
Please describe the county's approach to enabling access to same-day medications for addiction treatment (MAT) to meet the estimated population needs before July 1, 2029.

Describe how the county will assess the gap between current county MAT resources (including programs and providers) and MAT resources that can meet estimated needs
Marin County will assess the gaps between current county MAT resources and MAT resources that can meet estimated needs by analyzing data including, but not limited to:

- Prevalence rates of alcohol use disorders (AUD) and opioid use disorders (OUD) among the prospective service population
- Percentage of BHRS clients with an AUD and/or OUD who are prescribed MAT
- Timeliness data for accessing MAT services
- Inventory of number, type and capacity of organizations serving the prospective service population that offer MAT (e.g. location of MAT clinics, FTE/availability of MAT prescribers, MAT medications available, wait times for MAT, etc.)
- Mapping MAT availability and metrics such as overdoses and location of the service population
- MAT initiation and retention data, including analysis by race/ethnicity, primary language and other characteristics to understand any disparities in access, engagement and outcomes
- Solicit and analyze trends in qualitative data from hospital Substance Use Navigators on clients who are interested in MAT but for whom intake hours or appointment availability is a barrier
- Identifying the need for MAT initiation and maintenance in the jail and any gaps and strategies to address continuity of care upon release
- Other potential barriers to MAT, such as pharmacy access, stigma or other issues identified by individuals with an AUD or OUD and other stakeholders.

Select the following practices the county will implement to ensure same day access to MAT
Contract directly with MAT providers in the County
Leverage telehealth model(s)

What forms of MAT will the county provide utilizing the strategies selected above?
Buprenorphine
Naltrexone
Methadone

Housing Interventions

Planning

For related policy information, refer to 7.C.3 Program priorities and 7.C.4 Eligible and priority populations

System Gaps

Please identify the biggest gaps facing individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are Behavioral Health Services Act (BHSA) eligible in the county. Please use the following definitions to inform your response: No gap – resources and connectivity available; Small gap – some resources available but limited connectivity; Medium gap – minimal resources and limited connectivity available; Large gap – limited or no resources and connectivity available; Not applicable – county does not have setting and does not consider there to be a gap. Counties should refer to their local Continuum of Care (CoC) Housing Inventory Count (HIC) to inform responses to this question.

Supportive housing
Medium gap

Apartments, including master-lease apartments
Medium gap

Single and multi-family homes
Medium gap

Housing in mobile home communities
Large gap

(Permanent) Single room occupancy units
Large gap

(Interim) Single room occupancy units
Large gap

Accessory dwelling units, including junior accessory dwelling units
Medium gap

(Permanent) Tiny homes
Large gap

Shared housing
Medium gap

(Permanent) Recovery/sober living housing, including recovery-oriented housing
Large gap

(Interim) Recovery/sober living housing, including recovery-oriented housing
Medium gap

Assisted living facilities (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Large gap

License-exempt room and board
Medium gap

Hotel and Motel stays
Medium gap

Non-congregate interim housing models
Large gap

Congregate settings that have only a small number of individuals per room and sufficient common space (does not include behavioral health residential treatment settings)
Medium gap

Recuperative Care
Large gap

Short-Term Post-Hospitalization housing
Large gap

(Interim) Tiny homes, emergency sleeping cabins, emergency stabilization units
Large gap

Peer Respite
Large gap

Permanent rental subsidies
Medium gap

Housing supportive services
Medium gap

What additional non-BHSA resources (e.g., county partnerships, vouchers, data sharing agreements) or funding sources will the county behavioral health system utilize (local, state, and federal) to expand supply and/or increase access to housing for BHSA eligible individuals **?**
Marin will leverage vouchers, State, and Federal funding to expand supply. Additionally, Marin will utilize MCPs transitional rent to increase access to housing. CalAIM

Enhanced Care Management and Community Supports will be utilized to increase both access to housing and the number of individuals who stay permanently housed. In addition, Marin is utilizing Behavioral Health Bridge Housing (BHBH) Program to expand the supply of transitional housing, rental subsidies, and SLE subsidies. Of note, the Marin Housing Authority has been in a voucher shortfall since August 2024. This has slowed the availability for Section 8 Housing Choice Vouchers for unhoused individuals. Additionally, the Housing Authority has transitioned individuals and families who previously utilized an Emergency Housing Voucher onto the Housing Choice Voucher waitlist. These clients are prioritized higher than unhoused individuals, so they can retain housing. This has further reduced the availability of vouchers.

How will BHSA Housing Interventions intersect with those other resources and supports to strengthen or expand the continuum of housing supports available to BHSA eligible individuals?
Filling in gaps that will be left by both the end of the 6 month transitional rent subsidies by the managed care plans and by the end of BHBH in 2027, BHSA will be used to continue many of those successful programs. In addition, during this period of insufficient HUD vouchers, BHSA will be used to create 16 to 22 local Behavioral Health vouchers. In addition to rental assistance, BHSA Housing Interventions will also be used to create a peer respite facility and capital funding to complete a Homekey+ project converting a former convent into Permanent Supportive Housing.

What is the county behavioral health system's overall strategy to promote permanent housing placement and retention for individuals receiving BHSA Housing Interventions?
Marin views housing as a core component of treatment and recovery for people with serious mental illness and/or substance use disorders. The strategy centers on the idea that stable housing is the foundation which enables behavioral health treatment to be effective, and vice versa. The overall goal is to link people quickly to Coordinated Entry, behavioral health services, and housing. Marin expects that outreach staff will engage unsheltered individuals, especially in encampments, and provide warm hand-offs into BHSA-funded services, including initial behavioral health assessments and housing navigation. Specialized services including housing-focused case management and behavioral health treatment will be used to aid in housing retention.

What actions or activities is the county behavioral health system engaging in to connect BHSA eligible individuals to and support permanent supportive housing (PSH) (e.g., rental subsidies for individuals residing in PSH projects, operating subsidies for PSH projects, providing supportive services to individuals in other permanent housing settings, capital development funding for PSH)?
BHRS provides behavioral health treatment, including case management, to increase the likelihood that individuals stay in PSH. BHRS coordinates with the Marin Housing Authority through the Coordinated Entry process to ensure that BHSA-eligible clients can access tenant-based vouchers. BHRS and community providers deliver services needed for clients with SMI/SUD to utilize these subsidies successfully. Under this BHSA plan, the housing component will fund rental and operating subsidies at four different PSH programs and will invest in capital development funding for a new PSH in year one. Of

note, the Marin Housing Authority has been in a voucher shortfall since August 2024. This has slowed the availability for Section 8 Housing Choice Vouchers for unhoused individuals. Additionally, the Housing Authority has transitioned individuals and families who previously utilized an Emergency Housing Voucher onto the Housing Choice Voucher waitlist. These clients are prioritized higher than unhoused individuals, so they can retain housing. This has further reduced the availability of vouchers.

Please describe how the county behavioral health system will ensure all Housing Interventions settings provide access to clinical and supportive behavioral health care and housing services
BHRS will ensure that behavioral health services are easily accessible across all housing settings. BHRS will contract with providers to deliver on-site case management, peer support, and recovery groups, ensuring continuity of care. BHRS will ensure that individuals placed in BHSA housing settings are connected to behavioral health services, including but not limited to FSPs, outpatient mental health services, and substance use disorder services. BHRS will partner with MCPs to ensure individuals receive ECM and Community Supports.

Eligible Populations

Please describe how the county behavioral health system will identify, screen, and refer individuals eligible for BHSA Housing Interventions
Marin will continue to partner with community agencies and Marin's CoC to proactively identify individuals experiencing homelessness who may be eligible for BHSA Housing Interventions. Additionally, Marin will expand outreach and engagement to individuals experiencing homelessness through BHSA Housing Interventions. Marin will also continue to link existing BHRS clients to BHSA Housing Interventions through screening for housing needs at initial assessment and throughout treatment within clinical programs. BHRS will provide direct referrals to Marin's Coordinated Entry system and support clients through the process of securing housing.

Will the county behavioral health system provide BHSA-funded Housing Interventions to individuals living with a substance use disorder (SUD) only ?
Yes

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible children and youth **in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are:**

In, or at-risk of being in, the juvenile justice system
BHRS leadership continues to participate in the county's Executive Committee Juvenile Justice Workgroup, to address the unique needs of youth in, or at risk of, the juvenile justice system. In addition, Marin reviewed relevant data and incorporated community input to identify housing needs.

Lesbian, Gay, Bisexual, Transgender, Queer, Plus (LGBTQ+)
Marin Youth and Family Services partners with the Marin LGBTQ+ Center and other local advocacy groups to elevate the voices of LGBTQ+ youth. Through these relationships our leadership team can hear about changes in the experience and needs of LGBTQ+ youth in Marin County. Additionally, a LGBTQ+ focused session was held during community planning where housing and LGBTQ+ affirming services were identified as priorities.

In the child welfare system
Marin BHRS is a strong partner with our Child Welfare Division (Children and Family Services), who not only track data on affected children and youth, but also lead a quarterly multidisciplinary meeting (AB 2083) that reviews trends and needs in the Child Welfare population.

What actions or activities did the county behavioral health system engage in to consider the unique needs of eligible adults in the development of the county's Housing Interventions services (e.g., review data, engage with stakeholders, analyze research, etc.) who are

Older adults
BHRS has developed an understanding of the housing needs of older adult through the Helping Older People Excel (HOPE) Program which has been a successful 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. In addition to reviewing relevant data, BHRS engaged with stakeholders who represent the unique needs of older adults, including the Marin County Aging and Adult Services and the Commission on Aging. Marin also held two older adult-focused community planning sessions to inform Marin's Housing Interventions services for older adults. Marin's first priority population identified for specialty housing program under MHSA was older adults resulting in the development of two MHSA housing programs for older adults with serious mental illness: Fireside and Victory Village. The Marin CoC Homelessness Policy Steering Committee also maintains a subcommittee on Older Adult Homelessness which meets regularly to discuss strategies and progress and shares that information with BHRS.

In, or are at risk of being in, the justice system
Since 2006, Marin BHRS has operated the Support and Treatment After Release (STAR) Full-Service Partnership, which provides intensive services to justice-involved adults with serious mental illness who are at risk of homelessness, incarceration, hospitalization, or institutionalization. In addition to analyzing relevant local data, BHRS receives ongoing input on behavioral health priorities from community-based agencies and advocates and public safety partners. Marin's Innovation project "From Housing to Healing: A Re-Entry Community for Women" has provided healing-centered and holistic treatment for women with a serious mental illness and potentially co-occurring substance use disorders who have been incarcerated or otherwise resided in a locked facility since 2022. Originally starting with 6 residents, Carmelita House was expanded in 2023 to serve additional residents. An increased understanding of the unique needs of women with lived experience in the justice system informed the decision to add

a PSH component to Carmelita House.

In underserved communities
Marin County receives regular feedback on housing needs through ongoing partnerships with community agencies that serve BIPOC residents, immigrants, rural West Marin residents, and low-income communities disproportionately impacted by homelessness. Findings from the 2025 Community Health Assessment, which identified housing and homelessness as priority concerns, further informed planning. In addition, BHRS reviewed statewide behavioral health data on homelessness to identify disparities that Housing Interventions services can address in underserved communities. Additional analyses conducted by the Division of Homelessness and Coordinated Care has also identified a disproportionate number of BIPOC residents experiencing homelessness and the Division has crafted a series of race equity focused goals and strategies to reduce this disproportionate impact in homelessness.

Local Housing System Engagement

How will the county behavioral health system coordinate with the Continuum of Care (CoC) and receive referrals for Housing Interventions services?
BHRS will continue to partner closely with Marin County's Division of Homelessness and Coordinated Care, which acts as host for the Marin County CoC, to utilize existing referral pathways and expand outreach to individuals eligible for BHSA Housing Interventions.

Please describe the county behavioral health system's approach to collaborating with the local CoC, Public Housing Agencies, Medi-Cal managed care plans (MCPs), Enhanced Care Management (ECM) and Community Supports providers, as well as other housing partners, including existing and prospective PSH developers and providers in your community in the implementation of the county's Housing Interventions

Local CoC
BHRS will collaborate with Marin's CoC by providing direct referrals to Coordinated Entry and support clients through the process of securing housing.

Public Housing Agency
Partner with the Marin Housing Authority to maximize use of federal and local rental assistance. BHRS will provide coordinated supportive services to clients who are homeless or at-risk of homelessness. BHRS will assist in maintaining housing stability through supporting clients in finding and maintaining housing, verifying eligibility for clients being considered for vouchers, and navigating housing voucher bureaucracy via Shelter+Care.

MCPs
BHRS will leverage MCPs transitional rent and Enhanced Case Management services to serve clients who are homeless or at-risk of homelessness, reduce duplication of services, and expand reach. BHRS will collaborate with MCPs on referral tracking, utilization of MCP benefits, and monitoring outcomes.

ECM and Community Supports Providers
BHRS will align services to ensure ECM work in collaboration with BHRS clinicians, FSPs, and peers to provide team-based care. BHRS will work with ECM and Community Support Providers to create referral protocols where providers can refer individuals with unmet behavioral health needs to BHRS and conversely BHRS can connect eligible clients to providers for housing supports.

Other (e.g., CalWORKS/TANF housing programs, child welfare housing programs, PSH developers and providers, etc.)
BHRS will continue its partnership with CFS to identify youth at risk of homelessness and connect them to BHSA housing resources. BHRS will partner with nonprofit housing developers to integrate BHRS services into new PSH projects.

How will the county behavioral health system work with Homekey+ and supportive housing sites to provide services, funding, and referrals that support and house BHSA eligible individuals?
The County Behavioral Health System was the primary applicant on Marin's Homekey+ application with Catholic Charities of S.F. as the co-applicant. Marin BHRS committed to fund supportive services as well as rental and operating subsidies. In addition, BHRS plans to contract with Catholic Charities of S.F. for Specialty Mental Health Services onsite as well to promote a seamless service experience. Referrals for BHSA eligible individuals who are chronically homeless will be priorities through Coordinated Entry while up to three units may be filled with individuals who are at-risk of homelessness who will be prioritized through BHRS with a focus on those leaving incarceration or institutional settings.

Did the county behavioral health system receive Homeless Housing Assistance and Prevention Grant Program (HHAP) Round 6 funding?
No

BHSA Housing Interventions Implementation

The following questions are specific to BHSA Housing Interventions funding (no action needed). For more information, please see 7.C.9 Allowable expenditures and related requirements

Rental Subsidies (Chapter 7. Section C.9.1)
The intent of Housing Interventions is to provide rental subsidies in permanent settings to eligible individuals for as long as needed, or until the individual can be transitioned to an alternative permanent housing situation or rental subsidy source. (no action needed)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many individuals does the county behavioral health system expect to serve with rental subsidies under BHSA Housing Interventions on an annual basis?
Building up capacity and coordination with the Managed Care plans over the three year integrated plan period, we expect to be able to provide up to 22 local Behavioral Health vouchers by year 3 as well as support approximately 15 individuals per year in SLE settings offsetting rental costs. Currently the Marin Housing Authority has been in voucher shortfall for Section 8 since August 2024. Additionally, other voucher programs overseen by Marin Housing Authority that could serve this population, including Section 811 Mainstream and Shelter Plus Care have had limited availability. In addition, for project-based bundled rental and operating subsidies we will support 80 PSH units through the housing component as well as roughly 21 scattered site units, and 45 transitional units.

How many of these individuals will receive rental subsidies for permanent housing on an annual basis?
126

How many of these individuals will receive rental subsidies for interim housing on an annual basis?
50

What is the county's methodology for estimating total rental subsidies and total number of individuals served in interim and permanent settings on an annual basis?
The numbers stated above are the estimated number of individuals who will receive subsidies in the first year of the integrated plan. We anticipate the number to grow to 200 for number of individuals served in BHSA funded Term-limited settings in year 2 (including the Peer Respite program and BHBH programs that will be transitioned to BHSA) and 163 individuals served in non-time limited settings with the expansion of the Flex Pool and more individuals who will have utilized their initial 6 months with the managed care plan funding.

For which setting types will the county provide rental subsidies?
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Single and multi-family homes
Non-Time-Limited Permanent Settings: Shared housing
Non-Time-Limited Permanent Settings: Recovery/Sober Living housing, including recovery-oriented housing
Non-Time-Limited Permanent Settings: Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Non-congregate interim housing models
Time Limited Interim Settings: Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls)[134] (does not include behavioral health residential treatment settings)
Time Limited Interim Settings: Peer respite

Will this Housing Intervention accommodate family housing?
Yes

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
This intervention provides non–time-limited rental subsidies in a variety of permanent housing settings to eligible individuals living with serious mental illness or co-occurring conditions. The goal is to ensure that cost is never a barrier to housing stability, thereby promoting recovery, independence, and long-term wellness. Subsidies are provided for as long as needed, or until the individual transitions successfully to another permanent housing resource or alternative rental subsidy. Expected outcomes include increased housing stability, reduced homelessness, and improved behavioral health outcomes. By leveraging BHSA funds alongside federal, state, and local resources, this intervention maximizes impact while ensuring individuals have the housing and supports necessary for long-term stability.

Will the county behavioral health system provide rental assistance through project-based (tied to a particular unit) or tenant-based (tied to the individual) subsidies?
Project-based
Tenant-based

How will the county behavioral health system identify a portfolio of available units for placing BHSA eligible individuals, including in collaboration with other county partners and as applicable, Flex Pools (e.g., Master Leasing)? Please include partnerships and collaborative efforts your county behavioral health system will engage in
In the last five years of MHSA, Marin County BHRS has built up a number of different PSH for individuals who are BHSA eligible. In addition, BHRS plans to expand capacity with their contracted scattered-site housing provider through BHSA Housing Funds. BHRS collaborates closely with the Homelessness and Coordinated Care division of Marin County HHS who is charged with overall coordination of Marin County's homelessness response and prevention efforts, leading county-wide collaboratives with relevant parties.

Total number of units funded with BHSA Housing Interventions per year
116

Please provide additional details to explain if the county is funding rental subsidies with BHSA Housing Interventions that are not tied to a specific number of units
Approximately 22 people will receive tenant-based subsidies rather than project-based subsidies. In that case they are not tied to a specific number of units.

Operating Subsidies (Chapter 7, Section C.9.2)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
169

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
This intervention will provide operating subsidies to ensure the financial sustainability of housing programs serving individuals with serious behavioral health conditions. Operating subsidies will cover the gap between the actual costs of operating housing and the revenue generated, ensuring programs remain viable, stable, and accessible. BHSA Housing Interventions funding will be used to support a range of eligible costs, including building operations, property management, and staffing necessary for tenancy support. Through BHSA Housing Interventions funding, operating subsidies will provide ongoing financial support essential to maintaining both permanent and interim housing options, ensuring that individuals with behavioral health needs have consistent access to safe, affordable, recovery-oriented housing. This includes PSH, Peer Respite, and transitional housing.

For which setting types will the county provide operating subsidies?
Non-Time-Limited Permanent Settings: Apartments, including master-lease apartments
Non-Time-Limited Permanent Settings: Supportive housing
Non-Time-Limited Permanent Settings: Shared housing
Time Limited Interim Settings: Hotel and motel stays
Time Limited Interim Settings: Peer respite
Time Limited Interim Settings: Non-congregate interim housing models

Will this be a scattered site initiative?
No

Will this Housing Intervention accommodate family housing?
No

Total number of units funded with BHSA Housing Interventions per year
116

Please provide additional details to explain if the county is funding operating subsidies with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Landlord Outreach and Mitigation Funds (Chapter 7, Section C.9.4.1)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
This service is funded by BHBH funding through FY26/27. The County will use BHBH funding in FY26/27 rather than BHSA Housing. At this point Landlord Outreach and Mitigation funding has not prioritized as a BHSA Housing component program due to limited funding. However, if it proves to be a valuable priority under BHBH, this might be added in an annual update.

Anticipated number of individuals served per year
0

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
N/A

Total number of units funded with BHSA Housing Interventions per year
0

Please provide additional details to explain if the county is providing landlord outreach and mitigation funds with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Participant Assistance Funds (Chapter 7, Section C.9.4.2)

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
We will be utilizing BHBH funding for this service instead of BHSA Housing and learning from the implementation and utilization of this service under BHBH prior to committing any BHSA funds. At this point Participant Assistance Funds have not been prioritized as a BHSA Housing component program due to limited funding.

Anticipated number of individuals served per year
0

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
N/A

Housing Transition Navigation Services and Tenancy Sustaining Services (Chapter 7, Section C.9.4.3)
Pursuant to Welfare and Institutions (W&I) Code section 5830, subdivision (c)(2), **BHSA Housing Interventions may not be used for housing services covered by Medi-Cal MCP. Please select Yes only if the county is providing these services to individuals who are not eligible to receive the services through their Medi-Cal MCP (no action needed)**

Is the county providing this intervention?
No

Please explain why the county is not providing this intervention
This service is funded by both the Managed Care Plans and by BHBH funding. The County will use BHBH funding in FY26/27 rather than BHSA Housing. At this point Housing Transition Navigation Services and Tenancy Sustaining Services funding has not prioritized as a BHSA Housing component program due to limited funding and the availability of MCP covered benefits. After the first three-year plan period BHRS will have more data and understanding of how the MCPs in Marin are providing this benefit and whether additional funding allocated to this category should be a priority.

Anticipated number of individuals served per year
0

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
N/A

Housing Interventions Outreach and Engagement (Chapter 7, Section C.9.4.4)

Is the county providing this intervention?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

Anticipated number of individuals served per year
250

Please provide a brief description of the intervention, including specific uses of BHSA Housing Interventions funding
Engage unserved individuals experiencing homelessness in the behavioral health system so that they may receive the appropriate services. Provide peer outreach and engagement from individuals with lived experience who work to engage and build trust with individuals experiencing homelessness who potentially have a serious mental illness.

Capital Development Projects (Chapter 7, Section C.10)

Counties may spend up to 25 percent of BHSA Housing Interventions on capital development projects. Will the county behavioral health system use BHSA Housing Interventions for capital development projects?
Yes

Is the county providing this intervention to chronically homeless individuals?
Yes

How many capital development projects will the county behavioral health system fund with BHSA Housing Interventions?
1

Capital Development Project

Capital Development Project Specific Information
Please complete the following questions for each capital development project the county will fund with BHSA Housing Interventions

Name of Project
Carmelita House PSH

What setting types will the capital development project include?
Non-Time-Limited Permanent Settings: Supportive housing

Capacity (Anticipated number of individuals housed at a given time)
9

Will this project braid funding with non-BHSA funding source(s)?
Yes

Total number of units in project, inclusive of BHSA and non-BHSA funding sources
9

Total number of units funded with Housing Interventions funds only
0

Please provide additional details to explain if the county is funding capital development projects with BHSA Housing Interventions that are not tied to a specific number of units
N/A

Anticipated date of unit availability (Note: DHCS will evaluate unit availability date to ensure projects become available within a reasonable timeframe)
3/1/2027

Expected cost per unit (Note: the BHSA Housing Intervention portion of the project must be equal to or less than $450,000)
170213

Have you utilized the “by right” provisions of state law in your project?
Yes

Other Housing Interventions

If the county is providing another type of Housing Interventions not listed above, please describe the intervention
None

Is the county providing this intervention to chronically homeless individuals?
No

Anticipated number of individuals served per year
0

Continuation of Existing Housing Programs

Please describe if any BHSA Housing Interventions funding will be used to support the continuation of housing programs that are ending (e.g., Behavioral Health Bridge housing)
Yes, BHSA Housing Intervention funding will be used to continue BHBH programs in years 2 and 3 of this integrated plan.

Relationship to Housing Services Funded by Medi-Cal Managed Care Plans

For more information, please see 7.C.7 Relationship to Medi-Cal Funded Housing Services

Which of the following housing-related Community Supports is the county behavioral health system an MCP-contracted provider of?

For which of the following services does the county behavioral health system plan to become an MCP-contracted provider of?

Housing Transition Navigation Services
Undecided

Housing Deposits
Undecided

Housing Tenancy and Sustaining Services
Undecided

Short-Term Post-Hospitalization Housing
No

Recuperative Care
No

Day Habilitation
No

Transitional Rent
Undecided

How will the county behavioral health system identify, confirm eligibility, and refer Medi-Cal members to housing-related Community Supports covered by MCPs (including Transitional Rent)?
Marin County BHRS and HCC will refer clients in need of CS to either the County's CS program or other CS programs in Marin as needed and in alignment with the CalAIM required referral processes.

Please describe coordination efforts and ongoing processes to ensure the county behavioral health contracted provider network for Housing Interventions is known and shared with MCPs serving your county
HCC, in partnership with BHRS and other HHS divisions, will be convening a homelessness CalAIM working group to ensure that there is awareness of all currently funded ECM and CS programs in Marin between the County and all CBOs.

Does the county behavioral health system track which of its contracted housing providers are also contracted by MCPs for housing-related Community Supports (provided in questions #1 and #2 above)?
No

What processes does the county behavioral health system have in place to ensure Medi-Cal members living with significant behavioral health conditions do not experience gaps in service once any of the MCP housing services are exhausted, to the extent resources are available?
Most individuals with significant behavioral health conditions are also connected to BHRS' FSPs or through support from housing-based case managers under HCC's homelessness response system.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are an effective model to streamline and simplify administering rental assistance and related housing supports. DHCS released the Flex Pools TA Resource Guide that describes this model in more detail linked here: Flexible Housing Subsidy Pools - Technical Assistance Resource. Please reference the TA Resource Guide for descriptions of the Flex Pool model and roles referenced below including the Lead Entity, Operator, and Funder.

For related policy information, refer to 7.C.8 Flexible Housing Subsidy Pools .

Is there an operating Flex Pool (or elements of a Flex Pool, which includes (1) coordinating and braiding funding streams, (2) serving as a fiscal intermediary, (3) identifying, securing, and supporting a portfolio of units for participants, and/or (4) coordinating with providers of housing supportive services) in the county (please refer to DHCS' Flex Pools TA Resource Guide)?
No

Is the county behavioral health system involved in planning efforts to launch a Flex Pool in the county?
Yes

What role does the county behavioral health system plan to have in the Flex Pool?
Funder

Have you identified an Operator of the Flex Pool?
No

Does the county plan to administer some or all Housing Interventions funds through or in coordination with the Flex Pool?
Yes

Which Housing Interventions does the county plan to administer through or in coordination with the Flex Pool?
Rental Subsidies

Please describe any other roles and functions the county behavioral health system plans to take to support the operations or launch and scaling of a Flex Pool in addition to those described above
Marin will release an RFP to identify an Operator of the Flex Pool.

Behavioral Health Services Fund: Innovative Behavioral Health Pilot and Projects

For each innovative program or pilot provide the following information. If the county provides
more than one program, use the “Add additional program” button. For related policy information, refer to 7.A.6 Innovative Behavioral Health Pilots and Projects

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Does the county’s plan include the development of innovative programs or pilots?
No

Workforce Strategy

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.C.2 Securing Medi-Cal Payment.

Maintain an Adequate Network of Qualified and Culturally Responsive Providers

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The county must ensure its county-operated and county-contracted behavioral health workforce is well-supported and culturally and linguistically responsive with the population to be served.
Through existing Medi-Cal oversight processes, the Department of Health Care Services (DHCS) will assess whether the county:

Maintains and monitors **a network of providers that is sufficient to provide adequate access to services and supports for individuals with behavioral health needs; and**

Meets federal and state standards **for timely access to care and services, considering the urgency of the need for services.**

The county must ensure **that Behavioral Health Services Act (BHSA)-funded providers are qualified to deliver services, comply with nondiscrimination requirements, and deliver services in a culturally competent manner. Effective FY 2027-2028, DHCS encourages counties to require their BHSA providers to comply with the same standards as Medi-Cal providers in these areas (i.e. requiring the same standards regardless of whether a given service is reimbursed under BHSA or Medi-Cal), as described in the Policy Manual.**

Does the county intend to adopt this recommended approach for BHSA-funded providers that also participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Does the county intend to adopt this recommended approach for BHSA-funded providers that do not participate in the county's Medi-Cal Behavioral Health Delivery System?
Yes

Build Workforce to Address Statewide Behavioral Health Goals

For related policy information, refer to 3.A.2 Contents of Integrated Plan and 7.A.4 Workforce Education and Training

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Assess Workforce Gaps

What is the overall vacancy rate for permanent clinical/direct service behavioral health positions in the county (including county-operated providers)?
17%

Upload any data source(s) used to determine vacancy rate (optional)

For county behavioral health (including county-operated providers), please select the five positions with the greatest vacancy rates
Other qualified provider
Licensed Clinical Social Worker
Licensed Marriage and Family Therapist
Licensed Professional Clinical Counselor
Medi-Cal Certified Peer Support Specialist

Please describe any other key workforce gaps in the county
Unfortunately, the behavioral health positions listed above do not fully align with the job classifications in Marin County (e.g., Marin's job classification of Licensed Crisis Specialist can be held by a LCSW, a LMFT, or a LPCC). The job classifications in Marin with the highest vacancy rates are Social Service Worker II Bilingual, Social Service Worker II, and Licensed Crisis Specialist. The most challenging gap has historically been with our Crisis Specialist assisting with coverage during off-hours. Currently based on data our biggest gap has been with language access and positions that support that.

How does the county expect workforce needs to shift over the next three fiscal years given new and forthcoming requirements, including implementation of new evidence-based practices under Behavioral Health Transformation (BHT) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)?
Due to the implications of Proposition 1, the workforce is expected to undergo significant changes. This division will be responsible for identifying essential service areas and determining which functions may need to be reduced as a result of limited funding. At the same time, a key strategy will focus on preserving as many positions as possible, with the goal of avoiding layoffs.

Address Workforce Gaps

If the county is planning to leverage the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) workforce initiative to address workforce gaps including for FSP and CSC for FEP, such as through applying for and/or encouraging providers to apply for the following BH-CONNECT workforce programs, please specify below.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Scholarship Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Marin will advertise opportunities and encourage staff to apply.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Student Loan Payment Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Marin will advertise opportunities and encourage staff to apply.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Recruitment and Retention Program?
No

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Community-Based Provider Training Program?
Yes

Please explain any actions or activities the county is engaging in to leverage the program
Marin will advertise opportunities and encourage staff to apply.

Is the county planning to leverage the BH-CONNECT workforce initiative by applying for the Behavioral Health Residency Program?
No

Please describe any other efforts underway or planned in the county to address workforce gaps aside from those already described above under Behavioral Health Services Act Workforce, Education, and Training
Marin will leverage state workforce initiatives, pursue innovative local training and pipeline partnerships, and strengthen retention strategies to address workforce gaps.

Budget and Prudent Reserve

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 6.B.3 Local Prudent Reserve .

Budget and Prudent Reserve

Download and complete the budget template using the button below before starting this section

Please upload the completed budget template
Integrated Plan Budget_PUBLIC_COMMENT

Please indicate how the county plans to spend the amount over the maximum allowed prudent reserve limit for each component if the county indicated they would allocate excess prudent reserve funds to a given Behavioral Health Services Act component in Table Nine of the budget template

Behavioral Health Services and Supports (BHSS)
N/A - we are already below the new 20% reserve limit.

Full Service Partnership (FSP)
N/A - we are already below the new 20% reserve limit.

Housing Interventions
N/A - we are already below the new 20% reserve limit.

Enter date of last prudent reserve assessment
8/19/2025

Please describe how the use of excess prudent reserve funds drawn down from the local prudent reserve aligns with the goals of the Integrated Plan

BHSS
N/A - we are already below the new 20% reserve limit.

FSP
N/A - we are already below the new 20% reserve limit.

Housing Interventions
N/A - we are already below the new 20% reserve limit.

Plan Approval and Compliance

All fields must be completed unless marked as optional. You don't need to finish everything at once–your progress will be saved automatically as you go. Use "Return to plan" to navigate between sections and track overall progress. For more information on this section, please see 3.A.1 Reporting Period

Behavioral health director certification

Download and complete the behavioral health director certification template using the button below before starting this section

Please upload the completed Behavioral health director certification template
Marin County Behavioral Health Director Certification Signed.pdf

County administrator or designee certification

Download and complete the county administrator or designee certification template using the button below before starting this section

Please upload the completed County administrator or designee certification template
County_Administrator_or_Designee_Certification_Template signed.pdf

Board of supervisor certification

Download and complete the board of supervisor certification template using the button below before starting this section

Please upload the completed Board of supervisor certification template

Uploaded Documents

1. 2025.3.14 2024-25 integrated workplan Final
2. BHSA Community Planning Process Demographics and Feedback
3. Integrated Plan Budget_PUBLIC_COMMENT
4. Marin County Behavioral Health Director Certification Signed
5. County_Administrator_or_Designee_Certification_Template signed

Quality Assurance & Performance Improvement Work Plan
FY 2024-2025

Health & Human Services Department
Behavioral Health and Recovery Services Division
Todd Schirmer, PhD, CCHP, Behavioral Health Director

Quality Management Program

The Marin Behavioral Health and Recovery Services Division (BHRS) Quality Management (QM) program is responsible for monitoring effectiveness, providing support, and conducting performance monitoring activities which include: utilization management, utilization review, provider appeals, credentialing and monitoring, resolution of beneficiary grievances, and analysis of beneficiary and system outcomes. The QM program's activities are guided by federal and state regulations, including Title 42 of the Code of Federal Regulations, California Code of Regulations Title 9, California Welfare and Institutions Code, as well as BHRS' integrated contract with the California Department of Health Care Services (DHCS).

The **Utilization Management (UM) Team**, a component of the QM program assures that beneficiaries have appropriate access to specialty mental health and substance use treatment services. Program activities include: the evaluation of medical necessity determinations, and continuous monitoring of the appropriateness and efficiency of services.

The **Administrative Operations Committee** is led by Operations and Administrative representatives. The BHRS Operations Director and Administrative Services Manager (ASM)take primary responsibility for setting the agendas and sponsoring the work of the committee to identify and problem-solve issues across the BHRS system that relate to the Electronic Health Record (EHR) system, the practice management system, policies and procedures, documentation processing, credentialing and onboarding and other administrative tasks that are essential to the integrity of BHRS operations.

The **Quality Improvement (QI) Team**, monitors the overall service delivery system with the aim of improving care provision and increasing consumer and family member satisfaction and outcomes. QI is also responsible for the ongoing implementation of the Federal Managed Care Final Rule, including the Provider Directory, Network Adequacy submissions and other related documents.

The **Quality Improvement Committee** (QIC) is a combined mental health (MH) and substance use services (SUS) committee, and is comprised of a diverse group of stakeholders, including representatives from MH and SUS administration and clinical programs, the Behavioral Health Board,

peers/family members, the Patient Rights Advocate, and contractors/community partners from both MH and SUS agencies. Quarterly QIC meetings include findings from a range of compliance and quality improvement activities, and obtain input into these and other areas for improvement.

The **Incidence and Grievance Subcommittee** of the QIC is attended by the Medical Director, QI Coordinator, QM Division Director, Adult Services Division Director, Youth and Family Division Director, Substance Use Division Director, Program Manager Crisis Continuum of Care, Program Manager Adult Services, Program Manager for Substance Use Services, and on ad hoc basis Program Supervisors. It meets quarterly to evaluate and analyze trends of grievances, appeals, fair hearings, and unusual occurrences to identify issues or trends that require implementation of system changes. It also makes improvement recommendations. Findings from this meeting are presented to the QIC stakeholders as required.

The **Policy and Procedure Subcommittee meets** as needed to draft and/or update new or existing policies and procedures.

The **Equity and Community Partnerships Committee (ECPC)** which is comprised of BHRS management and staff, contract agency providers, consumer advocates, consumers, community leaders and stakeholders. There are working subcommittees within the Board responsible for discrete content areas such as training, policies, and access. The 20+-member board is tasked to analyze data, review existing improvement plans, examine practice approaches and make recommendations related to policy, service delivery, staffing and training needs, and system improvements.

Quality Assessment and Performance Improvement Work Plan

The Quality Assurance and Performance Improvement Work Plan creates systems whereby improvement related data is available in an easily interpretable and actionable form. The QAPI Work Plan is evaluated and updated annually. The elements of this Work Plan are informed by the quality improvement requirements BHRS' integrated contract as well as feedback received from the External Quality Review and DHCS Annual and Triennial audit findings.

I) Access To Care

1) Network Adequacy: 274 Compliance

Goal/Requirement	Programs involved	Actionable Items	Measurement
Report and assess Network Adequacy including submitting 274 files every month. Further, be able to submit 274 files with new Implementation guidelines 3.0 released by the State	- EHR team - SUD - QM	Work with the EHR vendor to change 274 file and meet the new state mandated format by May 10th and June 10th deadlines	Successful submissions of MH and SUD 274 files by DHCS deadlines

2) After hours services

Goal/Requirement	Programs involved	Actionable Items	Measurement
Develop performance metrics to measure performance of after hours care; Crisis Stabilization Unit, Mobile Crisis response, 24/7 Access hotline	- SUD - QM - CSU - Access	Develop Key Performance Indicators to measure performance of after hour services, based on quarterly MCRT data. Report performance at quarterly Quality Improvement Committee meeting	QIC minutes show performance was reported.

3) Access phoneline

Goal/Requirement	Programs involved	Actionable Items	Measurement
- Conduct test calls (including in languages other than English) and measure the time it takes to answer calls. Ensure that test calls are conducted during and after business hours - Reduce percent of all calls that go voicemail	- MH - SUD - Access	Improve the number of Test calls answered live Test call are appropriately logged 100% of the time Reorganize Access team staffing to increase staff available to answer calls Analyze percent of all calls that go to voicemail so that we can lay the foundation for an improvement project near year Report test call results on the quarterly 24/7 Access Line report	Successfully complete all test calls requirements. Percent of calls going to voicemail tracked

4) Timeliness: Follow-up and time to first appointment

Goal/Requirement	Programs involved	Actionable Items	Measurement
1. Offer follow-up for those undergoing a course of treatment for non-urgent MH services. (Goal is 10 days) 2. Time from first contact to first appointment for MH and SUD (10 days for routine care, 3 days for OTP)	- MH - SUD - Access	Improve the time to offer Follow-Up for those undergoing a course of treatment for Non-urgent services Report time from first contact to first appointment quarterly at QIC	Reduced the average for the number of days for Non-urgent follow up services from 13.7 to 10 90% of kept first appointments are within guidelines for time from first contact

5) Timeliness: Provider tracking

Goal/Requirement	Programs involved	Actionable Items	Measurement
Gather timeliness data using SmartCare timeliness form and develop training for providers	-SUD - MH	- Train providers how to use the timeliness form - Track completion quarterly - Discuss progress at site visits - Regular reminders	Reduce by 10% the number of missing timeliness forms completed for new clients, per SmartCare 'New Clients Program Specific […]TADT report'

II) Care Coordination

1) Substance Use Treatment Perception Survey responses

Goal/ Requirement	Programs involved	Actionable Items	Measurement
Improve client's perception that their care is coordinated (at least physical health, mental health, and substance use domains at a minimum)	- SUD	Review quantitative and qualitative TPS responses related to Care Coordination and identify improvement projects	- Discuss results at Provider Meeting and at SUD Admin staff meeting - Determine at least one project for improvement

2) Post-psychiatric Hospitalization Follow-Up and reduction of avoidable hospitalization

Goal/Requirement	Programs involved	Actionable Items	Measurement
Provide timely post-psychiatric hospitalization follow-up appointment in order to reduce avoidable re-hospitalizations	- MH - SUD	Partner with the Adult and Older Adult System of Care to identify root causes of 30 day recidivism	- Bring down Follow-up appointment post-psychiatric hospitalization average to 7 days - Bring down Post-psychiatric hospitalization readmission within 30 days to ≤10%

III) Beneficiary Rights and Satisfaction

1) Client Satisfaction

Goal/Requirement	Programs involved	Actionable Items	Measurement
Client Satisfaction Survey data (POQI and TPS) are reviewed, shared with providers, and used to identify internal or external performance improvement projects	- Quality Management - SUD	Review of response data with providers Identify PIP projects based on client data	- MH: Increase the overall number of POQI participants by 15% - SUD: At least 50% of contracted providers have PIPs related to client input proposed by 6/30/25

2) Client grievances and appeals and Change of Provider Request

Goal/Requirement	Programs involved	Actionable Items	Measurement
Respond to client dissatisfaction indicators in a timely way and analyze these data for trends that may identify areas for improvement	- MH - SUD	Review grievances and appeals on a quarterly basis at the QIC meeting Review provider change requests, grievances and appeals semi-annually with the grievance sub-committee to determine any feedback or policy revision and/or system changes.	Log and resolve all grievances and appeals in accordance with the timeframes identified by DHCS

IV) Documentation standards and compliance

1) Utilization Review – Clinical Documentation

Goal/Requirement	Programs involved	Actionable Items	Measurement
Improve quality of clinical documentation as evidenced by < 5% disallowance rates for 70% of programs reviewed during FY24-25	- Quality Management - MH - SUD	Provide clinical documentation training to all new clinical staff within six months after hire	Decrease UR disallowance rate for programs with a prior disallowance rate > 5% to < 5% by conducting re-reviews and training for those programs/providers within 6 to 9 months from the date the initial report is disseminated

2 Utilization Review – Frequency and rate of review

Goal/Requirement	Programs involved	Actionable Items	Measurement
Review a minimum of 5% of medical records from every BHRS mental health and substance use program and contract provider program reviewed annually and provide UR results to provider	- Quality Management - MH - SUD	Provide completed reports to programs within 30 calendar days of the utilization review	- Continue to review a minimum of 5% of medical records - Conduct re-reviews of programs that have high disallowance rates (>5%) following UR review (>5%) within 6-9 months

3) Utilization Management –Monitor Safe and Effective Medication Practices

Goal/Requirement	Programs involved	Actionable Items	Measurement
1. Ensure that all clients who are prescribed medication have a current, signed medication consent form on file, including all required elements (and any required JV-220 forms), 100% of the time 2. Increase the number of medication consent forms received	- Quality Management	Develop a strategy to consistently notate and track client consent to medication in the client record in the new EHR	QM staff and Medical Director or designee will continue to conduct medication monitoring reviews for at least 5% of the medical records, including review of required consent forms and any JV-220 forms, if applicable

V) Cultural and Linguistic Competence and Humility

1) Cultural Humility Training compliance

Goal/Requirement	Programs involved	Actionable Items	Measurement
1. Improve cultural humility and sensitivity within the delivery system and increase awareness of disparities for populations based on race/ethnicity and sexual orientation and gender identity and expression (SOGIE) 2. Increase number of providers that speak a language other than English	- Quality Management - Equity and Inclusion Dept	- BHRS WET Team will monitor Cultural Humility training hours completed to ensure that BHRS staff are in compliance	- At least 80% of Marin providers will complete the minimum Cultural Humility Training requirements - Number of providers who speak a language other than English per 274 reporting

VI) Performance Improvement Projects, Quality Improvement

1) PIP: FUA

Goal/Requirement	Programs involved	Actionable Items	Measurement
Improve substance use treatment follow up after an Emergency Department visit for a Substance Use reason	SUD	Continue current intervention of bilingual Recovery Coach assigned to clients in the ED. Work with CalMHSA to identify intervention(s) for new PIP cycle	At least one new intervention identified by June 2025

2) PIP: Timely Access (see also timeliness section above)

Goal/Requirement	Programs involved	Actionable Items	Measurement
Improve the number of new clients who receive their first non-urgent, non-psychiatric service within 10 business days of request	MH	Move assessments out of access and focus on screening tools and triaging to place clients in programs more quickly Adhere to no wrong door policy which allows clients to be seen for services prior to assessment being completed	At least one new intervention identified by June 2025

3) MAT penetration for SUD clients

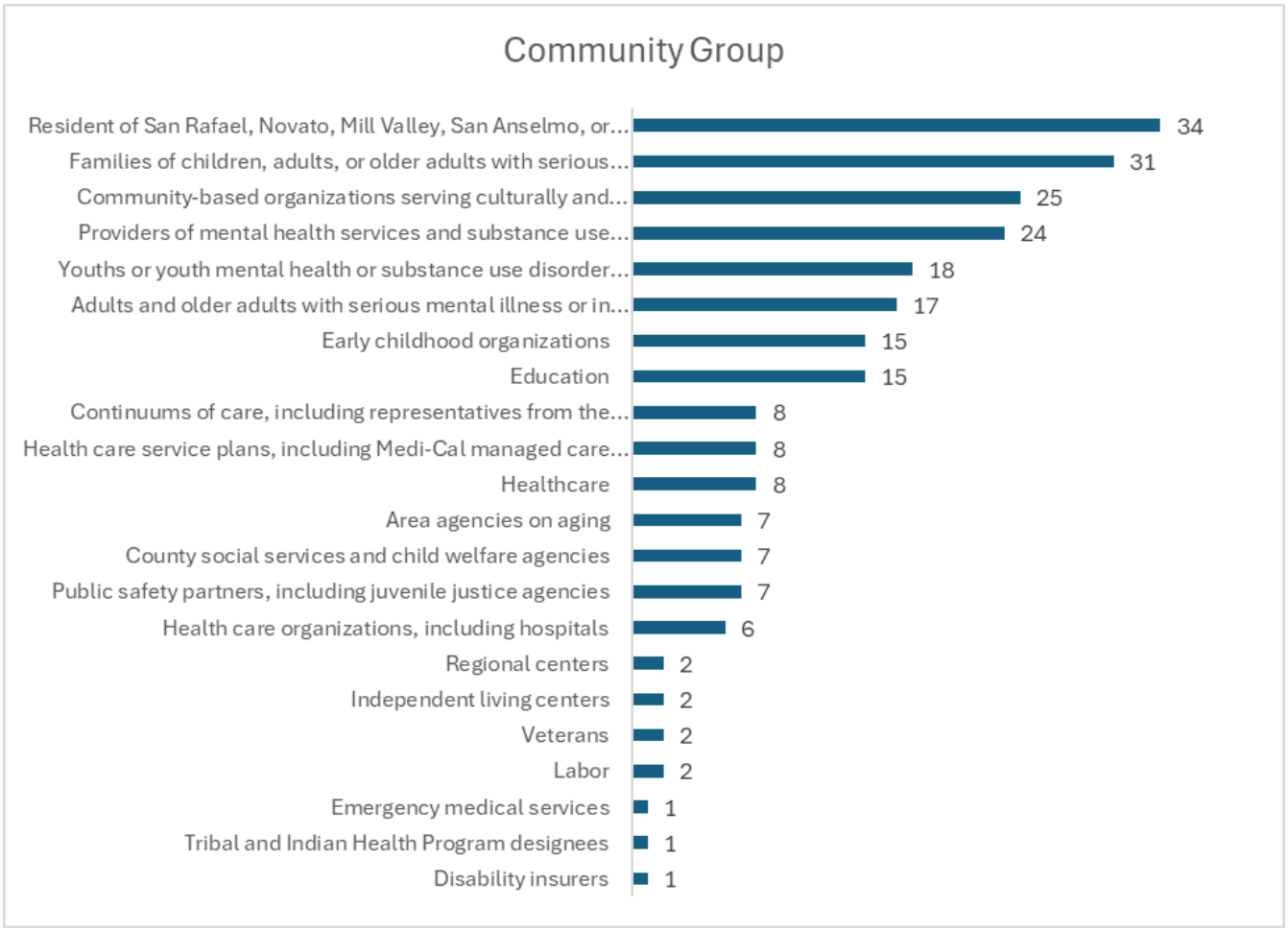
Goal/Requirement	Programs involved	Actionable Items	Measurement
Increase the percent of Substance Use clients who are also receiving Medications for Addiction Treatment (MAT)	SUD	- Incentivize providers to add more MAT prescribing capacity - Reduce stigma around MAT	% of SUD clients with opioid use disorder with MAT services in the year

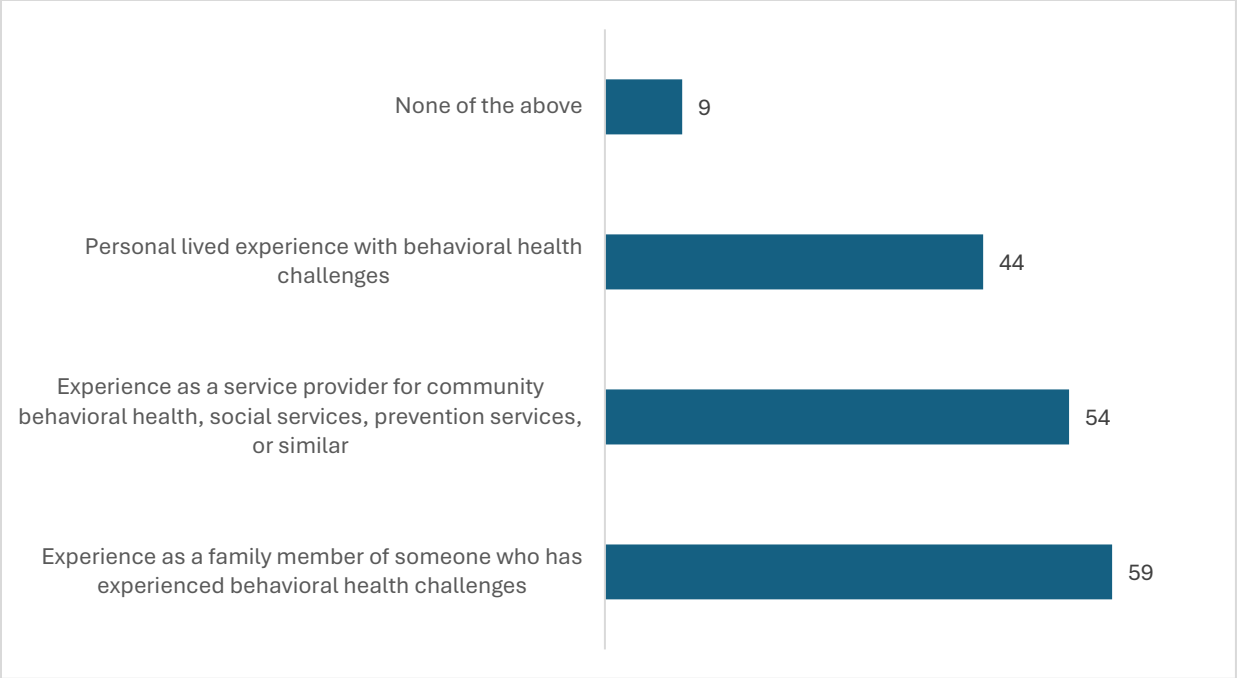
Community Planning Sessions

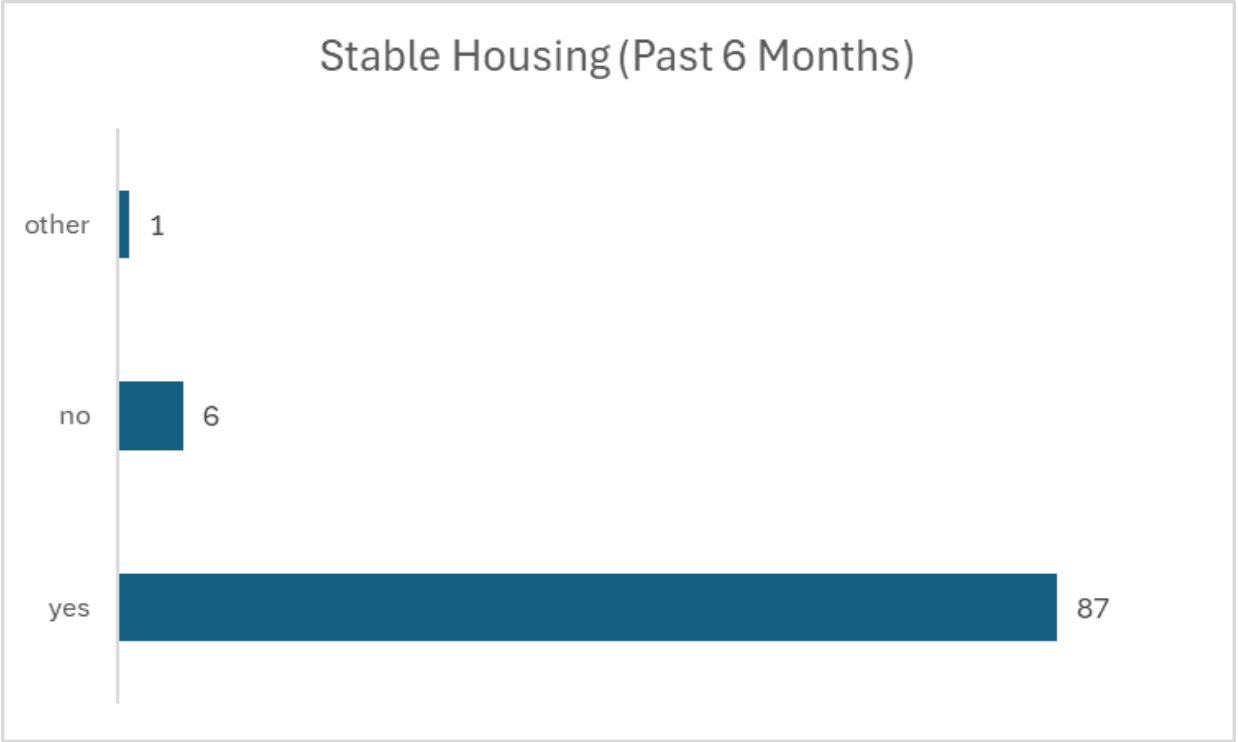
From 11/14/2024 – 5/21/2025, 31 in-person and Zoom sessions (including Lived Experience [family and consumer], Older Adult, LGBTQ+, Early Childhood, BHRS Staff)

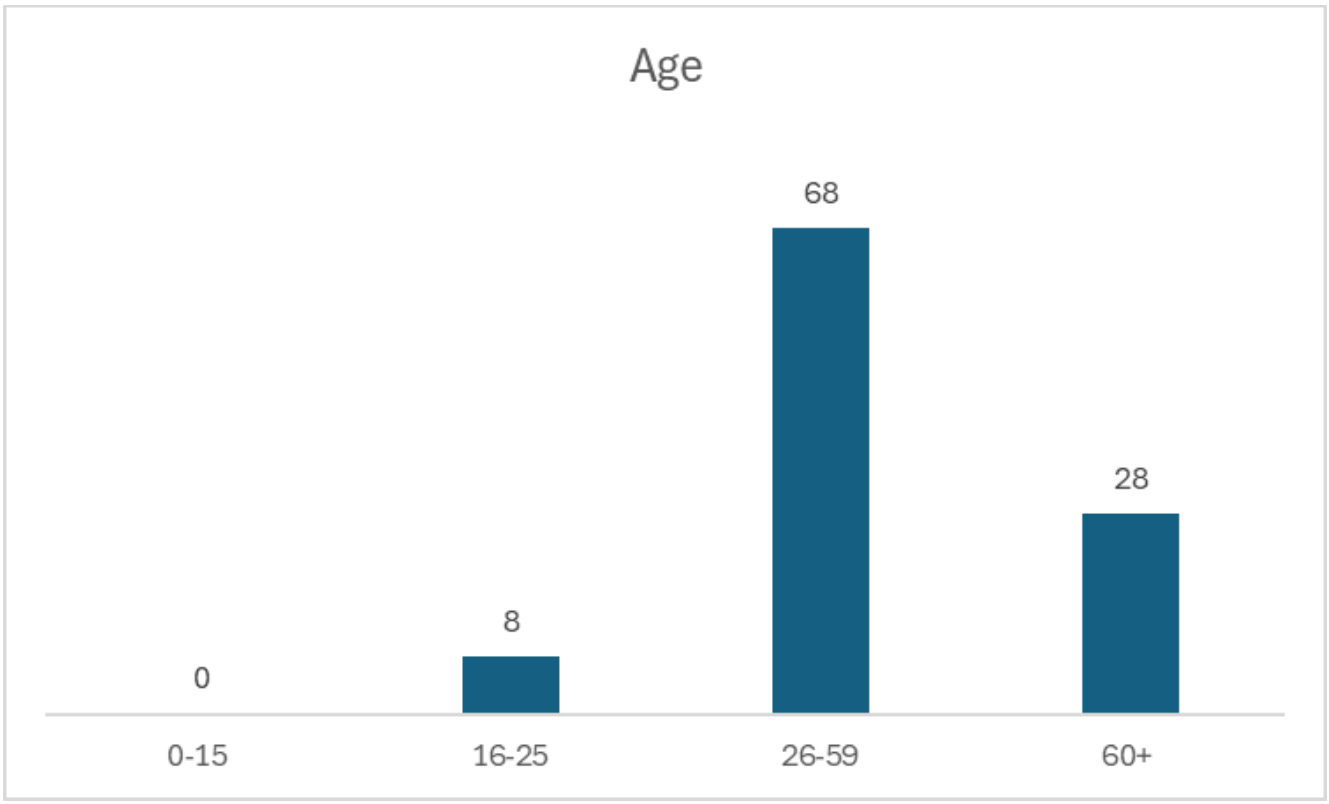
4 sessions held in Spanish, 1 in Vietnamese

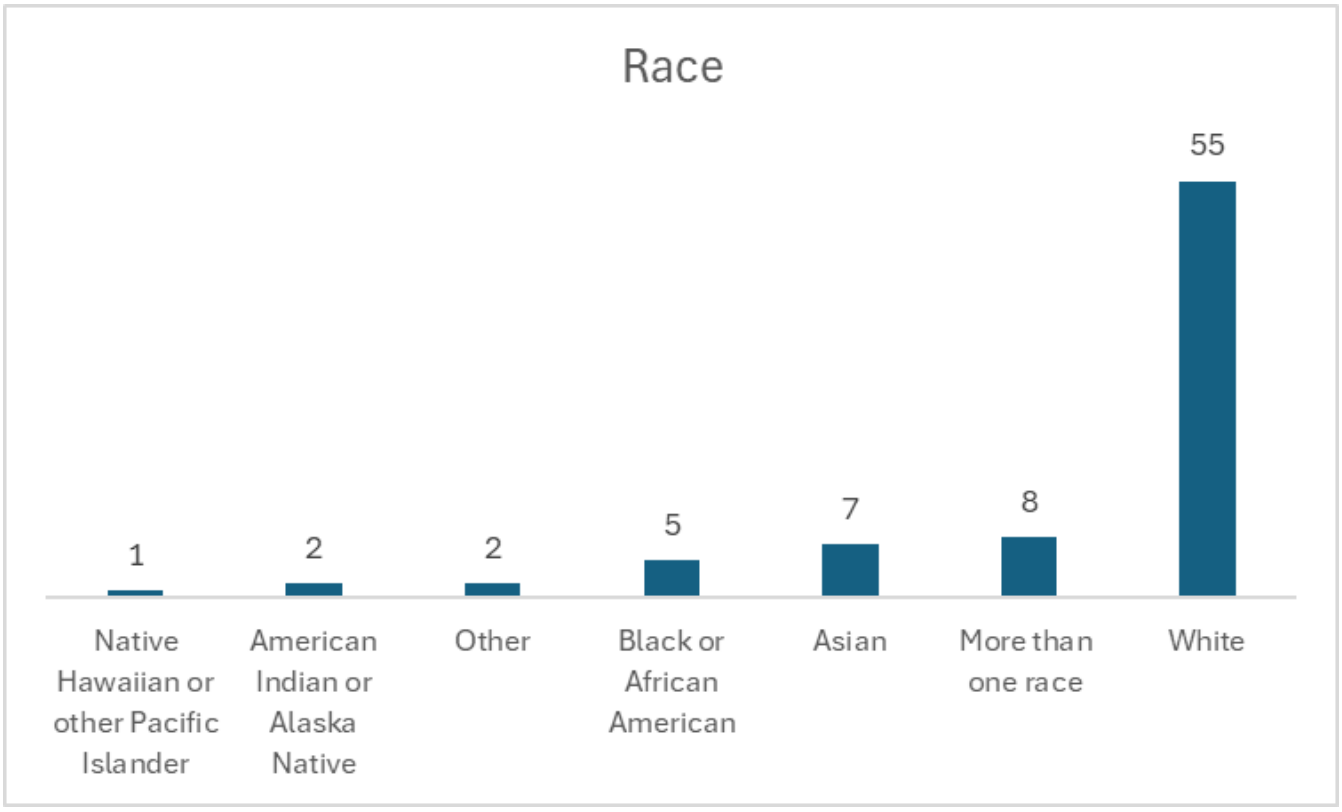
192 participants, 106 completed demographics

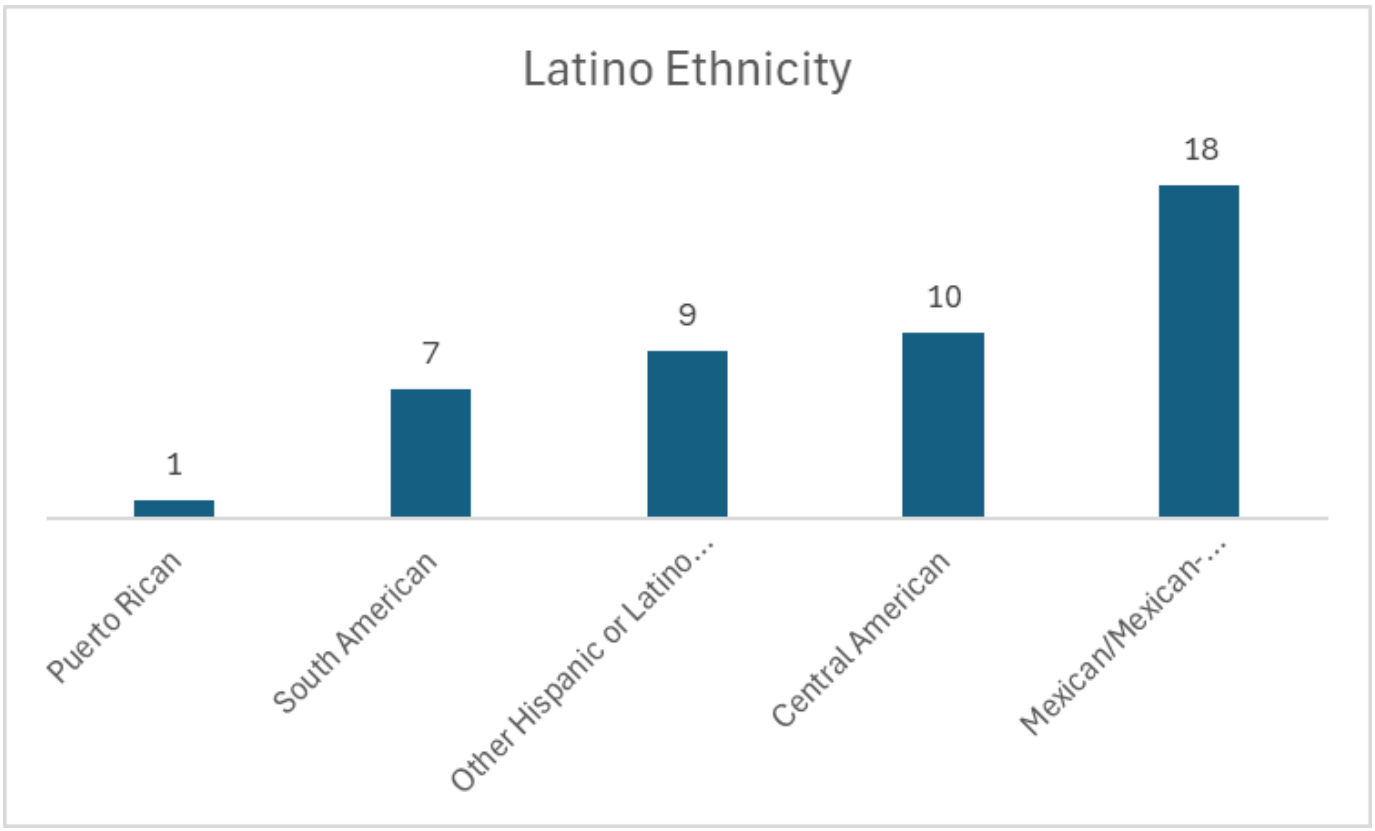


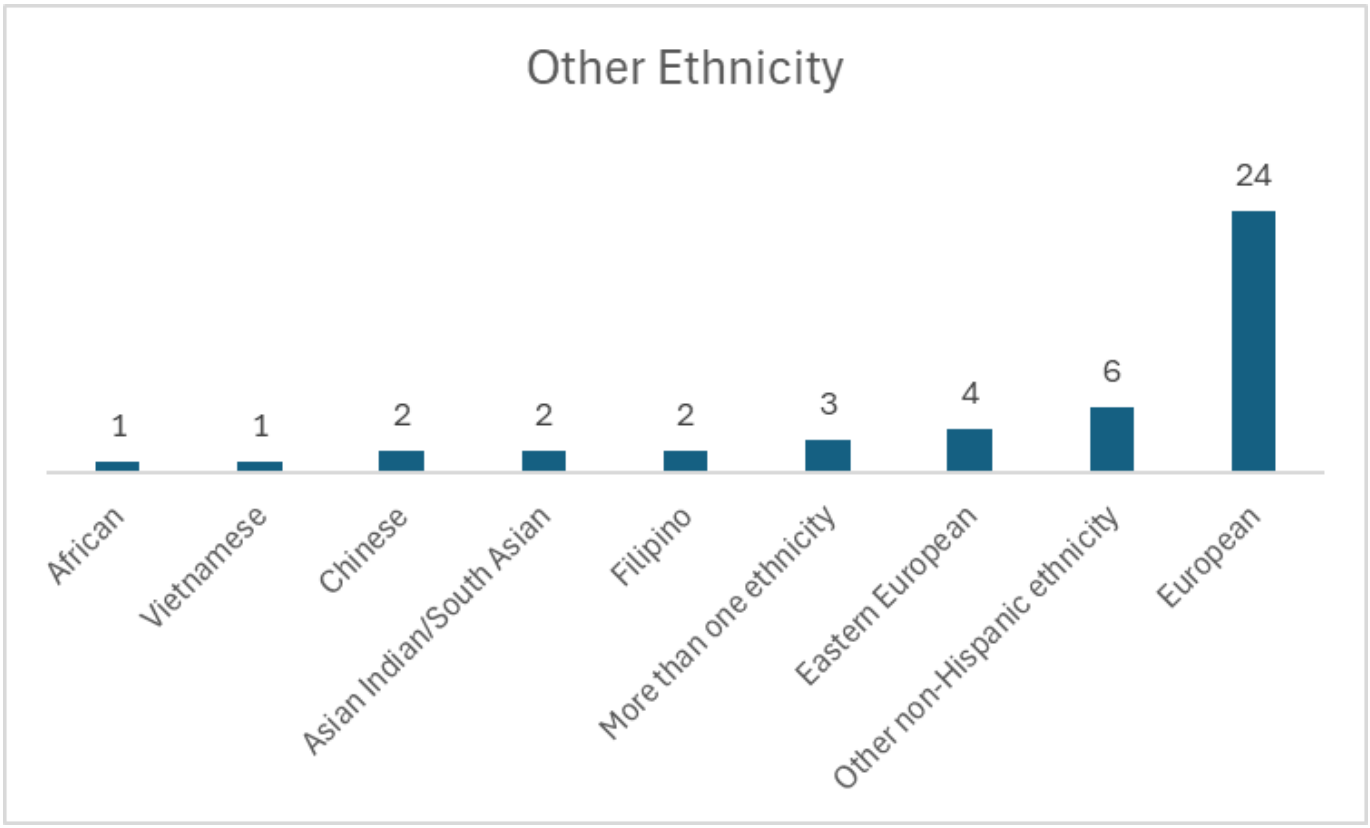

None of the above
9
Personal lived experience with behavioral health challenges
44
Experience as a service provider for community behavioral health, social services, prevention services, or similar
54
Experience as a family member of someone who has experienced behavioral health challenges
59

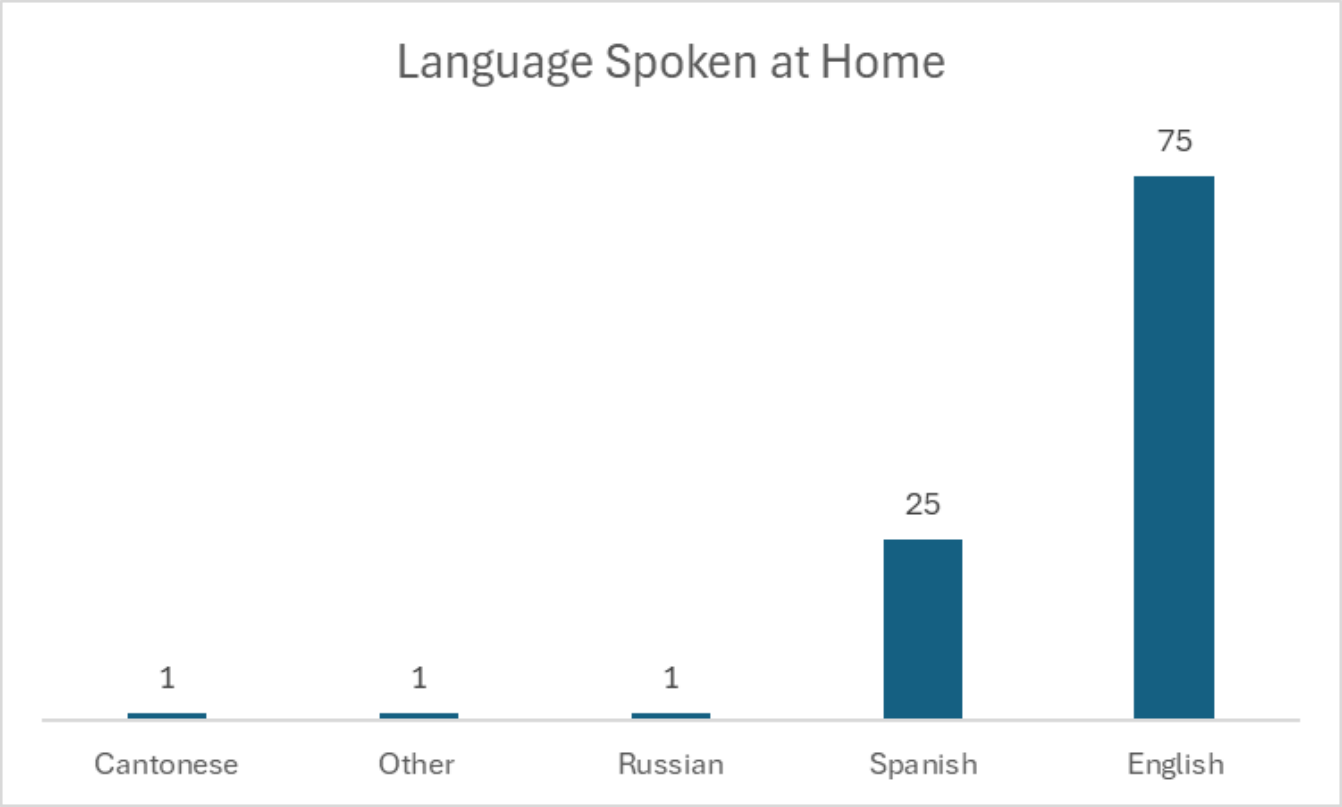

Stable Housing (Past 6 Months)
other
1
no
6
yes
87

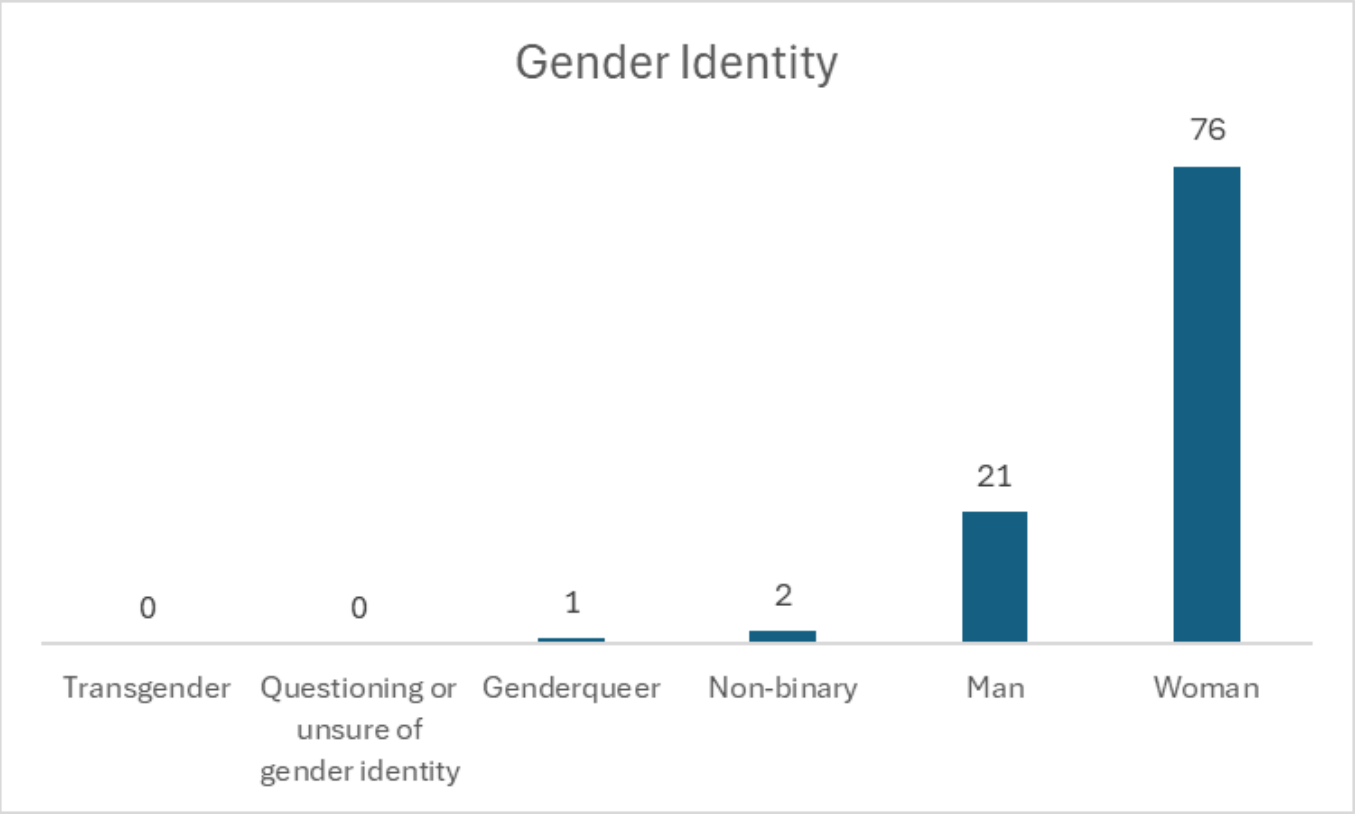

Age
0
8
68
28
0-15
16-25
26-59
60+

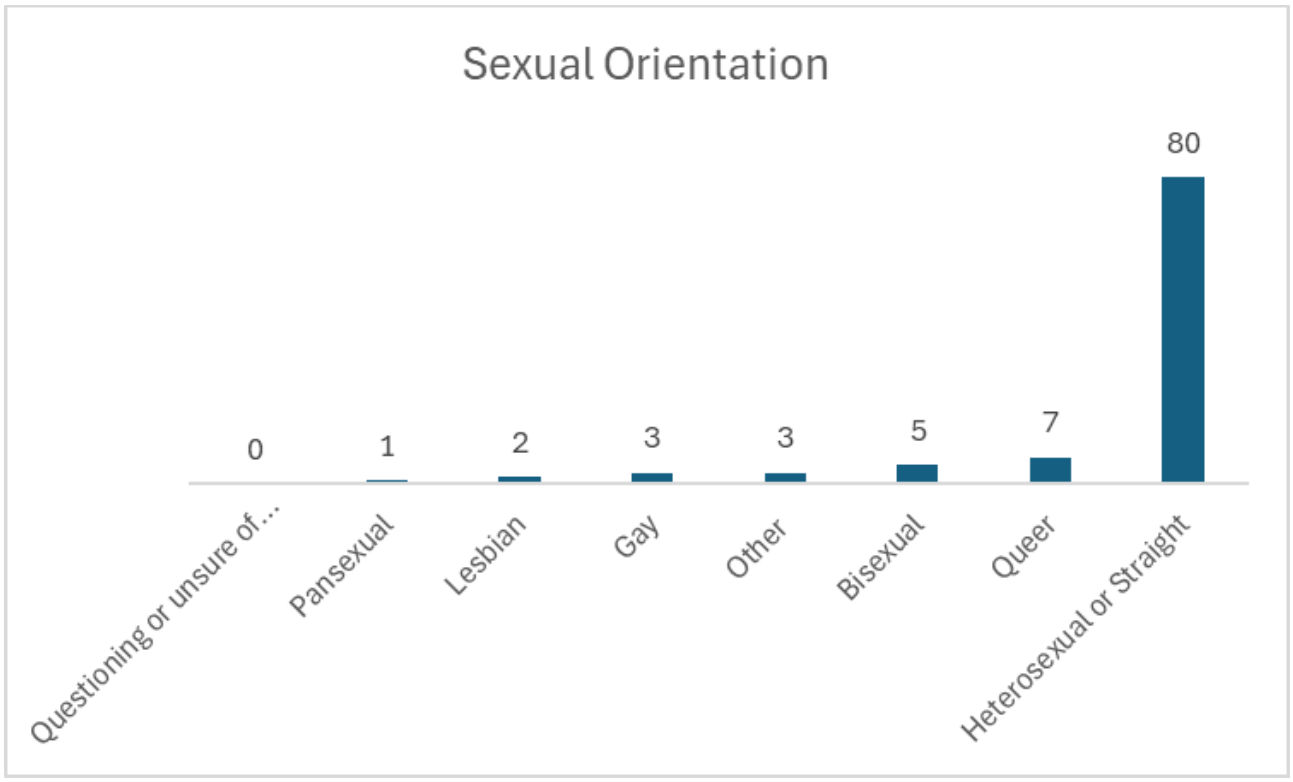

Race
1
2
2
5
7
8
55
Native Hawaiian or other Pacific Islander
American Indian or Alaska Native
Other
Black or African American
Asian
More than one race
White

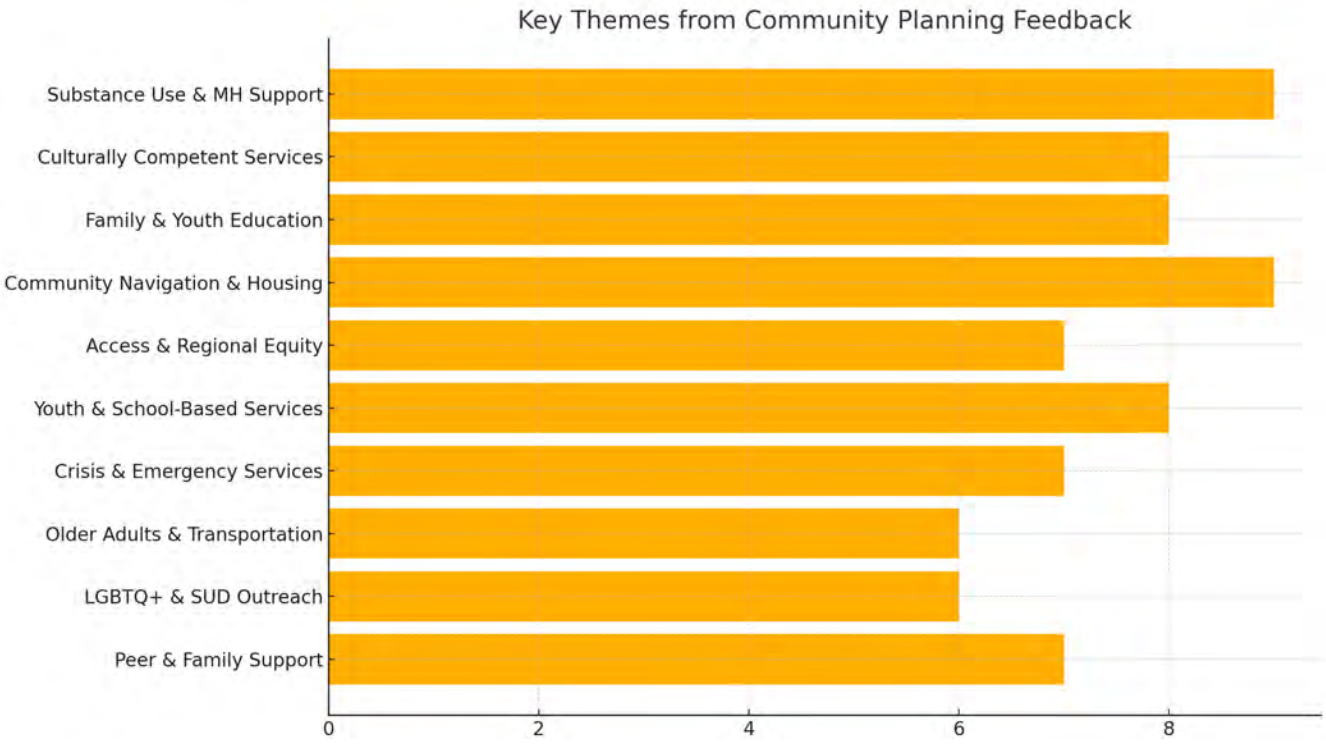

Latino Ethnicity
1
7
9
10
18
Puerto Rican
South American
Other Hispanic or Latino…
Central American
Mexican/Mexican-…


Other Ethnicity
1
1
2
2
2
3
4
6
24
African
Vietnamese
Chinese
Asian Indian/South Asian
Filipino
More than one ethnicity
Eastern European
Other non-Hispanic ethnicity
European


Language Spoken at Home
75
25
1
1
1
Cantonese
Other
Russian
Spanish
English


Gender Identity
76
21
0
0
1
2
Transgender
Questioning or unsure of gender identity
Genderqueer
Non-binary
Man
Woman

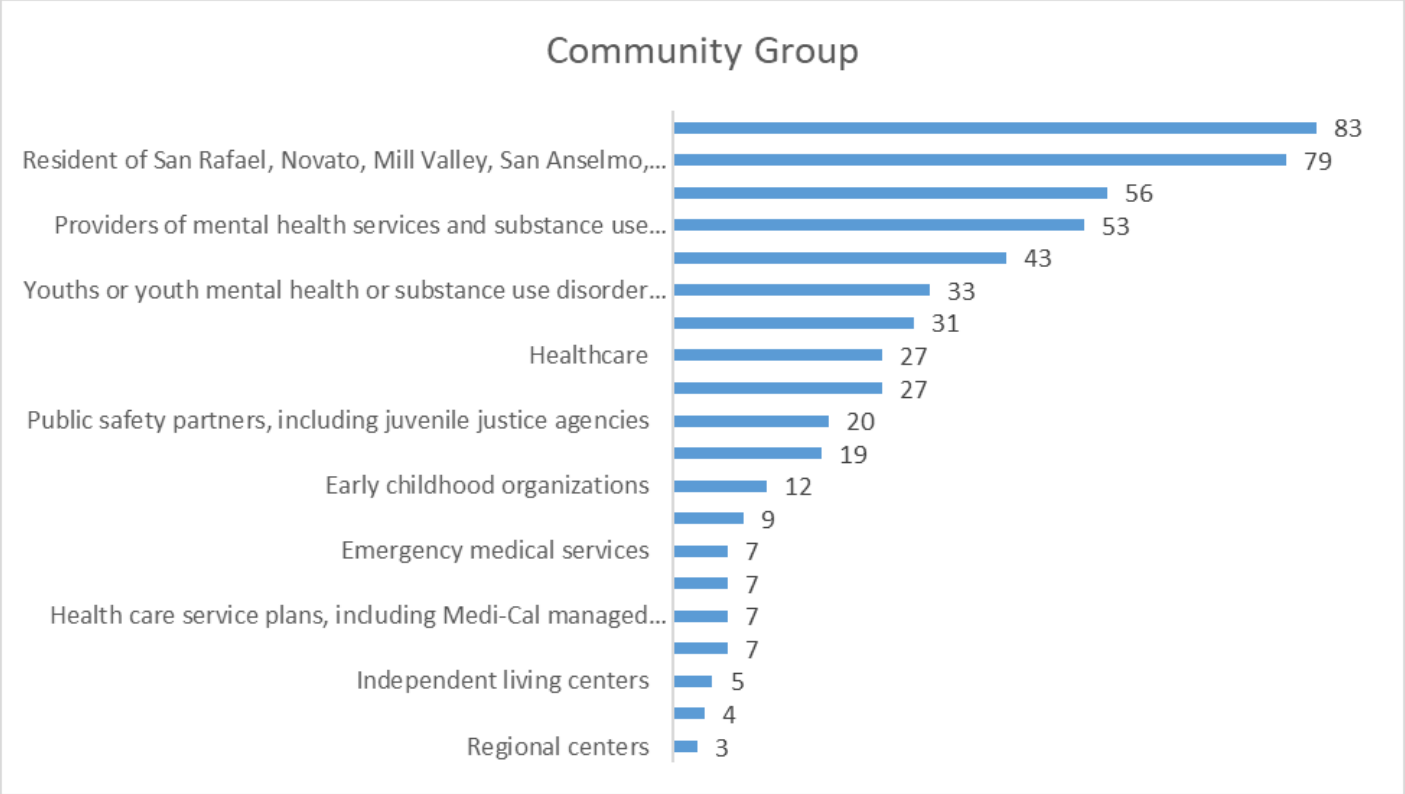

Sexual Orientation
0
1
2
3
3
5
7
80
Questioning or unsure of…
Pansexual
Lesbian
Gay
Other
Bisexual
Queer
Heterosexual or Straight

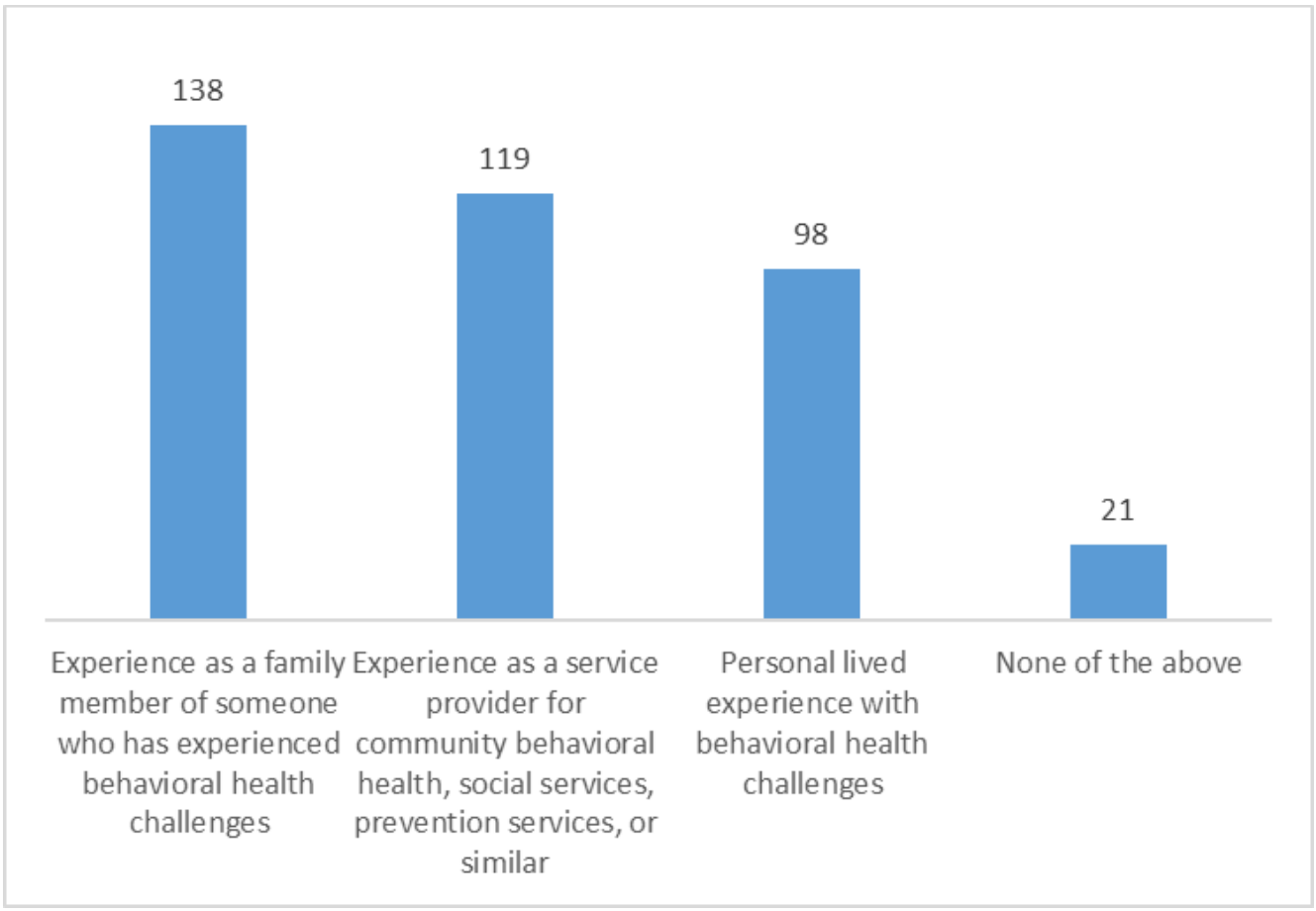

Key Themes from Community Planning Feedback
Substance Use & MH Support
Culturally Competent Services
Family & Youth Education
Community Navigation & Housing
Access & Regional Equity
Youth & School-Based Services
Crisis & Emergency Services
Older Adults & Transportation
LGBTQ+ & SUD Outreach
Peer & Family Support
0
2
4
6
8

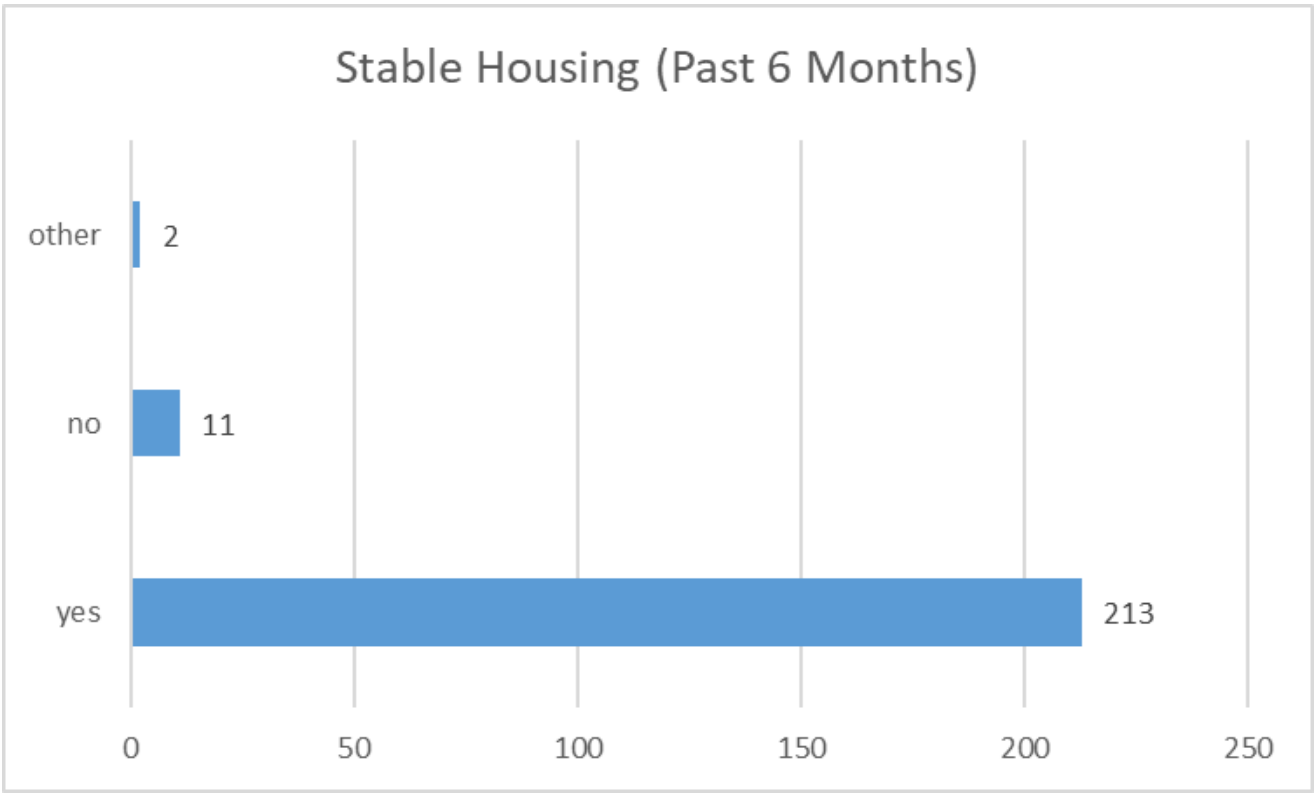
Behavioral Health Services Act (BHSA) FY26/27-FY28/29 Three-Year Integrated Plan Survey

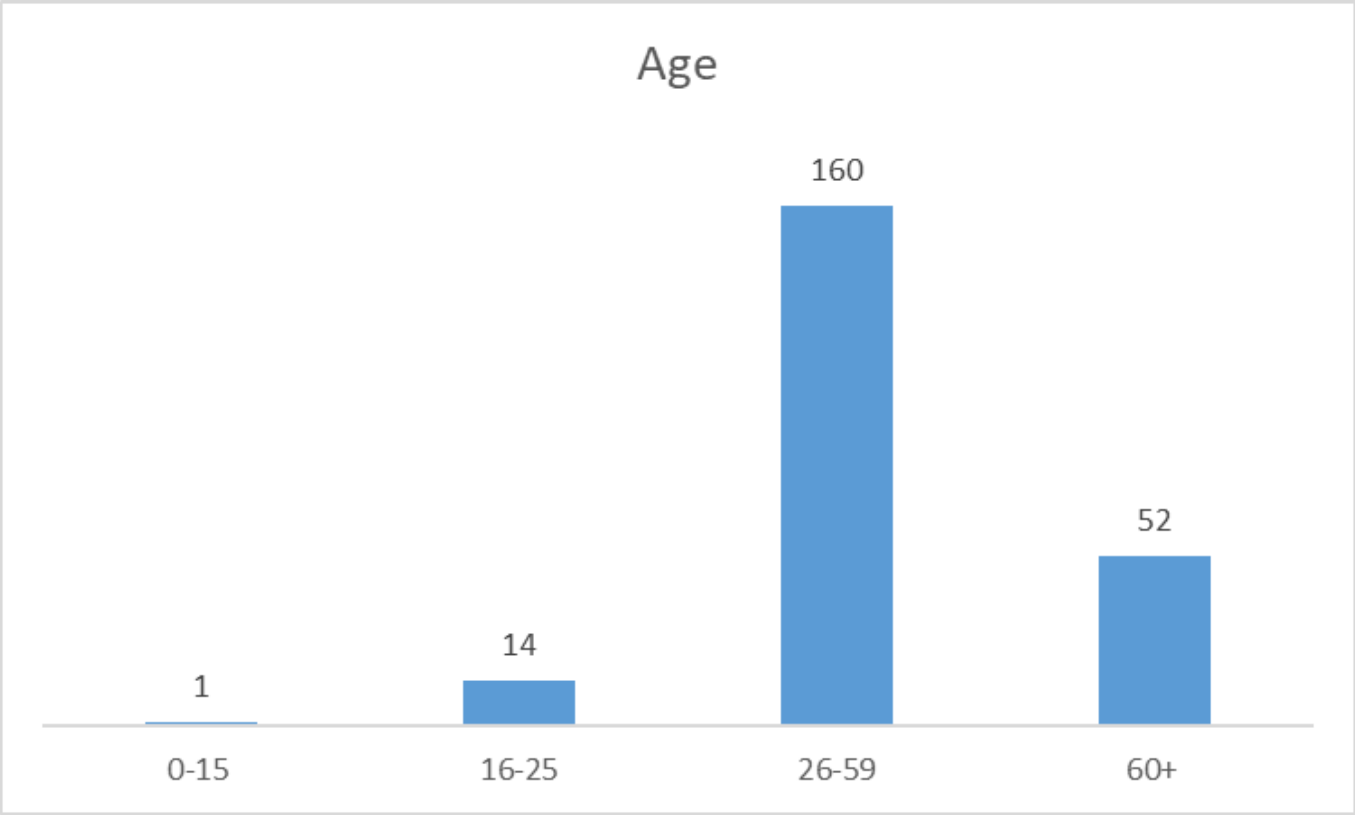
11/14/2024 – 5/21/2025, available in English, Spanish, and Vietnamese

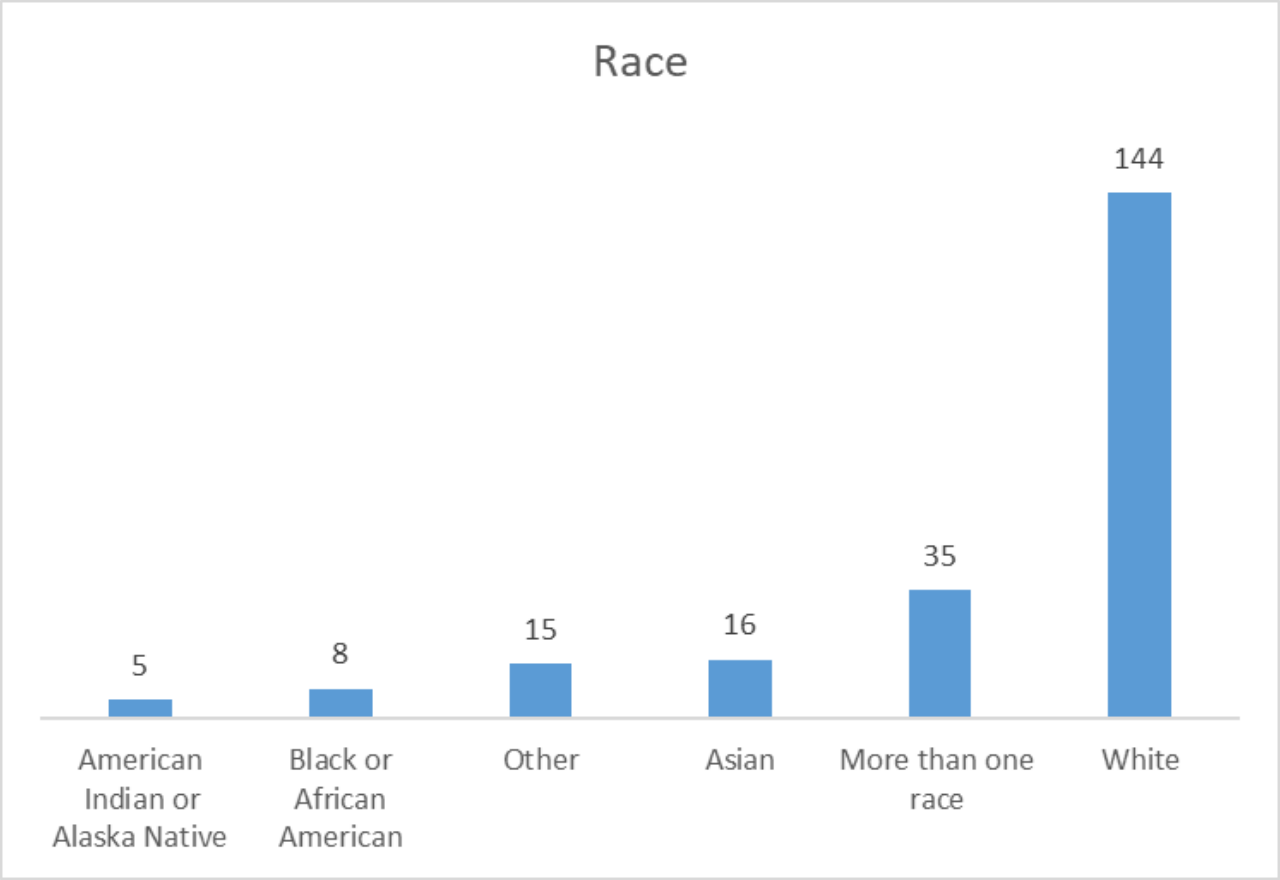
230 respondents

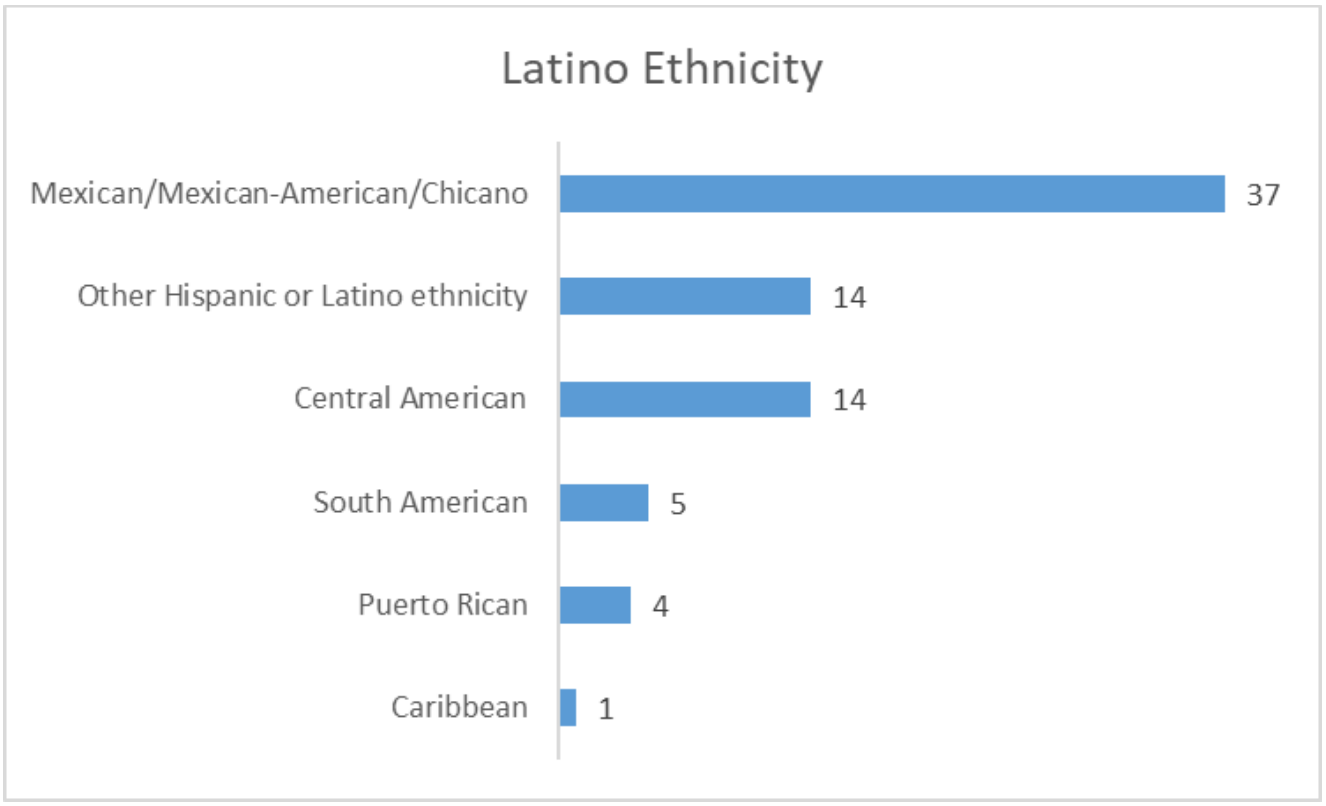


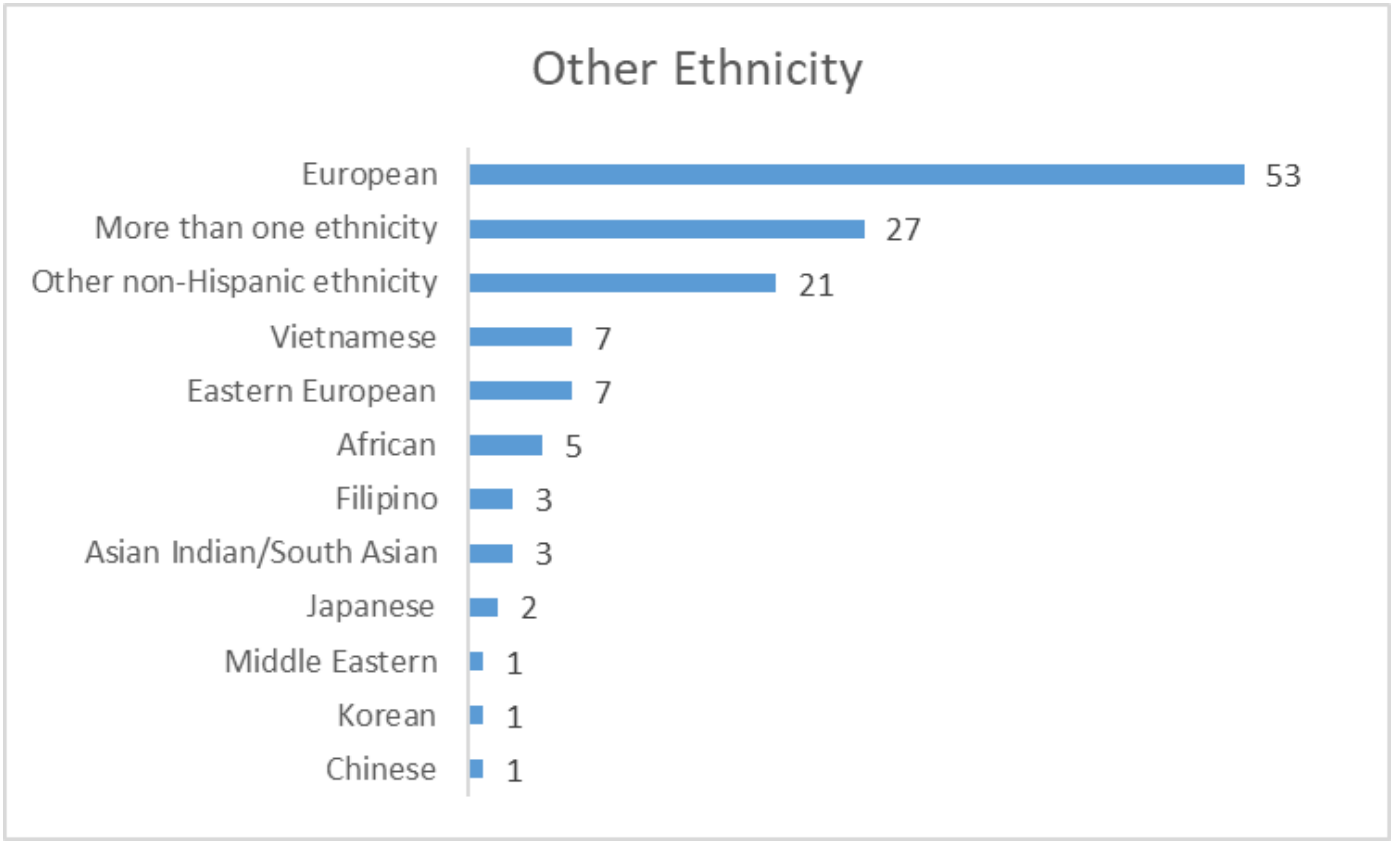

138
119
98
21
Experience as a family member of someone who has experienced behavioral health challenges
Experience as a service provider for community behavioral health, social services, prevention services, or similar
Personal lived experience with behavioral health challenges
None of the above

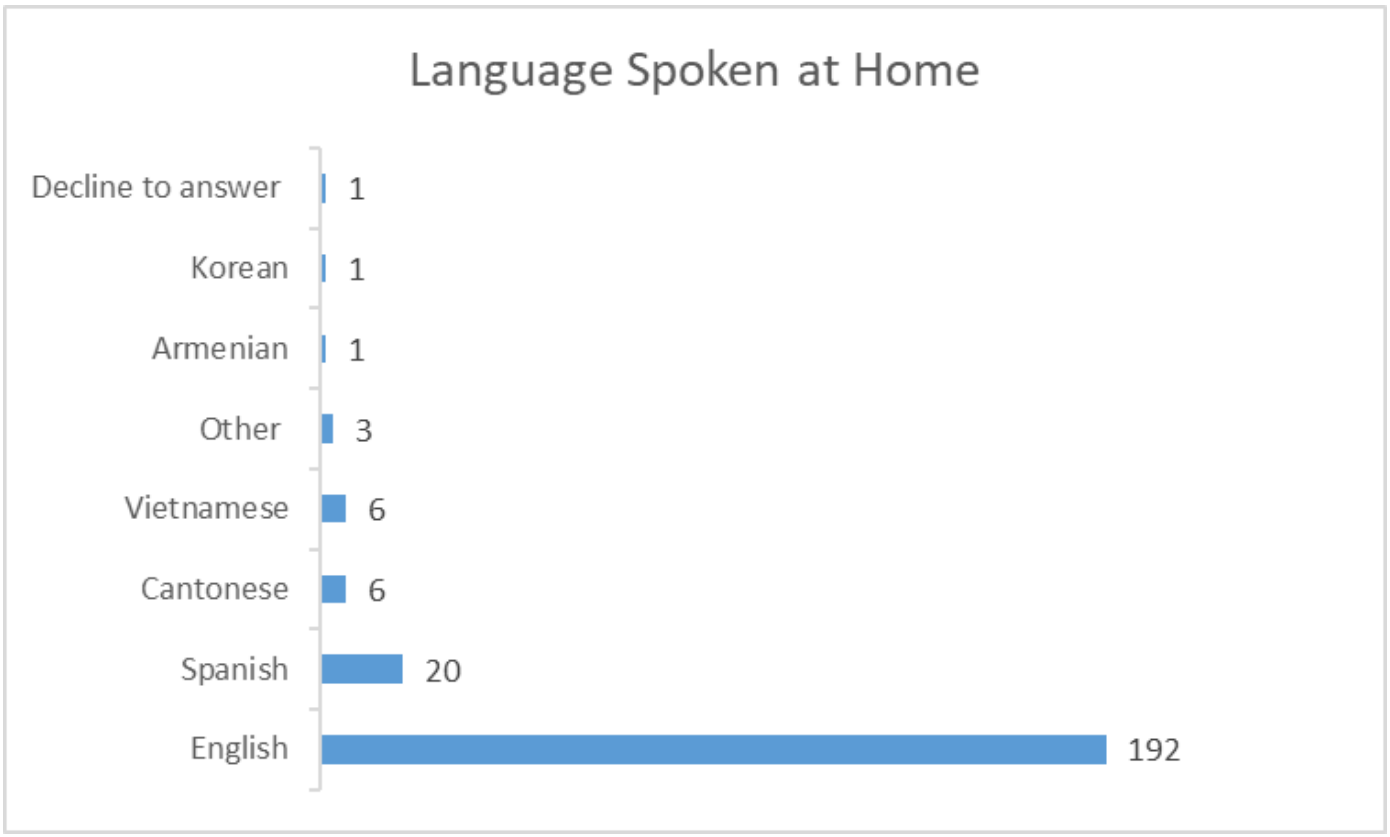

Stable Housing (Past 6 Months)
other
2
no
11
yes
213
0
50
100
150
200
250


Age
160
52
14
1
0-15
16-25
26-59
60+


Race
144
35
15
16
8
5
American Indian or Alaska Native
Black or African American
Other
Asian
More than one race
White


Latino Ethnicity
Mexican/Mexican-American/Chicano
37
Other Hispanic or Latino ethnicity
14
Central American
14
South American
5
Puerto Rican
4
Caribbean
1


Other Ethnicity
European
53
More than one ethnicity
27
Other non-Hispanic ethnicity
21
Vietnamese
7
Eastern European
7
African
5
Filipino
3
Asian Indian/South Asian
3
Japanese
2
Middle Eastern
1
Korean
1
Chinese
1


Language Spoken at Home
Decline to answer
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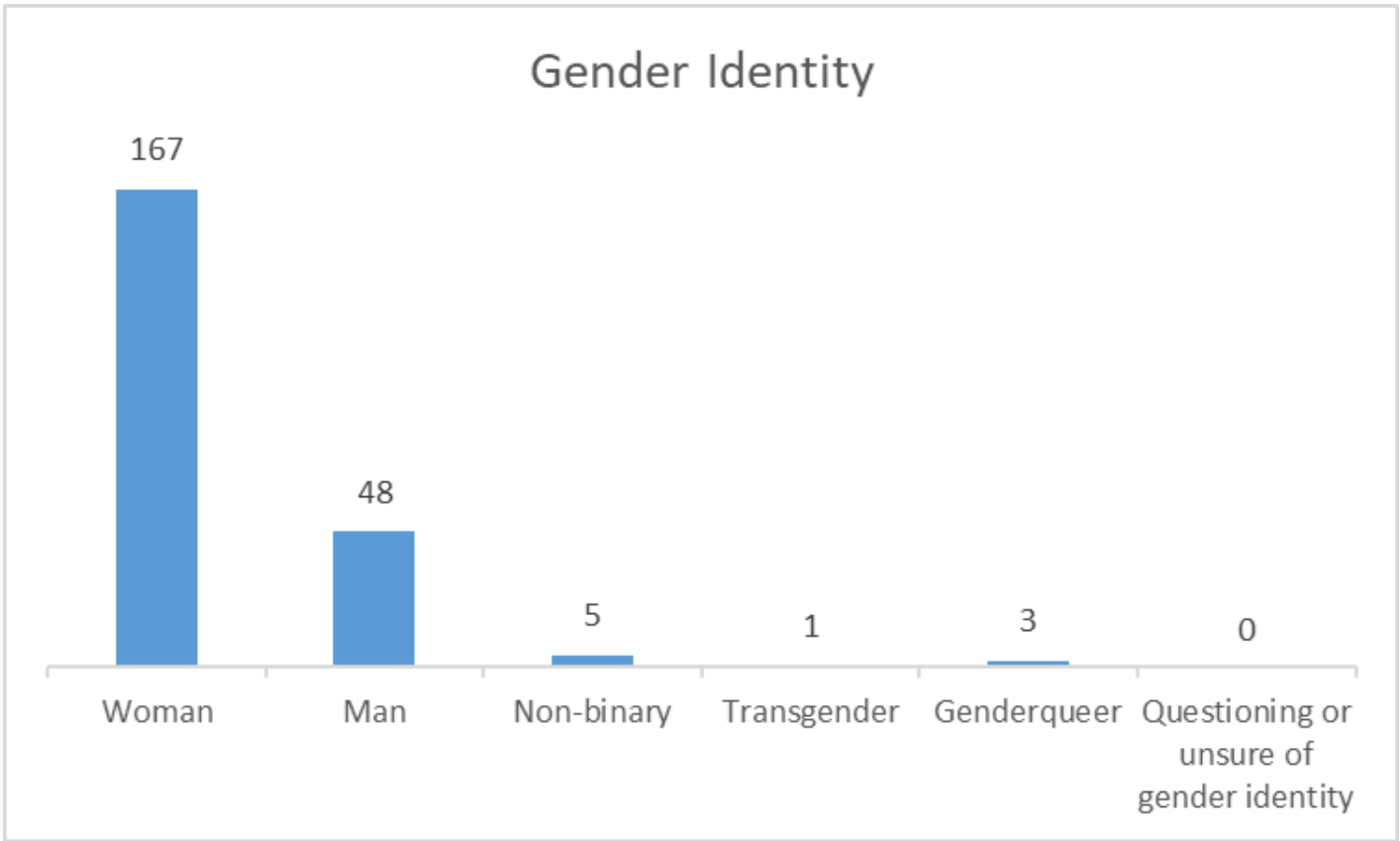
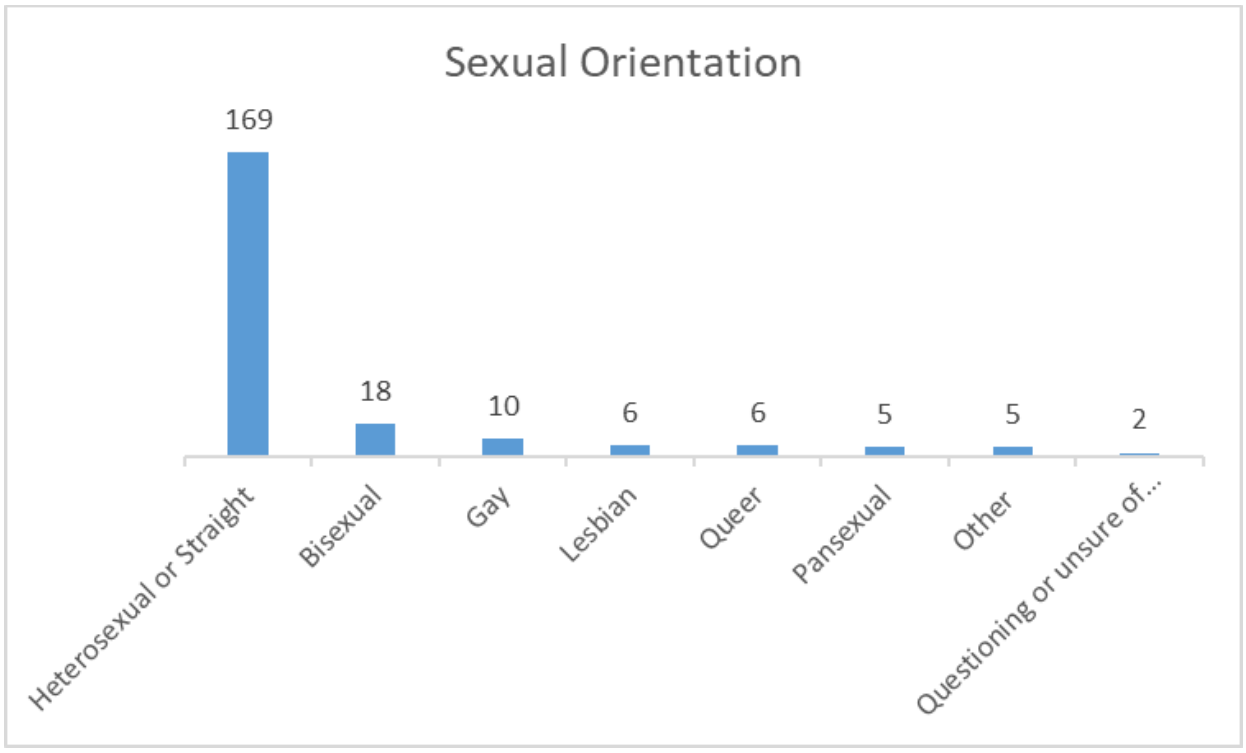
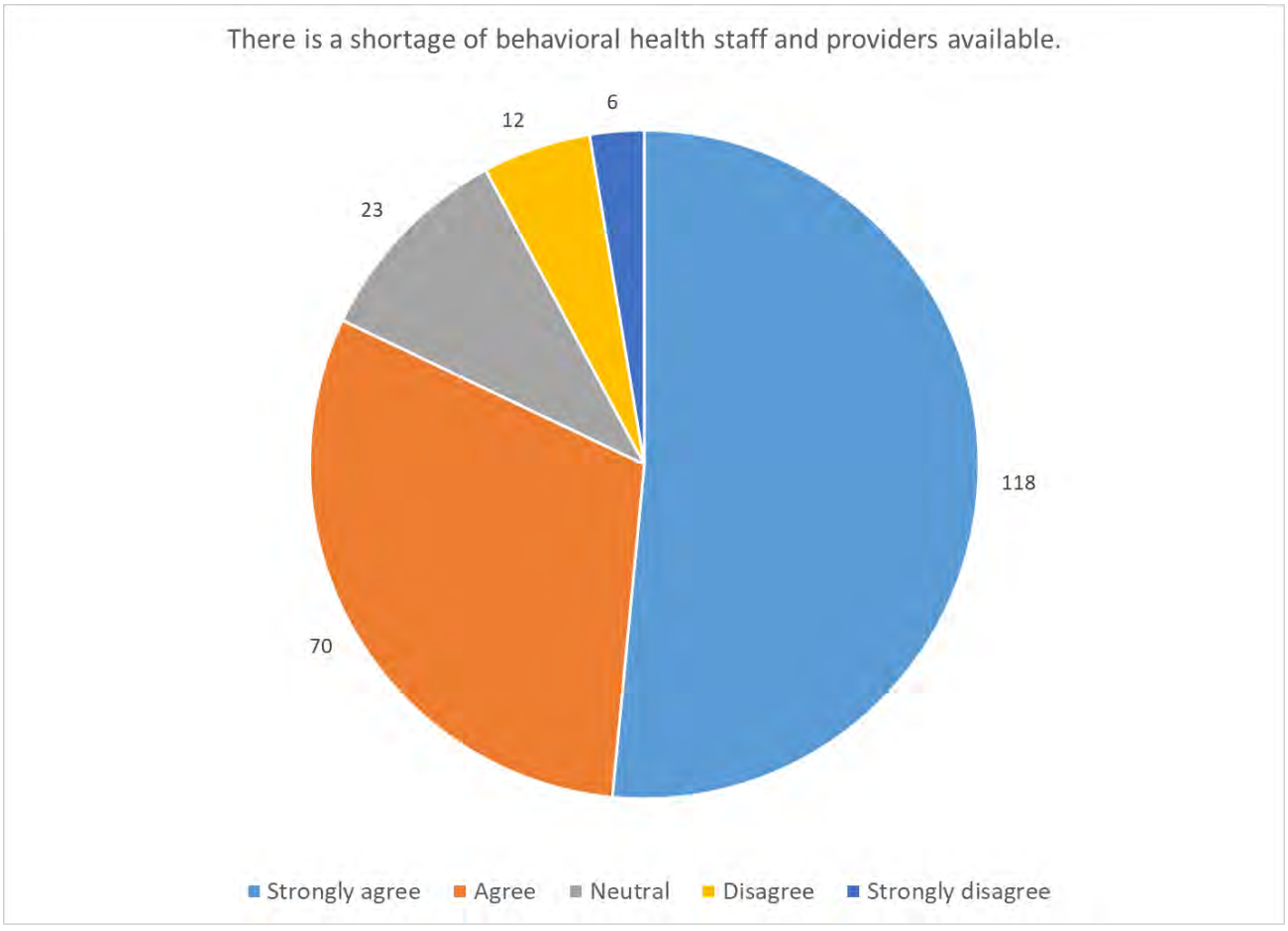
Korean
1
Armenian
1
Other
3
Vietnamese
6
Cantonese
6
Spanish
20
English
192


Gender Identity
167
48
5
1
3
0
Woman
Man
Non-binary
Transgender
Genderqueer
Questioning or unsure of gender identity


Sexual Orientation
169
18
10
6
6
5
5
2
Heterosexual or Straight
Bisexual
Gay
Lesbian
Queer
Pansexual
Other
Questioning or unsure of...


There is a shortage of behavioral health staff and providers available.
6
12
23
118
70
Strongly agree
Agree
Neutral
Disagree
Strongly disagree

BHSA Survey Ranked Priorities

1. Addressing barriers to accessing behavioral health services, including rapid intake assessments and reduced wait-times to first appointment with service providers
2. Housing and supportive housing services for individuals with a serious behavioral health disorder
3. Substance use treatment for adults and older adults
4. Increasing the number of peer providers or expanding peer programs to support individuals and their families
5. Increasing the number of bilingual and bicultural behavioral health providers
6. Increasing services for justice involved individuals with a serious behavioral health
7. Substance use treatment for youth and TAY
8. Additional supports for field-based mobile crisis teams
9. Creating a regional hub model to serve residents (e.g., South Marin, Central Marin, etc.)
10. Implementation of evidence-based practices
11. Sober living environments for adults
12. Residential treatment options for youth, including substance use treatment

BHSA Early Intervention Ranked Priorities

1. Early intervention with youth (0 – 18 years old) to address behavioral health needs that may indicate behavioral health difficulties and increase timely access to treatment services
2. Early intervention with individuals experiencing a suicidal, mental health and/or substance use-related crisis (e.g., hotlines, mobile crisis services)
3. Responding to the behavioral health needs of historically underserved communities, including but not limited to Black and African American, Hispanic, Asian, and LGBTQ+ to address barriers when accessing behavioral health services
4. Early identification of behavioral health disorders across the lifespan
5. Responding to the behavioral health needs of older adults (65 and over)
6. Responding to the behavioral health needs of pregnant and of postpartum women with an infant in the first year of life

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Behavioral Health Director Certification

Certification

1. I hereby certify that Marin County has complied with all statuses, regulations, and guidelines in preparing and submitting this Three-Year Plan (IP) for Behavioral Health Services and Outcomes, including all fiscal accountability and stakeholder participation requirements. I further certify that:

   - ☑ The information, statements, and attachments included in the Three-Year IP are, to the best of my knowledge and belief, true and correct
   - ☑ I understand and agree that the Department of Health Care Services (DHCS) reserves the right to request clarification regarding unclear or ambiguous statements made in the IP and other supporting documents submitted in the IP
   - ☑ The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute, regulations, and guidance
   - ☑ Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute, statute, regulations, and guidance
   - ☑ BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)
   - ☑ The IP was submitted to the local behavioral health board

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?

   - ○ Yes
   - ◉ No

a. Please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

N/A

County Behavioral Health Agency Director contact information

3. County Name

Marin County

4. Certification for

- (•) Three-Year Integrated Plan
- ( ) Annual Update

5. County Behavioral Health Agency Director name

Todd Schirmer, PhD, CCHP

6. County Behavioral Health Agency Director phone number

(415) 720-4779

7. County Behavioral Health Agency Director email

Todd.Schirmer@MarinCounty.gov

Additional contact information for counties with separate MH and SUD directors (optional)

8. Name

9. Title

10. Phone

DHCS | County Portal

11. Email

County Behavioral Health Agency Director signature

12. Print name

Todd Schirmer

13. Title

Director Behavioral Health & Recovery Services

14. Date

09/19/2025

15. Signature

Todd Schirmer Digitally signed by Todd Schirmer
Date: 2025.09.19 12:52:29 -07'00'

Additional signature for counties with separate MH and SUD directors (optional)

16. Print name

17. Title

18. Date

19. Signature

DHCS | County Portal

County Administrator or Designee Certification

The County Administrator may be known by other titles such as Chief Executive, County Manager, or Chief Administrative Officer. The County Administrator must be the individual who serves as the top staff member in county government and hold the highest level of administrative authority in the county or be the designee of that individual. This individual or their designee must work within the executive office of county government, and they may not be the county behavioral health director.

Certification

1. I hereby certify that:
   - [x] The County will use Behavioral Health Services Act (BHSA) funds to serve the targeted population(s) as described in statute
   - [x] Behavioral Health funding from all sources will be spent only on allowable uses as stated in statute
   - [x] BHSA funding will supplement, and not supplant, other funding available from existing state or county funds utilized to provide mental health services or substance use disorder treatment services (except that this non-supplant rule does not apply to the use of 2011 realignment funds provided to counties from the Behavioral Health Subaccount or Behavioral Health Services Growth Special Account)

2. Does the county wish to disclose any implementation challenges or concerns with these requirements?
   - ( ) Yes
   - (x) No

a. If answered yes above, please describe any implementation challenges or concerns with the BHSA fiscal accountability and stakeholder participation requirements

DHCS | County Portal

Signature

3. Print name

Derek Johnson

4. Date

9/29/2025September, 29, 2025

5. Signed by:

Derek Johnson

6868BBD4E53D44E...

Contact information

6. County Name

Marin County

7. Certification for

- [x] Three-Year Integrated Plan
- [ ] Annual Update

8. County Chief Administration Officer Name

Derek Johnson

9. County Chief Administration Officer Phone number

(415) 473-6358

10. County Chief Administration Officer Email

derek.johnson@marincounty.gov