NOTICE OF PUBLIC COMMENT PERIOD
November 3, 2017 to December 3, 2017

NOTICE OF PUBLIC HEARING
December 8, 2017

Nevada County Mental Health Services Act
Fiscal Year 2017/2018 through FY 2019/2020
Three-Year Program and Expenditure Plan
&
Annual Progress Report on FY 2015/2016 Activities

As directed by the Mental Health Services Act (MHSA), Nevada County Behavioral Health Department (NCBHD) is inviting all stakeholders to review and comment on Nevada County's MHSA Fiscal Year 2017/2018 through FY 2019/2020 Three-Year Program and Expenditure Plan (Three-Year Plan) and Annual Progress Report (APR) on FY 2015/2016 activities for a period of 30 days from November 3, 2017 to December 3, 2017.

To view the actual Nevada County's MHSA Fiscal Year 2017/2018 through FY 2019/2020 Three-Year Plan and APR on FY 2015/2016 activities and other required forms go to:

MHSA 3 – Year Plan Fiscal Year 2017-18 to 2019-20 Part 1:
https://www.mynevadacounty.com/DocumentCenter/View/21419

MHSA Annual Progress Report for Fiscal Year 2015-16 Part 2:
https://www.mynevadacounty.com/DocumentCenter/View/21418

Written public comments from interested parties related to the MHSA Fiscal Year 2017/2018 through FY 2019/2020 Three-Year Plan and APR on FY 2015/2016 activities are to be provided in writing by 5 P.M. on December 3, 2017. Public comments may be submitted in writing to NCBHD at Behavioral.Health@co.nevada.ca.us or via US mail to:

Nevada County Behavioral Health Department
500 Crown Point Circle, Suite 120
Grass Valley, CA 95945

A Public Hearing will take place at the Mental Health Board Meeting on December 8, 2017 at 9:30 AM. The meeting will be at 500 Crown Point Circle, Suite 120 in Grass Valley in the Crown Point Conference Room.

Please contact Michele Violett at (530) 265-1790 (Voice), (800) 735-2922 (TTY), or michele.violett@co.nevada.ca.us if you need:

- A hard copy of this posting and the document or
- A disability related reasonable accommodation to participate in this event by December 1, 2017.

Nevada County

Mental Health Services Act

FY 2017/2018 through 2019/2020

Three Year Program and Expenditure Plan

And

Annual Progress Report

FY 2015/2016

October 2017

Nevada County
Mental Health Services Act Plan
FY 2017/2018 to FY 2019/2020
&
Annual Progress Report FY 2015/2016

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Exhibit A

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Nevada County

☑ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director Name:	**Program Lead**
Rebecca Slade, MFT Telephone Number: (530) 470-2784 E-mail: Rebecca.Slade@co.nevada.ca.us	Name: Michele Violett Telephone Number: (530) 265-1790 E-mail: Michele.Violett@co.nevada.ca.us
Local Mental Health Mailing Address: 500 Crown Point Circle, STE 120 Grass Valley, CA 95919	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

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

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

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

Rebecca Slade, MFT
_____
Local Mental Health Director (PRINT)

_____
Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Nevada County

☑ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	**County Auditor-Controller / City Financial Officer**
Name: Rebecca Slade, MFT	Name: Marcia Salter
Telephone Number: (530) 470-2784	Telephone Number: (530) 265-1251
E-Mail: Rebecca.Slade@co.nevada.ca.us	E-mail: Marcia.Salter@co.nevada.ca.us
Local Mental Health Mailing Address: 500 Crown Point Circle, STE 120 Grass Valley, CA 95945	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Rebecca Slade, MFT

Local Mental Health Director (PRINT) _____ Signature _____ Date

I hereby certify that for the fiscal year ended June 30, _____, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30,_____. I further certify that for the fiscal year ended June 30,_____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Marcia Salter

County Auditor Controller / City Financial Officer (PRINT) _____ Signature _____ Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Nevada Date: 10/23/2017

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,266,656	1,099,490	620,685	46,341	-	
2. Estimated New FY2017/18 Funding	3,768,722	942,180	247,942			
3. Transfer in FY2017/18a/	-					
4. Access Local Prudent Reserve in FY2017/18						-
5. Estimated Available Funding for FY2017/18	5,035,378	2,041,670	868,627	46,341	-	
B. Estimated FY2017/18 MHSA Expenditures	4,160,000	1,319,000	75,000	46,341	-	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	875,378	722,670	793,627	-	-	
2. Estimated New FY2018/19 Funding	3,919,471	979,867	257,860			
3. Transfer in FY2018/19a/	-					
4. Access Local Prudent Reserve in FY2018/19						-
5. Estimated Available Funding for FY2018/19	4,794,849	1,702,537	1,051,487	-	-	
D. Estimated FY2018/19 Expenditures	4,160,000	1,336,500	75,000	-	-	
E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	634,849	366,037	976,487	-	-	
2. Estimated New FY2019/20 Funding	3,928,893	982,223	258,480			
3. Transfer in FY2019/20a/	-					
4. Access Local Prudent Reserve in FY2019/20						-
5. Estimated Available Funding for FY2019/20	4,563,742	1,348,260	1,234,967	-	-	
F. Estimated FY2019/20 Expenditures	4,160,000	1,336,500	75,000	-	-	
G. Estimated FY2019/20 Unspent Fund Balance	403,742	11,760	1,159,967	-	-	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	1,129,150
2. Contributions to the Local Prudent Reserve in FY 2017/18	-
3. Distributions from the Local Prudent Reserve in FY 2017/18	-
4. Estimated Local Prudent Reserve Balance on June 30, 2018	1,129,150
5. Contributions to the Local Prudent Reserve in FY 2018/19	-
6. Distributions from the Local Prudent Reserve in FY 2018/19	-
7. Estimated Local Prudent Reserve Balance on June 30, 2019	1,129,150
8. Contributions to the Local Prudent Reserve in FY 2019/20	-
9. Distributions from the Local Prudent Reserve in FY 2019/20	-
10. Estimated Local Prudent Reserve Balance on June 30, 2020	1,129,150

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Wraparound	1,600,000	370,000	675,000	0	550,000	5,000
2. Assertive Community Treatment	2,875,000	1,650,000	1,175,000			50,000
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. General System Development	4,325,000	1,425,000	1,000,000	450,000	575,000	875,000
2. Outreach and Engagement	175,000	175,000				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	540,000	540,000				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,515,000	4,160,000	2,850,000	450,000	1,125,000	930,000
FSP Programs as Percent of Total	107.6%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Wraparound	1,600,000	370,000	675,000	-	550,000	5,000
2. Assertive Community Treatment	2,875,000	1,650,000	1,175,000			50,000
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. General System Development	4,325,000	1,425,000	1,000,000	450,000	575,000	875,000
2. Outreach and Engagement	175,000	175,000				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	540,000	540,000				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,515,000	4,160,000	2,850,000	450,000	1,125,000	930,000
FSP Programs as Percent of Total	107.6%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Wraparound	1,600,000	370,000	675,000	-	550,000	5,000
2. Assertive Community Treatment	2,875,000	1,650,000	1,175,000			50,000
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. General System Development	4,325,000	1,425,000	1,000,000	450,000	575,000	875,000
2. Outreach and Engagement	175,000	175,000				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	540,000	540,000				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,515,000	4,160,000	2,850,000	450,000	1,125,000	930,000
FSP Programs as Percent of Total	107.6%					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Senior, Disabled & Isolated Home Visitor	38,000	38,000				
2. Wellness Center: Peer Support & Outreach Services	215,000	215,000				
3. Child & Youth Mentoring	17,000	17,000				
4. Teaching Pro-Social Skills in the Schools	45,000	45,000				
5. Homeless Rapid Rehousing	122,500	72,500	50,000			
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Alternative EI for Youth & Young Adults	110,000	20,000	50,000		40,000	
12. Homeless Outreach & Therapy	37,000	32,000	5,000			
13. Bilingual Therapy	147,000	67,000	40,000		40,000	
14. EI for Referred Chilren, Youth, Pregnant Women, Postpartum	298,000	108,000	50,000		100,000	40,000
15.	0					
PEI Programs - Other						
16. Access & Linkage	330,000	330,000				
17. Outreach: First Responder Training	10,000	10,000				
18. Stigma & Discrimination Reduction	76,500	76,500				
19. Suicide Prevention	188,000	188,000				
20.	0					
PEI Administration	90,000	90,000				
PEI Assigned Funds	10,000	10,000				
Total PEI Program Estimated Expenditures	1,734,000	1,319,000	195,000	0	180,000	40,000

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Senior, Disabled & Isolated Home Visitor	38,000	38,000				
2. Wellness Center: Peer Support & Outreach Services	215,000	215,000				
3. Child & Youth Mentoring	17,000	17,000				
4. Teaching Pro-Social Skills in the Schools	45,000	45,000				
5. Homeless Rapid Rehousing	140,000	90,000	50,000			
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Alternative EI for Youth & Young Adults	110,000	20,000	50,000		40,000	
12. Homeless Outreach & Therapy	37,000	32,000	5,000			
13. Bilingual Therapy	147,000	67,000	40,000		40,000	
14. EI for Referred Chilren, Youth, Pregnant Women, Postpartum	298,000	108,000	50,000		100,000	40,000
15.	0					
PEI Programs - Other						
16. Access & Linkage	330,000	330,000				
17. Outreach: First Responder Training	10,000	10,000				
18. Stigma & Discrimination Reduction	76,500	76,500				
19. Suicide Prevention	188,000	188,000				
20.	0					
PEI Administration	90,000	90,000				
PEI Assigned Funds	10,000	10,000				
Total PEI Program Estimated Expenditures	1,751,500	1,336,500	195,000	0	180,000	40,000

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Senior, Disabled & Isolated Home Visitor	38,000	38,000				
2. Wellness Center: Peer Support & Outreach Services	215,000	215,000				
3. Child & Youth Mentoring	17,000	17,000				
4. Teaching Pro-Social Skills in the Schools	45,000	45,000				
5. Homeless Rapid Rehousing	140,000	90,000	50,000			
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Alternative EI for Youth & Young Adults	110,000	20,000	50,000		40,000	
12. Homeless Outreach & Therapy	37,000	32,000	5,000			
13. Bilingual Therapy	147,000	67,000	40,000		40,000	
14. EI for Referred Chilren, Youth, Pregnant Women, Postpartum	298,000	108,000	50,000		100,000	40,000
15.	0					
PEI Programs - Other						
16. Access & Linkage	330,000	330,000				
17. Outreach: First Responder Training	10,000	10,000				
18. Stigma & Discrimination Reduction	76,500	76,500				
19. Suicide Prevention	188,000	188,000				
20.	0					
PEI Administration	90,000	90,000				
PEI Assigned Funds	10,000	10,000				
Total PEI Program Estimated Expenditures	1,751,500	1,336,500	195,000	0	180,000	40,000

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing Support	17,000	17,000				
2. Training & Technical Assistance	13,000	13,000				
3. Mental Health Career Pathways Programs	0	-				
4. Residency and Internship Programs	13,841	13,841				
5. Financial Incentive Programs	0	-				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	2,500	2,500				
Total WET Program Estimated Expenditures	46,341	46,341	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	0	0	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0					
Total WET Program Estimated Expenditures	0	0	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Integration of Rural MH Services	76,156	67,500	8,656			
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	7,500	7,500				
Total INN Program Estimated Expenditures	83,656	75,000	8,656	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Integration of Rural MH Services	76,963	67,500	9,463			
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	7,500	7,500				
Total INN Program Estimated Expenditures	84,463	75,000	9,463	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Integration of Rural MH Services	77,745	67,500	10,245			
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	7,500	7,500				
Total INN Program Estimated Expenditures	85,245	75,000	10,245	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Nevada Date: 10/23/17

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

THREE-YEAR PROGRAM AND EXPENDITURE FOR FY 2017/18 THROUGH 19/20

COMMUNITY STAKEHOLDER PLANNING PROCESS AND LOCAL REVIEW PROCESS

County: Nevada **30-day Public Comment Period Dates:** November 3, 2017 to December 3, 2017

Date: October 19, 2017 **Date of Public Hearing:** December 8, 2017

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update/update per Title 9 of the California Code of Regulations, sections 3300 and 3315.

Community Program Planning
1. A description of the local stakeholder process including date(s) of the meeting(s) and any other planning activities conducted. Description of how stakeholder involvement was meaningful.

In September 2005 a MHSA Steering Committee (SC) was formed to set priorities based on community input and to prepare a MHSA CSS (Community Services and Supports) proposal. This committee is still being utilized today for all of the MHSA components. The original SC was structured with a majority of consumers and family as members. The other members include various interest groups, community based organizations, service providers, and Nevada County Behavioral Health Department (NCBHD) staff. This committee worked on our plan through the use of meetings, work groups, and by e-mail. Today the MHSA SC meetings are attended by stakeholders from service providers, contract providers, program participant/family advocates, program participants, family members, County employees and interested community members. Any member of the public is welcome to attend any of the MHSA SC meetings and to provide input. Nevada County has employed subcommittees/ad hoc committees as needed to address specific needs.

The Steering Committee had meetings on the following dates in FY 16/17: 9/15/2016, 12/12/2016, 4/3/2017 and 6/16/2017. To date in FY 17/18 we had two meeting on 9/21/2017 and 10/30/17.

The MHSA Coordinator attended the FREED TAY Team public meeting on 2/2/2017 to hear from youth providers on what the local strengths and gaps in services are and solutions, from the perspectives of youth service providers.

MHSA information is shared throughout the year with the Mental Health Board. The Mental Health Board meets the first Friday of each month, unless it falls on a holiday. If the meeting falls on a holiday it is either moved to another date or cancelled.

The Recommendation of Needed Mental Health Services for FY 2017-2020 document was updated by the MHSA Steering Committee and supported by the Mental Health Board.

The MHSA Coordinator, Behavioral Health staff, and MHSA contractors attend meetings to:

1. Educate the public about MHSA
2. Get community impute on program planning, implementation, evaluation and budgeting
3. To collaborate and coordinate program implementation
4. Share information about MHSA programs that are being implemented in the County

5. Share MHSA Program Outcomes
6. Learn about gaps and needs in the community

Some of the meetings that the MHSA Coordinator, Behavioral Health staff and contractors have attended include, but are not limited to: Cultural Competency, Mental Health Board, MHSA Steering Committee, PFLAG's LGBT Support Groups, Transgender Support Group, Quality Improvement Committee, Substance Abuse Prevention and Treatment, Superior Region Workforce and Education and Training, Nevada County Behavioral Health (NCBH) Contractor's Meeting, Regional Housing Authority of Sutter and Nevada County, Veterans Services Office Community Town Hall Gathering, Hospitality House Supportive Service planning, community wide Homeless Point-in-Time Count, Nevada County Needs Assessment, community wide Homeless Coordinated Entry System, Homeless Management Information System Planning, Emergency Solution Grant Planning, Nevada County Coordinating Council for the Homeless, Tahoe Truckee Community Collaborative, and NCBH Staff Meeting.

In FY 16/17 Nevada County collected demographic information from staff, contractors, and community members attending meetings. The results by Unduplicated Age were: 46 adults, 17 older adults and 62 of unknown age. For Race the results were: one Asian, 58 White, one Other, two indicated more than one race, one declined to answer, and 62 were unknown. For Ethnicity the results were: three Mexican, one South American, two Eastern European, 19 European, seven other, eight unknown non-Hispanic, five more than one ethnicity and 66 unknown ethnicity. Primary Language results were: 61 English, one Spanish, one other language, and 62 unknown. Sexual Orientation results were: two gay, 49 straight, two bisexual, five declined to answer and 67 unknown. Gender results were: seven male, 53 female, two declined to state, and 63 unknown. The results for Gender Identity were: six male, 49 females, three declined to answer and 67 were unknown. Veteran Status results were: three served, seven were family members, 45 did not serve, three declined to answer and 67 were unknown. The Disability results were: one hearing difficulties, two developmental/mental disabilities, four physical disabilities, six health disabilities, two other disabilities, 41 no disabilities, three declined to answer and 66 unknown. The results for Affiliation were: 42 service providers, 10 support service staff, six family, five consumers, one peer, nine community members and 52 unknown.

Our plan is shared with e-mail lists of interested individuals. These lists contain approximately 180 individuals. These individuals range from family members, program participants, contractors, and community based organizations, interested community members, to staff from varies departments with Nevada County. Included in this list are our area's major media outlets.

At the same time that the plan is shared with the MHSA contact list the plan is posted to the County Website.

If any member of our community requests a hard copy of the plan it is provided to him/her for pick up at Nevada County Behavioral Health or another location in the community that is convenient for the community member. Hard copies of the plan are provided to SPIRIT Peer Empowerment Center, Turning Point Providence Center and in our lobby.

The Local Mental Health Board conducts a public hearing after the 30 day public review period. The Local Mental Health Board reviews the plan, public comments and makes the recommendation that the plan be

presented to the County of Nevada Board of Supervisors.

The 30-day review and comment period was November 3, 2017 to December 3, 2017 which served as the opportunity for the public to provide additional input to the MHSA Three-Year Plan and Annual Progress Report for FY 2015/2016.

The MHSA Annual Plan Update and Annual Progress Report Public Hearing was held at our local Mental Health Board on December 8, 2017 .

2. A description of the local stakeholder who participated in the planning process in enough detail to establish that the required stakeholders were included.

The stakeholders involved in the Community Program Planning Process included:

1. Family members from eastern and western Nevada County
2. Program participants
3. Nevada County Behavioral Health Contract providers:
    a. Uplift Family Services formally known as EMQ FamiliesFirst
    b. Victor Community Support Services, Inc.
    c. Turning Point Providence Center
    d. SPIRIT Peer Empowerment Center
    e. Community Recovery Resources
    f. Sierra Forever Families
    g. Nevada County National Alliance on Mental Illness (NAMI)
    h. Common Goals
    i. Sierra Mental Wellness Group
    j. Network Providers
    k. Welcome Home Vets
    l. 2-1-1 Nevada County
    m. FREED
    n. Truckee Family Resource Center
    o. Big Brothers Big Sisters
    p. Hospitality House
    q. Project MANA
    r. Tahoe Truckee Unified School District
    s. Nevada County Superintendent of Schools
    t. Sierra Family Medical Clinic
    u. Nevada County Housing Development Corporation
    v. Shellee Anne Sepko
    w. The Gateway Mountain Center
4. Nevada County Behavioral Health
    a. Adult staff
    b. Children's staff
5. Nevada County Probation Department
6. Nevada County Juvenile Hall
7. Nevada County Sheriffs' Department

THREE-YEAR PROGRAM AND EXPENDITURE FOR FY 2017/18 THROUGH 19/20

COMMUNITY STAKEHOLDER PLANNING PROCESS AND LOCAL REVIEW PROCESS

8. Nevada County Health and Human Services Agency
9. Nevada County Public Health Department
10. Nevada County Superior Court Personnel
11. Nevada County Board of Supervisors
12. Nevada County Chief Executive Office Staff
13. Nevada County Public Defender
14. Nevada County District Attorney
15. Nevada County Department of Social Services
    a. CalWORKs
    b. Child Protective Services
    c. Adult Services
    d. Veterans Services Office
16. Nevada County Mental Health Board
17. Health Clinics/Hospitals
    a. Chapa-de Indian Clinic
    b. Sierra Family Medical Clinic
    c. Western Sierra Medical Clinic
    d. Sierra Nevada Memorial Hospital
18. Nevada County Superintendent of Schools
19. Grass Valley Police Chief
20. Nevada City Police Chief
21. State Department of Rehabilitation
22. Community Based Organizations
    a. Drug Free Nevada County
    b. Charis Youth Center
    c. Community Collaborative of Tahoe Truckee
    d. Northern Sierra Rural Health Network
    e. Touched by a Child Foundation
    f. San Juan Ridge Family Resource Center
    g. Domestic Violence & Sexual Assault Coalition (DVSAC)
    h. Sierra Nevada Children Services

Local Review Process

3. Methods used by the county to circulate for the purpose of public comment the draft of the plan to representatives of the stakeholder's interests and any other interested party who requested a copy of the draft plan.

The Plan is posted to our County Website. Once the Plan is posted an email is sent out to our MHSA contact lists. These lists contain over 180 individuals. These individuals range from family members, program participants, contractors, community members and community based organizations to staff from varies departments within Nevada County. Additionally, an email press release is sent to all of the major media outlets that serve Nevada County. During the 30-day comment period the Three-Year Plan and Annual Progress Report is an agenda item at all MHSA meetings. Hard copies are provided to SPIRIT Peer

THREE-YEAR PROGRAM AND EXPENDITURE FOR FY 2017/18 THROUGH 19/20

COMMUNITY STAKEHOLDER PLANNING PROCESS AND LOCAL REVIEW PROCESS

Empowerment Center, Turning Point Providence Center, in our lobby and to others who request it.
4. Summary and analysis of any substantive recommendations received during the 30-day public comment period. A description of substantive changes made to the proposed plan. The county should indicate if no substantive comments were received.
TBD.

Nevada County Mental Health Services Act
FY 2017/2018 through 2019/2020
Three Year Program Plan

General Nevada County Information:

Nevada County is a small, rural, mountain community, home to an estimated 99,107 (2016 US Census Bureau estimate https://www.census.gov/quickfacts/) individuals. According to the 2016 US Census estimate over 93% of the Nevada County residents identified their race as White, while over 3% of residents combined identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander. Additionally, 3% identified themselves by two or more races. In regards to ethnicity, an estimated 85.5% of the population identified as Non-Hispanic or Latino and 9.5% of the population of Nevada County identified themselves as Hispanic or Latino. Therefore, Nevada County's one threshold language is Spanish.

The county lies in the heart of the Sierra Nevada Mountains and covers 958 square miles. Nevada County is bordered by Sierra County to the north, Yuba County to the west, Placer County to the south, and the State of Nevada to the east. The county seat of government is in Nevada City. Other cities include the city of Grass Valley and the Town of Truckee, as well as nine unincorporated cities.

I. Community Services and Supports (CSS)

A) Full Service Partnerships (FSP)

1) **Plan I: Children's Full Service Partnership (FSP)**

a) **Target Population**

(i) The targeted population served in Plan I are children (age 0-17) who are seriously emotionally disturbed. These individuals who because of their mental health diagnosis will:

- Be at serious risk of or have a history of psychiatric hospitalization, residential care, or out of home placement
- Children who are homeless or at risk of becoming homeless
- Be at risk of aging out of the juvenile justice system or foster care with no care or support
- Be at risk for dropping out of school, experiencing academic failure or school disciplinary problems
- Be at risk of involvement with the criminal justice system

b) **Children's System of Care Approach**

The Children's FSP utilizes a Children's System of Care approach to serving these high-risk children and youth age 0-25. Seventeen-year-old transition age youth can access this system and transition automatically to the adult supports and services, or remain on the Wraparound (WRAP) Team if that level of care is more appropriate for their specific developmental stage.

c) **Services and Supports**

(i) Plan services and supports will include, but is not limited to:

- Psychiatric services and/or non-psychiatric Network Provider services (Network Providers include Psychiatrists, Psychologists, Clinical Social Workers, and Marriage & Family Therapists licensed for independent practice)
- TAY support and peer counseling
- Housing services
- Employment and pre-employment services
- Outreach and Engagement activities throughout the county, and with inclusion for Latinos and residents of Truckee and North San Juan.
- Wraparound services and supports
- Case Management, rehabilitation and care coordination
- Peer/Family support, advocacy, training, and education
- Integrated treatment for co-occurring disorders
- Court liaison services
- "Whatever it takes" services

d) **Wraparound Treatment Teams**

Nevada County has comprehensive Wraparound Treatment Teams that provide services 24/7, utilizes small team-based caseloads, provides field based services, and emphasizes individual and family strengths. The Teams focus on reducing/preventing out-of-home placement through close interagency collaboration,

an individualized treatment plan, and a full range of services available within the Teams.

Peer and family support services are utilized. The term "support" in the context of peer and family support, is not meant to imply a level of licensing or certification. Similarly, the intent is to recruit peer support staff from available agencies, individuals, and organizations.

The Wraparound service model delivers services to children and families with severe and multiple problems being served by multiple agencies. Wraparound services refer to an individually designed set of services provided to high risk children/youth with serious emotional disturbance (SED) or severe mental illness (SMI), and their families. These services may include treatment services and personal support services, or any other supports necessary to maintain the child/youth in the family home. Services are delivered through an interagency collaborative approach that includes family participation as equal and active team partners.

Nevada County has Wraparound service providers that support both the western and eastern parts of the county. The Wraparound service providers provide for and/or arrange for all necessary services as indicated by individual needs. Substance use treatment is integrated within the context of overall services delivered by the Wraparound Team.

The plans include providing Wraparound services to Transitional Age Youth (TAY) age 16-25 whenever necessary and appropriate. The age limits and boundaries for inclusion in Wraparound services are intentionally flexible and will be directed by individual and family circumstances and needs.

e. Latino Outreach

The children's Wraparound providers may have bi-lingual and bi-cultural staff that works with families when clinicians with skills appropriate for the wraparound programs are available to be hired. Nevada County also has Promotoras, bi-lingual and bi-cultural health educators to help with outreach and engagement to Latino families for Wraparound service providers, to offer translation services and at times to join the treatment team. Comprehensive recruitment of bilingual staff is an ongoing challenge.

f. Peer and Family Support/Advocacy Services

The Wraparound Teams may include Peer and Family support/advocacy services by utilizing Parent Partners. These staff members help assure that provided services are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family. Family advocates work directly with families experiencing mental health issues.

g) Housing Services

Flexible funding for housing supports is included in this strategy. Whatever may be needed by the child, youth, or family member in order to maintain placement in the home, may be addressed with these funds. Some examples might include child care, cleaning services, rental assistance, utility assistance, furniture or appliances, and structured activities or classes on daily living skills.

TAY may be offered the full range of available Adult Residential Treatment

programs, including board and care and rental subsidies for independent living expenses.

h) **Employment and Pre-Employment Services**
Employment and pre-employment services may be provided by staff on the Wraparound Team to youth who are transitioning out of school or ready to approach the workforce. Supported employment services may also be offered to other family members, as part of the individualized service plan and as needed to keep the families intact and the child or youth living at home.

i) **Out of County Placement of Program Participants**
The primary focus of the Wraparound Team is directed toward individuals residing within the County. However, children who are placed, or who may be placed, out of the County will be part of the target population and therefore be offered the services of the Wraparound Team. The goal for these individuals will be to return to a less restrictive alternative placement, such as residing with their families within the county.

TAY who may be temporarily placed out of the County in inpatient psychiatric units, Institutes of Mental Disease (IMD), or Psychiatric Health Facilities (PHF), will continue to be supported by the Wraparound Team to facilitate a rapid return to a lower level of care and independent living.

2) **Plan II -Adult Full Service Partnership (FSP)**

a) **Target Population**
The targeted population served in Plan II are adults age 18 and up who are seriously mentally ill (SMI) individuals who service needs are unmet or so minimally met they fall into the unmet category placing them at risk of incarceration, institutionalization, becoming homeless or are currently homeless, or under involuntary care.

b) **Assertive Community Treatment (ACT)**
Provide Full Service Partnership services based on the Assertive Community Treatment (ACT) model, which features clinical/community based team coordinated care. Services are provided to adults, seniors, and TAY, over the age of 18.

c) **Assertive Community Treatment (ACT) Team**
The ACT Team directly provides services that include treatment, support, care coordination, and rehabilitation. Those services are individualized and described in a comprehensive and culturally competent service plan. Additional services are available in order to meet housing, employment, substance abuse, and physical health needs.

Team members share responsibility for the individuals served by the team. Members may receive services from any staff person on the treatment team. The staff to consumer ratio is small, approximately one staff member per 10 clients.

The range of treatment and services is comprehensive and flexible. Team staff members provide many different types of services to members, and these services may be outside of their respective discipline (within scope of practice if applicable). Interventions are carried out in vivo rather than in hospital or clinic settings. There is no arbitrary time limit on receiving services. Services are available on a 24–hour, 7 days per week basis. The team adopts an assertive attitude and is proactive in

engaging those individuals needing care. Membership on the Team is maintained as long as the individual desires continued services.

Additionally, the ACT Team will contain some specialized target functions and strategies relating to geographic, ethnic, and other specific community needs.

(i) **Step Down ACT Team**
Operate a step down ACT team to help FSP participants integrate into the larger community. The Step Down ACT Team is currently called New Directions. The New Directions team features clinical/community based team coordinated care. Services are provided to adults, seniors, and TAY, over the age of 18.

d) **Services and Supports**
(i) Adult FSP services and supports may include, but is not limited to:
- Peer/Family counseling
- Drop in services
- TAY support and peer counseling
- Assisted Outpatient Treatment or "Laura's Law": Engaging treatment resistive SMI individuals who may be involved with the criminal justice system. Unserved individuals must meet additional criteria for AOT as listed in W & I code 5345(a).
- Gay, lesbian and transgender peer services
- Psychiatric Services and/or non-psychiatric Network Provider services
- Rehabilitation, Case Management, and Care Coordination
- Integrated treatment for co-occurring disorders
- Outreach/engagement services to homeless
- Peer Supportive Services – Peer driven and staffed empowerment center focused on the SMI individual.
- Housing and employment support
- Veteran services
- "Whatever it takes" services

e) **Assisted Outpatient Treatment**
Nevada County makes ACT services available to individuals participating in the Assisted Outpatient Treatment (AOT) Program. A Licensed Mental Health Professional (LMHP) on the ACT Team acts as the Director of Behavioral Health's designee and is the liaison between the court and the Full Service Partnership program.

The LMHP receives referrals from Nevada County Behavioral Health, initiated by a qualified party including a family member, peace officer, probation, licensed treatment provider or others as identified in W&I code 5346(b) 2. The LMHP reviews the available treatment history, conducts an assessment, and develops treatment plans. If appropriate, the referred individual will receive comprehensive services from the ACT Team. No MHSA funds will be used for law enforcement or court staff.

The goal of Nevada County's ACT Team is to provide access to evidenced based practices, improve services, and increase services to unserved and underserved individuals. Individuals referred by the courts under AOT have not benefited or utilized conventional treatment approaches. Nevada County values consumer choice and individual responsibility, and will not discriminate enrollment in this full service

partnership based on legal status. Individuals who are conserved, on probation, on parole, or committed under AOT will be welcomed into the voluntary array of services provided by the ACT Team in an unlocked setting.

f) **Housing Support**
Supportive housing services are provided by the ACT Teams. Funds are provided for rent, security deposits, first and last month's rent, cleaning services, housing repairs, utilities, furniture and appliance needs. Funds may be used for items not listed above that will support a FSP participant or landlord that is working with the FSP team. Consideration will be given to creating a housing fund for loan purposes, for those individuals that possess the ability to secure and repay loans.

g) **Employment Services**
Employment services are included in this proposal which may include, but is not limited to the area of peer and family support opportunities. Many consumers and family members are expected to be employed on full and part time basis on the ACT Teams, at the Peer Counseling center, at community based organization, conducting outreach to Latinos, Veterans, and other unserved and underserved populations, and as consumer and family advocates.

h) **Out of County Placement**
Care Coordinators on the ACT Team maintain responsibility for their consumer partners, placed out of county, hospitalized, or receiving treatment in an Institute for Mental Disease. Care Coordinators will facilitate access to treatment, provide case management, engage in aftercare planning with the facility, and help prepare the consumer to return to their homes and/or to a less restrictive placement as soon as possible.

Consumers are offered a choice of placement options, whenever possible, with every effort made to provide for a local, in county, living arrangement. If an out of county placement is considered as an option, the consumer is informed of the pros and cons of this decision.

i) **Peer and Family Support/Advocacy Services**
Peer and family support/advocacy staff are integrated on the ACT Teams and work directly with program participants and their families. They support program participants and their family with assessment, diagnosis and treatment processes. They participate in training and provide education to providers, other agency staff, and families. They work closely with the ACT Teams and advocate flexibility of services delivery as determined by individualized needs of program participants and their family members that are involved.

Note: Transition Age Youth (TAY) have access to both of these Full Service Partnerships (FSP) Plans where it is appropriate for the individual to receive specialized individual services and supports.

B) General System Development

1) **Expand the Intern Program**: This expands service capacity, increases access, and broadens services in Western Nevada County and in Truckee. Interns may be funded through either of the two Plans. This also includes supervision of Interns.

2) **Expand Network Provider Program** (May be funded by either or both of the Plans). Expands service capacity, increases access and broadens services throughout the County.

3) **Expand Adult and Child Psychiatric Services.** Expand both adult and child psychiatric services. May provide psychiatric consultation and support (funded by either Plan) to low Federally Qualified Health Clinics, Sierra Family Medical Clinic and Western Sierra Medical Clinic.

4) **Expand Mental Health Treatment, Case Management and Outreach and Engagement Services in North San Juan** (funded by either or both plans).
   a) The North San Juan Ridge area is an area identified as being underserved due to geographic location. Sierra Family Medical Clinic (SFMC) provides medical and psychological services to individuals living in the North San Juan Ridge area.
   b) The FSP Teams collaborate with the SFMC to implement a variety of ideas to improve access to necessary mental health services, such as contracting with individual therapists, consulting with SFMC staff, and scheduling on site office time for FSP staff to review and receive new referrals.
   c) Services at SFMC may include, but is not limited to care coordination, outreach and engagement services, and treatment expansion.

5) **Provide Co-Occurring Disorders (COD) Participants with "Care Home" Model Services** (funded by either or both plans). Program provides adults and adolescents with co-occurring disorders (COD) with "Care Home" model services. A Care Home model creates a central access point for co-occurring services, medical services, and ancillary services such as anger management, job skills training, life skills training, and parenting, which pertain to the individuals co-occurring needs. The services may include, but are not limited to: assessments, treatment, strength-based case management, aftercare, medical services, psychotherapy, ancillary services, and drug testing (voluntary unless court ordered).

6) **Expand Adult and Children's Behavioral Health services.** Expand both adult and child Behavioral Health services. Additionally, expand Behavioral Health services to support and implement MHSA programs (funded by either or both plans).

7) **Expand Crisis and Mobile Crisis Intervention Services** includes **Respite Care, Crisis Stabilization Unit, and Crisis Residential facility.**
   a) Expand the **number and work location of crisis workers.**
   b) Expand **Crisis Intervention Services** which may include mobile crisis services (funded by either or both Plans). Crisis Intervention Services is being provided to the members of community in a limited capacity with the hopes of expanding when funds are available. Whenever necessary and practical, this response is coordinated with law enforcement, responding as a team to mental health crisis in the community. The goal is to deliver a more effective, appropriate, and rapid response at the start of a crisis episode and thus reduce trauma to the individual and the need for hospitalization or institutionalization. Ongoing specific training for mobile crisis intervention will be provided for participating law enforcement officers and crisis workers. Funds allotted to this service would allow the existing Crisis Service to expand its crisis worker response capacity.
   c) **Mental health stabilization services in Juvenile Hall** provide preventive interventions to individuals experiencing symptoms of serious mental illness. One-to-one interventions may provide enough support to stabilize or deescalate the emergent nature of a crisis situation and prevent an unnecessary hospitalization.

These services are provided by or closely coordinated with the Wraparound Team and move toward providing for urgent services, on site in the community, 24 hours/day, 7 days/week.

d) **Respite Care Facility**. Nevada County developed and opened a respite care facility in 2015. CSS funds may be utilized to support the day-to-day operations of the facility, staff and services provided.

e) **Crisis Residential Care facility**. Nevada County has not developed a Crisis Residential Care facility, but the need is high.

f) **Crisis Stabilization Unit (CSU)**. By utilizing SB 82 funds and MHSA CSS funds a CSU has been developed and is in operations on the same site as Sierra Nevada Memorial Hospital. CSS funds may be utilized to support the day-to-day operations of the facility, staff and services provided. Services provided in the CSU are on a voluntary basis.

8) **Emergency Department Outreach and Engagement, includes Respite Care and Crisis Stabilization Unit (CSU) facility supports**

a) In an effort to increase the quality of care for patients utilizing the Emergency Department (ED) and CSU for mental health needs and to reduce ED and CSU visits, an ED/CSU support and a follow-up service has been designed and is being implemented.

b) This service provides ED/CSU support, ED/CSU follow-ups and preventative care to individuals exhibiting the symptoms of serious mental illness who are treated and released from the hospital ED and who do not, at that time, meet 5150 criteria. Peer Advocates/Supporters build relationships with individuals and then provide warm handoffs to appropriate community service providers. The ED/CSU service support staff work in collaboration with the ACT Team, Peer Support Agency, NCBHD staff, Crisis support staff and other involved agencies. One-to-one follow-up by a Peer Supporter is offered to individuals experiencing the symptoms of serious mental illness within 72 hours of ED/CSU release. These individuals receive a phone "check in call" and an offer of support by a Peer Supporter trained in Peer Support which may include, but is not limited to, symptom management, community resource referrals, and family support.

9) **Truckee Outreach, Engagement, and Liaison**

Concerted efforts are made to outreach and provide services to unserved and underserved Truckee residents which may include the Latino population. Services may include case management, peer support services, training, counseling by licensed therapists, and community outreach services. Services are delivered by collaborative efforts in both Western and Eastern Nevada County. Services are culturally and linguistically competent.

10) **Provide Services to Veterans and Their family.**

During the MHSA community planning process it was determined that Veterans in Nevada County are an unserved and underserved population which is growing rapidly. Many of the services Veterans receive from the Veteran Affairs (VA) Office have to be obtained out of county or out of the State. Services provided in this program include a continuum of therapy services to veterans who have mental health needs related to service in the military. This continuum of services includes individual and group therapy, ongoing peer support group with professional oversight, and outreach and engagement activities. Similar services will also be available for family members of these veterans who are experiencing mental health needs related to coping with the veterans' mental health issues. All therapy will be provided under contract with licensed

therapists who are experienced in working with veterans and their families. In addition to the therapy services, community awareness seminars designed to increase community awareness of the cultural and psychological needs of veterans with military-related psychological trauma and their effect on the family and community may be conducted. Lastly, general community outreach and engagement activities will be conducted.

11) **Provide Housing and Supportive Services to the Severely Mentally Ill Homeless**
Services are provided to this population through CSS and PEI (Prevention and Early Intervention) funds. Services may include, but is not limited to: case management, mental health evaluations and assessment, linkage to mental health, physical and substance use services for individuals with co-occurring disorders, outreach to individuals at their camps, transitional support while transitioning to permanent housing, support and assistance while obtaining and maintaining housing, crisis intervention, forensic support, teaching/training on life skills, supporting and including family members, substance use counseling, mental health treatment/therapy, community referrals which include warm handoffs, transportation, consultation with other service providers, assistance with rental and security deposits, and short and long term rental assistance. This also includes supports for landlord needs that are collaborating with NCBHD to provide housing to the targeted population that Nevada County Behavioral Health serves.

May include support to service providers that support individuals and families that are homeless or are at risk of losing their housing. This includes: homeless prevention programs, emergency shelter programs, transitional housing, rapid rehousing programs and permanent supportive housing programs.

This also includes the use of CSS funds to purchase housing units to provide permanent supportive housing to SMI homeless individuals.

All of the remaining original CSS Housing funds were expended in July 2016. CSS funds may be used to support the two housing units purchased with the original CSS Housing funds and to provide the supportive services and resources that the tenant needs to obtain and retain housing in these two units.

Any new or unexpended CSS Housing funds may be used to assist existing MHSA housing or future MHSA housing units. This assistance includes: rental assistance or capitalized operating subsidies; security deposits, utility deposits, or other move-in cost assistance; utility payments; moving cost assistance; and capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless.

CSS and/or PEI funds may also be used to support the implementation of No Place Like Home Program (NPLH) and/or other housing grant funded programs that target mentally ill homeless individuals. Support may include: planning, outreach and engagement, implementation, evaluation, and reporting out on outcomes. Funds may be used on supportive services on site or off site to support NPLH/other grant program residents in obtaining and retaining housing. Support may be for housing, improving program participant's health status, and maximizing ability to live and, when possible, work in the community. Supportive services may include, but not limited to: care coordination/case management; peer support activities; mental health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups; substance use services, such as treatment, relapse prevention, and peer support groups; support in accessing physical health care, including access to routine and preventive health and

dental care, medication management and wellness services; benefit counseling and advocacy, including assistance in accessing SSI/SSP, enrolling in Medi-Cal and obtaining other needed services; basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, and money management); recreational and social activities; transportation planning and assistance for access to off-site services; educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process; and employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work.

12) **Training of Staff, Contactors, Community Stakeholders, Individuals with Lived Experience and Family Members**
Provide education, training and workforce development programs and activities that contribute to developing and maintaining a culturally competent workforce, to include individuals with client and family member experience that are providing client- and family-driven services that promote wellness, recovery, and resiliency, leading to measurable, values-driven outcomes.

C) Outreach and Engagement

1) Providing education to community members, peers and family members. Training opportunities are available to all individuals (funded by either or both plans).

2) All Behavioral Health staff and contracted staff involved in CSS provide outreach and engagement services.

3) Wellness Centers provide Peer Support services, this may include, but is not limited to: one-on-one Peer Support, support groups, theme-specific Peer Support/self-help groups, Peer Support training, outreach training to Peer Support staff and individuals that seek to empower themselves in school, working with employers and community agencies, resume assistance, job interviewing training, outreach to the community to educate the public about mental health prevention services, and to help end the stigma of mental illness. Services are available on a drop in basis and at no costs. Program participants may be unable or unwilling to access traditional services or cannot otherwise afford counseling or psychotherapy. Program can be funded with either CSS or PEI funds.

   Services provided may vary, but can include, but is not limited to: Weekly Support Groups, co-facilitated by Peer Supporters, community volunteer and/or a trainee and will cover various topics such as, but not limited to: Dual Diagnosis issues, Gay and Lesbian, Transitional Age Youth issues, Men's Group, Women's Group, Spirituality Group, and WRAP Plans.

   Training is available to Peer Support Staff and individuals that seek to empower themselves to work with their peers, media, potential employers, community agencies, community members, and family members. Participants learn how to, but not limited to:
   - Provide Peer Support/Mentoring services
   - Increase their life skills
   - Use a computer or increase their computer skills
   - Improve overall health/well being
   - Access community resources

D) Program Expenditures

Expenditures for this work plan may include all expenditures identified in the Original three-Year Plan (for FY 2005/2006 through 2007/2008), subsequent Annual Updates, and items on the MHSA Recommendations of Needed Mental Health Services FY 2017-2020 document, including but not limited to: staffing and professional services, operating expenses (office supplies, travel and transportation, client vouchers and stabilization funding to meet other client expenses needs based on the "whatever it takes" MHSA approach for FSP clients, translation and interpreter services, rent, utilities and equipment, medications, and medical support), telepsychiatry equipment, office furniture, capital purchases, training and education, food, client incentives, the cost of improving the functionality of information systems used to collect and report client information. Capital purchases may include the cost of vehicles, costs of equipping employees with all necessary technology (cellular telephones, computer hardware and software, etc) the cost of enhanced and/or increased space needs related to services, and other expenses associated with the services in this plan.

E) Future Programs

The expansion of services in the future may include any other activities approved in the original CSS Plan or subsequent Annual Updates or the MHSA Recommendations of Needed Mental Health Services FY 2017-2020 document, including, but not limited to: homeless outreach, support and engagement services; housing supportive services for the homeless or those at risk of homelessness, Latino outreach and engagement services; North San Juan Ridge and Truckee services; enhanced services to court involved families; enhanced jail services for inmates within six months of release from jail or juvenile wards at juvenile hall; foster youth care children; support for at risk youth in the school system and/or community; wellness centers; services to serve unserved, underserved and inappropriate served populations: consultation to clinics and Primary Care Physicians and other health care providers; contract services; services to Veterans and their families, use of Interns; expansion of crisis services including crisis residential, crisis stabilization units and Respite Care; expansion of services for treatment for Co-occurring disorders; peer support; expansion of Children's System of Care (CSOC) and Adult System of Care, and psychiatric services and/or non-psychiatric Network Provider services.

F) CSS Program Costs and Cost per Person

The estimated cost for CSS programs based on the number of individuals served in FY 15/16: 1) FSP programs is $2,020,000, 2) General System Development programs is $1,425,000, 3) Outreach and Engagement Programs and activities is $175,000, and 4) Administration cost is $540,000. The estimated total cost is $4,160,000. The average estimated cost per person involved in a CSS activity will be $685.68. This is the estimated cost of FSP, General System Development, Outreach and Engagement activities, and Administrative costs divided by the number of individuals served in FY 15/16 with CSS funds (6,067). We estimate serving during a given year 449 children, 432 TAY, 1,330 adults, 419 older adults and 3,437 individual's ages may not be known.

Estimated CSS Cost per Year by Age:

Age	Est. # Served/Year	Est. funds spend/year	% Cost/Age
Unknown age	3,437	457,000	.13
Children	449	874,400	.24
TAY	432	706,250	.20
Adults	1,330	1,241,600	.34
Older Adults	419	340,750	.09
Total	6,067	3,620,000	1

Estimated Cost by Age by CSS Program:

Age	# Served in FSP	% of the Total	Est. FSP cost/age	# Served in GSD	% of the Total	Est. GSD cost/age	# Served in O&E	% of the Total	Est. O&E cost/age
Unknown Age	0	0	$0	451	.22	$313,500	2,986	.82	$143,500
Children	118	.32	$646,400	331	.16	$228,000	0	0	$0
TAY	93	.25	$505,000	297	.14	$199,500	42	.01	$1,750
Adults	123	.33	$666,600	794	.39	$555,750	413	.11	$19,250
Older Adults	37	.10	$202,000	177	.09	$128,250	205	.06	$10,500
Total	371	1	$2,020,000	2,050	1	$1,425,000	3,646	1	$175,000

Note: These costs by age and CSS programs are only estimates, actual costs may vary greatly, and do not include administration charges. These costs only reflect first year budget and will change with each new FY's budget.

G) Prudent Reserve

NCBHD started to fund the Prudent Reserve with Unapproved FY 2005/2006 Estimate Funds in the amount of $158,857. In the Three Year Plan Update for FY 2008/2009 Nevada County directed $751,800 of FY 2006/2007 CSS Unapproved Planning Estimates into the Prudent Reserve. Additionally, in the FY 2008/2009 Three Year Plan Update Nevada County directed $118,493 of FY 2007/2008 CSS Unapproved Planning Estimates to the Prudent Reserve for a total of $870,293. Lastly, NCBHD requested to have FY 2007/2008 PEI Unspent Funds of $100,000 to be directed to the Prudent Reserve. To date the total amount Nevada County has dedicated to the Prudent Reserve is $1,129,150.

NCBHD will access the Prudent Reserve when there are not enough CSS or PEI funds to maintain the current CSS and PEI programs. Additionally, any CSS funds that may revert in any year will be transferred to the Prudent Reserve to avoid reversion of those funds.

H)MHSA CSS Administration

MHSA CSS Administration funding is used to sustain the costs associated with the intensive amount of administration support required to ensure ongoing community planning, implementation, monitoring and evaluation of the CSS programs and activities. The expenditures within the administration budget are recurring in nature. The increases in expenditures are due to expansion of personnel and contracts that are associated with the operating costs assigned and assisting in the delivery of the programs. All administrative cost in the original CSS plan and subsequent Updates are applicable expenses.

Besides the MHSA Coordinator the Administration costs includes other staff to support the CSS Programs. Supportive staff included, but is not limited to: the Behavioral Health Director, Adult, Children's and Drug and Alcohol Program Managers, Behavioral Health Adult and Children Supervisors, Behavioral Health Workers, Behavioral Health Technicians, Analyst, Administrative Assistant, Administrative Services Officer, and the Accounting Technician. All of the above staff are involved in the community planning, implementation, and/or monitoring and evaluation of the MHSA programs and activities. Yearly the benefits of assigned staff will be charged to MHSA CSS.

A Behavioral Health MHSA Program Evaluation committee may be created. The committee will be comprised of 5-7 stakeholders who will review annual reports and evaluate the program on how well they meet the program's/contract's stated outcomes, as well as making a difference in the lives of those they serve.

A formal group of consumer and family members may be created and funded to assist in the community planning, implementation, and/or monitoring and evaluation of MHSA programs and activities. The activities this group will be involved with will include, but is not limited to: community meetings, mental health surveys, focus groups, trainings, community events, community education, media outreach and engagement events, and stigma awareness and reduction campaigns.

Operating expenditures tend to increase yearly and are based on prior year actual expenses. The increases are due to increase in staff, contractors and program activities. Expenses may include, but are not limited to: office supplies, office furniture, other operating expenses, capital purchases, training and education, food, incentives, the cost of improving the functionality of information systems used to collect and report program participant and program information. Capital purchases may include the cost of vehicles, costs of equipping employees with all necessary technology (cellular telephones, computer hardware and software, etc.), the cost of enhanced and/or increased space needs related to services, and other administration expenses associate with the services in this plan.

County Allocated Administration is also a covered expense and is increasing due to the increase in staff working on MHSA projects and programs. Countywide Administration (A-87) expenditures are based on a formula prepared annually by the County Auditor based on the activities for the prior year.

Lastly, it is anticipated that the MHSA CSS programs will generate new Medi-Cal revenues. These funds will be used to help cover the costs to administer the MHSA CSS Programs.

II. Prevention and Early Intervention (PEI)

A) PEI Project Name: Early Intervention Programs

1) Project Name: Alternative Early Intervention for Youth and Young Adults

a) **Identification of the Target Population:**

- **Demographics:** Youth age 8-15, transitional age youth 16-24. Services will be provided to all gender and sexual orientation. Services are provided in Eastern and Western Nevada County. Program participants will be referred to as youth in this section.
- **Mental illness for which there is early onset:** Services will be provided for mental illness that is presented, including serious emotional disturbance, depression, anxiety, self-harm, suicidality, bi-polar disorder.
- **Brief description of how each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began. Program referrals typically come from families, school psychologists or therapists in the community.

b) **Identification of the type of problems and needs for which the program intended to address:** Youth who suffer from mental illness symptoms often have difficulty accessing effective treatment. Traditional therapy done in a 50-minute session, in an office is often not appealing for youth with mental illness. The youth needs to receive mental health services, but are not receptive to traditional mental health services. This program is more flexible, initially meeting the youth where they are at, and helping the youth access the natural world, engaged adventure, and connection to community. The problems the youth in this program may face include: hospitalization, suicidal ideation, removal from their home; involvement with law enforcement/courts; and/or failing in school. The program is intended to decrease the incidence of hospitalization, law enforcement/court involvement; school failure and improve engagement with family, school and community.

c) **The activities to be included in the program that are intended to bring about mental health and related functional outcomes:** The program goals are to guide youth program participants into experiences that help them increase their sense of self-efficacy, strengthen resiliency, expand self-image, and reduce vulnerability to stress and depression. The program provides individual therapeutic/behavioral services, rehabilitation, case management and crisis intervention services. The program provides nature-based therapeutic treatment sessions, which typically last for 3-5 hours and occur weekly. Trained therapeutic rehabilitation guides build authentic relationships with the program participants, provide immersive experiences in nature, embodied peak experience challenges, and provide settings for deep mindfulness and reflection. The staff over time is able to guide some program participants into community service opportunities which help program participants make and connect to their community. The therapeutic guides-to-youth participants are 1-3.

d) **Describe the MHSA negative outcomes that the program is expected to affect:** The program has a positive impact reducing 1. Suicide and suicidality, 2. Incarcerations, 3. School Failure and Dropout, 4. Prolonged Suffering, 5. Homelessness and 6. Removal of Children from their homes.

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** It is anticipated that the Youth Outcome Questionnaire (YOQ), CANS survey or another survey tool will be used to evaluate the reduction of prolonged suffering. Other survey methods may be used if deemed appropriate by the County for program participants.

- **Explain the evaluation methodology, including, how the evaluation will reflect cultural competence.** The evaluation tool is designed to describe a wide range of situations, behaviors, and moods that are common to adolescents; the evaluation tool is filled out by the program participant. The evaluations at a minimum will be done at the beginning of therapy and at program exit.

  In the Truckee operation there are three therapeutic guides who are native Spanish speakers; these specialists may also be used to work with Western Nevada County youth as needed to provide Spanish speaking services in evaluating the program.

e) **Provide a brief description, with specific examples of how each program will reflect and be consistent with all applicable MHSA General Standards:**
- **Community Collaboration:** Staff work closely with family members, school counselors and psychologists, private referring therapists, Family Resource Centers, and County behavioral health staff. Staff provides case management support when program participants are engaged with a multi-agency teams.
- **Cultural Competence:** The program and staff are completely youth focused. Staff have extensive experience working in alternative education settings, providing adventure activities and creative expression opportunities for young people. The program hires passionate, vibrant, embodied people who prior to their therapeutic work, came from the fields of education, ski coaching, youth development. Youth respond to staff authenticity and that staff truly respect and value who they are. The program has success in working with youth from the Latino Community, Latino therapeutic guides have been hired who also assist other staff who are working with Latino families. In addition, the program is part of a cohort of grantees from Youth Outside, which is working to increase Cultural Competence, equity and inclusion amongst outdoor education leadership to better serve youth of color. The director and key staff are involved in extensive trainings to improve these skills in Cultural Competence.
- **Program Participant Driven:** Youth program participants choose to participate in treatment programs; in most cases they report greater satisfaction in services, and greater and easier access to service provider personnel than is found in traditional treatment systems. Youth program participants participate in the development of treatment plans and program evaluations.
- **Family Driven:** The program staff works closely with program participant families. In a Wraparound setting the therapeutic guides participate in Family Team Meetings. Families are usually involved in the development of treatment plans.

- **Wellness, Recovery, and Resilience Focused:** The core concept of the treatment methods, within the framework of longer session times, creates the likelihood for an increase in wellness, recovery and resilience for program participants. Program staff are able to build a relationship, creating the space and conditions for the likelihood of increased self-awareness to develop, leading to behavioral change. Improvements in exercise habits, diet, reductions in reactivity and greater engagement with other resiliency building resources, are the hallmark of the program.
- **Integrated Service Experience for Program Participants and Their Families:** Services are integrated within the existing system of care, as well as school counselors, psychologists, teachers and resource staff. The program staff stay in close contact with referring therapists and often provide support for program participants as they access psychiatric care. Program staff help program participants navigate to other resources as needed.

f) **Explain how program helps to Improve Access to Services for Underserved Populations:** The majority of the youth program participants served do not have health insurance, and come from low-income families and communities. The youth served often also do not access to or have not been successful with traditional therapy in an office. Many of the youth come from difficult family situations where there is not a lot of support in accessing mental health treatment services.

g) **The intended setting(s) and why the settings enhance access for specific, designated underserved populations:** An important aspect of the success of the program is that staff meets the youth where they are, typically at their school right when school gets out. Staff then drives to the planned session location, usually an experience in a beautiful natural setting. Youth are more comfortable and willing to participate and benefit greatly from the exercise in nature that is part of most sessions. Another important aspect is that staff members are meeting them directly without specific involvement of the parent, which reduces the resistance to treatment, which can occur when a youth is brought to an office by a parent or guardian. Staff drives the youth home at the end of the session.

- **If the County intends to locate the program in a mental health setting, explain why this choice enhances access to quality services and Outcomes for the specific underserved population:** NA

h) **Explain how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** The program provides an increased session time, the relationship that is formed between therapeutic guides and program participant youths, and the self-efficacy building focus of the treatment methods, help program participants understand their symptoms in a broader and more supportive context, thus reducing their feelings and fears of stigmatization. Staff have a lot of experience in working with youth with a wide range of backgrounds, ethnicities, and sexual and gender orientations, staff members are very sensitive and supportive of all youth and their families.

i) **Estimate Number of Children, Transition Age Youth, Adults and Seniors Served Per Year-** It is estimated that 12 youth and their families will be served per year.

j) **The Estimated Cost Per Person:** Estimated Average Cost per youth and transition age youth served per year: $20,000/12 = $1,667

2) Project Name: Bi-lingual Therapy

a) **Identification of the Target Population:**
- **Demographics:** Services will be provided to Spanish speaking individuals. Services will be provided to all age groups, gender and sexual orientation. Services are provided in Eastern and Western Nevada County.
- **Mental illness or illness for which there is early onset:** Services will be provided for any mental illness that is presented that short term therapy is appropriate and that the Behavioral Health Department and contractors have the capacity to treat.
- **Brief description of how each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began.

b) **Identification of the type of problems and needs for which the program intended to address:** The Latino population in Nevada County is growing. This population is underserved in accessing Spanish speaking mental health resources. There are many reasons for this. To name a few of the reason: not enough professionals who speak Spanish, lack of transportation, lack of infrastructure to create networking opportunities, and stigma and fear about reaching out for help with mental health issues.

c) **The activities to be included in the program that are intended to bring about mental health and related functional outcomes:** Nevada County will serve the Latino population by hiring and/or contracting bi-lingual therapists who take referrals from the Family Resource Centers (FRC), the local Promotoras Programs, schools, the Woman Infant Child (WIC) Program and other community based services providers that serve the Latino population. The therapists provide early, short term intervention therapy with individuals whose mental illness has recently manifested or that treatment will decrease the negative effects of the illness.

Additionally, the therapist(s) will collaborate and work with community based Promotoras to consult one-on-one about individuals, to create psycho-education material, and attend psycho-educational groups.

d) **Describe the MHSA negative outcomes that the program is expected to affect:** Because the program sees all age groups and each person may have different needs, any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. It is anticipated that prolonged suffering will be decreased in all individuals served.
- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** Because the program sees all age groups and each person may have different needs, it is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools

may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.

- **Explain the evaluation methodology, including, how the evaluation will reflect cultural competence.** The evaluations at a minimum will be done at the beginning of therapy and at program exit. Spanish speaking therapist administer the evaluation. Evaluation forms are offered in Spanish. Program participants are offered the option of filling out the evaluation themselves or have it read to them.

e) **Provide a brief description, with specific examples of how each program will reflect and be consistent with all applicable MHSA General Standards:**

- **Community Collaboration:** This whole program is built on Community Collaboration. Multiple community based organizations, MHSA stakeholders, including program participants and their family are working together to provide a process that Spanish speaking individuals can receive therapy for needed mental health conditions.
- **Cultural Competence:** This program provides mental health treatment in the language of the individuals needing services. Therapist are collaborating and working with community based Promotoras. When mental health services are located at the County office Promotoras are bringing program participant's to the first appointments to ensure that they feel comfortable, and that a relationship is developed. Therapists are located at Family Resource Centers and schools, where individuals are already connected to and feel comfortable.
- **Program Participant Driven:** The program participant's chooses to participate in services and determines the treatment that they receive and participates in the creation of the Treatment Plan and the goals of the Treatment Plan. They determine if they want other family members to be involved in their treatment plan.
- **Family Driven:** Adults who want their spouse or other family members involved in their Treatment Plan are encouraged and supported to include them. Parents of children and youth have the primary decision-making role in the care of their children which includes determining the services and supports that would be most effective and helpful for their child(ren).
- **Wellness, Recovery, and Resilience Focused:** The program utilized Promotoras to help support the individual who wants to get help for their mental health needs. The program reflects the cultural, ethnic, and racial diversity of the population being served. The treatment services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. Each Treatment Plan is based on the individual's needs and goals.
- **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community based organizations, non-profits, and schools. Individuals and their families can enter the program from one of many doors. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

f) **Explain how program helps to Improve Access to Services for Underserved Populations:** The individuals in this program are not eligible and/or cannot access other programs because they do not have health insurance, are not legal immigrants, do not trust other organizations, their mental health issues are preventing them from

accessing care, etc. The program is improving access to services by out stationing and outreaching to the underserved by connecting to these individual's natural community support systems.

g) **The intended setting(s) and why the settings enhance access for specific, designated underserved populations:** This therapy occurs at the Behavioral Health Department, at the Family Resource Centers, schools, or at a location in the community that the individual chooses.
   - **If the County intends to locate the program in a mental health setting, explain why this choice enhances access to quality services and Outcomes for the specific underserved population:** Nevada County is a small county and has a very limited number of Spanish speaking therapists. Some of the therapist are located at community based organizations-Family Resource Center and the schools, but most are located at County offices. Nevada County does not have the population numbers to be able to out station all of the Spanish speaking therapists. The program has set up a process that the Promotoras bring new program participants into the Nevada County Behavioral Health office and does a warm handoff to the therapist for the individual's first appointment. Having any access to a Spanish speaking therapist enhances and improves the outcomes for this population.

h) **Explain how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** The Behavioral Health Department is collaborating and coordinating with the Family Resource Centers in communities where Promotoras are located. The Department is training Promotoras to increase and improve their knowledge, skills and attitudes around mental illness, so Promotoras will refer individuals to treatment services. The Behavior Health Department has one therapist providing services at the Family Resource Center in Truckee. In Western Nevada County as needed the Promotora accompanies the program participant to the Behavioral Health Department and does a warm handoff with the therapist. Lastly, the Behavioral Health Department hires Spanish speaking therapist in both their children's and adult programs when Spanish applicants apply. Evaluation forms are provided in English and Spanish.

i) **Estimate Number of Children, Transition Age Youth, Adults and Seniors Served Per Year-** It is estimated that 30 children, 10 transition age youth, 25 adults and five older adults will be served per year. A total of 70 individuals and 50 families.

j) **The Estimated Cost Per Person:** $67,000/70 individuals for a total of $957 per person

3) Program Name: Early Intervention for Referred Children, Youth, Pregnant Women, Postpartum Women and Their Families

a) **Identification of the Target Population:**
   - **Demographics:** Services in this program can be provided to children and youth of all ages: birth to 25. Services in this program can also be provided to pregnant women and postpartum women who have a child in the home under the age of five or gave birth within the last year.

- **Mental illness or illness for which there is early onset:** Services will be provided for any mental illness that is presented that short term therapy is appropriate and that NCBHD or contracted agencies have the capacity to treat. This includes screening and assessing pregnant women and postpartum women for depression.
- **Brief description of how each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began.

b) **Identification of the type of problems and needs for which the program intended to address:** The community is concerned about youth who are starting to use drugs, not doing well in school, and getting into trouble in and out of school; children and youth who are being neglected, abused and come into contact with the Child Welfare system; and youth that are involved with law enforcement, probation and juvenile hall. This program will provide short-term mental health treatment for these at risk children or youth and their families.

The community was concerned about the high occurrence of depression in pregnant and postpartum women. Depression in these women often results in functional impairments that impact their home, parenting, work, and social relationships. Depression impinges on all aspects of the parenting role. Maternal depression especially threatens two core parental functions: fostering healthy relationships to promote infant development and carrying out the management functions of parenting (scheduling, supervising, and using preventive practices).

c) **The activities to be included in the program that are intended to bring about mental health and related functional outcomes:** Therapy will be provided to the target population. Therapy services will be provided at schools, in the homes, in community settings and at the County to provide short-term therapy to at risk children, youth, pregnant and postpartum women and their families. Therapist will coordinate and collaborate with other service providers, non-profits, schools, and other County departments.

d) **Describe the MHSA negative outcomes that the program is expected to affect:** Because the program sees children, youth, pregnant and postpartum woman and their families each person may have different needs, any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. It is anticipated that prolonged suffering will be decreased in all individuals served.
   - **List the <u>mental health indicators</u> that the County will use to measure reduction of prolonged suffering:** Because the program sees all age groups and each person may have different needs, it is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.
   - **Explain the evaluation methodology, including, how the evaluation will reflect cultural competence.** The evaluations at a minimum will be done at the

beginning of therapy and at program exit. Spanish and English speaking therapists administer the evaluation. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or have it read to them.

e) **Provide a brief description, with specific examples of how each program will reflect and be consistent with all applicable MHSA General Standards:**
- **Community Collaboration:** The County is working with program participants, family members, schools, community based organizations and other service providers to plan and implement this program. Referrals for this program can come from any organization or individual that supports or serves the target population.
- **Cultural Competence:** The therapists are located out in the community and at the County. The Moving Beyond Depression program therapists provide services in the homes of the program participants. Spanish speaking participants are served through the Bi-lingual program and the Moving Beyond Depression program has hired a bi-lingual therapist. The County is creating a "no wrong door" approach to children and youth who are showing early signs of a mental illness.
- **Program Participant Driven:** The program participant chooses to participate in services and determines the treatment that they receive and participates in the creation of the Treatment Plan and the goals of the Treatment Plan. They determine if they want other family members to be involved in their treatment plan.
- **Family Driven:** Pregnant and postpartum women who want their spouse or other family members involved in their Treatment Plan are encouraged and supported to include them. Parents of children and youth have the primary decision-making role in the care of their children which includes determining the services and supports that would be most effective and helpful for their child(ren).
- **Wellness, Recovery, and Resilience Focused:** The programs utilized therapist who have been trained to provide services to children, youth, pregnant and postpartum women to help support the individual who wants to get help for their mental health needs. The program reflects the cultural, ethnic, and racial diversity of the population the program is serving. The treatment services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. Each Treatment Plan is based on the individual's needs and goals.
- **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community based organizations, non-profits, other County departments, service providers and schools. Individuals and their families can enter the program from one of many doors. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

f) **Explain how program helps to Improve Access to Services for Underserved Populations:** The individuals in this program are often not eligible and/or cannot access other programs because they do not have health insurance, are not legal immigrants, do not trust other organizations, their mental health issues are preventing them from accessing care, etc. The program is improving access to services by out stationing and outreaching to the underserved by connecting to these individual's

natural community support systems and working with these support systems to build trust.

g) **The intended setting(s) and why the settings enhance access for specific, designated underserved populations:** Depending on the service provider the therapy occurs at the County, at Family Resource Centers, schools, in the individual's home or at a location in the community that the individual chooses.

- **If the County intends to locate the program in a mental health setting, explain why this choice enhances access to quality services and Outcomes for the specific underserved population:** Nevada County is a small county and has a very limited number of Spanish speaking therapists and therapist trained to support children, youth, pregnant and postpartum women. Some of the therapist are located at community based organizations-Family Resource Center, the schools, but most are located at County offices. The therapists in the Moving Beyond Depression program provide services in the participants home. Nevada County does not have the population numbers to be able to out station a majority of children therapists. The programs have set up a process that potential program participants are screen and assessed. It is determined which program and service delivery is best for that individual. New program participants that are seen in County offices often have a warm handoff to the therapist for the individual's first appointment or by phone call. .

h) **Explain how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** The Behavioral Health Department is collaborating and coordinating with other County departments, school based partners, and community based partners who serve the homeless population. The Department is training community partners to increase and improve their knowledge, skills and attitudes around mental illness, so that community members will refer individuals to treatment services. The Behavior Health Department provides therapy at their offices and has contracts with community partners to provide therapy services in schools, in homes, and in the community. Lastly, the Behavioral Health Department hires Spanish speaking therapist in both their children's and adult programs when they have qualified applicants. Some contractors have also hired Spanish speaking therapist. Evaluation forms are provided in Spanish and English.

i) **Estimate Number Served Per Year:** It is estimated that 25 individuals will receive direct services. These individuals will represent 25 families.

j) The Cost Per Person: $4,320 ($108,000/25)

4) Project Name: Homeless Outreach and Therapy

a) **Identification of the Target Population:**

- **Demographics:** Homeless population: can be of any age, sex and ethnicity. The majority of the homeless are white (91%) and non-Hispanic (94%). The No Place Like Home (NPLH) program participants are eligible for this program along with Rapid Re-Housing Program Participants.

- **Mental illness or illness for which there is early onset:** Services will be provided for any mental illness that is presented that short term therapy and case management is appropriate and that the program has the capacity to treat.
- **Brief description of how each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began.

b) **Identification of the type of problems and needs for which the program intended to address:** Nevada County homeless frequently live in the woods or by one of the many rivers and lakes located in Nevada County. Per the January 2017 Homeless Point-in-Time Count, on any given day in Nevada County there are 371 individuals living in tents or different temporary shelters in the woods, in emergency shelters, transition houses, or in facilities not fit for human habitation. The homeless community represents all ages and ethnic backgrounds. Of the 371 homeless individuals, 29% identified as having a serious mental illness, 18% identified as having a substance use disorder, and 24% identified as survivors of domestic violence. Additionally, many of the homeless are people who mistrust government and government services.

Nevada County has limited resources to house and provided supportive services to the homeless population. Nevada County has one family emergency shelter, Booth Center, which can house nine families per night. The other emergency homeless shelter, Hospitality House, provides shelter and food to singles and families, but only has a capacity of 54 individuals per night. Additionally, some of the chronically and severely mentally ill homeless population receives services from SPIRIT Peer Empowerment Center, a Peer to Peer counseling center. Homeless individuals who visit SPIRIT Center receive food, showers and can do their laundry. This means that on any given night around 200 individuals are not sheltered.

c) **The activities to be included in the program that are intended to bring about mental health and related functional outcomes:** The activities in this program are to hire, train and supervise a therapist and case managers to conduct outreach and engagement services, assessments, therapy and referrals to homeless individuals out in the community.

Therapy and case management services will be provided to the target population. Therapy services and case management will be provided at emergency shelters, transitional housing facilities, community-based organizations, out in the woods where the homeless are located, and to support the homeless once they are housed. Besides short-term therapy the therapist and case managers will conduct outreach and engagement services, assessments and refer homeless individuals to needed community services. Therapist and case managers will coordinate and collaborate with other service providers, non-profits, schools, and other County departments.

CSS and/or PEI funds may also be used to support the implementation of No Place Like Home Program (NPLH). Support may include: planning, outreach and engagement, implementation, evaluation, and reporting out on outcomes. Funds may be used on supportive services on site or off site to support NPLH residents in obtaining and retaining housing. Support may be for housing, improving program participant's health

status, and maximizing ability to live and, when possible, work in the community. Supportive services may include, but not limited to: care coordination/case management; peer support activities; mental health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups; substance use services, such as treatment, relapse prevention, and peer support groups; support in accessing physical health care, including access to routine and preventive health and dental care, medication management and wellness services; benefit counseling and advocacy, including assistance in accessing SSI/SSP, enrolling in Medi-Cal and obtaining other needed services; basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, and money management); recreational and social activities; transportation planning and assistance for access to off-site services; educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process; and employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work.

d) **Describe the MHSA negative outcomes that the program is expected to affect:** Each homeless individual may have different needs, any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. It is anticipated that prolonged suffering will be decreased in all individuals served. It is anticipated that homelessness will decrease in some of the individuals served.
   - **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** Because the program sees all age groups and each person may have different needs, it is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.
   - **Explain the evaluation methodology, including, how the evaluation will reflect cultural competence.** The evaluations at a minimum will be done at the beginning of therapy and at program exit. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or have it read to them.

e) **Provide a brief description, with specific examples of how each program will reflect and be consistent with all applicable MHSA General Standards:**
   - **Community Collaboration:** The County is working with program participants, family members, schools, community based organizations and other service providers to plan and implement this program. Referrals for this program can come from any organization or individual that supports or serves the homeless population. Multiple organizations provide a variety of services depending on the need of the homeless individual.
   - **Cultural Competence:** The program was planned and establish with the assistance of the homeless community. The Homeless Outreach Therapist's office is located at a homeless shelter and goes to where the need is in the community.

- **Program Participant Driven:** The program participant chooses to participate in services and determines the treatment that they receive and participates in the creation of the Treatment Plan and the goals of the Treatment Plan. They determine if they want other family members to be involved in their treatment plan. Additionally, the program participants determine what other types of supportive serves they need to address their current needs and to help them move out of homelessness.
- **Family Driven: :** Adults who want their spouse or other family members involved in their Treatment Plan are encouraged and supported to include them. Parents of children and youth have the primary decision-making role in the care of their children which includes determining the services and supports that would be most effective and helpful for their child(ren).
- **Wellness, Recovery, and Resilience Focused:** The program utilizes a therapist who collaborates with a Homeless Outreach Care Coordinator to help support the individual who wants to get help for their mental health needs. The program reflects the cultural, ethnic, and racial diversity of the population being served. The treatment services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. Each Treatment Plan is based on the individual's needs and goals.
- **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community based organizations, non-profits, other County departments, service providers and schools. Individuals and their families can enter the program from one of many avenues. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

f) **Explain how program helps to Improve Access to Services for Underserved Populations:** Having the therapist in the field and at emergency shelters allows the therapist too screen and assess people where they are at and get them into services through the County or through other service providers. For individuals who cannot go elsewhere the program participant can start to receive mental health services where they are at.

g) **The intended setting(s) and why the settings enhance access for specific, designated underserved populations:** The intended setting is where the homeless are gathering. This is mainly at emergency shelters, SPIRIT Peer Empowerment Center and on the streets and in the woods. This enhances access because the therapist is going to the program participant and building trust and a relationship. The homeless have very little funds to travel, most do not have alarm clocks or computers to help them keep appointments, and many do not trust government or strangers.

h) **Explain how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** The Behavioral Health Department is collaborating and coordinating with other County departments, school based partners, and community based partners who serve the homeless population. The Department is training community partners to increase and improve their knowledge, skills and attitudes around mental illness, so that community members will refer homeless individuals to treatment services. The Behavior Health Department provides therapy at their

offices, Hospitality House Emergency shelter, and in the field. Evaluation forms are available in both English and Spanish.

i) **Estimate Number of Children, Transition Age Youth, Adults and Seniors Served Per Year-** It is estimated that 170 individuals/150 families will receive direct services.

j) **The Estimated Cost Per Person:** $188 ($32,000/170)

B) PEI Project Name: Outreach for Increasing Recognition of Early Signs of Mental Illness Programs

1) Program Name: First Responder Training

a) **Identify the types and settings of potential responders the program intends to reach:** For the sake of this program any community member who is the first person to respond to an individual in crisis is a "first responder." This may be a family member, another program participant, service provider, staff member, a safety officer, emergency personal, court personal or any member of the community.

(i) **Describe briefly the potential responders' setting(s):** Nevada County provides "First Responder" Trainings to the community. One of the evidence based "First Responder" training models that the county may use, but is not limited to, is modeled after the national NAMI (National Alliance on Mental Illness) Crisis Intervention Training (CIT). CIT training will help law enforcement and fire fighters respond with safety to people with mental illness in crisis. Additionally, other evidence based or community proven training will be provided to first responders, this may include but is not limited to Mental Health First Aid, ASIST (Applied Suicide Intervention Skills Training), WRAP (Wellness Recovery Action Plan), etc. The "First Responders" may respond to an individual in crisis in their home, on the streets, at school, on the job, at church, etc. Nevada County Behavioral Health Department would like to have as many Nevada County residents trained as "First Responders" as funds will allow to be trained. "First Responders" are often the facilitators for mental health services for people in the community. This activity decreases the disparity of services for people who may not otherwise get services.

b) **Specify the methods to be used to reach out and engage potential responders**

i. Forensic Trainings: Nevada County currently has a community collaboration group that is called the "Forensic Task Force." This group includes the courts, law enforcement, Probation, Behavioral health, and mental health consumers and family groups. The Forensic Task Force examines the local systems to determine the forensic and court involved community's need and agrees on strategies for meeting those needs and helps to organize some of the First Responder Trainings which may include CIT.

ii. Suicide Prevention Training: The Suicide Prevention Intervention (SPI) Coordinator is working with the Suicide Prevention Task Force, Nevada County, schools, community based organizations, businesses, and service providers to bring training to the community to create a more "suicide aware community." Trainings occur out in the community at service provider sites, community meetings, schools, faith based community programs, health sites,

etc. The trainings provided include, but is not limited to: Living Works, Mental Health First Aid, Know the Signs, and other evidence based curriculum as they become available.

iii. Crisis Training: The Crisis service provider has conducted surveys of law enforcement first responders to ask what kind of training that they need to handle crisis calls. The Crisis service provider created tailored training based on the specific needs as a result of his survey. Consumers and Peer Supporters requested WRAP trainings so that they could help themselves and others when they or others are in crisis.

iv. Latino Outreach: The SPI Coordinator is working with the community Promotoras to train them on the different Suicide Prevention trainings.

c) **Provide a brief description, with specific examples of how each program will reflect and be consistent with all applicable MHSA General Standards:**

i. **Community Collaboration:** The County is working with program participants, family members, schools, law enforcement, courts, faith based organizations, community based organizations and other service providers to plan and implement this program. When trainings occur, consumers and family members are usually part of the trainings to provide consumer and family member perspective and feedback.

ii. **Cultural Competence:** The trainings are tailored to the community that is receiving the training: law enforcement, schools, Latino population, etc.

iii. **Program Participant Driven:** program participants are part of the planning, creating, implementation and evaluation of first responder trainings.

iv. **Family Driven:** Family members and/or NAMI (National Alliance on Mentally Ill) usually have a member actively involved in the planning, creating, implementation and evaluation of the first responder training.

v. **Wellness, Recovery, and Resilience Focused:** Trainings reflect the cultural, ethnic, and racial diversity of the population being served. The trainings provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

vi. **Integrated Service Experience for Program Participants and Their Families:** This training program is an integrated program with community based organizations, law enforcement, faith based organizations, schools, other County departments, service providers schools, consumers and family members. Most of the trainings involve multiple representatives from multiple organizations as appropriate.

d) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations, as required in Section 3735, subdivision (a) (2).** This program will improve access to services because the program is reaching out to and targeting the general population and specific populations. The program is offering the trainings in Truckee, to Promotoras, to service providers that provide services to underserved populations, and to consumers and family members. Additionally, First Responders will be provided information about mental health resources available in the community, including Nevada County Behavioral Health services.

e) **For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations.** Trainings in general or not located at the Behavioral Health Department. The

program is providing trainings in the community. Depending on who is being trained, the training is occurring at their organization or at a community meeting room. This is done to increase the number of individuals trained, to lesson transportation costs for the First Responders and to have the trainings where people are most comfortable.

f) **The County intends to measure what outcomes and when?** The County may, but is not limited to measuring: number of individuals' trained, demographic info on those trained, pre and post-test on what the First Responder learned from the training and other indicators as directed by the training curriculum used. Outcomes will be collected at the beginning and/or end of trainings, as appropriate.

g) **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** Multiple different strategies are used depending on who the First Responders are:
   (i) Provide trainers that come from the group being trained, when feasible and available- if providing CIT training to a group of law enforcement officers, the BHD will use someone from law enforcement or from Crisis; if training youth providers, the BHD will utilize a trainer that has experience in the youth field. The BHD wants the First Responder to be able to relate to the trainers and have the trainings relative to what they are going to encounter on the job or out in the community.
   (ii) Another strategy the BHD uses is involving consumers and family members in the planning, creation, implementation, and evaluation of the trainings. Additionally, most of trainings have consumers and family members as part of the trainings. An example of this was at the CIT training NAMI hosted the lunch for the program participants and were available for questions and answers.
   (iii)The program has trained Promotoras who can work with the Latino population that they serve and communicate with individuals in the language they a comfortable with and in a culturally appropriate manner.

h) **Estimated number of Children, TAY, Adults, and Seniors to be served:** It is estimated that 100 individuals will received First Responder training in the year

i) **The Cost Per Person:** $100 ($10,000/100 individuals)

C) PEI Project Name: Prevention Programs

1) **The Program Name:** Homeless Rapid Rehousing (RRH) Program
   a) **Identification of the target population for the specific program, including:**
      - **Participants' risk of a potentially serious mental illness:** Participants in this program have a higher than average risk of serious mental illness due to inadequate living environments. The mere fact of living on the streets is a traumatic event. The longer an individual/family is on the streets the more vulnerable they become to physical and mental health issues. Many homeless individuals/families do not have the resources readily available to receive physical/mental health services and this population has shown to be at an elevated risk of Emergency Room visits and/or hospital stays.
      - **How the risk of a potentially serious mental illness will be defined and determined:** The risk of a potentially serious mental illness will start to be determined through informal observations by program staff which may include:

Outreach Workers, Monitors, Social Workers, Therapists, and/or Case Managers. In-house referrals will be made to on-site Therapist and volunteer (licensed) Behavioral Health workers within the organization. The program will also receive referrals from Turning Point, Nevada County Behavioral Health, Sierra Nevada Memorial Hospital (SNMH), Western Sierra Medical Clinic (WSMC), Chapa-De and other community medical providers. Program participants will be assessed using appropriate tools used for measuring and screening for mental health disorders.

- **Demographics:** This program will provide serves to the homeless population. In particular, families with children, those who are aged or disabled; the most vulnerable homeless individuals/families will receive priority. However, services are available to all homeless Nevada County residents regardless of age, gender, sexual orientation, or ethnicity. NPLH program participants are eligible for this program.

b) Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities to be included in the program: Program participants face a variety of barriers, including lack of transportation, inadequate communication tools/skills, lack of affordable housing, severe mental illness, substance addictions, lack of appropriate medical/Behavioral Health treatment, exposure to the elements, etc.

An Outreach Worker will actively seek out homeless individuals and families residing on the streets and in encampments. The Outreach Worker will be certified in Mental Health First Aide.

Housing Case Managers will respond to Homeless Rapid Rehousing inquiries from shelter guests, Outreach Worker referrals, individuals and families who have lost housing as a result of eviction, domestic violence, or for any other reason. The Housing Case Managers will screen for federal/other eligibility requirement for Federal Rapid Rehousing Program (RRHP) and/or PEI Homeless Rapid Rehousing Program (HRRP) support and will assist eligible applicants. Relationships with landlords and potential landlords will be maintained by the Housing Case Manager.

Case managers will respond to referrals made by the Outreach Worker, as well as working with emergency shelter guests to make appropriate referrals to mental, physical and dental health providers. The case managers will assist in obtaining documents necessary for services, housing, and other needs, including identification, birth certificates, and Social Security cards. Program participants will receive assistance with applying for Social Security Disability Income/Social Security Income (SSDI/SSI), using the SOAR (SSI/SSDI Outreach, Access & Recovery) Model. The case managers will assess program participants using screening and brief intervention techniques for referral purposes.

Program staff will provide training and/or referrals to increase skills necessary for program participants to obtain and maintain housing. These skills will be directed to:

- Decrease risk factors that may limit housing opportunities, such as, but not limited to:
  (i) Untreated substance use
  (ii) Untreated physical and/or mental health issues

- Increase protective factors/life skills, such as, but not limited to:
  (i) Job training
  (ii) Resume creation
  (iii)Job searching
  (iv)Securing financial benefits the individual/family is entitled to receive
  (v) Housing searching
  (vi)Family financing and budgeting skills
  (vii) Education/General Education Development (GED)
  (viii) Daily life skills
  (ix)Parenting skills

Program staff will provide mental health and other supportive services to ensure that program participants maintain housing. Mental health and other supportive services may come from program staff, contractors, or community based organizations. Program staff will follow-up, organize and support each individual/family as long as is needed for the induvial/family to maintain their housing.

Referrals will be made to Medi-Cal service providers, physical and/or behavioral health agencies, substance use agencies, employment and job training agencies and transportation providers.

Close relationships will be maintained with community partners, such as WSMC, SNMH, Turning Point, Common Goals, Chapa-de, Salvation Army, Family Resource Centers (FRC's), Emergency Assistance Coalition (EAC), & others included in the Continuum of Care (CoC) to end homelessness.

CSS and/or PEI funds may also be used to support the implementation of No Place Like Home Program (NPLH). Support may include: planning, outreach and engagement, implementation, evaluation, and reporting out on outcomes. Funds may be used on supportive services on site or off site to support NPLH residents in obtaining and retaining housing. Support may be for housing, improving program participant's health status, and maximizing ability to live and, when possible, work in the community. Supportive services may include, but not limited to: care coordination/case management; peer support activities; mental health care, such as assessment, crisis counseling, individual and group therapy, and peer support groups; substance use services, such as treatment, relapse prevention, and peer support groups; support in accessing physical health care, including access to routine and preventive health and dental care, medication management and wellness services; benefit counseling and advocacy, including assistance in accessing SSI/SSP, enrolling in Medi-Cal and obtaining other needed services; basic housing retention skills (such as unit maintenance and upkeep, cooking, laundry, and money management); recreational and social activities; transportation planning and assistance for access to off-site services; educational services, including assessment, GED, school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process; and employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work.

c) Specify any MHSA negative outcomes as a consequence of untreated mental illness that the program is expected to affect, including reduction of prolonged

suffering. Without adequate treatment, the consequences of untreated mental health could include:

- Advance to more severe condition resulting from further decline in mental health
- Lowered capacity to recognize physical health issues
- Increased urgent care/first responder/emergency room costs
- Increased use of resources- Fire Department, Emergency Medical Treatment, Law Enforcement, etc.
- Increase crime
- Increased problems with tobacco, alcohol, and other drugs
- Missed work or school, or problems related to work or school
- Legal and/or financial problems
- Self-harm or harm to others
- Weakened immune system leading to lower resistance to infections
- Heart disease/other medical conditions
- Poverty/Homelessness
- Social isolation
- Family conflicts
- Depression and fatigue
- Abnormalities in areas of the brain, particularly areas associated with memory
- Lack of impulse control
- Fear and anxiety

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** A reduction of prolonged suffering may be measured through evidence of an increase in program participant's quality of life. This may include: a decrease in ER/Hospital stays, a decline of criminal activity, the ability to obtain housing and an income source, the ability to maintain stable housing and employment, improvement of personal relationships, etc. An evaluation tool will be created to measure increase in protective factors and/or a decrease in individual/family risk factors.
- **Explain the evaluation methodology, including how the evaluation will reflect cultural competence:** Program participants will be given an assessment upon program entry. An onsite licensed behavioral health clinician will determine the needs of the program participant, along with identifying potential referrals, and case management service needs. Program participants will be provided with case management on a regular basis, and further behavioral health evaluations may be administered as needed. These evaluations may be conducted at the shelter, or in locations the individual feels most comfortable.

d) Provide a brief description of how each program will reflect and be consistent with all applicable MHSA General Standards:

- **Community Collaboration:** The Homeless Rapid Rehousing Program (HRRP) will use every available resource and community partner to deliver services through referrals, agency collaboration and participation within the Continuum of Care (CoC) to End Homelessness.
- **Cultural Competence:** Program staff will employ and maintain the awareness and consciousness of personal reaction to those who are different,

including staff members' own cultural bias and beliefs, so as to avoid incorporating those qualities in delivery of the program services.

- **Program Participant Driven:** The HRRP Program will employ case management service that empowers program participants to participants in all services delivered and to lead the process. A person-centered case plan approach that is consistent with the individual's culture and everyday lifestyle. Program personnel will be non-judgmental, recognizing that, with appropriate and adequate support, individuals living with chronic illnesses, behavioral health disorders and addictions are competent and capable of making life changes. Program participants will create their own goals and housing plans with the support of program staff.
- **Family Driven:** Program staff will assess the needs of the family as a whole, as well as the individual needs of each family member. Based on the needs assessment, staff in collaboration with the program participant will identify and prioritize support services that will enable the individual/family to obtain and remain in their home and/or community. The Case Manager will assure that the individuals and families have choice and control. A person-centered case plan approach will be consistent with the family's culture and everyday lifestyle. Staff will do the following to assist each individual within a family:
  (i) Assess needs and desired outcomes of each individual
  (ii) Develop individual case plans with program participants, program participant's family, and community partners who will be chosen by the program participant to be part of the service team
  (iii) Provide or locate support services identified in the case plan which will meet the needs stated by the program participant
  (iv) Provide or connect the program participant/family with the requested services
  (v) Coordinate support services with the family
  (vi) Meet regularly with the program participant to assess case plan progression
  (vii) Ensure that eligibility for funding stays current
  (viii) Advocate for needed support and services
- **Wellness, Recovery, and Resilience Focused:** Staff will empower program participants by allowing them to develop their own case plan and will respect the choices made by youth/families/individuals in transition. In any case where family members are in need of education regarding an individual's disabilities, referrals to appropriate service providers or resources will be provided by the staff. Rapid Rehousing Staff will implement an assessment tool to identify and detect the presence of co-occurring substance/mental health issues and/or physical health issues to be referred to clinicians as deemed necessary, as well as continually informing program participants of their rights and responsibilities. Lastly, staff will be in collaboration with other service providers so as to ensure continuity of care.
- **Integrated Service Experiences for Program Participants and Their Families:** The Homeless Rapid Rehousing Program will partner with community providers to include support to stabilize housing, reduce hospitalizations and incarcerations, conduct risk assessments, provide 24/7 crisis, medication management services, agency referrals, counseling and group therapy, SSI and Medi-Cal advocacy, home visits and assistance with doctor appointments, and employment services referrals.

e) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** Program personnel will be trained in SBIRT (Screening, Brief Intervention, and Referral to Treatment), SOAR, Mental Health First Aide, Cultural Competency or other appropriate models which will enable staff to recognize underserved populations and specific needs of said populations. Program Management will respond to referrals from community partners, service providers, individuals and the general public. The program will utilize outreach personnel, emergency shelter staff, and case managers.

f) **For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations:** Services will be provided in the following settings: camps/street, community congregate meals, emergency shelters, SPIRIT Peer Empowerment Center, shopping centers, etcetera. The program will provide services wherever the program participant feels most comfortable. This helps the individual maintain a sense of control regarding his/her responsiveness.

g) **Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (g) and, if so, what outcomes(s) and how will it be measured, including timeframes for measurement.** The program will collect and summarize information on an ongoing basis, determining the activities to continue, grow, modify, or improve. Periodically, program participants will be assessed to determine any change in his/her quality of life (i.e. decreased untreated mental illness, decreased urgent care or emergency room visits, decreased police/911 fire department calls, etc.). In addition, Management will identify staff and volunteer training needs, as it relates to the program.

h) **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** Program staff will be trained to maintain the awareness and consciousness of personal reaction to individuals who are different, including cultural biases and beliefs, so as to avoid incorporating discrimination into the delivery of the program. The Homeless Rapid Rehousing Program Staff will be trained in SBIRT, SOAR, Mental Health First Aid, and other appropriate models which will enable staff to recognize the underserved populations and the specific needs of the individual falling within that population. Program staff will provide services to any homeless individual seeking assistance, regardless of age, gender, sexual orientation, or ethnicity.

i) **Estimate Number Served Per Year:** 55 individuals/55 families: 40 adults and 15 older adults.

j) **The Cost Per Person:** $1,318 ($72,500/55) /program participant (Housing Stabilization Services & Rental Assistance)

2) **The Program Name:** Senior, Disabled and Isolated Home Visitor Program

a) **Identification of the target population for the specific program, including:**
- **Participants' risk of a potentially serious mental illness:** The participants in the program have a higher than average risk of a serious illness due to their age,

disabilities, isolation and lack of services, transportation and support. Additionally, the senior population has a lack of awareness of depression due to their generation having stigma on mental health needs.

- **How the risk of a potentially serious mental illness will be defined and determined:** Screening and referrals for this population is being done by nurses, social workers, service providers, family members and program participants (self-referral). Home Visiting Nurses and/or Volunteers, and/or other health workers are screening for depression by using the Beck's Depression scale or a similar tool.
- **Demographics:** This program is available to all individuals in the County that are homebound due to age and/or disability. All age groups, racial, ethnic and cultural populations are served.

b) **Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities to be included in the program:** The Home Visitor Program is a volunteer based program. The program trains senior or adult volunteers to visit home bound older adults, the disabled and isolated individuals. The Volunteer Home Visitor program goal is to increase the number of trained volunteers and maintain the volunteer pool. The outcome of the program is that program participants will not feel lonely and isolated and that their quality of life will be improved and will have less mental health issues (depression). The capacity of the program is expected to be 50 volunteers and 50 participants. These volunteers are assigned a program participant and visit program participates in person and/or by phone on a regular basis.

c) **Specify any MHSA negative outcomes as a consequence of untreated mental illness that the program is expected to affect, including reduction of prolonged suffering.** This program is expected to decrease "Prolonged Suffering."

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** The BHD department will be looking to decrease depression and anxiety and to improve the quality of life in the target population of homebound due to age and/or disability. For the program volunteers the BHD is looking to see that the volunteer's quality of life is improved and that they feel more comfortable to talk directly about depression, anxiety, and depression to the individual they are supporting.
- **Explain the evaluation methodology, including how the evaluation will reflect cultural competence:** The evaluations at a minimum will be done at program entry and annually and/or and at program exit. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or have it read to them. The evaluation can be conducted in person, by mail or by phone.

d) **Provide a brief description of how each program will reflect and be consistent with all applicable MHSA General Standards:**

- **Community Collaboration:** This program is the results of multiple organizations working together with consumers and family members to bring services into the home of isolated elderly and/or disabled individuals. This program collaborates intimately with Home Visiting nurses. Home visiting nurses are conducting a mental health screening with all individuals they visit

along with physical health and fall prevention screening. The nurses refer individuals that score high on the depression screening tool to physicians, mental health providers, community based organizations, family members and to the Home Visitor program.

- **Cultural Competence:** The program works to match volunteers with program participants that can connect at multiple levels, including at a cultural level.
- **Program Participant Driven:** The volunteers communicate and work with the program participants to determine when and how they want to interact and the activities to engage in.
- **Family Driven:** The volunteer includes family members, when appropriate, when planning and implementing program services.
- **Wellness, Recovery, and Resilience Focused:** The volunteer services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. The volunteers bring hope to the program participants. The program participants have someone to look forward to seeing and to share their stories with. The volunteers connect the program participants with community events, activities and service providers.
- **Integrated Service Experiences for Program Participants and Their Families:** This program is the result of multiple organizations coordinating together to provide services in the home of isolated elderly and/or disabled individuals. Referrals from the community are received. Volunteers from the community are recruited. The volunteers also refer the program participants to community based organizations as appropriate. These referrals may include: SPIRIT Peer Empowerment Center, NAMI, Nevada County Behavioral Health Department, PEI SPI Coordinator, primary care physicians, and other appropriate staff contracted or hired with PEI funds

e) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** The Program Manager and program volunteers are trained in recognizing the signs and symptoms of mental health conditions, how to make a secured referral, and to support the program participant follow-up with referred services. All referred program participants will be screened for depression. The Program Manager or volunteer will refer individuals that screen high on the depression screening tool to the Social Outreach nurse, their primary care physician or a mental health professional. Program staff and volunteers will support the program participant to seek outside treatment for their mental health needs.

f) **For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations:** The setting for this program is elderly and/or disabled individual's homes. Because this population is isolated and have limited capacity or ability to drive or utilize public transportation, services are brought to them. Another reason this program is delivered in the home is because individuals in this population can be so ill that it is not healthy for them to go out into the community for fear of picking up a communal infection.

g) **Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (g) and, if so, what outcomes(s) and how will it be measured, including timeframes for measurement.** Using a depression screening

tool/survey program participants will be evaluated at intake and annually to monitor levels of depression and to determine reduction of prolonged suffers by measuring a reduction in risk factors, indicators, and/or increased protective factors that will lead to improved mental emotional, and relational functioning.

h) **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** The BHD will be utilizing volunteer home visitors to interact with program participants. The volunteer will be matched with the program participants based on common traits, likes, activities, personality and culture. The volunteers will work with the program participant to set up a regular visiting routine and activities that the program participant enjoys engaging in. The volunteer will also call the program participant to visit and to check in on how they are doing. The BHD believe that when isolated and homebound individuals have a connection to an individual from the community their depression will decrease. The visitors bring hope and social connective to the program participant. Visitors encourage the program participants to self-determine their activities and level of activities that they can participant in. Visitors support the individual in determining the level and kind of support that they need for their physical and mental well-being from service providers or family members.

i) **Estimate Number Served Per Year:** 45 individuals/45 families

j) **The Cost Per Person:** $844 ($38,000/45)

3) **The Program Name:** Wellness Center: Peer Support and Outreach Services

Info on the Wellness Center that provides services to TAY 18 and over, adults and older adults can be found under the CSS Outreach and Engagement section of the Plan. The Youth Wellness Center Program is currently being funded with PEI funds, but each Wellness Center Program may be funded with either CSS or PEI funds or a combination of funds.

a) **Identification of the target population for the specific program, including:**
   - **Participants' risk of a potentially serious mental illness, either based on individual risk or membership in a group or population with greater than average risk of a serious mental illness:** Wellness Centers are for individuals with a mental illness that are seeking support from Peers and/or for individuals who are in crisis or having trouble with a life function (school, employment, relationship, housing, friends, family, drugs, law enforcement, mental health, etc.).
   - **How the risk of a potentially serious mental illness will be defined and determined:** The program participants are utilizing the program on a voluntary basis. They want to improve in at least one domain of their life and are participating in the Wellness Center to engage in self-improving activities.
   - **Demographics relevant to the intended target population for the specific program:** The Wellness Center programs target individuals with mental health conditions and/or emerging mental health issues, and/or individuals who want to decrease the prolong suffering they are experiencing. The BHD currently have two Wellness Centers, one for adults 18 and over and one for high school students in the Tahoe Truckee area. These Wellness Centers are open to all individuals'

regardless of race/ethnicity, gender, sexual orientation, language used and military status.

b) **Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities to be included in the program:** Individuals with mental health conditions or emerging mental health conditions need a place that they feel save, are understood, and can learn skills to cope with their unique challenges. Wellness Centers empower individuals by giving them a voice in decisions around creating their own well-being and developing sustainable wellness practices for life. Program participants help to shape the Wellness Center programs, which will teach them self-determination and valuing them as part of their communities. Wellness Centers provide a safe place for individuals to talk, learn relevant skills for improving well-being as they define it, and understand how to navigate and access community resources. The Wellness Centers are designed to help individuals access a broad spectrum of mental health services. The Wellness Center serves as a hub for individuals to talk to other caring people, connect to community resources and learn new skills to develop sustainable wellness practices.

c) **Specify any MHSA negative outcomes as a consequence of untreated mental illness the program is expected to affect, including reduction of prolonged suffering:** The Wellness Centers see individuals of all ages and their families, each person may have different needs, any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. It is anticipated that prolonged suffering will be decreased in all individuals served and/or for school age program participants a decrease in school failure or dropout. .

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering and/or decrease in school failure or dropout:** Because the program sees all age groups and each person may have different needs, it is anticipated that surveys will be used to measure the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program strategy, program participant and their specific goals and individual needs.
- **Explain the evaluation methodology, including, how the evaluation will reflect cultural competence:** Depending on the program strategy evaluations will occur per community event/training or at program entry and annual and/or program exit. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or have it read to them.

d) **Provide a brief description, with specific examples of how each program will reflect and be consistent with all applicable MHSA General:** Examples below are for the Youth Wellness Center Program.

- **Community Collaboration:** The Youth Wellness Center Program is a collaborative project between TTUSD (Tahoe Truckee Unified School District), Placer and Nevada County, Community Collaborative of Tahoe Truckee (CCTT) partners and local youth.

- **Cultural Competence:** Youth are trained in peer mentoring and leadership skills to better support themselves and their peers, as well as have authentic voices shaping school and community initiatives.
- **Program Participant Driven:** The Youth Wellness Center empowers youth by giving them a voice in decisions around creating their own well-being and developing sustainable wellness practices for Life. The youth are peers in shaping the Wellness program.
- **Family Driven:** Families of youth are engaged when the youth indicates that they need and what their family support to seek and utilize community resources for their personal emerging needs. Family members are engaged when a youth is a danger to themselves and/or to others and community resources are needed to support the youth.
- **Wellness, Recovery, and Resilience Focused:** The prevention services provided reflect the youth cultural being served. The prevention programs support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. The Wellness Center is designed to help high school students access a broad spectrum of mental health services.
- **Integrated Service Experiences for Program Participant and Their Families:** Wellness Center staff work with community adult volunteers and Youth Peer Mentors to improve the social, emotional and mental health of program participants and to connect program participants to community resources.

e) **An explanation of how the program will be implemented to help Improve Access to Services:** The Youth Wellness Center Liaison, adult volunteers and Youth Peer Mentors are trained in recognizing the signs and symptoms of mental health conditions, how to make a secured referral, and to support the program participant follow-up with referred services. The Wellness Center Liaison, volunteers, and Youth Peer Mentors support the program participant to seek outside treatment for their mental health needs. Participation in the Wellness Center is the first step in Access to Services.

The Adult Wellness Center provides Peer Support services, this may include, but is not limited to: one-on-one peer counseling, support groups, theme-specific peer support/self-help groups, outreach training to Peer Support staff and individuals that seek to empower themselves and to help end the stigma of mental illness. Program participants may be unable or unwilling to access traditional services or cannot otherwise afford counseling or psychotherapy. These programs help to build skills, encourage and support individuals to seek mental health treatment. Peer Supporters refer and conduct warm handoffs to individuals seeking mental health treatment.

f) **For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations:** The Youth Wellness Centers are located at and/or programs which are delivered at schools. The program is provided at sites where students can easily access the services and participate in program activities. Many of the youth participating in the program are not old enough to drive, if it was not at the schools they would have a hard time participating. Another benefit at having the program at schools is that the

students do not feel the stigma of going to a mental health office; they are just participating in a school sponsored wellness program.

The Adult Wellness Center is located out in the community and is run by Peer Supporters. The center is located in the largest city in western Nevada County and is served by the local bus system. Additionally, it is close to an adult homeless shelter, service providers and many of the community based organizations. This allows for easy access for individuals who do not own cars to easily participate in activities.

g) **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** The strategies being used in this program that make it non-stigmatizing and non-discriminatory are:
- The program is located and delivered on school sites and in the community.
- Youth and adults with mental health needs are involved in all aspects of the program-planning, implementation and evaluation.
- Youth orientated organizations volunteer at school sites.
- Wellness Centers welcome people to come as they are.

h) **Estimate Number Served Per Year:** 2800: 1,200 Children (7^{th}-10^{th} grades), 1,600 TAY (11^{th} & 12^{th} grades)/2,500 families

j) **The Cost Per Person:** $77 ($215,000/2,800)

4) The Program Name: Teaching Pro-Social Skills in the Schools

a) **Identification of the target population for the specific program, including:**
- **Participants' risk of a potentially serious mental illness:** Students/children at schools have a potential of serious mental illness for a variety of reasons:
  - Exposed to violence at school
  - Exposed to individuals who are not tolerant of differences,
  - Some students are emotionally fragile,
  - Bullying in the schools,
  - Children with mental health issues who became the target of negative behavior.
- **How the risk of a potentially serious mental illness will be defined and determined:** For this program all children enrolled in preschool to high school have a potential for a serious mental illness.
- **Demographics:** Program participants will be all children and youth enrolled in a participating school/ preschool/ Child Care facility.

b) **Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities:** At community meetings people spoke about the need for more screening and services for children and youth. Many Nevada County residents told us in the meetings that they thought students in the schools should be educated about mental health, social skills and violence prevention. Most thought this should start at an early age and continue through their school years. They thought education about mental health would reduce stigma, decrease bullying and make it easier for children to learn in school. They were concerned that children were not tolerant of differences or students who were emotionally fragile and those children with mental health issues often became the target of bullying. The school

administrators also voiced the above concerns. They said that they would like to include in their curriculum teaching social skills, emotional management, problem solving and cooperation. All hoped teaching pro-social skills would make the classroom a better place to learn and that the teachers would have to spend less time on discipline. It was also believed that if children were given the tools to handle conflict and emotions they would be less violence, see less violence and school disruption throughout the child's school life would decrease and the children would more likely succeed in school.

This Prevention activity increases the SECOND STEP program in schools and preschools. SECOND STEP has been implemented in the pre-schools to middle schools and is in the SAMHSA National Registry of Evidence-based Programs and Practices. It is a classroom based social skill program that teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research and social information processing theories. Each preschool and elementary school curriculum contains teaching kits that build sequentially and cover empathy, impulse control and anger management in developmentally and age appropriate ways. The Second Step Middle School Program aims to prevent or reduce aggression, violence and substance abuse through the promotion of attitudes and social and problem solving skills that are linked to interpersonal and academic success. The design draws on theory and research about adolescent development and utilizes a risk and protective factors framework. Risk factors include: inappropriate classroom behavior; favorable attitudes toward problem behavior; friendships with others who engage in problem behavior; early initiation of problem behavior; peer rewards for antisocial behavior; and peer rejection and impulsiveness. Protective factors include social skills, school connectedness, and adoption of conventional norms about substance abuse.

In this SECOND STEP expansion, when a child or family is identified as needing mental health services, the trainers refer these children and families to County Behavioral Health, community service provider or to the private sector. The trainers have a list of resources that includes mental health providers in the community as well as providers of other services. The SECOND STEP trainers train their teachers on accessing resources in the community.

This program will be implemented from pre-schools through high school as funds will allow. Implementation began with preschoolers and elementary schools and was expanded to middle school..

c) **Specify any MHSA negative outcomes as a consequence of untreated mental illness that the program is expected to affect, including reduction of prolonged suffering:**

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** The Second Step curriculum which works to strengthen protective factors and helps children develop self-regulation skills, manage their emotions, treat others with compassion and solve problems without anger. The Second Step program evaluates the child's ability to identify emotions, brainstorm alternative solutions to problems, and generate pro-social responses to problems, and a reduction in disciplinary issues.

- **Explain the evaluation methodology, including, and how the evaluation will reflect cultural competence:** Approaches to collect data and determine results may include, but is not limited utilizing School-Wide Information System data, referrals, pre and post testing using 12 measures of the Desired Results Developmental Profile from the Self and Social Development Domains that support the protective factors completed at the beginning of the program and at the end of the school year, and teacher feedback surveys.

d) Provide a brief description of how each will reflect and be consistent with all applicable MHSA General Standards:

- **Community Collaboration:** This program is being implemented in both the Tahoe-Truckee and the Nevada County school districts. School personnel are collaborating with Nevada County Behavioral Health Department and other service providers in the community.
- **Cultural Competence:** Second Step kits are provided in English and Spanish. Teachers are utilizing kits and trainings that are appropriate for the age of the student.
- **Program Participant Driven:** When a child or family requests or is identified as needing mental health services, the trainers' work with the family and refers these children and families to County Behavioral Health, community service provider or to a private sector service provider.
- **Family Driven:** In Truckee "Parent Nights" are held to provide information and engage parents in supporting curriculum at home and Truckee started a Second Step Community blog so that parents would talk to each other and ask counselors questions.
- **Wellness, Recovery, and Resilience Focused:** The Second Step Program provides age appropriated training to build protective factors in students across the school spectrum. The prevention programs support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. The Second Step program is designed to build protective factors in preschool to help high school students so that students can have mental health wellbeing.
- **Integrated Service Experiences for Program Participant and Their Families:** *:* In the Tahoe-Truckee school district not only are the teachers and school councilors trained in Second Step, but paraprofessional staff, food service workers, bus drivers, office workers and other school staff are also trained on the concepts and vocabulary of Second Step. The whole culture of the school is in step with the program.

e) An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations: The Second Step program has educated school and preschool staff about mental health wellbeing. Along with this education has been education on how to refer students who may be struggling with life issues to a school counselor. School counselors are working with parents, community based organizations, the Behavioral Health Department and other health providers to refer and link students to needed services.

f) For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations. The

setting for the Second Step program is preschool and schools. The setting enhances access to the program because all students are required to attend school. The students are learning the same protective factor skills from preschool to high school. And, the parents are reinforcing and continuing the education at home.

g) **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory, including a description of the specific strategies to be employed and the reasons the County believes they will be successful and meet intended outcomes:** The strategies that are being used are:

- Training as many school personnel as funds will allow and parents that interact with the youth so that the lessons and skills being taught are uniform and consistent.
- All youth are being taught the same lessons, no children are singled out, all youth are learning together. This allows the youth to practice and use the skills that they have been taught.

h) **Estimate of Number Served per Year:**

- Grass Valley: Approximately 500 children and 15 adults will receive direct services. Approximately 375 families will be impacted through their children receiving these services.
- Truckee: Approximately 1,500 children and 55 adults will received direct services. Approximately 800 families will be impacted through their children receiving these services.

i) **The Cost Per Person:**

- Grass Valley: The cost per person for the direct services to individuals/groups is approximately $46 ($23,730/515) per person.
- Truckee: The cost per person for direct services to individuals/groups is approximately $14 ($21,270/1,555) per person.

5) The Program Name: Child and Youth Mentoring

a) **Identification of the target population for the specific program, including:**

- **Participants' risk of a potentially serious mental illness:** The population served by the mentoring program will be youth that are at risk of failing or falling behind in school. These youth will be referred to the program by a parent, teacher, school counselor or community member. These youth will have a risk factor occurring in their life that is or most likely will interfere with their ability to perform well in school.
- **How the risk of a potentially serious mental illness will be defined and determined:** Youth will be referred to the program by a parent, teacher, school counselor or community member. These youth will have a risk factor occurring in their life that is or most likely will interfere with their ability to perform well in school. This could be a trauma, illness, economic or social change that has occurred to the youth or their family that is affecting the child's ability to perform at school.
- **Demographics relevant to the intended target population for the specific program:** This program will be available to school age youth of all races and ethnicities.

b) **Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities to be included in the program:** The community spoke about the need to mentor children and youth. The community is concerned about children who have a number of risk factors in their life and do not have an adult in their live that can help to build protective factors. In Nevada County there are a number of different mentoring programs; in some of these programs the mentoring take place in the community and in others the mentoring takes place in the schools. The school based mentoring programs connect older teens to mentor young children in the schools or have a trained aid that connects with the child. Individuals in the community want to continue and expand mentoring programs; because these programs help children build resilience, feel safe and connected at school. Mentoring gives young children in rural communities a connection in the community which helps to breakdown isolation risk factors. School based mentoring works to reduce school absenteeism, gives young children a reason to attend school and a better chance to perform in school.

c) **Specify any MHSA negative outcomes as a consequence of untreated mental illness that the program is expected to affect, including reduction of prolonged suffering:**
   - **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** The Children's Behavioral Health Department, community members, schools and mentoring agencies wanted to increase at risk youths school performance, create relationships with peers and parents/adults; decrease risky behaviors, and improve social-emotional competence.
   - **Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence:** Approaches to collect data may include but is not limited to: surveys, that may include, Strength of Relationship at the beginning and end of the program year, interviews on an on-going basis with teachers, parents, mentor and mentees, screening tools and other program documents.

d) **Provide a brief description of how each program will reflect and be consistent with all applicable MHSA General Standards:**
   - **Community Collaboration:** The Mentoring project is a collaboration project between the schools, community based organizations, community-based service organizations and the Behavioral Health Department.
   - **Cultural Competence:** Each youth who is assigned a mentor is matched with an individual who has shared interests. These interests may be based on racial/ethnic, cultural or community interests.
   - **Program Participant Driven:** The youth receiving mentoring services get to decide who their mentor will be, what they will do during their mentoring time, and switch mentors if needed.
   - **Family Driven:** Family members provide information on the situation that the youth is going through, provides feedback on how the mentoring match is going, and provides recommendations on activities that may help their child.
   - **Wellness, Recovery, and Resilience Focused:** Mentoring programs help to increase children's self-esteem, the sense of community and connectedness.

School based mentoring works to reduce school absenteeism, gives young children a reason to attend school and a better chance to perform in school.

- **Integrated Service Experiences for Program Participant and Their Families:** The Mentoring program is administered by a community based program at school sites. Youth who need additional support beyond mentoring services receive services from school staff, community service providers and community-based service providers.

e) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** Mentors are provided training on the signs and symptoms of mental health illness. When a mentee is not responding to the mentoring relationship the youth is assessed and if needed a referral is provided to a community based or community service provider. The mentoring programs provide community mental health resources, a secured referral and follow up services.

f) **For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations:** The mentoring services are provided in the school setting. The mentors are meeting the mentees in a place that is safe and is known to the mentee. If the mentors need help or assistance with the mentee school personnel can be accessed.

g) **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** Nevada County mentoring programs are a well-accepted part of the community and the community's goals have been to expand these programs. The strategies to be used are:

- Mentoring programs connect a teen with an elementary school child or they connect a caring adult with the child. The mentoring programs that use adolescents as mentors have the same result for the adolescent mentor. These children and youth will be more successful with their school work with this connection.
- The teen mentors and the mentoring coordinators receive training in mental health issues.
- Services are provided at the mentees schools where they are familiar with their surroundings and feel safe.

h) **Estimate Number Served Per Year:** Approximately 40 children and 40 youth mentors will be served/80 families.

i) **The Cost Per Person:** $213 ($17,000/80)

D) PEI Project Name: Access and Linkage to Treatment Programs

1) Program Name: 211 Nevada County

a) **An explanation of how the program and strategy within each program will create Access and Linkage to Treatment for individuals with serious mental illness:** A website called www.211nevadacounty.com and a 211 Call Center has been established with all the health and human resources available to people living in Nevada County.

211 Nevada County is a call center that takes calls from people who are looking for help with a wide variety of health and human service's needs, from looking for shelter, food, or looking for a mental health provider. This is an information and referral service with a personal follow up for callers who need follow-up services and can provide warm handoffs by phone to service providers.

b) **Explain how individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance:** Individuals will self-identify by requesting referrals for the services they need.

c) **Explain how individuals, and, as applicable, their parents, caregivers, or other family members, will be linked to county mental health services, a primary care provider, or other mental health treatment:** 211 Referral Call Specialists will listen to the information provided to them from the caller and the Referral Specialist will provide the caller a referral(s) to service providers..

d) **Explain how the program will follow up with the referral to support engagement in treatment.** Someone can call who is experiencing social anxiety and is unable to leave their home. This person would receive a follow up call at an agreed upon time and phone number. This follow up call would make sure that they connected to the resources needed and asses need for additional resources. An additional feature is the 211 center "warm referral model," this feature connects the individual caller on the phone with community resources as they are talking to the Call Specialist. A conference call is created with the caller, the 211 operator and the service provider.

e) **Indicate if the County intends to measure outcome(s):** 211 Nevada County staff collects data on each phone call received. This Data is reviewed by 211 Nevada County staff and posted to their Website Monthly. 211 Nevada County also tracks the number of "warm handoff" phone calls and follow-up phone calls and the agency that these calls were connected to. Cumulative and detailed data will be provided to the Behavioral Health Department.

f) **Provide a brief description of how each program will reflect and be consistent with all applicable MHSA General Standards:**
   - **Community Collaboration:** Establishing and maintaining a 211 system has been a community wide endeavor. Community members are collaboratively funding the program and all service providers have to communicate any changes to their program as they happen.
   - **Cultural Competence:** The 211 call center has access to many languages by being connected to a language service that has approximately one hundred and fifty different languages available. Caller's identification is kept confidential.
   - **Program Participant Driven:** Callers tell the 211 Referral Call Specialists what services they need. 211 Referral Call Specialists ask callers if they would like follow-up services or "warm-hand-off" services. The caller determines how many and the type of referrals they need.
   - **Family Driven:** It is common for family members that are trying to help out their loved ones to call 211. The 211 Referral Call Specialists will provide referrals based on the information received.
   - **Wellness, Recovery, and Resilience Focused:** The 211 Call Center supports the Recovery Vision of: hope, personal empowerment, respect, social

connections, self-responsibility, and self-determination by allowing callers to determine what they need referrals too and the amount of support they need.

- **Integrated Service Experiences for Program Participant and Their Families:** Nevada County was the first rural county in California to have a 211 Call Center. Nevada County was able to do this due to all of the community based and community service providers working together to have one centralized location where people could go to receive referrals for services.

g) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** Regardless of your race, ethnicity, language all individuals calling will get referrals for their requested needs. The service can be reached by phone or computer 24/7, 365 days a year.

h) **For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations:** Having a centralized 211 Call center allows individuals to find resources from the comfort of their homes, place of employment or from wherever they have access to a phone or computer. In a county that is spread so far apart and public transportation is so limited it is great to be able to get referrals and be connected to service providers without having to drive all over the county.

Additionally, 211 Nevada County offers enhanced services during and after a county wide emergency. Information is provided to 211 Nevada County by emergency personnel regarding specific resources to affected individuals. 211 Nevada County helps with the immediate needs from county wide emergencies as well as the long term effect of trauma of emergencies, referring callers to mental health treatment. Individuals experiencing trauma could use the call center for finding local mental health services or providers.

i) **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** Some of the strategies used are:

- Centralized location- community only needs to call one number to get referrals for their service needs and service providers only need to communicate with one organization when they have a change of information.
- The service is available by phone or computer.
- The service is available 24/7, 365 days a year.
- The 211 call center has access to a language service that has approximately one hundred and fifty different languages available.

j) **Estimate Number Served Per Year:** 8,500 callers, with an additional 16,500 web searches conducted from unique IP addresses by individuals for whom no demographic information is available.

k) **The Cost Per Person:** $2.48 ($21,088/8,500)

2) Program Name: Access and Linkage to Underserved Populations: Seniors, Disabled and Isolated, Homeless, Forensic Involved, Veterans, and Youth

a) **An explanation of how the program and strategy within each program will create Access and Linkage to Treatment for individuals with serious mental illness:** Each program will:
   - Screen or assess an individual for mental health conditions. The screening may range from a formal screening/assessment instrument to a conversation with an individual.
   - Based on the results of the screening/assessment services a referral(s) will be provided.
   - Also, based on the results of the screening/assessment supportive services/care coordination may be provided. As needed supportive services/care coordination will be provided until the individual is engaged in referred services.
   - For each population served unique individuals are utilized to implement the program. These individuals are connected to the population or specially trained to provide the services in a culturally competent manner.
   - The screening/assessment and supportive services are provided to the individual or family in their homes, at community based organizations, community based service providers, local government offices and in schools. Program staff members meet the individual where they are at.

b) **Explain how individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention program:** Individuals for the program may self-refer, be referred by a family member, service provider, community member, at special events, and program staff will outreach and engage specific subpopulations. Examples:
   - A Forensic Liaison is trained and working with jail, law enforcement personal, community members and family members. When the jail has an inmate who is going to be released from the jail and there is concerned about the mental health of the individual the Forensic Liaison will go to the jail and build a relationship with the individual and assess them for what level of service they will need upon release.
   - For the homeless population program staff works with homeless individuals and families at homeless camps, at shelters and food giveaways.
   - For the senior, disabled, and isolated population Nurses or other trained individuals go to the homes of these individuals and utilizing a depression screening tool along with other physical health and fall prevention screening tools.
   - For Veterans the Veteran Services Office staff is connecting with veterans that come into their office and may not be eligible to Veteran's benefits or need to travel so far to receive services that they cannot obtain them.
   - For youth a screening program has been developed that occurs at all of the local public high schools. The screening occurs on all youth that signed a permission slip along with their parents. The target population is youth in the 9th and 10th grade.

c) **Explain how individuals, and, as applicable, their parents, caregivers, or other family members, will be linked to county mental health services, a primary care provider, or other mental health treatment.:** Depending on the individual being screened and referred will depend on where they ae referred. Referrals can be done by email, program referral form, phone, fax and in person. Program staff members

provide care coordination services to the individual and family. This service includes driving the person to their appointment(s), helping to arrange rides to appointments, and showing the individual how to utilize transportation through their medical care provider.

d) **Explain how the program will follow up with the referral to support engagement in treatment.** If the individual needs support and encouragement to attend treatment services program staff will provide the support until the individual is fully engaged in services. Most of the programs have an assigned staff member to provide follow-up services. Assigned staff will continue to be the care coordinator for the individual until they have engaged in services or refused services. Each program has a different method to determine if an individual engaged in services or not. And, it depends on the individual's situation and release of information that is signed will determine how follow-up is conducted. Program staff can call the individual and ask; call the service provider (if releases have been signed); talk to parents of youth or other family members (if releases are signed), and look at Electronic Health Record.

e) **Indicate if the County intends to measure outcome(s):** Each program will track:
- The number of referrals to treatment and the number of individuals who follow through on the referral and engage in treatment.
- The duration of untreated mental illness of individuals who are referred to treatment and who have not previously received treatment.
- The interval between the referral and engagement in treatment

f) **Provide a brief description of how each will reflect and be consistent with all applicable MHSA General Standards:**
- **Community Collaboration:** Each of the programs being implemented in the Access and Linkage for Underserved Populations has had to collaborate with multiple organizations for the programs to be successful.
- **Cultural Competence:** For each population served unique individuals are utilized to implement the program. These individuals are connected to the population or specially trained to provide the services in a culturally competent manner.
- **Program Participant Driven**: Each program works with the program participant to determine what referral should be made to what organizations and the level and kind of support needed for the program participant to connect to the referred service provider.
- **Family Driven:** For each program family members are engaged in the planning, referring and supporting of the program participants to engage in referred services.
- **Wellness, Recovery, and Resilience Focused:** Each program supports the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination by allowing program participants to determine what referrals they need and the amount of support they need to meet the goals or objectives that they are striving towards.
- **Integrated Service Experiences for Program Participants and Their Families:** Each program has staff members who are trained in the availability of community resources available to meet the holistic service needs of the program participant. The program participant is assisted on addressing all

their needs in a holistic manner addressing their physical and mental health needs.

g) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** Multiple contracts with a variety of community based organizations that have existing connections or staff specially trained to provide services to the identified subpopulations that need Access and Linkage services are utilized. All of the programs are designed to build a relationship of mutual trust, respect and support with the program participate and support the program participant until they have engaged in treatment or refused services. Program participants are screened, referred and provided transportation if needed to their appointments.

h) **For each program, the County shall indicate the intended setting(s):** Each program is delivered in a setting that accommodates the program participants:
- **Social Outreach Nurse-** provides services in the homes of seniors, disabled and isolated individuals.
- **Homeless Outreach Worker-**provides services at emergency shelters, food giveaway programs, on the streets, in parks, at homeless camps (homeless individuals homes), anywhere homeless individuals gather.
- **Forensic Liaison-**provides services in the jail, at homes, in the community, at county offices, schools, anywhere the program participant is comfortable at engaging in services.
- **Youth Outreach-** provides services at school sites.
- **Veterans Outreach-**provides services at the Veterans Service Office, Veteran's Stand Down, community events, at community based organizations, schools, and at service providers organizations.

Each program tries to meet the program participant in a setting that the program participant is familiar with, so that the program participant is comfortable, safe and able to engage with program staff. Program staff engages with program participants to build a relationship of mutual trust, respect and support.

i) **What Strategies that are Non-stigmatizing and Non-Discriminatory will be used:** Some examples are:
- Meet the program participant in a setting that they are familiar with or comfortable with.
- Hire staff that are connected to the population served or are trained on the subpopulations specific needs and/or culture.
- Include mental health screening tools as part of the program intake process.
- Including care coordination, "warm handoffs", and follow-up services as part of program processes and procedures.
- Listening to the program participant's goals and objectives and providing referrals that will help the program participant reach their goals.

a) **Estimate Number Served Per Year:** 800 individuals served per year

b) **The Cost Per Person:** $386 ($308,912/800)

E) PEI Project Name: Stigma and Discrimination Reduction Programs

1) **The Program Name:** Latino Outreach
   a) **Identify whom the program intends to influence:** Nevada County will outreach and engage the Latino population.

   b) **Specify the methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness and/or seeking mental health services:** Nevada County will serve the Latino population by expanding existing "Promotoras" programs. Nevada County has two small Promotoras programs in the Truckee and Grass Valley areas. Traditionally Promotoras are "community health workers" who are lay members of the community who usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Promotoras in Nevada County are Spanish speaking bi-cultural and/or bi-lingual paraprofessionals who help Latino families connect to resources mostly for physical health care in the community. Promotoras offer interpretation and translation services, provide culturally appropriate physical health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individuals and community health needs. The BHD funds the Promotoras to expand the services they provide to include mental health education, support and advocacy. The Promotoras conduct outreach and conduct psycho-educational groups for Latino families in Spanish about mental health care. Psycho-education groups will educate people about mental health issues to decrease stigma about reaching out for help for mental health issues. By decreasing stigma about mental health conditions the program will promote, maintain, and improve individual and community mental health. Childcare may be offered at mental health education classes. In the Latino Outreach Project the Promotoras link individuals and families that they serve to needed services in the community which includes mental health services and when necessary accompany individuals to their first appointment for a warm handoff to the mental health professional.

   c) **Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:**
      - **Evidence-based standard: provide a brief description of relevant evidence applicable to the specific intended outcome:** In the Promotora model, the Promotoras are members of the target population that share many of the same social, cultural and economic characteristics. As trusted members of their community, Promotoras provide culturally appropriate services and serve as a patient advocate, educator, mentor, outreach worker and translator. They are often the bridge between the diverse populations they serve and the health care system. The Promotora model has been applied in the United States and Latin America to reach Hispanic communities in particular. It has been used widely in rural communities to improve the health of migrant and seasonal farm workers and their families (Community Health Workers Evidence-Based Models Toolbox, HRSA Office of Rural Health Policy, August 2011). The County plans to build the skills of the existing community Promotoras, so will utilize the existing evidence based practice that is in existence in the community.

d) **Provide a brief description of how each program will reflect and be consistent with all applicable MHSA General Standards:**
   - **Community Collaboration:** This whole program is built on Community Collaboration. The Family Resource Centers, community based organizations, MHSA stakeholders, County government, representatives from the Latino community are working together to provide outreach, advocacy, support, education and training to the Spanish speaking individuals in the community so that mental health stigma to access and receive treatment is decreased.
   - **Cultural Competence:** This program provides training, education, and support in the language of the individuals needing mental health services. Local bi-lingual and/or bi-cultural Promotoras are implementing the program. When mental health services are located at the County office Promotoras are bringing program participant's to the first appointments to ensure that the program participant feels comfortable, and that a relationship is developed between the program participant and service provider. Therapists are located at Family Resource Centers where the target population are already connected to and feel comfortable.
   - **Program Participant Driven:** The program has been developed with the input of the Latino population, they have influenced the way outreach, implementation and evaluation of the program is conducted.
   - **Family Driven:** Parents of children and youth who have the primary decision-making role in the care of their children continue to be involved in the planning, implementation and evaluation of the program.
   - **Wellness, Recovery, and Resilience Focused:** The program utilized Promotoras to help support the individual(s) and families who want to learn about mental health needs so that they can break the tradition of not talking or speaking about mental health and not accessing treatment services. The program reflects the cultural, ethnic, and racial diversity of the population being served. The trainings, education and support provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
   - **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community based organizations, non-profits, schools, government agencies, families and consumers. Individuals and their families can participate in multiple training and education opportunities offered at different locations in the community. Multiple entities that are funded by a variety of funding sources are providing services and supports in a coordinated comprehensive manner to individual and their family.

e) **Explain how program helps to Improve Access to Services for Underserved Populations:** The program participants in this program are not accessing services due to multiple barriers: stigma about mental illness and accessing treatment for mental illness; cannot access other programs because they do not have health insurance, are not legal immigrants, do not trust other organizations, their mental health issues are preventing them from accessing care, transportation limitations, etc. The program is improving access to services by out stationing and outreaching to the underserved by connecting to these individual's natural community support systems. The Promotoras roles include: Creating effective linkages between the Latino population and the health care system; managing care and care transitions; ensuring cultural competence among health care professionals; providing culturally appropriate mental and physical

health education on topics related to mental health, chronic diseases prevention, physical activity and nutrition and cultural competence; advocating for Latino individuals to receive appropriate services; provide informal counseling; and build community capacity to address mental health issues.

f) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** This program improves access to services by addressing stigma about mental illness in the Latino population. This program is decreasing stigma pertaining to seeking and receiving mental health services by educating individuals on what mental illness is, signs, symptoms and resources to get support and treatment and how mental illness relates to overall health. The Promotoras are partnering with the Behavioral Health Department so that they have a therapist on site or available at the County to refer individuals for screening, assessment and treatment.

g) **For each program, the County shall indicate the intended setting(s):** The Promotoras services are located and provided in the community, at community based organizations and/or schools where the Latino population is already living, attending or utilizing services. The Promotoras are already recognized as a paraprofessional in the community and have trusting relationships with the individuals and families in the targeted population.

h) **Indicate if the County intends to measure outcomes:** The programs will track:
- Demographic information of individuals served.
- Changes in attitudes, knowledge, and/or behavior related to mental illness.
- Changes in attitudes, knowledge, and/or behavior related to seeking mental health services.
- Referrals to mental health services

The approaches to collect data may include, but is not limited to:
- Participants receive written pre and post-tests at meeting with a single theme or a series of meetings on the same theme; which indicate not only increase of knowledge, but also opportunity for a review of the topic.
- The Promotoras use an informal testing model based on conversation, which provides for honest narrative through a means that is not daunting to the program participant. The Promotoras complete a pre-workshop evaluation that consists of a group conversation in which questions are allowed to be asked and discussion is encouraged. Through this initial evaluation, the Promotoras gain a sense of the knowledge base that each participant holds; areas of interest and gaps in knowledge can be identified and addressed. At the end of each workshop, the Promotoras conduct an evaluation through informal small group discussions. The purpose of the discussion format is to provide a comfortable atmosphere for participants to express the knowledge that they have gained from the workshop. The Promotoras use a template of questions to gauge the increase in knowledge of their participants. The pre and post tests are directly correlated and allow the Promotoras and contracted staff to determine the levels of increased knowledge and awareness. Detailed narratives of the discussion allow for a qualitative analysis of results.

- Written and verbal feedback from program participants and the Promotoras plays an important role in understanding the impact of workshops for the workshop participants.
- Additionally, the number of people who opened up and asked for help and referrals to Behavioral Health is tracked.

i) What Strategies that are Non-stigmatizing and Non-Discriminatory will be utilized:

1. Programs are offered in Spanish: Research by Brown University in 2002 showed that offering programs in Spanish shows respect for the culture and helps to build trust.
2. Programs include a family outreach approach: According to a 2003 report by the national Latino children's Institute, Hispanics and Latinos are more inclined to engage as a family rather than only as adults. This includes multigenerational family members as well. Accommodations are made to engage for care and/or to include children at outreach, community and education and training events.
3. Programs utilize cultural differences: Generally, Hispanics and Latinos value family, youth, cultural art, food and music. The programs find ways to incorporate these values into program activities- outreach, community and education and training events.
4. Programs provide education opportunities that focus on understanding mental illness and the mentally ill: The programs provide the opportunity to reject/combat stigma as a family and as a community; provides de-stigmatizing activities for community members to participate in; conducts anti-stigma campaigns; involves consumers in community activities and promotes persons recovering from mental illness in educational programs.
5. Using indirect methods for collection data: research and experience from Oregon State's 4-H Latino Outreach program concludes that Latinos and Hispanics feel more comfortable working as a group rather than as an individual. Group dialogue and reflection are effective data collection methods. Direct questions to an individual should be avoided. Nevada County has also experienced that a large number of program participants have limited or no ability to read or write in Spanish or English. The Promotoras complete a pre-workshop evaluation that consists of a group conversation in which questions are allowed to be asked and discussion is encouraged. Through this initial evaluation, the Promotoras gain a sense of the knowledge base that each participant holds; areas of interest and gaps in knowledge can be identified and addressed. At the end of each workshop, the Promotoras conduct an evaluation through informal small group discussions. The purpose of the discussion format is to provide a comfortable atmosphere for participants to express the knowledge that they have gained from the workshop.

j) Estimated Number Served Per Year:

- Grass Valley- Approximately 230 individuals will be served: 105 children (0-15), 20 TAY (16-24), 100 adults (25-59) and 5 seniors (60+). The number of families served will be approximately 85 either directly or indirectly.
- Truckee-Approximately 2000 individuals will receive direct services: 1100 children (0-18), 850 adults, and 10 seniors. The program hopes to serve 20 families.

k) **The cost per person:**
- Grass Valley: the cost per person is approximately $202 ($46,500/230) per person
- Truckee: the cost per person is approximately $15 ($30,000/2,000) per person

F) PEI Project Name: Suicide Prevention Programs

1) **The Program Name:** Suicide Prevention Intervention (SPI) Program

a) **Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.** Nevada County hired a PEI Coordinator/Suicide Prevention Intervention (SPI) Coordinator. The SPI Coordinator's charge is to help create a more "suicide aware community." To create a more "suicide aware community" the Coordinator will: 1) Raise awareness that suicide is preventable; 2) Reduce stigma around suicide and mental illness; 3) Promote help seeking behaviors; and 4) Implement suicide prevention & intervention training programs.

The SPI Coordinator uses "Living Works", "Mental Health First Aid", "Know the Signs" and other evidence based curriculum and other evidence based practices to conduct outreach in the community, build community capacity and provide linkage to services. The Coordinator is trained in evidence based practices and is able to lead training groups in the community on suicide prevention and intervention. The Coordinator is also trained to increase community capacity to address suicide prevention and intervention. The coordinator conducts outreach, capacity building activities and trainings in the schools, in the faith based organizations, business community, county offices, public health sites, city offices and others that request the assistance. The SPI Coordinator reaches people in the community that ordinarily would not be aware of mental health resources or how to access them. The Coordinator contributes to the reduction in disparities in access to mental health services.

b) **Indicate how the County will measure changes in attitude, knowledge, and/or behavior related to reducing mental illness-related suicide: consistent with requirements in section 3750, subdivision (e) including timeframes for measurement.** The county is utilizing multiple evaluation/survey tools to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific programs/ training being implemented.

c) **Provide a brief description, with specific examples of how each program will reflect and be consistent with all applicable MHSA General Standards:**
- **Community Collaboration:** Nevada County has formed a Suicide Prevention Task Force. The Nevada County Suicide Prevention Task Force has created a Community Action Plan based on the California Strategic Plan on Suicide Prevention 2008. Membership of the Task Force reflects a broad range of local stakeholders with expertise and experience with diverse at-risk groups. The SPI Coordinator is collaborating with Family Resource Centers, community based organizations, MHSA stakeholders, County government, and representatives from the Latino community, schools, faith based organizations and others.
- **Cultural Competence:** This program provides training, education, and support in in Spanish to individuals needing suicide prevention and intervention services.

Local bi-lingual and/or bi-cultural Promotoras are trained in suicide prevention, early identification, referral, intervention and follow-up services.

Training is also provided to service providers providing services to multiple other cultures and groups: primary care; first responders, licensed and non-licensed mental health and substance abuse treatment professionals; Peer Supporters, youth providers, Veteran and senior service providers.

- **Program Participant Driven:** The program has been developed, implemented and evaluated with the input of survivors of suicide attempts.
- **Family Driven:** The program has been developed, implemented and evaluated with the input of family members of individuals who committed suicide and/or survived a suicide attempt.
- **Wellness, Recovery, and Resilience Focused:** Nevada County is creating a more "suicide aware community." To create a more "suicide aware community" the program is: 1) Raising awareness that suicide is preventable; 2) Reducing stigma around suicide and mental illness; 3) Promoting help seeking behaviors; and 4) Implementing suicide prevention & intervention training programs. The trainings, education and support provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
- **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community based organizations, non-profits, schools, government agencies, families and consumers. Individuals and their families can participate in multiple training and education opportunities offered at different locations in the community. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

d) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** The training and education provided is to educate individuals on the early identification, referral, intervention and follow-up care individuals need who are showing signs of early mental illness and or suicidal thoughts. Local community resources are shared with program participants.

e) **For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations.** The SPI Coordinator provides outreach and education to all racial/ethnic and cultural populations in Nevada County. Most of the services are provided out in the community at service provider sites, community meetings, schools, faith based community programs, health sites, etc.

f) **What Strategies that are Non-stigmatizing and Non-Discriminatory, are being used:** Nevada County is using multiple evidence based models depending on the population that is being served. The SPI Coordinator tries to match the training to the population being served. When possible one and/or both trainers have an existing connection or relationship with the population being served. Additionally, consumers and family members are a part of the program so that their perspective is a part of the training.

g) **Estimate of Number Served per Year:** It is estimated that the program will serve 12 children (0-15), 44 transition age youth (16-25), 106 adults (26-59), and 38 Older Adults (60+) for a total of 200 individuals.

h) **Cost per Person:** $940 ($188,000/200)

i) Evaluation Process:
- Approaches Used to Select Outcomes and Indicators: The Suicide Task Force utilizes the strategies in the *California Strategic Plan on Suicide Prevention* (Plan) which was approved by the Governor's Office on June 30, 2008 to select outcomes and indicators. Additionally, depending on the evidence based practice utilized, the practice will have selected outcomes and indicators.
- Approaches Used to Collect Data and How Often Collected: depending on the activity may include, but is not limited to: pre and post-test, attendance sheet, participant evaluation, finished work product and other documents as they are created. Data is collected at each event.
- Approaches used to determine results: SPI Coordinator collects data, compiles results and analyses results.
- How often are results shared: results are shared with the Suicide Task Force on a regular monthly basis. Additionally, results are shared with the MHSA Coordinator and the MHSA Program Evaluator Biannually and/or annually who shares them with the community.

G) PEI Funding Expenditures

PEI funding for all programs listed above may be used to fund expenditures for all expenditures identified in the Original Three-Year Plan and the subsequent Annual Updates, or for activities listed in the MHSA Recommendations of Needed Mental Health Services FY 2017-2020 document, including but not limited to: staffing, professional services, stipends, operating expenses (office supplies, travel and transportation, program participant vouchers, translation and interpreter services, rent, utilities and equipment, etc.), tele/video psychiatry equipment, office furniture, capital purchases, training and education, food and incentives for meetings, and the cost of improving the functionality of information systems used to collect and report program participant information. Capital purchases for staff and contractors may include the cost of vehicles, the cost of equipping new employees or contractors with all necessary technology (cellular telephones, computer hardware and software, projectors, etc.), the cost of enhanced and/or increased space needs related to services and other expenses associated with activities in this plan.

H) PEI Program Costs and Cost per Person

The estimated cost for 1) Early Intervention programs is $227,000, 2) Outreach programs is $10,000, 3) Prevention Programs is $387,500, 4)Access & Linkage Programs is $330,000, 5) Stigma and Discrimination Programs is $76,500, 6) Suicide Prevention Program is $188,000, 7) PEI Assigned Funds is $10,000 and, 8) Administration $90,000. The estimated total PEI program costs are $1,319,000. Using an estimate number based partially on the number served in FY 15/16, it is estimated that 13,451 individuals will receive PEI services and the average cost

per person involved in a PEI activity will be $97 ($1,309,000 /13,451). This is the average cost of individuals involved in all PEI Projects. This does not include PEI Assigned Funds.

Note: These are only estimates and the actual cost by program and number served may change affecting the average cost per person.

I) PEI Future Funded Activities

The expansion of services in the future may include any other activities approved in the original PEI Plan or subsequent Annual Updates or the MHSA Recommendations of Needed Mental Health Services FY 2017-2020 document, including, but not limited to: additional Latino outreach; additional homeless outreach, homeless housing support services; early intervention and prevention services (this may include mental health services and supports); additional services to seniors; additional or enhanced services to court involved families; juvenile wards at juvenile hall and Foster Care children; services on the San Juan Ridge and Truckee; additional or enhanced jail services for inmates within six months of their release; additional support for at risk children and youth; additional peer support; additional contract services; consultation to primary care clinics; additional Children's System of Care (CSOC) and Adult System of Care (ASOC) services; and psychiatric services.

J) MHSA PEI Administration

MHSA PEI Administration funding is used to sustain the costs associated with the intensive amount of administration support required to ensure ongoing community planning, implementation, monitoring and evaluation of the PEI programs and activities. The expenditures within the administration budget are recurring in nature. The increases in expenditures are due to expansion of personnel and the associated operating costs assigned and assisting in the delivery of the programs. All administrative cost in the original PEI plan and subsequent Updates are applicable expenses.

In FY 2008/2009 the MHSA Coordinator position was expanded. Additionally, in FY 2008/2009 the number of supportive staff was increased and the amount of time supportive staff was dedicated to MHSA PEI activities. In FY 2013/14 a MHSA Evaluator was hired. The supportive staff included, but is not limited to: the Behavioral Health Director, Adult and Children's Program Managers, Behavioral Health Adult and Children Supervisors, Behavioral Health Workers, Behavioral Health Technicians, Analyst, Administrative Assistant, Administrative Services Officer and the Accounting Technician. All of the above staff are involved in the community planning, implementation, and/or monitoring and evaluation of the MHSA programs and activities. Yearly the benefits of assigned staff will be charged to MHSA PEI.

In the future a formal group of consumer and family members will be created and funded to assist in the community planning, implementation, and/or monitoring and evaluation of MHSA programs and activities. The activities this group will be involved with will include, but is not limited to: community meetings, mental health surveys, focus groups, trainings, community events, community education, media outreach and engagement events, and stigma awareness and reduction campaigns.

Operating expenditures tend to increase yearly and are based on prior year actual expenses. The increases are due to increase in staff and program activities. Expenses my include, but are not

limited to: office supplies, office furniture, other operating expenses, capital purchases, training and education, food, incentives, the cost of improving the functionality of information systems used to collect and report program participant and program information. Capital purchases may include the cost of vehicles, costs of equipping new employees with all necessary technology (cellular telephones, computer hardware and software, etc.), the cost of enhanced and/or increased space needs related to services, and other administration expenses associate with the services in this plan.

Administration funds may also be used to pay for training and education expenses for county staff, contractors and community stakeholders including program participants and their family. Training and education cost may include, but is not limited to: travel, food, lodging, airfare, parking, registration fees, incentives, etc.

County Allocated Administration is also a covered expense and is increasing due to the increase in staff working on MHSA projects and programs. Countywide Administration (A-87) expenditures are based on a formula prepared annually by the County Auditor based on the activities for the prior year.

Lastly, it is anticipated that the MHSA PEI programs may generate new Medi-Cal revenues. These funds may be used to cover the costs to administer the MHSA PEI Programs.

III) Workforce Education and Training (WET):

All proposed education, training and workforce development programs and activities contribute to developing and maintaining a culturally competent workforce, to include individuals with client and family member experience that are capable of providing client- and family-driven services that promote wellness, recovery, and resiliency, leading to measurable, values-driven outcomes. This WET component has been developed with stakeholders and public participation. All input has been considered, with adjustments made, as appropriate.

A. Workforce Staffing Support-

1. Action #1 – Title: MHSA Coordinator and MHSA Support Staff
   a. Description: The MHSA Coordinator is a full time position dedicated to the implementation of the local MHSA plan. This position has the responsibility of coordinating all aspects of planning and implementation phases of the WET plan. An estimated 25% of this individual's time is dedicated to WET. This is a key leadership role including attendance at local, regional and statewide stakeholder planning process meetings; participation in regional meetings, statewide meetings; planning, creating and implementing stakeholder surveys; coordination of all tasks related to the planning, development and implementation of the WET components; and timely submission of all reports and plan updates to the Director of Nevada County Behavioral Health Department and to State entities California Department of Health Care Services (DHCS), Mental Health Services Oversight and Accountability Commission (MHSOAC), and Office of Statewide Health Planning and Development (OSHPD).
   b. A clerical position supports the administrative requirements of the MHSA Coordinator with all WET activities. This includes maintaining documentation, minutes, agendas, reports, website, purchasing incentives, food and beverages for meetings/trainings and administration of the multi-media library.
   c. Administrative Analyst to plan, coordinate and implement data collection, data analysis and evaluation requirements.
   d. Other Staff to support the WET Plan planning, implementation and evaluation process

2. Budget Information:
   a. Salary and benefits for the MHSA Program Coordinator/NCBH Management staff/Evaluator and clerical support at $17,000.

      Nevada County is requesting $17,000 in WET funding to support the continued operation of this Action per year through the end of Fiscal Year 2017/2018. These funds may be used for salaries, benefits, contracted staff time, stipends, travel, mileage, supplies, materials and any other stakeholder needs to implement this activity. Nevada County intends to provide ongoing support of the WET Component though the MHSA Integrated Three-Year Plan beginning in Fiscal Year 2014/2015. This support will continue until funds are exhausted.

      Note: any funds not utilized by this activity in FY 16/17 and beyond can be utilized for Action #4: Expansion of Nevada County's Internship Program

B. Training and Technical Assistance-

1. Action #2: Development of Staff, Contract Providers, Community Partners, Consumers and Family Members
   a. Description: Training for staff, service providers, and stakeholders has several components. Consultants and training experts will be hired to train on various topics in their expertise that have been targeted through the survey process, training evaluation process, and by stakeholder requests. In addition, teleseminars/webinars will be available at various facilities in the county. The last component is the continued support and development of the Behavioral Health lending library for those who are unable to attend training or for those topics where it is more feasible for an individual to study on their own.
   b. This training is designed to provide a coordinated, consistent approach to training and to enhance staff and management development through the integration of advancements in the field (e.g. evidence-based practices, best practices, leadership and management practices.). Trainings will be offered to county and contract community based organizations (CBO) management and staff, consumers and family members and other key stakeholders, as appropriate. Transitional Age Youth (TAY) clients, adult consumers and family members who have completed peer trainings will be recruited as co-trainers, facilitators, and presenters to model wellness and recovery, as well as contract trainers, consultants, staff and contract provider (Any individual, organization, or agency that has a contractual arrangement with the county for the provision of services under a contract) experts. Training in a variety of different areas is needed to transform the workforce to provide services with the MHSA essential elements. NCBHD will design and incorporate outcome measures to evaluate the effectiveness of the training programs.

2. Budget justification:
   a. Training and technical assistance for trainers, materials, consultant fees and conference space. This may include the purchase of curriculum, rental of training facilities, and fees for trainers/content experts. Trainers/content experts are budgeted for training, facility rental, supplies, copying and curriculum.
   b. Teleseminars/webinar including the cost of the copies and general supplies for each session.
   c. Library materials, including books, audio materials, DVD and computerized software.
   d. Total Annual Cost: $13,000
      Nevada County is requesting $13,000 in WET funding to support the continued operation of this Action through the end of Fiscal Year 2017/2018. The cost may include travel, food, lodging, training and technical assistance for trainers, training materials, consultant fees, conference space, incentives, stipends, the purchase of curriculum, rental of training facilities, child care fees, fees for trainers/content experts, cost for teleseminars/webinars, copies, general office supplies to support training needs, library materials which may include books, audio materials, DVD, computers, projectors, computer software, furniture and any other supplies needed to conduct a training or support the lending Library. WET Training and Technical funds may be used to support or in combination with CSS, PEI and Innovation funds. This support will continue until funds are exhausted.

      Note: any funds not utilized by this activity in FY 16/17 and beyond can be utilized for Action #4: Expansion of Nevada County's Internship Program

C. Mental Health Career Pathway Programs

1. Action #3: Mental Health Career Ladder Program- All funds for this activity have been expended.

D. Residency, Internship Programs-

1. Action #4: Expansion of Nevada County's Internship Program
   a) Description: The internship program will provide opportunities to engage, train, and recruit potential employees. Internships offer opportunities for trainees to learn about public mental health in a variety of settings and to increase their "real world" focus and understanding. This Action is designed to coordinate and expand internships in order to increase the number of students placed within Nevada County settings, thereby increasing the possibility of recruiting these students for employment in the Nevada County workforce. In fiscal year 2011/2012 the scope of services was expanded to providing stipends to interns. Stipends will be provided to attract more interns. This includes the possibility of employment of family members, consumers, and community stakeholders to deliver services and collaborate as a community to develop the workforce of mental health providers.
   b) The greatest challenge to increasing the number of internships is the staff supervision required for students to earn supervised clinical hours towards licensure. Nevada County staff members have identified specific supervision and training needs related to expanding internship placements and to assist in the development of strategies that support interns needs. The internship coordinator will coordinate non-clinical activities and serve as the single point of contact for educational institutions to publicize internship opportunities within Nevada County. In fiscal year 2011/2012 the funding for supervision was increased due to the expected number of increase of interns due to providing interns with stipends.

2. Budget justification:
   a) Salary and benefits for a clinical supervisor to supervise interns and manage the program.
   b) Stipends to pay interns.
   c) Total Annual Cost: $13,841
   d) Nevada County is requesting $13,841 in WET funding to support the operation of this Action through the end of Fiscal Year 2017/2018. Funds may be used to fund clinical supervisors to supervise interns and manage the program and to pay stipends to interns and the related costs for interns to work in an office. This support will continue until funds are exhausted.

E. Financial Incentive Programs-

1. Action #5 –Loan Assistance and a Speaker's Bureau-It is requested that any funds remaining in this Action Item after June 30, 2016 be transferred to Action Item #2 and/or #4.

F. WET Cost per Person

The number of individuals served in FY 2015/16 (121 individuals) is being used to estimate the average cost per person involved in a WET activity will be $383 ($46,341/121. This is the average cost of individuals involved in all five WET Projects: Workforce Staffing Support, Training and Technical Assistance, Mental Health Career Pathway Programs, Residency and Internship Programs, and Financial Incentive Programs. This also includes administration costs of $2,500.

Note: The cost per person is an estimate and actuals may differ. Cost per person will change as funding changes.

G. WET Funding Expenditures

WET funding in Action #1-5 may be used to fund expenditures for all expenditures identified in the Original Three-Year Plan and the past Annual Updates or for activities listed in the MHSA Recommendations of Needed Mental Health Services FY 2017-2020 document, including but not limited to: staffing, professional services, stipends, operating expenses (office supplies, travel and transportation, client vouchers, translation and interpreter services, rent, utilities and equipment, etc.), tele/video psychiatry equipment, office furniture, capital purchases, training and education, food and incentives for meetings, trainings, and the cost of improving the functionality of information systems used to collect and report client and program information. Capital purchases for staff and contractors may include the cost of vehicles, the cost of equipping new employees or contractors with all necessary technology (cellular telephones, computer hardware and software, projectors, etc.), the cost of enhanced and/or increased space needs related to services and other expenses associated with activities in this plan.

All WET funds have to be expended by 6/30/18 to avoid reversion. Any funds not expended after 6/30/18 will be returned to the State.

IV) Innovation (INN)

Nevada County's Innovation Plan was approved in a separate process by the Mental Health Services Oversight and Accountability Commission.

V) Technological Needs:

Nevada County has utilized all of the original allotment of Technological Needs funds.

VI) Capital Facilities

Nevada County has utilized all of the original allotment of Capital Facilities funds.

The Nevada County Mental Health Services Act (MHSA) Steering Committee has created a MHSA Recommendation of Needed Mental Health Service for the MHSA 3-Year Plan. The information in this document comes from information/data from surveys, community meetings, MHSA meetings, MHSA Annual Progress Reports, Mental Health Board Meetings and Behavioral Health meetings. Information was received from consumers; family members; individuals from non-profit organizations; Behavioral Health staff; community based behavioral health service providers; business/community members; school staff; and other local government staff. This document is expected to be a living document that can be adjusted and changed as needs are addressed or discovered.

The purpose of this document is to provide the Mental Health Board and the Behavioral Health Director with recommendations of where the community would like to see mental health care funds expended. Also, included in this document is the Community Collaborative of Tahoe Truckee Mental Health Service Needs that represents the Tahoe Truckee mental health needs that they updated in 2017.

The needs listed below are not ranked in order of need; they are listed in random order.

1. Nevada County Recommendations of Needed Mental Health Service

Recommendation A: *Improve System Values*-This includes increasing cultural competency for a variety of cultures, which includes Latino, LGBTQ, youth and young adults, seniors and individuals with mental health and physical health disabilities, and Veterans; create a trauma informed care system; infusing recovery model into the system; utilize Peer Advocates/Navigators and create a no wrong door and welcoming system.

Recommendation B: *Integrate Trauma-Informed Care Principles*-Integrate Trauma-Informed Care Principles for individuals throughout the Mental Health system.

Recommendation C: *Improve our Crisis Continuum of Care*- The Crisis Continuum of Care may include: Warm Line, Respite Care Home, Mobile Mental Health Crisis Team, Crisis Stabilization Unit at the hospital, Crisis Residential and Community Based Crisis Facility. The Crisis Continuum of Care will also include transportation, utilize Peer Advocates/Navigators, preventative, intervention, and follow-up services and training. Utilize Peer Supporters on the Mobile Crisis teams.

Recommendation D: *Increase Number and Type of Housing Options*-Increase short term and long term housing opportunities. This includes: emergency housing, transitional housing, permanent housing with supportive services, homes for youth and adults with co-occurring disorders, and low income housing. Included in this is homeless outreach and supportive services which includes a mobile outreach van that can provide services to individuals living on the streets; incentives and supports to landlords; and advertising and other activities to build relationships with landlords.

Recommendation E: *Increase Co-Occurring Disorder (COD) Services*- Provide more COD programs, services and trainings. COD services need to be integrated with existing behavioral

health services/programs. There needs to be follow-up COD services/support upon program exit. Expand services to individuals who are high risk and high users of the system. Lastly, increase the use of harm reduction service model in COD programs.

Recommendation F: *Create and Enhance Services for Individuals Engaged with Law Enforcement and/or the Criminal Justice System-* Provide more programs, services and trainings for individuals who are in the criminal justice system and/or interacting with law enforcement. Services need to be integrated with existing behavioral health services/programs. There needs to be services in place to prevent criminal justice and law enforcement involvement, reduce the negative impacts for people involved in the criminal justice system and follow-up services/support upon separation from the criminal justice system. Utilize Peer Supporters in the services provided to criminal justice and law enforcement involved individuals, including individuals in jail.

Recommendation G: *Create and Implement a Stigma Reduction and Community Education Campaign*-Utilize media (written, radio, television and internet) to outreach and educate the public on existing mental health programs and to reduce stigma and discrimination towards individuals with mental health needs. Utilize peer services providers, mental health service providers, community stakeholders, consumers and family members to create a community wide plan and campaign. The community plan and campaign needs to be inclusive of different cultural needs.

Recommendation H: *Increase services in Geographically Isolated Areas-* Provide transportation to and from service locations; utilize existing service providers; increase mental health services at established service providers; purchase vehicles for mental health service access; utilize outreach nurse to serve isolated areas and outreach to isolated populations; and utilize Peer Advocates/Navigators. Truckee: see the detailed list below in the Truckee Section.

Recommendation I: *Enhance Services to MHSA Identified Age Groups*-Increase access to services, quality of services, COD services, and psychiatrist and therapeutic services.

> *Children (0-15):* Screen and provide services to the whole family (including parenting support). Provide: specialized services for 0-5 age group; parental mental illness services; LGBTQ services; bullying programs; mentoring programs for at risk children; outdoors/extracurricular activities; eating disorder services; post-traumatic stress disorder (PTSD) services; and increase the number of Wraparound service slots.
>
> Mental health services need to be coordinated and provided in the community: schools, churches, non-profits including Family Resource Centers, and community based mental health service providers.
>
> *Youth and Young Adults (16-24):* Screen and provide services to the whole family (including parenting support). Provide: LGBTQ services; bullying programs; eating disorder programs; mentoring programs for at risk youth; provide non-traditional forms of therapy which includes outdoors/extracurricular activities; supported employment;

system navigators; transitional services; PTSD services; and increase the number of Wraparound service slots.

Mental health services need to be coordinated and provided in the community: schools, churches, non-profits including Family Resource Centers, and community based mental health service providers.

Adult Services (25-59): Provide supported services for: parenting, employment, mainstream benefits, parental mental illness, PTSD and the most vulnerable populations (e.g. homeless, isolated, co-occurring, and physical disabilities).

Older Adult Services (60+): Provide services to: access mainstream benefits, increase outreach and engagement activities to support individuals so they can remain in their home; PTSD, and the most vulnerable populations (e.g. homeless, isolated, co-occurring, and physical disabilities).

2. Truckee Recommendations of Needed Mental Health Service

The Community Collaborative of Tahoe Truckee (CCTT) is comprised of over 45 health, education and social service agencies who work together to address the fundamental needs of families in the Tahoe Truckee region. This list of recommendation of mental health service needs is created and supported by CCTT leadership and represents the collective sense of mental health needs in the Tahoe Truckee region at this time.

The Truckee Recommendation's listed below are based on input from the CCTT Tahoe Truckee Mental Health Accomplishments and Priority 2017 document.

Recommendation A: Youth Behavioral Health: Ensure a comprehensive system of supports exists for youth in the Tahoe Truckee region.

Current programs that need to be maintained:

- School based therapy services available throughout TTUSD (Tahoe Truckee Unified School District) and county partnership
- School Based Wellness Services
- Youth health navigation services
- LGTBQ groups at the high schools
- Multidisciplinary Family Support Team/SMART Team
- County Based Services and expanded mental health supports-Tahoe SAFE Alliance full time therapist, Sierra College full time therapist, Gateway Mountain Centers Whole Hearts Therapeutic Based Mentoring Program expanded and new Truckee Boys and Girls Club site

Current Priorities for expansion of services:

- Expand Transition Age Youth Services
- Increase access to WRAP Services for Truckee youth

Recommendation B: Adults with Severe Mental Illness: Support adults on the path to recovery through comprehensive services that improve their wellness and quality of life. The lack of a critical mass of adults with severe mental illness makes funding comprehensive and intensive services, such as full serve partnerships, challenging.

Current programs that need to be maintained:

- Case Manager position
- Psychiatrist in Placer County
- Nursing support in Nevada County

Current Priorities for expansion of services:

- Increase access to full service partnership type of services
- Supportive housing
- Peer programming
- Increased opportunities for social connectedness

Recommendation C: Homeless Issues: Maintain and expand services and supports for individuals experiencing Homelessness.

Current programs that need to be maintained:

- Weather-triggered Emergency Warming Center
- Homeless Outreach Coordinator
- Successful homeless count

Current Priorities for expansion of services:

- Better coordination with Law Enforcement and Tahoe Forest Hospital District
- Build connections with shelter programs elsewhere so that the homeless can be connect to services.
- Work with county partners to bring new programs for homeless people like Whole Person Care to Eastern County
- Convene jurisdictional partners (leadership from the two counties and Town of Truckee) to look at resources and solutions
- More affordable housing including supported housing

Recommendation D: Suicide Prevention and Crisis Services: Decrease the number of suicides through effective prevention and crisis response programs. The incidence of suicide continues to be a concern for the Tahoe Truckee community, and while there has been an increase in prevention and postvention capacity, more work in this area is still needed.

Current programs that need to be maintained:

- Successful Know the Signs campaign reaching 4,000-5,000 local residents
- Ongoing Suicide Prevention Coalition with expanded focus on adults as well as youth
- Implementation of youth lead prevention messaging through Giving Voices Project
- Creation of Suicide Response Protocol to assist with brining prevention efforts into the post-suicide setting

- Improve functioning of 5150 process

Current Priorities for expansion of services:

- Continue to strengthen follow up for people assessed for 5150
- Explore off site crisis assessment (right sizing mobile response)
- Grow suicide prevention messaging campaign for males and seniors
- Strengthen community capacity for targeted suicide crisis response

Recommendation E: Cultural Competency: Improve capacity to provide culturally competent mental health services. The Tahoe Truckee region has a growing number of Latino residents, many of whom are monolingual Spanish speakers. It is a struggle to provide adequate services that are culturally appropriate and linguistically accessible. In addition there is a lack of people with lived experience working in the mental health system.

Current programs that need to be maintained:

- Growth of Promotora programs
- Creation of high school groups for LGBTQ youth

Current Priorities for expansion of services:

- Increase Medi-Cal managed care network for Spanish speaking providers
- Address "thinness" of system- need some redundancy so system is not so reliant on a few providers
- Increase number of people with lived experience embedded in the mental health system
- Support family and community engagement strategies such as Parent University which focuses on GED (General Equivalency Degree), ESL (English as a Second Language), computer literacy and career exploration.

Recommendation F: Drug and Alcohol Services: Decrease the rates of drug and alcohol use and abuse in the region.

Current programs that need to be maintained:

- Refunding of Future without Drug Dependence
- Tahoe Forest Hospital District adoption of SBRT (Screening, Brief Intervention and Referral to Treatment) and Craft Screenings.
- Gateway Mindfulness Based Substance Abuse Treatment (MBSAT)
- Positive trend lines around youth alcohol use
- Growing success of school based programs through CoRR (Community Recovery Resources).

Current Priorities for expansion of services:

- Streamline access to county authorized detox and residential treatment services
- Continue to explore alternative/expanded drug and alcohol treatment options
- Continue to explore "after-care" support services for youth to create a culture of recovery.

Nevada County Mental Health Services Act (MHSA) Annual Progress Report for Fiscal Year 2015/2016

Overall Implementation Progress Report on Fiscal Year (FY) 2015/2016 Activities

General Nevada County Information:

Nevada County is a small, rural, mountain community, home to an estimated 99,107 (2016 US Census Bureau estimate https://www.census.gov/quickfacts/) individuals. According to the 2016 US Census estimate over 93% of the Nevada County residents identified their race as White, while over 3% of residents combined identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander. Additionally, 3% identified themselves by two or more races. In regards to ethnicity, an estimated 85.4% of the population identified as Non-Hispanic or Latino and 9.5% of the population of Nevada County identified themselves as Hispanic or Latino. Therefore, Nevada County's one threshold language is Spanish.

The county lies in the heart of the Sierra Nevada Mountains and covers 958 square miles. Nevada County is bordered by Sierra County to the north, Yuba County to the west, Placer County to the south, and the State of Nevada to the east. The county seat of government is in Nevada City. Other cities include the city of Grass Valley and the Town of Truckee, as well as nine unincorporated cities.

Notes:

The definition of "unduplicated number (N)" seen throughout the report; this refers to the count of each individual once, regardless of the number of services received or groups attended in the fiscal year.

Due to the small population of Nevada County, participant confidentiality is a concern. Only the unduplicated total number of program participants will be reported. Program participants' demographic information (e.g., race or gender) will not be reported here, but will be submitted to the MHSOAC separately.

MHSA Program Updates:

Community Services and Supports (CSS)

Full Service Partners:

VICTOR COMMUNITY SUPPORT SERVICES' (VCSS)

Program Description

Program Overview

Intensive Treatment Services Program in Grass Valley serves children diagnosed with a serious emotional disturbance or mental illness and their families through three modalities. The Assertive Community Treatment (ACT) model provides mental health services, case management, medication support, crisis intervention; Therapeutic Behavioral Services (TBS); and Family Vision Wraparound which provides case planning and therapeutic services. This report covers outcomes for children and youth being served through any of these modalities. Victor Community Support Services (VCSS) clinicians and staff create individualized service plans for each youth and family and work to build upon each family's unique strengths, needs, and existing community supports. Almost all services are delivered within the homes, schools, and communities of the youth and families served.

During fiscal year 15/16 Victor reduced their management structure to a .5 FTE Director and two clinical supervisors. There were no other significant changes in the program.

Target Population

MHSA ACT services are targeted to serve Nevada County children and their families. These children/youth meet the established Nevada County criteria for identification as seriously emotionally disturbed or seriously mentally ill. Welfare and Institutions Code Section 5878.1 (a) specifies that MHSA services be provided to children and young adults with severe mental illness as defined by WIC 5878.2: those minors under the age of 21 who meet the criteria set forth in subdivision (a) of 5600.3- seriously emotionally disturbed children and adolescents. Services are provided to children up through age 22 that meet program eligibility requirements.

Evaluation Activities and Outcomes

- **Housing**: During fiscal year 15/16, 98% of the 100 individuals served remained in a community living situation and avoided a higher level of residential care. One person experienced a group home placement, and one experienced temporary homelessness.
- **Employment and education**: VCSS achieved its contractual goal of ensuring at least 80% of parents report youth maintained a C average or improved on their academic performance;

97% of parents surveyed reported their child maintained a C average or improved their academic performance. Additionally, based on the CANS (Comprehensive Child and Adolescent Needs and Strengths) item "Academic Achievement," 84% of individuals were maintaining at least a C average and were not failing any classes at discharge.

VCSS achieved its contractual goal of ensuring at least 75% of youth maintain regular school attendance or improve their school attendance; 94% of discharged individuals reported regular school attendance or improvement in school attendance (based on the CANS item "School Attendance").

VCSS achieved its contractual goal of ensuring that at least 70% of youth have no new suspensions or expulsions between admit and discharge; 84% of individuals did not experience a suspension or expulsion in FY 15/16.

- **Criminal Justice involvement:** VCSS achieved its contractual goal of ensuring at least 70% of youth have no new legal involvement (arrests/violations of probation/citations) between admission and discharge. In FY 15/16, 94% of individuals had no new legal involvement while receiving services.
- **Acute Care Use**: Ninety-seven percent (97%) of individuals served did not experience a psychiatric hospitalization during this fiscal year.
- **Emotional and Physical Well Being**: Throughout the 2015/2016 fiscal year, VCSS Grass Valley successfully supported the strengthening and development of individual, caregiver, and family members' emotional and physical well beings.

  VCSS achieved its contractual goal of ensuring at least 65% of children being able to identify at least one lifelong contact. Based on the CANS item, "Relationship Permanence," 100% of individuals served were able to identify at least one lifelong contact.

  VCSS achieved its contractual goal of at least 80% of parents/caregivers reporting an increase in their parenting skills. In FY 15/16, 92% of surveyed caregivers reported they learned additional strategies to address behaviors at home.

  VCSS achieved its contractual goal of ensuring at least 75% of caregivers report maintaining or increasing connection to natural supports. Seventy-eight percent of surveyed caregivers reported maintaining natural supports and 76% reported increased connections in the community.

  VCSS achieved its contractual goal of ensuring at least 80% of individuals improve their scores on the CANS instrument between intake and discharge. During FY 15/16, 84% of individuals with a planned discharge improved in at least one of the following CANS domains: Life Functioning, Mental Health/Behavioral/Emotional Needs, Risk Behaviors, and Educational Needs. CANS outcomes for FY15/16 planned discharges were strong, with 71% improving in Life Functioning, 65% improving in Mental Health/Behavioral/ Emotional Needs, 92% improving in Risk Behaviors, and 71% improving in Educational Needs.
- **Service Access and Timeliness**: Excluding transfers between reporting units, there were a total of 51 discharges in this fiscal year. For the 2015/2016 fiscal year, the average length of service (ALOS) for the discharge population was 13.2 months, 9% shorter than the ALOS of the previous fiscal year.

VCSS has a contractual goal of attempting initial contact with referrals within three (3) business days of receipt of referral. While initial contact was attempted for all individuals within three days, initial contact was successfully made with 67% of referrals in this period.

VCSS achieved its contractual goal of making face-to-face contact with 60% of referrals within ten (10) business days of receiving the referral, serving 85% of referrals within ten days.

- Outreach and Engagement was provided to 38 potential partners throughout FY 15/16.

Challenges, Solutions, and Upcoming Changes

A major barrier to service is the difficulty of communicating with individuals. Individuals and referrals frequently lack a phone or available phone-minutes, and cell phone service can be limited in rural areas. As a result, it can be hard to establish and maintain contact with referrals and contacts. To ensure individuals receive service and support, VCSS has occasionally provided reloadable cell phones for individuals in need.

Full Service Partners:

UPLIFT FAMILY SERVICES

Program Description

Program Overview

Uplift Family Services is a wraparound/full service partnership program that serves families of youth who have a serious mental illness or serious emotional disturbance, and are either at imminent risk of out-of-home placement or are returning from an out-of-home placement. The program philosophy includes developing individualized service plans for each youth and family in order to wrap services around the family which build upon their unique strengths and needs. Traditional and non-traditional support services are provided to participating youth and families with the ultimate goal of stabilizing each youth so that s/he can be successful at home, in school and in their community.

Target Population

Wraparound services are targeted to Nevada County children and young adults and their families who meet the established Nevada County criteria for identification as seriously emotionally disturbed or seriously mentally ill child/youth. Welfare and Institutions Code Section 5878.1 (a) specifies that MHSA services will be provided to children and young adults with severe mental illness as defined by WIC 5878.2: those minors under the age of 21 who meet the criteria set forth in subdivision (a) of 5600.3- seriously emotionally disturbed children and adolescents. Services can be provided to children up through age 21.

Evaluation Activities and Outcomes

Ninety-six individuals were served by this program in FY 15/16.

- **Length of Stay** - Since inception, the average length of stay, for the 233 youth who were enrolled for 60 days or more, is 15 months. For youth discharged in FY 15/16, 29 youth had a length of stay of 60 days or more, and had an average length of stay of 22.51 months.
- **Youth will Improve Functioning** - Since 2011, 97 matched pairs first completed/discharge Child and Adolescent Needs and Strengths (CANS) tool were available to analyze. Seventy-eight percent of youth improved in at least one domain based on the Reliable Change Index (RCI). In FY 15/16, paired data for 17 youth were available and 71% of youth improved in at least one domain based on the RCI.
- **Youth will Identify at least One Lifelong Contact** - Since 2011, 97% of youth maintained or increased lifelong contacts. In FY 15/16, 95% of youth maintained their lifelong contacts.
- **Caregivers will Maintain or Increase Connections to Natural Supports** - Since 2011, 95% of caregivers maintained or increased their connections to natural supports. In FY 15/16, 93% of caregivers maintained their connections to natural supports.
- **Youth will be Stabilized at Home or in Foster Care** - Since inception, 84% of youth who participated in the Nevada Wraparound Program for at least 60 days were stabilized at home or in foster care at discharge. In FY 15/16, 80% of youth were stabilized at home or in foster care at discharge.
- **Youth Will Attend School Regularly** - Since 2011, 94% of discharged youth maintained regular school attendance or improved by attending school 4+ days/week. In FY 15/16, 87% maintained or improved their school attendance.
- **Youth Will Improve Academic Performance** - Since inception, 76% of discharged youth maintained their academic performance or improved their school achievement during participation in the Nevada County Wraparound Program. In FY 15/16, 88% of youth maintained or improved their school achievement.
- **Youth Will Be Out of Legal Trouble** - Since 2011, 93% of discharged youth maintained zero arrests, probation violations, or days spent in custody in the six months prior to FSP program discharge. Eight percent of youth with a history of juvenile justice involvement since 2011 reduced their involvement from admit to discharge. In FY 15/16, 94% of youth remained out of trouble while 50% of youth with a history of involvement reduced occurrences with the juvenile justice system.
- **Reason for Discharge** - Since inception, 58% of youth with a length of stay of 60 days or more, discharged from the program because they met their treatment goals. For the 29 youth who discharged in FY 15/16, and had a length of stay of 60 days or more, 52% were discharged because they met their treatment goals.
- **Percent of Youth and Families Satisfied** - Since inception, 75% of caregivers and 59% of youth indicated satisfaction with the program. In FY 15/16, 72% of caregivers and 60% of youth indicated satisfaction with the program. Satisfaction is defined by an average total score of 4.0 or higher.

Goals	Measures	FY 16 Actual Outcome
80% of youth will improve functioning.	CANS Score – RCI; paired admit & discharge CANS	71% (n=12/17)
80% of parents will report an increase in their parenting skills.	CANS CGSN Domain – RCI; paired admit & discharge CANS	21% (n= 3/15)
65% of youth will be able to identify at least one lifelong contact.	CANS LDF Relationship Permanence Item – rating of 0-2; paired admit & discharge CANS	95% (n=16/17)
75% of caregivers will report maintain or increase connections to natural supports.	CANS CGSN Social Resources – rating of 0-2; paired admit & discharge CANS	93% (n=13/14)
80% of youth will be stabilized at home.	Master-client Living Situation, CEDE – *Home is defined as Bio/Adopt, foster care, ILP, guardianship, kinship, and family friend;* Paired admit & discharge CEDE	80% (n=23/29)
75% of youth will maintain regular school attendance or improve their school attendance.	CANS LDF School Attendance Item; paired admit & discharge CANS	87% (n=14/16)
70% of youth with a history of suspensions or expulsions will have no new occurrences.	CEDE School Suspensions & School Expulsions; paired admit & discharge CEDE	100% (n=1/1)
80% of parents will report youth will maintain a C average or improve their academic performance	CANS LDF School Achievement; paired admit & discharge CANS	88% (n= 14/16)
70% of youth with history of legal involvement will have no new legal involvement (arrests/violations of probation/citations).	CEDE Arrests, Sustained Offenses, Probation Violations, Days in custody items - paired admit & discharge CEDE	50% (n=1/2)
72% of youth will have an initial contact attempted by the agency within 3 business days of receipt of referral	TIER	81% (n=13/16)
60% of youth will have a face-to-face contact with the agency within 10 working days of receiving the referral.	TIER	57% (n=24/42)
80% of youth and families will be satisfied with services.	YSS, YSS-F (% satisfied = mean score of 4 or higher on Total Satisfaction)	YSSF: 72% (n= 23/32) YSS: 60% (n=18/30) Adult Survey: 100% (n=2/2)

- Outreach and Engagement was provided to 250 potential partners throughout FY 15/16.

Challenges, Solutions, and Upcoming Changes

Uplift Family Service's Nevada County Wraparound program experienced significant staff turnover and vacancies in FY 15/16. This presented challenges in maintaining staff morale and ongoing engagement with families. To combat this issue Uplift Family Services implemented enhanced recruitment and hiring strategies. The implemented strategies were successful in filling all vacancies by the end of the fiscal year. Despite these staffing limitations, the program was able to maintain its contracted census throughout the fiscal year.

Client Story

Seth (name changed to protect confidentiality) is a 12 year old male who, together with his family, participated in Uplift's Wraparound FSP program during Fiscal Year 2015/2016. Seth and his family have many admirable qualities. Seth is a bright, outgoing, friendly young man who enjoys many sports and is skilled in baseball. He is creative and fun to be around. His mother is very resourceful and works hard to provide for her family. She is diligent and a strong advocate for her son. The family has demonstrated persistence and resilience over the years.

At the time of referral to Uplift, Seth and his mother were homeless and staying with the maternal grandmother off and on. Seth's mother was unemployed and struggling with substance abuse and extreme anxiety. Seth was referred to services for emotional outbursts including verbal and physical aggression at home and at school. He had been receiving special education services to support his behavioral-emotional needs since age 5.

Uplift and the family developed a plan together that included behavioral interventions in the classroom and at home to support emotional regulation and the development of coping skills. Uplift worked with the mother on implementing parenting strategies in the home setting and supported the mother with identifying and accessing community resources to address complex family needs related to mental health, substance use, self-care, and basic needs. In addition, Uplift supported the family with making and strengthening connections with positive natural supports.

Seth was eventually able to mainstream into the general education setting and has been performing at grade level without the need for behavioral support. He is now a solid A/B student, is involved in school sports, is playing baseball and participates in community youth programs. During the course of services, the family obtained stable housing via the Housing Choice Voucher Program (formally called Section 8) and qualified for Social Security income. As Seth's behaviors and his mother's symptoms of anxiety improved, his mother was able to maintain full-time employment and transitioned the family off of Social Security Insurance. Seth transitioned to a lower level of care, continuing therapy with an outpatient therapist and the family has successfully graduated from Uplift's Wraparound program.

Full Service Partners:

TURNING POINT COMMUNITY PROGRAMS
Providence Center

Program Description

Program Overview
Turning Point Community Programs (TPCP) - Providence Center provides Adult Assertive Community Treatment (AACT), an evidence-based practice that supports individuals with a severe psychiatric illness at risk of or with a history of psychiatric hospitalization, incarceration, or out-of-home placement. AACT individuals are sometimes homeless, at risk of being displaced from family, jobs, etc. or at risk of losing access to basic needs. AACT is designed to help adults (18 years and older) with a severe psychiatric illness with recovery oriented services and supports. Individuals served may also have a co-occurring substance use or medical issue requiring treatment. Services are provided in the community, hospital (medical or psychiatric), or correctional facility settings and are available 24 hours a day, seven days a week. Services are grounded in a culturally responsive, respectful manner that fosters independence, self-determination and community integration.

Included in AACT services are individuals who may also meet criteria for Assisted Outpatient Treatment (AOT). AOT, also known as Laura's Law, offers an opportunity for individuals who meet specific criteria to receive needed mental health treatment through an alternative court process. While AACT and AOT treatment are virtually the same, the criteria for AOT are greatly narrowed. In order to receive AOT services, an individual must reside in the county where they would receive treatment, be a minimum of 18 years of age, have a serious mental disorder, and must be unlikely to survive safely in the community. They must also have a lack of adherence with treatment indicated by: two out of 36 months in hospital, prison, jail and/or one out of 48 months with serious and violence acts, threats, attempts to self/others. Additional criteria include the following:

- The person has been offered an opportunity to participate in treatment and either failed to engage or refused
- Condition is deteriorating
- Least restrictive placement
- Necessary to prevent 5150 condition
- Will benefit from treatment

Target Population
The AACT target population consists of individuals over the age of 18 with severe mental illness (SMI).

Included in AACT services are individuals who may also meet criteria for Assisted Outpatient Treatment (AOT), designed for members who, in addition to having a severe psychiatric

disability, may have committed an act of violence or made a serious threat of violence (within 48 months of the AOT referral) due to untreated mental illness.

Evaluation Activities and Outcomes

- **AACT:**

OUTCOMES OF DISCHARGED INDIVIDUALS

- Total # of Discharges during reporting period
  - o 41 Discharges
- Discharge Settings (top 2)
  - o 43.9% of Individuals Chose to Discontinue Services
  - o 26.8% discharged to a Lower Level of Care

DOMAIN OUTCOMES

Psychiatric Hospital Days

- Total Psychiatric Hospital Days for reporting period
  - o 612 Days
- Number of Individuals Accruing Psychiatric Hospital Days
  - o 15.4% of Individuals
- Number of Individuals Accruing Zero Psychiatric Hospital Days
  - o 84.6% of Individuals

Jail Days

- Total Jail Days for reporting period
  - o 632 Days
- Number of Individuals Accruing Jail Days
  - o 15.4% of Individuals
- Number of Individuals Accruing Zero Jail Days
  - o 84.6% of Individuals

Homeless days

- Total Homeless Days for reporting period
  - o 2,440 Days
- Number of Individuals Accruing Homeless Days
  - o 26.5% of Individuals
- Number of Individuals Accruing Zero Homeless Days
  - o 73.5% of Individuals

Emergency Interventions

- Total Emergency Interventions for reporting period
  - o 104 Emergency Interventions
- Number of Individuals Accruing Emergency Interventions
  - o 24.8% of Individuals
- Number of Individuals Accruing Zero Emergency Interventions
  - o 75.2% of Individuals

MILESTONE OF RECOVERY SCALE (MORS)
Of the 117 unduplicated individuals served within the 15/16 Fiscal Year, 48.7% received a MORS score in both July 2015 and June 2016. The 21 individuals who were admitted after July 2015 and the 29 individuals who were discharged before June 2016 are not included within the report as they do not have a true pre-post comparison. Only those 57 individuals are included within this analysis.

One positive outcome is that the number of individuals who were high risk/engaged in July 2015 decreased by 50.0%. Another positive outcome is that the number of individuals who were at an extreme risk in July 2015 decreased by 80.0%. Also, the number of individuals who were at an early recovery in July 2015 increased by 70.0%.

The average score and the most common score within the fiscal year remained at a six (Coping/Rehabilitating). Additionally, of the 57 individuals included within this analysis, 38.6% increased their score, with scores increasing by one to six levels.

CONSUMER SATISFACTION SURVEY
All TPCP programs disperse the Consumer Satisfaction Surveys as part of each individual's annual assessment. In order to properly present the outcomes, only individuals who have a least one year's tenure within the program, have an annual cycle come due, and are still enrolled within the program during the reporting period are included within the outcomes below.

Between July 2015 and June of 2016, of the 117 individuals served, a total of 69.2% of surveys were administered. The remaining 36 were not distributed due to the individual either being too new to the program or not having their annual cycle come due for review by the end of the reporting period. Of the 81 surveys administered, 63.0% completed the survey. The remaining 37.0% declined to participate.

All seven domains had satisfaction rates above the favorable 80% threshold, which is a very positive outcome. Overall, the Providence Center received a favorable satisfaction rate of 84.6%.

- **AOT:**

DOMAIN OUTCOMES
Psychiatric Hospital Days
Between May 1, 2015 and March 15, 2016, a total of 208 psychiatric hospital days were accrued by five individuals or 35.7% of the total 14 individuals observed. The majority of individuals (64.3%) did not accrue any psychiatric hospital days in the reporting period. Additionally, one individual accrued 108 days, or 39.6%, of the total 273 psychiatric hospital days suggesting the presence of outliers.

# of Days Accrued by Those Who Volunteered to Receive Services	0 (0.0%)
# of Days Accrued by Those Who Were Court Ordered	208 (100.0%)

Jail Days
Between May 1, 2015 and March 15, 2016, a total of two jail days were accrued by 1 individual or 7.1% of the total 14 individuals observed. The majority of individuals (92.9%) did not accrue any jail days in the reporting period.

# of Days Accrued by Those Who Volunteered to Receive Services	0 (0.0%)
# of Days Accrued by Those Who Were Court Ordered	2 (100.0%)

Homeless Days

Between May 1, 2015 and March 15, 2016, a total of 273 homeless days were accrued by five individuals or 35.7% of the total 14 individuals observed. The majority of individuals (64.3%) did not accrue any homeless days in the reporting period. Additionally, two individual accrued a sum of 205 days, or 75.1%, of the total 273 homeless days suggesting the presence of outliers.

# of Days Accrued by Those Who Volunteered to Receive Services	103 (37.7%)
# of Days Accrued by Those Who Were Court Ordered	170 (62.3%)

Emergency Interventions

Between May 1, 2015 and March 15, 2016, a total of eight emergency interventions (EIs) were accrued by four individuals or 28.6% of the total 14 individuals observed. The majority of individuals (71.4%) did not accrue any EIs in the reporting period.

# of Days Accrued by Those Who Volunteered to Receive Services	0 (0.0%)
# of Days Accrued by Those Who Were Court Ordered	8 (100.0%)

MILESTONE OF RECOVERY SCALE (MORS)

Out of 14 individuals served in May 2015 and April 2016, 10 have been included in the following analysis (four individuals were excluded due to insufficient data points). Each individual's first MORS score following their referral date has been compared to their most recent MORS score. Some individuals have been discharged within the time frame; however, the majority had their most recent score given within the month of February 2016 (March scores are not entered until mid-April).

On average, at the time the first MORS score is assigned, the majority of individuals were at Poorly Coping/ Engaged (a score of 5) (80.0%). At the time of their most current MORS score assignment the majority were either Poorly Coping/Engaged with staff (a score of 5) (40.0%) or Coping/Rehabilitating (score 6) (30.0%). Overall, 60.0% of the individuals included in the analysis had an increase between their initial to their most current MORS score, ranging from 1 to 3 score levels. This is a very positive outcome showing that progress was made towards recovery once the Providence Center began providing services.

CONSUMER SATISFACTION SURVEY

Between May 2015 and March of 2016, of the 14 individuals served, a total of 28.6% of surveys were administered. The remaining 10 were not distributed due to the individual either being too new to the program or not having their annual cycle come due for review by the end of the reporting period. Of the four (4) surveys administered, 75.0% completed the survey. The remaining 25.0% declined to participate.

All seven domains had satisfaction rates above the favorable 80% threshold, which is a positive outcome. Overall, the Providence Center AOT individuals received a favorable satisfaction rate of 86.2%.

- Outreach and Engagement was provided to 168 potential partners throughout FY 15/16.

Full Service Partners:

NEW DIRECTIONS

Program Description

Program Overview

The New Directions Program in Nevada County Behavioral Health Department is a lite AACT program, which serves individuals with severe, persistent mental health issues and accompanying challenges to daily living. The program facilitates consumers transitioning from county services to independence and community living. In previous years reporting on this program included both Full Service Partners and less acute non-Full Service Partners. For FY 15/16 the numbers reported here only include Full Service Partners participating in the New Directions Program. For that reason, the numbers may be lower in FY 15/16 than reported in previous years. Consumers in the following age categories were served in FY 15/16: three Transitional Aged Youth (16-25 years), 37 Adults (26-59) and 18 Older Adults (60 years and above). The New Directions team maintains a strong commitment to providing services which include Supported Independent Living, Supported Employment, educational and therapy groups, individual therapy and WRAP (Wellness Recovery Action Plans). During FY 15/16 New Directions provided services to 58 consumers across the three age categories.

Service Intensity:

During the FY 15/16 service intensity varied by individual for the 58 participants served. The focus of increased services across all age categories is to decrease hospitalization by utilizing intense case management, temporary placement at Odyssey House transitional home, medication caddy services, and nightly calls to the most high risk consumers. Comparing the year before partnership to the second year of receiving services through New Directions, the number of individuals in a Psychiatric Hospital decreased from five to four. The number of participants in an Emergency Shelter decreased from two to one. The number of individuals in Residential Placement remained the same at five and the number of participants Supervised decreased from five to three.

Program Options:

Housing:

- *Self-Sufficient Support (S^3)* - Residents who are successfully capable of living independently with minimal support are classified as "self-sufficient". These participants receive support on an "as needed" basis from Personal Service Coordinators (PSC). The residents are able to handle and problem solve most basic daily situations of independent living. Comparing the year before partnership to the first year of receiving services through New Directions, the number of Independent Living days increased from 4,846 to 5,385 days. Also, comparing the year before partnership to the second year of receiving services through New Directions, the number of Homeless days decreased from 423 to 234 days.

- *Supported Independent Living (SIL)* - Residents need regularly scheduled support to remain successful in independent living. Identified shared houses are supported by Nevada County Behavioral Health in the following manner:
  - Deposits are paid by MHSA flex funds.
  - If a room is vacant, MHSA funds are used to pay the monthly rent to maintain stability of the house until residents can locate a new housemate.
  - A "basic needs" list for residents is created by staff and obtained by either individuals' resources, donations and/or MHSA flex funds.
  - PSCs provide support with medication, housemate conflict resolution, money management skills, paying bills, meal planning, budget planning, shopping, leisure skill planning and other daily living skills.
  - PSCs work with landlords to ensure support for both the resident and the landlord.
- New Directions continued support for the six SIL (Supported Independent Living) houses, housing 11 people.
- Housing was provided for eight homeless adults or previously homeless adults who struggled with severe and persistent mental illness using subsidies from the HUD Supported Housing Program grants. This included Winters' Haven house and scattered sites in the Summer's Haven and Home Anew Projects. See MHSA Housing section of this report for more details.
- *The Catherine Lane House (a joint venture with Turning Point)* - The Catherine Lane House offers 24/7 support services to residents with independent living skills challenges. This permanent supported house includes a focus on single room occupancy that facilitates residents in achieving their maximum level of independence. This house enables residents to live independently and keep their current community support network intact. In FY 15/16 the New Directions Program had one participant living at the Catherine Lane House.
- *The Willo House*- The Willo House is a program which provides intensive support services for participants who are on conservatorship or in need of one or more staff contacts per day. This setting provides participants an opportunity to live in the community with greater independence than an IMD (Institute for Mental Disease) or Board and Care facility. The Willo House is a three bedroom unit. In FY 15/16 the New Directions Program housed two participants in Willo House.

The Supported Housing component of the New Directions program continues to have challenges related to staffing restrictions. These restrictions limit the number of units which can be adequately developed and managed to meet the participant's needs.

Employment/Volunteer Employment:

- *Snack Shack* - Vocational training is available through the Snack Shack program. The Snack Shack program is a collaborative effort between NAMI, the Behavioral Health Department and Consumers. It is a consumer driven retail program providing vocational skills and structure. Participants learn customer service, cash register skills and team building. Management of the program is provided by consumers and a consumer with bookkeeping experience balances the receipts. In FY 15/16, six participants volunteered to work in the Snack Shack program for a total of 1,345 hours.
- *Peer Support Training* - Peer Support Training is an eight month program where consumers develop skills to counsel and support peers. The goal of the support services is to promote self-empowerment, independence and interdependence, facilitating consumers functioning and thriving in their community. Training requirements are no more than four missed

sessions and completion of a mock peer support session. The training offers two outcomes: 1) a certificate of graduation or 2) a certificate of participation. Consumers are then introduced to volunteer opportunities in the community. In FY 15/16, nine participants completed Peer Support Training and within the graduates of the program:

- Six participants took the training for personal enrichment.
- One participant helped manage a clean and sober supportive living home.
- Two participants worked for Respite Center positions.

Peer support challenges continue. As peer support continues to expand, so does the need to find paid or volunteer community placements for program graduates. Ongoing outreach to community based agencies and groups is continually needed to provide options for graduates to utilize their skills. Additionally, once a Peer counselor has a paid or volunteer position in the community they typically need intermittent support. Staff members schedule an alumni meeting once a month to provide support for the individuals working in the community. Staff members also facilitate visits to other agencies to foster knowledge of future referral resources, as well as meet prospective employers.

Supportive Services:

- *Weekly Groups:*
  - Healthy Living - Healthy Living courses provide education to consumers and healthy options for independent living. Choices include coping and time management skills; nutrition, social and budgeting skills; leisure and development of Wellness Recovery Action Plans (WRAP) and social activities based in the community.
  - Saturday Adventure Outings - Saturday Adventure Outings serve high risk consumers who have a history of being isolated on weekends. The goal of the program is to engage these individuals socially with other peers that result in decreased symptoms of mental health issues and increased quality of life. The consumers organize the adventure and determine the activities each week. Two peer staff members provide transportation utilizing Behavioral Health vehicles. The staff also provides support and referral services during the program. This creative solution has enabled individuals to access social interactions through activities they determine. In FY 15/16 the New Directions Program had two participants in the Saturday Adventure Outings program who were Full Service Partners. The lead therapist/program team coordinator provided qualitative data in collaboration with the larger Behavioral Health clinical team indicating that this program had a direct role in reduction of symptoms and the need for more intensive services for program participants.
- *Therapy Support and Service Coordination:*
  - Therapy services are provided by interns through the intern program. The program offers an opportunity for interns to be trained in the mental health field while offering services to individuals who might otherwise wait or not receive individual therapy services. The long term benefit is quality services for the consumer and training for a new generation of clinicians who have developed skills which they will bring to a variety of community based settings.
  - The Interns are individuals in the process of completing or who have completed their Master's degree in psychology, sociology or a related field. Supervision is provided by a licensed therapist with the New Directions Program.
  - Program treatment options range from service coordination to providing mental health rehabilitation, including medication delivery.

  - Individual and group therapy provides participants the opportunity to further their goals of developing healthy life options, including choosing the abstinence or harm reduction model for recovery from substance use disorders as a component of their co-occurring disorder.
- *After Hour Services* - Nevada County is a small county and resource availability within the Behavioral Health Department is limited, given budget constraints. In order to meet the criteria of 24 hour/seven day a week services, the following adjunct supports have been developed for holidays, weekends and overnight coverage. Individuals have use of the 24 hour crisis line of Nevada County Behavioral Health as a contact resource. They have the further option of requesting contact with the program team coordinator or designee alternate for support in managing critical issues through the crisis line. For participants in New Directions utilizing daily medication deliveries, service coordinators from Behavioral Health make weekday morning deliveries.

Evaluation Activities and Outcomes

Notable community impact is reflected by these program outcomes.

- Decreased hospitalizations were recorded. Comparing the year before partnership to the second year of receiving services through New Directions, the number of individuals in a Psychiatric Hospital decreased from five to four.
- There was a decrease in legal issues (six individuals with arrests prior to partnership, decreased to four partners with arrests during the first year of service).
- Independent Living was maintained or increased which reduces the impact on community based homeless resources. Comparing the year before partnership to the first year of receiving services through New Directions, the number of Independent Living days increased from 4,846 to 5,385 days. Also, comparing the year before partnership to the second year of receiving services through New Directions, the number of Homeless days decreased from 423 to 234 days.
- Comparing the year before partnership to the second year of receiving services through New Directions, the number of individuals in Residential Placement remained the same at five and the number of participants Supervised decreased from five to three.
- Programs focused on medication adherence, nutrition and physical health reduced utilization of emergency room services (10 individuals with emergency room visits before partnership, decreased to five partners during the first year of partnership).
- Comparing the year before partnership to the second year of receiving services through New Directions, the number of participants in an Emergency Shelter decreased from two to one.
- The employment program provided enrolled consumers with additional resources which they spent locally and thereby became financially contributing members of the local community.

Program Participant Story

A peer who graduated from the peer counseling program had a remarkable journey in recovery. He had been homeless, addicted to substances, and suffering from PTSD for many years. It took him two separate stints in the peer counseling program to eventually graduate. However, since then he has been a leader among peers. He has been regularly working as peer counselor in a paid position for over a year now.

General System Development:

INTERN PROGRAM EXPANSION

Program Description

Program Overview

In FY 15/16 Intern Program Expansion added service capacity, increased access, and broadened services in Nevada County. Interns and their clinical supervision were funded through CSS GSD. In FY 2015/2016 eleven interns provided 13,074 hours of services to 237 adults (5,532 hours) and 189 children (7,542 hours). Additionally, nine hours of intern supervision were funded by MHSA CSS GSD.

General System Development:

NETWORK PROVIDERS

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) has licensed therapists, Network Providers, who work in the community at private offices. They see children, Transition Aged Youth (TAY), adults and older adults referred to them by NCBH. Nevada County Behavioral Health refers program participants with less acute needs to the Network therapists. These are individuals who do not appear to need medication or significant case management. Network providers help to serve additional individuals and offer individuals and families a variety of specialties and locations that NCBH would not be able to offer otherwise. Network providers are funded under both the Adult and Children's programs within CSS. In FY 15/16 89 unduplicated participants were served. The number served has dramatically decreased from FY 14/15's total of 238 due to contract cuts based on budget constraints.

General System Development:

EXPAND ADULT AND CHILD PSYCHIATRIC SERVICES

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) Children's Services provided Expanded Psychiatric services to 21 children with MHSA CSS funds in FY 2015/2016. Some of the children were being wrapped with Full Service Partner (FSP) providers. Some of these children continue to see the NCBH doctor individually and work with the WRAP team.

Nevada County Behavioral Health Adult Services provided Expanded Psychiatry to Case Management/Auxiliary program participants using General System Development funds. These funds payed for 140 individuals in FY 15/16. Expansion of psychiatry services and expansion of behavioral health services within the Adult System of Care included the same individuals. All Auxiliary program participants received both psychiatric and case management services.

Target Population

The expansion of Adult and Child Psychiatric Services targets FSP, Auxiliary and New Directions program participants who are funded by General System Development.

General System Development:

COMMUNITY RECOVERY RESOURCES (CoRR)
Co-Occurring Disorders (COD) Program, Adolescent Services and Co-Occurring Disorders (COD) Program Adult Services

Program Description

Program Overview

Community Recovery Resources (CoRR): Co-Occurring Disorders (COD) Program, Adolescent Services and Co-Occurring Disorders (COD) Program Adult Services provide services to people struggling with concurrent issues of substance use and mental illness, with program components for both adults and adolescents. The adolescent component also specializes in services to youth in YES Court (Youth Empowerment System, formerly known as Juvenile Drug Court). Co-Occurring Disorders services are an integration of both mental health and substance use treatment. Services are recovery-oriented and driven by the unique needs and strengths of individuals. They are community based, family-centered and culturally relevant. Services

include case management, an individualized myriad of rehabilitative life skills development and therapeutic interventions such as mood management and trauma work. The program is based on a COD best-practices model within a recovery-oriented system of care and employs evidenced-based approaches in an integrated manner within COD specific treatment stages to address and promote mental health and substance use disorders recovery. All COD program services are provided by a multidisciplinary, integrated treatment team that functions within a framework of intensive provider collaboration both internally (within CoRR) and externally (within the greater system of care including Uplift Family Services, Victor Services, Behavioral Health, Probation, Courts, Child Protective Services, etc.).

Target Population

Services are provided to people who have a moderate to severe substance abuse problem and have moderate mental health problems that meet Medi-Cal medical necessity, diagnostic and other criteria for Medi-Cal specialty mental health services. Services include substance abuse treatment, individual and family psychotherapy and evidence based therapy to individuals and their families. Therapy modality is individualized according to individual need. Staff members treat youth in the Yes Court program and utilize the Co-Occurring Disorders (COD) practice where clinically appropriate.

Evaluation Activities and Outcomes

Adult Program Outcomes:
The COD Adult program served 20 unduplicated participants. Of the 20 Adults, 10 remain enrolled, five were completed, two were transferred to other services, one lost her Medi-Cal, one moved out of the area and one withdrew. This is a 50% completion rate over the course of the year (goal was 75%), however this COD program is not time limited, and will move at a pace determined by the enrolled individual's personal need.

The program continues to see a faster than expected increase in the time it takes individuals to move from the pre-contemplative stage to contemplative and action stages/readiness for change (URICA Scale), due to the influence of the service delivery environment. Enrolled individuals have also increased their access to and utilization of Primary Care, also due to satellite medical services onsite in the clinic. Again this year the program tracked data that demonstrated decreases in homelessness and episodes of substance misuse, and increases in employment/volunteerism, reported stable living environments, self-help/social support networks and personal connection for individuals in the COD program. Of enrolled adults 79% were successful in adopting a program of Recovery, and increased understanding of the role of substance misuse/addiction in their lives. Interestingly, the most prevalent drugs of choice for adults remain alcohol and methamphetamine, with an uptick in opioids. Families engaged in services reported greater involvement with the enrolled individual, resolution of conflict and improvement in communication (treatment team tracking, progress notes, assessments, BASIS-24).

The Quality of Life Scale demonstrated improvements in most categories across the scale early on, and as wellbeing increased over time, scores began to drop again for some individuals; a phenomenon attributed to increasing discernment and awareness of how things have been and

what people realize they really want, as people became substance free and emotionally more stable and supported.

Of enrolled individuals 29% reported a reduction in psychological/psychiatric symptoms from initial enrollment, while 37% reported increases in their coping and life management ability (BASIS-24).

Child Program Outcomes:
The COD program served 13 unduplicated youth, 10 of whom were on Juvenile Probation; one remains enrolled at years end, five were successful completions, three were transferred to other services/levels of care, and four withdrew. This is a 30% completion rate over the course of the year (goal was 75%), however this COD program is not time limited, and will move at a pace determined by the enrolled individuals personal need.

The most prevalent drugs of choice for youth were marijuana and alcohol. Of youth served, 100% were misusing substances upon enrollment, 30% became abstinent while in the program; 20% chose to adopt a program of recovery to achieve abstinence and shift their focus; 60% successfully participated in an individualized harm reduction goal and reduced their use of substances while in the program; 100% reported an increased awareness of the role and impact of substances on their lives. There were no incarcerations for new offenses for anyone during their enrollment in services. Four youth became gainfully employed, and one completed community service hours. Twenty percent of participants reported an increase in supportive connections (treatment team tracking, progress notes, and assessments).

Of the 13 enrolled youth 90% had previous significant traumatic events with resulting Mental Health symptoms, and 23% of those demonstrated a reduction in multiple symptoms (YO-Q).

Of youth enrolled 38% had their parents participate in services. Most families that engaged in services identified their own substance misuse as having an impact on their children. Families reported benefiting from psychoeducation/skill building around parenting, communication skills and the dialogue with their children that resulted from their participation in the program.

Challenges, Solutions, and Upcoming Changes

This program was cut to $108,000 for the FY 15/16 resulting in a significant decrease in group services (not enough individuals to support appropriate and effective group milieu's based on individual needs) and a reduction in staffing. The smaller the program, the less group services were possible due to number of available individuals enrolled and the appropriate milieu match for group therapy, skill/rehab groups (i.e. gender specific, trauma focused, Stage of Change, interpersonal capacity). The necessary shift to a primary emphasis on individual modalities limited the benefits to individuals to group learning and social recovery, two of the most effective components of co-occurring treatment. This population continues to experience difficulty maintaining their eligibility for their Medi-Cal benefits, resulting in interruption or discontinuation of full-scope Medi-Cal benefits, the only funding the program can accept. Access to psychiatric services continues to be a barrier, regardless of the program's linkage

efforts. Psychiatrists experienced with this population are significantly limited in Nevada County.

The program has been increased to $145,000 for the upcoming fiscal year, a 33% from FY 15/16. This will increase census.

Program Participant Story

At the time of his treatment at CoRR, Tom (pseudonym) was a middle aged single, man who voluntarily sought treatment due to his inability to stop drinking. He connected his use of alcohol with a need to "numb" intense anxiety that left him unable to manage his life. In adulthood, he was forced to return home to Grass Valley to live with his highly verbally abusive father and passive mother. He experienced severe panic attacks, irritability, hypervigilance, and was reliving of traumatic events from the past; the severe physical abuse he endured at the hands of his father as a child. In CoRR's Co-occurring Disorders Program (COD) Tom was seen by a licensed clinical social worker for individual therapy twice a week and a certified rehab counselor for Substance Use Disorders counseling once per week. Tom agreed to a harm-reduction focus regarding marijuana, with continued total abstinence from alcohol and all other substances. Tom also revealed to his therapist that he was gay, something that he had never disclosed to anyone other than his brother and his former partner. Tom determined his primary treatment goals, which focused on managing his symptoms of PTSD, self-acceptance as a gay man, and decreasing use of marijuana while maintaining abstinence from all other substances.

He soon responded to his treatment team's use of motivational interviewing, psychoeducation to understand the connection between his PTSD and alcohol use disorder, and training on effective tools to manage his symptoms of severe anxiety. Training tools included diaphragmatic breathing techniques and Cognitive Behavioral Therapy skills. He was also referred to Western Sierra Medical Clinic for support with nutritional changes and to encouraging an exercise program. Tom responded well to his team's use of unconditional positive regard and non-judgmental stance throughout his treatment. He reported a decrease in the intensity of his anxiety when his PTSD symptoms were triggered. He continued to maintain his abstinence from alcohol and attended one self-help group per week, which he reported enjoying very much. He found a sponsor, a woman who identified as lesbian, and began step work with her. Tom became focused on moving out of his parents' home, getting employed, and returning to an ideal weight. In attending to his health, he made the decision to stop all use of marijuana. At one year in the COD program and being clean and sober, Tom was offered a coaching job at a private all-female high school out of state. He readily accepted the job. At his COD team's suggestion, he attended 12-step meetings each time he flew to his new home state. He also connected with a large LGBTQ program that offered support groups and therapy.

Tom did not hesitate to connect his success with managing his co-occurring disorders to the treatment team's work with him in COD. He has kept in touch with a member of the team through occasional emails, and reported in his last email that he felt "happy, joyous and free."

General System Development:

EXPAND ADULT AND CHILD MENTAL HEALTH SERVICES

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) Children's Services provided Expanded Mental Health services to 47 children with MHSA CSS funds in FY 2015/2016. Some of the children were being wrapped with Full Service Partner (FSP) providers. Some of these children continue to see NCBH staff individually and work with the WRAP team. This data excludes services provided by interns. Intern services are funded separately.

Nevada County Behavioral Health Adult Services provided Expanded Mental Health services to Case Management/Auxiliary program participants using General System Development funds. These funds payed for 140 individuals in FY 15/16. Expansion of psychiatry services and expansion of mental health services within the Adult System of Care included the same individuals. All Auxiliary program participants received both psychiatric and case management services. This data excludes services provided by interns. Intern services are funded separately.

Target Population

The expansion of Adult and Child Mental Health Services targets FSP, Auxiliary and New Directions program participants who are funded by General System Development.

General System Development:

CRISIS WORKERS
CRISIS SUPPORT TEAM

Program Description

Program Overview

MHSA funding provides a Crisis Worker Position and Crisis Support Team at the Crisis Stabilization Unit at the local Sierra Nevada Memorial Hospital. They are available 24 hours a day, seven days a week. These services are exclusive to western Nevada County. Funding sources used to support the Crisis Services included Medi-Cal, Senate Bill 82 Triage Grant, 1991 Realignment funds, MHSA-CSS funds.

The crisis workers provided direct crisis intervention services to program participants by phone contact and face-to-face evaluation. Crisis staff also responded to other locations as required including Sierra Nevada Memorial Hospital, Wayne Brown Correctional facility, and juvenile

hall. Workers collaborated with other human service providers and law enforcement to determine whether hospitalization was required and what resources for referral were appropriate.

In early December 2015, the Crisis team was trained on using Nevada County Behavioral Health's (NCBH) Electronic Health Record system, Anasazi.

On December 16, 2015 the Crisis Response Team moved to new offices within the Crisis Stabilization Unit (CSU), and the CSU began to accept individuals. This offered an integrated service where people being held on a 5150 could, if appropriate, be moved from the hectic atmosphere of the local emergency room to a higher and more appropriate level of care at the CSU. It also offered a place where individuals experiencing a crisis could stay for 23 hours on a voluntary basis with therapeutic help, and perhaps, eliminate the need for a 5150 hold.

Evaluation Activities and Outcomes

In FY 15/16 853 individuals received Crisis Services. These individuals receiving mental health services, by six (6) month increments and service type, is shown in the below table. As shown, individuals received a broad range of mental health services. This illustrates the range of available services. The data below shows the number of persons that received each type of service. One person can receive one, or several different types of services.

Number and Percent of Clients, by Mental Health Services Received

Number of clients receiving each type of MH service	Reporting Period 1A April 2014 - September 2014	Reporting Period 1B October 2014 - March 2015	Reporting Period 2 April 2015 - September 2015	Reporting Period 3 October 2015 - March 2016
100 Assessment - MH	69	68	65	63
105 Collateral-MH	47	67	59	49
107 Individual Therapy - MH	50	67	52	40
108 Group Therapy - MH	9	7	3	3
109 Individual Rehab Intrvntns	73	89	79	73
110 Group Rehab -MH	37	39	33	35
111 Plan Development - MH	88	120	103	92
112 Intensive Care Coord-KTA	4	3	3	3
113 Intensve Home-Bsd Srvc-KTA	3	2	1	2
114 Case Managmnt Brokerage-MH	83	105	89	85
115 Case Management -IMD - MH	2	5	3	1
140 Med-Assessment-Initial	18	31	23	15
141 Medication Eval Ongoing	104	113	101	86
142 Medication Injection	16	16	21	19
143 Med Refill Doctor	31	35	40	38
146 Medication-Plan Develpmnt	4	15	16	14
147 Med Consent/Med Altrntv Ed	0	0	0	0
914 Adult Residntial Day Trans	11	12	7	8
995 Day Rehab - Full Day	0	0	0	0

Challenges, Solutions, and Upcoming Changes

The Electronic Health Record (EHR) program, Anasazi, proved to be challenging. The complexity of the program made each crisis evaluation take much longer. Each crisis team member was able to see fewer individuals. The individuals had longer wait times for evaluation. An Administrative Assistant with extensive knowledge of the program was hired to help the staff adapt to the new program. She supported and assisted staff when they got stuck. A few staff members who were not able to adapt to the EHR program were moved to services that required less computer work.

Integration of two staff teams, the Crisis Team and the CSU Team, with different levels of experience was initially challenging. There was a tendency to practice in old patterns and forget the benefits of the new and valuable service being offered. Integration of the two staff groups as one working body whose goal was to assist individuals experiencing crisis was the next step. The supervisor for the CSU was hired from the long-term Crisis Team to help with that integration. In May 2016, that person became the supervisor for both teams to further the goal of integration and continuity.

A form was developed for the Crisis Team to fill out after evaluating an individual. That form was used in the presentation to the CSU. It helped the Crisis staff understand what information the CSU staff required, and offered the CSU staff a full picture of the individual to be admitted. It was a valuable basis for communication and understanding. The Crisis Response Team also needed to be trained to supply the CSU staff with all the necessary documentation and to work with the emergency room staff to get that information.

Program Participant Story

An older woman presented in the ED in crisis. She had been in the ED several times seeking help, but not knowing how to actually ask for it. She was afraid to be exposed as having "issues". She had not been previously diagnosed, but an initial assessment showed a generalized anxiety disorder and possibly an unspecified mood disorder.

She had been evaluated by the Crisis Worker one other time, but did not meet criteria for a 5150. When she presented at the ED, she told the ED staff that she was suicidal. In the ED, she was transferred to the CSU on a 5150 hold for Delirium Tremens (DTs), which is a Severe Form of Alcohol Withdrawal. It quickly became apparent that she was experiencing detox symptoms of alcohol. Throughout her day at the CSU, the woman slowly opened up and eventually shared with CSU staff the fact that she in fact that she was an alcoholic and she had been binge drinking to manage extreme anxiety. She had been afraid to admit to the drinking issue, but due to the safe, supportive, and kind environment that she encountered in the CSU, she was able to freely talk about her struggles and receive support with her detoxing process. She also received talk therapy and resource information.

She not only received support from the CSU staff and other guests in the unit, but from SPIRIT Peer Empowerment Center's Crisis Peer Counselor, who provided this individual with more resources and a place to go for support.

The woman admitted that she wasn't ever actually suicidal; she just needed help, and was afraid to ask. She thanked the staff at the CSU profusely for being there for her and allowing her a safe place to sort through her numerous pressures and medically work through the detox process. CSU staff was able to rescind her 5150 hold and she went home with a clear Recovery Plan, and hope.

General System Development:

CRISIS STABILIZATION UNIT (CSU)

Program Description

Program Overview

Nevada County Behavioral Health opened a new Crisis Stabilization Unit (CSU) on December 16, 2015, on the grounds of the Sierra Nevada Memorial Hospital. The CSU is located in a new modular building next door to the ED. This four-bed unit provides up to 23 hours of Crisis Stabilization services to help stabilize people, and when possible, to help them return to the community and prevent a psychiatric hospitalization. The CSU was funded with an SB 82, Investment in Mental Health Wellness grant and MHSA CSS funds. CSS funds may be utilized to support the day-to-day operations of the facility, staff and services provided. The CSU is open 24 hours a day, seven days a week. The CSU helps to expand the crisis continuum of care and provide crisis services in the community.

Evaluation Activities and Outcomes

A total of 28 5150s were rescinded due to CSU involvement in FY 15/16. This was 37% of all 5150s in the CSU. The unduplicated count of individuals admitted was 119. Satisfaction surveys, filled out by program participants, indicated a high level of consumer satisfaction with the services received. Staff reported job satisfaction as good to excellent. Outreach is being done to help fill beds going forward.

	Total admits	# of Medi-Cal/Medi-Medi	% MediCal or Medi-Medi	Average duration in hrs	# Riscind 5150
Dec '15	8	7	88%	19.88	3
Jan '16	21	18	86%	24.90	4
Feb '16	32	23	72%	30.69	10
Mar '16	22	18	82%	16.69	2
Apr '16	19	16	84%	25.60	5
May '16	21	20	95%	22.12	1
Jun '16	14	11	79%	22.05	3
Totals	137	113	82%	23.13	28

Challenges, Solutions, and Upcoming Changes

This program was designed from the ground up. The floor plan and furnishings needed to provide for safety, comfort, accessibility and privacy. Policies and procedures had to be written for a fairly new concept which had few models. Relationships and parameters had to be developed with Sierra Nevada Memorial Hospital who were partnering with Nevada County in this endeavor. The program was based on the premise that a need existed for two Medi-Cal covered individuals per day in residence. That proved to not be the case. The average number of individuals in FY 15/16 was less than one per day in residence. At the end of the fiscal year the CSU had served 119 individuals.

The floor plan and furnishings met the need well. Relationships with Sierra Nevada Memorial Hospital are at an all-time high. The hospital emergency room boarding time (patients waiting in rooms) was cut in half. Solutions to increasing the census are still being sought. Other counties, without a CSU, have been contacted to contract for Nevada County CSU beds. Outreach to community partners has begun and county and CSU supervisors are reevaluating the guidelines for CSU admission.

Program Participant Story

An older veteran, long-term Behavioral Health program participant, was evaluated by crisis staff in the emergency room and placed on a 5150 hold. The participant previously had many emergency room visits as the result of his psychiatric condition and substance use. His homelessness, and non-compliance with psychiatric medication were factors in these admissions. Presenting with loud, frequently unintelligible, rapid-fire speech, he was disruptive and scary for the emergency room staff and other patients. At each of these admissions, the emergency room staff quickly became frustrated and afraid, consequently treating him unkindly and using strong anti-psychotic medications to manage his behaviors.

In the first six months that the CSU was opened, this individual was brought to the emergency room by law enforcement. Staff decided to take a chance on admitting this easily agitated, disruptive individual with a tendency to go AWOL (Absent without Leave) into the CSU. From the moment he entered the CSU he was treated with kindness and recognition of his ability to recover. The difference between how he behaved in the CSU vs. the Emergency Room was nothing short of amazing. Staff handled his well-known inability to self-regulate with gentle reminders to practice being respectful of others' space and needs. He learned to manage the agitation of his manic episodes by doing jumping jacks in his room, often without even being reminded. He continued to be loud, but responded well to staff reminders to lower his voice the best he could.

He blossomed in the caring atmosphere which allowed the staff to experience the difference their attitude and care could make. Once transferred to a psychiatric facility, he required less time to be stabilized at his baseline than on previous admissions.

General System Development:

INSIGHT PEER RESPITE CENTER

Program Description

Program Overview

The Nevada County Insight Peer Respite Center opened in Grass Valley in July 2015. It has four bedrooms and guests can stay up to 28 days. The Insight Respite Center is peer-run and offers 24/7 services to up to four (4) individuals at a time. The Insight Respite Center staff offer a safe and supportive environment for persons at risk of needing mental health crisis intervention that is delivered in a less-restrictive, wellness, resiliency, and recovery-oriented setting.

Insight Respite staff are comprised of trained Peer Counselors who offer respite services as an alternative to ED-based crisis intervention and/or as a safe and stable environment for persons leaving the ED and/or stepping down from inpatient hospitalization services or the Crisis Stabilization Unit (CSU). The Insight Respite Center provides individuals with a supportive environment to help them stabilize their crisis symptoms before returning to their community living situation.

Insight Respite Center is an unlocked home in a peaceful setting, located in Grass Valley. Initial stays are up to 2 weeks. If needed, the stay may be extended to a total of 28 days. From the time the center opened in July 2015, through June 2016, 62 individuals have been served. The average length of stay is 11.8 days.

While at the center, guests receive peer support services that provide a safe alternative to crisis services like the Crisis Stabilization Unit, and/or provide a step down following inpatient hospitalization. Insight Respite allows guests to recover in a calm, safe environment where he/she can work through a difficult time in a supportive setting.

After leaving Insight Respite, guests are also offered a number of additional services. These aftercare services include:

- Follow-up phone calls from Peers after 2 weeks and 2 months;
- A 24/7 warm phone line for former guests;
- Visiting hours;
- Regular alumni lunches

Target Population

The program serves adults ages 18 years and older who are: medically stable, able to maintain personal hygiene, able to prepare and clean-up their own meals, willing to follow house rules, able to understand and sign documents, have a mental illness or are experiencing a first episode/re-emergence of severe symptoms, are not currently under the influence of drugs and/or alcohol, and have a place to return to when they are ready to leave.

Evaluation Activities and Outcomes

- Insight Respite is 87% peer staffed
- In FY 15/16 62 unduplicated individuals were served
- There was an increase of 11.5% (from 79.9% to 82.4%) upon discharge of guests that felt they now knew how to do things to make themselves feel better when they are starting to feel triggered
- There was an increase of 10.6% (from 81.2% to 91.8%) upon discharge of guests feeling they now know how to keep from hurting themselves when they are feeling bad
- Respite guests received 129 linkages to community resources
- At admission, 40.4% of guests lived in a house/apartment/family home/Supported housing
- At discharge, 72.6% of guests lived in a house/apartment/family home/Supported housing
- At discharge, 72.6% met their goals
- Prior to admission, 11.3% had a psychiatric hospitalization in the previous six (6) months
- After discharge from the center, 4.8% had a psychiatric hospitalization in the six (6) months following discharge
- A number of guests have found such a high value in the program that they have returned and are now employed as peers

Challenges, Solutions, and Upcoming Changes

Barriers/Challenges: Hiring and keeping staff that identify as peers and will work for minimum wage is a challenge. Accommodating staff needs for frequent scheduling adjustments due to self-care is difficult as well. Respite services are still not well understood and underutilized by community partners.

Solutions to Barriers: Due to ongoing advocacy Respite was able to give a pay increase to staff members. Making sure that job openings are advertised through multiple avenues in order to attract potential employees to be able to accommodate frequent schedule needs has helped. Staff members have been reaching out to more community partners on an ongoing basis to promote additional awareness. Respite is beginning to increase staff's computer knowledge so they can bill Medi-Cal to recoup money to sustain the program. Staff will be ready to start using an Electronic Health Record System in the near future.

Program Participant Story

Written by a Guest
Well, as I arrived as a guest here at Respite, I was having a lot of distorted thinking. The stay here and support of Peer Support Specialist staff provided a good sounding board (of people) who could relate. I was able to calm down, think things out, use the pros and cons to weigh out and balance the issues I had when I arrived. I've been able to observe the peer supporters in their positions to see how guests are cared for to help with returning home. All I can say is, "thank

you all", but thanks can't be enough. I've realized that I want to help others too. I've learned so much in Sue Haddon's class, that when I'm stable, I will submit an application to return as a Peer Supporter and help someone else with the issues they are experiencing. Respite is, and should be expanded worldwide, a pit-stop on the track of life. I am on a path with fresh tires and a full tank of fuel! I see the green light. Thanks to all.

NOTE: This experience, along with other guest's stories are framed, and hung in the entryway at Insight Respite. These stories help inspire others who visit the Insight Respite Center to embrace wellness, recovery, and change in their lives.

General System Development:

EMERGENCY DEPARTMENT (ED) CRISIS PEER COUNSELOR PROGRAM
SPIRIT ED

Program Description

Program Overview

The SPIRIT Peer Empowerment Center (SPIRIT Center) has expanded the hours of their Crisis Peer Counselors to provide additional on-call support to individuals in crisis in the Emergency Department (ED). The SPIRIT Center is a peer-run center that offers Peer support services in a warm, welcoming environment. The SPIRIT Center Peer Counselors have lived experience, are in recovery for a mental illness, and are trained with a minimum of 24 hours of training. The Crisis Peer Counselors are in the process of applying for their Peer Support Specialist State Certification. The trained and experienced SPIRIT Center Crisis Peer Counselors (CPC) are available to respond to a call from a Crisis Worker, and immediately come to the ED. CPCs are available from 12:00 p.m. (noon) until 10:00 p.m., seven days per week since their hours have been expanded.

The Crisis Peer Counselors are extremely effective at supporting individuals and their families at the ED during the crisis intervention service. The SPIRIT Center Crisis Peer Counselors work closely with the clinical crisis intervention and the hospital ED staff to offer recovery-oriented services in the ED. They also provide a follow-up call to each person the next day, or following an inpatient admission, to provide additional support, information, and help link the person to needed services.

There are five (5) Crisis Peer Counselors, and one (1) additional on-call counselor who provides back-up to the team. In 2014/15, these counselors provided service to 163 individuals. In 2015/16, they provided services to 188 individuals.

Target Population

The SPIRIT ED program targets individuals in crisis in the Emergency Department (ED).

Evaluation Activities and Outcomes

The total number of unduplicated people served in FY 15/16 by the SPIRIT ED program was 188. There were 99 Action plans developed, 79 Stress Reduction Techniques discussed, 36 Stress Reduction Techniques used, 400 referrals made and at least 54 resources accessed in the fiscal year. The most ED calls/visits were in the second quarter of the year, 62 unduplicated calls were counted that quarter. The average over the year was 54.5 unduplicated visits per quarter.

Challenges, Solutions, and Upcoming Changes

There was concern that individuals being seen in the ED were not being retained as permanent participants over at the SPIRIT Peer Empowerment Center. Without this link those served were not always able to access the services the county provides. It became clear that two follow up calls were not enough to engage participants to come to the SPIRIT Center to receive services. Another challenge was formally gathering demographic data while individuals were in crisis. To combat these issues, staff began making three follow-up calls, and encouraging the participants to meet the Crisis Peer Supporters at the SPIRIT Center. People served at the ED have begun registering as SPIRIT Center participants to join groups, receive ongoing peer support and access other services. During their Team Leader shifts, Crisis Peer Counselors are coming in to support those people who have been seen in the ED whenever possible. This fiscal year approximately 54 people have become/or are SPIRIT participants. The additional benefit of bringing the individuals seen in the ED back to the SPIRIT Center is that their full demographic data can be gathered through the Center's registration system.

Program Participant Story

The Crisis Worker at the Emergency Department (ED) called me at 12:15 p.m. and asked me to come to the ED to support Kayla (not her real name) while she waited to be seen by the ED staff. Kayla had come into the ED at 10:00 that morning, and she was still waiting in the waiting room to be seen when I arrived at the ED at 12:30 p.m. I sat down with her, and told her I was here to sit with her, support her, listen to her, and get her whatever she needed.

I told her that I was here to help her, but it was her choice if she wanted me to stay with her. "The choice is yours – you are empowered to make your own decision about what you want."

You could see the smile in her eyes, knowing that I was just there to support her, listen to her, hold her hand, and provide mutual support. I got her some food to eat. When she offered to pay me for the food, I told her that I was here to support her and I would pay for the food. I let her use my cell phone, so she could call her family and let them know she was OK. I held her hand. I ended up staying an extra hour past my shift, since the next Crisis Peer Counselor who was coming, was delayed an hour. I told her I was going to stay until the next person arrived. She

was finally seen by the ED doctors at 6:05 p.m. She had waited for eight (8) hours. She didn't need to wait alone. I asked if I could call her the next day she is at home. She agreed.

After I learned that she came back home, I called and talked with her, providing support and information about resources in the community. We talked for 45 minutes. She said I gave her a voice that matters; I helped her find the next steps, and provided the support she needed to be strong and focus on her wellness and recovery. She is doing well and said she is so thankful that the Crisis Peer Counselors are the support that is needed during a time of crisis. She has learned about the SPIRIT Peer Empowerment Center and comes to visit regularly.

General System Development:

TRUCKEE OUTREACH & ENGAGEMENT LIAISON

Program Description

Program Overview

Sierra Mental Wellness Group (SMWG) was contracted to hire a Personal Service Coordinator (PSC) to act as a Truckee Outreach and Engagement Liaison. The PSC reaches out to provide services to unserved and underserved Truckee residents, including the Latino population. Services may include case management, peer support, training, counseling by licensed therapists, and/or community outreach services. These culturally and linguistically competent services are delivered by collaborative efforts in both Western and Eastern Nevada County. The program was CSS funded from 4/1/2016 to 8/25/2016. It was then changed to an Innovation project to learn the best way to run this program.

Target Population

The Truckee Outreach & Engagement Liaison program targets unserved and underserved Truckee residents, including the Latino population.

Evaluation Activities and Outcomes

Seven individuals were served by this program in FY 15/16. Due to staff turn-over and the short time this program was funded under CSS, there was not enough activity to develop or collect evaluation or outcomes data.

Challenges, Solutions, and Upcoming Changes

This program changed to an Innovation project in FY 16/17.

Program Participant Story

Due to staff turnover, no individual story was available.

General System Development:

WELCOME HOME VETS

Program Description

Program Overview

Welcome Home Vets (WHV) provides a portion of Nevada County's Veteran population with mental health services not provided by the Department of Veteran's Affairs. Although those afflicted by combat-related Post Traumatic Stress Disorder (PTSD) are treated locally through a contracted VA provider, at the time of the original contract those Veterans were required to go to Auburn or Reno for continued treatment once they received a disability rating for PTSD from the VA. Rather than go out of the county to see a new therapist and join a therapy group with which they were not familiar, most Veterans would discontinue treatment. WHV was initially formed for the purpose of keeping those Veterans involved in the treatment they needed, and to do so locally. The CSS contract has been a major factor in funding that ongoing treatment, thus ensuring that some Veterans who are at a high risk for suicide, involvement with the legal system, divorce and psychiatric hospitalization received the help they needed.

Target Population

The Welcome Home Vets program targets the veteran population of Nevada County and their families.

Evaluation Activities and Outcomes

Including the group sessions from the peer group, WHV exceeded their contracted therapy session goal of 270 sessions by providing 39 Group Sessions, 143 sessions by Licensed Clinical Psychologists (LCP), and 306 sessions by Licensed Marriage and Family Therapists (LMFT), for a total of 488 sessions in FY 15/16 to the 29 individuals served. Basis 24 Survey Results are as follows:

- Veterans incarcerated in jail or prison during the time of treatment = 0%
- Veterans in treatment reporting having suicidal thoughts only a little or none of the time = 100%
- Veterans in treatment, not hospitalized in a psychiatric hospital during the treatment period = 100%
- Veterans in treatment reporting being in a shelter or homeless on the street more than once during treatment = 0%

- Veterans in treatment reporting feeling less short tempered during a week = 50%
- Veterans in treatment reporting getting along well in social situations half of the time or more during a week = 63%.

WHV has recently completed a relocation of the office to the Grass Valley Veterans Hall, a move that is very much in tune with the mission of Welcome Home Vets, increasing visibility as a veterans' organization, and greatly reducing expenses. Less money for rent equals more money for veterans.

During the 15/16 program year, WHV significantly increased their outreach and engagement activities around fostering community awareness of PTSD issues. A volunteer team was established to ensure coverage of community meetings and events to make certain a veteran's voice was at the table. Collaboration with other community groups who were not previously familiar with WHV mission was also expanded.

Major outreach events during the year included the Jason Moon concert, the Sierra College Health Fair, the Image Nation Veteran Photography Show, the Sierra Veterans Voices Writing Workshop, a KVMR Public Radio Forum on Veteran Issues at the Nevada Theater, the Love in Nevada County (LINC) Volunteer Event, Veterans' Stand Down, and the Roamin' Angels Car Show. WHV was particularly pleased with the variety of event types, engaging the local arts community, local churches, and antique car enthusiasts.

WHV was awarded a grant from Sierra Health Foundation that will increase their ability to serve the community with wellness classes around veterans' issues. Being able to train and pay leaders will add significant value to the peer-group sessions.

Challenges, Solutions, and Upcoming Changes

During the 15/16 fiscal year, WHV delivered 39 group sessions, but were only able to pay therapists for 26 of them. Of the 143 individual sessions delivered by LCPs, psychologists were only paid for 111. An amazing 306 individual sessions were delivered by LMFTs, but reimbursement was only made for 187 sessions. More funding is needed.

The program continues to leverage their resources through further development of their connections and relationships within the Nevada County community. WHV continues to seek out grants and explore additional fund-raising opportunities to further their mission, and so therapists are not continually asked to treat individuals without payment.

WHV operates peer-supported group sessions which are not currently tracked. Also, therapists do not always mark sessions appropriately, so that when a session is in fact a family session, it is simply billed as individual session. This affects tracking and billing.

A data collection method has been established to improve reporting from the peer-supported groups so that the group work that is happening can be reflected in the reported statistics. Work continues with the therapists to improve communication and to get complete information from them utilizing the Basis 24 survey. This should help statistics to become more accurate.

This year, while there was a gratifying and valuable increase in community events that served to raise awareness of veterans' issues, WHV was not able to maintain the schedule of community classes. This was due to a lack of funding to pay teachers. Challenges have been primarily financial in nature as this is a volunteer run organization including the executive director position. This limits the ability to be as effective as possible, although the organization is quite fortunate to have several dedicated long term volunteers who are able to accomplish a tremendous amount.

The grant from Sierra Health Foundation in the amount of $14,565.00, will not only fund the revamping and modernizing of the class curriculum, but will also fund a teacher, and the training and compensation for peer group session leaders. Classes will be offered once again on a regular basis, beginning in September, 2016. These include classes on military culture, PTSD and other psychological trauma diagnoses, effects on the family, options for treatment and learning how to cope as a family member. This grant also includes funds to pay a professional billing service which will provide full compensation to the therapists for their time and thus expand the program's ability to serve more of the veteran community.

Program Participant Story

A veteran showed up at Welcome Home Vets (WHV) in the early spring. He was homeless, wet, cold, and was living with his dog in his pickup truck. He was just looking for some help and advice to get a home to break the cycle of homelessness. This veteran needed therapy, help navigating the VA benefits system, and mostly he needed hope that there was help available to find him a home of his own. WHV got involved with a referral to the VA homeless program in Auburn. WHV also connected this veteran with therapy benefits and helped to review his claim which was currently on appeal. During this process, the vet would occasionally show up at the office just to get out of the rain and to warm up. WHV was glad he had the patience to stick with the process. While the process took a long time to complete because the veteran had to be service connected with his disabilities before eligibility for housing could be established, perseverance paid off. Through the U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program, this veteran was able to finally move into his own apartment. The apartment allowed him to have his dog which was extremely important to him. The veteran is on the road to healing and recovery and is a productive member of society. WHV was also able to be a vital part of gaining the benefits he had been fighting for. With his VA benefits award, the vet is no longer completely dependent upon community systems for his financial needs. This story represents just one out of many veterans who are served every single day by government as well as nonprofit organizations in Nevada County.

General System Development:

HOUSING & SUPPORTIVE SERVICES
MHSA Housing,
Homeless Resource Council of the Sierras (HRCS), and
Nevada County Housing Development Corporation (NCHDC)

Program Description

Program Overview

Housing and Supportive Services to the Severely Mentally Ill (SMI) Homeless was provided through the MHSA Housing program, the Roseville/Rocklin/Placer-Nevada Continuum of Care (CoC); the lead agency identified as administrator is the Homeless Resource Council of the Sierras (HRCS) and the Nevada County Coordinating Council (NCCC) to End Homelessness.

The Homeless Resource Council of the Sierras (HRCS) operated the Nevada-Placer Continuum of Care during 2015/16 fiscal year. Services provided during the 2015/16 fiscal year included:

- Consistently held stakeholder meetings at varying levels of engagement throughout the continuum; meetings included public agency staff, private service providers, public service providers, outreach agencies, homeless and formerly homeless individuals, continuum staff and advocacy agencies. Stakeholders meetings focused on the priorities of the continuum in order to maintain funding, increase participation and engagement of the local communities, establish compliance and performance measures at the continuum and program level, and improve the observance of the HRCS as the lead agency in homeless endeavors.
- Successfully developed grant applications for funding in support of administration of the homeless continuum of care administration and homeless programs and services; funding received from multiple sources, including county government.
- Developed a Continuum of Care Operating Manual that supports Continuum of Care (CoC) and Emergency Solutions Grant (ESG) funding.
- Developed a coordinated entry (CE) team that is working to establish Dial 211 as the lead agency for homeless service referrals; the team has met monthly and has developed a vulnerability assessment tool, flow chart, a question tree and has partnered with local service providers to expand the Homeless Management Information System (HMIS) to providers not currently using the system for data tracking; the CE system will implement the pilot project in August, 2016.
- Participated in the Emergency Solutions Grant (ESG) Balance of State Application process, inclusive of technical assistance meetings, development of a local Request for Funding, rating and ranking of competitive and non-competitive applications for rapid re-housing and emergency shelter funding, ESG program standard and priorities and developed a Conflict of Interest Form for the grant review committee to ensure integrity of the process.

Evaluation Activities and Outcomes

- Thirty-six individuals were served by this program in FY 15/16
- The HRCS has developed and implemented some critical elements necessary to functionally operate a CoC at a competitive grant level, inclusive of: ESG and CoC program and performance standards, CoC operating manual, coordinated entry system, CoC/ Placer Consortium on Homelessness (PCOH)/NCCC strategic plans, housing inventory count, point in time count, CoC and ESG funding application processes
- The HRCS successfully attained additional funding in support of CoC administration and activities. Increased funding for FY 2016/17 will be: Nevada County-$10,000; Placer County-$32,000; Roseville Citizen's Grant-$7,500; Roseville Community Development Block Grant (CDBG) - $6,000. CoC project level funding in the amount of $1,217,665 was secured for on-going programs.
- The HRCS is now being considered the lead entity for homeless programs, engagement, planning and coordination within the jurisdiction.
- The HRCS has been very successful in engaging other service providers, local health and human services departments, elected officials, homeless and formerly homeless and other stakeholders in the collaboration and coordination of resources, service provisions and partnerships towards ending homelessness; something that was not present in year's prior.

Housing Choice Vouchers (HCV) (formally known as Section 8):
Many Behavioral Health and contracted service provider program participants are on the Housing Choice Voucher wait list. The Personnel Service Coordinators from Behavioral Health and contracted service providers helped program participants that were selected for Housing Choice Vouchers to complete paperwork; find housing units, if they were not already housed; and move homeless individuals into their new homes.

Second MHSA House:
Nevada County Housing Development Corporation (NCHDC) entered escrow for a second MHSA funded house. Escrow closed in July 2016. The home has six bedrooms and is in Grass Valley.

Nevada County Housing Development Corporation (NCHDC):
A landlord that remodeled a large Victorian home into nine apartments approached the County to master lease the whole building from him. The County has partnered with NCHDC to master lease the building and sub-lease the apartments to Behavioral Health program participants. All of the apartments were rented out in the fiscal year to Behavioral Health program participants. All were low income and the majority were homeless and received housing vouchers from the programs listed below.

Winters' Haven:
NCHDC purchased a five-bedroom house in Grass Valley in October 2011. The corporation renovated the house in FY 2011/2012. The first tenants moved into the House in December 2012 and by June 2013 the house was full with five tenants.

In FY 15/16 there were seven tenants, two individuals left the house mid-year; both for another permanent housing opportunity. Of the seven tenants: three lived in the house at the beginning of the fiscal year, two came from Emergency Shelters and two came from places not fit for human habitation. Four of the tenants had a source of income at the end of the fiscal year, three had Supplemental Security Income (SSI) and one had General Assistance. One tenant had no income. Lastly, there were three tenants that had been housed for over one year, two had been housed for over six months, and two for less than six months.

Winters' Haven had its third California Housing Finance Agency (CalHFA) housing inspection and the inspection resulted in a few minor findings that were corrected within 30 days.

Summer's Haven Project/ Supportive Housing Project (SHP)

The Behavioral Health Department applied for a renewal of their SHP housing and received a renewal grant from Housing and Urban Development (HUD) Continuum of Care (CoC) grant in the amount of $110,841 to provide permanent supportive housing to a minimum of 13 individuals with severe mental illness enrolled in the MHSA Full Service Partnerships.

In FY 15/16 the SHP vouchers were utilized by nineteen households consisting of twenty-one individuals. Most of the tenants had physical or mental health conditions. The residence of the individuals prior to program entry varied: four were from emergency shelters, fifteen were from a place not meant for habitation, and two were from another permanent supportive housing program. All households had a source of income. Sources of income included earned income, SSI, Social Security Disability Benefits (SSDI) and General Assistance. The two individuals to leave the program moved to permanent housing. The average length of stay for the tenants was 902 days. Of the twenty-one adult program participants, all were enrolled in the program for at least 6 months (housing stability measure).

The largest barrier to implementing this program was finding landlords that would master lease to NCHDC.

Home Anew:

The Behavioral Health Department (BH) submitted an application to HUD for three additional Permanent Supportive Housing grant vouchers for chronically homeless individuals with a serious mental health condition in FY 13/14. BH was awarded the grant for $20,270 for two vouchers in FY 14/15. The renewal grant funding was approved for $20,270 for FY 15/16.

In FY 15/16 the Home Anew vouchers were utilized by three households for five individuals, three adult males and two adult females. Three individuals were between the ages of 25 and 59, and two were 60+. All five were white. All five tenants had a mental health conditions and one had a developmental disability. One residence came from an emergency shelter and the other four came from a place not meant for human habitation. All five tenants had a source of income: SSI. Two individuals left and moved to permanent housing. They had an average stay of 247 days. The three remaining tenants were just shy of a six month stay: 174 days.

Sheltered Homeless Count January 25, 2016:

A Sheltered Homeless Count was conducted for the night of January 25, 2016 for individual in Emergency shelters and Transitional Houses. Homeless shelter service providers were asked to

survey the individuals who participated in their programs on the night of January 25, 2016. Below are some of the results of the survey:

- A total of 156 individuals were homeless
  - 72% were individuals/couples with no children
  - 28% were living in families
- Where they slept on January 25, 2016
  - Emergency Shelter = 88%
  - Transitional Housing = 12%
- Age
  - Children under 18 years of age = 19%
  - Adults 18-25 = 6%
  - Adults 26-59 = 69%
  - Adults 60+ = 4%
- Gender
  - Females = 58%
  - Males = 42%
- Chronically Homeless (homeless for a year or longer, or homeless four times in three years)
  - Only Adult Individuals = 14%
  - Families with Children = 0%
  - Veterans = 5%
- Subpopulations
  - Veterans (only adults) = 5%
  - Adults with a Serious Mental Illness = 22%
  - Adults with a Substance Abuse Disorder = 19%
  - Adult Survivor of Domestic Violence = 22%
  - Adults who have lived in Foster Care or Group Homes = 0%
  - Adults who have a physical or developmental disability = 24%

Challenges, Solutions, and Upcoming Changes

The main challenge comes from a lack of funding within the CoC to support a full-time coordinator to implement the ever-changing regulations and standards necessary to obtain Housing and Urban Development (HUD) funding and meet compliance standards. The Board of Directors is working with local governments to gain financial support for the activities that are required of the CoC.

Outreach and Engagement:

NATIONAL ALLIANCE ON MENTAL ILLNESS

Program Description

Program Overview

National Alliance on Mental Illness (NAMI) provides free educational classes for parents, caregivers, and family members of children, teens and adults with mental illnesses. Classes are Signature NAMI programs and are offered throughout the country. Additionally, the local chapter provides free Inside Mental Illness classes for providers of services for individuals with mental illnesses. These classes feature personal stories by young adults, adults and older adults with lived experience of mental illnesses that punctuate the presentation of knowledge and skills which are tailored for the audience.

Target Population

NAMI targets parents, caregivers, and family members of children, teens and adults with mental illnesses.

No demographic information was available from the contractor for FY 15/16.

Evaluation Activities and Outcomes

NAMI provided Inside Mental Illness classes with the Unitarian Universalist Community of the Mountains for 26 individuals in FY15/16. Family to Family Education was also provided at the Bonnie Bechtel Sugar Pin Quilt Shop.

Challenges, Solutions, and Upcoming Changes

This contract was not renewed in FY 16/17.

Outreach and Engagement:

FULL SERVICE PARTNERSHIP AGENCIES AND OTHER CONTRACT CSS SERVICE PROVIDERS

Program Description

Program Overview

Full Service Partnership Agencies and Other Contract CSS Service Providers conducted outreach and engagement services throughout the fiscal year. These services were done for individuals, families, and other stakeholders through Turning Point, New Directions, Victor, Uplift Family Services, Insight Respite Center, and Welcome Home Vets. Outreach and engagement activities were provided to 2,672 individuals under these programs in FY 15/16. This number does not include services provided by the individual programs listed separately in this section of the report.

Outreach and Engagement:

SIERRA FAMILY MEDICAL CLINIC

Program Description

Program Overview

The Sierra Family Medical Clinic (SFMC) provides outreach, engagement and care coordination services to individuals in the underserved area of North San Juan Ridge. Services include connecting program participants to therapy services either at SFMC or with a provider of preference in the community who accepts the individual's insurance. Other services include connecting people to food and other county resources; housing, insurance, disability assistance, encouraging program participants to identify and connect with family and/or community support systems; education regarding resources; supporting individuals in connecting to resources for victims of domestic violence.

Target Population

SFMC targets the unserved and underserved segment of the County's population with mental health needs, primarily individuals in the North San Juan Ridge Area.

Evaluation Activities and Outcomes

Seventy-one individuals were served by this program in FY 15/16. Care coordination was provided to 100% of program participants until the participant became engaged in referred services. The coordinator engaged with existing and new participants, and connected with them to assess needs. Using warm hand-offs, the coordinator helped participants in medical care engage with Behavioral Health services, either through the SFMC's Behavioral Health (BH) department, or through a therapist outside of the clinic. Participants who were seeing a medical provider/therapist and were then referred to SFMC were connected with community-based services.

SFMC is part of a team that looks at consumer's entire health and wellness needs and then confirms that the consumer has engaged with the services to which they were referred. Out of all of the referrals, 80% of individuals engaged in referred services within 90 days. Engagements in referrals are tracked through provider scheduled contacts or by the care coordinator until needs are met and/or changed. Sometimes, individuals change their minds about what they need and staff members revisit the need later. This can cause the time to engagement to be greater than 90 days. Sometimes the consumer's circumstances change which changes the need. Individuals were referred to a total of 90 services consisting of Hospitality House, Logisticare transportation, Medi-Cal, CalFresh, Family Resource Center, Domestic Violence and Sexual Assault Coalition, SPIRIT Center, 211, Divine Spark, Common Goals, Nevada County Behavioral Health, FREED, Nevada County Family Law Facilitator, Community Legal, Dept. of Rehab, One Stop Business Center, Interfaith Food Ministry, Salvation Army, North San Juan Senior Center, and community therapists.

Challenges, Solutions, and Upcoming Changes

Insufficient housing continues to be a major need, especially on North San Juan Ridge where options are extremely limited. A recurring challenge continues to be finding affordable housing and temporary housing for individuals who are not eligible for current programs; some program participants continue to live in substandard housing and crowded conditions.

Although managed care Medi-Cal patients can access transportation now for medical appointments, it can be limited and does not support obtaining prescriptions or ancillary needs. The ability to receive assistance for food and social supports can also be impeded due to lack of public transportation in the area.

Common Goals has a co-location program at SFMC which helps a number of program participants with substance use problems and mild mental health conditions. However, challenges continue in addressing the needs of individuals with serious mental health conditions and/or significant personality disorders who require more intensive support, especially if facing co-occurring substance use issues.

Clinic primary care providers are not able to address patients with complex psychiatric needs. At present tele-psychiatry is only available to individuals on Anthem Blue Cross managed care Medi-Cal.

Staff members continue to problem-solve with NCBH to obtain treatment for psychiatric patients with complex needs. Collaborate continues with other community stakeholders to try to resolve these issues. SFMC will participate in helping program participants enroll in the Housing Choice Voucher program to give them a chance at better housing.

Outreach and Engagement:

SPIRIT PEER EMPOWERMENT CENTER

Program Description

Program Overview

SPIRIT Center serves individuals who are facing some of life's challenges, and intend to make some changes, as their journey permits. This includes the homeless population which accounts for approximately 35% of program participants. SPIRIT offers a variety of different support groups including Co-Occurring Disorders, Anxiety and Depression, Bipolar, Men's, and Women's groups and an LGBTQ group. SPIRIT teaches Peer Support and Group Facilitation to the community so that they can also become peer supporters. This prepares individuals for Peer Support jobs within Nevada County and at large. SPIRIT also offers a wide variety of volunteering opportunities including work in one of the facility's two organic gardens. SPIRIT also accepts participants from community service and work release programs.

Target Population

The SPIRIT Center targets individuals 18 years and older with severe, moderate and mild mental illness.

Evaluation Activities and Outcomes

- During the Fiscal Year 15/16 SPIRIT had 4,884 duplicated walk-in visits (about 400 per month) and out of that 589 were unduplicated.
- The SPIRIT Center was open 1,409 hours during the fiscal year.
- Fundraising efforts included a holiday letter that was sent out, a donation jar and other random donations all totaling $3,225.54 for the year.
- SPIRIT's volunteers contributed 5,928 hours maintaining the facility that resulted in a savings of $88,920 in potential wages.
    - Some of their jobs were front desk, property maintenance, one-on-one peer support, group facilitation and interning for the Team Leader.
- SPIRIT provided 734 one-on-one peer support counseling sessions and 512 peer support counseling training hours during the year.
- SPIRIT held roughly eight (8) support groups per week (104 per quarter) with an overall attendance of 1,516.
- SPIRIT provided 381 showers; 148 loads of laundry were also done.

- SPIRIT also assisted its participants with access and linkage to other community resources, provided assistance with completing other agency applications for services, and assisted with locating housing and jobs. Referrals included:
    - 200 people to Outpatient Clinics (Chapa-De, Anew Day, Behavioral Health, etc.)
    - 118 people to Peer Services
    - 27 people to Psychiatric Inpatient Facilities
    - 16 people to Emergency Housing (Hospitality House)
    - 10 people to the Department of Social Services (CalFresh, Medi-Cal, etc.)
    - 14 people to the Domestic Violence and Sexual Assault Center
    - 47 people to Outpatient Substance Abuse services (CoRR, Common Goals, Turning Point)
    - 22 people to Primary Care Physicians (Chapa De, Western Sierra Medical Center, Sierra Family Medical Center)
    - 33 people to Support Centers (FREED, Family Recourse Center, Churches)
    - 21 people to a warm line (211)
    - 67 people to other services (NAMI, Insight Respite)
- The program continues to provide food that is donated from The Food Bank of Nevada County. In FY 15/16 355 bags of food were provided to participants.
- SPIRIT provided four social activities per week for peers and consumers, for a total of 208 activities during the year. The following social activities were attended by a total of 925 consumers:
    - Garden Project
    - Beading for Wellness
    - Saturday Brunch
    - Creative Expressions
- One "Stomp Out Stigma" presentation was held each quarter throughout the year for a total of four presentations. These were provided to the Police Department, Hospitality House homeless shelter, In Home Supportive Services and Eastfield Ming Quong (EMQ) (In FY 15/16 they were called EMQ FamiliesFirst, but are now known as Uplift Family Services).
- SPIRIT sponsored structured educational classes for peer supporters. In FY 15/16, 28 peers graduated from the Peer Support 101 class, six completed the WRAP course, and eight completed the Yoga WRAP training.

Challenges, Solutions, and Upcoming Changes

With the deep budget cuts faced in 2015/2016, staffing was the biggest challenge. The number of shifts was reduced, and consequently the amount of coverage. This put an extra burden on staff, so volunteers were sought to back fill some of the lost shifts, from organizations such as RSVP and Experience Works. With a deep passion for the SPIRIT Center program, staff rolled up their sleeves, and began the difficult job of doing more with less money.

The long-time SPIRIT program participants were not comfortable with the influx of homeless participants into SPIRIT (over one-third of members). This change in demographics has brought about a culture shift for the organization. Staff members were provided with multiple trainings that address the "No Wrong Door" philosophy as well as "Cultural Competency" to facilitate comfort and acceptance in working with all kinds of individuals.

Prevention and Early Intervention (PEI)

PEI Project Name: Early Intervention Program

UPLIFT FAMILY SERVICES
Nevada County School Therapeutic Services

Program Description

Program Overview

Uplift Family Services provides therapy for children ages 5-15 years and Transition Age Youth (TAY) ages 16-22. One half-time clinician is stationed at schools that are determined by the Tahoe Truckee Unified School District (TTUSD). The clinician receives referrals from school professionals. After receiving consent to treat from the student's parents, the clinician requests authorization from Nevada County Behavioral Health for mental health services and treats the child, if appropriate, using individual therapy services, case management, and, if necessary, crisis intervention.

Individual Services offer early intervention and/or treatment services to an individual and/or family. Individual Services are planned services that occur on a routine basis for a period of time (e.g. weekly for 10 sessions). Individual Services may include individual counseling, peer support, and/ or family services, when the family is present during sessions.

Target Population

Uplift Family Services serves children and TAY ages 5-22 in the Tahoe Truckee Unified School District.

Evaluation Activities and Outcomes

Uplift collects evaluation activities for MHSA including demographic information on each individual receiving services. In addition, information on the type of service received, date of service, location of service, and duration of the service is collected for individual and group services. The Child and Adolescent Needs and Strengths (CANS) outcome measure is collected at admission, periodically, and at discharge. Perception of care surveys are collected annually and at the end of services. Information on referrals to community services is also reported.

Eleven youth were served in FY 2015/2016. The clinician conducts outreach in the community to generate new referrals.

In FY 2015/16, 10 of the 11 youth served remained living with family and one (1) went to juvenile hall and then was placed out of the home. Seven (7) youth showed significant improvement in overall functioning based on CANS results and four (4) showed little or no

improvement. Out of 11 youth served, all remained in school and eight (8) had average or above average grades. All 11 youth had satisfactory school behaviors during FY 2015/16. Out of 11 youth served, four (4) were employed part-time, two (2) showed improved social connections, and two (2) demonstrated reduced encounters with law enforcement. A total of 10 individual families were served.

Challenges, Solutions and Upcoming Changes

There was a slow start in implementing the program. No services were available from July to October, 2015 because a clinician was not available to take referrals until November 2015. By the start of 2016, referrals began to slowly come in, and by the start of summer, 2016, the clinician was serving eight (8) youth. During summer, the availability of participants was limited due to summer vacation. By the end of FY 15/16, 11 youth were being served, and more referrals were coming in. It was anticipated that the program would be fully functioning in FY 2016/17. The clinician will continue to offer outreach proactively in the community and within the various schools in the district.

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Bilingual Early Intervention

Program Description

Program Overview

Staff provide psychotherapy to children, adolescents, and adults using a wide range of modalities, including individual, family, and play therapies. Individual therapy primarily involves Motivational Interviewing and Cognitive-Behavioral Therapies (CBT), with an emphasis on Trauma-Focused CBT for children and exposure-based trauma treatments for adults. Family therapies include Attachment-Based Family Therapy and systemic family therapies. Play therapy is primarily Parent-Child Interaction Therapy (PCIT), which provides direct, real-time coaching using PCIT labs in both Truckee and Grass Valley.

Staff members work closely with community agencies that have already built trust with Latino families by providing needed basic services. Examples of such community agencies are Child Advocates of Nevada County, Tahoe Safe Alliance, and the Family Resource Center (FRC) of Truckee.

Nevada County Behavioral Health (NCBH) maintains good communication with these community agencies by:

- coordinating care of mutual individuals;
- funding programs at the FRC, including the Bilingual Peer-Counseling Program;
- providing training to the FRC Peer-Counselors;

- staffing the FRC with an NCBH therapist for one hour per week;
- delivering quality service and treatment of individuals referred from the FRC and Tahoe Safe Alliance; and
- providing clinical supervision to Tahoe Safe Alliance Marriage and Family Therapy Interns.

Target Population

Bilingual Early Intervention primarily aims to serve the Spanish-speaking population, but will provide services to any individual.

Evaluation Activities and Outcomes

In FY 15/16 69 individuals were served by this program. The Bilingual Early Intervention Program collects demographic and service-level data through NCBH's Electronic Health Record (Cerner). In addition, the Child Behavior Checklist (CBCL) is administered at the beginning and end of services for children, and, for adults, the Basis 24 is administered. These instruments document changes in behaviors over time as a result of services.

NCBH is in the process of implementing Electronic Behavioral Health Solutions, a software and support product that will facilitate efficient quantitative data-gathering and aggregation of outcome measures including the Achenbach Child Behavior Checklist (for children/youth) and Basis 24 (for adults). It is expected that in the next six months there will be quick access to aggregate outcome data. A maximum of 69 individual families were served.

Challenges, Solutions, and Upcoming Changes

Cultural beliefs about therapy and mental health can create challenges because due to mental health stigma, people who could benefit from treatment do not always come in for it. For example, Mexican men are often more reluctant than Mexican women to participate in psychotherapy. To involve fathers in family therapy, staff members stress the importance of getting the father's perspective, even if that perspective is rooted in stereotypes of psychotherapy (e.g., "therapy is just for crazy people").

Another challenge is that many individual families are from rural areas of Mexico, where yelling and corporal punishment, are more accepted parenting practices. To meet this challenge, staff utilize techniques from various therapies: Attachment-Based Family Therapy motivates change for new practices by helping parents make sense of their own upbringing; Mental Research Institute (MRI), Family Systems Therapy, challenges "more of the same solutions" with a 180 degree change in perspective; Motivational Interviewing creates a safe space for exploring both sides of parental ambivalence about change. Staff members also provide psychoeducation on the long-term consequences of corporal punishment.

The interference of extended family in treatment is another challenge. In many Mexican families, extended family members have significant influence over parenting decisions. For

example, a grandparent's suggestion that a grandchild does not need therapy, or should not be on a certain medication, can be decisive. At the extreme, the dominant dyad in the family system may be the father and grandparent, rather than the mother and father. One solution is to involve the extended family in family therapy sessions, especially when these family members are involved in caring for the child/individual. Another option is to use Structural Family Therapy to change the hierarchy and put the parents in charge, while being sensitive to the fact that this approach may be directly challenging certain cultural practices.

In Nevada County, the Latino population often works at lower-paying jobs with long hours, where there is less flexibility to take time off to participate in mental health services. NCBH provides a flexible schedule to allow for sessions to begin as late as 5:00 pm, to accommodate individual work schedules.

The program has added another bilingual therapist, Ana Rivera, to the NCBH team. This addition will increase access for Spanish-speaking families living in the Western side of the County.

Program Participant Story

Individual #1
This individual was an older, Latina woman referred to NCBH by another individual, who said that this individual had been crying, was severely depressed, and was thinking about suicide.

On bad days, this individual was thinking about suicide all day long. She was at the point of taking a knife out of the drawer, holding it to her wrist, and standing there for up to five minutes, thinking about whether or not to kill herself.

Staff met with the individual and administered Post-Traumatic Stress Disorder (PTSD) and depression measures. The individual met criteria for both PTSD and Major Depression. In discussing treatment goals, the individual said, "I would like to get rid of my depression and my crying."

The individual has suffered multiple traumas. While growing up, her parents split up and her mother and her mother's new partner physically abused her, at one time to the point that the individual lost consciousness. Because of her family's extreme poverty, the individual was often hungry, and she had to begin working before she was 10 years-old. The individual married at a young age, as a way to escape her home.

Staff provided treatment to the individual using evidence-based practices. She was treated at home because she watched her grandchildren during the day and she did not drive. Treatment began in August and by December, the individual had successfully met her treatment goals. She said she felt less sadness, anger, worry, and she had higher self-esteem. She felt ready to end treatment.

Individual #2
This individual was an adult, Latina woman, referred by a local community agency. At intake, she was in her first trimester of pregnancy, undocumented, and living with a family member.

The referring agency and NCBH staff met with her and administered depression measures. The individual met criteria for Major Depression.

The individual was mourning the loss of her life in her home country, including the loss of connection to family and friends, loss of her career, and the loss of her father, who had passed away a few years prior. In addition, the father of her unborn child was not in the picture. She had contemplated suicide, but she had not acted on it because of thoughts of her family, including her young child.

The individual's treatment was based primarily on Cognitive-Behavioral Therapy (CBT). Using CBT techniques, the individual learned to assess the effectiveness of her worry strategy, which involved spending most of her time worrying about her problems in the hope that she would find a solution. Treatment also included helping the individual to notice the many strengths she had shown during her life, particularly her ambition, and high ethical standards.

Treatment began in April and by July she reported feeling much better. In a follow-up phone call in August, she said she was still doing well and that she felt comfortable with closing her chart.

PEI Project Name: Early Intervention Program

NEVADA COUNTY PUBLIC HEALTH
Moving Beyond Depression - Every Child Succeeds

Program Description

Program Overview

Moving Beyond Depression is a voluntary, evidenced-based program for women experiencing prenatal or postpartum depression (i.e., perinatal depression; PND) who are enrolled in a home-visitation program. Moving Beyond Depression offers In Home-Cognitive Behavioral Therapy (IH-CBT) in 15 weekly sessions and a one month follow-up booster session. Therapy is provided by two licensed therapists and supervised by a psychologist.

One therapist serves the Truckee community, and the other therapist serves the western area of Nevada County. The therapist who primarily serves the Truckee community speaks Spanish and English and provides services to the western area of the county on an as-needed basis.

Target Population

This program is designed to meet the needs of low-income, underserved women who are pregnant or postpartum. The program also serves women who have young children in the home, are experiencing PND, and are enrolled in a home visitation program in Nevada County.

Evaluation Activities and Outcomes

Moving Beyond Depression collects evaluation activities for MHSA including demographic information for each individual receiving services. In addition, information on the type of service received, date of service, location of service, and duration of the service is collected for individual services. Perception of Care surveys are collected annually and at the end of services. Individuals receiving services also complete an Edinburgh Postnatal Depression Scale (EPDS) at intake, during ongoing services, and at discharge from the program. Individuals receiving services also complete the Interpersonal Support Evaluation List-Short Form (ISEL-SF) to assess perceived social support at intake to and discharge from the program. Information on referrals to community services is also reported.

There were 22 women referred since the start of the program. Fifteen accepted services in FY 15/16. Thirteen received more than one assessment. Seven (7) individuals completed the initial 15 Cognitive Behavioral Therapy (CBT) visits during the fiscal year.

Of the 13 individuals with more than one assessment, 92% reported a decrease in depression as measured by their EPDS scores. One individual's score remained unchanged. Of the five (5) individuals who completed a discharge, 100% noted an increase in perceived social support as measured by the ISEL-SF. A total of 15 individual families were served.

Edinburgh Postnatal Depression Scale (EPDS)	% Improved
Improvement Pre to Post *(N=13)**	92.3%

*Note: Thirteen (13) individuals were assessed two (2) or more times.

Interpersonal Support Evaluation List - Short Form (ISEL-SF)	% Improved
Improvement Pre to Post *(N=5)***	100.0%

**Note: Five (5) individuals were assessed during Session 1 and Session 15 (Discharge).

Onset of Mental Health Symptoms	# Served	% of Served
1 month ago	2	13.3%
2 - 6 months ago	3	20.0%
7 - 12 months ago	-	-
1 - 4 years ago	9	60.0%
5 years ago or longer	1	6.7%
Other	-	-
N/A	-	-
Unknown	-	-
Unduplicated Total	**15**	**100.0%**

Challenges, Solutions, and Upcoming Changes

The financial cost of Moving Beyond Depression increased this year because two new therapists were hired. They attended the required out-of-state trainings, which increased costs for this year. The number of individual referrals vary depending upon the staffing and capacity of the program.

In an effort to expand the number of referrals, outreach and training was delivered to community partners and medical professionals about the scope of the program and criteria for referral.

In order to support the program, county leadership is exploring options for Medi-Cal billing. In addition, modifications to staffing patterns may include hiring a supervising therapist who has direct home visiting experience to help provide support to staff.

One of our therapists was hired by NCBH to be a supervisor, which left a vacancy with the program. We are actively engaged in hiring a qualified therapist to provide services to the eastern area of the county. Priority will be given to hiring a Spanish-speaking person who lives in the area. This will prevent complicated travel issues and facilitate the ability to provide therapy services in a timely and efficient manner.

Program Participant Story

Individual #1
A very young mother, with three (3) young children was referred to the Moving Beyond Depression program. The mother reported Perinatal Depression. She had become self-isolating and agoraphobic; she did not want to leave her home. The mother received in-home Cognitive Behavioral Therapy (CBT) treatment with the Moving Beyond Depression therapist while she attended weekly meetings with the Foothills Healthy Babies Program. After several weeks, the mother reported great improvement in her overall well-being. She is now able to leave her house

with her children. In addition, she has rekindled friendships, enriching her social network. Importantly, she reports feeling more confident in her role as a mother, stating, "I am a good mom."

Individual #2
A mother of a young infant was experiencing severe perinatal depression and threatening harm to herself, as well as her infant. The mother was threatening to drive herself and her baby off of a cliff in a remote area of the county. Among other actions, the father of the baby alerted The Moving Beyond Depression therapist of the situation. The therapist acted swiftly to protect the mother and infant, by coordinating services for the family and linking the mother to the intensive services she needed. After receiving these services and treatment, the therapist was able to provide ongoing home therapy to the mother. Both the mother and infant are now healthy and safe.

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Homeless Early Intervention Services

Program Description

Program Overview
Nevada County Behavioral Health (NCBH) Early Intervention provides therapy, referral and linkage to Behavioral Health Services, and outreach and engagement services to the guests at Hospitality House. Staff members also assist in immediate intervention with guests exhibiting troublesome behaviors due to ongoing mental health issues, stress, difficulty adjusting to Shelter life, and frustration with current life events.

Target Population
(NCBH) Early Intervention serves people who are homeless in Nevada County.

Referral Data
February 2016 – June 2016*

	# Referrals	% Referrals
Partner Agency	1	1.7%
Mental Health	10	16.7%
Crisis Stabilization Unit	7	11.7%
SPIRIT	12	20.0%
A New Day	3	5.0%
Cultural-Specific Services	1	1.7%
CoRR	3	5.0%
School/ Training Program	1	1.7%
Chapa De	5	8.3%
Physician/ MD	2	3.3%
Therapist/ Psychiatrist (Private)	5	8.3%
Western Sierra Medical Clinic	6	10.0%
Social Services Agency	1	1.7%
IHSS	1	1.7%
Human Services (Benefits)	1	1.7%
Other	1	1.7%
Total Referrals Made**	**60**	**100.0%**

Outreach Data
February 2016 – June 2016*

Estimated Age Group	# Contacts	% of Contacts
Children	1	0.8%
TAY	27	21.3%
Adults	93	73.2%
Older Adults	6	4.7%
Total	**127**	**100.0%**

*Data collection for Early Intervention began in February, 2016.
**Each individual may receive multiple referrals.

Evaluation Activities and Outcomes

Staff members collect demographic information on individuals who have had multiple contacts. In addition, information on referrals and linkage to community services is collected for each person referred.

There was a total of 236 service contacts delivered to Shelter Guests. Most Guests were seen on the same day of the request, and all were seen within approximately three (3) days of the initial request. Approximately 10 individuals were referred to NCBH for more intensive services. Of those individuals, seven (7) followed through. At least 11 individuals were referred to other mental health services through Western Sierra Medical, Chapa De, and private providers who accept Medi-Cal. At least five (5) of these individuals received services.

Data collection started in February, 2016. The total number of service hours, the number of unduplicated individuals served, and the average number of hours per individual between February, 2016 and June, 2016 are reported below. A maximum of 44 individual families were served.

Service Hours February 2016 - June 2016	
Total Number of Individual/Family Therapy Hours	116.25
Unduplicated Number of Individuals Served	44
Average Number of Hours per Individual	**2.6**

Challenges, Solutions, and Upcoming Changes

Many of the individuals who receive services at Hospitality House are transient, so it is difficult to consistently track outcomes over time. Lack of transportation also provides a barrier to receiving services for many individuals. In order to address this, the NCBH service coordinator provides bus passes, and/ or transportation support to help individuals keep appointments. Substance use is also an ongoing issue, and staff members coordinate with substance use disorder treatment providers to help provide access to services.

Program Participant Story

Sandra (name has been changed) had been in and out of the shelter for the last year. She had spent some of that time "camping out" in the forest with her boyfriend. Both have a history of meth use and were using during this time. The boyfriend would become abusive to Sandra at times. Because of his violent behavior, he was not allowed to stay at the shelter. Sandra, however, could stay at the shelter when she tested clean. When she was clean and staying at the shelter, Sandra would utilize therapy and other support services but would struggle with the guilt she felt for leaving the boyfriend out in the forest. Sandra has a serious mental illness, takes medication, and is on Disability. While camping and using meth, Sandra would not see her psychiatrist nor take her medication regularly, neglecting her mental health.

Sandra returned to the Shelter one day after having been badly beaten by her boyfriend. Sandra was encouraged and supported during her stay and was provided with a safe environment that enabled her to make use of mental health counseling and substance use treatment. She was also connected to community resources. Eventually, Sandra became stable and healthy enough to be housed through the Rapid Rehousing program at Hospitality House and continues to thrive. She has reestablished relationships with her family. She visits Hospitality House occasionally and is a different person, both in appearance and attitude. She remains connected to Hospitality House staff through the Rapid Rehousing program and continues to receive support and guidance. She has over seven (7) months substance free, continues with Narcotics Anonymous (NA) groups, and has a full social life.

PEI Project Name: Outreach for Increasing Recognition of Early Signs of Mental Illness Program

NEVADA COUNTY BEHAVIORAL HEALTH
Mental Health First Aid

Program Description

Program Overview

Mental Health First Aid (MHFA) is a training program that helps community members learn skills to understand and respond to signs of mental illnesses and substance use disorders. MHFA is an interactive, 8-hour course that presents an overview of mental illness and substance use disorders, introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common services and treatment.

Participants learn a five-step action plan encompassing the skills, resources, and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care. Nationally, 25% of adults, 20% of youth, and 30% of soldiers returning from war are affected by mental illness. Aside from accidents, suicide is the leading cause of death among youth. Developing skills and strategies for community members is therefore a national priority.

Target Population

The target population is first responder service providers and other interested community members.

Training Attendance Data
FY 2015/2016

Mental Health First Aid *Unduplicated N=25*	Number of Trainings	2
	Attendance	25
	Average Attendance per Training	12.5
Youth Mental Health First Aid *Unduplicated N=14*	Number of Trainings	1
	Attendance	14
	Average Attendance per Training	14.0
Total Attendance (All Programs) ***Unduplicated N=39***	**Number of Trainings**	**3**
	Attendance	**39**
	Average Attendance per Training	**13.0**

Affiliation & Location Data
FY 2015/2016

Role in Community or Organization Membership	# Served	% of Served
Community Member	1	2.6%
Domestic Violence and Sexual Assault Coalition	1	2.6%
HHSA	1	2.6%
High School Staff	1	2.6%
High School Student	14	35.9%
MH Board Member	1	2.6%
Milhous Children's Services	12	30.8%
Sierra Forever Families	2	5.1%
SPIRIT Center	1	2.6%
Sugarloaf Mtn. School	1	2.6%
Turning Point/NCBH	1	2.6%
Victim Advocate/Truckee	1	2.6%
N/A	1	2.6%
Unknown	1	2.6%
Unduplicated Total	**39**	**100.0%**

Training Location	# Served	% of Served
Rood Center Nevada City	25	64.1%
Seven Hills/Nevada City	14	35.9%
Unduplicated Total	**39**	**100.0%**

Evaluation Activities and Outcomes

Evaluation activities include collecting brief demographics for each person attending the MHFA training. In addition, each participant completes a survey at the end of training to provide information on their perception of the training.

I feel more confident that...	% Agree or Strongly Agree Responses
I can be aware of my own views and feelings about mental health problems. *(N=24)*	100.0%
I can assist a person who may be dealing with a mental health problem to connect with supports. *(N=24)*	100.0%
I can assist a person who may be dealing with a mental health problem to seek professional help. *(N=24)*	100.0%
I can offer a distressed person basic "first aid" reassurance about mental health problems. *(N=24)*	100.0%
I can actively and compassionately listen to someone in distress. *(N=24)*	100.0%
I can ask a person whether s/he is considering killing her/himself. *(N=24)*	95.8%
I can reach out to someone who may be dealing with a mental health problem. *(N=25)*	100.0%
I can recognize the signs that someone may be dealing with a mental health problem. *(N=25)*	92.0%

Challenges, Solutions, and Upcoming Changes

It is a challenge for instructors to meet the requirement set up by MHFA-USA to conduct three (3) MHFA workshops within a 12 month period.

MHFA has no upcoming changes to report.

PEI Project Name: Prevention Program

Homeless Rapid Rehousing (RRH) Program

Program Description

Program Overview

Program deferred to FY 17/18.

PEI Project Name: Prevention Program

FREED
Friendly Visitor Program

Program Description

Program Overview

The FREED Friendly Visitor Program is designed to provide prevention and early intervention mental health services by reducing isolation in seniors and persons with disabilities.

The Friendly Visitor Coordinator meets with the consumer in their home, gets to know their needs and interests, and matches them with an available volunteer. All volunteers have completed applications, interviews, background, and reference checks. Volunteers also attend an orientation on consumer-centered services as well as regular monthly trainings and volunteer support groups. Volunteers are expected to spend a minimum of one hour per week visiting with their matched consumer, but many volunteers spend several hours more than the minimum.

In addition to providing community contact, the FREED Friendly Visitor Program complements other mental health programs, and connects individuals to other necessary mental health services. The program is administered by FREED Center for Independent Living, an organization that provides a consumer-driven, peer support model of services to people with any type of disability in the community, including mental health.

Target Population

The FREED Friendly Visitor program serves individuals ages 60 and older as well as persons with disabilities who are isolated in their homes. Individuals are referred by family members and friends, or by a variety of local agencies.

Referral Data
FY 2015/2016

Agency	# Referrals	% Referrals
211	2	8.7%
APS	3	13.0%
Gold Country Stage	1	4.3%
Helpline	1	4.3%
Helping Hands	1	4.3%
IHSS	1	4.3%
Legal Services of N. Cal	1	4.3%
Pacific ADA	1	4.3%
Private provider	1	4.3%
Project Go	1	4.3%
Public Authority	1	4.3%
Public Law Library	1	4.3%
Social Outreach Nurse	3	13.0%
SNMH	1	4.3%
Spirit Center	1	4.3%
Tahoe Forest Home Health	1	4.3%
Telecare	1	4.3%
The Lift	1	4.3%
Total Referrals Made*	**23**	**100.0%**

**Each individual may receive multiple referrals.*

Evaluation Activities and Outcomes

The FREED evaluation activities include collecting demographic information on each individual receiving services. In addition, information on outreach activities, individual activities, referrals, and discharges are collected. Information on each of the volunteers participating in the program is also reported.

The number of visits from last year increased by eight visits, and the number of hours spent supporting seniors and people with disabilities increased by 90 hours. The personal stories learned from the volunteers and consumers were heart-warming, and staff members feel honored that the program has an opportunity to provide this community service.

Surveys collected from 12 FREED consumers in 2016, indicated excellence in satisfaction with services. All of the consumers indicated that they received regular phone calls and visits from their visitors. Importantly, most consumers indicated that these visits made them feel less anxious and depressed, and improved their quality of life.

Surveys were collected from 17 FREED volunteers in 2016, as well. All volunteers indicated that they felt comfortable discussing depression, anxiety, and suicide with the consumers, when they felt the consumers exhibited signs of these issues. Some volunteers felt a need for further training to help identify signs of these issues, as well as learning how to deal with dementia, grief, and documenting family history. A maximum of 48 individual families were served.

Data Fiscal Year 2015/2016

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	**Year End Totals (Unduplicated)**
Total number of current matches	23	22	22	27	**48**
Number of visits	226	236	250	253	**965**
Number of phone calls	14	8	41	34	**97**
Number of hours	403	395	347	375	**1,520**
Total number of volunteers	28	27	30	41	**44**
Total number of consumers	71	75	83	78	**71**
Number of new consumers	16	6	12	7	**41**
Number of new volunteers	6	1	9	5	**21**
Number of successful new matches	6	2	10	9	**27**
Number of consumers leaving program	7	2	4	3	**16**
Number of volunteers leaving program	5	2	6	8	**21**
Wait List	41	45	26	20	-

Challenges, Solutions, and Upcoming Changes

There was a large decrease in the number of referrals from the new Social Outreach Nurse this year, compared to last year. A total of three (3) referrals were received, compared to an average of three (3) per month. Staff from FREED are working with the Social Outreach Nurse to discuss appropriate referrals and identify opportunities to increase the number of referrals to the program.

Increasing communication with the Social Outreach Nurse will increase the number of referrals to the program. Other agencies made referrals, such as private therapists, other service providers, Adult Protection Services (APS), and senior outreach nurses, so this helped compensate for the smaller number of referrals from the Social Outreach Nurse. Many of the programs serve the same people, so the individuals who most needed services were referred to this program.

Program Participant Story

One individual was an older man who lived in a home he had shared with his wife until she passed away. He shared that everything was going fine until he failed a recent driving test and lost his license. It was devastating to him. The only person he had in his life was a neighbor who would get groceries for him. The social outreach nurse was connected to him and referred him to the Friendly Visitor Program.

This individual immigrated to the United States and loves his native language. He requested a Friendly Visitor who spoke Spanish. Fortunately, one of the Friendly Visitor volunteers is learning to speak Spanish. This Friendly Visitor called and said he would love a person to visit who spoke Spanish, so he could practice. It was a perfect match.

The two started having weekly visits. The individual wanted to pass his driving test. The Friendly Visitor obtained a Spanish DMV booklet that the two studied together. Recently, the individual passed his driving test! He is back on the road again. But it gets better...

The individual was going to have a milestone birthday. His Friendly Visitor wanted to have a party for him, so he arranged with his Spanish class to host a birthday party! They brought food from his native country and learned a few native songs to sing for him. The individual was beyond excited. It was a fun party, and he was so moved and happy.

We have a great community!

PEI Project Name: Prevention Program

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
Wellness Program

Program Description

Program Overview

The Tahoe Truckee Unified School District Wellness Program is a collaboration between the school district, Nevada and Placer Counties, and the Community Collaborative of Tahoe Truckee partners (e.g., Gateway Mountain Center, Tahoe Safe Alliance, Adventure Risk Challenge, etc.) to provide a youth-friendly point of entry for students to connect to supportive adults and access wellness services at the school sites. Students learn relevant skills for improving their well-being and understanding how to navigate and access community resources. This program allows students to access services and supports that address physical, mental, and emotional concerns and engage in activities that will increase their resiliency and overall well-being.

The TTUSD Wellness Program has Wellness Centers at North Tahoe High and Truckee High. The Wellness Centers provide a comfortable setting for students to drop-in during their breaks to

ask questions, get support, or just relax. The Centers are furnished with cozy beanbag chairs, couches, artwork, music, games, art supplies, and healthy snacks to make it a fun place for students to hang out. The program also partners with Gateway Mountain Center to create an integrated Wellness Curriculum at Sierra High and Placer County Community School that provides individualized supports and tools for students to develop sustainable wellness practices.

Key Focus Areas include:

Youth Voice - The TTUSD Wellness Program facilitates a Peer Mentor Program that trains students to become Peer Mentors and teaches them skills to better support themselves and their peers. The Peer Mentors run 9th grade Peer Mentor Support Groups, 9th grade educational workshops and offer support to middle school students. This year, the Peer Mentor Program is expanding to include Link Crew. Link Crew is a nationally recognized program that trains upperclassmen to become Peer Leaders so they can connect with, mentor and provide ongoing support for incoming freshmen. Wellness staff and school counselors will also be outreaching to 8th graders this winter by facilitating educational workshops about the ins and outs of high school. The goal is to start making connections earlier and offer a more seamless transition into high school. The new Link Crew Program will expand and deepen the existing Peer Mentor Program and offer more comprehensive supports for our 8th graders and incoming 9th graders.

The Wellness Centers also provide leadership opportunities for students to have an authentic voice in shaping school and community initiatives, such as: Sources of Strength Club, Be the Change Club, Pride Club, GSA Club, youth leadership workshops, 9th grade Challenge Days and participation in Community Collaborative and County meetings.

Support - TTUSD Wellness Centers provide trained staff and volunteers to listen to, support, and connect students to community health and wellness resources. The Wellness Centers offer a variety of empowerment and peer support groups (coping skills, social skills, girls and boys groups) to build stronger connections with students and provide ongoing social emotional supports. This year, Tahoe Forest Hospital created a new position called the Youth Health Navigator. This person is a licensed social worker who staffs both Wellness Centers each week to connect with students, offer health screenings and support student's access to primary, reproductive, behavioral, oral and vision health services. The Wellness Program also collaborates with school and county partners to provide additional mental health resources for students on campus, such as: Coordinated Care Teams, Uplift school-based therapists and the What's Up? Wellness Checkups Program.

Education - The TTUSD Wellness Program offers a variety of wellness workshops to provide students with practical tools to improve their overall health. Topics cover the range of social, emotional, mental, and physically healthy choices and lifestyle tools, such as: Healthy ways to deal with stress, Heart Math, Know the Signs, Mindfulness, and 9th grade Challenge Days.

The TTUSD Wellness Centers offer three types of programming. The program tracks data for these three types of programming:

1. **Group Services:** TTUSD Wellness Centers offers several ongoing groups that bring students together to discuss their experiences, share ideas, and provide emotional support for one another. The following are the types of groups that are offered:
    a. Girl's Groups

b. Boy's Groups
c. Coping Skills Groups
d. Peer Mentor Meetings
e. The Another Project (SOS) Club
f. Pride Club
g. GSA Club

2. **Drop-In:** The Wellness Center is open for students to drop-in at any time to receive support, be connected to resources, socialize, or just take a break when needed.

3. **Outreach:** The TTUSD Wellness Centers outreach to students by hosting workshops, leadership development days, presentations in the health classes and Wellness Days at Sierra High and the Community School.

Wellness Center Locations and Hours:

- North Tahoe High – The Wellness Center is located in Room 217 and is open Monday-Thursday: 7:30-2:30, Friday: 10:30-12:30
- Truckee High – The Wellness Center is located in Room M1 Monday-Friday: 9-:2:30

Target Population

The TTUSD Wellness Centers program primarily serves high school students, ages 14-18 years, but it also provides peer mentor supports, wellness workshops, and Sources of Strength (SOS) trainings to middle school students, ages 11-13 years. Most of the high school students served seek out Wellness Center programming on their own, but the program also receives referrals from the counselors, psychologists, school administrators, and teachers.

**Note: The following data show the youth from both Placer and Nevada County who attended the Tahoe Wellness Center's TTUSD Wellness Program.*

Attendance Data for Support Groups and Trainings
FY 2015/2016

Girls Group *Unduplicated N=11*	Number of Groups	4
	Attendance	44
	Average Attendance per Group	11.0
Giving Voice *Unduplicated N=22*	Number of Groups	18
	Attendance	261
	Average Attendance per Group	14.5
Mental Health Training *Unduplicated N=12*	Number of Groups	1
	Attendance	12
	Average Attendance per Group	12.0
North Tahoe Peer Mentors *Unduplicated N=14*	Number of Groups	7
	Attendance	68
	Average Attendance per Group	9.7
Peer Mentor 9th Grade Group *Unduplicated N=16*	Number of Groups	5
	Attendance	39
	Average Attendance per Group	7.8
Peer Mentor Training *Unduplicated N=15*	Number of Groups	2
	Attendance	30
	Average Attendance per Group	15.0
PRIDE *Unduplicated N=22*	Number of Groups	8
	Attendance	140
	Average Attendance per Group	17.5
SOS *Unduplicated N=9*	Number of Groups	5
	Attendance	40
	Average Attendance per Group	8.0
Youth Suicide Prevention *Unduplicated N=11*	Number of Groups	3
	Attendance	18
	Average Attendance per Group	6.0
Attendance (All Programs) ***Unduplicated N=95***	**Number of Groups**	**53**
	Attendance	**652**
	Average Attendance per Group	**12.3**

Evaluation Activities and Outcomes

TTUSD collects evaluations for MHSA including collecting demographic information on each individual receiving services. In addition, information on the type of service received, date of service, location of service, and duration of the service is collected for group services. Perception of Care surveys are collected annually. Information on referrals to community services is also reported.

OUTCOME #1- YOUTH:

- We trained 62 youth in peer mentor, Signs of Suicide (SOS), and leadership skills to better support themselves and their peers, as well as have authentic voices in shaping school and community initiatives.

OUTCOME #2- SUPPORT:

- We supported and made new connections with approximately 750 students at Truckee High, North Tahoe High, Sierra High, and Community School through assemblies, workshops, groups, clubs, peer mentoring, tutoring, and lunch time socialization.
- We worked in-depth with 176 students to listen to, support, and help them improve their social, emotional, and mental health.
- We linked 16 students to outside community referrals, such as: Uplift therapist, Nevada County Behavioral Health, Child Protective Services, Teen Clinic, What's Up? Wellness Checkups, Adventure Risk Challenge (ARC), Family Resource Center, and Boys and Girls Club. Of the sixteen student referrals, only three (3) students did not get connected to services. We also found that one (1) student had been experiencing mental health symptoms for less than six (6) months, six (6) students had been experiencing symptoms for six (6) to 12 months, eight (8) students had been experiencing symptoms between one (1) and four (4) years, and one (1) student had been experiencing symptoms for five (5) to nine (9) years.

OUTCOME #3- EDUCATION:

- We delivered 27 educational presentations to approximately 1,800 youth and adults on the following topics: Heart Math, Mindfulness/Stress Reduction, Self-Empowerment, Know the Signs, LGBTQ, youth drug and alcohol addiction, social media, mental health stigma, leadership, kindness/anti-bullying. Youth were able to learn practical skills to improve their overall health and well-being.
- Our health teachers reported that 70% of their Health Class students identified stress management week and mental health week as being the most important part of the class. Students shared that they learned new skills for reducing stress and that they are able to better recognize the signs of suicide and what to do if a friend is having suicidal thoughts. Students shared that they regularly use Heart Math techniques to reduce stress and anxiety. Sierra High and Community School students also shared that they have learned new ways of calming themselves down after participating in Mindfulness Classes.

HIGHLIGHTS FROM FY 2015/16:

- We offered a Summer Program for 11 Sierra High girls. This program provided additional supports for a group of high-need Sierra High girls, so they stayed connected to the school counselor and each other during the summer.
- We conducted 55 individual Core Gift interviews with Sierra High students to help them identify their gifts and ways they can contribute to their school and broader community.
- We trained 30 Peer Mentors and taught them skills to better support themselves and their peers. The Peer Mentors ran 9th grade educational workshops and support groups. We trained an additional 32 youth in SOS, LGBTQ, and Mental Health stigma education.
- We facilitated youth leadership activities: 9th grade Challenge Days, Community Collaborative Youth Forum, Newcomer Lunch, Stu Cabe middle school and high school workshops.
- We partnered with Tahoe Forest Hospital to create a new youth Health Navigator position as a strategy to increase youth access to local community health services.
- We created Coordinated Care Meetings at both school sites to improve communication and coordination of student social emotional supports. This has helped us strengthen relationships with school counselors, psychologists, and administration.
- We hosted a number of community events to engage youth and parents in conversations about how to support youth who are struggling with depression or suicide and help them have a better understanding of mental health.
- A maximum of 95 individual families were served.

Challenges, Solutions, and Upcoming Changes

Fortunately, there were few barriers and challenges this year. Some smaller challenges were: scheduling the peer mentor retreat, the delay in getting a Health Navigator started, and coordinating with school administration to find the best time to pull students out of class for support groups.

The results of an end-of-year school staff survey about the effectiveness of the Wellness Program showed that while staff members are very happy overall with the Wellness Center, there are some teacher concerns about students being pulled out of class too often.

Coordinating the best times to pull a student out of class will be an area of focus in the upcoming school year. We plan to improve communication with individual teachers about the students we are working with and increase coordination of support services. This proves to be an ongoing area of growth for us.

Program Participant Story

Brian (name has been changed) is one of our regulars who has been frequenting the Wellness Center all four years of high school. As a freshman, he was a gregarious, spastic boy who was always making people laugh but had a nervous energy to him. As we got to know him, he began

to share that he didn't always feel happy but he was afraid to let people know the real him. He worried about letting people down and he felt pressure to be the funny guy. He also expressed that he felt anxious a lot of the time. Over the next two years, our Wellness Liaison provided regular check-ins and encouraged him to seek therapeutic support for his anxiety.

At the beginning of his junior year, he opened up and shared that he realized over the summer that he was gay. He said that he had been having this feeling for a while but hadn't had the courage to come out until then. Our Wellness Liaison was the first person he told. She listened to him and supported him in finding his truth. She assisted him in joining a Boys Group and becoming one of our Peer Mentors. Through his participation in these groups, he was able to find his voice and finally come out to his mom. She supported him in seeking out therapy to process his feelings, learn tools to manage his anxiety and build his self-confidence.

This year, Brian joined our PRIDE club and openly came out to his peers. He has since become one of the club leaders and is a role model for many other students. He now speaks about his gender and sexual identity with pride. He has surrounded himself by a loving and accepting group of friends who appreciate him for who he is. He still can be very high energy and struggles with anxiety but he is receiving the help he needs to manage it in a healthy way. He seems to have found more of a sense of calm, balance and confidence. We feel so lucky to have been a part of his journey in discovering and finding peace within himself.

PEI Project Name: Prevention Program

NEVADA COUNTY SUPER INTENDENT OF SCHOOLS
Second Step for Early Learning

Program Description

Program Overview

The Nevada County Superintendent of Schools (NCSOS) brings the Second Step Curriculum into preschools and transitional kindergartens of the Western Nevada County Region as a component of the County's MHSA Prevention and Early Intervention (PEI) Program.

Second Step is a curriculum that teaches social and emotional learning for children. Goals for the Second Step program are for children to develop self-regulation skills, learn to manage their emotions, treat others with compassion, solve problems without anger, and develop strong bonds to school. The curriculum is implemented by the classroom teacher each day in several short segments. The teacher uses scripted lesson cards with photographs, boy and girl puppets, music, and skills practice activities that lead to role playing and discussions. Parents are sent weekly Home Link letters to inform them of what their children have learned and to give them ideas for supporting these concepts at home.

Target Population

The target population for NCSOS Second Step is preschool teachers and students who are in each preschool.

Attendance Data for FY 2015/2016		
Second Step *Unduplicated N=27*	Number of Trainings	**9**
	Attendance	**27**
	Average Attendance per Training	**3.0**

Evaluation Activities and Outcomes

NCSOS collects evaluation activities for MHSA including collecting demographic information on each preschool teacher that implements the program and each preschool student receiving the program. The Desired Results Developmental Profile (DRDP) is collected at the beginning and end of the year to measure the impact of the program on the student's behavior. Information on referrals to community services is also reported.

During FY 15/16, Second Step Staff provided nine (9) on-site trainings for 27 adults working in 11 different classrooms. There were new teachers in eight (8) classrooms. Staff modeled the first two (2) weeks of daily lessons with their students and provided guidance on working the program activities into their existing schedule. This includes two (2) special education classrooms: one (1) with mostly non-verbal preschoolers and one (1) Special Day Class - kindergarten through 3rd grade age. We gave one (1) curriculum kit and six (6) Unit 1 curriculum storybooks to each first-time classroom. At the end of each unit, we met with all new teachers to check in, gather feedback, provide support and deliver curriculum story books from our library.

Staff also connected with 35 potentially active classrooms: eight (8) with new lead teachers, 23 continuing, and four (4) on hiatus for this year for various reasons.

Staff collected data and feedback from everyone, except from one Large Family Center whose owner confirmed they are still using Second Step, but does not want to provide additional information anymore.

A total of 557 children in Western Nevada County participated in Second Step for Early Learning this year. Two hundred fifty-one (251) books were checked out this year. A maximum of 584 individual families were served.

Site Participation over Time

Number of Years	Number of Sites
5 years	9 sites
4 years	10 sites
3 years	4 sites
2 years	3 sites

Measures for Growth in Self-Regulation and Social-Emotional Competence

Social Emotional Skills	Regular Classes Percent Improvement	Special Education Preschool Percent Improvement
Self-Control of Emotions and Behavior	87%	71%
Shared Use of Space and Materials	76%	29%
Identity of Self in Relation to Others	86%	71%
Social and Emotional Understanding	86%	57%
Relationships and Social Interactions with Familiar Adults	84%	71%
Relationships and Social Interactions with Peers	82%	71%
Conflict Negotiation	83%	29%
Responsible Conduct as a Group Member	79%	57%
Reciprocal Communication and Conversation	88%	43%
100% of students showed some growth in at least one (1) area.		

For FY 15/16, the percentage of growth for the K-3 Special Day Class is not reported, as they only completed 11 weeks of the program.

Teacher Reporting

100% of teachers responded YES to the question: 'Do you feel that Second Step is beneficial to the mental health of your students and teachers?'

There were four (4) mental health referrals along with referrals for Student Success Teams (SST) and suggestions were given that a particular child or family may benefit from counseling.

There was a 65% reduction in discipline problems since beginning Second Step in new classrooms.

Teacher Ratings for Areas of Growth

Area of Growth	Teacher Rating Scale of 1(lowest) to 5 (highest)
Self-Regulation Growth	4.2
Social-Emotional Growth	4.3
Overall program	4.8

Challenges, Solutions, and Upcoming Changes

It became increasingly difficult to collect all of the demographics and forms from continuing sites, especially Large Family Centers, because the teachers and owners are very busy. There was also high teacher turnover.

Coordinating between the different school and teacher schedules in order to meet everyone's needs also presented a challenge. The limited number of work hours funded for a single person and the lack of dedicated work space made it harder to effectively provide services at the preschools.

In the upcoming year, it will be important to stay connected with the schools to keep track of when staff changes occur. This will facilitate prompt re-training, as needed. Of the 55 classroom trainings provided in the last five (5) years, 24% have been for staff in classrooms previously trained.

It would be helpful to simplify data collection for certain sites after the first couple years of participation. It would also be helpful to streamline data gathering and reporting to focus primarily on those items required by our contract. Some challenges may be resolved when NCSOS moves to a new building in the upcoming year. Flexibility and organization are going to be key for improving our program in FY 2016/17.

Teacher Success Stories

Teachers shared the following feedback about Second Step:

"Kids now know how to help each other and remind each other to calm down and take deep breaths. It happens daily!"

"Second Step offers very specific, practical tools to children to help them navigate relationships, community, and their own emotional growth."

"A child was demonstrating 'calm–down breathing' at home when mother was exhibiting stress."

"If I am unable to reach children with Second Step to help them regulate their social emotional development, it helps me know who I need to give referrals to for outside support."

"Awesome program that produces great results!"

PEI Project Name: Prevention Program

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
Second Step for Early Learning

Program Description

Program Overview
Second Step is a research-based, Social Emotional Program for preschool to 8th grade in the Tahoe Truckee Unified School District. This is the sixth year of implementation. The program is taught on a weekly basis by the classroom teacher for approximately 20-24 weeks. The Second Step kits were purchased, and training has been ongoing for teachers, newly hired staff, bus drivers, support staff, and employees of the Boys and Girls Club at Truckee Elementary School.

Target Population
The target population is teachers of preschool to 8th grade in the Tahoe Truckee Unified School District. Second Step also serves the students in the Tahoe Truckee Unified School District.

Training Data
FY 2015/2016

Number of Trainings	2
Attendance	12
Average Attendance per Training	6.0
Unduplicated Total	**12**

Evaluation Activities and Outcomes

Activities: One new preschool is using the Second Step program, and training took place at Glenshire Elementary School. There was more training for the Boys and Girls club at Truckee Elementary as well as training for Boys and Girls Club on the Lake side schools. There is ongoing training for all new staff.

Teachers and school staff demonstrate that they feel supported by ongoing training, support and technical assistance from the counselor/facilitator and the administration. Early childhood educators feel supported by assistance form the Early Learning Trainer.

All three (3) Nevada County Sites, Glenshire Elementary, Truckee Elementary, and Alder Creek Middle school are implementing Second Step. At Glenshire Elementary 100% of teachers are trained and using Second Step, and at Truckee Elementary, 90% of teachers are trained and using Second Step. At Alder Creek Middle school 70% of the teachers are trained and using the program.

Two (2) preschool visits were made, and they are using Second Step.

Outcomes: The program has checks for understanding built into each lesson and students consistently demonstrate new skills. The language is also visible on the playground, in the cafeteria and in each classroom. Anecdotally, teachers report that they see evidence that the lessons have a positive impact on student behavior and support sound decision-making skills. Altogether, the program served 1,462 individuals in FY 15/16.

Every school site within the Tahoe Truckee Unified School District develops an annual School Accountability plan and one of the goals specifically addresses school climate. All three schools implementing the program list Second Step as one of the activities that supports their positive school climate goal. Second Step is well integrated into the school culture at all three (3) campuses and the program provides the foundation for our Character Education and Positive Behavior Support approach on campus. Re-teaches from the Second Step program are often used as an alternative to school suspension when inappropriate behavior does occur. As a district, we are committed to keeping students in class and actively engaged. We diligently look for alternatives to suspension that teach appropriate behavior. A maximum of 1,462 individual families were served.

Challenges, Solutions, and Upcoming Changes

The biggest challenge has been for the teachers. It has been hard to allocate time to consistently teach the entire program. The administration plays an important role in the implementation and fidelity of the program, and time needs to be built into the schedule for teaching the curriculum.

It has also been a challenge to train teachers across the region, and try to coordinate the different schedules across several schools. In addition, there has been a high turnover rate for teachers, counselors, and secretaries, which delays fully implementing the program.

It has been difficult to collect data. It would be helpful if there was an easier, more streamlined way to get the data and demographics needed.

Going forward, Second Step is planning Parent Focus Nights on the importance of the social/ emotional aspect of learning these skills in the school setting. It is a goal to continue to use pre and post evaluations by students and staff using Second Step. Newly-hired staff will also continue to receive training. Second Step staff members continue to provide information on the value of the program to help implement this program for teachers across all age groups.

Program Participant Story

Second Step Trainee story: I teach the third-grade lesson on emotion regulation with kids having a tough time with friends. This lesson describes the hand as the brain, with the thumb as the feeling brain and the four fingers as the thinking brain. Kids are taught to use their thinking brain instead of using their feeling brain when reacting to situations that anger them. I will often wave my four fingers at kids to remind them when they show signs of agitation. This one time, though, I was upset with a student and forgot, myself, to remain calm in the situation. The student waved his four fingers at me and said, "remember Mrs. Weber (name has been changed), use your thinking brain, not your feeling brain." I burst out laughing and said, "You are so right!"

PEI Project Name: Prevention Program

BIG BROTHERS, BIG SISTERS
Pal Program

Program Description

Program Overview
The Big Brothers, Big Sisters Pal Program serves at-risk elementary and middle school youth, called Little Pals, by providing them with a high school mentor, or Big Pal. The Big Pals help the Little Pals develop the skills to manage the trials of growing up, while also providing academic support.

High School juniors and seniors are matched with elementary and middle school students, Grades 3 - 7, for a weekly mentoring meeting. All meetings are held on the school campus. Students are referred by administrators/teachers from one of four schools: Scotten, Lymon Gilmore – Grass Valley School District, Deer Creek, and Seven Hills – Nevada City School District. High School Big Pals are recruited from the following schools: Nevada Union High School, Forest Charter School, and Bitney College Preparatory High School. The Pal Program Coordinator recruits, screens, trains, and matches all children and teens, conducts match support meetings on a bi-monthly basis, and works closely with the schools and teachers to set goals and review progress towards those goals throughout the school year.

There were a smaller number of matches made this year. One match closed due to the Little Pal moving, and another match closed because the Big Pal lost contact with our Pal Program Coordinator. There are four matches from this year that are continuing into the next school year.

Target Population
The Pal Program serves at-risk elementary and middle school youth, Grades 3 - 7.

Evaluation Activities and Outcomes

Big Brothers, Big Sisters of Nevada County and North Lake Tahoe have been conducting effective mentoring programs for at-risk youth for the past 35 years. Two surveys are used to assess the quality of the relationships between the Big Pals and the Little Pals and the impact of the Program on the children served: the Strength of Relationship (SoR) survey and the Youth Outcomes Survey (YOS).

Each child and mentor completes the SoR survey after three (3) months of being matched, to establish a baseline. Thereafter, they both complete the SoR annually on their anniversary. This survey assesses the quality of the relationship between the child and the mentor by looking at how close they feel to one another, how much they trust one another, and how important the relationship is to them.

The YOS is given to youth in the program before they are matched, then annually on their match anniversary. This measures the impact of the mentoring relationship on the child's self-confidence, school performance, healthy behaviors, and interpersonal relationships.
Big Brothers, Big Sisters also measures program impact by the length of the mentoring relationship. Big Brothers, Big Sisters expects a one-year minimum commitment from mentoring matches because research has shown that matches that remain together for one year or longer demonstrate higher relationship quality and more positive outcomes for the children being mentored.

Big Brothers, Big Sisters also collects evaluation activities for MHSA including collecting demographic information on each individual person receiving services. Demographics showed 22 individuals served by this program in FY 15/16. In addition, information on the type of service received, date of service, and duration of the service is collected for individual services. Information on referrals to community services is also reported.

According to surveys that the Little Pals received and returned, there was improvement in multiple areas. Little Pals had an increased sense of social acceptance (83.3%), and higher educational expectations (33.3%). There was also an increase in their understanding that skipping school is not okay (16.7%), which was an issue for some Little Pals at the beginning of the school year.

From staff observations of their behavior, there was a lot of improvement in their social skills with one another and with their Big Pals. The 8th grader that graduated from the program wants to be a Big Pal once he is old enough. Two of the Little Pals, and their Big Pals, came to ask the Pal Program Coordinator if they could stay matched together next year because of how much they enjoyed spending time together.

There were no referrals made to other organizations in FY 2015/16. A total of 19 individual families were served.

Challenges, Solutions, and Upcoming Changes

There were only a few challenges seen in our program since our last Annual Report. This year, we struggled with recruitment of high school students for Big Pals. Some interested students weren't eligible to be Big Pals because of their transportation situation (e.g., they did not have a driver's license, or they did not have a car).

Most of the issues involving our Little Pals were actually issues with their parents. There were multiple instances in which their mailing/home address and/or phone number had changed without notifying the program. This made it difficult to get forms turned back in, including permission slips for the Pal Games.

Constant communication with Big Pals, and those interested in volunteering, has been essential to expanding the number of children served. The Pal Program Coordinator visited classrooms at the end of the school year, before and after the Pal Games, to encourage students to sign up. So far, the sign-up sheet of interested students is at 51. That number will change based on the number of Little Pals referred to our program and possible changes to the Big Pals' schedules and availability. Staff members constantly work with students, their schedules, and their teachers to make volunteering in the Pal Program possible. Being flexible with the match deadline is essential because some really excellent Big Pals were matched later in the year because of their driver's license or car situation.

In order to work better with the parents of the Little Pals, staff will continue to make regular check-ins with them and make sure their contact information is correct.

Program Participant Story

One of the greatest matches of FY 2015/16 was between a 7th grade girl and her new Big Pal. The Little had been in our program for a couple of years, and even though she was older, she still wanted to be a Little Pal. She was matched with a high school junior that had wanted to be a Big Pal since she was in elementary school and saw her friends hanging out with their Pals. The two girls clicked immediately, calling each other "sister" and making cards for each other. The girls felt like their meeting times flew by because of how much fun they were having together.

Although our program usually doesn't have 8th graders as our Littles, we kept this girl in our program because she and her Pal insisted that they be matched together again the next year. The Little was encouraged to do her best in school and make good choices. Her Big helped her through some tough times, such as when she decided to stop being friends with some girls at school who were making bad choices. Her Big was there to help her with some of her homework and congratulate her on her good grades. Currently, this Little is setting some high goals for herself and her future regarding a career and where she would like to go to college.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA-SIERRA CONNECTING POINT PUBLIC AUTHORITY
2-1-1 Nevada County

Program Description

Program Overview
2-1-1 Nevada County is a resource and information phone hub that connects people with community, health, and disaster services through a free, 24/7, confidential phone service and searchable online database. By dialing 2-1-1, Nevada County residents can access health information, community services, and disaster services throughout Nevada County. This program offers assistance in multiple languages, and is accessible to people with disabilities. Trained information and referral specialists give personalized attention to each caller by utilizing a comprehensive computerized database of more than 1,282 nonprofit and public agencies at 1,739 different locations in Nevada County. Specialists can refer callers to a variety of services to best meet the caller's needs, offer a "warm referral" - direct connection to resources, and offer follow-up calls to ensure referral needs were met.

Target Population
2-1-1 Nevada County serves the entire population of Nevada County and anyone calling the 2-1-1 Line seeking information about community resources.

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on each caller, the number of referrals to community resources, and the number of follow-up calls.

Staff participated in a variety of training opportunities. These included:

- AIRS (Alliance of Information and Referral Systems) CIRS (Certified Information and Referral Specialist)
- Mental Health First Aid, Motivational Interviewing, and safeTALK Suicide
- Alertness, Identity Theft/Fraud Prevention, Language Line, Transportation Trip Planning with Gold Country Stage, CA Department of Aging-Security Awareness, and Quality Assurance for Information & Assistance Specialists

A total of 9,973 calls were handled, and there were 4,907 unduplicated callers.

- 1,503 were follow-up calls.
- 873 callers were offered a "warm referral" direct connection to resources.
- 42 callers were warm transferred to Nevada County Behavioral Health.
- 479 callers requested mental health services.
- 10,506 referrals were provided to callers.

There were 123,969 searches and resource page views from 14,732 unique IP addresses conducted on the 2-1-1 Nevada County website.

Challenges, Solutions, and Upcoming Changes

There were no challenges in FY 2015/16. No significant changes will be made.

Program Participant Story

Every person who reported suicidal ideation received a referral to a suicide prevention specialist.

One caller identified as having suicidal ideation and was warm transferred to the Behavioral Health Crisis Line. Another caller whose son was threatening suicide was also warm transferred to the Crisis Line.

One caller reported thoughts of suicide for many years. After lengthy discussion during which the caller stated he was not suicidal at the moment and didn't want to be transferred to a suicide prevention specialist, the call specialist requested a welfare check from the Sheriff's Dept.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY ADULT SERVICES
Social Outreach Nurse

Program Description

Program Overview

The Social Outreach Nurse program provides a Registered Nurse (RN) to make home visits to older adults and adults with disabilities. The Social Outreach Nurse assesses for depression, anxiety, and risk of falling while building rapport with the individuals. The nurse also provides support by listening, advocating, and making referrals to various public and private services.

The number of visits and phone contacts varies with each person, based on need. Follow-up "check-in" calls are frequently conducted, and the participants are always encouraged to call if a need arises. At times, consumers call after several months when they need assistance, circumstances change, or they need someone to talk to for support.

An integral part of this program is coordinating outreach activities by networking with other individuals and organizations. The Social Outreach Nurse partners closely with the Falls

Prevention Coalition, FREED Friendly Visitor Program, RSVP Telephone Reassurance Program, Senior Outreach Nurses, Adult Protective Services, and multiple other county programs and resources.

Target Population

The Social Outreach Nurse Program targets older adults, ages 60 years and older, and adults with disabilities who live at home and wish to remain independent.

Referral Data

FY 2015/2016

Agency	# Referrals	% Referrals
Partner Agency	6	7.8%
SPIRIT	1	1.3%
A New Day	1	1.3%
FREED	10	13.0%
Physician/ MD	6	7.8%
Therapist/ Psychiatrist (Private)	8	10.4%
Sierra Nevada Memorial Hospital	1	1.3%
Social Services Agency	2	2.6%
IHSS	5	6.5%
Veteran Services	2	2.6%
Faith-Based Organization	2	2.6%
211	6	7.8%
Other	27	35.1%
Total Referrals Made*	**77**	**100.0%**

**Each individual may receive multiple referrals.*

Evaluation Activities and Outcomes

The Social Outreach Nurse program collects information on each person who receives a home visit. This information includes demographic details, date of the outreach, location, and number of services. The program also collects the number of referrals made to community agencies. A Depression Screening Tool is used at the beginning and end of services.

Outcomes for FY 2015/16 have been positive. The total number of individuals served was 24. There were 77 referrals made to outside services. Of these referrals, 41 (53.2%) resulted in a service. Depression screenings were administered to twenty-one (21) individuals, which revealed seven (7) (33.3%) individuals with moderate to severe levels of depression; the individual who presented with a severe level of depression was immediately referred to a mental health clinician. Ten (10) individuals screened at mild levels of depression and four (4) had no depression symptoms. Of

the four (4) individuals who showed no symptoms of depression, all reported having episodes of occasional depression in the past.

Geriatric Depression Scale*		No symptoms	Mild symptoms	Moderate to Severe Symptoms	Unduplicated Total
Unduplicated Individuals	# Individuals	4	10	7	**21**
	% Individuals	19.0%	47.6%	33.3%	**100.0%**

** Note: Of the 24 individuals for FY 2015/16, 21 individuals were assessed at admission.*

It is anticipated that FY 2016/17 the program will continue to receive an increasing number of new individuals to serve.

Challenges, Solutions, and Upcoming Changes

The greatest challenge during FY 2015/16 was the vacancy of the Nurse position. The position remained vacant for the first four (4) months of the contract period. The Social Outreach Nurse was hired and started work in mid-October. Trainings and the inherent learning curve attached to any new position created a lag time before the nurse could make independent home visits. A second challenge was developing an individual base in Truckee. The program was fully operational by January 2016.

The number of home visits and outreach activities in the community increased once the nurse was hired and trained. The late start created the opportunity to expand the number of hours the nurse could work. The nurse often worked eight (8) or more hours a day and was able to increase the number of home visits and individual supportive phone calls.

Program Participant Story

Overall, all of our individuals have verbalized appreciation for the Social Outreach Nurse Program, and for the emotional support, hope, and Registered Nurse guidance given.

More specifically, there is the story of an older gentleman from a Spanish-speaking country, who is fiercely independent, lives alone, and is no longer able to drive. The Social Outreach Nurse referred the individual to FREED's Friendly Visitor Program, and FREED was able to provide a Spanish-speaking volunteer for this individual in early 2016. The Social Outreach Nurse also worked with the man and was eventually able to help him and his son see the benefit of having the son move into the older man's home. This would provide safety and help meet the man's transportation needs.

PEI Project Name: Access and Linkage to Treatment Program

HOSPITALITY HOUSE

Program Description

Program Overview

Hospitality House is a nonprofit community shelter for people who are homeless in Nevada County. Hospitality House is committed to ending homelessness by providing intensive case management services to all of its guests. Hospitality House also offers outreach services including rapid rehousing, Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) application assistance, birth certificate and California ID fee waiver assistance, referral services, transportation, clothing and clothing vouchers, food and drink, and camping gear. Hospitality House strives to empower people who are homeless and help them develop the skills they need to overcome the barriers that prevent them from successfully obtaining and maintain stable housing. The mission of Hospitality House is to bring homeless people in Nevada County into a circle of community caring that offers shelter, sustenance, medical care, advocacy, opportunity, dignity, and hope as we assist them in transitioning from homelessness to housing.

Target Population

Hospitality House serves individuals who are homeless in Nevada County.

Evaluation Activities and Outcomes

Safety provisions are provided for outreach individuals and may include tarps, tents, sleeping bags, toiletries, clothing/clothing vouchers, and food to offer nutrition and protection from the elements.

Case managers deliver culturally sensitive services to help develop trusting and ongoing relationships with a number of chronically homeless outreach individuals. Case managers will speak to individuals in their language and meet with them on the individual's terms. This sensitivity toward the individuals has resulted in vulnerable individuals having a more willing attitude to engage in shared problem solving to address practical and attitudinal barriers.

In FY 15/16 a total of 103 unduplicated individuals were served by this program. Of those, 16 or 15.5% were housed at exit.

Case managers encourage the individual's willingness to invest time and effort into recovery and treatment, as well as encourage the individual's participation in recognizing and identifying barriers. Case managers work with individuals to create a realistic and attainable plan for change. With the understanding that change comes slowly, case managers aid individuals through

challenges, supporting them as they make even the smallest changes in their behaviors. Over time, the small changes add up and the individual's persistence and the case manager's reinforcement allow the individual to progress. The support of the case manager helps to cement trust in the provider - individual relationship, which yields progress for the individuals. In addition, individuals have come to better understand their entitlements and develop the capability to access and engage in mainstream services. Many have taken responsibility for their futures, and are more hopeful and motivated. They can think beyond their current situation and plan their future.

Challenges, Solutions, and Upcoming Changes

Challenges we have faced include some of our guests having mental health and/or substance use disorders, being survivors of domestic violence, and/or having experienced exploitation. These hardships can create a barrier to continuing services. In addition, some guests lack emotional coping skills, have a low sense of self-worth/self-esteem, and have a limited support system or are estranged from family, which also creates barriers to service.

Challenges our guests have faced include a lack of budgeting and money management skills, a lack of knowledge navigating resources and/or obtaining benefits, and a lack of access to personal hygiene facilities. In addition, our guests lack stable, reliable transportation. Finally, there is a lack of transitional housing options and housing services for people who are homeless in Nevada County. There is a need to expand resources and identify additional resources to meet the complex needs of persons who are homeless in Nevada County.

In order to address the challenges that our guests face, Hospitality house will provide case management involving referrals to and facilitation of services for medical/dental, behavioral health, housing, SSDI/ SSI when appropriate, transportation, money management, and peer counseling. In addition, Outreach staff members offer linkage to county entities (e.g., Community Recovery Resource, Common Goals, etc.). Depending on the individual, a harm reduction model helps support a process towards sobriety, housing, and/or employment. Outreach individuals also have access to assistance in navigating resources or benefits systems.

There were multiple staffing changes during FY 2015/16, which created a lack of timely reporting. The initial outreach case manager during this grant period was hired in February, then resigned in late May. Despite these changes, services continued at the street level, for the camping individuals, and at Hospitality House.

The past year's complex transitions within the shelter are being addressed by hiring a new Executive Director (ED) and by staff restructuring. This should help support more timely data reporting. Despite the 2016 grant reporting issues, outreach services never lapsed or fell short and individuals continued receiving services.

Program Participant Story

M.B., a female individual in her 50s lost her stable job. This led to the loss of her home, and ultimately her boyfriend, due to her chronic issues with alcohol. Not wanting to let her children and family know about her living situation, she became estranged from them, as well.

M.B.'s relationship with Hospitality House (HH) began in May 2015, when she was referred to the shelter by a friend. She initially came as an outreach individual, receiving a tent, tarp, and sleeping bag. Over time, a trusting relationship developed between M.B. and the outreach worker and she realized that she would be less vulnerable in the shelter. The shelter case manager worked diligently with M.B. and was able to establish a positive relationship. M.B. was referred to the Outreach Eligibility Worker from the Department of Social Services and to the Deputy Public Defender outreach program, both of whom offered monthly services through HH. Her lost ID and Social Security card were replaced with assistance from HH. During the course of the year, M.B. cycled between sobriety and relapse, while staying at the shelter periodically. She was adamant that her main goal was finding work, not sobriety.

During one of her sober periods, M.B. was encouraged to join Hospitality House Serves, a culinary job training program for guests at HH. She joined and received her California Food Handler's Permit, acquiring the necessary kitchen skills to obtain employment. Upon completing the course, and with the assistance of the culinary instructor and support of the case manager, she found a job. Earning enough money to sustain housing, she was assisted by the Rapid Rehousing Program to secure an apartment.

M.B. stayed sober for a long period of time, but during a post-housing visit, the case manager discovered she had relapsed and could barely get off her couch. She had lost her job and was once again in danger of losing her housing. Assistance was enlisted for M.B. by the case manager from the on-site mental health provider. With their continued visitations, support, and their encouragement to contact her sponsor, M.B. got up from the couch, regained her sobriety, and once again sought and obtained employment. She remains housed, is once again attending meetings, and has regular contact with her sponsor. She has re-established positive family relationships and, importantly, now states her main focus is to maintain her sobriety.

PEI Project Name: Access and Linkage to Treatment Program

PROJECT MANA
Truckee Homeless Outreach, Access, and Linkage to Treatment Program

Program Description

Program Overview

The Truckee Homeless Outreach Program provides outreach, access, and linkage services for homeless individuals in the Truckee area. One goal of the program is to engage with homeless

individuals in order to reduce the risk of harm and enhance safety. Homeless Outreach Coordinators work with homeless individuals to connect them to benefits/jobs, housing, services, and treatment. Homeless Outreach Coordinators also support and assist individuals to utilize warming shelters, when available.

In addition, the program also provides essential items to homeless individuals including socks, sleeping bags, jackets, blankets, clothes, personal hygiene items, etc.

Target Population

The Truckee Homeless Outreach Program serves individuals who are homeless or at risk of homelessness in the Truckee area.

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on the people served, the location of services and number of persons referred to community resources, including housing. Demographics showed that 25 unduplicated individuals were served in FY 15/16.

Project MANA served 17 unduplicated individuals at the Emergency Warming Center and 15 unduplicated individuals at the Food & Resource Support Center.

Multiple connections to other services and agencies were made. One (1) individual was connected with the Nevada County Behavioral Health Case Manager to explore permanent housing options. One (1) individual was connected to medical care. One (1) family was connected with gas vouchers to access a permanent shelter in Grass Valley. One (1) individual was connected with the Pedal Project to provide transportation to and from work. One (1) individual was connected with a doctor and transportation to an appointment to begin a Social Security Disability Insurance (SSDI) application. In addition, local bus passes and camping supplies were purchased to disburse to individuals and families.

Challenges, Solutions, and Upcoming Changes

There are too few permanent shelter options, transitional housing options, and services for people who are homeless in the Truckee area. There is a need to expand resources and identify additional resources to meet the complex needs of persons who are homeless in Truckee. A possible solution to the lack of services in the Truckee area is to create more programs such as permanent shelters, transitional housing and mental health and substance abuse treatment for homeless individuals in the Truckee area. However, with existing budget constraints, this solution may be out of reach. Until Truckee has the numbers and resources to create new programs, having knowledge of and utilizing already existing programs in western Nevada County is a more realistic solution.

There is also a need to train community members about the complex needs of persons who are homeless, specifically those who are severely mentally ill and/or with co-occurring mental health and substance use disorders. A possible solution is for the Homeless Outreach Coordinator to

raise awareness in the community by attending community forums, providing training, and advocating for our individuals.

Program Participant Story

A male experiencing homelessness accessed the Emergency Warming Center at the beginning of the season. He primarily said that he was just "supporting" the efforts of the Warming Center and really didn't need any help. After the Homeless Outreach Coordinator developed a trusting relationship with this man, he expressed some medical issues that were inhibiting him from being able to work. The Homeless Outreach Coordinator connected him with a doctor who was willing to provide pro bono care and provided transportation to Reno multiple times. The gentleman is now able to walk more freely than before, hold down a job, and he plans to reconnect with friends and family.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY BEHAVIORAL HEALTH
Forensic Outreach

Program Description

Program Overview

Forensic Specialist Services aims to prevent and decrease law enforcement contact and incarceration for individuals experiencing mental health conditions. The program provides assessment of needs and obstacles, referrals to community resources, support accessing substance use disorder treatment, consultation, and direct counseling interventions. The Forensic Specialist engages with numerous community resources including Law Enforcement, Mental Health Court, Public Defender, Behavioral Health, Adult Protective Services, Hospitality House, Community Recovery Resources (CoRR), Common Goals, National Alliance for the Mentally Ill (NAMI), SPIRIT Peer Empowerment Center, and other social service providers.

Target Population

Forensic Outreach provides services for persons with mental health conditions who have law enforcement involvement and/or who may be, or have been, incarcerated and are ready to be released. Many of the people referred to the program are homeless or at risk of homelessness.

Forensic Program Participants were Referred to the Following Agencies:
FY 2015/2016

Agency	# Referrals	% Referrals
Partner Agency	6	2.8%
Nevada County Behavioral Health (NCBH)	30	13.9%
Insight Respite House	3	1.4%
Crisis Stabilization Unit	7	3.2%
SPIRIT	10	4.6%
Hospitality House/Homeless Shelter	31	14.4%
A New Day	1	0.5%
Freed	6	2.8%
CoRR	14	6.5%
Common Goals	19	8.8%
First Five	1	0.5%
Chapa De	2	0.9%
Physician/ MD	5	2.3%
Therapist/ Psychiatrist (Private)	5	2.3%
Sierra Nevada Memorial Hospital	4	1.9%
Western Sierra Medical Clinic	19	8.8%
Social Services Agency	9	4.2%
Food Bank	1	0.5%
APS	2	0.9%
IHSS	1	0.5%
Human Services (Benefits)	23	10.6%
Employment(one-stop)/ CalWORKs	5	2.3%
Legal Services	1	0.5%
Veteran Services	2	0.9%
Faith-Based Organization	4	1.9%
DVSAC	3	1.4%
Sierra Family	1	0.5%
Other	1	0.5%
Total Referrals Made*	**216**	**100.0%**

**Each individual may receive multiple referrals.*

Timeliness of Assessments
FY 2015/16

Average Days between Request for Services and Date of Assessment *(N=69)**	8.4

**One individual had no assessment, and three individuals requested services twice.*

Evaluation Activities and Outcomes

Data collected for this program includes demographics and referrals made to community programs.

Over the course of FY 2015/16, the Forensics Specialist engaged with 67 unique individuals from a variety of agencies across the Nevada County continuum of care. In serving these individuals, the Forensics Specialist was able to build relationships with agencies and area non-profits, increasing the ability to communicate and coordinate a variety of services. Over half of all individuals were connected to the Department of Social Services (DSS) prior to or upon release from jail, ensuring that Medi-Cal and CALFresh benefits were active when they were released.

Nineteen (19) individuals were referred to and received full mental health evaluations from NCBH. Thirteen (13) were enrolled into NCBH services, and six (6) were referred to Turning Point/Assisted Outpatient Treatment (AOT).

Referral sources to the Forensics Specialist program expanded significantly. Referrals now come from Hospitality House, the public defender's office, other county agencies, Domestic Violence and Sexual Assault Coalition, Grass Valley and Nevada City Police, and Community Legal.

Four (4) individuals were connected to treatment programs with treatment starting immediately upon release. Work with these individuals resulted in a streamlined process for others in custody to apply for treatment while in custody. Individuals who express high motivation for treatment can now apply for treatment while in custody and work with the jail therapist to fulfill all requirements for the program prior to release. This increases the likelihood that a bed with a housing service provider will become available before they are released and allows the Forensics Specialist to focus on coordinating a release time and transportation to the identified program.

With the help of the Forensics Specialist, five (5) individuals are currently in the process of applying for SSI benefits, and four (4) individuals had SSI benefits reinstated after being released.

Two (2) individuals received housing vouchers with one (1) now housed and the other looking for housing. Three (3) individuals were connected to Transitional Housing.

Challenges, Solutions, and Upcoming Changes

The main challenges this year were the lack of available, affordable housing and the long waits for treatment programs. Individuals in custody express a high degree of interest in these services and support, but when they are released, it is often difficult for them to remain committed to these goals. This makes it harder for the Forensics Specialist to remain in contact and provide case management services for these individuals.

The Forensics Specialist has been working closely with Wayne Brown Correctional Facility staff to identify ways to provide more access to individuals in custody. Early identification of candidates provides more time to enroll individuals in post-release treatment and explore housing options such a Transitional Housing.

Mentally Ill Offender Crime Reduction (MIOCR) funding can be used in conjunction with additional identified funding sources to help ensure that individuals have the financial resources to cover the costs of housing and/or treatment. In addition, the Forensics Specialist has increased communication and built relationships with Common Goals T-housing and the CoRR treatment facility. The Forensics Specialist is working to use those connections to fast track Forensics and MIOCR participants into those programs.

In the long term, re-alignment of Medi-Cal dollars towards housing stability, rental assistance, and affordable housing development could help bridge the gap for houseless individuals coming out of custody by increasing available housing options and resources. In addition, ongoing work on the Bost House treatment facility will be complete in 2017, providing an option for in-county treatment beds.

Program Participant Story

Overall, a huge success has been assisting individuals in custody with developing release plans that include full assessments and establishing vital resources prior to release. This includes ensuring that those who already receive Supplemental Security Income (SSI) benefits but have had those benefits shut off while incarcerated have all the documentation they need to re-activate SSI benefits upon release.

On an individual level, the ability to leverage MIOCR funds to pay the cost of treatment has been huge. One individual in particular stands out. This individual has had a long history of alcoholism that resulted in extreme levels of public nuisance, Law Enforcement contact, and arrests. The Forensics Specialist was able to intervene at the court level with this individual. The Forensic Specialist was able to offer the Public Defender, the District Attorney, and the Courts a concise plan that included funding treatment and transitional housing. This allowed the individual to exit custody and enter treatment. Successful completion of this court ordered case agreement will result in dismissal of numerous charges for this individual. So far, the individual has completed treatment and remains stable and sober in transitional housing. The individual has been successful at accessing additional services and is working to resolve family issues.

PEI Project Name: Access and Linkage to Treatment Program

WHAT'S UP? WELLNESS CHECK UPS

Program Description

Program Overview

The What's Up? Wellness Checkups (WUWC) program screens Nevada County high school students for suicide risk, depression, anxiety, and other emotional health issues. WUWC screens students at the Nevada Joint Union High School District (NJUHSD) and Tahoe Truckee Unified School District (TTUSD). Students privately take a brief computerized diagnostic questionnaire. A one-on-one interview with program staff is provided as a follow-up. Staff members then connect students with treatment referrals, community resources, in-school supports, and/ or case management and crisis support as needed. The program identifies and helps youth at risk, promotes teen wellness, increases peer support systems, and strengthens family connectedness.

WUWC staff members provide crisis management for some consumers. Because of the need for an immediate connection or referral, the WUWC staff serve as one of the primary, if not the only, support system for the student's family, providing both in-person and phone-based crisis intervention and referrals to local crisis agencies.

WUWC recruits, trains, and supervises screening volunteers and group facilitators. The program collaborated with the Domestic Violence and Sexual Assault Coalition (DVSAC) and Nevada County Public Health to provide in-school groups, like the Boys Groups and Mindfulness Skills Groups at Nevada Union (NU) and Bear River High schools. Additionally, WUWC created ongoing, up-to-date referral guides for case management including therapy resources and provider insurance guides.

WUWC coordinates with district officials, school administration, and staff to find on-campus screening sites and provide student follow-ups. The program supports community awareness of screenings and suicide prevention via newspaper, radio (including the NPR station in Reno), social media, website, presentations at parent-teacher meetings, and school, community, and fundraising events. WUWC attended local collaboratives and agency meetings, including the Suicide Prevention Task Force, MHSA, and Nevada County Behavioral Health. The program shared resources, coordinated services, and participated in events with a local youth-serving organization, NEO.

Parent consent forms are integrated into the online enrollment for 2016/17. Parent follow-up notifications are sent regarding students who are not able to be screened due to refusal, absence, graduation, or having transferred out of the district.

Translation and interpretation services are provided by the Truckee and Grass Valley Family Resource Centers (FRCs). Staff members have continued to develop systems to ensure that Spanish-speaking families are receiving outreach, case management, and follow-up services.

Target Population

WUWC screenings have taken place at the NJUHSD schools including Bear River, Ghidotti, Nevada Union (NU), Park Avenue Campus, and Northpoint Academy high schools. Screening at the TTUSD schools includes North Tahoe, Truckee, and Sierra high schools. WUWC focuses on sophomore students for outreach, as Grade 10 has the highest national suicide completion rate.

WUWC Program Participants were Referred to the Following Agencies:
FY 2015/2016

Agency	# Referrals	% Referrals
Partner Agency	10	6.3%
Mental Health	26	16.4%
Hospitality House/ Homeless Shelter	1	0.6%
NAMI	2	1.3%
Cultural-Specific Services	2	1.3%
Chapa De	1	0.6%
Physician/ MD	1	0.6%
Therapist/ Psychiatrist (Private)	13	8.2%
Food Bank	1	0.6%
Employment/ CalWORKS	2	1.3%
Legal Services	1	0.6%
Family Resource Center	2	1.3%
DVSAC	2	1.3%
211	3	1.9%
Community Teen Center	1	0.6%
School Based Services:	24	15.1%
Mental Health Support	18	11.3%
Academic Support	9	5.7%
Support Group	24	15.1%
Other	16	10.1%
Total Referrals*	**159**	**100.0%**

**Each individual may receive multiple referrals.*

Evaluation Activities and Outcomes

WUWC collects evaluation activities for MHSA including demographic information for each individual person receiving services. In addition, information on the type of service received, date of service, location of service, and duration of the service is collected for group services. Information on referrals to community services is also reported.

SERVICES

- Two hundred and ninety-two (292) high school students screened
- Seven (7) on-campus screening sites coordinated with TTUSD and NJUHSD high school administration/ staff
- Ninety-eight (98) students received in-depth clinical interviews to assess need for further evaluation/ treatment
- Seventy-five (75) students and their families received case management services including referrals, screening summaries, and in-person family meetings
- Thirty-three (33) students at Bear River and NU high schools participated in Boys and Mindfulness groups
- Thirty-eight (38) WUWC Prevention Groups (e.g., Mindfulness groups, Boys' groups) provided
- WUWC media outreach provided through radio and newspaper reaching up to 64,000 listeners and readers

TRAINING

- Six (6) WUWC program presentations provided at district, high school staff, teacher, and parent meetings
- WUWC outreach presentations provided to approximately 200 community members including local business owners and members of service organizations, banks, realtors, and churches
- Two (2) trainings provided to WUWC staff/volunteers including safeTALK and Mindfulness Skills trainings
- Two (2) new training guides developed and implemented for WUWC Screening Volunteers and Group Facilitators

ADDITIONAL STAFF ACTIVITIES

- Five (5) WUWC Group Facilitators recruited, trained, and supervised
- Four (4) WUWC Screening Volunteers recruited, trained, and supervised

Challenges, Solutions, and Upcoming Changes

Three (3) out of four (4) volunteers who were provided training left due to being offered paid employment and/or health issues. This high rate of turnover creates the need to continually recruit and train new volunteers. In order to recruit longer-term volunteers, WUWC will be offering clinical supervision and is actively seeking interns or trainees in need of hours towards their degree or license.

To increase participation, WUWC will offer incentives during the student consent process in the 2016/17 school year. Additionally, a new TTUSD parent outreach plan has been developed through consultation with Marin TeenScreen. We hope this will increase the number of students who participate in the screenings and increase the number of parents who consent for their youth to participate.

PEI Project Name: Stigma and Discrimination Reduction Programs

FAMILY RESOURCE CENTER OF TRUCKEE
Promotora Program - Latino Outreach Services

Program Description

Program Overview

The Family Resource Center of Truckee (FRCoT) has a Promotoras Program, which utilizes paraprofessionals to help Latino families connect to health resources and offer health education.

Traditionally, Promotoras are "community health workers" who are lay members of the community and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Promotoras in Nevada County are Spanish-speaking, bi-cultural, and/or bi-lingual paraprofessionals who help Latino families connect to resources in the community. Promotoras offer interpreter services, provide culturally appropriate physical health education and information, assist people in receiving the care they need, give informal support and guidance on health behaviors, and advocate for individuals and community health needs.

Promotoras participate in capacity-building trainings based on health and mental health outreach and education, including Chronic Disease Self-Management and Crisis Support. They also conduct outreach and psycho-educational groups for Latino families in Spanish about mental health care. Psycho-education groups educate people about mental health issues to decrease stigma about reaching out for help for mental health issues. By decreasing stigma about mental health conditions, the program promotes, maintains, and improves individual and community mental health.

The Promotoras link individuals and families that they serve to needed services in the community, which include mental health services, and when necessary, they accompany individuals to their first appointment for a warm handoff to the mental health professional. Promotoras can refer individuals and families to NCBH Spanish-speaking therapists in Truckee. The therapists provide services to individuals, or if the consumer is a child, services are provided to the child and their family.

Target Population

The Family Resource Center of Truckee Promotora Program primarily serves Latino families who could benefit from supportive services and assistance to link them to needed services in the community.

Outreach Data
FY 2015/2016

Estimated Age Group	# Contacts	% of Contacts
Children	1,117	56.3%
TAY	1	0.1%
Adults	861	43.4%
Older Adults	6	0.3%
Total	**1,985**	**100.0%**

Evaluation Activities and Outcomes

FRCoT collects evaluation activities for MHSA including collecting demographic information on each individual person receiving services. Demographics showed 61 unduplicated individuals served in FY 15/16. In addition, information on the Family Room group services, outreach, and discharge is collected. This includes date of service, location of service, and duration of the service is collected. Information on referrals to community services is also reported.

Trainings/Workshops	Dates	# of Participants
En Mi Familia Empieza el Mundo (Reported on in Q3)	3/9/16-3/20/16	11
Bisuteria y Salud Mental (Reported on in Q3)	3/11/16-4/29/16	18
Bisuteria y Salud Mental	5/17/16-6/28/16	14
Individual Health Education Sessions	Year Total	28
Tomando Control de Su Salud – Chronic Disease Self	5/5/16-6/16/16	14
Depression Workshops with Dr. Paula Lauer	Mondays, Spring	Varied 3-5

Twenty participants completed surveys regarding attitudes toward mental health before and after attending our psycho-educational groups. All 20 individuals (100%) reported an increased feeling of comfort speaking about mental health. Eighteen of the twenty (90%) reported an increase in self-confidence, while two (10%) reported no change. Finally, 16 of the 20 (80%) reported an improvement in their connection to their broader community, while four (20%) reported no change.

Challenges, Solutions, and Upcoming Changes

One challenge has been that the demand for the Promotora Program workshops is higher than we are able to serve. Community members regularly call the FRCoT to request further workshops. In addition, evaluations and feedback request additional services and trainings. Promotoras would like to build their capacity through more trainings.

From an administrative perspective, it has been hard to balance the community need, the Promotora team's efforts/hopes/ideas, the FRCoT's limitations, and our mixed requirements from different funding sources. The Promotoras Program would benefit from expanding the number of FRCoT administrative staff.

In order to improve the program, we would like to provide training to Promotoras (in Spanish) to help enhance their skills (e.g., Motivational Interviewing, Trauma Informed Care). We would also like to develop community-wide opportunities to promote the activities of the Promotoras (i.e. Vision y Compromiso trainings).

All in all, our challenge is to grow so that we can reach our arms wider around our community.

Program Participant Story

Marisol (name has been changed) became a participant at the Family Resource Center five (5) years ago. She had recently lost her husband shortly after she had suffered a debilitating accident at work. The accident left her unable to work. She became an FRC individual because she needed help navigating her worker's compensation case. During the five (5) years that her FRC Advocate worked with Marisol, she went through several surgeries, saw many pain specialists, and had several unrelated health issues, including a cancer diagnosis. The hard work that she put in during those five years included a seemingly endless battle to qualify for Social Security Disability benefits. She struggled through many years of overwhelming poverty, unable to work as her SSDI applications were denied one after the other. She persisted with the encouragement of her FRC Advocate and was able to finally secure the disability qualification and focus on recovery.

Despite many referrals to the Promotora Program and other mental health specialists during those five years, Marisol was never able to make it to events or mental health appointments. She was either too busy, too overwhelmed, too shy, unable to find transportation, or a combination of those things.

After years of battling insurance companies, communicating with doctor's offices, attending countless physical therapy appointments, and spending many difficult hours recovering in her small mobile home, she is finally able to walk without pain. Her social security benefits were approved and her financial burden was greatly alleviated.

Things were finally going well for Marisol, but she was left with an energy for life that was largely unrealized. She struggled with depression and would often tell her advocate that "I am

not good for anything." Her advocate started to visit her at home and to encourage her to attend the Promotora art workshops. She likes to knit, so she agreed to go to their knitting workshop. During the workshop, she met other women like her. She started to open up and laugh, to talk about her chronic disease, her joys, her pain, her disappointments, and her losses. She tells her advocate that she has found a space to "desahogarse - un-drown herself." The Promotoras and her Advocate continue to encourage her to see a mental health professional, but she has not agreed to that, yet. For now, she has taken one more step in the long path to mental wellness awareness.

PEI Project Name: Stigma and Discrimination Reduction Program

NEVADA COUNTY SUPERINTENDENT OF SCHOOLS
Promotora/ Latino Outreach

Program Description

Program Overview

The NCSOS Promotora/ Latino Outreach Program consists of Mental Health Outreach and Engagement groups for the Latino Community. The goal of these groups is to educate individuals and to decrease stigma and fear about mental health issues in the Latino Population. These groups are conducted in Spanish and childcare is always available during group meetings. Meetings take place at the Family Resource Center (FRC) and the Grass Valley Charter School, facilities of the Nevada County Superintendent of Schools (NCSOS).

Traditionally, Promotoras are "community health workers" who are lay members of the community and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Promotoras in Nevada County are Spanish speaking bi-cultural and/or bi-lingual paraprofessionals who help Latino families connect to resources for health care in the community. Promotoras offer interpretation and translation services, provide culturally appropriate physical health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, and advocate for individuals and community health needs. Promotoras also link individuals and families that they serve to needed services in the community, which includes mental health services and, when necessary, accompany individuals to their first appointment for a warm handoff to the mental health professional.

Target Population

NCSOS Promotora/Latino Outreach Program serves the Latino population in the Grass Valley area. This program serves children, transition age youth (TAY), adults, and older adults.

Evaluation Activities and Outcomes

The NCSOS Promotora/Latino Outreach Program collects evaluation activities for MHSA including demographic information on each person receiving services and/or being trained. Demographics showed 228 unduplicated individuals served in FY 15/16. In addition, information on individual and outreach services is collected. An attitude survey is collected at the end of services. Information on referrals to community services is also reported.

This program collaborated with multiple other organizations in FY 15/16, including: Sierra Nevada Memorial Hospital (SNMH) Summer Institute, Nevada Union (NU) High School Senior Project, Domestic Violence and Sexual Assault Coalition (DVSAC), Foothill Healthy Babies, Western Sierra Medical Clinic, Suicide Prevention Task Force, Community Recovery Resources (CoRR), Nevada County Behavioral Health, Drug and Alcohol, Child Protective Services (CPS), and School District Individual Education Plan (IEP) translations.

The program also provided multiple services in FY 15/16. There were eight (8) Wellness and Recovery Action Plan (WRAP) sessions, one (1) Know the Signs, and three (3) safeTALK workshops. In addition, there were 15 meetings: One (1) Diabetes and Mood group, four (4) Nutrition and Yoga for Stress groups, and 10 English as a Second Language (ESL) Mental Health Conversations. In addition, 149 referrals were made to outside agencies.

The Promotora service has fostered positive, trusting relationships with the Latino community. It continues to engage families to participate in educational programs where they learn to access health and community services. Some of the Latino families who we have assisted have become their own advocates, have better English language skills, and successful management of their needed resources. The ESL classes not only increased their language knowledge, but also their comfort conversing about mental health issues. The individuals who receive our services feel more freedom to talk about mental health and substance abuse.

WRAP sessions are a strategy for individuals to find and identify triggers, change behaviors and attitudes, and develop self-advocacy, which aids in preventing or reducing negative outcomes. For instance, a family feud was resolved through a carefully developed WRAP Plan. In another family, the mother developed a Plan to prevent herself from "losing it" with her children. In addition, one adult now advocates for herself and has a list of who and how to request help when she feels depressed.

The Promotora links individuals to alcohol and substance abuse treatment (e.g., CoRR). In addition, these linkages of individuals to detox facilities may occur in one day, thereby helping to reduce the duration of untreated addiction. The Promotora's close relationship with the community resources and trusting relationships with the individuals brings about more efficient referrals for treatment.

The freedom to talk about mental health disorders and alcohol abuse is growing in the community. A person came to the FRC and to find resources for a friend who drinks heavily. This friend had told the person that he wanted to "end it all!" The person was provided a "Know the Signs" brochure to talk with the friend about getting help.

Challenges, Solutions, and Upcoming Changes

The difficulty to attract a new audience to educate regarding mental health disorders s an ongoing challenge. There is interest and a need to participate in Alcoholics Anonymous (AA) and AL-ANON meetings, but local meetings are in English and language becomes one more barrier in the journey to sobriety. The program has made ongoing advocacy contacts to encourage AA and AL-ANON organizations to have local meetings in Spanish.

High prices preclude ineligible adults from receiving health insurance, services, or medication. To address these challenges, we advocate for payment plans with local health providers and institutions, interpretation and translation services, provide application assistance, referrals, and transportation to facilitate access to resources.

Our availability to serve the Latino community with confidentiality and trust makes us able to include mental health and/or substance abuse as a part of the conversation.

Program Participant Story

A young mother came to the FRC and requested to talk with our Promotora. The individual needed help and described symptoms that had been bothering her for a long time. Sometimes her heart would race, and fear would overcome her. She would become anxious about passing out or being unable to breathe. She stayed home and worried for her children's safety if she had to drive. She always felt very tired and finally decided to ask for help.

During their conversation, our Promotora gave her a pamphlet about Anxiety and Panic Disorder and asked her to see if the pamphlet described what she was feeling. After reading it, the individual agreed to be referred to Behavioral Health for therapy with our bilingual therapist.

Months later, the individual was much more relaxed and stated she was feeling better. At a meeting, she approached the Promotora and said, "I'm feeling well, and I'm planning to go to school and get my diploma." No more needed to be said. She was back in control of her life.

PEI Project Name: Suicide Prevention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Suicide Prevention and Intervention

Program Description

Program Overview

The Suicide Prevention and Intervention (SPI) Program was developed to create a more "suicide aware community." An SPI Coordinator organizes and leads the implementation of this

program. The SPI Coordinator works with consumers, individuals, families, support groups, task forces, community-based organizations, local and state governments, schools, crisis lines, and health clinics. The goals of the program are to raise awareness that suicide is preventable, reduce stigma around suicide and mental illness, promote help-seeking behaviors, and implement suicide prevention and intervention training programs.

The SPI Coordinator uses an evidence-based curriculum, such as SafeTALK, and other evidence-based practices to conduct outreach in the community, build community capacity, and provide linkage to services. The Coordinator provides these services in schools, faith-based organizations, business communities, county offices, public health sites, city offices, and to individuals and organizations that request assistance. The SPI Coordinator reaches people in the community who ordinarily would not be aware of mental health resources or how to access them.

Presentations, in-services, and best practice training programs that were accessible to a broad range of community members:

- Know the Signs (KTS)
- SafeTALK
- Community Response Protocol Project
- Applied Suicide Intervention Skills Training (ASIST)
- FEMA Social Media Training
- Critical Incident Stress Management (CISM)
- Individual and Group Crisis Intervention
- Workplace Violence Prevention
- Coping with Secondary Trauma and Compassion Fatigue

Target Population

The SPI program serves the entire population of Nevada County.

Attendance Data
FY 2015/2016

safeTALK *Unduplicated N=92*	Number of Trainings	4
	Attendance	93
	Average Attendance per Training	23.3
Know the Signs *Unduplicated N=69*	Number of Trainings	6
	Attendance	72
	Average Attendance per Training	12.0
Attendance (All Programs) ***Unduplicated N=159***	**Number of Trainings**	**10**
	Attendance	**165**
	Average Attendance per Training	**16.5**

Outreach Data
FY 2015/2016

Estimated Age Group	# Contacts	% of Contacts
Children (0-15)	4	7.1%
TAY (16-25)	19	33.9%
Adults (26-59)	30	53.6%
Older Adults (60+)	3	5.4%
Total	**56**	**100.0%**

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on each participant in the training. In addition, a survey is collected at the end of training to provide information on the perception of the training. In total, 161 unduplicated individuals were served by this program.

safeTALK Feedback Questionnaire	Percent Responses: Mostly or Well Prepared
How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide? *(N=74)*	**97.3%**

The Directing Change Program & Film Contest is part of Each Mind Matters: California's Mental Health Movement. The program offers young people the opportunity to participate in the movement by creating 60-second films about suicide prevention and mental health that are used to support awareness, education and advocacy efforts on these topics. Across the state, 451 films were submitted from 126 schools and community-based organizations, representing 31 counties. This year, seven (7) films were submitted from Nevada Union High School. It is the first year that Nevada County schools have participated.

At the Sierra College Health Fair, there was campus-wide outreach to college students. There was a health fair booth that provided games, information about the MY3 phone app, stigma reduction, relevant helping resources, and material debunking myths.

After the KTS in Primary Care Settings, 86% of participants, at some level, agreed that they felt more prepared to address suicide risk and would know how to intervene.

PFLAG held a Candle Light Vigil in response to the Pulse Club shooting. Nevada County Behavioral Health offered free counseling services available to the LGBTQ community, families, friends, or allies affected by the shootings.

Onset of Mental Health Symptoms	# Served	% of Served
1 month ago	-	-
2 - 6 months ago	-	-
7 - 12 months ago	1	1.1%
1 - 4 years ago	1	1.1%
5 years ago or longer	7	7.6%
Other	1	1.1%
N/A	34	37.0%
Unknown	48	52.2%
Unduplicated Total	**92**	**100.0%**

**Note: Demographic data was not collected for the KTS trainings delivered in FY 2015/16 (69 participants).*

Challenges, Solutions, and Upcoming Changes

There is limited visibility, awareness, acceptance, support, and access to health care services for people who are transgender, a group that poses a high risk for suicide. Transgender Day of Remembrance (TDoR) is a day to memorialize those who have been killed as a result of transphobia (the hatred or fear of transgender and gender non-conforming people) and to bring attention to the continued violence endured by the transgender community. In order to observe this day and address some of the challenges transgender individuals face, there was a community forum at a meeting of Parents, Families, and Friends of Lesbians & Gays (PFLAG).

The Suicide Community Response Protocol Project (Tahoe/ Truckee/ Grass Valley) facilitates building trusted relationships, addresses concerns about how to navigate within and between systems, and how to communicate sensitive information. The project included a Tahoe Truckee Community survey to help understand community perspectives. The project required months of coordination and commitment from consultants, Tahoe Truckee Suicide Prevention Coalition (TTSPC) steering committee, and community partners. Meetings and conference calls helped keep communication strong and the project moving forward.

When planning KTS in Primary Care Settings, it was challenging to figure out the best way to have primary care providers attend. It was hard to access Primary Care Providers' email addresses, and there was a lack of availability, interest, and perceived relevance. To address this, we will partner with Sierra Nevada Memorial Hospital (SNMH) to help with dissemination and outreach of the KTS in Primary Care Settings training.

CALMHSA STATEWIDE PEI PROJECT

Program Description

Program Overview

In Fiscal Year 2015/2016, 42 counties collectively pooled local PEI funds through CalMHSA to support the first year implementation of the Statewide PEI Project. Statewide, the funding supports programs such as maintaining and expanding social marketing campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to counties, schools and local community based organizations, providing stigma reduction trainings to diverse audiences, and building the capacities of higher education schools to address stigma reduction and suicide prevention.

CalMHSA created culturally proficient materials. Nevada County utilizes the materials for conducting outreach activities. These materials provide information and training on social marketing, and stigma and discrimination reduction best practices. Nevada County is able to utilize these trainings and resources at a reduced rate.

Target Population

The Statewide PEI project is meant to serve all California residents.

Evaluation Activities and Outcomes

The agencies, schools, and organizations that were reached with Statewide PEI Programs included the Nevada County Public Health Department, John Muir Charter School, and Nevada Union High School. They received outreach materials, training, and technical assistance about stigma reduction and suicide prevention through the Statewide PEI Project.

For training, the Each Mind Matters (EMM) Team provided two trainings in Nevada County on suicide prevention in the primary care setting. In addition, representatives from Nevada County attended the El Rotafolio Training in Butte County on May 25-26, 2016. The training included safeTALK certification in Spanish and training on the use of the El Rotafolio (flipchart).

For technical assistance, follow-up support to individuals who participated in the training on suicide prevention in the primary care setting was provided. There were also monthly emails from Resource Navigator, which included Each Mind Matters updates, descriptions of new resources, and relevant resources that support specific target audiences. Nevada County had access to a designated Each Mind Matters Resource Navigator and participated in CalMHSA's monthly County Liaison calls.

Between July 1, 2015 and June 30, 2016, nearly 1,000 materials were disseminated across Each Mind Matters programs, and initiatives were disseminated throughout the county.

Directing Change Materials	131
Each Mind Matters Promotional Items	780
Know the Sings Outreach Materials	35

Workforce Education and Training (WET)

Nevada County's WET plan was approved on June 17, 2009. Implementation is proceeding as outlined in the plan in several areas. These include Workforce Staffing Support, Training & Technical Assistance, Mental Health Career Pathways and Expansion of the Internship Program when funds are available.

NEVADA COUNTY BEHAVIORAL HEALTH
Workforce Staffing Support

Program Description

Program Overview

The MHSA Coordinator worked on the implementation of the plan including providing updates as required to the Mental Health Board and the MHSA Steering Committee. The MHSA Coordinator participated in the state-wide WET conference calls and meetings, and provided leadership for ongoing trainings, WET activities and development. Clerical staff supported the ongoing administration for the MHSA Coordinator, Behavioral Health staff, contractors, program participants and families as related to WET implementation. A total of 265 hours were billed to Workforce Staffing Support in FY 15/16.

NEVADA COUNTY BEHAVIORAL HEALTH
Training and Technical Assistance

Program Description

Program Overview

Numerous training events have been offered by the County for staff, service providers, and stakeholders, including program participants and family members. When appropriate, MHSA PEI and WET funds were utilized for training opportunities. For FY 15/16 events/conferences/ trainings included: Acute Anxiety & Depression, American Art Therapy Association, Behavioral Health Information Management Conference, Bipolar an Updated Slant on the Disorder, California Quality Improvement Conference (CALQIC), Building Strong Partnerships, California Association of Mental Health Peer-Run Organizations (CAMHPRO) Annual Consumer Conference, Challenging Geriatric Behaviors, Clinical Supervision for Psych - Home Study, Cognitive Behavioral Therapy (CBT) & Relapse Prevention Strategies, Compassion Fatigue Prevention & Resiliency: Fitness for the Frontline, Continuum of Care, Coping with Secondary Trauma & Compassion Fatigue, California State Association of Counties (CSAC) Credentialing, CSAC-Financial Reporting & Budgeting, De-escalating Potentially Violent Situations, Early Intervention for Psychosis Clinical - Case Managers training and Professionals

training, Ethics & Risk Management in the Age of the Affordable Care Act, Forensic Mental Health, Housing Application Information Sessions, Know the Signs - Suicide Prevention for Primary Care, Law & Ethics, Making Connections-Overcoming Conflicts, Mental Health First Aid, Mental Status Exam, Mindfulness-Based Stress Reduction, Motivational Interviewing Advanced, Moving Beyond Depression - Home Visitor Training and Therapist & Team Leader Training, Medically Underserved Area/Population (MUA/MUP) Workshop, On Poverty and Families, Parent-Child Interaction Therapy (PCIT) Conference & Training, Project Management, Post-Traumatic Stress Disorder (PTSD) and Complex PTSD: Ways to Bolster Resilience, Small County HIPAA Training, Small County Wellness Training Series (SCWTS): Obstacles to Recovery: Psychiatric Symptoms and the Social/Physical Environment, SCWTS: Recovery Oriented Services and Programs for Wellness Centers, SCWTS: Reducing Stigma by Becoming a Visible and Valued Part of the Community, Suicide Prevention & Outreach Training-Spanish, Superior Region Peer Provider Core Competency Training, Texting & Email with Patients, The Body Keeps the Score with Bessel van der Kolk, M. D. , The Superior Region WET Partnership Presents: Basic WRAP Training, The Transforming of Power of Self-Compassion, Trauma Competency Conference, Trauma Informed Care Training, Workplace Violence, and WRAP Facilitator Refresher Training.

Purchases continue to be made to expand the training library. Staff and providers are welcome to check materials out and use these resources as it fits their schedules. Continuing Education Units (CEU) are available for some of the materials.

A total of 169 duplicated and 121 unduplicated individuals attended a training, conference or event in FY 15/16.

NEVADA COUNTY BEHAVIORAL HEALTH
Mental Health Career Pathway Programs

Program Description

Program Overview

In FY 11/12, it was decided to utilize $15,000 in Mental Health Career Pathway funds to further support the Wellness Recovery Action Plan (WRAP) Facilitators in Nevada County. Originally, 18 individuals were either trained to be a WRAP Facilitator or had a booster training. These individuals were representatives of a wide range of organizations/groups. Individuals from SPIRIT Peer Empowerment Center, The Alliance for Wellbeing, Grass Valley PARTNER Family Resource Center, Family Resource Center of Truckee, Community Recovery Resources, Women of Worth, Domestic Violence and Sexual Assault Coalition, and New Directions (a Nevada County Behavioral Health Full Service Partner provider) participated in the training. These individuals included: program participants, peer support specialists, young adult peer supporters, Promotoras, drug and alcohol counselors, domestic violence counselors/employees, and therapists. The County continues to support the WRAP Facilitators by providing training, meeting space and materials to conduct WRAP Facilitator Support Meetings. WET funds are also used to provide WRAP Facilitation Group implementation materials.

In FY 15/16 the county provided for three instructors to come and present a five-day WRAP Facilitator Workshop to 13 peers, along with food, the venue, transportation, etc. using WET funds. The county also sent two peer counselors to WRAP Facilitator Refresher Training and purchased these additional resources for the ongoing program using WET funds: 140 WRAP books, 10 WRAP For Addictions books, 110 My WRAP books, and 10 WRAP for Veterans and People in the Military books.

NEVADA COUNTY BEHAVIORAL HEALTH
Expansion of Nevada County's Internship Program

Program Description

Program Overview
This program was primarily funded under CSS in FY 15/16. See CSS section above for details.

NEVADA COUNTY BEHAVIORAL HEALTH
Financial Incentives

Program Description

Program Overview
Nevada County Behavioral Health WET funds are no longer used for this program.

Innovation (INN)

There were no Innovation programs for FY 15/16.