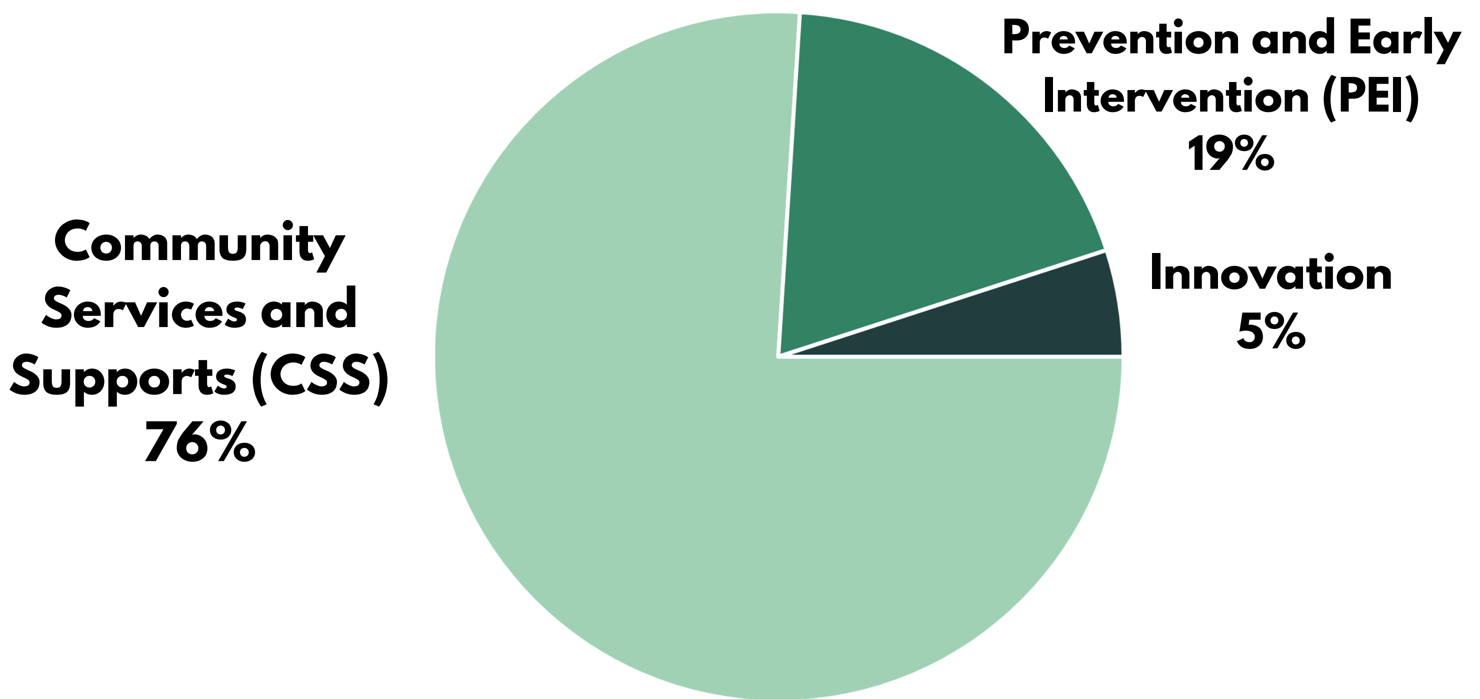
NEVADA COUNTY
MHSA ANNUAL PROGRESS REPORT
FISCAL YEAR 21/22

NEVADA COUNTY
CALIFORNIA

MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL PROGRESS REPORT FOR FY 2021/2022

Due to the small population of Nevada County, program participants' demographic information (e.g. race or gender) is not reported here, but is submitted to the MHSOAC confidentially.

MENTAL HEALTH SERVICES ACT (MHSA) COMPONENTS



PEI programs (19% of total funding) aim to prevent mental health issues, and implement early strategies to keep serious mental illnesses from being disabling, if possible. 51% of funding set aside for individuals 25 years or younger.

CSS programs (76% of total funding) provide treatment and recovery services to individuals living with serious mental illness or emotional disturbance. 51% of CSS funding is set aside for Full Service Partnerships (FSP) – "whatever it takes" services. CSS funds can also be used to fund Workforce Education & Training and Capital Facilities & Technological Needs

Innovation programs (5% of total funding) are novel, community-driven approaches that test and implement new mental health models, and can last for up to 5 years.

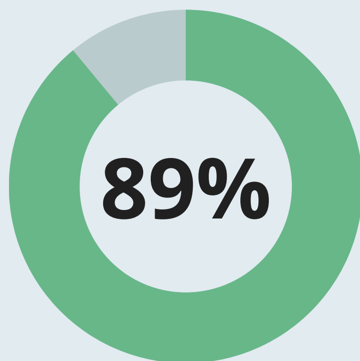
ADULT FULL SERVICE PARTNERSHIP

Performance Outcomes July 2021 - June 2022

Adult Full Services Partnership (FSP) programs are designed for individuals 18+ years old who have been diagnosed with a severe mental illness and would benefit from a more intensive outpatient program. In Fiscal Year 2021/2022, Turning Point Community Programs was the primary Adult FSP provider in Nevada County.

The range of treatment and services is comprehensive and flexible, and services are available 24 hours per day, 7 days per week. “Whatever it takes” services may include peer/family counseling, assisted outpatient treatment, psychiatric services, treatment for co-occurring disorders, and housing and employment support.

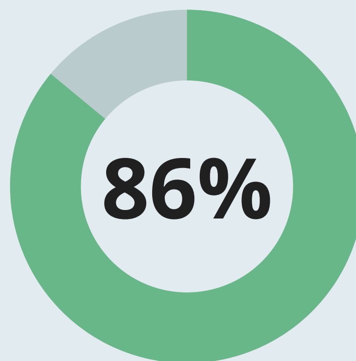
HOUSING & HOMELESSNESS



SUCCESSFULLY REMAINED HOUSED

71 individuals

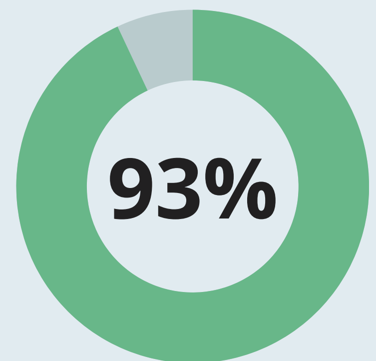
PSYCHIATRIC HOSPITALIZATION



AVOIDED PSYCHIATRIC HOSPITALIZATION

69 individuals

CRIMINAL JUSTICE INVOLVEMENT



AVOIDED ARREST OR INCARCERATION

74 Individuals

TURNING POINT
COMMUNITY PROGRAMS
A Path to Mental Health

CHILDREN'S FULL SERVICE PARTNERSHIP

Performance Outcomes July 2021 - June 2022

Children's Full Service Partnership (FSP) programs are intensive mental health treatment programs for children under age 21 diagnosed with a serious emotional disturbance or mental illness and their families. In Fiscal Year 2021/2022, Victor Community Support Services (VCSS) was the primary Children's FSP provider in Nevada County.

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.

131 YOUTH SERVED

4% increase from previous year

96%

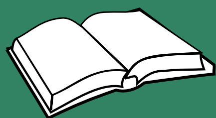
SUCCESSFULLY REMAINED HOUSED

96%

AVOIDED PSYCHIATRIC HOSPITALIZATION

98%

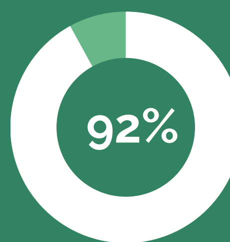
AVOIDED NEW LEGAL INVOLVEMENT



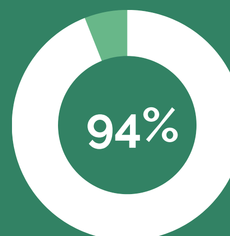
ACADEMIC PERFORMANCE

- **80%** maintained a C average or improved their academic performance
- **95%** did not experience a suspension or expulsion
- **91%** of discharged youth reported regular school attendance or improvement in school attendance

CAREGIVERS



of caregivers reported increased connections in the community



of caregivers reported their parenting skills increased or improved

COMMUNITY SERVICES AND SUPPORTS (CSS)

GENERAL SYSTEM DEVELOPMENT

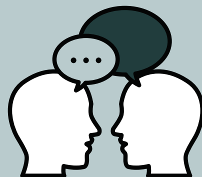
Key Program Outcomes for FY 2021/22

General System Development provides funds to improve the County's mental health service delivery system and pays for specified mental health services and supports for beneficiaries and their families.

with serious mental illness housed through Nevada County Housing Development Corporation

50%

of individuals on 5150 holds were stabilized without hospitalization

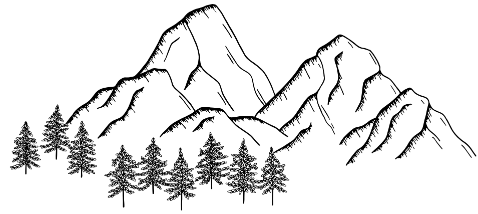
173 

individuals in crisis received peer support at the Emergency Department or Crisis Stabilization Unit

66

individuals utilized the Insight Respite Center for short term peer-centered respite care

8 Eastern County youth participated in alternative and nature-base therapy resulting in increased stability and connections



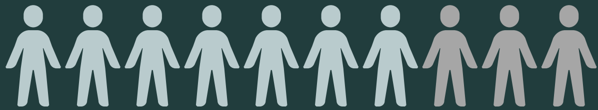
of 127 children served by Stanford Sierra Youth & Families were stabilized at home or in foster care

NAMI provided family education and support to 68 individuals, including holding 10 educational meetings

- 2,162 individuals received crisis intervention services
- 14 individuals were served by network providers (9 children and 5 adults)
- Nevada County Behavioral Health provided expanded services to 743 individuals

OUTREACH AND ENGAGEMENT

Outreach and Engagement funds activities to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County.



Sierra Family Health Clinic connected 74% of its patients with identified needs to behavioral health services w/in 90 days in the North San Juan ridge region

1,369

peer support sessions provided by SPIRIT Peer Empowerment Center

81 **veterans and their families with mental health needs served by Veterans Services Office**

67 **individuals & families received therapy through Welcome Home Vets**

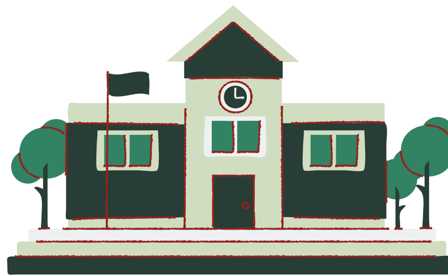
36 **individuals served by embedded case manager at Hospitality House**

PREVENTION AND EARLY INTERVENTION (PEI)

YOUTH OUTCOMES

463

Nevada County high school youth screened for mental health needs



434

Eastern County high school youth supported at school-based Wellness Centers

All 7 mothers who completed 6 or more sessions in the Moving Beyond Depression program showed improvement in depression symptoms

66 individuals in the Truckee region experiencing homelessness received case management & referrals to services

87%

of 14 youth mentorships for elementary schoolers were sustained throughout the year

PREVENTION AND EARLY INTERVENTION (PEI)

15 youth in crisis in Tahoe/Truckee received immediate access to alternative nature-based therapy mentorships pending connections to appropriate levels of long-term care

70 Boys and Girls Club youth members in the Tahoe/Truckee region completed the "Positive Action" curriculum to promote social & emotional learning

85% of the 113 Tahoe/Truckee families who participated in parenting classes demonstrated improved parenting skills

LATINX OUTCOMES

39 individuals received bilingual therapy

Promotoras are bilingual and bicultural community health workers who promote mental health among the LatinX community

36 mental health referrals made by Promotoras

411 individuals educated on mental health issues & services

PREVENTION AND EARLY INTERVENTION (PEI)

OLDER & HOMEBOUND ADULT OUTCOMES

97%

of Social Outreach Program participants receiving home visits reported an increase in social activity or increased positive mood

97%

of older adults and homebound adults surveyed by the FREED Friendly Visitor program reported an improvement in their quality of life

OTHER PEI OUTCOMES

- 50 young adults in the Tahoe/Truckee region participated in Youth Empowerment groups
- 80 individuals attended Mental Health First Aid trainings
- Suicide prevention trainings provided to 204 individuals
- 6 youth completed the 12 program module and certified in Mindfulness Based Substance Abuse Treatment (MBSAT)
- The SAFE (Stability-Access-Foundation-Empowerment) program served 60 youth, improving housing stability for 52 of those youth ages 12-26 engaged in their program.

HOMELESS OUTREACH AND MEDICAL ENGAGEMENT (HOME) TEAM - FY 21/22

The Homeless Outreach and Medical Engagement (HOME) Team aims to provide access and linkage to services for individuals who are experiencing chronic homelessness. The team includes a Nurse, Personal Services Coordinators, Certified Drug and Alcohol Counselor, and Peer Specialist.

MEDICAL SERVICES

196 individuals received medical engagement from the Nurse

710 individual face-to-face medical contacts were made

528 hours spent engaged in face to face medical services to individuals

181 referrals for services from the HOME Nurse

MENTAL HEALTH SERVICES

10 assessments completed

8 connected to treatment

SUBSTANCE USE DISORDER

30 assessments completed

29 connected to treatment

Community Services and Supports (CSS)

Children's Full-Service Partnership (FSP):

VICTOR COMMUNITY SUPPORT SERVICES (VCSS)

Program Description

Program Overview

Victor Community Support Services (VCSS) is an intensive treatment service program in Grass Valley that served children diagnosed with a serious emotional disturbance or mental illness and their families through two modalities throughout this past fiscal year: Family Vision Wraparound, which provides high fidelity wraparound services, including case planning, therapeutic services, medication support, and crisis intervention; and Therapeutic Behavioral Services (TBS). This report covers outcomes for children and youth being served through both 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. A significant portion of services were provided via telehealth for the duration of this fiscal year as a response to COVID-19.

Target Population

MHSA 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.

Individuals are referred to Victor from the SMART Team, Children's Behavioral Health, Child Welfare Services, Probation, or school districts, including youth qualifying for Medi-Cal, and/or Katie A services.

Evaluation Activities and Outcomes

In FY 21/22, VCSS provided 131 youth with mental health and/or Wraparound services, a 4% increase over the total served in FY 20/21. Fourteen of these youth were served at VCSS Truckee and 117 were served at VCSS Grass Valley. The goals of these services are to reduce hospitalizations and recidivism for juvenile offenders, improve school performance, improve

targeted behaviors, increase community connections, and provide effective services to ensure the most efficient, least restrictive, and most appropriate level of care for youth and their families.

- **Housing** (decrease in homelessness, decrease in number of days homeless, decrease in emergency shelter use, increase in independent living, decrease in out of home placement and residential status for children): During FY 21/22, 96% of the 131 youth served remained in a community living situation and avoided a higher level of residential care. No youth required group home placements, and there were two total changes in foster care.

- **Employment and education** (increase in paid or unpaid employment, improve school attendance and grades): VCSS achieved its contractual goal of ensuring at least 80% of parents report youth maintained a C average or improved on their academic performance. All parents surveyed reported their child maintained a C average or saw improvement in their child's academic performance by discharge. Additionally, based on the Child and Adolescent Needs and Strengths Assessment (CANS) item "Academic Achievement", 80% of discharged youth had a C average or higher at discharge.

VCSS achieved its contractual goal of ensuring at least 75% of youth maintain regular school attendance or improve their school attendance, as 91% of discharged youth 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 admission and discharge. All 131 youth served did not experience an expulsion in this fiscal year, while 95% did not experience a school suspension.

- **Criminal Justice involvement** (decrease in arrests, decrease in time and number of days incarcerated): VCSS achieved its contractual goal that at least 70% of youth have no new legal involvement (arrests/violations of probation/citations) between admission and discharge. In FY 21/22, 98% of youth had no new legal involvement while receiving services.

- **Acute Care Use** (decrease in time and number of days in Psychiatric Hospital, decrease in mental health emergency events): Ninety-six percent (96%) of youth did not experience a psychiatric hospitalization during the fiscal year.

- **Emotional and Physical Well Being** (decrease in mental health symptoms, decrease in depression, decrease in trauma, improvement in recovery/quality of life, reduction in substance use, improvement in physical health): VCSS Grass Valley successfully supported the strengthening and development of youth, caregivers, and family members' emotional and physical well-being throughout the fiscal year.

VCSS achieved its contractual goal of ensuring that at least 65% of children served were able to identify at least one lifelong contact. Based on the CANS item "Relationship Permanence", 96% of youth served were able to identify at least one lifelong contact.

VCSS achieved its contractual goal of at least 80% of parents/caregivers reporting that there was an increase in their parenting skills. In FY 21/22, 94% of surveyed caregivers reported their parenting skills increased or improved.

VCSS achieved its contractual goal of ensuring that at least 75% of caregivers report maintaining or increasing connections to natural supports, with 92% of surveyed caregivers reporting maintaining natural supports and increasing support connections in the community.

Victor achieved its contractual goal of ensuring that at least 80% of individuals improved their scores on the Comprehensive Child and Adolescent Needs and Strengths (CANS) instrument between admission and discharge. During FY 21/22 91% of individuals with a planned discharge improved in at least one of the following CANS domains: Life Functioning, Behavioral/ Emotional Needs, Risk Behaviors, and/or Educational Needs; all three engaged discharges at VCSS Truckee achieved this goal. Additionally, 92% of surveyed caregivers reported their child's targeted behaviors had decreased at time of survey.

- **Stigma and Discrimination** (decrease level or degree of stigma of mental illness either at the client or community level): Victor implemented a Racial Justice Committee during this fiscal year to analyze and combat mental health disparities as they relate to racial injustice in the community.

- **Service Access and Timeliness** (percent of non-urgent mental health service appointments offered within 10-15 business days of the initial request for appointment, number and percent of acute psychiatric discharge episodes followed by a psychiatric readmission within 30 days during a one-year calendar period, percent of acute [psych IP and PHF] discharges that receive a follow up outpatient contact or IMD admission within 7 days of discharge): Excluding one transfer between reporting units, there were 61 discharges this year, with 56 (92%) fully engaged in services (including 3 of 4 in Truckee). For FY 21/22, the median length of service for engaged discharged populations was 11.3 months for Grass Valley (n=52) and 10.2 months for VCSS Truckee (n=2).

VCSS nearly achieved its contractual goal of attempting initial contact with referrals within three (3) business days of receipt of referral. Initial contact was attempted for 96% of referrals within three business days, while initial contact was successfully made with 77% of referrals within three business days.

VCSS achieved its contractual goal of offering an appointment for face-to-face contact with 80% of children and families within 10 business days of receiving the referral, as 80% of eligible referrals were offered an appointment date in this time frame. Additionally, all referrals received an offer for a face-to-face appointment within 10 business days of contact made, with 89% receiving a face-to-face contact within 10 business days of contact made.

Challenges, Solutions, and Upcoming Changes

During this fiscal year, Victor has continued to refine the high-fidelity wraparound model adopted by the program in 2017. The leadership team continues to emphasize in-service coaching, targeted skill building, and ongoing development of staff as it pertains to wraparound implementation. Victor continues to employ a team of Clinicians, Facilitators, Parent Partners, and Family Support Counselors who all receive training and supervision specific to the wraparound model.

Effectively maintaining the physical safety of staff, youth, and the community against COVID-19 while continuing to provide excellent services was a primary challenge during FY 21/22. Victor quickly adapted their service model to serve youth and their families primarily via telehealth, and staff have demonstrated consistent persistence and adaptability while continuing to meet individual needs. While COVID-19 management remains an ongoing challenge, Victor has identified core strategies to provide effective telehealth care as necessary.

Victor remains committed to increasing connectedness for youth and families served by continuing to add more group-based services, community-building activities and events, and further integrating the wraparound philosophy into our process in both virtual and in-person settings. We plan to emphasize the inclusion of family voice and choice as a primary principle of services during the next fiscal year. We will continue to serve all youth referred to our program utilizing FSP and wraparound principles according to their individualized needs, strengths, and treatment plan goals. Length and intensity of services will be determined by assessment and current need. Our anticipated length of stay will remain 8-10 months on average.

Program Participant Story

Victor worked with a 13-year-old boy whose older sibling (age 16) also received services from Victor during this year. The youth presented with behaviors including non-compliance, emotional dysregulation, verbal aggression, and property damage when triggered. When referred for services the youth had been living with a foster-to-adopt family for nearly 1 year. This was his 25th placement since entering foster care at a younger age.

During the course of services, the youth began to present with sexualized behaviors which created significant discomfort and feelings of lack of safety for his foster mother. With the youth's placement at immediate risk, Victor facilitated a multi-disciplinary team meeting which brought together supports and service providers to brainstorm alternatives to placement disruption. With the support of the team, the foster parents agreed to maintain the placement and work closely with our team to address the challenges.

Victor provided the youth with therapeutic services including supporting a relationship with a therapist specialized in youth's behavioral presentation, Aggression Replacement Training (ART), intensive care coordination, and significant collateral support to youth's foster parents. Victor assisted youth's foster mother in processing her own feelings of safety related to youth's behaviors and assisted with crisis response as necessary. Through these interventions, the foster parents

learned new parenting strategies which did not trigger youth's trauma related to previous abandonment.

Youth's caregivers were extremely collaborative with Victor and open to learning. Family therapy was provided which, along with intensive and practical safety planning, allowed the family to heal their relationships and work to understand one another more successfully. Youth's behaviors improved significantly, and youth presented as extremely committed to continuing therapeutic work. At the time youth successfully graduated services, the family was just a few months away from finalizing youth's adoption.

Adult Full-Service Partnership (FSP):

TURNING POINT COMMUNITY PROGRAMS
Providence Center

Program Description

Program Overview

Turning Point Community Programs (TPCP) - Providence Center promotes wellness and recovery, partnering with individuals 18 and older living with severe and persistent psychiatric disabilities. Clients are referred for individualized, locally based outpatient treatment. Assertive Community Treatment (ACT) and Assisted Outpatient Treatment (AOT) support individuals in achieving and maintaining a higher level of independence and quality of life within the community. Services strengthen community integration, mental and physical well-being, vocational and educational opportunities, healthy relationships, and sense of independence.

Target Population

The AACT target population consists of individuals 18 years old and over 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:

In the FY 21/22, the Providence Center FSP served **80** individuals.

- **Housing**:

- During FY 21/22, 71 (88.8%) individuals successfully remained housed in either temporary or permanent housing, avoiding homelessness. The remaining 9 (11.3%) individuals accrued a total of 1,016 homeless days.
- A total of 71 individuals carried over from FY 20/21 and continued to accrue services in the FY 21/22. Of those 71 individuals, 65 (91.5%) either continued to avoid homelessness or decreased the number of homeless days accrued.

- **Employment and education**:
  - **Employment**: Of the 80 individuals served within FY 21/22, a total of 14 (17.5%) individuals were reported as having some form of employment (paid or unpaid) at the end of the reporting period. When comparing to the Partnership Assessment Form (PAF), 13 individuals who were reported as being unemployed prior to their enrollment in the Providence Center were now employed at the end of FY 21/22.
  - **Education:** In FY 21/22 a total of 16 individuals were reported as having spent at least one day in school since enrollment. 9 (56.3%) of those 16 had not been attending school within the 12 months prior to their enrollment.

- **Criminal Justice involvement**:
  - During the FY 21/22, 74 (92.5%) of the 80 individuals avoided incarcerations or the accrual of jail days. The remaining 6 (7.5%) individuals accrued a total of 158 jail days.
  - Of the 71 individuals who carried over from FY 20/21 and continued to receive services through the Providence Center in FY 21/22, 66 (93.0%) either continued to avoid jail or decreased in the number of jail days accrued.
  - With regards to arrests, during FY 21/22, 74 (92.5%) individuals avoided arrests. The remaining 6 (7.5%) accrued a total of 8 arrests amongst them. Between FY 20/21 and FY 21/22, 2 (2.5%) individuals were reported as having accrued arrests in both fiscal years.

- **Acute Care Use**:
  - **Psychiatric Hospitalizations:** Within FY 21/22, 69 (86.3%) individuals avoided psychiatric hospitalizations. The remaining 11 (13.8%) accrued a total of 351 psychiatric hospital days. A positive outcome is of the 71 individuals who carried over from FY 20/21 and continued to receive services, 62 (87.3%) continued to avoid psychiatric hospitalizations.
  - **Emergency Interventions:** Within FY 21/22, 52 (65.0%) individuals avoided the need for an emergency intervention. The remaining 28 (35.0%) accrued a total of 55 emergency interventions. A positive outcome is that of the 71 individuals who carried over from FY 20/21 and continued to receive services, 48 (67.6%) continued to avoid emergency interventions completely.

- **Emotional and Physical Well Being**:
  Turning Point continues to emphasize trauma-informed care with individuals served. This allows participants to feel respected and cared for in their recovery process and allows staff the opportunity to see people through a trauma-informed lens. In the last year, with the COVID-

19 pandemic Turning Point has focused on both the mental health of employees as well as those served.
Turning Point has been able to provide stable housing for individuals served who have experienced homelessness. This has drastically supported some individuals, providing hope, the ability to reduce their substance use, and improvement in their overall health and wellbeing.

- **Stigma and Discrimination**:
  Over the last year Turning Point has increased the use of Peer Support Specialists as well as gained a Family Advocate position. One of the Peer support specialists has been chosen to be an ambassador for the Superior Region to represent the peers of the region. With the increased use of Peers in the workforce there is a decrease in the stigma of mental illness. Throughout the community, Turning Point continues to support the individuals served in a strength based, respectful manner, role modeling for other people in the community.

- **Service Access and Timeliness**:
  - 100% of non-urgent mental health services appointments were offered within 10-15 business days of the initial request for appointment.
  - In the 21/22 FY there were 12 psychiatric admissions accrued by 11 individuals. Only 1 (8.3%) of these 12 admissions were followed by a psychiatric readmission within 30 days during a one-year calendar period.
  - 100% of acute [psych IP and PHF] discharges received a follow up outpatient contact or IMD admission within 7 days of discharge.

- **AOT Summary**:
  - **11** individuals were served in the AOT Program, on AOT orders, for the 21/22 fiscal year.

- **Milestone of Recovery Scale (MORS)**
  The Milestone of Recovery Scale (MORS) is both a clinical and administrative tool. It measures where individuals are in their journey of recovery and produces data that describes the journey of recovery over time.
  - A total of 59 individuals received a score at admission and at the end of the fiscal year or at discharge.
  - Sixteen (27.1%) individuals had a higher MORS score at the end of the reporting period, suggesting movement towards recovery, including a lower level of risk, an increase in the level of skills and supports beyond program services, and an increase in the individual's level of engagement with program staff.
  - Thirty-five individuals (59.3%) remained at the same score. As many individuals served have higher MORS scores, stability in their current coping levels is positive.
  - Six individuals (10.2%) had a lower MORS score at the end.
  - Two individuals (3.4%) had at least one score of unable to rate.

- **Productivity**
  - **Objective A:** Minimum productivity standard of 70% of billable time for hours worked.

- Productivity average of 82% of billable time for hours worked.

- **Objective B:** 90% of all clients are Medi-Cal eligible.
    - All TPCP clients for FY 20-21 were Medi-Cal eligible.

- **Objective C:** 5% denial rate for billed and audited services.
    - Received no denial of billed services this year.

- **Objective D:** Each Medi-Cal service provided must meet medical necessity guidelines and meet Medi-Cal requirements as described by service and activity/procedure code.

- **Objective E:** Contractor shall document and maintain all clients' records to comply with all Medi-Cal regulations.
    - Turning Point conducts chart reviews monthly.

Challenges, Solutions, and Upcoming Changes

Due to the COVID-19 pandemic, Turning Point experienced staffing challenges. In this year, Turning Point has made increases to pay rates to make pay more competitive and positions more desirable. In addition, clear pathways have been outlined for Turning Point employees to have opportunity to advance their careers. Performance and evaluation plans as well as career development plans are designed to support efforts to work with employees so they feel supported in their growth and provides opportunity for regular merit increases based on performance. Turning Point is offering sign on bonuses for clinicians, as this has been a position that has been particularly difficult to recruit for. Individuals served who are interested in peer support positions are being trained through the career exploration program so they may join the peer support work force in the future.

Program Participant Story

In this last fiscal year, Turning Point had a return participant to services. His mother had moved him and herself to San Bernadino County hoping for a better life and more access to services for this young man. The plan did not go as hoped, and he ended up homeless in San Bernadino after being discharged from a psychiatric hospital to the streets with no communication to his family. This young man could not access his family for help due to his psychiatric illness and his mother was unable to locate him due to the size of the city and the large population of homeless individuals there. She spent months looking for him and eventually befriended a law enforcement officer that helped her find him.

When he moved back to Nevada County, he was living with his mother and stepfather and was struggling significantly with his symptoms. He was referred under the AOT program, but after engaging with him, he voluntarily agreed to services, stating he remembered the staff at Turning Point and always appreciated the support he received. While living with his parents he was constantly bombarded by voices and urges to harm and even kill his mother and stepfather.
His parents were calling constantly requesting for him to be housed elsewhere. Respite was utilized for a short time and then he moved to a hotel, paid for with flex funding. When emergency hotel funding was made available last year, it enabled him to remain sheltered at the hotel while he applied for an apartment at Brunswick Commons. With this gentleman housed in a hotel Turning Point was able to provide medication outreach services to him every day and support him with his needs.
This gentleman has had zero incidents involving law enforcement or needing extra psychiatric support in a hospital or at the CSU during this time of stable shelter and support.
His relationship with his mother has greatly improved and this has given him back the natural support system necessary to reduce his risk of hospitalization or jail. There have been no signs of disruption from substance use during the time he has been sheltered. He is scheduled to move into his new apartment in September.

General System Development:

NEVADA COUNTY ADULT & CHILDREN'S SYSTEM OF CARE
Expand Network Provider

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) partners with 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 individuals do not appear to need medication or significant case management. Network providers help to serve additional individuals and offer partners and families a variety of specialties and locations that NCBH would not be able to offer otherwise.

Target Population

The target population for this program is children, Transition Aged Youth (TAY), adults and older adults referred from NCBH who have less acute needs. These individuals do not appear to need medication or significant case management.

Evaluation Activities and Outcomes

In FY 21/22, 14 unduplicated participants were served. This included 9 individuals served in the Children's System of Care and 5 individuals served in the Adult System of Care. Four Network Providers are contracted with Nevada County Behavioral Health to provide these services: two for Adult Behavioral Health and two for Children's Behavioral Health.

Baseline and annual Basis 24 outcome measure surveys are usually collected for individuals served by the Adult System of Care. Unfortunately, due to COVID and beneficiaries receiving few in-person sessions, none of these individuals were on-site and asked to complete a Basis 24 in FY 21/22.

The NCBH Children's System of Care is collecting the Child and Adolescent Needs and Strengths Assessment 50 (CANS 50) and the Pediatric Symptom Checklist 35 (PSC-35) outcome measures per state requirement. Of the three youth who received multiple CANS assessments, two showed improvement and one showed no change.

Challenges, Solutions, and Upcoming Changes

One challenge has been maintaining an adequate number of network providers in our system of care. Towards the end of FY 21/22, the department revisited its rate structure with network providers to help with recruitment and retention, including incentives for specialties such as experience with eating disorders, 0-5 population, and bilingual capabilities.

General System Development:

NEVADA COUNTY ADULT & CHILDREN'S SYSTEM OF CARE
Expand Adult and Children's Behavioral Health & Psychiatric Services

Program Description

Program Overview

The Mental Health Services Act (MHSA) can be utilized to expand mental health services and/or program capacity beyond those services provided in 2004, referred to as "baseline services". This program encompasses expanded mental health and psychiatric services provided by Nevada County Behavioral Health (NCBH), as well as housing and flexible funds to support NCBH clients in meeting their treatment goals.

In FY 21/22, NCBH provided 28,417 mental health and psychiatric services to 1,055 unduplicated individuals. 743 individuals were served by the NCBH Adult System of Care and 313 individuals were served by the NCBH Children's System of Care.

Target Population

The expansion of services targets Nevada County Behavioral Health beneficiaries needing psychiatric services who are funded by General System Development.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Expand Crisis and Mobile Crisis Intervention Services
Crisis Workers, Crisis Support Team

Program Description

Program Overview

MHSA funding provides a Crisis Worker Position, a Mobile Crisis Position, a Youth Mobile Crisis Position, and a Crisis Support Team at the Crisis Stabilization Unit (CSU) at the local Sierra Nevada Memorial Hospital (SNMH). The Crisis Worker and CSU support team are available 24 hours a day, seven days a week, while Mobile Crisis is available 7 days a week, 12 hours per day. These positions are exclusive to western Nevada County; however, we serve clients from anywhere within the county. Funding sources used to support Crisis Services included Medi-Cal, 1991 Realignment funds, and MHSA-CSS funds.

The Crisis Workers provide direct crisis intervention services to program participants by phone contact and face-to-face evaluation. Crisis staff respond to other locations as required including Sierra Nevada Memorial Hospital, Wayne Brown Correctional Facility, and the mobile crisis worker responds to any incident within Nevada County. Workers collaborate with other human service providers and law enforcement to determine whether hospitalization is required and what resources or referrals are appropriate.

The location of the Crisis Worker in the CSU at SNMH offers an integrated service where people being held on a 5150 (an involuntary 72-hour hold, for evaluation) can, if appropriate, be moved from the hectic atmosphere of the local emergency room to a more appropriate level of care at the CSU. It also offers a place where individuals experiencing a crisis can stay for 23 hours on a voluntary basis with therapeutic services, resources, and support. If on a 5150 hold, the CSU can potentially eliminate the need for a transfer to a higher level of inpatient psychiatric hospitalization.

Target Population

All adults and minors in need of crisis services, assessment, referral, involuntary detention, and brief crisis counseling comprise the targeted population.

Evaluation Activities and Outcomes

In FY 21/22 the targeted goal was for Crisis Specialists to serve 1,152 individuals. The result was 955 unduplicated individuals served, representing 83% of the goal achieved. In the prior fiscal year 19/20, the Crisis Workers performed a total of 2,144 evaluations. This fiscal year, Crisis provided 2,117 evaluations, 995 were performed in the Emergency Department, 772 were performed at the Crisis Stabilization Unit, 19 were performed at the Correctional Facility, 228 were performed in the field, and 103 services were performed in Truckee. There were 738 WIC 5150's written and 372 of those were placed at higher level inpatient psychiatric facilities.

Reports from the community have been anecdotally provided by the hospital medical staff and by law enforcement. Consumers have expressed satisfaction with the immediate crisis service and additional resources. Crisis Specialists can provide quicker crisis stabilization with the CSU in the same building as the Crisis office. With the walk-in policy from 9am–12am, consumers get immediate crisis response without having to go through the Emergency Room during daytime hours.

Challenges, Solutions, and Upcoming Changes

Two major challenges that have occurred this year include the continued COVID-19 pandemic and the global staffing crisis. Crisis workers implemented many safety precautions including all staff wearing masks, sanitizing all surface areas within the Crisis office as well as the CSU every shift, and requiring consumers that come to the CSU to shower and wash their clothing upon admittance. The staffing crisis allowed for creativity regarding coverage including on-call positions, management working additional shifts to support, as well as collaboration with community partners to work together to meet client needs.

Another significant and positive change this year was to the Mobile Crisis Team. A second clinician was added who is embedded with law enforcement, allowing for 7 day a week coverage for approximately 12 hours per day. A Youth Mobile Crisis Clinician was also added who is non-law enforcement embedded and responds to youth in the community ages 25 and under. These positions have supported the community in responding to crises, offering sound crisis interventions, providing education and prevention to the community, as well as following up with consumers with post-crisis intervention.

In addition, the Truckee hospital expressed challenges in the previous FY regarding consistent client care during the time of an individual being placed on a hold. There is a full-time on-site clinician Monday-Friday to support the needs of the hospital and community in Truckee. This

position can also co-respond with multiple law enforcement agencies and respond to local schools in need of immediate crisis intervention during the week.

Program Participant Story

An individual had multiple contacts with the Mobile Crisis clinicians and law enforcement over the course of 3 months and it was identified that they were in crisis but did not meet criteria for a hold. They had many risk factors that if left unattended, could have left this individual very vulnerable. After several months of building rapport, this person felt safe enough to come to the CSU. Ultimately, they were placed on a 5150 hold, but were able to be stabilized, connected to services, and released from their hold at the CSU. The individual has since been stable due to the diligent work of the Crisis and CSU clinicians recognizing this person's unique needs. This individual frequently returns to inform our staff of their progress and how supported they felt during their stay.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Expand Crisis and Mobile Crisis Intervention Services
Crisis Stabilization Unit (CSU)

Program Description

Program Overview

The Crisis Stabilization Unit (CSU) opened on December 14, 2015 to better serve individuals experiencing a mental health crisis or emergency. It is a 4 bed, unlocked unit with a mental health professional and a licensed medical professional on-site at all times. Psychiatrists are on-call 24 hours a day, 7 days a week. Sandy Farley, a Registered Nurse, works in close partnership with the Crisis Response Team Supervisor, Samantha Perkins, MA, MFT. She answers calls for any medical needs or operational questions. Individuals may be admitted voluntarily for a maximum stay of 23 hours or while awaiting placement on a WIC 5150 hold. For the Fiscal Year of 21/22 the CSU, has served 321 individuals with 677 total admissions which is a 4% increase from FY 20/21.

Per Medi-Cal requirements, individuals are allowed to stay 23 hours. During that time, they are assessed by the licensed medical professional for medical issues that may be contributing to their crisis. Current medication interactions are investigated along with assistance is provided in making appointments for any needed follow up for medical concerns with their primary care

doctor. Upon request the nurse helps establish a primary care doctor or psychiatrist by assisting them with new patient forms for local offices and clinics.

Target Population

The CSU was established with the intention of reducing the need for psychiatric hospitalization when someone is in crisis due to exacerbation of symptoms resulting from a mental illness, or as a reaction to life stressors, or both. Medi-Cal clients on a WIC 5150 hold whose crisis can possibly be relieved by a 23 hour stay in the CSU with therapeutic and medical intervention, is the primary goal of the program. The program also serves and admits uninsured and privately insured individuals 18 years or older as a voluntary or WIC 5150 client if they meet admissions criteria. The target goal for FY 21/22 was 460 and 323 were reached.

Evaluation Activities and Outcomes

The CSU program has resulted in the rescinding of 15 of the 97 individuals placed there on a WIC 5150 and 9 of the 97 WIC 5150 being able to expire during the FY 21/22 by stabilizing them and connecting them to local doctors and resources. Collaboration by therapists with an individual and their loved ones, development of a personalized recovery/safety plan and follow up appointments made by the CSU staff helped to stabilize individuals to rescind their holds or let them expire. The CSU serves as an additional resource as part of the individual's safety plan. For the individuals served, it is a safe haven away from the stressors that are often catalysts to their crisis and a way to be connected with a therapist, nurse, and resources in the local community that can support them. The mobile crisis team is able to bring individuals to the CSU after evaluating them in the community which improves access to CSU services.

The CSU has been a success with those served. Satisfaction surveys were completed by 62% of individuals that stayed in the CSU during the 21/22 fiscal year. They report a 96% degree of satisfaction with the treatment they received and the progress they made during their stay.

Sierra Nevada Memorial Hospital (SNMH) is also appreciative of the CSU. It provides a place for individuals with a psychiatric need to receive care for those needs that are not traditionally provided in an emergency room setting. Individuals evaluated in the emergency room, who meet CSU admissions criteria, are presented to the CSU and transferred to the CSU as quickly as possible. This results in more beds being freed up for patients in the emergency room and individuals in crisis being served in an environment that is calmer and has a therapist and nurse available to work with them individually to meet them where they are at in their crisis.

The county jail, NCBH, Granite Wellness, Hospitality House, FREED, Common Goals, therapists and local clinics often refer directly to the CSU. Work with the HOME team has continued to be successful for the individuals who are homeless and not linked to any other county resources.

Challenges, Solutions, and Upcoming Changes

One unexpected challenge is the staffing shortage that is impacting services everywhere, as well as challenges due to the COVID-19 pandemic. The CSU has increased advertising of job openings, changed nurses to 12-hour shifts, and are internally supporting existing staff. The CSU has increased outreach to local graduate schools about the CSU and current job openings and listen to staff input about solutions they have to perceived challenges. With Manager approval, individuals can be supported for more than 1 night at the CSU. This helps reduce the psychiatric hospitalization rate and costs for the county.

Program Participant Story

An individual who had intermittent challenges with maintaining housing and staying on their psychiatric medications presented to the CSU early in the FY after relapsing. They had lost their housing, job and were not going to their appointments with their psychiatrist or therapist. The staff worked at supporting the individual over multiple nights, getting them linked back to their psychiatrist and therapist and medications restarted at the CSU. This prevented them from having to be hospitalized and they were able to go to Insite Respite for 2 weeks. The individual was linked to Hospitality House after Respite and then received housing support through AMI. This individual came back 2 months later and was doing good. They were still on their medications and had a part time job. They were very thankful for the help and support they got at the CSU.

General System Development:

TURNING POINT
Expand Crisis and Mobile Crisis Intervention Services
Insight Peer Respite Center

Program Description

Program Overview

Turning Point's Insight Respite Center (IRC) is a peer-centered program where guests seeking relief from symptom distress are treated as equals on their path to recovery. Creating a bridge between health care providers, individuals, and the community is the essence of interdependence and serves to strengthen the community and the individual. The approach is based on the core

values of mutual respect and mutual learning. It is about guests connecting with someone in a way that supports them in learning, growing and healing.

In collaboration with Nevada County Behavioral Health, Insight Respite Center is committed to providing guests with an environment and connections that help individuals move toward their desired goals. Located in a lovely rural setting, IRC works with Nevada County Behavioral Health to accept referrals from community partners such as Hospitality House, the Homeless Outreach & Medical Engagement (HOME) Team, SPIRIT Peer Empowerment Center, Turning Point Providence Center and Nevada County Behavioral Health to offer alternative resources for eligible adults that may prevent the need for hospitalization. Peer supporters, trained in trauma informed models, are available 24 hours per day, offering hope, compassion and understanding in a stigma free environment.

Services provided include the following:

- Crisis intervention
- Rehabilitation
- Guest advocacy
- Life skills
- Community resource referrals

Target Population

IRC serves guests 18 years of age and older, who have a mental illness, and because of the disorder, are at risk of needing a higher level of care. Guests could be at risk of needing psychiatric hospitalization, placement in an Institute of Mental Disease (IMD), Mental Health Rehabilitation Center, or Crisis Stabilization Unit. Guests may be recently discharged from one of these placements or experiencing a first episode or re-emergence of a psychotic break. Individuals must be assessed, medically cleared and approved by Nevada County Access Team, and then screened to determine appropriate fit by the IRC Leadership Team. Guests may not be under the influence of alcohol and/or illicit drugs and must be able to maintain acceptable hygiene. Guests are responsible for preparing meals and cleaning up after themselves. Guests must be able to understand and sign necessary documentation, be willing to follow the guest agreement upon entering the house and have a place to return to when leaving IRC, even if that is a homeless shelter.

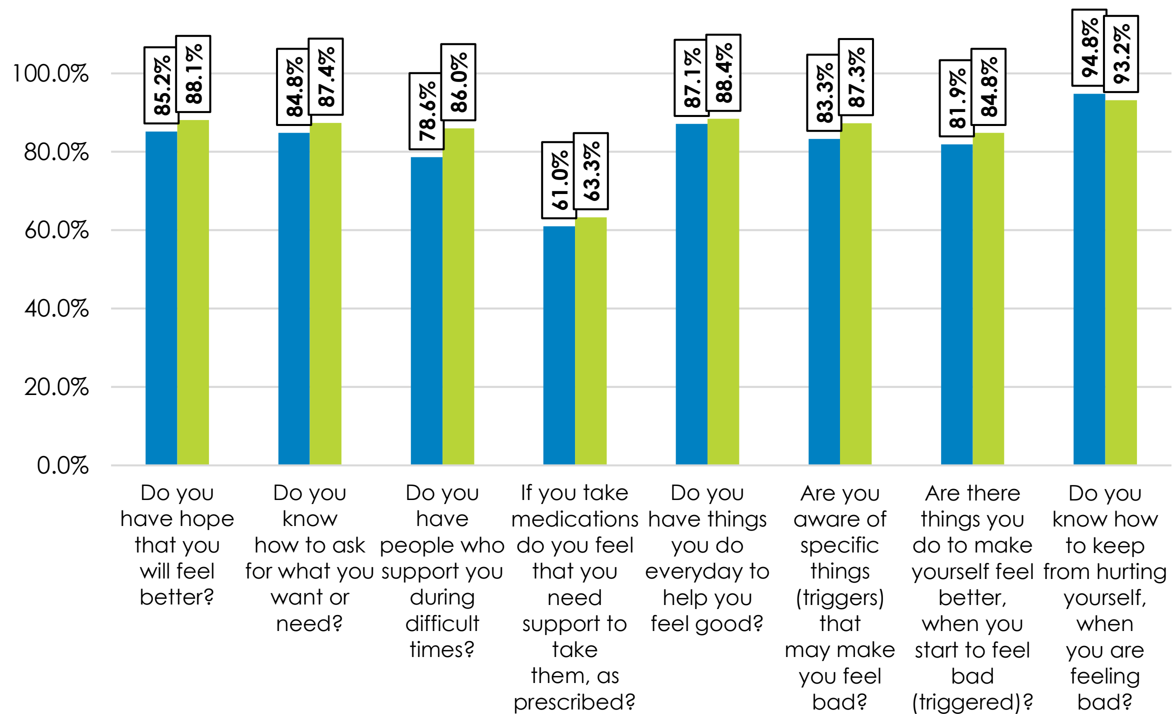
Evaluation Activities and Outcomes

In the 21/22 FY:

- Referrals:101
- Duplicated individuals served:101
- Unduplicated individuals served:66
- Discharged individuals: 97
- Linkages made to community resources: 69
- Overall client satisfaction score:92.7%

Pre-Post Outcome Survey

CSS Funded Programs
NCHDC Annual Report



Challenges, Solutions, and Upcoming Changes

FY 21/22 began with relocation of the program site to the current location in a lovely, rural setting. Due to the continuing Covid-19 pandemic, continued health and safety protocols have been put in place in FY 20/21 to ensure the health and safety of colleagues and those served. These protocols made it possible for IRC to continue offering services in a Covid-19 infection free environment. IRC continues to focus on increasing Medi-Cal billing in order to raise revenue and support the viability of the program and its services. IRC has experienced staffing challenges, as has been common nationwide, but have found the internal resources necessary to continue offering services.

Program Participant Story

"It's hard to really write things down like this, but truly, I feel that coming here saved me in so many ways. In all my time here conversing with other clients and with staff, I learned how to stand up on my own and that road I follow is a good one. I could ramble on all day about how wonderful this place is, but I'm king of too tired right now to bother with such a thing!"

- *Former Guest*

General System Development:

Submit Annually by August 1st

CSS Funded Programs
NCHDC Annual Report
SPIRIT
Emergency Department Outreach and Engagement
Emergency Department (ED) Crisis Peer Support Program

Program Description

Program Overview

The Emergency Department Program (EDP) Crisis team serves individuals in crisis at the Crisis Stabilization Unit (CSU) and Emergency Room at Sierra Nevada Memorial Hospital. The program offers a valuable peer perspective to assist the individual in the present moment of crisis and increases rates of warm handoff referrals between the CSU and SPIRIT. The program strengthens transitions between crisis services and community-based programs such as mental health outpatient clinics, case management services, and reduces re-hospitalization rates among intensive service recipients. EDP Crisis Supporters continue to fill the gap and provide the bridge post- hospitalization to gently guide individuals through follow-ups into one or more of the appropriate long-term recovery focused programs. The SPIRIT Crisis Peer team is on-call, seven days a week from 11 am -7pm. Overall the EDP Crisis services improve care, reduce the frequency, cost, and length of stay of emergency visits and shifts vital Nevada County Behavioral Health resources away from Emergency Care into effective community-based long-term solutions.

Target Population

Anyone over 18-years-old, in the Emergency Department/Crisis Stabilization Unit in crisis that indicates they would like peer support.

Evaluation Activities and Outcomes

In FY 21-22, the Emergency Department Program (EDP) continued to serve individuals in the Crisis Stabilization Unit (CSU) and because of COVID-19 restrictions still impacting access, offered a more limited Crisis Peer Support service in the Emergency Room at Sierra Nevada Memorial Hospital. At the beginning of the year, the EDP Program was evaluated based on contract review objectives, including improvement of active in-service hours, number of individuals receiving outpatient referrals, improvement in housing situation, and level of overall program participation. Progress was made to increase the in-service to on-call hour ratio. This objective was achieved by reducing the daily hours from 10 hours to 8 hours per day, using this time to make follow up calls, and outreach activities during the shifts. The EDP program started the year at 10% in-service hours and completed the year at 40% in-service to on-call hours. Many of the EDP participants are referred to the SPIRIT resiliency or housing assisted program. Progress was made toward improving participants' housing situations. Most individuals served reported significant improvement in psychological distress after meeting and a follow-up call from crisis, peer, and resiliency housing teams.

Data: The SPIRIT Emergency Department/Crisis team completed FY 21/22 above target numbers for in-service hours. Follow-up calls and referrals have increased from previous years. The Emergency Room COVID-19 restrictions decreased but still have an impact on the number of

individuals the team served in the year. The restrictions will likely continue to have an impact the Crisis' team ability to be in service in the ER. The Crisis supporters completed the year with a total of 173 intakes, 88 action plans, and 62 stress reduction plans implemented and a total of 409 referrals to various partnering agencies made. The team made 238 follow up calls with 69 leading to one-on-one peer support and further support at The SPIRIT Center, including linking them to the Housing Resiliency Team which supports participants with housing referrals, support groups and healthy lunches. (see following data).

SPIRIT EDP DATA Q4 FY 21/22						
		Q1	**Q2**	**Q3**	**Q 4**	**FY 21-22**
Results: Total Served Target is 140 unduplicated/yr.	Parts A & B of Contract	54	35	39	45	173
Duplicates		2	0	3	7	12
Unduplicated for FY		52	35	36	38	161
Follow Ups		53	61	59	65	238
Referrals		97	100	92	120	409
Completed follow-ups		53	59	50	65	227
Not Yet Complete		0	0	0	0	0
Refused Contact		3	1	0	0	4
No Permission		2	3	0	1	6
Left Message		35	24	32	26	117
Action Plan Developed		17	19	33	19	88
Stress Plans Discussed		13	8	22	19	62
Resources Accessed		12	21	13	25	71
EDP SPIRIT Referrals		9	15	19	26	69
Male/Female		32M 22 F	19M 16 F	18M 21 F	28M 17 F	97M 76F
ER/CSU		16E 37C	11E 24C	11E 28C	11E 24C/ Spirit 11	49E 113C/11S
5150's		35	25	24	14	98

Challenges, Solutions, and Upcoming Changes

CSS Funded Programs
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Challenges and Changes: The overall challenges continue to increase in serving an extremely high-need mental health, homeless and recovery population. The Crisis Peer Supports continue to see an increase in individuals experiencing homelessness, addiction issues, domestic violence, depression, and anxiety. The participants experience difficulties maintaining housing due to the costs, requirements, and availability. Additional challenges are the increasing number of unhoused individuals and the gap in low-income housing solutions. The lack of basic needs adds to the struggle of moving forward with life goals. All these challenges increase stress levels, fear, worry and can be a major factor in triggering a mental health crisis. As a crisis team and organization, SPIRIT is implementing several solutions that will assist in increasing service to the community.

Solutions and Successes: The Emergency Department Program (EDP) focused on several solutions to meet the increasing demands for high level peer support, housing resiliency, and job search assistance.

1. The SPIRIT Housing Specialists continue offer case management, advocacy, and facilitate multiple groups aimed at helping individuals to better their own lives. Meeting basic needs along with nurturing and assistance is a necessary part of building a foundation for mental health and lowering the number and intensity of Emergency (ER) and Crisis stabilization Unit (CSU) visits.

2. The solution to increase the in-service hours was first to reduce the on-call hours from 10-hour to 8-hour daily shifts. Additionally, the Peers are doing their follow-up calls during the shift. The program goal over the quarter was to increase the in-service by 10% and a 40% increase was achieved.

3. In January SPIRIT designed a post card with contact information and a brief description of the EDP Program. The Crisis Team gives the post card to individuals in the ER and the CSU that the EDP Team cannot visit with but can reach out after the crisis. The SPIRIT EDP services increase the number of ER/CSU participants that enter a long-term targeted program such as SPIRIT Peer Empowerment Center or one of the many other non-profits that work in collaboration with this population.

Program Participant Story

Story: Several Crisis Counselors met with an individual at the CSU. She was living in her van, had just left an abusive relationship, was emotional and feeling hopeless. It has been 2 months since these first visits. She has regularly been a participant at SPIRIT, did a complete housing intake, has attended all the resiliency groups, receives daily one-on-one support from the on-site SPIRIT Peer Supports, and is provided a daily warm lunch. She is now stable, living at Sierra Guest Home, and actively looking for work. Already the outcomes are immense! There has been a total transformation in this participant due to her hard work with dedicated SPIRIT staff and the additional onsite housing program.

General System Development:

STANFORD SIERRA YOUTH AND FAMILIES

CSS Funded Programs
NCHDC Annual Report
Intensive Services for Youth

Program Description

Program Overview

Stanford Sierra Youth & Families (SSYAF) provides comprehensive specialty mental health services for children and their families throughout Nevada County. Specialty Mental Health Services provided are based on established medical necessity criteria for mental health services due to behavioral, emotional, and functional impairments meeting Nevada County Behavioral Health (NCBH) Plan eligibility.

Target Population

All programs at Stanford Sierra Youth & Families primarily target children and families in pre- and post-adoptive stages, families who have guardianship over children, families at risk of Child Welfare involvement with special treatment focus on issues related to trauma, attachment, and permanency for youth who have been removed from their birth families.

Evaluation Activities and Outcomes

Goal	Objective	Fiscal Year '21-'22
To prevent and reduce out-of-home placements and placement disruptions to higher levels of care.	80% of children and youth served will be stabilized at home or in foster care.	100% (127/127)
Youth will be out of legal trouble.	At least 70% of youth will have no new legal involvement between admission and discharge.	95.35% (41/43)
Youth will improve academic performance.	At least 80% of parents will report youth maintained a C average or improved on their academic performance.	79.09% (34/43)
Youth will attend school regularly	At least 75% of youth will maintain regular school attendance or improve their school attendance.	86.05% (37/43)
Youth will improve school behavior	70% of youth will have no new suspensions or expulsions between admit and discharge.	83.72% (36/43)
Caregivers will strengthen their parenting skills	At least 80% of parents will report an increase in their parenting skills.	66.67% (8/12)
Every child establishes, reestablishes, or reinforces a lifelong relationship with a caring adult.	At least 65% of children served will be able to identify at least one lifelong contact.	92.31% (48/52)
Caregivers will improve connections to the community	At least 75% of caregivers will report maintaining or increasing connection to natural supports.	93.02% (40/43)

SSYAF collects demographic and service-level data for participants of programming. In addition, the Child and Adolescent Needs and Strengths (CANS) is collected at intake, periodically, and at discharge from the program.

CSS Funded Programs
NCHDC Annual Report

The following CANS scores are for youth served in FY 21/22. Stanford Sierra Youth & Families received **70** referrals in the fiscal year and served **127** unduplicated youth and their families. As data collection and reporting strategies progress, data outcomes for individual domains will be shown. CANS Summary**: 79.07%** of individuals' CANS scores improved this fiscal year.

Challenges, Solutions, and Upcoming Changes

A primary challenge for the program in FY 21/22 was maintaining sufficient staffing due to the ongoing workforce challenge, particularly impacting rural areas. To address this challenge, Family Preservation expanded its intern training program, hiring four new clinical student interns to develop the next generation of clinicians. SSYAF also increased targeted advertisement of open positions within Nevada County community resources and worked collaboratively with NCBH to secure a contract increase for FY 22/23 that will increase both the hiring and full salary range for Family Preservation staff. The SSYAF board is also currently reviewing proposed changes to the agency's benefit and vacation packages to improve staff recruitment and retention.

A need was also identified, in collaboration with NCBH and Nevada County Child Welfare, to increase the training of Family Preservation staff in working with children aged 0-3. SSYAF was able to utilize one-time grant funding to train all Family Preservation staff in the DC 0-5 model of assessment for children aged 0-5, and also to finalize plans for all program staff to obtain training in PC-CARE, a 6-session dyadic treatment program for families of children ages 1-10 designed to improve caregiver-child relationships and teach new child behavior management strategies. The implementation of PC-CARE in the Family Preservation program is designed to meet the dual purpose of addressing the needs of the youngest children and their caregivers, as well as improving overall outcomes in the goal area of strengthening caregiver parenting skills. SSYAF will also introduce a new question on the post-discharge follow-up survey that will allow us to collect more targeted data regarding our success towards this goal.

An upcoming change for FY 22/23 will be the addition of a Full Service Partnership (FSP) program. This will allow an expanded spectrum of available services to better meet the needs of the highest-risk children while minimizing disruptions in their care. The program will also expand to include a Parent Partner ("peer") who will use their shared lived experience to serve as mentor, guide, and advocate for parents to increase parent engagement, give them voice in decision making, and empower them to access and navigate systems.

Finally, a goal area for the coming year will be to increase youth's academic performance, school attendance and school behavior. Where applicable, targeted case management goals will be added to address coordination of care between the youth's treatment team and school-based team. SSYAF treatment team members will prioritize the utilization of interventions targeted at improving school behavior paired with active collaboration with youth's school teams. Family Preservation staff will also offer quarterly trainings in Positive Behavioral Intervention, Trauma-Informed Care, and other relevant mental health-related topics to interested school districts of youth served in order to support the schools in better meeting the needs of students with mental health concerns. In addition, post-discharge survey questions will be added to specifically gather information related to progress in these goal areas and supplement existing CANS score data.

CSS Funded Programs
NCHDC Annual Report

Program Participant Story

Reason for referral: 9-year-old Caucasian male Pathways to Wellness Youth was referred for symptoms of Generalized Anxiety Disorder and ADHD, frequent panic attacks, self-harm, and suicidal ideation. Youth was born with a positive toxicity screen and had been living with his great grandmother since he was 4 days old. Youth and family were struggling during COVID-19 and distance learning. Biological mother struggled with substance use and mental health issues, making visitations with youth limited and inconsistent, and she was not available to participate in treatment at the time of services. Youth was also getting bullied at school and struggling with connecting with peers at school.

Services Provided: Treatment included individual and family therapy, collateral support to caregivers, individual rehab, In-Home Behavioral Support (IHBS), school support, and Child and Family Team meetings (CFT). In therapy, the clinician utilized Trauma-Focused CBT to process past trauma as well as incorporated play and art therapy interventions targeted at improving youth's self-esteem. Rehab/IHBS focused on supporting youth with practicing emotion regulation and healthy coping skills. Coaching was also provided in the school to help implement effective behavior strategies in the classroom. Regular family therapy focused on increasing positive connection between the client and his great grandmother, and parent coaching focused on expanding Great-Grandmother's capacity for attuned and effective parenting.

Summary of Success Achieved: After 12 months of service, the youth was able to meet treatment goals and graduate. The youth's home placement was stabilized, with both youth and great-grandmother reporting improved connection. Youth was able to practice expanding his window of tolerance for distressing emotions, learn coping skills, build friendships at school, and process past trauma. Great-grandmother was able to shift from viewing youth's behavior as intentional to using a trauma-informed lens to understand his behavior while increasing structure, routine, and consistency at home. The youth and caregiver were able to work together to build a shared vision of their family's future, identifying that they wanted to be "cycle-breakers" who changed a long family history of abuse and relationship disruption. In one of the final team meetings, Great-Grandmother was observed reaching for the youth's hand, one of the first displays of physical affection the team ever observed between them, and the two then walked to the car hand in hand, marking a notable shift in treatment.

General System Development:

NEVADA COUNTY HOUSING DEVELOPMENT CORPORATION (NCHDC)
Housing and Supportive Services to the Severely Mentally Ill Homeless
MHSA Housing

CSS Funded Programs
NCHDC Annual Report

Program Description

Program Overview

In 2021-2022 NCHDC, the Nevada County branch of AMI Housing, operated 19 properties, totaling 69 units. NCHDC programs include Permanent Supportive Housing, The Orchard/Prop 47, and Purdon/28 Day House. NCHDC also master leases a home operated by Turning Point to serve higher needs individuals. Formerly homeless individuals housed in NCHDC Permanent Supportive Housing (PSH) units receive twice weekly case management as well as other supportive services. PSH tenants live in a variety of settings, including apartments, houses, and efficiency suites. NCHDC works with local homeowners by master-leasing their rental units and subletting to PSH tenants. The Orchard/Prop 47 program receives referrals from the Public Defender's office and Probation for individuals experiencing a high level of recidivism and who are currently homeless. Orchard/Prop 47 tenants receive case management services including transportation, housing search assistance, substance use referrals, and assistance obtaining income or other necessary services. During 2021-2022 this program moved locations, allowing NCHDC to house 5 additional individuals or couples. The Purdon/28 Day House provides temporary respite for homeless individuals who are awaiting placement in other housing such as a substance use treatment facility, apartment, or an opening at another transitional house. NCHDC has provided numerous repairs to master leased units, provided over 800 rides, and has obtained dozens of Housing Choice Vouchers (formerly known as Section 8) for individuals in our community.

Target Population

NCHDC serves Nevada County's most vulnerable and hard to house individuals. NCHDC tenants have mental health diagnoses, are experiencing or have previously experienced homelessness, have poor or no rental histories and no or low income. NCHDC works closely with Nevada County Behavioral Health, FREED, Hospitality House, and Turning Point to house clients with high vulnerability scores. Over 60% of the individuals in NCHDC housing units have been chronically homeless in Nevada County.

Evaluation Activities and Outcomes

NCHDC utilizes HMIS data to observe and report on trends, discrepancies, and gaps in service. NCHDC installed a formal case management system in 2022 which includes a digital tenant filing system that is audited for compliance. In FY 2021/22, NCHDC served 116 individuals, approximately a 35% increase from the last fiscal year. Of these individuals, 11 were children, 9 were transitional age youth (16-24), 4 were veterans, and 58 were identified as meeting criteria for chronically

homeless. The average length of stay in permanent supportive housing is just under 3 years, though 18 individuals have been successfully housed in PSH for over 5 years. Seventy-nine persons served had a mental health disorder and 36 had both alcohol and drug use disorders. Forty-four persons served have a chronic health condition. Prior to being housed at NCHDC, 36 individuals came from the shelter, 4 from transitional housing, 16 were either camping or sleeping in their vehicle, 3 were in a recovery residence, 2 were in a hotel, 7 were renting their own unit, and 3 were in a psychiatric facility or skilled nursing facility. NDHDC assists individuals by providing housing stability, case management services, and life skills training provided by direct care staff. NCHDC direct care staff include Service Coordinators and Peer Counselors who are trained in delivery of several evidence-based life skills curriculums and experienced with a variety of behavioral health interventions. Direct care staff are supervised and evaluated weekly.

Challenges, Solutions, and Upcoming Changes

The housing market in Nevada County was a persistent challenge in 2021/22. The lack of inventory, high rents and heavy competition are all barriers to housing; however, the primary barrier faced by NCHDC tenants is stigma associated with symptoms of their diagnoses. The income to rent disparity is a secondary challenge, in an area where the average income is $26,000 a year while the average rental is $1300 a month. Organizationally, staffing has been an issue with an average of 70% staffing throughout the fiscal year. In 2022 NCHDC hired a new Director, a Facilities Technician, and an Administrative Assistant. Additionally, job requirements for entry level positions were adjusted to meet the qualifications of the regional employment pool. In 2021/22 NCHDC acquired 3 new properties, increased the number of master leased properties and is in the process of renovating a hotel that will create permanent housing for around 30 people, including single parent households and disabled veterans. NCHDC continues to expand its reach and is seeking new property owners and managers to enter master-lease agreements.

Program Participant Story

An individual came to NCHDC housing as a referral from Nevada County Behavioral Health during the peak of the COVID 19 pandemic. She suffered a mental health crisis that resulted in hospitalization. She stabilized at the CSU and upon discharge, needed a permanent housing solution. She was referred to NCHDC and enrolled in PSH. She was placed in the last available NCHDC unit. This placement provided her with the stable housing she needed to begin to work with her NCBH case manager to ensure that she had the resources to maintain her mental health. As she stabilized further, she secured employment, built self-efficacy, and ultimately graduated from NCHDC’s PSH program. She worked closely with her NCHDC Service Coordinator to find independent housing. She applied, was approved for, and will be moving into her own apartment on August 1st. This apartment is also providing an opportunity for her to explore re-unification with her son.

General System Development

GATEWAY MOUNTAIN CENTER
Alternative Early Intervention for Youth and Young Adults
Whole Hearts, Minds and Bodies

Program Description

Program Overview

Whole Hearts, Minds and Bodies (WHMB) pairs clinically supervised Mental Health Workers (MHW) & Mental Health Rehabilitation Specialists (therapeutic mentors) with high need youth and transitional age youth in the Tahoe-Truckee community in a one-on-one relationship. Mentors meet with their mentees once a week for two to four sessions. Using the therapeutic model, “4 Roots for Growing a Human”, sessions are centered around Authentic Relationships, Connection to Nature, Embodied Peak Experiences and Helping Others in order to support participants’ health and growth.

Target Population

Outdoor Rehabilitation is targeted to serve Nevada County children and their families. Children/Youth who meet the Nevada County criteria for seriously emotionally disturbed or seriously mentally ill are eligible. Services can be provided to children (and their families) up through age 21 who meet this criterion and live in eastern Nevada County.

Evaluation Activities and Outcomes

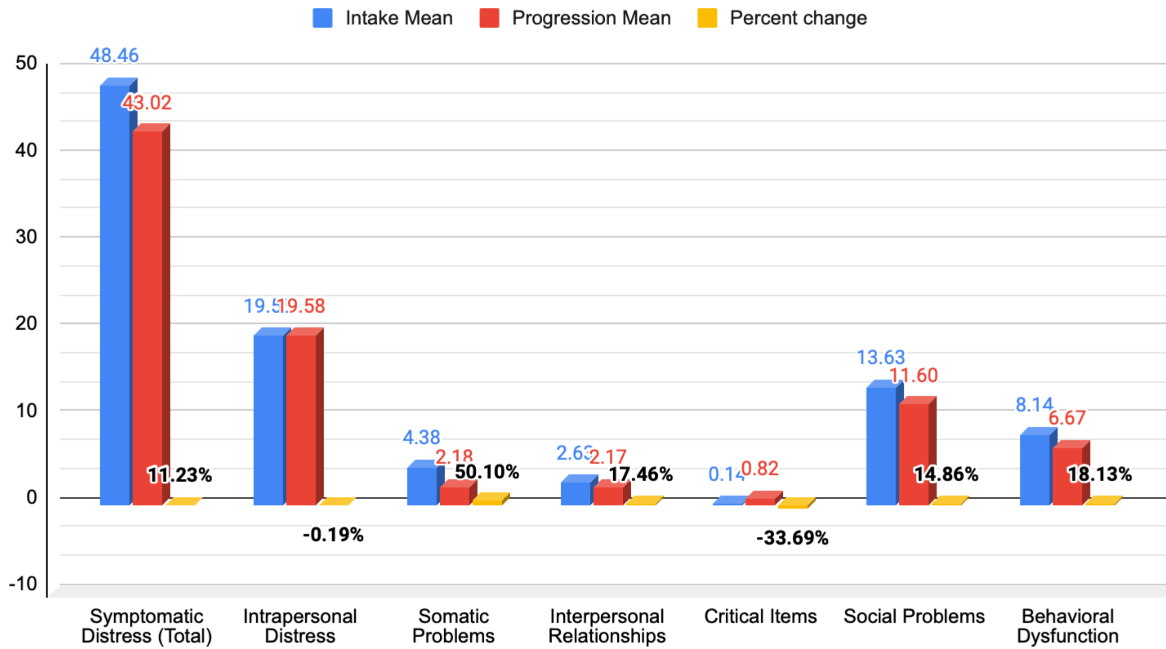
Gateway successfully served 8 youth and families in the Truckee region in the 21/22 fiscal year.
Please see the chart below with data from all youth who completed YOQ-SR surveys for WHMB 2021/2022 which provides meaningful data regarding the overall climate of youth in these programs. Most notably are declines in symptomatic distress, behavioral dysfunction, and critical items.
Additionally, although the data set collected from Perception of Care surveys was quite small, data showed the following:

- 100% of youth felt welcomed, respected and that staff was sensitive to their cultural backgrounds.

- 66.7% reported improvements in the following areas: ability to do things that are more meaningful to them, doing better in social situations, and better ability to do things they want to.

- Decrease the negative outcomes of untreated mental illness in 80% of youth served.

- 3 youth have taken only the initial screening, 5 have completed at least one additional screening, 2 have completed more than one progression screening, 0 have completed post screening for this fiscal year.
- 78% of Youth within Whole Hearts, Minds & Bodies saw improvements in Symptomatic Distress, Somatic Problems, Interpersonal Relationships, Social Problems, Behavioral Dysfunction.



Challenges, Solutions, and Upcoming Changes

The ever-changing environment of the Covid-19 pandemic continues to stress resources, staffing, engagement, and overall morale. However, during the pandemic WHMB was successful at continuing in person outdoor sessions throughout the year, as well as building up robust recruiting and training efforts. WHMB has modified procedures to increase assistance and compliance with timely assessment completion and is researching potential assessment options that provide even more meaningful data for program outcomes. Two new roles have been added to the WHMB team; administrative support and a group coordinator. WHMB will continue recruitment of a full-time bilingual case manager in hopes of creating additional resources and support to the diverse community. Integration of the data management software began in December 2021.

Program Participant Story

“I just want to say thank you for **** and your program. My daughter loves **** and I can see that she’s already making a difference in her life. We’re so appreciative for the support.”

**** has such a mellow way about him. He really respects (mentee) and working with him has helped improve communication with my family.”

“My experience with **** has been very positive. My grandson always enjoys his time with **** and I have noticed positive changes in my grandson’s behavior.”

General System Development

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)
Family Education and Support

Program Description

Program Overview

- To provide peer-led education and support meetings three times per month. One of these meetings will be in collaboration with Turning Point (TP), and one will be school-based for parents of school-aged youth.
- Provide educational meetings 12 times per year.
- Develop relationships with families of youth and young adults affected by mental health conditions and facilitate linkage with NAMI Basics, a 6-session education program for parents, caregivers and other family who provide care for youth (ages 22 and younger) who are experiencing mental health symptoms.
- Provide follow-up education and support.
- Hire or contract with navigator to help families navigate community systems while providing specific support, education, and coaching to individual families who are struggling with understanding and navigating the forensic, education, social services, and treatment arenas.

Target Population

Families and friends of adults and children who are affected by mental health conditions, especially severe and persistent mental illnesses.

Evaluation Activities and Outcomes

- In FY 21/22 68 unduplicated individuals were served.

- Number and attendance of education and support meetings, including topics and speakers of educational meetings: 4 support meetings are held each month—2 in person and 2 on zoom for a total of 48 meetings. The attendance range is 4 to 14, the average attendance is 8 participants. Support meetings were expanded to 4 weeks/month. Due to COVID-19 complications, NAMI was not able to provide a school-based support program.

- Total of 10 educational meetings featuring the following speakers: Turning Point/Nevada County Behavioral Health leadership staff; Randall Hagar, co-author of Laura's Law & Dr. Romer; Jeff Cowen, Turning Point on Housing; Nevada County Crisis Response Team—Deputy Spittler and Ernesto; Suzanne McMaster, NCBH; Jennifer Price, CEO AMI Housing; Judge Tom Anderson; Cathy and Rich Stone—NAMI Family to Family; TED talk: Imagine There Was No Stigma to Mental Illness featuring Dr. Jeffrey Lieberman., Professor and Chair of Psychiatry at Columbia University and past President of the American Psychiatric Association; and Dr. Romer.
- Number of participants linked to NAMI Basics program—12 registered; 2 began; none have finished.
- Number of participants provided navigation services—56.
- 70% of participants will demonstrate improvement according to the Caregiver Strain Questionnaire—the questionnaire was distributed to participants in the support program; of the 27 responses, 100 % felt their scores improved over 6 months.

Challenges, Solutions, and Upcoming Changes

Due to the challenges of COVID-19, and although in-person support has been wonderfully received, most services have been provided remotely via zoom and telephone. As a result, there are numerous one-on-one navigation and support services provided. Due to complications beyond NAMI's control, a partnered family orientation program has not yet been developed, but they are working to remedy that challenge and help create written orientation materials that are family friendly. Families can have difficulty in understanding and navigating services which were previously unknown to them. One challenge for families is understanding Laura's Law/Assisted Outpatient Treatment. NAMI developed a family-friendly informational flyer for AOT in collaboration with NCBH and the AOT Steering Committee and presented it to the Forensic Task Force on Mental Illness. Family members can have challenges articulating their concerns, even with a current Release of Information, so families receive coaching on how to communicate with treatment providers. Another challenge has been outreaching to families of youth. Although NAMI has reached out through counselors at the schools and other youth service treatment providers, there have not been any referrals. Due to the increase in youth utilizing the Emergency Department, NAMI worked with the ED Director of Nursing to provide educational materials, picture books, and activity supplies for patients waiting for placement, and are in process of developing NAMI outreach materials for Sierra Mental Wellness staff to provide to families. A challenge that has persisted is the limited education of teachers and school staff regarding of the impact of serious and persistent mental illness on children and their families. NAMI is aware of situations where a child is discharged from a psychiatric hospital and returns to school the next

day. NAMI families know how children can be traumatized from how they are treated by other children and teachers and NAMI helps to change that.

Program Participant Story

The overarching purpose of the Family Support and Education program is to help families on their journey addressing the profound trauma that results when someone you love develops a severe mental illness, while also providing psychoeducation, helping families navigate treatment options, build personal resilience to manage and have one's own life, and providing support for ill family member[s]. This typically takes years. An essential part of the educational and support program is teaching and coaching the LEAP method of communication as described in Dr. Xavier Amador's book, I'm Not Sick, I Don't Need Help. Three years ago, one mother was profoundly traumatized by the experiences that have resulted in her adult child being hospitalized three times and in Assisted Outpatient Treatment for several 6 months terms. He currently is not stable and is not regularly taking medication for his psychiatric illness. Through continual participation in services, she has learned how to use the LEAP communication method, partner with her adult child, navigate and understand previously unknown treatment services, and now is a touchstone for her adult child with regular contact.

Outreach and Engagement:

SIERRA FAMILY HEALTH CENTER
Expanded Mental Health Services in North San Juan

Program Description

Program Overview

Sierra Family is honored to provide outreach, engagement, and care coordination services to patients in underserved areas while keeping abreast of community services that are available to help patients and their families. Services include connecting patients to therapy services either at the Clinic or with a provider of preference in the community which accepts the patient's insurance. Staff meet with each individual to determine patient needs, including potential new patients, as well as existing patients who need assistance. Other services include connecting patients to food and community resources; housing, insurance, disability assistance, encouraging patients to identify and connect with family and/or community support systems, patient education regarding resources, supporting patients in connecting to FREED, Hospitality House, Community Beyond Violence, and other community agencies.

Target Population

Low income and underserved**.** Approximately 60% of patients seen have some type of Medi-Cal coverage, 29% have Medicare, and 4% have no insurance. Discounted assistance is provided to patients under 200% of the Federal Poverty Level. Patients receive assistance with enrolling in Medi-Cal as their primary insurance and for those needing Medi-Cal as secondary to Medicare.

Evaluation Activities and Outcomes

During the past year, 69 unique patients needed assistance, and 51 (74%) patients engaged in accessing community supports within 90 days. Patients are provided with remote and in-person services for therapy and care coordination. Care Coordinators provided services to 80% of program participants until the participant became engaged in referred services.

Access to food continues to be the highest need; individuals have been referred to the following food programs: FREED (22); Nevada County Left Coalition food assistance (10); Food Bank (14); Interfaith Food Ministry (13). Additional referrals Hospitality House (9); Modivcare transportation (16), Medi-Cal or assist with changes (35), CalFresh (31), Alta Regional Center (1), Community Beyond Violence (7), Granite Wellness (4), Common Goals (2), NCBH for either Mental Health or Substance Use (9), FREED (21), Workforce Development (2), Connecting Point (17), Salvation Army (2), community therapists (9). Medication assistance was provided to 12 eligible patients who received free/discounted medications from pharmaceutical companies.

Challenges, Solutions, and Upcoming Changes

Housing is the highest overall challenge for patients. The number of patients with housing insecurity has more than doubled over the past year. Although offered, patients typically prefer to sleep in cars, camp, or couch surf rather than going to a congregate facility such as Hospitality House (HH), although referrals are made and patients are encouraged to look at services that HH can provide.

Secondly, transportation continues to be a challenge as the cost of gas has increased and SFHC has opened up for in-person visits. There is a continuing gas card assistance program, although it is no longer funded by Dignity Health. The isolation from the pandemic has increased the mental health acuity for a significant number of patients who now are being seen frequently, and SFHC has hired an additional clinician due to demand.

Finally, SFHC is working to add another Behavioral Health clinician to the team due to increasing demand for services.

Program Participant Story

One patient was fighting homelessness, was uninsured for medical care, as well as was in the Emergency Department several times for acute medical conditions intermittently for several weeks as he was not able to afford prescription coverage. SFHC worked with the patient to help him obtain medication assistance through a pharmaceutical company, assured that he received sufficient food, and assisted him in obtaining Medi-Cal insurance. The patient's health issues resolved, and he is now more stable in his housing.

Outreach and Engagement:
HOSPITALITY HOUSE & TURNING POINT COMMUNITY PROGRAMS
Case Management and Therapy for Homeless Individuals with Mental Illness
Housing Assistance Program (HAP)

Program Description

Program Overview

The Housing Assistance Program (HAP) is a collaboration with Hospitality House and Turning Point Community Programs. The goal of the Housing Assistance Program is to deliver mental health services to participants of the Hospitality House shelter and outreach program. One (1)

Shelter Case Manager is responsible for assisting Hospitality House participants in meeting their expressed mental health-related goals, including specific assistance with medication management, housing, counseling, medical services, support, brokerage for other needed services, and advocacy. The Shelter Case Manager works directly under the supervision and direction of the Hospitality House Social Services Manager and a Turning Point Manager.

The Housing Assistance Program began serving individuals in April 2018.

Target Population

The target population for the Housing Assistance Program includes individuals who are homeless in Nevada County and shelter guests from Hospitality House.

Evaluation Activities and Outcomes

1. Serve approximately 60 unduplicated individuals/families
   Outcome: During this period the HAP program served 36 unique individuals.
2. One third (20) shelter guests, Rapid Re-housing tenants, and Outreach Program participants maintain their housing or improve their housing situation.
   Outcome: 6 individuals (17%) exited into transitional housing, 2 individuals (6%) exited into permanent supportive housing, 1 individual (2%) exited into treatment, 14 individuals (39%) stayed in the emergency shelter, and 13 (36%) individuals exited to a place not meant for human habitation.
3. Ninety percent of program participants (*with permanent housing in #2 above)* maintain their permanent housing or improved housing situation.
   Outcome: As of 6/30/2022, 100% of individuals in permanent supportive housing maintained their status.
4. Program participants receive the services and benefits they need to obtain or maintain permanent housing or to be a successful shelter guest. Ninety percent of program participants have identified at least one service or benefit they need and have received that service or benefit.
   Outcome: All 36 individuals enrolled in the program have received at least one service following the initial intake and needs assessment.
5. Ninety percent of program participants show a decrease in prolonged suffering from mental illness measuring reduced symptoms and/or improved recovery, including mental, emotional and relational functioning. Data is obtained through the Behavioral Health Client Perception Survey.
   Outcome: Unfortunately, there was no Client Perception Survey data available this reporting year. The surveys are distributed at the end of treatment, but due to a staffing shortage the survey was not able to be dispersed. However, Turning Point continues to emphasize trauma informed care in working with those served. This allows participants to feel respected and cared for in their recovery process and allows staff the opportunity to see people through a trauma informed lenses in all the work they do. Individuals served through this program at Hospitality House have reported improved relationships with their support people and increased hope via interactions with the embedded case worker.

6. Ninety percent of program participants show a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning. Data is obtained through the Behavioral Health Client Perception Survey.
   Outcome: Unfortunately, there was no Client Perception Survey data available this reporting year. The individuals served through this program have reported improved relationships with their support network, therefore increasing their protective factors and decreasing their risk factors. Enhancing their lives with employment and housing opportunities has increased their hope and supported them in reducing their risk factors.

7. Seventy percent of program referrals provided to program participants are followed up on by the program participant.
   Outcome: During the reporting period the HAP program made 18 referrals to outside agencies, unfortunately due to the pandemic and other challenges participants were only able to follow up on 9 of those referrals.
8. Ninety percent of mental health referrals provided to program participants are followed up by program participants.
   Outcome: During the reporting period the HAP program made 11 referrals to Nevada County Behavioral Health. Of those referrals, 6 (55%) were accepted, 3 (27%) were canceled in NCBH and 2 (18%) were declined.

Challenges, Solutions, and Upcoming Changes

The biggest challenge faced by the HAP program has been an ongoing struggle with COVID-19 as throughout this reporting period the shelter has fluctuated from shelter-in-place to a return to the overnight model. The evolving shelter policies continue to negatively impact HAP participants' mental health and housing opportunities. The risk of becoming ill is much higher amongst homeless populations, and at the beginning of the outbreak, there was much concern over contracting and spreading COVID-19. As the pandemic has progressed the fears of contracting COVID-19 have continued. Further, with a frozen housing market and much of the program year spent under shelter-in-place protocols many of the individuals have been sheltering at Utah's Place. The setting of 65-bed emergency shelter for extended periods of time has been reported as having a great impact on the mental well-being of the clients served by the HAP program. The program also remained without an embedded case manager from October 2022 until June 30, 2022 which resulted in lower than expected numbers.

Program Participant Story

An individuals served had a reputation for being a hard worker, maintaining full-time employment for years, and living independently until he fell on hard times. Due to his age and long life of physical work, his health began to decline, causing him to become unemployed. He also struggled with a substance abuse disorder. Because of this, he faced homelessness.

As a guest at Hospitality House, he has stayed committed to sobriety. He is receiving assistance with social and human health services and transportation to and from medical appointments. Recently, his struggles with his health resulted in surgery. Thanks to partnership with Sierra Nevada Memorial Hospital, he was able to come back to Hospitality House and stay in a recuperative care room that allowed him the safe, clean environment needed for a successful healing process.

He has remained dedicated to his journey towards healthy living, and as a result his health has improved. With support from staff and his case manager Fred Skeen R.N., this individual has now secured monthly income from his retirement and Social Security. Now that he has his health intact, is maintaining his sobriety, and has secured reliable income, he is working to secure permanent housing.

Outreach and Engagement

NEVADA COUNTY SYSTEM OF CARE
Forensic Liaison

Program Description

Program Overview

Forensic Specialist Services aim 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, Nevada County Behavioral Health (NCBH), Adult Protective Services, Hospitality House Homeless Shelter, Granite Wellness Center (GWC), 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 people who are, or have been, incarcerated and who are ready to be, or have been, released back into the community. Many of the people referred to the program are homeless or at risk of homelessness.

Evaluation Activities and Outcomes

Forensic Outreach collects evaluation activities for MHSA including demographic information on each individual receiving services. In addition, information on referrals to outside agencies is collected. Referrals are only reported if the participant successfully connected with the agency. Therefore, all reported referrals have been successfully connected.

During FY 21/22, Forensic Outreach provided services to 32 unduplicated participants. The program provided 37 referrals to participants over the year. See the table below for more detailed referral information.

Agency/Program Referred To:	**# of Referrals**
SUD Treatment	9
HOME Team	8
AA/NA	6
County MH Treatment	5
Hospitality House/Homeless Shelter	5
CBV	1
Human Services (Benefits)	1
Veteran Services	1
Crisis Stabilization Unit	1
TOTAL	**37**

Services: The Forensic Liaison delivered 36 total services including benefits assistance, housing assistance, care coordination, and brief counseling.

Challenges, Solutions, and Upcoming Changes

Staffing remains the largest challenge for this program. The Forensic Liaison is a contracted position, and there were significant challenges in refilling the position after it was vacated in March 2021. The position was not filled again until January 2022 and was only filled for three months until it was vacated again in March 2022. Challenges with the contracted position include lack of benefits and issues passing the various jail clearance requirements, especially with such high staff turnover. In FY 23/24, this position will shift from a contracted position to a benefited County position, which should help with both recruitment and retention.

Another significant obstacle to overcome while working with inmates is locating a safe shelter to where the individual can exit. A shelter is a key element of participant success, in addition to being a basic need. Having shelter can reduce criminality related to meeting basic needs, it gives the individual's support system a place to locate them, a place to receive mail, a place to safely store belongings, and a myriad of other benefits which contribute to rehabilitation and encourage

prosocial behavior. Very few inmates being released from jail have the means to enter traditional housing and Hospitality House is the only shelter option available to them. Hospitality House, however, does not have enough beds to support the entirety of the shelter needs for Nevada County's population facing homelessness. Additionally, Hospitality House does not accept individuals with a history of violent felonies, arson charges, or sex offences. In response to this challenge the Forensic Liaison refers individuals into Recovery Residence transitional housing, as most individuals meet the Recovery Residence criteria of 30 days of sobriety due to their incarceration.

Program Participant Story

Due to the resignation of the Forensic Liaison, there is no Program Participant Story to share.

Outreach and Engagement

NEVADA COUNTY VETERANS SERVICE OFFICE
& WELCOME HOME VETS
Veterans' Services & Therapy

Program Description

Program Overview

Nevada County is in the Sierra Nevada foothills of California with a person per square mile rate of 103, compared to 251 in California. The rural population of 99,814 live across a 974-square-mile region that spans from the foothills, over the Sierra Nevada's and extending East to the California/Nevada border. The three incorporated cities (Nevada City, Grass Valley, and Truckee) comprise approximately 32,000 residents, leaving more than 66,000 persons living in very rural areas. Veterans comprise more than 8.6% of the county population.

According to the 2018 VetPop data, there are 8,548 Veterans calling Nevada County home, of which 5% are WW II Veterans, 59% Korean / Vietnam War Veterans, 13% Peacetime Veterans and 23% Gulf War Veterans. The 2019 Housing and Urban Development (HUD) Point In Time count identified 34 homeless Veterans within Nevada County. According to the Substance Abuse and Mental Health Services Administration, **20 to 25%** of the homeless population in the United States suffers from some form of severe mental illness.

Most Nevada County residents live 60-90 miles from the closest VA Medical Center. A small VA outpatient clinic in Auburn, CA is located 30 miles from Grass Valley. This clinic is where many Veterans are seen for their primary care and where only a single psychologist is available. The clinic is associated with the Mather VA Medical Center, which is 56 miles away.

Mental Health services for combat Veterans are provided by a therapist in Grass Valley through a contract with the Citrus Heights Vet Center. These services will allow for a veteran who suffers from combat-related PTSD to continue to be seen by a local therapist. However, if the Veteran receives a disability rating for PTSD due to a stressor that is not combat-related, the veteran is then required to receive treatment through the VAMC at Mather.

Welcome Home Vets (WHV) is a non-profit organization that provides mental health services through contracted licensed-therapists and serves Veterans in the Nevada County area. These therapists are competent in both military culture and in treatment of military related psychological trauma. This support service allows Veterans to continue receiving treatment in Nevada County. Family members can also receive free mental health services, including individual, group, and supervised peer-support therapy. WHV also provides education to the community on military related trauma through agencies such as faith-based organizations, the court system, junior college system and the Community Support Network, a non-profit collaborative.

The Nevada County VSO received the Mental Health Services Act (MHSA) Community Services and Supports (CSS) Outreach and Engagement Funding Grant through the Nevada County Behavioral Health Agency for FY 21-22 in the amount of $52,445 and partnered with WHV ($32,445) to provide free quality mental health services to 30 Veterans in the county through this program. The Nevada County Veterans Services Office dedicated $20,000 of this funding to focus on expanding its current outreach programs and strengthening its collaborative network of services with outside agencies.

Target Population

Immediately upon separating from military service, many Veterans focus on providing for their family, starting a new career, or focus on continuing their education. During this new journey, many Veterans fail to file for benefits or seek treatment for the psychological trauma they experienced during their service. For some Veterans in Nevada County, it has been 30 years or more since they left the military. This same group of Veterans are just now coming to terms with their service and are seeking benefits and treatment.

The Nevada County Veterans Services Office provides services to veterans, their dependents, and surviving spouses in every era of conflict and peacetime.

Evaluation Activities and Outcomes

In January of 2022, the NCVSO released its second annual "All Veterans County Survey", where targeted information and data were collected from the veterans of Nevada County and were compared to the previous year's responses. The information from this survey communicated that the community was enthusiastic about the diversity of services it worked to implement. Additionally, the results of the survey showed the community was seeing improvements with its efforts to increase its presence on social media, continued participation in radio interviews, and the monthly written articles for local newspapers and circulars. The Veterans Services Officer (VSO) met monthly with different outside service providers, agencies, and local Veterans Services Organizations to educate the public on the mental health services that were available to them

through its “Virtual VSO” platform. Additionally, the NCVSO focused on improving its “Underserved Veterans Population” Outreach Coordinator program. The Underserved Veterans Population Outreach Coordinator continues to meet with veterans at the county jail, receives weekly reports from the probation department, and performs bi-weekly outreach at local rehabilitation clinics and homeless shelters.

The first two months of the fiscal year proved to be an extremely difficult period for the veterans of Nevada County. During this time 23 unduplicated veterans were enrolled for services through Welcome Home Vets. It was during this time the United States made the decision to withdraw from Afghanistan. This decision had a negative impact on the veterans of conflicts in the Vietnam War and Afghanistan/Iraq War Veterans. A total of 20 unduplicated veterans were referred to WHV over the course of the next 4 months. Over the final six months of the fiscal year an additional 37 unduplicated veterans were referred for free and confidential mental health services for a total of 29 unduplicated veterans who enrolled in the program.

The NCVSO was responsible for the enrollment of 29 unduplicated veterans during the fiscal year through Welcome Home Vets. This is because Welcome Home Vets’ ability to conduct its own outreach continues to be severely impacted by the pandemic and by the fact that is has experienced a complete change in leadership since the beginning of the pandemic. Welcome Home Vets maintains its office at the Grass Valley Veterans Memorial Building and meets referrals on an appointment basis.

The Nevada County Veterans Services Office (NCVSO) was successful in providing 81 referrals for mental health services to the proper agency depending on the eligibility criteria of the different services available. Of these 81 referrals, 33 were made to the Citrus Heights Vet Center, 47 were made to Welcome Home Vets, and a single referral was made for emergency services at the VA Medical Center at Mather.

- VSO Outcomes:
  - Served 81 unduplicated individuals/families with mental health needs.
    - Scheduled monthly meetings with service providers to ensure enrollment in services.
  - Participated in a total of six physical Outreach Events
    - Held Northern California’s only Stand Down Event (Drive-Thru), approximately 242 attendees.
    - Presented on efforts of CVSO to Nevada County Board of Supervisors, approximately 5,000 attendees (included virtual attendees).
    - Attend Vietnam Veterans of America Christmas Dinner for Active-Duty Airmen & Women from Beale AFB, approximately 120 attendees.
    - Raise Them Up event for underprivileged children, approximately 25 attendees.
    - Spoke to Nevada City Rotary Club, approximately 50 attendees.

        - Participated in Grass Valley's Armed Forces Day, approximately 2,500 attendees.
        - Monthly newsletters
        - KNCO Radio interview, approximately 5,000 listeners.
- WHV Outcomes:
    - Served 67 (target of 60) unduplicated individuals/families receiving therapy between CalVets Prop 63 Grant (29) and the MHSA funding (38).
    - 35 group therapy sessions were led by a Licensed Clinical Psychologist, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, or Peer Specialist (Goal = 50)
    - 399 individual therapy sessions were led by a Licensed Clinical Psychologist (Goal = 100)
    - 388 individual sessions by a Licensed Marriage and Family Therapist or a Licensed Clinical Social Worker (Goal 225).
  - The 24-item Behavior and Symptom Identification Scale Basis-24 results:
        - 0% Percent of veterans incarcerated in jail or prison during the time of treatment (Goal = less than 5%)
        - 11% Percent of veterans in treatment report thinking about ending their life only a little or none of the time (Goal = 95%)
        - 0% of veterans in treatment hospitalized in a psychiatric hospital during the treatment period (Goal = 10% or less)
        - 0% of veterans in treatment reporting being in a shelter or homeless on the street more than one time during treatment (Goal = 15%).
        - 88% of veterans in treatment reporting feeling short-tempered less often during a week (Goal = 70%)
        - 100% of veterans reported that they got along well in social situations half the time or more during a week (Goal = 70%)

Challenges, Solutions, and Upcoming Changes

The COVID-19 pandemic and the restrictions that were implemented out of safety concerns for the citizens of Nevada County continued to be a major challenge to conducting outreach and engaging with veterans in 2021/22. However, state restrictions were gradually relaxed and opportunities for outreach presented themselves, the NCVSO continued to focus on how it can improve the services it provides, and it focused on expanding the opportunities for collaboration with outside agencies. The following is a list of program improvements and changes that the VSO has implemented or are developing to engage more veterans as they continue to strive to connect every veteran with the benefits that he or she is entitled to.

- Continued use of Virtual VSO.
- Released the second Annual "All Veterans County Survey".
- Expanded and developed the "Underserved Population" Outreach Coordinator Program.

- Developed a comprehensive training program to keep VSO staff up to date with VA changes.
- Increased focus on various social media platforms.
- Ability to apply for select benefits through CVSO website.
- Increased focus on digital services.
- Increased efforts on positive communication with local veterans' service organizations.
- Collaborative Participation with CalVet's Northern California Rural County Collaborative.

Fiscal year 22/23 will bring new challenges to the NVCVSO. It is expected that the President will soon sign into law the Honoring our PACT Act, which is the most comprehensive bill to impact the VA in generations. It is expected that the VA claims backlog will continue to grow and impact the timeliness that it makes decisions for claims that are submitted by veterans. Additionally, the VA is aiming to hire 2,000 additional staff to handle the expected increase in workload. This will bring its own set of challenges in terms of accuracy of decisions, the correct application of laws & regulations that govern VA benefits, and confidence of veterans in the VA.

It will be essential that the VSO continues to focus on training, educating the public, and informing veterans of current challenges within the VA.

Last, inflation and an expected recession will have a negative impact on the economy within the next year. It will be imperative that the VSO builds strong collaborative relationships with agencies that can assist veterans in obtaining jobs, writing resumes, and receiving training. Additionally, the continued financial stress of a recession will bring greater requests for mental health services.

Additionally, WHV is recruiting and filling vacant volunteer positions. WHV is conducting a targeted recruiting effort that will match qualified applicants with vacant positions. The organization is also implementing a social media/public communications position.

Program Participant Story

In July of 2021, the County of Nevada announced that it had reduced its number of homeless veterans from a high of 45 to 29 and therefore, the county had entered the "last mile" of reducing veterans' homelessness to functional zero. This announcement brought highlighted attention to the services that the VSO provided and encouraged community agencies to work together to solve the problem of veteran homelessness in Nevada County.

The Nevada County VSO was made aware of a female veteran in the community that was abusing illicit substances, was homeless, and was on the verge of losing custody of her children. During the initial interview with the veteran, it was learned that she was a victim of Military Sexual Trauma (MST), who was self-medicating and was unaware that veterans' services were available to her.

The VSO worked to get her placed on the county by name list, which allows multiple agencies to work together to share their resources to provide more opportunities to house veterans. The VSO then made a referral for mental health services to Welcome Home Vets who provided counseling while the VSO focused on assisting her with filing a claim for PTSD due to MST with the VA. Additionally, she self-enrolled in rehabilitation and has been successful in her sobriety. The VA decided her claim in her favor, and she was awarded $1,900 per month in VA benefits. This monthly benefit was then used to assist her with securing long-term housing.

Last, the VSO received a referral from Child Welfare Services (CWS) that the veteran's 8-year-old daughter needed braces and the veteran was unable to pay for them. The VSO reached out to the veteran community to see if we could raise $5,800 to pay for the child's first set of braces. The community agreed that a smile is a key to a young girl's confidence and successfully raised the necessary funding and assisted with the veteran's daughter getting braces.

Outreach and Engagement:

SPIRIT
Adult Wellness Center
SPIRIT Peer Empowerment Center

Program Description

Program Overview

SPIRIT Center is open five days a week for people seeking support with issues related to mental health and/or recovery. A significant number (about 90%) of those seeking services are unhoused. Our entirely peer-run Center offers one-on-one peer support to individuals and hosts a variety of support groups and classes. These include Diagnosis with Dignity, Depression and Anxiety, and Women's and Men's Groups. Additionally, Spirit has recently added two groups to assist the unhoused: Steps to Home (formerly Housing Circle) and Resiliency & Relationships. The goal is to create pathways towards connection and creativity, in a way that meets each individual's interests and stage of growth. There is a variety of planned activities throughout the week. Some of these include Peer Music, Beading for Wellness, Creative Expressions, and Gentle Yoga. Participants may also get their hands dirty tending our organic garden.

Target Population

Adults with mental health issues who indicate they would like to make positive changes in their life; this may include those with substance use issues, co-occurring conditions, or currently experiencing homelessness.

Evaluation Activities and Outcomes

SPIRIT Center Stats F/Y 21-22	Year End Total 21/22
# of Individuals each quarter	**1252**
# of New Each Quarter	**828**
# New Participants to SPIRIT from EDP	**69**
Empower peers to engage in the highest level of work or productive activity appropriate as measured by:	
Volunteer hours spent maintaining the facility	**740**
Peer Support sessions	**1369**
Peer Support phone sessions	**71**
Number of bi-lingual Support Sessions/Assistance	**386**
Peer Support training hours	**171**
Opportunities offered to peers to optimize productive activity (list hours for each service):	
Data Entry/Front Desk	**1830**
Group Facilitation	**526**
Reduce isolation of persons with mental illness as measured by:	
Duplicated Visits (Walk-ins)	**8641**
Support Groups per Quarter	**194**
-Support Group's Attendance	**1024**
Social Activities per Quarter	**118**
-Social Activity Attendance	**998**
Physical Movement Sessions per Quarter	**49**
-Physical Movement Attendance	**263**
# of people in SPIRIT sponsored structured educational class:	
Peer Support 101	**30**
WRAP I	**38**
WRAP II	**12**
Improve quality of life of homeless individuals as measured by:	
# of Showers to homeless	**1396**
# of Loads of Laundry to homeless	**441**
# of Bags of Food given to homeless	**594**
# of Meals given to homeless	**5173**
# of Homeless receiving basic services (enrolled)*	**313**

Un-interviewed Individuals (e.g. one-time vist or class)	**416**
* Estimated total homeless	**739**
# of homeless participants who obtained housing	**39**
# of peers who obtained gainful employment	**26**
Survey Results - # of clients who improved in each of these areas: Note: Performed in 4th Qtr	
Help with Employment	**16**
Help with Housing	**16**
Building Life Skills/Coping Skills	**44**
Avoiding Hospitalizations	**20**
Avoiding Suicide	**24**
Court/Legal	**18**
Developing Education	**18**
Managing Substance Abuse	**24**
Feeling Better	**62**
Other Data to be collected:	
Fundraising (Holiday Letter, donations, outreach)	**$7,792**
Bus passes issued	**278**
Number of public computer use sessions	**416**
Hours the Center was open	**1386**

With the addition of several new programs including Housing and Resiliency, Hot Healthy Lunch and new support groups like Grief Group and Steps to Home and Relations Resiliency there has been an increase in participation as well as a positive result in outcomes. SPIRIT is proud to state that through the Housing Program, 39 participants were housed this fiscal year. SPIRIT also gave out an astounding 5,173 lunches, resulting in countless Peer Support Sessions, and personal stability. This program has embellished the normal services at SPIRIT and resulted in more positive outcomes in the lives of participants.

Collaboration has always been an integral part of the work at SPIRIT; however, this last fiscal year has seen an increase in those efforts. SPIRIT participates in multiple group meetings, which has been a very productive way to help participants make progress in their lives. For example, SPIRIT participates in the bi-monthly HRT and HOT team meetings, and Coc and Shelter Committee to name a few. SPIRIT also connects with colleagues from Hospitality House, FREED, NCBH and CBV on a daily basis, providing additional case management. HMIS is used in order to stay current on the details of participants. This collaboration is tremendously

beneficial to participants, resulting in the successful housing of 39 individuals, and countless others.

Despite the challenges, staff have been dedicated to Spirit's mission and vision – to provide support and services to the target population. SPIRIT continues to look for traditional and creative ways to offer peer support and case management to individuals who enter SPIRIT's doors so they can reach their goals and continue on a path of successful living.

Challenges, Solutions, and Upcoming Changes

The largest and most significant challenge SPIRIT faces on a daily basis is the need for the services offered exceeds current capacity. Participant population has evolved over the last several years, and now stands at over 90% experiencing homelessness. Although the primary mission and purpose is to empower others to overcome their challenges, the immediate and primary needs of the participants require immediate focus on the part of staff. Current capacity is 40 participants per day, and it is a struggle to stay within those parameters. The need is well above the capacity.

SPIRIT has developed multiple programs to address the daily chores required to maintain a hygienic and safe environment for all who attend SPIRIT, which helps with the workload on staff.

The staff at SPIRIT continues to address behavior issues with our participants, including conflicts with each other as well as substance use. SPIRIT has elected to address this by increasing our staff trainings, as well as reaching out to the agencies collaborated with. There are monthly one-day trainings, with topics including "Healthy Boundaries", "Wellness Recovery Action Plans", "Conflict Resolution" and "PEARLS (Program to Encourage Active and Rewarding Lives)". They have had a profound and personal impact on staff. These additional trainings enable the staff to feel more prepared and centered so that they can provide the confident and excellent service required for this work. SPIRIT is dedicated to continued training and support for staff so that they can perform to the best of their ability.

SPIRIT continues to work very closely with Law Enforcement and the HOME Team to ensure a safe environment for participants and staff. SPIRIT also has close contact with the case managers at other agencies like Hospitality House, FREED, Connecting Point and Communities Beyond Violence, in order to provide a consistent approach.

Program Participant Story

After 26 years of homelessness, tremendous PTSD and trauma, one of SPIRIT's dear participants has moved into a trailer of his own. Along with finally being out of the weather, having comfortable furniture to rest on, and a safe place for he and his beloved dog, he often mentions that he is most excited to be able to have fun with his RC cars, something he has collected for years. The effort to get this participant housed has been enormous and included months of diligent case management, and an endless number of peer support sessions. SPIRIT will continue to provide this important work, as staff are very committed to seeing this person find the success they desire.

Prevention and Early Intervention (PEI)

PEI Category: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH (NCBH)
Bilingual Therapy
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.

Staff work closely with community agencies that have already built trust with Latinx families by providing needed basic services. Examples of such community agencies are Child Advocates of Nevada County, Tahoe Safe Alliance, and the Sierra Community House (SCH).

NCBH maintains good communication with these community agencies by:

- coordinating care of mutual participants
- funding programs at the SCH, including the Bilingual Peer-Counseling Program
- providing training to the SCH Peer-Counselors
- staffing the SCH with an NCBH therapist for one hour per week
- delivering quality service and treatment of participants referred from the SCH
- providing clinical supervision to SCH 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

The Bilingual Early Intervention Program collects demographic and service-level data through NCBH's Electronic Health Record (Cerner). NCBH uses a dashboard within Cerner to facilitate efficient quantitative data-gathering and aggregation of outcome measures.

During FY 21/22, the program served 39 individuals. Five people were served in eastern Nevada County and 34 people were served in western Nevada County. The average number of hours of service each participant received was 18. See the tables below for more information on services.

	FY 21/22		
Service Category	**Number of Hours**	**Number Served**	**Average Hours per Participant**
Assessment/ Screening	62.2	28	**2.2**
Individual/ Family Therapy	519.0	30	**17.3**
Rehab./ Mental Health Services	27.3	5	**5.5**
Collateral	55.4	15	**3.7**
Other	22.7	23	**1.0**
Total (All Services)	**686.5**	**39**	**17.6**

In FY 21/22 Child Adolescent Needs and Strengths (CANS) outcomes showed that 43% (six out of 14) of reassessed participants had a decrease in symptoms related to actionable items (scored as 2 or 3) identified in the CANS. Decrease in symptoms is evidenced by a rating that decreased from a 3 to a 2 or 1, or from a 2 to a 1. It is anticipated that this percentage decrease will improve with additional treatment. The Basis 24 adult outcome measure showed 67% (two out of three) of reassessed participants improved outcomes on reassessment.

	FY 21/22		FY 20/21		FY 19/20	
Assessment/Reassessments with Outcomes	**Number of Participants**	**Percent of Participants**	**Number of Participants**	**Percent of Participants**	**Number of Participants**	**Percent of Participants**
CANS Assessments	20	51%	22	30%	35	61%
CANS Reassessments	14	36%	9	12%	15	26%
CANS % Improved (Decrease 2s, 3s)		41%		67%		83%
Basis 24 Assessments	N/A		12		11	
Basis 24 Reassessments	N/A		2		2	
Basis 24 % Improved		N/A		50%		100%
Unduplicated Total	**39**		**74**		**57**	

Challenges, Solutions, and Upcoming Changes

An ongoing challenge since the pandemic began has been clinical workforce shortages, particularly for bilingual staff. Our bilingual clinical position in eastern county remained vacant for many months without any qualifying applicants. We were able to find an experienced bilingual, bicultural case manager who is a member of the eastern county community and is a Master of Social Work practicum student for the role. With clinical supervision support, in collaboration with a bilingual case manager, this intern clinician is helping meet the needs of our bilingual families.

In eastern Nevada County, Peer Support programming has increased capacity for helping MHSA-funded individuals through Sierra Community House, providing not only clinical supports but also relevant cultural, linguistic, and case management supports. The eastern county hospital has also increased its "Promotora" care coordination services to help meet the unique and often complex needs of MHSA-funded individuals.

Program Participant Story

This individual is a 17-year-old Hispanic female who was originally referred to Nevada County Children's Behavioral Health at age 12 by her school. While the family declined to utilize psychiatry services with Nevada County, the client did start regular therapy and was referred to the Gateway Mentorship Program to help her with symptoms of depression, anxiety, anger, and impulsivity that were threatening her ability to stay at her school and in her home.

During the client's time in treatment with Nevada County Behavioral Health, the client did at one time have to say goodbye to one clinician who left her position and continue her treatment with a new clinician. The client also had to navigate a change in service venue during the Covid-19 pandemic, as well as learn to cope with new kinds of emotional and interpersonal stressors. Through regular therapeutic and mentorship contact and a variety of clinical modalities, the client remained engaged with services and progressing toward her treatment goals.

Now, the client is preparing to graduate from high school with a GPA above 3.0. She is actively applying to colleges. She has a strong social support system and is holding a job. She is preparing to graduate from Nevada County Behavioral Health services, with significantly reduced mood symptoms, improved coping, improved use of impulse control techniques, and improved self-esteem.

PEI Category: Early Intervention Program

NEVADA COUNTY PUBLIC HEALTH

Perinatal Depression Program
Moving Beyond Depression- Every Child Succeeds

Program Description

Program Overview
Moving Beyond Depression (MBD) is a voluntary, evidenced-based program for women experiencing prenatal or postpartum depression (i.e., perinatal depression) who are enrolled in a home-visitation program. MBD offers In Home-Cognitive Behavioral Therapy (IH-CBT) in 15 weekly sessions and a one (1) month follow-up booster session. Therapy is provided by licensed therapists and supervised by a licensed therapist in NCBH.

MBD is in partnership with home visitation programs in Nevada County: Healthy Babies, Early Head Start, the Young Parents Program of the Nevada Joint Union High School District, the STEPP Program of TTUSD, and the Nevada County Maternal-Child Public Health Nurses. In addition, Nevada County Public Health in conjunction with the Department of Social Services, has begun an evidence-based home visiting program call Brilliant Beginnings, which utilizes the Parents as Teachers foundational model. This new home visiting program will also promote the Moving Beyond Depression program.

Target Population
This program is designed to meet the needs of low-income, underserved parents who are enrolled in a home visitation program in Nevada County and who are experiencing perinatal depression. Though mothers are the target population, through providing services to parents, the program supports prevention and early intervention for infants and children, as well as the whole family.

Evaluation Activities and Outcomes

MBD collected evaluation activities for MHSA including demographic information for each individual person receiving services, along with any children in the household. In addition, information on the date of the service was collected. Individuals receiving services also had an Edinburgh Postnatal Depression Scale (EPDS) completed at intake, during ongoing services, and at discharge from the program. Individuals receiving services also have a completed Interpersonal Support Evaluation List-Short Form (ISEL-SF) to assess perceived social support at intake to and discharge from the program. Perception of Care surveys were collected at the end of services. Information on referrals to community services was also collected. Demographic, service, EPDS, and ISEL-SF data were collected and managed using REDCap

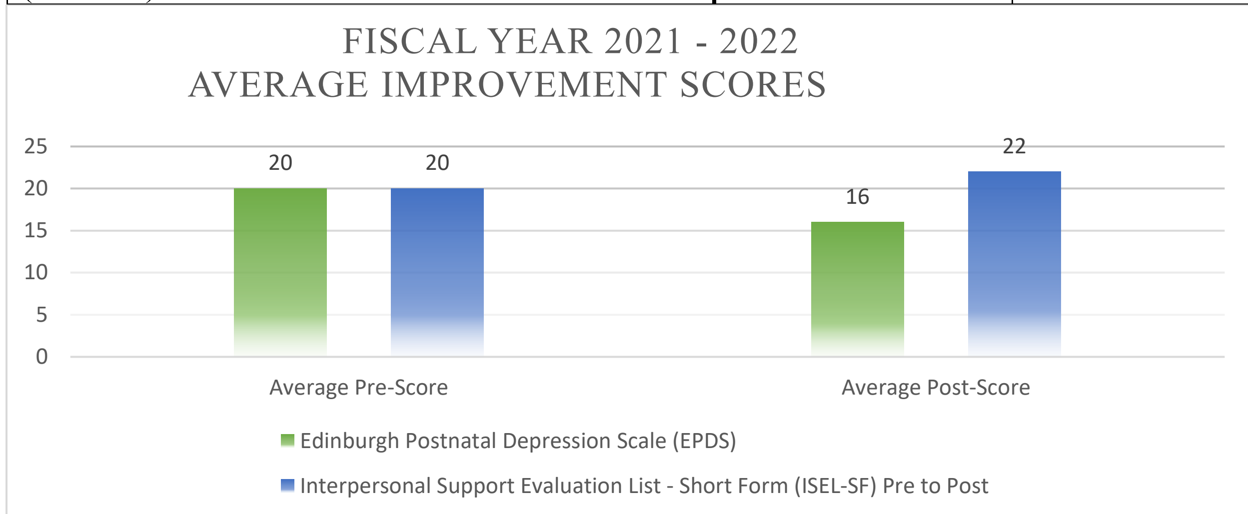
electronic data capture tools hosted at NCBH[1]. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources.

During FY 2021-22, MBD offered services to 17 unduplicated participants. Of the 17 offered services, 11 enrolled in the program, with 7 completing at least six sessions. Demographics were collected for participants receiving services including their children.

	FY 2021-2022	
	# Served	**% Improved by 6th session**
Clients Completing Six Sessions or more	7	60%

Participants who completed the MBD program showed overall improvement in both their EPDS and ISEL-SF scores. A decrease in a client's EPDS score demonstrates a decrease in symptoms of depression. An increase in ISEL-SF scores indicates that participants perceive better social support. Below are average improvement scores for FY 2021-22 for both EPDS and ISEL screens. Three of the 11 clients who participated in the program completed the program. The average decrease in EPDS was *20% and increase of the ISEL score was* 10% for those who completed the program.

	FY 2020-2021	
	Average Pre-Score	**Average Post-Score**
Edinburgh Postnatal Depression Scale (EPDS)	20	16
Interpersonal Support Evaluation List - Short Form (ISEL-SF) Pre to Post	20	22



[1] Paul A. Harris, Robert Taylor, Robert Thielke, Jonathon Payne, Nathaniel Gonzalez, Jose G. Conde, Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support, J Biomed Inform. 2009 p;42(2):377-81.

In addition, the Participant Perception of Care survey was administered in FY 2021-22. Responses indicated better social functioning at completion of the program. See the table below for more perception of care information.

	FY 2021-22	
Participant Perception of Care Survey	**% Agree**	**N**
I am getting along better with my family.	100%	3
I do better in school and/or work.	60%*	2
My housing situation has improved.	100%	3
I am better able to do things that I want to do.	60%	3
I am better able to deal with crisis.	100%	3
I do better in social situations.	100%	3
I have people with whom I can do positive things.	100%	3
I do things that are more meaningful to me.	100%	3
I have learned to use coping mechanisms other than alcohol and/or other drugs.	100%	3
In a crisis, I would have the support I need from family or friends.	100%	3
Staff welcome me and treat me with respect.	100%	3
Staff are sensitive to my cultural background.	100%	3
Average/ Total Surveys Submitted	**93%**	

*Some participants indicated that this statement was not applicable to them and responded with N/A. These were not included in score.

During FY 2021-22, MBD made three (3) referrals to NCBH. While two accepted services, one declined, as mother felt too overwhelmed with the younger child's needs. Two referrals were made to non-county local Behavioral Health specialists. Of the participants referred for mental health services, three had not been previously treated for their current symptoms. These individuals did not know the duration of their untreated mental illness.

It is important to note that through providing parents with IH-CBT, the positive effects of the therapy are felt by the whole family. Participants can be first-time parents or parents of multiple children; however, regardless of what their family orientation is, all participants find value in this program. Many of these participants are challenged with high Adverse Childhood Experiences Scores (ACES), with significant trauma history. By reaching out for their mental health, the work they do in this program helps them function better within their family. This program provides early intervention and prevention of negative downstream consequences for their children.

Challenges, Solutions, and Upcoming Changes

During this FY2021-22 reporting period, service capacity was affected due to not having a bilingual Spanish-speaking therapist, leaving a service gap in our Spanish-speaking community. The need for bilingual services is very high in both the Western side of the county and the Truckee region.

Another challenge was the change in MHSA structure when applying for funds. Beginning in the last funding cycle, Eastern and Western counties are now serviced separately. Therefore, each side of the county needed its own funding application, which was several binders of information. This separation between sides of the county made the funding request difficult to meet. Therefore, services are now restricted to the Western side of the county.

Lastly, the biggest challenge in the last year continues to be the COVID-19 pandemic. With additional, highly infectious variants, many reinfections and surges have occurred. The silver lining in this last year has been the invention of the vaccine, which has been a game changer regarding hospitalizations and deaths associated with COVID. However, with the continued pandemic response, home visiting programs across the state have been affected by low acceptance rates and retainment of both clients and staff. Virtual visits continue to be the norm for some home visiting programs, such as Healthy Babies. Though some clients appear to do well with virtual visits, others have stated that the virtual visits are not optimal. Additionally, clients appear to have had greater needs during this pandemic. Social isolation, economic issues, health concerns have all exacerbated depression in those families that we have seen. This increased anxiety and depression manifested in longer time in the program for some, requiring additional sessions.

A silver lining in the COVID storm was that, by doing virtual appointments which decreased the therapist's having to drive to appointments, she was able to serve more individuals.

During this funding period, MHSA and public health have been able to increase the therapist's hourly wage closer to the market (and Medi-Cal) rate. This has in turn increased the therapist's personal satisfaction, making her feel more valued.

Program Participant Story

As a home visitor of Heathy Babies, the program coordinator has witnessed many times the success of the Moving Beyond Program. Recently the coordinator enrolled a mother who reported she had difficulty sleeping, felt tired, even after sleeping, and felt a lingering lack of motivation. This mother agreed to try out Moving Beyond Depression, and in the end, it made a positive influence in her life.

Another mother had some past trauma and grief mixed in with her feelings of depression. She said she figured out she could not overcome her past trauma and grief because of this lingering lack of depression. However, after meeting with her MBD therapist, this mother said she felt

better about herself, was able to sleep, get up in the morning and think about alternative thoughts that helped her reframe her negative thought patterns. She said she felt she was able to *lift a tremendous weight* off from her shoulders, because of the tools she learned through MBD.

Lastly, a mother that has completed the MBD program and was referred to another program that is helping with her past trauma and grief. Recently she has told me, *"If it wasn't for the MBD program she would have never been able to move forward from her past trauma and grief and was so grateful her home visitor connected her with MBD. "*

The MBD program has a non-binary parent that just finished the program after struggling to find a therapist that fits their needs in the private sector. They really connected with the MBD Therapist and made huge leaps forward with their anxiety and postpartum depression. They are now connecting better with baby and going outside for walks and even has started to go camping with family and friends now instead of staying inside all the time.

PEI Category: Early Intervention Program

GATEWAY MOUNTAIN CENTER
Early Intervention for Youth in Crisis (Eastern County Only)

Program Description

Program Overview

There is a strong need in the Tahoe/Truckee region for crisis response and family support in cases of youth with early onset symptoms of mental illness or serious substance use disorder, specifically for those youth who do not qualify for County Behavioral Health services (i.e., who have private insurance). Due to limited provider availability in the region, families often wait weeks for support services after experiencing a crisis. Through this Gateway Mountain Center program, Whole Hearts, Minds & Bodies provides the following services:

- Engages youth and families in crisis through collaborations with the hospital and crisis system.
- Enrolls referred youth in Whole Hearts program, including family counseling and support through a social worker.
- Provides support over a 90-day period, while providing case management and discharge planning to the appropriate level of care (i.e., County behavioral health services or community mental health services).

Target Population

Whole Hearts serves high-need and under-resourced youth in crisis, ages 8 to 17, in the Tahoe/Truckee region.

Evaluation Activities and Outcomes

In FY 21/22 the following Performance Outcome Measures were tracked:

Goal 1: Serve 15 youth/families per year across Nevada and Placer Counties
Outcome 1: Unduplicated youth served YTD: 20

Goal 2: 100% of youth will be discharged with adequate supports in place and/or to appropriate levels of long-term care as applicable.
Outcome 2: For the reporting period, 9 participants were discharged from the program. Of those:

- 5 were referred internally to ongoing support programs
- 4 were assessed and did not require more intensive or ongoing services
- None of the discharged participants completed the YOQ-SR post report

Goal 3: 60% of youth show an increase in at least one of the following outcomes: stability in living situation; improvement in school attendance; reduction in substance use/abuse; increase in positive social connections; reduction in involvement with LE agencies.
Outcome 3: Of the 20 individuals served:

- None had involvement with a law enforcement agency.
- 78% of participants served have seen improvements in the following areas; Symptomatic Distress, Somatic Problems, Interpersonal Relationships, Social Problems, Behavioral Dysfunction.

Goal 4: Reduce number of 5150s for youth and TAY in the Tahoe/Truckee region. 75% of youth will not utilize crisis services during treatment.
Outcome 4: Of the program participants served during the reporting period:

- Required a 5150 hold: 0
- Incarcerated : 0

Overall Program Statistics:

- Referrals made: 0
- Youth participated in YOQ-SR: 10 (10 youth across all WHMB)
- Youth Utilized Crisis Services YTD: 2 (86% of youth did not utilize crisis services)
- Youth Participated in Connect Group Early Intervention Services YTD: 5

Challenges, Solutions, and Upcoming Changes

- Administration & Staff capacity/retention: was an ongoing challenge. Solution: An administrative support role was added to Whole Hearts, Minds & Bodies to assist with capacity building, and are continuing with a robust recruiting program to build staff.

- Solution & Upcoming Change: Gateway has implemented a case management software to assist with tracking. This software has needed work to develop and adjustments to work more efficiently for the program. Additionally, the program is working on revamping the assessment protocol and looking into the possibility of a different assessment program.

Program Participant Story

A family member just wants to say, "Thank you for **** and your program. My daughter loves **** and I can see that she's already making a difference in her life. We're so appreciative for the support".

Another participant stated, "**** has such a mellow way about him. He really respects (mentee) and working with them has helped improve communication with my family."

A participant stated, "My experience with **** has been very positive. My grandson always enjoys his time with **** and I have noticed positive changes in my grandson's behavior."

PEI Category: Access and Linkage to Treatment Program

SIERRA COMMUNITY HOUSE
Homeless Outreach
Truckee Homeless Outreach

Program Description

Program Overview

Sierra Community House's Homeless Outreach Program utilizes a Homeless Outreach Coordinator to provide outreach to individuals experiencing homelessness in the North Tahoe region. The Coordinator works to:

- Promote Safety: engage with individuals experiencing homelessness in order to reduce the risk of harm and enhance safety (e.g., provide sleeping bags on cold nights); and stabilize acute symptoms via crisis intervention.
- Form Relationships: engage with individuals in a manner that promotes trust, safety and autonomy, while developing relevant goals.

- Learn Common Language Construction: attempt to understand individuals by learning the meaning of his or her gestures, words, and actions; promote mutual understanding; and jointly define goals.
- Facilitate and Support Change: prepare individuals to achieve and maintain positive change; explore ambivalence, reinforce healthy behaviors, develop skills, and create needed supports; and utilize Change Model and Motivational Interviewing Principles.
- Form Cultural and Ecological Considerations: prepare and support individuals for a successful transition to new relationships, ideas, services, resources, treatment, etc.

The Tahoe/Truckee Homeless Outreach Coordinator works in conjunction with multiple agencies to assist individuals experiencing homelessness in the region. In addition to building trust and relationships with the homeless population, the Coordinator works to connect individuals with services to promote health, safety, and housing. The Coordinator spent 4 hours per week in the field performing outreach to the unhoused and two days a week at the resource center. When outreaching to the individuals in the field, they are working to meet basic needs, share resources, referrals and encourage folks to come into the resource center. This provider responded to calls from the community (police, hospitals, business owners, and community members) when there is an unhoused neighbor in need. While in the office at the center they are providing support to individuals in getting connected to resources, light counseling, and supporting individuals in meeting whatever goals are important to them.

Target Population

The target population of the Homeless Outreach Program is individuals in the Truckee and North Tahoe region experiencing homelessness or at risk of becoming homeless. The Coordinator receives both intra- and inter-agency referrals, conducts outreach in the community, and works at the Emergency Respite Day Center to identify community members in need of assistance.

Evaluation Activities and Outcomes

Goal 1: Contractor shall serve a minimum of 36 individuals or families per year in Eastern Nevada County and North Tahoe (Eastern Placer County).
Outcome 1: The Homeless Outreach Coordinator served 66 individuals during fiscal year 21/22 quarters of this year. Exceeding the goal by 188%

Goal 2: 90% of homeless will be referred to the Coordinated Entry Homeless Management Information System (HMIS).
Outcome 2: Of the 66 individuals served, 62 or 94% were referred to Coordinated Entry HMIS.

Goal 3: 90% of homeless and severely mentally ill individuals with no Social Security income (or other source of income) will be offered assistance with a referral to the Social Security office and/or an application for benefits so that the individual can receive Social Security income.
Outcome 3: The Homeless Outreach Coordinator screens every individual and offers support to all eligible individuals. Year to date 2 of 2 or 100% of clients eligible for SSI engaged and are being supported with applying for and obtaining benefits.

Goal 4: 90% of homeless and severely mentally ill individuals will be referred to mental health services.

Outcome 4: The Homeless Outreach Coordinator discusses mental health services with all individuals experiencing any level of mental illness. This is a subject that is addressed during ongoing case management and often takes a lot of relationship & trust building before our typical individual is interested in engagement. Year to date, of the 51 unhoused and severely mentally ill individuals screened, 100% were referred to mental health services. Seven were successfully connected to mental health services.

- 51 individuals were identified as needing MH referrals. Of the 51 referrals to mental health services that were made, 7 were connected (14%).
    - 24 were referred to Nevada County Behavioral Health. 8 of the individuals had not been previously treated for their symptoms and had experienced them for over 10 years. 5 of them were successfully connected. The referrals took an average of one month.
    - 27 referrals went to other mental health providers. 2 of the referrals were successfully connected and it took on average a month for the connection to take place.
- 22 referrals were made to physical health care providers. Of the 22 referrals, 11(55%) were successful which took on average a month to be connected.
- 2 referrals were made to the Crisis Stabilization Unit. Of the 2 referrals, 1 (50%) was connected on the same day.
- 26 other referrals were made to agencies like: Hospitality House (1), Sierra Community House (11), FREED (2), Connecting Point (10), and Sierra Senior Services (2) for a total of 26 referrals made. Of those 26 referrals, 26 (100%) were connected in an average of 1 week.

Challenges, Solutions, and Upcoming Changes

One of the challenges faced is the rising cost of housing and lack of affordable housing in the community. The community is offering solutions by building more affordable housing as well as offering incentives to community members housing locals. A parent organization has purchased and is remodeling a 12 unit building in Kings Beach which will be supportive housing opening this December.

Program Participant Story

A program participant injured his leg in a car crash in 1999, after trying for a few years to work on his injured leg, the pain was too great to continue. His leg was amputated in 2005. This individual faced many challenges including losing his bicycle and being discriminated against by the local police department. In 2012, he became homeless and arrived in the Truckee area. Although he was not a great fan of coming to the center, with the persistence of our outreach team, they were able to support him in completing a housing application and an application for a

Housing Choice Voucher (HCV) through Regional Housing Authority (RHA) for Placer County. After having applied and getting the news that a move-in was imminent. This individual chose to become sober from alcohol and quit smoking cigarettes. He moved into his unit, has remained sober, and began re-engaging with his passion for art. He continues to engage with his case manager to take steps forward on his health needs and obtaining SSDI. With housing, the support of the HCV, Bob sees himself staying in housing as his future.

PEI Category: Access and Linkage to Treatment

FREED
Senior, Disabled and Isolated Outreach Program
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 people with disabilities.

The Friendly Visitor Coordinator does a thorough intake either by phone or meets with the participant 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 participant-centered services as well as regular monthly training and volunteer support groups.

The program transitioned this past year from phone calls only, because of the Covid restrictions, to being able to visit in the participant's home. Many individuals still receive one call a week from volunteers as we build up our volunteer team.

The Program to Encourage Active, Rewarding Lives (PEARLS) was implemented in 2020 as a strategy to meet the need of older adults who were experiencing an increase in symptoms of depression. A FREED Person-centered Counselor collaborated with the Senior Outreach Nurse, and the Social Outreach Coordinator to provide services. Participants engage in 8 sessions of problem-solving activities and planning for increasing social events, physical activities, and enjoying pleasant events.

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 participant-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. Participants are referred by family members and friends, or by a variety of local agencies.

Evaluation Activities and Outcomes

A year-end survey was given to both participants and volunteers in June 2021. 88% of volunteers responded to an emailed survey. 37% of Participants responded to a phone survey. All participants were administered a PHQ-2 as a pre-assessment when they either entered the program this year or at their annual goal setting meeting. They were given a Post PHQ-2 again in June 2022.

Goal 1: 70 unduplicated individuals will receive weekly Friendly Visitor home visitations or phone calls by trained and screened volunteers annually.

> **Outcome 1**: 78 unduplicated individuals received visits or phone calls by trained and screened volunteers.

Goal 2: 10 unduplicated individuals will participate in the Program to Encourage Active, Rewarding Lives (PEARLS), a national evidence-based program for late-life depression.

> **Outcome 2**: 11 unduplicated individuals who qualified have completed the PEARLS Program. 10 people completed several sessions but dropped before completing all sessions because of a variety of reasons (moved, illness, family member died). 14 are currently engaged in the process. There was a total of 41 people who were referred and screened for the PEARLS process. There are currently 4 people waiting for services.

Goal 3: 75% of consumers will demonstrate improvement in depression symptoms as measured by the pre/post PHQ-2, once a year at their goal renewal meeting.

> **Outcome 3**: 82 % of participants demonstrated improvement in depression symptoms as measured by the PHQ-2.

Goal 4: 75% of PEARLS consumers will demonstrate improvement in depression symptoms as measured by the PHQ-2.

> **Outcome 4:** 89% of PEARLS Participants who completed 4+ sessions demonstrated significant improvement in their depression Symptoms as measured by the PHQ-2.

Goal 5: The consumer satisfaction survey will be given annually. At least 75% of consumers will report: ♣ Improvement in quality of life ♣ Enhanced mental health

> **Outcome 5**: 97 % reported that the quality of their life had improved since receiving calls or visits. 86% reported having more interest and pleasure in doing things and feeling less down, sad, or hopeless.

Goal 6: At least 75% of volunteers will express comfort in talking about depression, anxiety, and suicide with the people they visit or call, as measured by a survey given annually.

> **Outcome 6:** 88% of the volunteers expressed comfort in talking about depression, anxiety, and suicide with the people they visit or call, as measured by a survey given annually. 100% reported that they felt comfortable in talking to a FREED staff member about these issues.

The FREED Friendly Visitor Program conducted 12 outreach activities during FY 2021-2022 to over 900 potential participants.

Participant Information:

- 78 unduplicated Individuals received services.
- 2 are on a wait list for in-person visits.
- There were 1988 visits/calls during the reporting period.

Volunteer Information:

- 30 volunteers actively served in the Friendly Visitor Program YTD.
- 20+ relevant online or in person trainings and workshops were offered to all volunteers YTD.
- 29 volunteers participated in one or more training.
- Volunteers were offered training in:
  - Mandated Reporting
  - Dementia and Memory Loss Workshops
  - Communication with People who have Alzheimer's Disease
  - Suicide Prevention Training, Know the Signs
  - Mental Health First Aid
  - Community Resources
  - Active Listening Skills
  - Three Caregiver support Workshops
  - We also encouraged volunteers to engage in self-care and distributed the class brochures from Summer-Fall and Winter- Spring that is sponsored by Connecting Point.
- Volunteers gave participants additional information about: Fall Connecting Point Community Classes, the PEARLS Program, FREED's Referral List, PG&E funded support services during the power outages, assistance developing an evacuation plan, COVID-19 Vaccine Clinic options, Duke University Happiness Strategies, Care Team Medical Services, the new Mental Health Hotline, the Travel Bill of Rights for people with Disabilities, and the link to see the movie, *Angst*.

Referrals:

- Three referrals were made to Behavioral Health. Two connected and the average time for connection was seven days. Two individuals were not previously treated for their mental health symptoms and the average length of time they did not have treatment was six months.
- There were 945 referrals made throughout the year. 934 connected in an average of two days.
- Most referrals were made to FREED's services, including the PEARLS Program and Grief Group, Transportation, 211 Connecting Point, Physical Health Providers, and services for food.

Challenges, Solutions, and Upcoming Changes

The Friendly Visitor Program planned to serve at least two consumers from Eastern Nevada County during the reporting period, however was only able to serve one participant in the region. Moving forward the program is focused on increasing the number of participants in the eastern region through targeted outreach efforts in the area.

The program plans to increase the number of volunteers who will visit in a participant's home using Covid protocols during the next reporting period. To do this, FREED is increasing community outreach efforts as opportunities become available to table at community events.

Three additional PEARLS coaches have completed the PEARLS training and are joining the team from Spirit Center and FREED. They are meeting with PEARLS participants starting on July 1, 2022.

Program Participant Story

This year, a program participant, who had been receiving calls, became well throughout the year. Her anxiety and depression symptoms decreased significantly. This spring, she decided that she no longer needed to receive calls, she wanted to make them and support others, the way she had been supported! She was ready and able to give back to the community and be there as a peer supporter to pay it forward. She is now a volunteer for both the Phone Reassurance and the Friendly Visitor Programs.

PEI Category: Access and Linkage to Treatment

SIERRA NEVADA MEMORIAL HOSPITAL FOUNDATION
Senior, Disabled and Isolated Outreach Program
Social Outreach Program

Program Description

Program Overview

The Social Outreach Program provides a social worker (MSW), herein referred to as the Program Coordinator, to make home visits to older adults and adults with disabilities. The Program Coordinator assesses for depression, drug/alcohol abuse, and risk of falling while building rapport with the individuals. The Program Coordinator provides support by listening, advocating, making referrals and linking participants to various public and private services, and providing transportation for linkage when needed.

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, which allows additional opportunities to link participants to long-term supportive services.

An integral part of this program is coordinating outreach activities by networking with other individuals and organizations. The Social Outreach Program Coordinator partners closely with the Falls Prevention Coalition, FREED Friendly Visitor Program and Telephone Reassurance Program, Senior Outreach Nurses, Adult Protective Services, and multiple other county programs and resources.

Target Population

The Social Outreach Program targets older adults, ages 60 years and older, and adults with disabilities who live at home and wish to remain independent and live in Nevada County.

Evaluation Activities and Outcomes

The Social Outreach Program collected information on each person who received a home visit during the FY21/22 reporting period. This information includes demographic details, date of the contact, location, and number of services. The program also collected the number of referrals made to community agencies. A depression-screening tool and a drug/alcohol screening tool were completed at the beginning of services. A follow-up depression screening tool was used to determine changes to individuals score.

The Social Outreach Program delivered services to 68 unduplicated participants during FY 2021/22.

During FY 2021/22, the Program Coordinator made 217 referrals to other agencies/services. Of these, 6139 (64%) successfully connected with the agency or service with an average connection time of 13.3 days (See Chart). No referrals were made to County Mental Health Programs.

Referrals Made to Other Providers		# of Referrals Made	# of Referrals Connected	Average Interval - Referral Date to Connected Date
Other Non-County Mental Health Providers:				
Adult Mental Health Services		37	24	16
211/Connecting Point		15	12	10
Crisis Stabilization Unit		1	0	
FREED		27	20	14
Friendship Line		19	9	12
Gold Country Senior Services		4	4	6
Hospitality House/Homeless Shelter		1	0	
Senior Outreach RN		4	4	11
SPIRIT		6	2	16
Transportation - Lift, etc.		8	7	15
Other - List:	Advocates for Mentally Ill (AMI) Housing	3	2	19
Other - List:	Alzheimer's Outreach Program	7	6	13
Other - List:	Crisis Lines	3	0	
Other - List:	Del Oro Caregiver Resources	3	1	9
Other - List:	In Home Supportive Services (IHSS)	11	9	20
Other - List:	Lifeline Phone	4	2	12
Other - List:	Project Heart	5	5	25
Other - List:	Well-Connected	3	1	3
Other - List:	Various	56	31	12
		217	**139**	**13.3**

FY 2021-22 Goals and Outcome Measures:

Goal: 50% of the participants served who scored moderate-severe on the pre-screening tool will score lower on the post-screening tool.
Outcome: 80% of the participants served who completed a post-screening tool scored lower (8/10).

Goal: 50% of the participants served who haven't seen their primary provider in the past year will have made and kept an appointment.
Outcome: 0% of the new participants served made and kept an appointment with their primary provider (0/3). One participant moved out of the area, so follow-up was not possible. One participant was seeing specialists and did not feel they needed to make a primary care appointment during the case management period. One participant reported fearfulness due to the Covid pandemic as well as a belief that they did not go to their primary care unless they were actively ill which they were not.

Goal: 50% of the participants served will report an increase in social activity or increased positive mood at the time of follow-up.
Outcome: 97% of the participants served who completed at post-screening tool reported an increase in social activity or increased positive mood at follow-up (34/35).

Other Outcome Measurements:
1. Of the new individuals seen how many scored at a moderate-severe risk using the pre-screening tool? 34% of participants scored moderate-severe risk (19/56).
2. Of the new individuals seen how many hadn't seen their primary physician in the past year? 4% had not seen their primary physician in the past year (3/68).
3. Of the follow-up visits completed how many scored lower using the post screening tool? 89% of the participants served who completed a post-screening tool scored lower (31/35).

Challenges, Solutions, and Upcoming Changes

A primary and ongoing challenge for the Social Outreach Program this fiscal year was the COVID-19 pandemic. Participants have become more isolated which further impaired their mental health, quality of life, and access to services. While some community supports and services became available again, there many continued to be limited, unavailable, impacted, or inaccessible to participants, particularly those without technology skills or equipment. This continues to require additional case management to obtain available and accessible resources for participants to meet their needs. Phone related socialization services such as FREED Phone Reassurance, Front Porch Social Call and Well-Connected classes/groups were frequently utilized to assist with this need for technologically impaired participants. For those that were able to utilize technology there were additional on-line classes, meetings, groups and other associated supports. Additionally, as in FY 20/21, therapists were able to continue to provide telehealth services for mental health support. However, it was challenging this fiscal year to connect participants and therapists due to the ongoing impact of the pandemic and mental health challenges for the general population. This resulted in many therapists having full practices requiring additional case management time locating available therapists for mental health services/support for participants. The pandemic has required the Social Outreach Coordinator to be more creative and diligent in connecting participants to currently available and accessible long-term supports and services as well as engaging and encouraging development of additional natural supports where available.

Program Participant Story

The Social Outreach Coordinator connected with a new participant who was homebound and experiencing depression symptoms impairing their psycho-social functioning and life satisfaction. Additionally, the participant had experienced sudden and significant medical challenges and had to move due to limited mobility causing overwhelming grief. The participant did not experience clinical depression prior to the health changes and while a therapist had been utilized during the participant's life at times due to stressors they were not connected with a therapist. Over a period

of approximately two months the Social Outreach Coordinator provided assessments, built rapport, and connected the participant to long-term support and services in alignment with their identified needs and interests. This included a therapist who was able to provide home-based visits once a week for mental health support. At the end of the active support period, they reported reduced depression symptoms and increased social activities and engagement though the referrals provided. This resulted in a positive outcome and increased life satisfaction for the participant. Furthermore, the individual reported that the Social Outreach Program was vital to their improved quality of life.

PEI Category: Access and Linkage to Treatment

WHAT'S UP? WELLNESS CHECKUPS
Mental Health Screening in High Schools

Program Description

Program Overview

What's Up Wellness Checkups (WUWC) is a suicide prevention program serving Nevada and Placer County youth since 2012. Modeled after TeenScreen, an evidence-based screening program developed by Columbia University, WUWC offers universal, no-cost, confidential screenings to identify risk factors associated with suicide, depression, anxiety, eating disorders, PTSD, alcohol and substance abuse as well as other mental health conditions. Case management services are offered to families and students to assist in access and linkage to mental health treatment and other vital resources. WUWC prevention groups are provided on high school campuses teaching youth coping skills and ways to find resilience in their lives and community at large.

Target Population

What's Up Wellness Checkups currently offers mental health screenings to primarily 9th graders in nine high schools in Nevada and Placer counties: Nevada Union High School; Silver Springs High School; Ghidotti Early College High School; Bear River High School; North Point Academy High School; Bitney Prep High School; Truckee High School; North Tahoe High School; Forest Charter School Truckee.

Evaluation Activities and Outcomes

Goal 1: A minimum of 350 high school students will be screened in Nevada County FY 21/22
Outcome 1: 463 students were screened in Nevada County FY 21/22

- Western Nevada County: 360
- Eastern Nevada/Placer County: 103

Goal 2: 100% of students who screen positive will receive in-depth clinical interviews to assess need for further evaluation or treatment.
Outcome 2: 100% of 171 students who screened positive received clinical interviews

- Western Nevada County: 143
- Eastern Nevada/Placer County: 28
- 36.9% Total Positive Screening Rate

Goal 3: For those who receive clinical interviews, 100% of all students who need support will be offered case management services.
Outcome 3: 100% of 171 screened students were offered case management services.

- Western Nevada County: 143
- Eastern Nevada/Placer County: 28
- 36.9% of Total Screened Students offered WUWC Case Management Services

Goal 4: 100% of individuals who receive a referral and accept case management services will receive follow-up services until they see a provider at least once or until services are no longer requested.
Outcome 4: 100% of 141 students received a referral, accepted case management services, and received follow-up services until they saw a provider at least once or until services were no longer requested.

- Western Nevada County: 111
- Eastern Nevada County: 30
- 30.4% of Screened Students received WUWC Case Management Services
- 82.4% of Students Screening Positive received WUWC Case Management Services

Goal 5: Once the students and parents' consent is in place, 100% of individuals who have untreated mental health symptoms will be referred to a mental health service.
Outcome 5: 100% of 87 students with untreated mental health symptoms were referred to one or more mental health services.

- Western Nevada County: 72
- Eastern Nevada County: 15
- 18.7% Mental Health Treatment Referral Rate of Total Students Screened

Goal 6: A minimum of 10 prevention group meetings will be conducted at participating high schools.
Outcome 6: WUWC provided 14 total prevention group meetings. Mindfulness group series' were hosted in person at Nevada Union, Silver Springs, and Bitney Prep High Schools serving 18 students total in Western Nevada County.

Goal 7: As a result of the prevention group meetings, at least 70% of the participants will report a decrease in suffering related to mental illness and/or a 70% increase in protective factors.
Outcome 7: 71% - 86% of participants reported moderate to significant increase in protective factors from attending groups including 1) increased awareness of the manageability of stress 2) in-group stress reduction 3) increased awareness of helpful ways to manage stress outside of the group.

TOTAL # SERVED: 481 Students (screenings and group participation)

REFERRALS
Mental health treatment referrals: 87 students screened were identified as needing one or more mental health treatment referrals (130 total referrals). One student was referred to Children's Behavioral Health whose duration of untreated mental health symptoms was 1 year.

- Of the 130 mental health treatment referrals that were made, 67 of these referrals were successful (51.5%). The one student referred to Children's Behavioral Health was not connected to treatment.

Medical/Dental treatment referrals: There were 19 students referred to medical care or dentistry. 15 students were referred to medical doctors.

- Of the 19 students referred, 12 were successfully connected (66.6%).

Local agency/youth support referrals: There were 47 students who were referred to local agencies/youth supports.

- Out of the 47 students referred to local agency/youth supports, 18 students/families were connected (38.2%).

In-school support referrals: Students received 173 in-school support referrals this year.

- There were 115 successful in-school support connections out of 173 referrals (66.4%).

LGBTQ+ support referrals: Students received 68 referrals to LGBTQ+ supports both locally and virtually.

- 20 students were successfully connected out of 68 referrals to LGBTQ+ supports both locally and virtually (29.4%).

Treatment support meetings/consultations: There were 381 referrals/meeting/consultation efforts to help support student mental health treatment.

- There were 313 successful connections out of 381 referrals/meeting/consultation efforts to help support student mental health treatment (82.1%).

Virtual mental health support referrals: There were 738 virtual mental health support referrals offered to students - 44 individual referrals and 694 general referrals sent via post-screening emails.

- Out of the 44 individual referrals, 40 were connected (90.9%).

OUTREACH
Total # 'Yes' Parent Consent Forms: 616
Western Nevada County: 491 (out of 649 total 9th grade students at NJUHSD and 22 9th graders at Bitney Prep Charter)

- 73% Yes Consent Return Rate

Eastern Nevada/Placer County: 125 (out of 340 total 9th grade students at TTUSD and 45 total Forest Charter Truckee students)

- 32% Yes Consent Return Rate

Instagram Analytics: 155 new posts/stories, 1704 reached on posts, 317 post likes, 131 new followers, 80 post shares
Facebook Analytics: 19 new page likes, 70 posts, 201 total reached on posts, 342 post likes
What's Up Wellness Website: 1407 unique visits, 2639 page views, 13 new members WUWC mailing list

Western Nevada County: 19 total outreach activities including WUWC program presentations, parent outreach, school and other collaborations to increase program and mental health awareness.

Eastern Nevada County: 7 total outreach activities including WUWC program presentations, parent outreach, school and other collaborations to increase program and mental health awareness.

Challenges, Solutions, and Upcoming Changes

The main WUWC challenge in FY 21/22 was the significant rise in the mental health needs of youth impacted by the pandemic and the obstacles WUWC faced in order to meet those needs. Various stressors on youth including transitioning back to in person school during the pandemic appears to have had significant psychological repercussions. This along with the simultaneous burdens faced by families, school systems and staff seem to have contributed to the challenges youth faced this year. In 21/22 the screening program revealed increased numbers of high-risk cases, near-crisis cases, more complex mental health needs, more school absences, and high levels of academic stress. These results were concurrent with once more-accessible resources also being at capacity - local youth mental health treatment providers, school mental health providers, school staff and other on campus resources facing higher-than-ever levels of demand.

In response to these obstacles, new WUWC systems were developed. Follow-up meetings with students became protocol when treatment was delayed or inaccessible, particularly for students reporting higher levels of need. Not only did these ongoing meetings provide temporary mental health support giving clinicians an opportunity to check in on safety plans/risk, but served as a protective factor for youth knowing that there was an adult supporting them until treatment or another resource could be accessed. Clinicians worked hard with case managers on identifying alternative supports and virtual resources that could fill some need for connection, as well as on-campus strategies to help reduce psychological stress. Weekly clinical consultation meetings increased to 2-3 times/week providing time to process multi-layered clinical/academic needs and identify appropriate follow-up responses and referrals. New forms and team spreadsheets were developed to help with referral tracking as cases were compounding, making sure no students fell through the cracks. Intensified collaboration with school staff became the norm, initiating more meetings and making multiple efforts in ensuring connections to school counselors and other supportive staff. Additional funding mid-year was a boon to these solutions, allowing WUWC to

contract with two new clinicians and an additional case manager to manage the increased demand for services and the time needed to meet that demand.

In 22/23 upcoming changes include 1) new WUWC Clinical Coordinator to provide focused team clinical oversight for higher risk/higher need screening outcomes 2) What's Up Wellness website redesign/overhaul with the intention of providing increased resource access, youth engagement, and stigma reduction with parents and community at large 3) What's Up Wellness housing of new LGBTQ+ project in the schools to create safe access points for LGBTQ+ youth in attempts to reduce suicide risk and increase supports. The project will partner with WUWC's screening program to support school engagement and increase student referrals.

Program Participant Story

A WUWC screening clinician met with a youth who was a recent victim of cyberbullying - a social media "hate page" was created about this youth as retaliation for ending a romantic relationship. In their interview, this youth revealed that they were in grief from the loss of the relationship, suffered with severe, untreated mental health symptoms including panic, and struggled with isolation living in a remote area of the County with unreliable internet access. This youth explained that they lived with their grandparent, their guardian who often doesn't drive due to financial barriers and age-related challenges. The student requested therapy services to help manage their symptoms but was concerned about impacting their grandparent, revealing that their prior therapy services had been terminated by them in the past.

This referral was given to our WUWC case manager who connected this youth immediately to on-campus mental health services (STARS) to help create a safe, interim connection at school for support with bullying issues and some immediate coping skills. The case manager then began working on ongoing mental health services and reached out to the grandparent to help identify access barriers and connect the youth to treatment. The case manager found the grandparent was accessible via phone only after the calls were screened but seemed open to starting new therapy services if WUWC could support them through the process. Our case manager then reached out to numerous therapists to determine availability and was able to find limited but some openings of therapists accepting their insurance. The case manager then was able to connect these therapists directly to the grandparent, but when following up the case manager found that there was still no linkage despite these direct connections. Our case manager then took the initiative with this access issue and connected with one therapist who agreed to reach out directly to the student themselves. The case manager contacted the grandparent, asking permission to set the student up directly with the therapist - the grandparent then put the teen on the phone to talk. The student was shy but open to connecting with the provider. The case manager then texted with the therapist to let her know that the student was available to talk to set up a first appointment. The linkage was then made for accessible, mental health treatment.

Despite multiple barriers in connecting this youth to treatment, the commitment of WUWC case management services was crucial in facilitating a successful treatment connection. The increased funding this year for more comprehensive WUWC case management services allowed staff to

spend more time with youth and families such as this one, who required more intensive support to get the mental health care they need.

PEI Project Name: Access and Linkage to Treatment Program

BRIGHT FUTURES for YOUTH
Homeless Outreach

Program Description

Program Overview

SAFE stands for Stability-Access-Foundation-Empowerment. Bright Futures for Youth help youth find safe and consistent housing, such as an apartment, a room to rent or a cottage behind a house, a host family, or a temporary housing situation. The program also support them in stabilizing their current situations, sometimes turning a temporary situation into a more long-term solution, which is especially important in a community that is lacking in affordable housing development in general. Still, services go beyond housing assistance, helping youth to move towards housing stabilization through comprehensive service provision.

The program provides comprehensive case management supports, encouraging family stabilization and reunification where possible, and helping youth to identify natural supports. They also provide youth with funds and support to access certified copies of birth certificates, driver's licenses and/ or identification cards. Additionally, they help with life skills and basic needs such as credit checks and credit repair, resume creation and budgeting, job search, and career counseling. Youth are supported in building healthy relationship skills and provided resources for substance use prevention and harm reduction. Further, youth are encouraged and supported through continuing education/ college enrollment, financial aid and grant applications, transportation help, Cal Fresh and Medi-Cal application supports, car repairs, hygiene supplies, and gas and food gift cards– all to enhance youth's stability and self-sufficiency, creating pathways out of poverty and an end to homelessness. The program provides mental health and health care referrals and collaborates with other agencies/ organizations to meet the needs of these youth. In this way, the program ensures they are following best practices and due diligence. Overall, the program has exceeded their initial goals and are actively working to expand the program to include even more supportive services.

Bright Futures for Youth now has 5 SAFE program staff, including the program director, program manager, lead case manager/ intake coordinator (via MHSA PEI), housing case manager, and a youth support partner, helping them to expand their reach and provide more services for more youth in need.

Target Population

The SAFE program serves youth ages 12-26 years old, including unaccompanied minors, young adults, and young families. They have helped more than 100 youth since the program launched in

early 2019 and are currently serving 60 youth, ranging in age from 15-24, including pregnant and parenting youth.

Evaluation Activities and Outcomes

Contract Goals & Outcomes:

Goal 1: Program will serve 30 youth and families.
Outcome 1: Year to date 60 youth including 3 young families, for a 100% increase over the annual goal.

Goal 2: Using the Youth Thrive survey as a baseline and post intervention tool, 80% of the SAFE Program Participants will report an increase in:

- Youth Resilience
- Social Connections
- Knowledge of Adolescent Development
- Concrete support in times of need
- Cognitive and social-emotional competence

Outcome 2: As a pilot use of the survey, 7 youth took the Youth Thrive Survey for baseline analysis, increasing from 6 participants surveyed in Q3 as indicated. The program then initiated implementation of the assessment the third quarter. Going forward, a cross sectional analysis of an annual point-in-time surveying of youth will be utilized. The program will be looking at the length of time young people have been in the program and comparing scores of those who have been in the program for 3 months, 6 months, 1 year, and longer than a year. In this way, they will be able to gauge the program's impact on protective and promotive factors.

Goal 3: Improve housing stability for 40% of program participants.
Outcome 3: 86.7% (52 of the 60) youth have improved housing stability.

Examples of ways clients are increasing housing stability/access: Clients are signed up or assisted in renewing CalFresh, Medi-Cal, CalWORKs. They are also referred and connected to: Community Beyond Violence, Connecting Point, HRT team, Regional Housing Authority, Hospitality House, FREED, AMHI, Spirit Center, physical health care providers, and mental/ behavioral health services including therapy. Several youths have secured permanent housing or are staying with host families. Clients receive comprehensive case management, help with goal setting, budgeting, and resume building. Participants are provided with supplemental food, food gift cards, cell phone minutes and data, clothing, diapers, hygiene products to help them meet their basic needs and have more income to put towards housing. We also support with transportation to and from appointments and provide gas cards and bus fare to support independence. Clients are also provided with deposits and rental support payments as needed to secure long term housing options.

Goal 4: Provide referrals for youth and young adults.

Outcomes 4:

- Thirteen individuals identified as needing MH referrals. One was referred to the County CBH Program and had a seven-month gap in mental health service provision/ untreated mental illness prior to connection. Three were referred to children's mental health providers locally, five were referred to adult mental health practitioners, and four were referred to other mental health agencies who serve both children and adults.
- Of the 13 referrals to mental health services that were made, thirteen were connected (100%). Of the connected referrals, three were connected/ contacted in less than 24 hours.
- One hundred and eighteen other referrals were made to agencies like: Nevada County Social Services like Medi-Cal, CalFresh, etc. (60), Physical Health Care Providers (10), Hospitality House (1), FREED (5), 211/ Connecting Point (11), SPIRIT (1), AMIH (8), Regional Housing Authority (12), Community Beyond Violence (8), and Home Team (2), for a total of 130 referrals made. Of those 130 referrals all were connected in an average of 9 days.

Challenges, Solutions, and Upcoming Changes

One challenge the program continues to experience is lack of available affordable permanent housing options, especially opportunities tailored to youth 18-26. Income contingent/ affordable/ attainable housing options are impacted with long waiting lists in Nevada County. For youth with minimal if any credit and/or work experience, this becomes an additional barrier to securing housing. Another challenge was case management capacity. It was critical to have more case managers to assist youth with housing search, credit building, obtaining legal documents, and building self-sufficiency and life skills to sustain permanent housing. The program was able to add to our program staff in the past year, including a lead case manager/ intake coordinator funded through PEI. This dramatically increased the program's capacity to serve youth.

Bright Futures for Youth will be opening the first drop-in service center for youth in late fall 2022. This will further expand the capacity to provide immediate basic needs support services for minors and young adults. Initially, the drop-in center was to be located at the NJUHSD McCourtney Road school site. Due to unforeseen infrastructural challenges, the executive director and board quickly had to pivot to locate another opportunity. Fortunately, space became available in the Litton Building where the program is currently located. The second floor is now being built out for the drop-in service center. The first floor will be the NEO Youth Center. All three of the Bright Futures for Youth prevention and early intervention programs, SAFE, NEO, and The Friendship Club, will be located on the same campus, near area schools and Sierra College. This will enable SAFE to increasingly identify needs and provide prevention and early intervention services to more youth in Western Nevada County. The program staff are excited to continue to grow and evolve, ensuring they can provide youth with capacity, hope, and opportunity to thrive.

Program Participant Story

One client, we will call her Jamie, has grown immensely this past year. She has been in her program since she was a young pregnant minor, not even 17. Through her tenacity and drive to succeed, she managed to graduate from high school while pregnant and homeless, find her way out of postpartum depression, and escape an abusive relationship with the help of Bright Futures for Youth and Community Beyond Violence.

Jamie is a loving and attentive mother to her one-and-a-half-year-old daughter. They are now securely housed in an apartment. She is enrolling in Sierra College for the Fall as her daughter enters day care. She is also considering becoming a Youth Support Partner at the Bright Futures for Youth drop-in center, advocating for other young people at risk of and experiencing homelessness. She is also a member of our Youth Action Board. She is actively using her lived experience to help others and is interested in the social and behavioral sciences field. We are incredibly proud of this young woman and are excited to see her potential continue to blossom.

PEI Category: Outreach for Increasing Recognition of Early Signs of Mental Illness

WHAT'S UP? WELLNESS CHECKUPS
Mental Health First Aid

Program Description

Program Overview
Mental Health First Aid (MHFA) is an 8-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind Mental Health First Aid demonstrates that it helps people to feel more comfortable managing a crisis situation and builds mental health literacy — helping the public identify, understand and respond to signs of mental illness.

Target Population
What's Up Wellness provides in-person and virtual trainings to high school students and adult community members in Nevada County. Three types of MHFA trainings are offered 1) Mental Health First Aid teaching adults how to provide mental health first aid to other adults 2) Youth Mental Health First teaching adults how to provide mental health first aid to youth 3) Teen Mental Health First Aid teaching teens on how to provide mental health first aid to other teens.

Evaluation Activities and Outcomes

Evaluation activities include collecting brief demographics for each person attending each training. In addition, participants complete a survey to provide information on their perception of the training.

Outcomes:
In FY 21/22 a total of 80 unduplicated individuals were served.

The following series were offered in FY 21-22; one virtual Mental Health First Aid, one virtual Youth Mental Health First Aid, and 4 in-person on-campus Teen Mental Health First Aid.

Goal 1: 90% of training participants will demonstrate a positive change in attitude and/or knowledge about mental illness.
Outcome 1: Combined responses for trainings show an average of 93.5% of participants reporting a positive change in attitude and/or knowledge about mental illness (see below)

Mental Health First Aid - Online training
1) 12 out of 14 participants responded.

2) Changes in attitude and knowledge data were provided by 100% of the 12 responding participants.
3) 100% of 12 participants agreed that as a result of the training, they felt more confident that they can assist a person who may be dealing with a mental health problem, substance use challenge or crisis to connect with appropriate community, peer and personal supports.
4) 100% of 12 participants responded that the course was helpful and informative. and/or better prepared them for work they do professionally.
5) 0% of all participants responded that they did not benefit from this course.

Teen Mental Health First Aid - Ghidotti

1) 34 out of 35 participants responded.
2) Changes in attitude and knowledge data were provided by 100% of the 34 responding participants.
3) 97% of 34 participants agreed that as a result of the training, they felt more confident in supporting a friend with a mental health challenge.
4) 97% of 34 participants agreed that as a result of the training, they felt more confident in supporting a friend in a mental health crisis.
5) 97% of 34 participants agreed that as a result of the training, they felt more familiar with resources and support available to help a friend with a mental health challenge or mental health crisis.
6) 94% of 34 participants agreed that as a result of the training, they felt more familiar with mental health signs and symptoms in themselves or in their friends.
7) 94% of 34 participants agreed that as a result of the training, they were more aware of self-care and using coping skills when feeling stress.

Teen Mental Health First Aid - Silver Springs

1) 8 out of 16 participants responded.
2) Changes in attitude and knowledge were provided by 100% of the 8 participants.
3) 87.5% of 8 participants agreed that as a result of the training, they felt more confident in supporting a friend with a mental health challenge.
4) 87.5% of 8 participants agreed that as a result of the training, they felt more confident in supporting a friend in a mental health crisis.
5) 87.5% of 8 participants agreed that as a result of the training, they felt more familiar with resources and support available to help a friend with a mental health challenge or mental health crisis.
6) 87.5% of 8 participants agreed that as a result of the training, they felt more familiar with mental health signs and symptoms in themselves or in their friends.
7) 87.5% of 8 participants agreed that as a result of the training, they were more aware of self-care and using coping skills when feeling stress.

Youth Mental Health First Aid - Online training

1) 13 out of 15 participants responded.
2) Changes in attitude and knowledge were provided by 100% of the 13 responding participants.
3) 100% of 13 participants agreed that the training was helpful and informative.

4) 100% of 13 participants agreed that after taking this course, they are more likely to have a supportive conversation with a youth experiencing signs and symptoms of a mental health or substance use challenge or crisis.
5) 100% of 13 participants agreed that after taking this course, they are more likely to use the Algee action plan to connect a youth to appropriate help or resources if experiencing a mental health or substance use challenge or crisis.

Mental Health First Aid Training Participants/Potential Responders:
Mental Health First Aid 9/29/21 - 14 Participants
Teen Mental Health First Aid 1/26/22 - 3/9/22 - 17 Participants
Teen Mental Health First Aid 1/27/22 - 3/10/22 - 18 Participants
Teen Mental Health First Aid 4/27/22 - 5/18/22 - 7 participants
Teen Mental Health First Aid 4/27/22 - 5/18/22 - 9 participants
Youth Mental Health First Aid 6/13/22 - 15 participants

Training Settings:
Virtual - Zoom
Ghidotti Early College High School Classrooms
Silver Springs High School Tech Center

Types of Training Participants/Potential Responders:
High School Students
School Teachers/Staff
Staff from Community Agencies: Family Resources, Crisis Response, Disability Supports, Housing Support, Suicide Prevention, Homeless Outreach, WIC
Mental Health Professionals
Peer Supporters
Public Health
Harm Reduction Coalition Member
Community Members/Parents

Mental Health Referrals:
- There were no participants referred to county mental health programs.
- 4 training participants identified as needing mental health resources. 1 was referred to Community Beyond Violence, 1 was referred to Psychiatry, and 2 were referred to School Counselors.
- Of the 4 referrals to mental health supports that were made, 3 were known to be connected (75%). Of the connected referrals, 100% were identified as connecting with services on the same or next day.
- No other referrals were made.

Challenges, Solutions, and Upcoming Changes

The main training challenges in FY 21/22 were the issues that arose during virtual trainings. There were multiple tech issues that arose in the virtual trainings as well as reduced

engagement/participation on Zoom. WUWC created more engaging activities for participants as well as brought on a tech assistant in the virtual training to help with any tech barriers that arose. What's Up Wellness plans to provide more in-person training in FY 22/23 if possible. Another challenge was the participants' struggles with navigating the often confusing National Council training portal. A redesign of the What's Up Wellness website is in the works to help support MHFA attendees in their use of the training portal, as well as to help them find relevant resources and other training materials to help support their MFHA response in general. Changes in FY 22/23 include providing an additional day-long training in Adult Mental Health First Aid this next year and a new MHFA website page to help support participants.

Program Participant Story

Post-training survey feedback from students of TMHFA included "I feel well informed about how to take care of myself and others in difficult situations and crisis." Students also felt "confident," "accomplished", and "grateful" after taking the training. Feedback from Youth and Adult Mental Health First Aid trainings included that the training was a "great presentation" that was "perfectly paced," and participants felt "truly inspired," "better prepared" and were given "more confidence." One participant remarked that they felt "informed with actual resources to back me up."

PEI Category: Prevention

BIG BROTHERS, BIG SISTERS
Youth Mentoring

Program Description

Program Overview

Big Brothers, Big Sisters serves youth facing adversity by providing them with a mentor. Each of the children identified for services through Big Brothers, Big Sisters (BBBS) are subjected to mental health issues in their environments. Relationships with mentors help children with social emotional learning, positive outcomes, and a greater sense of support.

One-to-one meetings take place at a variety of locations. Most matches are meeting in the more traditional program called the Community-Based Program, where they meet with their Big Brother or Big Sister in the community and do activities with them in no one particular setting. We have also re-introduced our Site-Based, PAL program in the Spring which will continue to grow as we approach the new school year.

The BBBS Program Manager, intakes all the children and families into the program by conducting an intake interview and assessment. Additionally, all potential volunteers are screened and assessed by the Program Manager before they are matched into the program. The Program Manager conducts match supports meetings on a bi-monthly basis with the children, parents and volunteers to ensure youth goals, relationship development and child safety are being met.

Target Population

Big Brothers, Big Sisters mentoring programs serve children ages 6-18. Our mentoring population consists of high school students (PAL's) and adult volunteers of varying ages.

Evaluation Activities and Outcomes

Goal 1: A minimum of 25 matches will be made (15 Western Nevada County, 10 Eastern Nevada/Placer County).
Outcome 1: Fourteen matches have been supported in the 21-22 Fiscal Year, with six in Western Nevada County, and eight in Eastern Nevada/Placer County. We have thirteen volunteer Bigs that are at various stages in the enrollment process, with three in Eastern Nevada/ Placer County and ten in Western Nevada County. Our current waiting list specific to the target service area contains twelve youth who are ready to be matched, with seven in Western Nevada and five in Eastern Nevada/Placer, respectively. Should the volunteers complete the intake process and be compatible with the youth who are waitlisted, BBBS is tracking toward meeting this match goal.

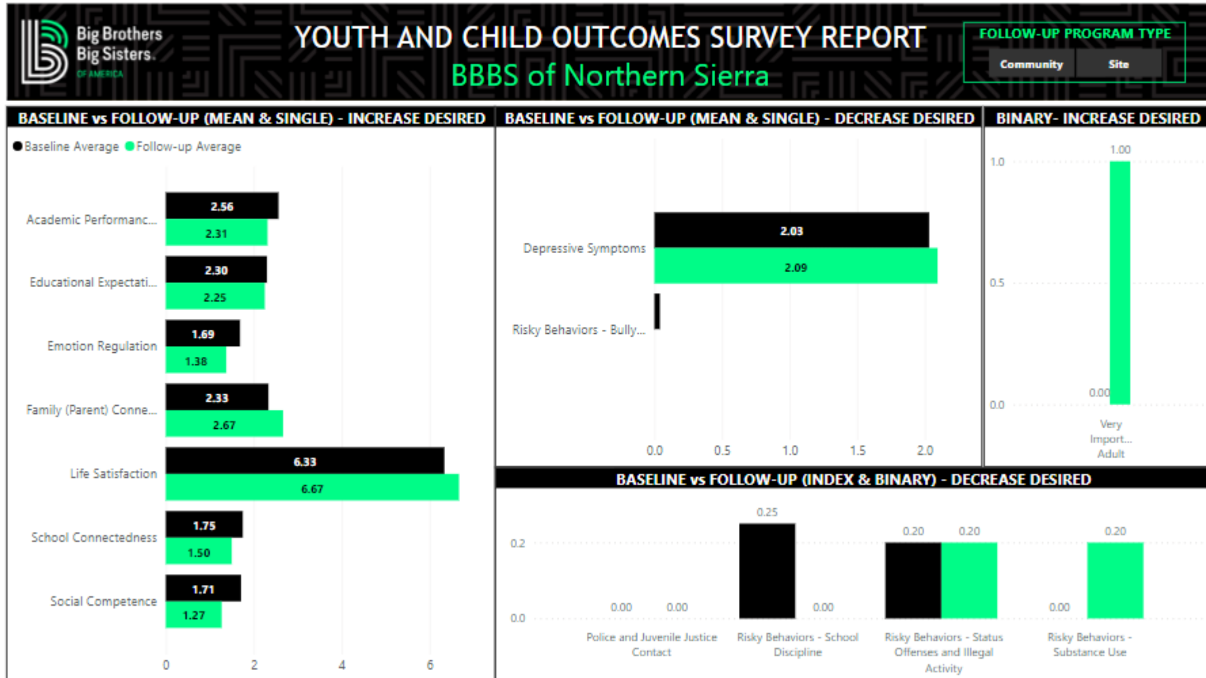
Goal 2: 90% of matches will be sustained throughout the school year.

Outcome 2: 87% of matches have been sustained for over one year or more. There were seven total match closures, two of which, were premature (<1 year). One of the premature match closures was prompted by the family moving out of our service area 6-months after the match was made. The second match closure was closed less than one month in after the Little had a change of heart in their desire to participate; the match did not get together after the initial match meeting.

Goal 3: 95% of matches that were successful for one year or more will show positive change on the Strength of Relationship survey.
Outcome 3: Of the twelve matches that reached or exceeded their one-year anniversary, 14 participants individually reported a successful and positive match with their Big or Little on the Strength of Relationship survey. Of the surveys collected (aggregate of 3-month and Annual), there was an average rating of 3.8 out of 5, indicating that most matches report feeling close to their respective Big/Little. The median response for Bigs polling the degree to which they feel close to their Little was 3.5/5, based on the completion of 7 Annual SOR's and 3 three-month SOR's. Of the four Annual SOR's collected from Little's, the median response polling the degree to which they feel close to their Big was 4.5/5—indicating positive change. Based on the available data (reflective of 8 matches, with surveys collected from one or both participants), BBBS is tracking toward our goal of 95% of matches showing positive change.

As new matches are made, three-month and annual SOR's will continue to be administered to determine if both Bigs and Littles are developing positive relationships. It should be noted that BBBS makes every effort to capture these surveys as they come due, but staff are often challenged by a lack of response/engagement from our matches when it comes to implementation—resulting in less data to reference when demonstrating this goal metric.

Goal 4: 95% of matches that were successful for one year or more will show a positive change on academic performance, behavior and other key indicators of success using the Youth Outcomes Survey.
Outcome 4: 42% of youth (5 of 12) completed a follow-up Youth Outcomes Survey one year from when the baseline YOS was administered. Averages from this subset indicated significant, positive change in the following domains: Family (Parent) Connectedness, Life Satisfaction, Risky Behaviors (Status Offenses & Illegal Activity), and the Presence of a Very Important Adult [Please use the chart below for reference]:



Assessment of survey data, along with routine case management, allows BBBS to identify areas where additional support is needed. Professional staff develop tailored goals and individualized plans to promote growth and development in targeted domains by virtue of coaching participants during case management.

Goal 5: 80% of Case Management will be completed on or before due date
Outcome 5: On-time case management is currently at 82% for on-time completion.

Goal 6: Number served in Eastern County versus Western County
Outcome 6: Of the 14 total matches served, 6 were in Western County and 8 in Eastern Nevada/Placer County. BBBS notes the differences of locations in an effort to grow both service areas.

There is no referral data for FY 21/22. As of right now, with the 14 matches BBBS has made, there have not been referrals made to outside agencies for additional services. During the monthly match support contacts with the parents/guardians and volunteers, referrals may be discussed as options, but no formal referrals have been made.

Challenges, Solutions, and Upcoming Changes

Provided our programs have significantly downsized post-merger, we are still in the process of growing the number of matches in Nevada and Eastern Placer Counties—and by extension, adding to our BBBS team. BBBS of Northern Sierra continues to focus our efforts on expanding our presence in both counties of service through strategic partnerships with schools, youth-serving and volunteer-based organizations, as well as social/public service agencies. There are also targeted

marketing campaigns in the works, and we have taken advantage of several opportunities to engage with the community by tabling local events. What is more, we are moving our office to Nevada City where we will have greater exposure and accessibility to the public on Main Street. As we work to cultivate new/existing relationships and grow our programs, we hope to see an increase in the number of matches reflected in both counties. We are encouraged by our developing partnership with the Boys & Girls Club, who holds great promise in referring prospective Littles—resulting in a higher match yield. There has also been an internal restructuring of roles/responsibilities to place a greater emphasis on community outreach and enrollment to meet our target goal of 25 matches.

Program Participant Story

A Big Brother has been matched with a 15-year-old Little over two years. The Big Brother truly goes the distance in supporting his match, and is prepared to take on any adventure, engagement, or opportunity that may be of interest to his Little. They both enjoy spending time together in the great outdoors, which translates into a lot of their match activities. You will often find the two hiking, flying airplanes, or grabbing a bite to eat. Big Brother encourages Little to do well in school and is a steadfast outlet for whatever challenge he may be weathering in his home life. Big Brother was proud to report that Little ended the school year with very high marks (all A's and B's), a significant improvement compared to last year, and was sure to attribute his strong finish to the significant effort Little put forth. He has also taken the initiative to get involved in more school events by helping the football team and participating in track and field. The Big Brother has also established a supportive partnership with Little's mom, and with his feedback and advocacy, Little is now receiving the mental health services he needs to thrive.

PEI Category: Prevention

BOYS & GIRLS CLUB OF NORTH LAKE TAHOE
Youth Mentoring
Youth Prevention

Program Description

Program Overview

The Boys & Girls Club of North Lake Tahoe provides year-round, out-of-school time youth development programs for children ages 4-18 from across the North Tahoe-Truckee region. Among the prevention programs, BGCNLT offers an evidence-based program entitled "Positive Action" that teaches social and emotional well-being with an approachable curriculum that encourages participants to understand their self-concept and then make positive choices to continually improve that over time.

The Positive Action Program at the Kings Beach Clubhouse and Truckee Elementary School is for students in grades 2-4.

Target Population

BGCNLT programming is offered to all children from the North Tahoe and Truckee region ages 4 through18. Programs are offered for all young people, but are targeted to those who needs them most, whether for social and emotional support, academic support, or otherwise. Positive Action, a targeted program, is offered to all 2nd through 4th graders in the Boys and Girls Club program.

Evaluation Activities and Outcomes

Attendance data is taken for each Positive Action session. The intent is for children to participate in every session offered so that they can get the full benefit of the curriculum. Participants also fill out a pre and post program survey that helps to gauge whether they gained knowledge, skills, competencies around a positive self-concept.

28 children completed the Positive Action program in Kings Beach (Placer) and 42 completed the program in Truckee (NV County). 61 social factors surveys were completed in the fall, 70 in the winter and then 70 again in the Spring. Notable data points on the surveys include:

- 12 participants who were classified as "always" participating in the program reported only "sometimes" or had no response to whether they were "making effective decision-making skills". In the Spring, only 5 total participants were classified in the "sometimes" category and the remainder were in "often" or "always". This demonstrated to us that participants did acquire knowledge and confidence in making positive decision for themselves.
- 11 participants started in the fall only saying that they "sometimes" had a network of friends or a peer group. In the Spring, only 5 "sometime" reported having a network with all remaining saying that they often or always did. We felt that the existence of the group itself contributed to this change and offered participants a new network of peers.
- No responses on the survey were marked as "never", which we felt was positive as it reflected that some base knowledge was there from the beginning and that knowledge wasn't lost over time.
- 100% of participants showed static scores or positive change on key indicators of success such as academic performance, behavior, social/emotional & character, physical health and mental health utilizing the School Age Social Factors Survey.

Challenges, Solutions, and Upcoming Changes

Consistent staffing was a challenge for the organization but was solved by keeping good notes to be shared, and training multiple staff members to both run and evaluate the Positive Action

program. Moving forward, the goal is to have multiple staff members trained on how to implement and report on Positive Action.

Some of the lessons were more engaging and well received than others. Now that program staff have become more familiar with the Positive Action program, they plan to seamlessly introduce the ideas and philosophies of Positive Action into everyday programming and not just in isolated program time.

Program Participant Story

While the curriculum itself provides support and lessons for kids, the staff members, and participants themselves are also a crucial part of the group, providing companionship, friendship, and mentoring to kids. A small cohort of girls who previous to this year were shy and hesitant to participate in programming, seemed to build confidence, form bonds, and grow as Club members and leaders. One of our participants, who often would cry for her family, used to cling to one friend in our program. If that one friend was not present, she would break down and refuse to participate in any other program, almost paralyzed with fear to be alone. After being a part of Positive Action, she gained friends, skills, confidence, and tools that she could use both in Club and in school. She now can attend Club confidently knowing she has other friends, that she has adult mentors, and staff members who are there for her, resulting in her starting to enjoy her time more and more in Club.

PEI Category: Prevention

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
Youth Wellness Center (Eastern County Only)
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, Sierra Community House, 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, Truckee High, Alder Creek Middle School, and North Tahoe Middle School, as well as supportive Wellness

Programming at the Sierra High Continuation High School. The Wellness Centers provide a comfortable setting for students to drop-in during their breaks to ask questions, access support, and get connected to school and community mental health resources.

Target Population

The TTUSD Wellness Program primarily serves middle school and high school students, ages 11-18 years. Most students seek out Wellness Center programming on their own, but the program also receives referrals from the counselors, school psychologists, school administrators, and teachers.

Evaluation Activities and Outcomes

TTUSD collects evaluation activities for MHSA including collecting demographic information on each individual receiving services

GOAL 1-YOUTH: At least 100 youth will be trained in peer mentor and leadership skills to better support themselves, their peers and incoming 9th graders' transition to high school.
Outcome 1: 163 youth leaders were trained as Peer Mentors in Link Crew, WEB (Where Everyone Belongs) and Hope Squad.

- 95% of Link Leaders reported that Link Crew provided them with the support to be a Peer Mentor.
- 95% reported feeling comfortable with their ability to actively listen to others.
- 80% reported that they have the skills to support other people when they need help.

GOAL 2 – SUPPORT: At least 200 youth will receive individual support from Wellness Center Staff to improve their social, emotional, and mental health and opportunities to access community wellness resources.
Outcome 2: This school year, TTUSD Wellness supported approximately 415 students through individual sessions and 434 students through participation in 220 group sessions at the four TTUSD Wellness Center sites. TTUSD Wellness served 12,853 (duplicated) student walk-in visits to the NTHS, THS, North Tahoe School, and Alder Creek Middle School Wellness Centers. On average, 73 students used the Wellness Centers each day.

TTUSD Wellness made 53 referrals to outside mental health and community services. Of these, 9 referrals were made to County Mental Health and 100% of the students were connected to county services. All 9 students had not been treated for mental health symptoms in the past. The average duration of untreated mental illness was 1 yr. 44 referrals were made to community partners: 37 to private therapists and 7 to community-based organizations. Of these 44 community referrals, 87% were connected to services.

Out of 136 students who participated in the year end Wellness Center Survey, 96.3% reported that the Wellness Center improved their sense of safety and well-being, 90.4% report having more

support in their life, and 97.8% reported that the Wellness Center staff provided them with appropriate outside resources.

GOAL 3 – EDUCATION: At least 500 youth will learn practical tools to improve their overall health and well-being.
Outcome 3: This school year we offered 61 educational workshops and trainings to 2,483 participants on the following topics: Social Emotional Learning (SEL) Lessons, Breaking Down the Walls, Know the Signs/Sources of Strength, Heart Math/Stress Management, Parent Know the Signs Trainings, and ANGST screenings. 90% of students shared that they learned new stress management and suicide prevention skills to improve their overall health and well-being.

Challenges, Solutions, and Upcoming Changes

Challenges

This year program staff were excited to get back to a regular school schedule but didn't anticipate all the challenges that would be faced. From wearing masks and everyone being frequently quarantined, to students and staff relearning how to be back together in a school community, it turned out to be a very challenging year. Staff saw an increase in anxiety, depression, emotional dysregulation, and disruptive student behaviors. There was also pressure on teachers to make up for lost learning time. The teachers were already burned out from having to navigate the challenges of teaching during a pandemic and then were faced with even greater stress trying to resume some sense of normalcy while closing the learning gap.

Solutions

In response to this, the TTUSD Wellness Program offered more staff support by training all TTUSD staff in Trauma-Informed Schools and providing access to a year-long Trauma-Informed Online Academy. Wellness Centers were launched in local middle schools - Alder Creek Middle School and North Tahoe School. The middle school Wellness Centers were met with high demand and supported a large number of students within a month of opening in January. TTUSD continued to contract with school therapists one day a week at each middle school and high school site and launched a new School Social Worker Program, consisting of part-time Social Workers at each middle school and high school site. The School Social Workers were able to provide comprehensive supports to 75 students and their families by connecting students to an array of school and mental health services that included providing case management for students with complex family issues to help them navigate services, offering short-term counseling, conducting risk assessments, and assisting school coordinated care teams in developing student behavior management plans.

Upcoming Changes

This upcoming school year, TTUSD is planning to contract with a SEL (Social Emotional Learning) Specialist to expand the SEL program within the district. This will support the TTUSD Wellness Program to improve school climate, strengthen students' SEL competencies, build a stronger infrastructure, and provide more comprehensive TTUSD SEL/Wellness education and supports.

Program Participant Story

A student who was a regular in the Wellness Center for a couple of years would come in during her lunch breaks to socialize and hang out with friends. Over time, she developed a strong relationship with the Wellness Center Specialist. One day during lunch, the group had a conversation about eating disorders and the participant stayed on afterwards to talk to the Wellness Center Specialist. She shared that she struggled with her body image and thought that she might have an eating disorder. The Wellness Center Specialist listened, offered support, and shared resources about eating disorders The Wellness Center Specialist continued to meet with this individual over the next couple of months to help her identify her eating disorder, offer mental health resources, and teach her self-care techniques and tools.

During this discussion, it came to light that she had been the victim of a sexual assault and it was significantly impacting her mental health and self-worth. She also shared that the perpetrator was a student at her school. The Wellness Center Specialist supported the individual to make a police report and let her parents know about the incident. The Wellness Center Specialist then referred her to the school therapist to receive therapeutic services and to Sierra Community House for Sexual Assault Advocacy services. This student regularly engaged in these services and continued to meet with the Wellness Center Specialist for the remainder of the school year. She also joined a Girls Empowerment in the spring and found a safe space to get support from her peers. As a result of these interventions, the individual showed significant improvements in her mental health, her understanding of how her eating disorder was connected to her desire for control in her life, and her overall self-esteem.

The Wellness Center was also able to offer support to the student who was the perpetrator in the sexual assault incident. We referred him to our school therapist for therapeutic services. As she worked with him, she discovered that his family was experiencing a number of significant challenges. The school therapist worked with the school counselor to refer his family to WRAP but his family was too overwhelmed to engage in services. Then the School Social Worker reached out to his mother to encourage and offer her support in navigating the county services. As a result, the family is now participating in WRAP and receiving critical county mental health supports. The school's Coordinated Care Team continues to check in with the student and his family and feel hopeful that his family is receiving the support they need.

PEI Category: Prevention

SIERRA COMMUNITY HOUSE
Family Support/Parenting Classes (Eastern County Only)

Program Description

Program Overview

Families face significant stressors in the region, including isolation, tourism-dependent employment, high cost of living and limited resources. Free programs for families and parents are particularly scarce. The Program provides support groups and classes aimed at decreasing family isolation, fostering development of peer networks and building skills and confidence in parents. Staff trained in curricula including but not limited to Parent Project®, Loving Solutions®, and The Incredible Years facilitates group workshops in response to community need.

For many families, these classes provide a first point of contact to the broader continuum of care as class facilitators provide referrals and information to assist families with accessing healthcare enrollment, mental health services, childcare resources, and other systems navigation services. Parent’s Café, Family Room and Mom’s Café, promote the development of peer networks and support, while fostering the knowledge of child development.

Staff is ready to share with participants information about resources and refer them to available services when they express needs in relation to safety, mental and behavioral health. Many participants who attend the parenting classes respond to media promoting classes throughout the community. These parents self-identify as wanting additional knowledge and support around parenting their children. Means of promotion include Facebook, Twitter, the organization's website, and traditional print media, including fliers distributed in the community and through the school district. Some participants are referred from County agencies, including Child Welfare services, Placer/Nevada County Court, and Placer and Nevada County WRAP programs. Tahoe Truckee Unified School District (TTUSD) school counselors and local mental health therapists in the community also refer parents to this program.

Target Population

All program participants live in the Tahoe Truckee region and are typically parents of children attending school within TTUSD.

Evaluation Activities and Outcomes

The Program served 113 community members through its different activities. Twelve program participants received individual services. Twelve referrals were made including two to Nevada County Behavioral Health. Other services that individuals were referred to were: Peer Support Services at Sierra Community House, Benefits, Legal Services and Speech Therapy.

Among the clients served, 58 identified as Latino and 36 as Non Hispanic/Non Latino.

Two six-week Parent’s Café sessions in Spanish and two in English were offered during this reporting period. Mom’s Café weekly meetings were offered between October 2021 and June 2022.

Program outcomes for FY21/22 included:

- 90% of individuals demonstrated improvement in overall mental health, as evidenced by improved score on the Participant Perception of Care posttest.
- 85% of individuals demonstrated improved parenting skills, as evidenced by improved overall Problem score on the Eyberg Child Behavior Inventory posttest.
- 85% of individuals demonstrated improved parenting skills, as evidenced by improved overall Intensity score on the Eyberg Child Behavior Inventory posttest.

Challenges, Solutions, and Upcoming Changes

The work with the communities we serve continued to be determined by the effects of the ongoing COVID pandemic. As the situation evolved, the need for various adjustments on service delivery came up as a challenge for the organization.

Sierra Community House continued to provide different instances of connection and interaction for the community such as classes, workshops and activities on parenting, mental health prevention, nutrition, health and wellness, open to the everyone in the community.

However, services continued to be provided virtually during this period and moving towards in-person. This represented a challenge to the core of our work and even as our community members accepted the changes quickly and were ready to work together with our staff, several challenges remained, mostly around engagement in activities.

As activities happened virtually, the component of childcare offered to parents attending was suspended. This resulted in the loss of a unique opportunity to provide children's workshops while parents engage in the cafes and educational activities.

Overall, participants showed an increased knowledge about protective factors, increased knowledge of parenting and child development, confidence in parenting, knowledge about the importance of social and emotional competence of children, social connections, as well as how relevant it is to obtain concrete support in times of need.

Program Participant Story

"Kathy" is a community member who have been engaged with the program's services for over 1 years. She was referred to the program due to domestic violence at her home. She became mother of a boy, who is now 8, when she was a teen, and was pregnant of her second child when the DV incident happened.

She came to the program with a little or no hope that her circumstances would ever change. First thing the Advocate worked on with her was around a plan to keep her safe, as she was actively fleeing her place. The Advocate was able to enter her into our Safe House shelter, where she

could stay up to three months with her child, before moving to a safe, long term location that our Transitional Housing program would help attain and financially support during 18 months.

She was also connected with other resources that could provide support to her as a parent during these times. Besides receiving Peer Support from our Crisis Advocates, she started participating in our Parents Cafe workshops and also our Zumba classes.

The Advocate first working with “Kathy” also helped her enroll and receive Placer County benefits.

The program was also able to offer support to her partner, who had also been a parent teen and had had an difficult upbringing. He accessed therapy services from a local provider.

“Kathy” left the Safe House after some time there and moved in with relatives supporting her. She is trying really hard to put together all the pieces so she can move forward with her life. She is making the decisions around what is best for her family, and the program is continuing to provide the support and resources that will help her thrive.

PEI Category: Stigma Reduction and Discrimination Reduction

SIERRA COMMUNITY HOUSE
LatinX Outreach
Promotora Program - Latino Outreach Services

Program Description

Program Overview

Sierra Community House - SCH Promotoras are bi-cultural and bi-lingual community educators who strive to reduce the stigma and discrimination around mental health issues. They receive specialized training to provide basic health education in the community and provide guidance in accessing community resources. The Promotoras serve as liaisons between their community, health professionals, human and social service organizations to help connect Latino community members to mental health resources and to promote well-being.

Through cultural Spanish workshops, support groups and/or peer support services, Promotoras connect Latino individuals to mental health education and support. The Promotora Program aims at increasing knowledge within the Latino community about the symptoms of depression, anxiety, and normalizing open and honest discussions about mental health. The programs are focused on reducing negative feelings and perceptions related to mental health as well as reducing stigma related to accessing support and treatment. Promotoras promote the well-being of the Latino community in the Tahoe/ Truckee region.

Target Population

The program primarily serves Latino families and individuals who could benefit from supportive services and assistance to link them to needed services in the community.

Evaluation Activities and Outcomes

The program collects evaluation activities for MHSA including demographic information on each individual receiving services.

During FY 21-22, the program delivered services to 118 unduplicated individuals. Of these, 88 identified as Hispanic or Latino and 30 as Non-Hispanic/Non-Latino.

A total of 27 referrals were made to County Behavioral Health programs of which 15 were connected within an average of nine days. Two other referrals were made to other mental health services and connected within an average of two days. Twenty-five referrals were made to services directly provided by Sierra Community House within an average of five days, and three referrals were made to Peer Support Specialists who engaged within an average of three days.

From the results of the Stigma and Discrimination Reduction Survey assessing attitudes towards mental health that was administered to the attendees of the groups during the fiscal year, 82% of individuals demonstrated an improvement in attitudes, knowledge, and/or behavioral change related to mental illness and 80% of individuals demonstrated an improvement in attitudes, knowledge, and/or behavior related to seeking mental health services.

Challenges, Solutions, and Upcoming Changes

Data collection and entry continued to be a challenge in part due to changes in the systems used. In order to improve in this area, the program plans to train staff and establish processes that allow for more effective collection of the data at the source and a more organized recording and entry into the system continue to be a critical effort.

Additionally, the program continued with the process of shifting activities to a virtual format. This included staff familiarizing themselves with different technologies while, at the same time, slowly moving back to in-person activities towards the end of the period, readjusting to changing circumstances. By the end of the reporting period, staff came back in person to the offices five days a week, with the expectation of having the ability to offer all our groups and activities in person.

The peer support service started building capacity staff training and education. Peer supports provided 336 individual 1-2 hour sessions during FY 21-22 and continue to be a main point of access for the community to the broader mental health continuum of care.

Program Participant Story

One set of parents, who happen to be immigrants, and similar to other parents, strive for the best outcomes for their children. They work very hard to provide a good life for their children, so they are safe and happy.

There had been a suspected abuse and/or neglect report referral for them from the Children System of Care - CSOC, with a Path 2 category assigned. But, this time, the referral was different in the sense that there were no indications of actual violence at home. When Promotoras staff met the couple, they did disclose being stressed and feeling overwhelmed by the different issues they were going through. Both parents were working all days of the week. One of the parents only gets to rest one day a week. The children, boys ages 11 and 8, were spending many hours a day by themselves. The children were feeling depressed, getting behind in school, and fighting with peers.

Nonetheless, the parents were willing to overcome these obstacles and try to improve their current circumstance. Their place was clean and organized and the children were overall all right. The couple was glad they had connected with SCH because they felt they needed support from

outside the home to figure things out. They wanted to work on reaching a better balance and a healthier relationship between all of them. The couple was referred to an SCH parenting group.

Where they talked about the importance for parents to allow for free, playful, and recreational time with the kids. In addition to the idea of going out together and spending more time with them. The kids' behavior outside the home was somehow a way for them to cope with the situation they were living in at home. The couple eventually agreed with the fact that they were working more than they should.

They were also offered sessions with a Peer Support Specialist at Sierra Community House and were assisted by an advocate with MediCal to complete an application since they were uninsured during this time. They were also connected to swimming lessons at the local recreation center, since the boys had been living by Lake Tahoe and didn't know how to swim. Also, this might be a way of sharing an activity that would help them connect with each other at a different level.

PEI Category: Stigma Reduction and Discrimination Reduction

NEVADA COUNTY SUPERINTENDENT OF SCHOOLS (PARTNERS FAMILY RESOURCE CENTER) LatinX Outreach Grass Valley Partners FRC Promotora/ Latino Outreach

Program Description

Program Overview

The Nevada County Superintendent of Schools (NCSOS) Promotora/ Latino Outreach program at Grass Valley Partners Family Resource Center (FRC) consists of mental health outreach and engagement for the Latino community. Promotoras are Spanish-speaking paraprofessionals who help Latino families connect to community resources by offering interpretation and translation, and by advocating for the physical and mental health needs of community members.

The Latino community needs to have a level of comfort and confidence that when they reach out for help, they won't be let down. This type of relationship is built on helping them with the basic needs they have, such as interpreting at a physical healthcare doctor's appointment, and helping to direct them on how to navigate where they need to go for a particular need. Once the trust is there, they have confidence to ask for help for themselves or family members in mental health matters. Developing and maintaining a rapport with the members of the community the staff member serves remains the foundational element of this position.

The Grass Valley FRC Promotora offers psycho-educational group meetings in order to decrease the stigma of mental health issues through evidence-based curriculum. The goal of these groups is to educate individuals and decrease stigma and fear about mental health issues in the Latino

community. These groups are conducted in Spanish and childcare is available as needed during group meetings.

Target Population

NCSOS Promotora/ Latinx Outreach serves the Latinx population in Western Nevada County. According to the Census Quick Facts, the Latinx/Hispanic community presently accounts for 9.8% of the population. This program serves children, transition age youth (TAY), adults, and older adults.

Evaluation Activities and Outcomes

The Promotora/ Latino Outreach Program collects evaluation activities for MHSA including information on individual demographics, outreach, and referrals to community resources on each person receiving services and/or being trained. The Promotora provided varied services, such as: assistance with medical and dental appointments, school issues, individualized education programs (IEPs), and referrals for immigration and other family legal issues, translation assistance with medical applications, and other documents. Also provided was an English as a Second Language (ESL) tutor and an Aerobic Wellness Class. Two Teen Suicide Prevention Awareness presentations were facilitated for the ESL students at Nevada Union High School, along with 15 sessions of mental well-being Brain Breaks for children at Bell Hill School. WRAP Walks continues to help participants develop a personal wellness plan by blending mental wellness with physical movement. A more intensive individualized WRAP program, as well as a group WRAP was also offered. Mental health awareness pamphlets were distributed during each Ritmos exercise class.

FY 21/22 Outcome Measures

Goals

1. 16 Psycho-educational meetings yearly
2. 5+ unduplicated participants for each meeting type
3. 50 adults and 15 children/youth will receive education on mental health issues per year.
4. 3 to 5 individuals will have prepared their Wellness Recovery Action Plan
5. 80% of individuals will report satisfaction with the services provided.
6. Decrease in the negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discriminations related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and increase in acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families by doing the following: Increase in knowledge of mental health and substance use services and treatment resources available in Nevada County. Increase comfort in talking about mental health illnesses and symptoms. Increase comfort in seeking mental health services for themselves or others.

Outcomes

1. Year to date, 50 psycho-educational meetings have been held.
2. Year to date:

- 43 participants from Nevada Union High School English Language Development in 3 sessions of Teen Suicide Prevention
- 3 participants in an individual WRAP – 16 sessions
- 1 participant in 76 sessions of WRAP Walk
- 16 Participants in 2 sessions of Group WRAP 1
- 8 participants in 1 session of Nutrition for Elementary Children
- 10 participants in 12 sessions of Ritmos para el Bienestar (Exercise)
- 212 student participants from Bell Hill Academy in 15 sessions of Brain Breaks for Wellness

3. Year to date, 36 adults and 257 children/youth have received education on mental health.
4. Year to date, 20 individuals have prepared an individual WRAP. 16 individuals participated in a group WRAP 1.
5. 30 out of 81 teens and adult clients completed surveys, 100% reported satisfaction with services provided.
6. Year to date, 228 Individuals have participated in programs and 33 teen/adults completed the Promotora survey. See survey results below:

NCSOS Promotora MOQA Survey Results	%
Increase in knowledge of mental health and substance use services and treatment resources in Nevada County with adults.	52
Increased comfort in talking about mental health illnesses and symptoms.	76
Increased comfort in seeking mental health services for themselves or others	100
Percentage of the surveys demonstrated that it is within the individual comfort zone to allow others to know about mental health issues within their family. (New survey will continue to capture this information for future programs.)	67

Referral Summary

1. 9 individuals identified as needing mental health referrals, 6 were referred to County mental health programs, and the remaining 3 were referred to other mental health agencies. 100% of individuals were successfully connected to MH services. Only 2 individuals were able to clearly identify the time of onset of symptoms. They had an average length of time for untreated mental health symptoms of 23 years.
2. Other referrals were made to agencies like: Family Resource Center (63), Spirit (21), Nevada County Social Services (19), Turning Point (11), and others, for a total of 262 referrals made. 251 of those 262 were successfully connected in an average of 1 day.

Challenges, Solutions, and Upcoming Changes

Challenges:

- Due to the post-COVID economic recession the Latino community is experiencing negative effects in employment, housing, etc. "Survival mode" makes it difficult to prioritize mental health needs. The information and support the Promotoras provide is crucial.

- The lack of Spanish-speaking resources in our county creates a challenge in meeting the needs of the community.
- It continues to be a goal to reduce the time that it takes new families to integrate into the community and to bridge the gaps in service that come with these transitions.

Solutions:
- Continue to gain connections with individuals in the community to further develop the phone tree for rapid communication.
- Actively work through schools to reach parents for Parenting Classes and WRAP.
- Look for more opportunities to advertise and invite people to Wellness and Recovery Action Plan (WRAP) meetings, one-on-one or in groups of children, youth, and adults.
- Seek to provide more mental wellness educational experiences for school-aged children in school setting.
- Promote WRAP to help people learn how to care for their own wellness during crises.
- Increase modes of communication with the community.
- Continue to seek assistance for providing housing to members of the Latino community.
- Utilize the developed relationships with school staff to keep up to date on students/families that are new to the community.
- Seek to foster opportunities to collaborate with other agencies in our county to better meet the needs of the Latino community.

Upcoming Changes:
- Continue seeking volunteers with Spanish language skills who are interested in participating in Latino Outreach to help with outreach and support during program presentations.
- Focus on conducting programs that address mental health stigma and discrimination in meetings that are designed to survey a positive change of attitude.

Program Participant Story

This year has had a lot of ups and downs at our Family Resource Center with COVID illness in participants and staff. Despite this persistent challenge, this year has provided numerous opportunities for some new activities and connections with the Latino Community. One of the ladies that had been connected to other service providers thought that the NCSOS Latino Outreach program could help her and realized that perhaps she would be able to help her husband that was dealing with some serious anxiety since he had COVID by asking a Promotora. She asked if there was a way to help him with mental health services. He was referred and connected to our Spanish speaking therapist at Behavioral Health. Apparently, he had suffered with anxiety in the past and with COVID pandemic the stresses placed on him, both financial and relationally, brought back panic and stress full force. He participated in creating his own individual WRAP plan and would call for support, as he needed it. It was encouraging to see his progress as time went on. It has been over a month since he called for support. He has developed his network of supporters that were around him all the time and has learned a few strategies to take care of his own mental health. He sent a message last week to communicate that he is doing well.

Mental illness in the Latino Community is generally still viewed as a very negative, taboo topic and it requires a very good rapport with individuals so they will identify their need, or a loved one's need and share it with a trusted person that can help them address the mental health challenge that is being experienced. The goal continues to be maintaining rapport and reaching others that do not know about the services available to them through the Promotora at the PARTNERS Family Resource Center.

PEI Category: Stigma Reduction and Discrimination Reduction

GATEWAY MOUNTAIN CENTER
LatinX Outreach

Program Description

Program Overview

Through the LatinX Youth and TAY Leadership Development program, LatinX youth in the Tahoe/Truckee region will be recruited and nurtured to be peer mentors. Mindfulness Based Substance Abuse Treatment (MBSAT) is an evidence-based practice used to help individuals with substance use disorders develop better strategies for managing stress, and executive skills to develop and exercise self-control, and reduce reactivity to cravings. Four older transitional aged youth (TAY) are recruited, trained, and supported to become certified in MBSAT. They then, as youth leaders provide peer counseling at the Youth Wellness Center and assist in leading planned Community Wellness Walks in Kings Beach.

Target Population

The target population is Tahoe/Truckee area older transition aged youth to be trained in MBSAT and local High School Students who will receive counseling.

Evaluation Activities and Outcomes

In FY 21/22 this program served 121 unduplicated individuals.

Mindfulness Based Substance Abuse Treatment (MBSAT) - 2 cohorts - 25 sessions

Goal 1: Increase Emotional Regulation Questionnaire (ERQ) score for MBSAT students by 10% from baseline:
Outcome 1: Of the 3 Youth that completed the Spring MBSAT cohort, all 3 reported an increase in ERQ score greater than 15%, with one individual showing an increase of 200%.

Goal 2: Reduce reported substance use in the past 30 days by 10% from baseline for youth in MBSAT classes.

Outcome 2: 83% of the youth who completed the full MBSAT course reported reduced substance use by 10% or more in the past 30 days.

- 4 youth and 2 TAY completed the 12 module program and certified in MBSAT.
- 7 youth did not complete the 12 module program
  - Of the youth that did not complete, one was incarcerated, one was sent to a two-month psychiatric rehab, and one withdrew to attend a more intensive healing retreat.
  - The other 4 attended between one and four classes and then chose not to pursue program completion.
- Training and Narcan were distributed to two groups, serving 21 youth in total.

Referrals

- Four individuals requested mental health referrals. All four were referred to non-county mental health services with: BetterHelp, Quest Counseling, and Gateway Whole Hearts Minds and Bodies. 100% of referrals were connected to mental health services.
- Four individuals needed referrals to recovery services. Referrals were made to: Truckee Alcohol Anonymous/Narcotics Anonymous (AA/NA), Truckee AA/NA for teens, and Elevate Addiction Services. Of the four referrals to recovery services, only one reported connecting with service.

On Campus pipeline / Intro to Substance Use Programming:

- Promotional Outreach happened for 6 campuses - with two or three 5-10 week programs per campus
- A total of 16 programs were delivered at local school campuses, totaling 64 sessions, serving 114 youth.
- This year, “post”-covid we were asked by TTUSD to provide the maximum support that we could for all campuses.
- We were also asked to customize the programming per each campus - as the behavioral health needs were manifesting in many different ways - sleep issues, procrastination, apathy, loss of ability to focus, emotional lability, conflictual interpersonal relations, self-control, reduction of reactivity, managing stress, and trouble finding joy.
- We created a menu of services from our MBSAT curricula that drills down into specific areas that need support. These targeted, more in-depth curricula pieces were selected by TTUSD school counselors and psychologists based on the interventions that were needed.
- These programs created interest and usage of our 4Roots Wellness Center for youth - which we opened in April of 2022. MBSAT, Mindful Warriors peer-led support, and other early intervention programs were accessed through our drop-in Wellness Center - open M-F 12:30 to 6:00
- We awarded one scholarship in Wellness to a graduating Sierra High Senior for her exemplary growth in taking Care of Self - as part of taking care of others.
- We supported one peer leader in joining a 6-month online program at Tarzana Treatment Center College for addiction training and certification; with a teaching

practicum at Valley State Prison. This education meets the requirements of the three California certifying bodies to become a certified SUD Counselor.

Challenges, Solutions, and Upcoming Changes

- COVID protocols continued to open and close campuses and delayed the opening of the Youth Wellness Center by several months. Once open, attendance was sporadic and not conducive to pre and post-assessments.
- The very short time period of five classes lasting 45 minutes proved very challenging to create high-quality group cohesiveness, deliver high impact and engaging programming, and administer pre and post-assessments. The short time frame created a feeling of pressure to win the hearts and minds of the youth so that they will engage with program staff and participants in more in-depth ways. As a resole, the program chose to increase the length of the course to add more time for group content, rapport building, and data collection.
- The program set a goal to recruit, train, and support older and transitional-age youth to become certified in Mindfulness-Based Substance Abuse Treatment (MBSAT). Two recruits were lost due to relapse. The program was able to retain and further support one as well as recruit two new youths for peer mentor training and practice for fall 2022.

Program Participant Story

TTUSD Youth Voice Testimonials:

- "I felt a lot of joy and happiness. I de-stressed too. That was cool."
- "I started meditating in my daily life after this".
- "In my daily life I will use the core values in the My Life As A Tree exercise. I want to use the branches to help me expand and grow".
- "I learned it's OK to take a break for my well-being".
- "I was feeling upset; and this program really brought my joy up".
- "After that, I will use mindfulness whenever I feel upset."

Spring 2022 MBSAT YWC Cohort:
"I can definitely say I have a different way of thinking now, and I don't want to go back to my old habits. You guys made me realize I actually really do have a future, and that I didn't throw my life away. I feel like you guys were the only people who really believed in me. And you guys actually thought that I wasn't crazy - and you gave me a real second chance."

"I liked the meditations, and I used to hate it when people would tell me to take a deep breath - I used to just walk away from that. Now I use deep breaths every day to calm myself, and I use mediations every night to help myself sleep. This program definitely helped me. Meditations are better than Nyquil."

"I really liked the discussions, because some of the items that we discussed made me realize I was not the only person who was going through it. It was really nice talking about it with a group

of people who could relate. You guys really helped a lot, because you knew how to lead us - you know just what to say. I can definitely trust you with a lot of things. I've said things to this group that I have never told anyone before."

"I liked the brain science which showed me why I should stop using, and what could happen in the future - what are the long terms and the short terms. You didn't just tell me to stop using. You showed me why."

PEI Category: Stigma Reduction and Discrimination Reduction

SIERRA COMMUNITY HOUSE
Youth Empowerment

Program Description

Program Overview
Empowerment Groups are offered to students to enhance a variety of skills and opportunities. Topics for these groups include creating positive environments and communities, promoting healthy friendships, relationships and choices, increasing positive self-worth, engaging and empowering youth to speak out and model healthy lifestyles, and increasing the understanding of mental health stigmas including how to support others and seek help. Empowerment groups will help individuals identify personal strengths and supportive resources and develop new ways of thinking and addressing challenges-both internal and external. Facilitators build rapport with youth and provide the space and opportunity for students to open up through discussion, activities, writing, media and art. Multiple curricula are used, depending on the topic needs and focus of the specific group. Young Men's Work and Young Women's Lives are often referenced for training curricula.

Target Population
Youth in grades 4-12 in the North Lake Tahoe-Truckee community. Students are often referred by school counselors and teachers as those who would benefit from extra support, and students are also referred for being identified as those who could take new skills and teach/influence their peers.

Evaluation Activities and Outcomes

Goal 1: Contractor will serve a minimum of 56 youth each year.

Outcome 1: During the FY21/22 reporting period, the program served 50 students in Youth Empowerment Groups. Of those participants, 19 were Placer County residents and 31 were Nevada County residents.

Goal 2: 75% percent of individuals will demonstrate an improvement in attitudes, knowledge, and/or behavioral change related to mental illness.
Outcome 2: During the reporting period, 8 students completed the Stigma and Discrimination Reduction Survey (SDRS). Of those participants, 100% answered “Yes” to the question “I have a better understanding of how to access mental health resources in my community”. Additionally, 4 participants answered the question, “I would be comfortable discussing mental health issues with others (family, close friends, doctor),” and 75% answered “Yes”. Five participants answered the question, “If someone in my family had a mental illness, I would be comfortable if people knew about it,” and 80% answered “Yes”.

Of the 11 youth participants that completed the Participant Perception of Care (PPC), 67.2% answered “Agree” for all 12 questions, implying those students had a positive experience in group and saw a positive change in their social-emotional health. 100% of participants responded “Agree” to the question, “I have learned to use coping mechanisms other than alcohol and/or other drugs.” Other notable responses of participants answering “Agree” at 80% or higher were, “I am better able to do things that I want to do”, “I am better able to deal with crisis,” and “I do things that are more meaningful to me”.

A majority of our Youth Empowerment participants were aged 11 and under this fiscal year, and therefore did not complete either the SDRS or PCC, as they are for participants 12 and older. However, topics around mental health stigmas were discussed at an age-appropriate level with the younger participants. Many activities and discussions focused on stressors, unhealthy and healthy coping skills, and self-care, as well as the normalization, understanding, and empathy around anxiety and depression for people of all ages. Our school year-long high school Empowerment Group focused on educational sessions for the participants the beginning of 2022. These trainings included definitions of mental illnesses, warning signs and symptoms, myths vs. realties of mental health, different methods of treatment, and how to support a friend. The trainings are crucial for students to have a common understanding of mental health and illness. It also provided information and resources on how to support their peers if they notice any warning signs or symptoms.

There were no referrals made to outside agencies during this fiscal year.

Challenges, Solutions, and Upcoming Changes

The program faced many challenges in providing Youth Empowerment Groups this fiscal year. New volunteer requirements were implemented in the Tahoe-Truckee Unified School District (TTUSD), which led to not being able to provide in-person services until November. Schools chose to wait for the ability for group programs to meet with the students in-person, rather than starting groups virtually. In addition, in January the program was once again not allowed access to the schools due to a spike in COVID-19 cases in the district. At this time, school staff chose to suspend groups until they were able to come back in-person, rather than switch to virtual programming in the interim. Additionally, staff changes occurred in April and May, leading to a few groups being cut short, and another group that was scheduled to start never happened. By the

end of the fiscal year, the program had a new Coordinator in place and promising candidates for the Educator position. Youth Empowerment staff are hopeful and excited to meet with students in-person next fiscal year with fewer, or no, interruptions!

With the Suicide Prevention Coordinator moving into a full time position, there are plans to have a few more Youth Empowerment Groups focused on mental health stigma reduction and prevention!

Program Participant Story

In all the Youth Empowerment Groups, group members are provided an anonymous survey to complete during the last group session. The feedback from this survey is used to inform groups moving forward. The following is feedback from a 6th Grade Girls Group that the facilitator felt was a particularly successful group. Some of the responses have been consolidated into repeat answers:

What did you learn from group? “I loved how we talked about being girls. I learned to stand-up for myself. I learned from the other girls. I learned how to deal with bullies and recognize toxic relationships. I learned I'm not the only one that goes through bad things, and while I was at group I could really tell and share how I was feeling. I learned different types of communication and ways to deal with stress and anger. I learned how to talk about how I am feeling.”

What did you like about group? “Getting to know new people. The fun activities. Making new friends. The trust in the group. The pizza party. “The facilitator” and how she really listened to us.”

What would have made group better for you? “If it was longer.” (all 6 participants present at the last session responded with this answer).

PEI Category: Suicide Prevention

NEVADA COUNTY PUBLIC HEALTH & NEVADA COUNTY BEHAVIORAL HEALTH Suicide Prevention and Intervention Program (SPI)

Program Description

Program Overview

The Suicide Prevention Program (SPP) was developed to create a more suicide aware community in Nevada County. The Health Education Coordinator in the Public Health Department and the Clinical Supervisor in the Behavioral Health Department share implementation of the SPP.

The SPP's focuses include facilitating the Nevada County Suicide Prevention Task Force, providing outreach, education, and training on suicide prevention in the community, and coordinating postvention services for suicide loss survivors.

The SPP engages with a variety of stakeholders, including consumers, individuals, families, support groups, community-based organizations, coalitions, local and state governments, the Sheriff/Coroner and law enforcement, and schools, among others. The goals of the program are to raise awareness about suicide prevention, reduce stigma around suicide and mental illness, promote help-seeking behaviors, implement suicide prevention and intervention training programs, and support individuals, families and communities after a suicide or suicide attempt.

The Health Education Coordinator uses evidence-based curricula and trainings, including Know the Signs trainings and other evidence-based practices to build community awareness and capacity and provide linkage to services. The coordinator provides these services in a variety of settings, including schools, non-profits and other agencies, organizations and individuals that request assistance.

The Clinical Supervisor coordinates postvention services, including contacting families and significant relations affected by suicides in Nevada County to provide support and linkages to resources. In the event of a suicide at a school or other community institution, the clinical supervisor coordinates crisis response and postvention to those in need of support and counseling.

The coordinator also convenes the Suicide Prevention Task Force (SPTF) in Western Nevada County, supports the work of the Tahoe Truckee Suicide Prevention Coalition in Eastern Nevada County, and collaborates with many other organizations and agencies.

Target Population

The SPP serves the entire population of Nevada County. Some outreach strategies and trainings are adapted or tailored to meet the needs of specific groups. Postvention services target suicide loss survivors.

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on each participant in trainings as well as collecting data at the end of trainings to provide information on participant perceptions of the training and how much they learned (results shown below).

As a direct result of this training:	**%Agree FY19/20**	**% Agree FY20/21**	**% Agree FY21/22**
I am better able to recognize the signs, symptoms and risks of suicide.	93%	100%	100%
I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide.	92%	100%	100%
I am more willing to reach out and help someone if I think they may be at risk of suicide.	92%	99%	100%
I know more about how to intervene (I've learned specific things I can do to help someone who is at risk of suicide).	92%	98%	100%
I've learned how to better care for myself and seek help if I need it.	82%	89%	90%
Please tell us how much you agree with the following statements:			
The presenters demonstrated knowledge of the subject matter.	94%	100%	100%
The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.).	93%	88%	90%
This training was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).	91%	90%	91%

**includes respondents answering “strongly agree” or “agree”*
*** FY19/20 = 149 participants, FY20/21 = 393 participants (100 responses), FY21/22 = refer participants (40 responses)*

SPP provided trainings to 204 unduplicated participants in FY 21/22. As a result of the COVID-19 pandemic, all but one of the trainings took place virtually and all the trainings were Know the Signs trainings. In addition, the SPTF hosted a virtual Suicide Prevention Town Hall in September 2021 that had 52 attendees and supported a Spanish Know the Signs training for the Truckee area.

No attendees were referred to other agencies during the fiscal year.

The Clinical Supervisor followed up with many suicide loss survivors, including relatives and other close relations.

Challenges, Solutions, and Upcoming Changes

The two primary challenges in FY 21/33 were the continued impacts of the pandemic and staff transitions in the spring of 2022. Since the beginning of the pandemic, the SPP has gone almost exclusively to virtual trainings. Because two suicide pretention training modalities—*safeTALK* and *ASIST*—are required to be in-person, those trainings have not been ordered. All events were also virtual, including the Suicide Prevention Town Hall.

SPP staff were also given responsibilities related to COVID-19 during the first half of FY21/22, which took some time away from suicide prevention activities. Finally, in March 2022 the Health Education Coordinator with Public Health assumed a new role within the department. A new Health Education Coordinator is scheduled to start in August 2022.

Program Participant Story

Below are some quotes from training evaluation forms on participants' experience in suicide prevention trainings hosted by the county:

"Although I have received similar trainings many times, I find there is always something new to absorb and it is great to get refreshed. I have used the information I have learned in these trainings several times in real life, both professionally and personally."

"I had no idea there were so many resources."

"The presenter was clearly knowledgeable about the subject presented."

"The presenter does an excellent job of presenting the information in a manner that demonstrates what the best practices are: calm and straightforward and nonjudgmental."

PEI Category: Suicide Prevention

SIERRA COMMUNITY HOUSE
Truckee Tahoe Suicide Prevention Coalition

Program Description

Program Overview

The Tahoe Truckee Suicide Prevention Coalition (TTSPC) formed in 2013 out of concern for the mental health and safety of youth in the community. Since that time, the goal of the TTSPC has grown to provide education, outreach and strategies that will mobilize and support all members

of the community, while preventing future suicides. This is a collaborative effort involving several community agencies, including the local school district (TTUSD), Tahoe Forest Hospital District (TFHD), Nevada and Placer County Health & Human Services and the Tahoe Truckee Community Foundation (TTCF).

Target Population

The target population that TTSPC serves is North Lake Tahoe and Truckee residents.

Evaluation Activities and Outcomes

Goal 1: Provide 15 trainings to an estimated 300 attendees, per year on various suicide prevention curricula and topics.

Outcome 1: Through fiscal year 2021/2022, 14 suicide prevention trainings were facilitated for 265 participants. TTSPC provided the community at large access to free and on-demand online Question Persuade Refer (QPR) training, and 25 individuals took the online QPR The Suicide Prevention Coordinator participated in a virtual Suicide Prevention Town Hall meeting as a panelist, answering questions from community members and event moderator about recognizing early warning signs of suicide, available resources and programs, and community involvement, and 53 community members attended. Know the Signs was facilitated for 17 staff at a private school in our region and was also facilitated for parents of teens and young adults in a joint effort by Nevada County, Tahoe Truckee Unified School District, Community Collaborative of Tahoe Truckee, and Sierra Community House. Twenty-five youth who were participating in a local leadership program attended a training on mental health and suicide prevention. Also, an evening Mental Health in the Mountains speaker series provided 14 community members information on how to support survivors of suicide loss. QPR was facilitated during a collaborative Crisis Intervention Training between Stand-Up Placer and Sierra Community House on two occasions, where 35 mental health professionals and volunteers were trained in suicide prevention. Additionally, a Cyber Safety for Teens and Parents virtual training was held with 8 participants in attendance, and a May is Mental Health Awareness Month Book Club, featuring *Notes on a Nervous Planet* by Matt Haig, was held with 8 participants.

Through Quarter 4, approximately 28 attendees of trainings were age 25 or younger. There may have been more participants in that age range, but that is all the information that was able to be gathered.

Goal 2: Utilize media outreach through news, radio, social media, website, and e-mail distributions to provide suicide prevention education and information with an estimated 2,000 impressions**.**

Outcome 2: From Quarters 1-3, Tahoe-Truckee Suicide Prevention Coalition (TTSPC) social media accounts posted a cumulative total of 44 posts, 143 Instagram stories, and gained 88 followers. Additionally, all TTSPC social media accounts and website experienced an 142% increase in engagement during this time. In the last quarter of the fiscal year, TTSPC social media posted 15 posts and 54 stories, saw an increase of 38 followers, and experienced 54%

increase in engagement from the previous quarter across both platforms. Additionally, the TTSPC website saw 433 views and 233 unique visits. Posts included messages of hope, resources, and upcoming events.

Goal 3: Attend an estimated 10 community events with an estimated 250 community members with information about suicide prevention and education.

Outcome 3: Through Quarter 4, the Suicide Prevention Coordinator (SPC) participated in outreach efforts at 11 community events engaging with approximately 217 community members. Two Farmers Market events, a Wellness Day at a local university, and a Community Collaborative of Tahoe-Truckee meeting were attended. Additionally, three screenings of the documentary *Angst*, a Hike for Hope suicide prevention and awareness event, and tabling at a Denim Day at a local college campus were attended. At all events, resources, promotional items and training opportunities were offered. Unfortunately, many tabling/outreach opportunities were canceled due to unhealthy air quality (smoke) and COVID during the earlier part of the reporting period.

In total 545 unduplicated individuals were served during FY 21/22 in the Suicide Prevention Program. There were no referrals to outside organizations made from this program.

Challenges, Solutions, and Upcoming Changes

During the 2021/22 Fiscal Year, challenges related to the COVID-19 pandemic continued to present themselves. The need for continued social distancing and remote work in the first half of the fiscal year led the Suicide Prevention Coordinator and coalition to focus on creating a more robust social media presence, making the TTSPC website more user friendly, and providing regular online training such as Know the Signs and QPR. Social media during this fiscal year focused on men's mental health, BIPOC communities & mental health, and youth suicide prevention. In the upcoming year, changes will include returning to in-person programming (as state and local mandates allow) as well as the suicide prevention coordinator having a presence in TTUSD schools providing youth empowerment groups and suicide prevention trainings.

Program Participant Story

On December 15, 2021, the Suicide Prevention Coordinator (SPC) attended a workshop for SOS Outreach youth participants as a panelist. SOS Outreach is a Lake Tahoe based organization that works with at risk youth between the ages of 8-18 using progressive outdoor programs and long-term mentorships. SPC educated approximately 25 students aged 14-17 on local suicide prevention and mental health efforts, and the organizations that facilitate and organize them. SPC

then spent 45 minutes collaborating with the participants to create a project in which they could positively contribute to community mental health and suicide prevention efforts in a sustainable and impactful way. The students ultimately decided to create flyers to be distributed their schools that displayed a QR code which led to links containing mental health resources. The director of SOS outreach expressed that the students were very excited about spreading awareness at school, and several participants wanted to become further involved with suicide prevention efforts and getting more of their peers involved as well.

PEI Assigned Funds - CalMHSA

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CalMHSA)
Statewide PEI Project

Program Description

Program Overview

California counties collectively pool local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the PEI Project at a Statewide level. The PEI Project is a collection of campaigns which seek to expand the awareness of mental health needs and supports, reduce stigma, prevent suicides, and teach individuals how to achieve mental wellness. These campaigns are: Know the Signs, Directing Change, and Each Mind Matters (EMM). The EMM campaign was the original stigma reduction campaign and primarily focused on reducing stigma around mental health. The EMM campaign was an early trailblazing effort in stigma reduction. Following the direction of the CalMHSA Board of Directors, CalMHSA staff sought to reimagine the next iteration of the PEI Project towards one that is building off the work done by EMM to move California into a new phase of Taking Action. The *Take Action for Mental Health* campaign helps individuals learn how to Take Action for the mental health of themselves and those around them through three pillars: Check In, Learn More, and Get Support.

In FY 20/21, CalMHSA selected Civilian through a Request for Proposals (RFP) process to begin developing the social marketing campaign that would build on the legacy of the EMM campaign, with a new focus and expanded reach to traditional and non-traditional partners. In addition, the campaign will more tightly connect each of the campaigns, and the RAND evaluation efforts, to provide counties with a more interconnected suite of campaigns to support their communities. In FY 21/22, the *Take Action for Mental Health* campaign expanded through development of a website, a storefront, new materials and resources, a May is Mental Health Matters Month toolkit, an influencer, and more.

Strategies of the PEI Project in FY 21/22

Funding to the PEI Project supported programs such as:

- Continued production, promotion, and dissemination of the *Take Action for Mental Health* campaign's materials and messages
- Providing technical assistance and outreach to Members contributing to the PEI Program
- Providing mental health and suicide prevention trainings to diverse audiences
- Engaging youth through the Directing Change program
- Strategizing on evaluation and best practices with RAND Corporation

Target Population

The Statewide PEI project is meant to serve all California residents.

Evaluation Activities and Outcomes

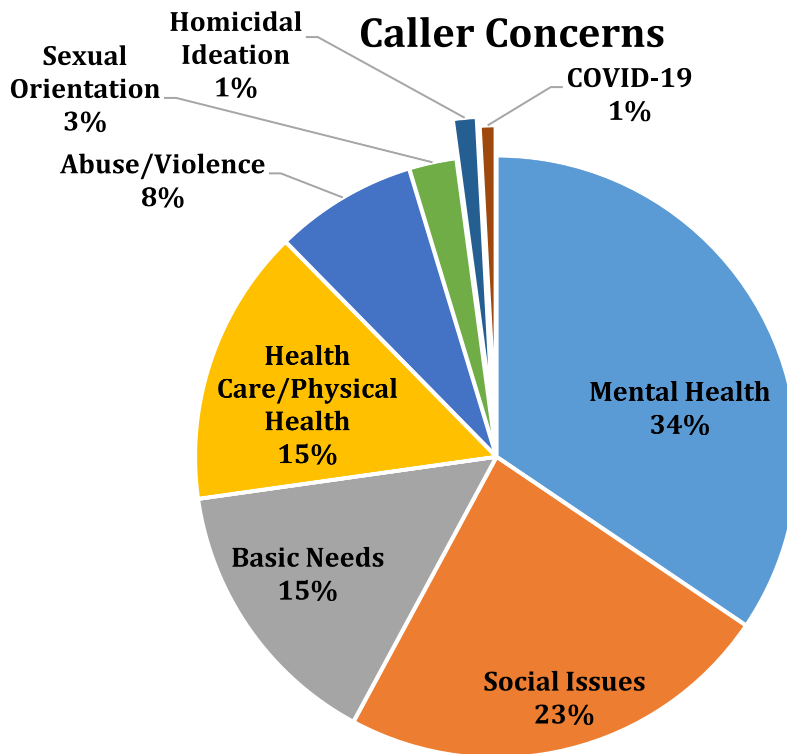
The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of *Take Action for Mental Health* is critical for creating a culture of mental wellness and wellbeing regardless of where individuals live, work or play.

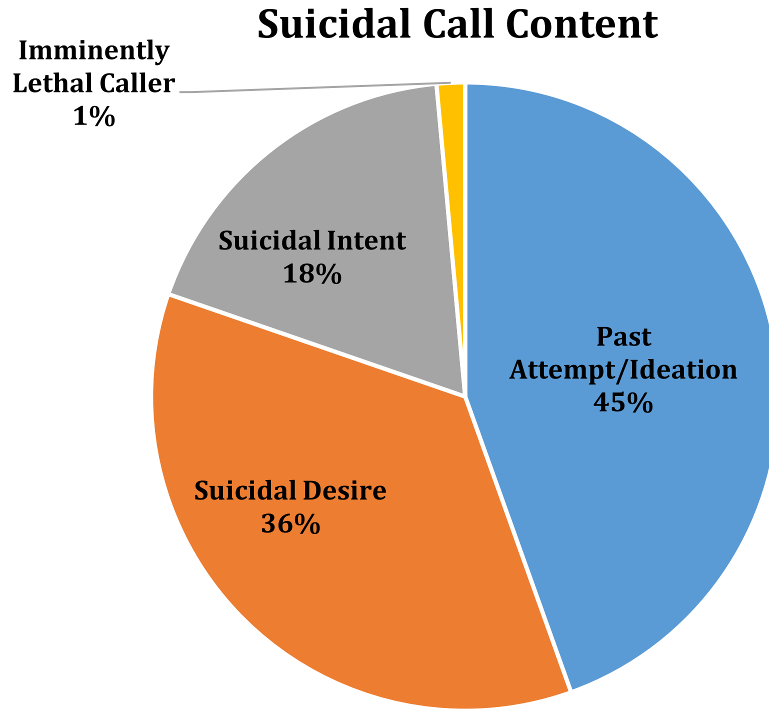
Key statewide achievements of the Statewide PEI Project in FY 21/22 included:

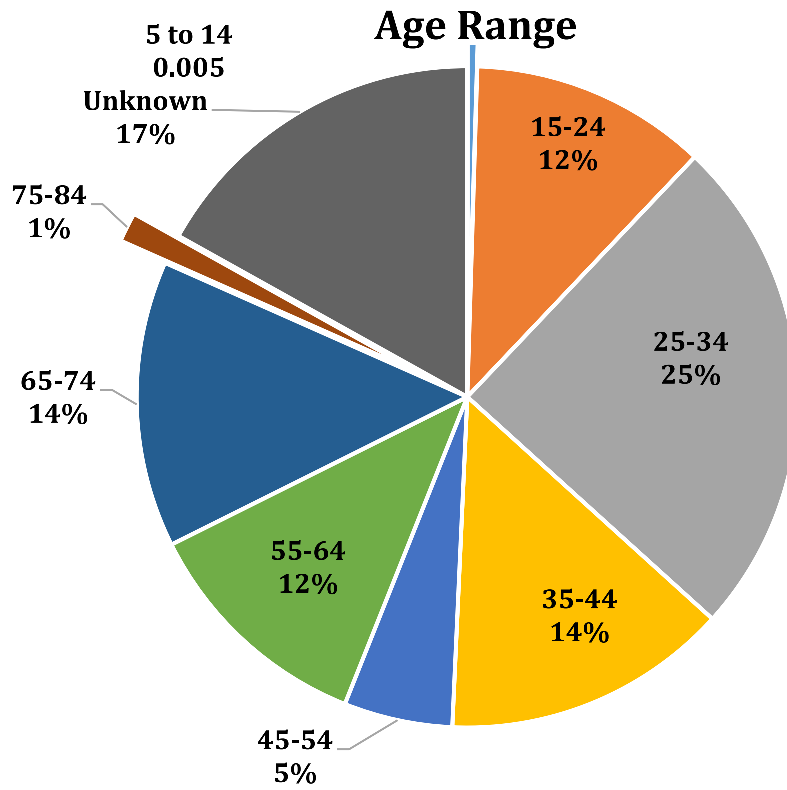
- The YSM team conducted regular meetings with PEI contributing counties throughout the year to provide technical assistance and resource navigation.
- The Directing Change Program received 1,242 videos submissions from 176 schools across California, engaging over 2,500 students.
- 34,154 parents were reached through Directing Change webinars and Facebook Live events.
- More than 13,250 youth, parents, and community members reached through Directing Change awareness activities created by youth and educators through mini grant funding to 31 schools.
- 8 monthly contests through the Directing Change Hope and Justice Category
    - "You Are Not Alone" (September 2021)
    - "Back to School: The Good, the Bad, and the Unexpected" (October 2021)
    - "Art of Gratitude" (November 2021)
    - "What are your hopes for 2022?" (December 2021/January 2022)
    - "#TakeAction4MH" (March 2022)
    - "Hope for Change" (April 2022)
    - "Dear Future Me" (May 2022)
- *Take Action for Mental Health* developed a new identity that included a brand toolkit, logo, collateral, resource materials, templates, and the launch of a new website
- *Take Action for Mental Health* developed and disseminated materials and information for the May is Mental Health Matters Month toolkit in English and Spanish which included (see following section for image examples and more data):
    - Social media posts
    - Social media calendar
    - Mirror clings
    - Scavenger Hunt
    - Web banners
    - Pens
    - Notepads
    - Green ribbons
    - Pocket cards
    - Resources
    - Eblasts
    - More!
- *Take Action for Mental Health* campaigns' 3 Earned Media Pushes (Take Action

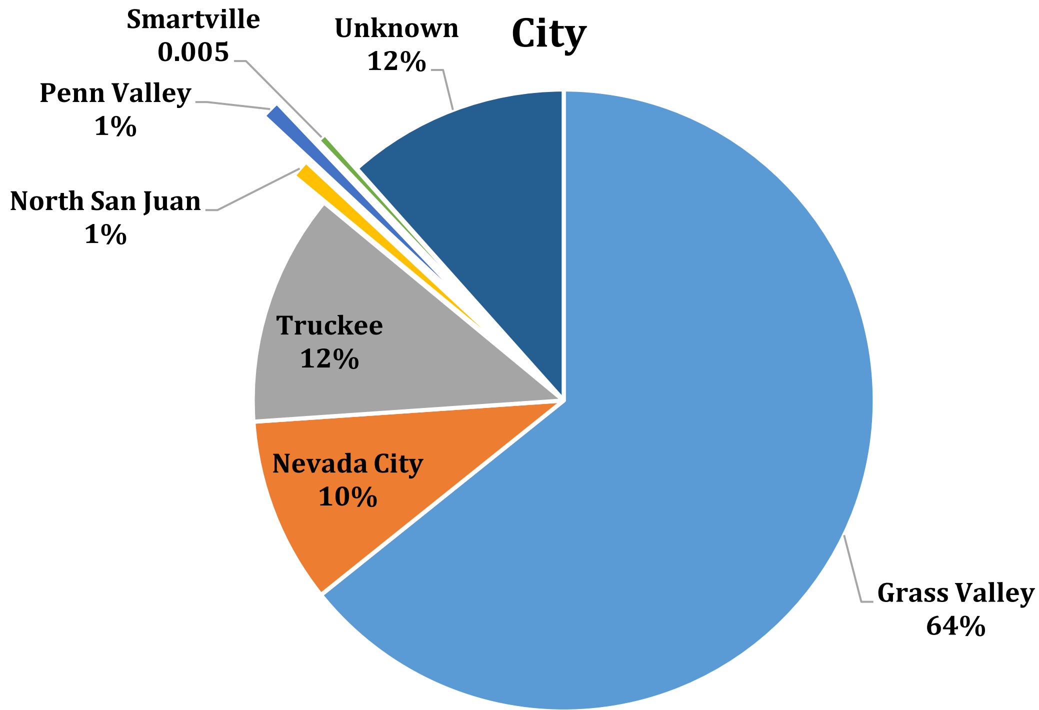
brand launch, Suicide Prevention, and Directing Change) included $1,619,529.47 total earned in media coverage as well as 32 articles that had coverage in 16 counties throughout California
- *Take Action for Mental Health* launched an Influencer campaign with *Queer Eye's* Karamo Brown which included 2 Take Action Action Facebook posts + Karamo's Instagram stories shared. This garnered 393,518 total impressions across the campaign and an ROI of $109.27 CPM
- *Take Action for Mental Health* campaign's social media platforms saw growth:
    - Facebook: +8% growth
    - Instagram: +14.6% growth
    - Twitter: +6.2% growth
- Take Action for Mental Health's Paid Media efforts generated over: 11 million impressions, 69,000 impressions, and 40,000 website clicks

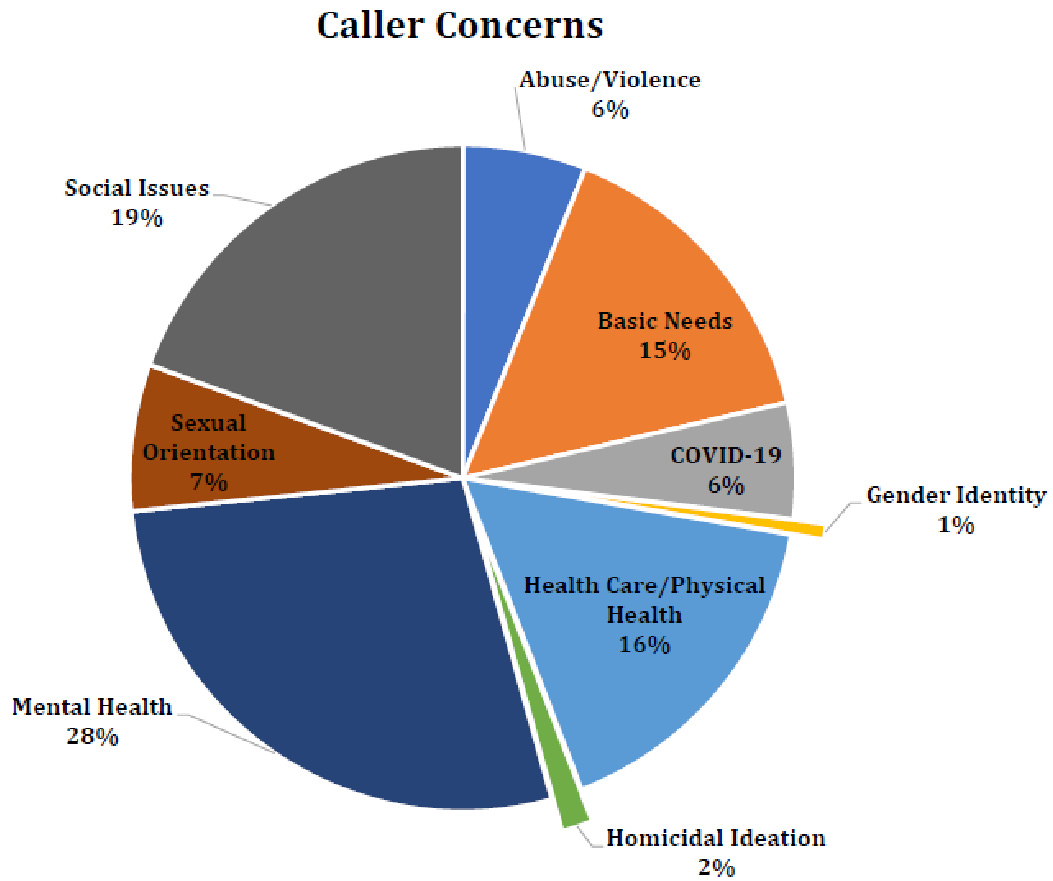
In FY 21/22, the North Valley Suicide Prevention Hotline addressed 134 crisis calls from Nevada County residents, including 26 moderate or higher lethality calls, 22 calls requiring follow up and 2 active rescue callers. Active Rescues are initiated to secure the immediate safety of a caller at risk if, in spite of the crisis line counselor's best efforts to engage the at-risk caller's cooperation, they remain unwilling and/or unable to take actions likely to prevent their suicide, or they remain at imminent risk/danger to themselves or others. In addition to incoming calls, 73 outgoing follow-up calls were placed. Of Nevada County callers, 35% identified as male, 49% as female, and 16% were unknown.

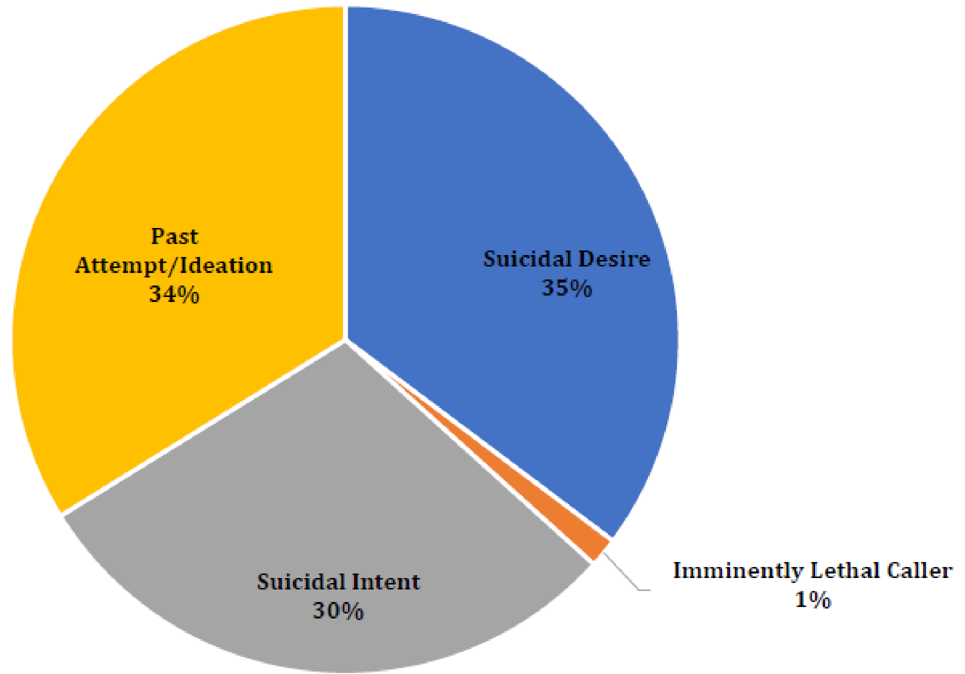



Suicidal Call Content
Imminently Lethal Caller 1%
Suicidal Intent 18%
Past Attempt/Ideation 45%
Suicidal Desire 36%


Age Range
5 to 14 0.005
Unknown 17%
15-24 12%
75-84 1%
25-34 25%
65-74 14%
55-64 12%
35-44 14%
45-54 5%


City
Smartville
0.005
Unknown
12%
Penn Valley
1%
North San Juan
1%
Truckee
12%
Nevada City
10%
Grass Valley
64%


Caller Concerns
Abuse/Violence
6%
Social Issues
19%
Basic Needs
15%
Sexual Orientation
7%
COVID-19
6%
Gender Identity
1%
Health Care/Physical Health
16%
Mental Health
28%
Homicidal Ideation
2%


Suicidal Content
Past
Attempt/Ideation
34%
Suicidal Desire
35%
Suicidal Intent
30%
Imminently Lethal Caller
1%

Innovation Project Name: Homeless Outreach and Medical Engagement (HOME) Team

NEVADA COUNTY BEHAVIORAL HEALTH (NCBH), HOSPITALITY HOUSE, TURNING POINT COMMUNITY PROGRAMS & ADVOCATES FOR MENTALLY ILL HOUSING (AMI)

Program Description

Program Overview

The Homeless Outreach and Medical Engagement (HOME) Team includes a Nurse, a Personal Services Coordinator, and a Peer Specialist to identify physical health, mental health, and substance use disorder needs in a welcoming and destigmatizing manner. The HOME Team meets with individuals who are experiencing chronic homelessness at locations in the community where they are living. The Team employs strategies directed at the specific needs of Nevada County community members struggling with chronic homelessness. The Team engages people through:

- Providing physical health care services first, which is a less stigmatized form of care than substance use or mental health services.
- Embedding a Peer with lived experience in the team who is able to address issues of mistrust in this population.
- Offering low-barrier, housing-first options that do not require sobriety or service engagement for entrance.
- Creating a close connection with the County jail and law enforcement staff so that people who are arrested or incarcerated are quickly offered services and housing.

Target Population

Chronically Homeless residents of Nevada County.

Evaluation Activities and Outcomes

Demographics were collected for 192 of the 222 unduplicated individuals served by this program in FY 21/22.

HOME Team Client Engagement:

- 222 unduplicated individuals were engaged by the HOME Team. Engagement includes linkages and service connections and limited case management. This exceeds the target goal of 150 individuals engaged per year.
- 63 SPARS Intakes Completed. This refers to individuals who have completed an intake through the Substance Abuse and Mental Health Services Administration's Performance Accountability and Reporting System (SPARS).

- 108 unduplicated individuals received Intensive Case Management (ICM) services. This is the cumulative number of individuals who have completed a SPARS intake and are considered "intensively case managed" by the HOME Team during the fiscal year.
- 196 individuals received medical engagement from the Team Nurse.
- 30 unduplicated individuals completed assessments for substance use disorders (SUD) with the goal of placement in appropriate SUD services.
- 29 unduplicated individuals were placed in inpatient and/or outpatient SUD treatment programs.
- 10 Mental Health Assessments were completed through Nevada County Behavioral Health (NCBH).
- 8 connected to Behavioral Health Services.

Housing Data:
38 individuals obtained housing during the reporting period. Of those 38 individuals, 22 obtained permanent housing and 16 were placed in transitional housing.

HOME Team Services: A total of 2,487 services were provided to 222 unduplicated individuals in FY 21/22. A breakdown of the services provided is listed below:

Service Provided	Count
Case/Care Management	906
Local Automobile Transportation	494
Relationship Development Intervention	242
Local Bus Fare	131
Meals	87
Clothing	81
Housing Search Assistance	78
Gas Money	75
Housing Counseling	70
Food Banks/Food Distribution Warehouses	52
Crisis Intervention	45
Benefits Assistance	33
Long Distance Transportation	26
Health Care Referrals	16
Street Outreach Programs	15
Personal/Grooming Supplies	14
Gift Card Donation Programs	13
Homeless Motel Vouchers	12
Private Mail Services	9
Substance Use Disorder Services	9
Identification Card Fee Payment Assistance	7
Emergency Shelter	6
Pet Food	5

Employment Preparation	5
Automotive Repair and Maintenance	5
Driver License Fee Payment Assistance	5
Medical Equipment/Supplies	5
Medical Information Services	5
Mental Health Support Services	5
Rent Payment Assistance	4
Supportive Housing Placement/Referral	4
General Medical Care	3
SSI Applications	3
Long Distance Bus Fare	3
Outreach Programs	3
Gift Card Distribution Programs	2
Emergency Medical Care	1
Cell Phones	1
Mental Health Evaluation	1
State Government Agencies/Departments	1
Cell Phone Donation Programs	1
Bus Fare	1
Pet Boarding/Sitting Services	1
Movers	1
Landlord/Tenant Dispute Resolution	1
Grand Total	**2487**

Referrals: The HOME Team program made 399 referrals to 105 unduplicated individuals. Of those referrals 318 (80%) were accepted. The number of referrals excludes referrals made by the HOME Team Nurse. Nursing referrals are denoted under the "HOME Team Medical Engagement" section of the report. See referral breakdown by provider/agency name and need type below:

The top needs/reasons for referrals are listed below:

Need Type of Referral	Count
Substance Use Disorder Services	87
Emergency Shelter	60
Assessment for Substance Use Disorders	60
Housing Search Assistance	23
Mental Health Evaluation	20
Supportive Housing Placement/Referral	18
Housing Counseling	18
Crisis Intervention	15
Case/Care Management	13
Food Banks/Food Distribution Warehouses	13

Benefits Assistance	11
Health Care Referrals	11
Rent Payment Assistance	9
Mental Health Support Services	8
Street Outreach Programs	5
Homeless Motel Vouchers	5
General Medical Care	3
Emergency Medical Care	3
Rental Deposit Assistance	2
Social Security Disability Insurance Applications	2
Clothing	2
Medical Equipment/Supplies	1
Gas Money	1
Automotive Repair and Maintenance	1
Mental Health Care Facilities	1
Local Bus Fare	1
Dentures	1
Banking Services Information and Support	1
Local Automobile Transportation	1
Medical Information Services	1
Pet Food	1
Employment Preparation	1
Grand Total	**399**

The list of agencies individuals were referred to is below:

Referred To- Provider Name	Count
Nevada County Behavioral Health	101
Granite Wellness (Formerly CoRR)	52
Utah's Place (FHH)	40
Alcoholics/Narcotics Anonymous	26
Common Goals, Inc.	21
Freed	21
Referral Provider	15
AMI Housing, Inc.	14
Sierra Roots	12
Interfaith Food Ministry	12
Community Beyond Violence	10
Foothill House of Hospitality (FHH)	10
Nevada County Dept. of Social Services	9

Crisis Stabilization Unit	9
Chapa De	9
Sierra Nevada Memorial Hospital	8
Veteran Services Referral	6
Coordinated Entry	3
Home Team (FHH)	3
Mental Health Referral	2
AEGIS	2
ARGP Services Only (FHH)	2
Social Security	2
Regional Housing Authority of Sutter and Nevada Counties	1
CalWORKS HSP - Nevada (AMIH)	1
Bridges 2 Housing (AMIH)	1
Food Bank Referral	1
Odyssey House	1
Pathways Recovery	1
Law Enforcement	1
Pet Program (FHH)	1
Emergency Shelter (CBV)	1
Insight Respite	1
Grand Total	**399**

Exit Data:
A total of 64 individuals were exited from the HOME Team Intensive Case Management program in the Homeless Management Information System (HMIS) during the reporting period. Of those exited:

- 24 exited to positive housing destinations
- 22 exited to temporary housing destinations
- 10 exited to institutional settings (including SUD/Detox centers, jail or detention facility, psychiatric facilities, or skilled nursing placement)
- 8 exited to "other" destinations

HOME Team Medical Engagement:
During the reporting period the HOME Team Nurse provided intensive medical engagement services to HOME Team participants. She provided additional support to individuals who are unhoused and support staff by providing COVID screening, testing, and vaccines to individuals throughout the year. Additionally, she continued to see an influx and need of women experiencing pregnancy with high case management and medical needs. Some grant year accomplishments by the HOME Team Nurse are as follows:

- 196 unduplicated individuals received Medical Engagement from the Nurse. For those who received medical engagement services:

- 710 individual face-to-face client contacts were made
- The average number of contacts per induvial was 8
- Each client contact was an average of 50 minutes
- Total of 528 hours spent performing direct face to face medical services to clients.
- 181 referrals for services were made and provided warm hand off by the HWT Nurse.

The primary medical need for each medical encounter was tracked and is reported below.

Primary Med Need	Count
Other	379
Wound Care	76
Cancer	39
Medication Outreach	50
Chronic Pain	54
Pregnancy	35
Hypertension	39
Cardiovascular Disease	15
SUD Assessment	14
Stroke	1
Diabetes	5
Asthma	1
Total	**708**

The HOME Team Nurse made a total of 181 referrals in addition to the referrals made by the team's Outreach Workers. The referrals made by the nurse are as follows:

Referral	Count
Rest and Recovery Prevention Program	43
Primary Medical Care	38
Hospitality House	28
Children's Medical and Family Support Services	19
Housing Resources	15
Cal Works	6
CSU	6
Nevada County Behavioral Health	6
HOME Team	5
LHI testing site	3
211	2
FREED	2
Adult Protective Services	1

IHSS Office	1
Insite Respite	1
Jail Medical Psych call	1
Medi-Cal	1
Mobile Crisis Unit	1
Moving Beyond Depression Community Psych	1
Nevada County Public Health	1
Total	**181**

Emergency Room (ER) recidivism data was collected on the 24 individuals who received the highest number of contacts by the nurse. These individuals had participated in services with the HOME Team Nurse for long enough of a duration to analyze data collected for six months prior to working with the nurse and six months following working with the nurse. These 24 individuals accounted for a total of 378 individual contacts over an average span of 212 days receiving services from the nurse. The average number of contacts with each of these 24 individuals was 16 contacts and they worked with the nurse for an average duration of 212 days from intake to discharge. 7 of the 24 individuals had an overall reduction in ER visits, 9 individuals showed no change, and 8 individuals had an increase of ER visits. Of the indidividual who showed an increase of ER visits, 3 were terminally ill, 1 was transferred out of county for services, and 1 was pregnant. These conditions/circumstances accounted for the increase in ER visits.

Emergency Room Recidivism Data				
# of Clients	Average # of Contacts	Average Duration of Services	# of ER Visits Pre-Intervention	# of ER Visits Post Intervention
24	16 contacts	212 days	37	39

Challenges, Solutions, and Upcoming Changes

- **Increase in Families Served-** The HOME Team saw an increase in the number of families and pregnant mothers served over the past report period. This shift meant the need for new and strengthened collaborations with agencies who specialize in serving families and children.

- **Shift to ECM services through the CalAIM Initiative-** As the county plans and shifts for sustainable options for the HOME Team, CalAIM funding has been utilized to expand the number of staff serving the grant's target population. This shift has come with its own set of challenges including determining the delineation of clients between the funding sources for the

purposes of tracking and reporting outcomes, tracking funding, and preventing duplication of services. Despite the challenges during the transitional period, the county hopes to continue to work to find sustainable options to provided services to the target population.

- **Staffing**- The HOME Team saw an influx of staffing through the reporting period. When positions were vacated, they were able to be filled, but staff often moved on to different positions within the community. Having vacant positions and needing to onboard new staff impacted direct client services due to limited team capacity. The HWT Nurse (MHSA Innovation funded) shifted to primarily providing services under the CalAIM Enhanced Care Management Team. While the ECM Team worked collaboratively with the HWT Team, this created an additional need for collaboration and communication to meet the needs of individuals being served by both teams.

- **Housing:** A key challenge in successfully housing program participants has been low housing inventory within the county. The County, the local Continuum of Care organization, and cities in Nevada County are actively working to address the affordable housing crisis that is facing, not just Nevada County, but the entire state of California.

  Nevada County was awarded Project HomeKey Funding and purchased and renovated a local hotel to provide an additional 22 units of permanent housing for local residents who are experiencing homelessness and need support with their mental health and/or substance use concerns.

  In addition to Project HomeKey, Nevada County has four new affordable housing projects:
    - The Brunswick Commons project in Grass Valley provides 28-units of low-income housing (rent set at 30% of Nevada County's average median income) and 12-units of Permanent Supportive Housing (PSH) for chronically homeless individuals with severe mental illness who are receiving supportive services from the County's Department of Behavioral Health. This housing is scheduled to be move in ready in the summer of 2022.
    - The Cashin's Field project in Nevada City aims to create a community setting by providing the local workforce with 56 affordable long-term apartments. This housing is scheduled to become available in the spring of 2023.
    - The Lone Oak Senior Apartments in Penn Valley brought 31 new units of affordable senior housing, in the 2021. The project houses low-income seniors earning between 30-60% of the median income for Nevada County.
    - With No Place Like Home funding, Nevada County is working to remodel an existing county facility to double the units count at that facility from three to six units. These units will continue to serve as housing for Permanent Supportive Housing (PSH) for chronically homeless individuals with severe mental illness who are receiving supportive services from the County's Department of Behavioral Health. This final plan was approved by the Nevada County Board of Supervisors in early 2023 and will begin renovations.

Additionally, SAMHSA-GBHI carryover funds used for housing supports were utilized both to help individuals obtain permanent housing in these new housing units, and to house individuals in

motels long term while they stabilized and waited for other housing opportunities to come online. The ability for the HOME Team to quickly use housing support funds demonstrated the need for expanded and sustainable temporary housing options for the target population.

Program Participant Story

The HOME Team began working with an individual who has mental health and substance use concerns and has been chronically homeless. They were able to build rapport with the individual and work collaboratively to set goals of becoming housing ready, gathering and storing supporting documents, gaining employment, and establishing a primary care provider to address their medical needs. Over the course of the HWT working with the individual they were connected to Insight Respite Center after leaving Hospitality House homeless shelter. They connected to NCBH for therapy and with AHMI housing for potential bridge housing. The individual was also connected with Western Sierra Medical Clinic (WSMC) to address their medical needs. The individual left the Crisis Stabilization Unit (CSU) and was placed straight into Insight Respite. They were able to attend an in person interview to be placed into the Purdon House for up to 90 days with the placement at Sierra Guest Home. Client has connected with WSMC to establish a Primary Care Physician. During the course of working toward and meeting their goals the individual stated, "This is the happiest and safest I have felt in years. I feel like I actually can be productive and I appreciate all the support".

Workforce Education and Training (WET)

NEVADA COUNTY BEHAVIORAL HEALTH
Intern Supervision

Program Description

Program Overview

In FY 21/22 WET resources added service capacity in Nevada County by funding clinical supervision of behavioral health interns. In FY 21/22, 804 hours of intern supervision were funded by this source, including 612 hours to Children's Behavioral Intern Supervision and 192 hours to Adult Behavioral Health Intern Supervision.