Nevada County

Mental Health Services Act

FY 2018/2019 Annual Update

Three Year Program and Expenditure Plan

And

Annual Progress Report
FY 2016/2017

March 2018

Nevada County
Mental Health Services Act Plan Update for FY 2018/2019
&
Annual Progress Report for FY 2016/2017

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MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Nevada County

☐ Three-Year Program and Expenditure Plan
☑ Annual Update

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

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

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on May 22, 2018.

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

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

Phebe Bell, MSW _____ _____
Interim Local Mental Health Director (PRINT) Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Nevada County

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

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

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

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

Phebe Bell, MSW

_____ _____

Interim Local Mental Health Director (PRINT) Signature Date

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

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

Marcia L. Salter

_____ _____

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

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

FY 2018/19 Mental Health Services Act Annual Update

EXHIBIT C

Funding Summary

County: Nevada

Date: 3/20/18

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,086,008	1,231,817	819,105			
2. Estimated New FY 2018/19 Funding	3,704,163	926,041	243,695			
3. Transfer in FY 2018/19[a/]	(14,200)					14,200
4. Access Local Prudent Reserve in FY 2018/19						0
5. Estimated Available Funding for FY 2018/19	5,775,971	2,157,858	1,062,800	0	0	
B. Estimated FY 2018/19 MHSA Expenditures	4,335,000	1,412,100	75,000		0	
G. Estimated FY 2018/19 Unspent Fund Balance	1,440,971	745,758	987,800	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	1,129,150
2. Contributions to the Local Prudent Reserve in FY 2018/19	14,200
3. Distributions from the Local Prudent Reserve in FY 2018/19	0
4. Estimated Local Prudent Reserve Balance on June 30, 2019	1,143,350

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

FY 2018/19 Mental Health Services Act Annual Update **EXHIBIT C**

Community Services and Supports (CSS) Funding

County: Nevada Date: 3/20/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Wraparound	1,605,000	370,000	680,000	0	550,000	5,000
2. Assertive Community Treatment (ACT)	3,085,000	1,650,000	1,315,000	120,000	0	0
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. General System Development	4,159,999	1,600,000	1,880,000	95,000	575,000	10,000
2. Outreach and Engagement	175,000	175,000	0	0	0	0
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	540,000	540,000	0	0	0	0
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,564,999	4,335,000	3,875,000	215,000	1,125,000	15,000
FSP Programs as Percent of Total	52.0%					

FY 2018/19 Mental Health Services Act Annual Update **EXHIBIT C**

Prevention and Early Intervention (PEI) Funding

County: Nevada Date: 3/20/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Senior, Disabled & Isolated Home Visitor	38,000	38,000	0	0	0	0
2. Wellness Center: Peer Support & Outreach	215,000	215,000	0	0	0	0
3. Child & Youth Mentoring	20,600	20,600	0	0	0	0
4. Teaching Pro-Social Skills in the Schools	45,000	45,000	0	0	0	0
5. Housing Assistance Program	122,500	72,500	50,000	0	0	0
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention	0					
11. Alternative EI for Youth & Young Adults	110,000	20,000	50,000	0	40,000	0
12. Homeless Outreach & Therapy	37,000	32,000	5,000	0	0	0
13. Bilingual Therapy	147,001	67,000	40,000	0	40,000	0
14. Early Intervention for Referred	372,500	182,500	50,000	0	100,000	40,000
PEI Programs - Early Intervention						
15. Access & Linkage	350,500	330,000	3,000	0	500	17,000
16. Outreach: First Responder Training	40,000	40,000	0	0	0	0
17. Stigma & Discrimination Reduction	76,500	76,500	0	0	0	0
18. Suicide Prevention	188,000	188,000	0	0	0	0
19.						
20.						
PEI Administration	75,000	75,000	0	0	0	0
PEI Assigned Funds	10,000	10,000				
Total PEI Program Estimated Expenditures	1,847,600	1,412,100	198,000	0	180,500	57,000

FY 2018/19 Mental Health Services Act Annual Update **EXHIBIT C**

Innovations (INN) Funding

County: Nevada Date: 3/20/18

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

FY 2018/19 Mental Health Services Act Annual Update **EXHIBIT C**

Workforce, Education and Training (WET) Funding

County: Nevada Date: 3/12/18

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

FY 2018/19 Mental Health Services Act Annual Update **EXHIBIT C**

Capital Facilities/Technological Needs (CFTN) Funding

County: Nevada Date: _____

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

FY 2018/19 ANNUAL UPDATE TO MHSA THREE-YEAR PROGRAM AND EXPENDITURE

COMMUNITY STAKEHOLDER PLANNING PROCESS AND LOCAL REVIEW PROCESS

County: Nevada **30-day Public Comment Period Dates:** April 3, 2018 to May 3, 2018

Date: March 30, 2018 **Date of Public Hearing:** May 11, 2018

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

Community Program Planning
1. A description of the local stakeholder process including date(s) of the meeting(s) and any other planning activities conducted. Description of how stakeholder involvement was meaningful.
In September 2005 a MHSA Steering Committee (SC) was formed to set priorities based on community input and to prepare a MHSA CSS (Community Services and Supports) proposal. This committee is still being utilized today for all of the MHSA components. The original SC was structured with a majority of consumers and family as members. The other members include various interest groups, community based organizations, service providers, and Nevada County Behavioral Health Department (NCBHD) staff. This committee worked on our plan through the use of meetings, work groups, and by e-mail. Today the MHSA SC meetings are attended by stakeholders from service providers, contract providers, program participant/family advocates, program participants, family members, County employees and interested community members. Any member of the public is welcome to attend any of the MHSA SC meetings and to provide input. Nevada County has employed subcommittees/ad hoc committees as needed to address specific needs. The Steering Committee had meetings on the following dates in FY 17/18: 9/21/2017, 10/30/17, 3/27/18 and 3/28/18. The MHSA Coordinator attended the Tahoe Truckee Community Collaborative 11/7/17 meeting to hear from youth on what the local strengths and gaps in services are and solutions, from the perspectives of youth. MHSA information is shared throughout the year with the Mental Health Board. The Mental Health Board meets the first Friday of each month, unless it falls on a holiday. If the meeting falls on a holiday it is either moved to another date or cancelled. The Recommendation of Needed Mental Health Services for FY 2017-2020 document was updated by the MHSA Steering Committee and supported by the Mental Health Board. The MHSA Coordinator, Behavioral Health staff, and MHSA contractors attend meetings to: 1. Educate the public about MHSA 2. Get community impute on program planning, implementation, evaluation and budgeting 3. To collaborate and coordinate program implementation 4. Share information about MHSA programs that are being implemented in the County

5. Share MHSA program outcomes
6. Learn about gaps and needs in the community

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

In FY 17/18 Nevada County collected demographic information from staff, contractors, and community members attending some of the above meetings. The results by Unduplicated Age were: 72% adults, 22% older adults and 6% decline to state. For Race the results were: 4% American Indian, 1% Asian, 1% Native, 89% White, 2% more than one race and 3% declined to state. For Ethnicity the results were: 5% Mexican, 2% other Hispanic, 1% Asian, 2% Eastern European, 38% European, 1% Filipino, 7% other Non-Hispanic, 15% declined to state, 24% unknown, and 5% more than one ethnicity. Primary Language results were: 88% English, 2% Spanish, 1% other language and 9% known. Sexual Orientation results were: 7% gay, 75% straight, 4% bisexual, 11% decline to state and 3% unknown. Gender results were: 19% male, 80% female, and 1% declined to state. The results for Gender Identity were: 18% male, 76% female, 5% declined to state and 1% unknown. Veteran Status results were: 4% served, 6% were family members, 84% did not serve, 2% declined to state and 4% were unknown. The Disability results were: 1% developmental/mental disabilities, 5% physical disabilities, 6% health disabilities, 4% had other disabilities, 72% had no disabilities, 4% declined to state and 8% unknown. The results for Affiliation (individuals could choose more than one) were: 69% service providers, 16% support service staff, 9% family, 7% consumers, 4% peer, and 21% community members.

The Plan was posted for 30-day public review to the County Website.

After the plan is posted on the Website it is shared with e-mail lists of interested individuals. These lists contain approximately 180 individuals. These individuals range from family members, program participants, contractors, community based organizations, interested community members, law enforcement, school personnel, substance use service providers, and staff from varies departments within Nevada County. Included in this list are our area's major media outlets.

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

FY 2018/19 ANNUAL UPDATE TO MHSA THREE-YEAR PROGRAM AND EXPENDITURE

COMMUNITY STAKEHOLDER PLANNING PROCESS AND LOCAL REVIEW PROCESS

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

The 30-day review and comment period was April 3, 2018 to May 3, 2018 which served as the opportunity for the public to provide additional input to the MHSA Annual Update to the Three-Year Plan and Annual Progress Report for FY 2016/2017.

The MHSA Annual Plan Update and Annual Progress Report Public Hearing was held at our local Mental Health Board on May 11, 2018.

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

The stakeholders involved in the Community Program Planning Process included:

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

6. Nevada County Juvenile Hall
7. Nevada County Sheriffs' Department
8. Nevada County Health and Human Services Agency
9. Nevada County Public Health Department
10. Nevada County Superior Court Personnel
11. Nevada County Board of Supervisors
12. Nevada County Chief Executive Office Staff
13. Nevada County Public Defender
14. Nevada County District Attorney
15. Nevada County Department of Social Services
    a. CalWORKs
    b. Child Protective Services
    c. Adult Services
    d. Veterans Services Office
16. Nevada County Mental Health Board
17. Health Clinics/Hospitals
    a. Chapa-de Indian Clinic
    b. Sierra Family Medical Clinic
    c. Western Sierra Medical Clinic
    d. Sierra Nevada Memorial Hospital
18. Nevada County Superintendent of Schools
19. Grass Valley Police Chief
20. Nevada City Police Chief
21. State Department of Rehabilitation
22. Community Based Organizations
    a. Drug Free Nevada County
    b. Charis Youth Center
    c. Community Collaborative of Tahoe Truckee
    d. Northern Sierra Rural Health Network
    e. Touched by a Child Foundation
    f. San Juan Ridge Family Resource Center
    g. Community without Violence formally known as Domestic Violence & Sexual Assault Coalition (DVSAC)
    h. Sierra Nevada Children Services

Local Review Process

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

The Plan is posted to our County Website. Once the Plan is posted an email is sent out to our MHSA contact lists. These lists contain over 180 individuals. These individuals range from family members, program participants, contractors, community members and community based organizations to staff from varies

departments within Nevada County. Additionally, an email press release is sent to all of the major media outlets that serve Nevada County. During the 30-day comment period the Annual Plan Update and Annual Progress Report is an agenda item at all MHSA meetings. Hard copies are provided to SPIRIT Peer Empowerment Center, Turning Point Providence Center, in our lobby and to others who request it.

4. Summary and analysis of any substantive recommendations received during the 30-day public comment period. A description of substantive changes made to the proposed plan. The county should indicate if no substantive comments were received.

Pauli Halstead provided a suggestion to add property managers, landlords, and community volunteers as potential first responders under the First Responder Training Program. This information was added to page 39.

All other opinions, observations, viewpoints and requests that were received were provided to the Interim Behavior Health Director and Mental Health Services Act Coordinator and will not be used to change the proposed plan.

Nevada County Mental Health Services Act
FY 2018/2019
Annual Update to Three Year Program Plan

I. *General Nevada County Information:*

A. *General Nevada County Information:*

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

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

II. *Community Services and Supports (CSS)*

A. *Full Service Partnerships (FSP)*

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

a. Target Population

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

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

b. Children's System of Care Approach

The Children's FSP utilizes a Children's System of Care approach to serving these high-risk children and youth age 0-25. Seventeen-year-old transition age

youth can access this system and transition automatically to the adult supports and services, or remain on the Wraparound (WRAP) Team if that level of care is more appropriate for their specific developmental stage.

c. Services and Supports

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

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

d. Wraparound Treatment Teams

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

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

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

Nevada County has Wraparound service providers that support both the western and eastern parts of the county. The Wraparound service providers provide for and/or arrange for all necessary services as indicated by individual needs.

Substance use treatment is integrated within the context of overall services delivered by the Wraparound Team.

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

e. Latino Outreach

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

f. Peer and Family Support/Advocacy Services

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

g. Housing Services

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

TAY may be offered the full range of available Adult Residential Treatment programs, including board and care and rental subsidies for independent living expenses.

h. Employment and Pre-Employment Services

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

i. Out of County Placement of Program Participants

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

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

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

a. Target Population

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

b. Assertive Community Treatment (ACT)

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

c. Assertive Community Treatment (ACT) Team

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

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

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

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

d. Step Down ACT Team

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

e. Services and Supports

i. Adult FSP services and supports may include, but is not limited to:

- ♦ Peer/Family counseling

- ♦ Drop in services
- ♦ TAY support and peer counseling
- ♦ Assisted Outpatient Treatment or "Laura's Law": Engaging treatment resistive SMI individuals who may be involved with the criminal justice system. Unserved individuals must meet additional criteria for AOT as listed in W & I code 5345(a).
- ♦ Gay, lesbian and transgender peer services
- ♦ Psychiatric Services and/or non-psychiatric Network Provider services
- ♦ Rehabilitation, Case Management, and Care Coordination
- ♦ Integrated treatment for co-occurring disorders
- ♦ Outreach/engagement services to homeless
- ♦ Peer Supportive Services – Peer driven and staffed empowerment center focused on the SMI individual.
- ♦ Housing and employment support
- ♦ Veteran services
- ♦ "Whatever it takes" services

f. Assisted Outpatient Treatment

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

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

The goal of Nevada County's ACT Team is to provide access to evidenced based practices, improve services, and increase services to unserved and underserved individuals. Individuals referred by the courts under AOT have not benefited or utilized conventional treatment approaches. Nevada County values consumer choice and individual responsibility, and will not discriminate enrollment in this full service partnership based on legal status. Individuals who are conserved, on probation, on parole, or committed under AOT will be welcomed into the voluntary array of services provided by the ACT Team in an unlocked setting.

g. Housing Support

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

h. Employment Services

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

i. Out of County Placement

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

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

j. Peer and Family Support/Advocacy Services

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

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

B. *General System Development*

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

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

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

4. **Expand Mental Health Treatment, Case Management and Outreach and Engagement Services in North San Juan** (funded by either or both plans).

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

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

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

7. **Expand Crisis and Mobile Crisis Intervention Services includes Respite Care, Crisis Stabilization Unit, and Crisis Residential facility.**
   a. Expand the **number and work location of crisis workers**.
   b. Expand **Crisis Intervention Services** which may include mobile crisis services (funded by either or both Plans). Crisis Intervention Services is being provided to the members of community in a limited capacity with the hopes of expanding when funds are available. Whenever necessary and practical, this response is coordinated with law enforcement, responding as a team to mental health crisis in the community. The goal is to deliver a more effective, appropriate, and rapid response at the start of a crisis episode and thus reduce trauma to the individual and the need for hospitalization or institutionalization. Ongoing specific training for mobile crisis intervention will be provided for participating law enforcement officers and crisis workers. Funds allotted to this service would allow the existing Crisis Service to expand its crisis worker response capacity.
   c. **Mental health stabilization services in Juvenile Hall** provide preventive interventions to individuals experiencing symptoms of serious mental illness. One-to-one interventions may provide enough support to stabilize or deescalate the emergent nature of a crisis situation and prevent an unnecessary hospitalization. These services are provided by or closely coordinated with the Wraparound Team and move toward providing for urgent services, on site in the community, 24 hours/day, 7 days/week.
   d. **Respite Care Facility**. Nevada County developed and opened a respite care facility in 2015. CSS funds may be utilized to support the day-to-day operations of the facility, staff and services provided.
   e. **Crisis Residential Care facility**. Nevada County has not developed a Crisis Residential Care facility, but the need is high.

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

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

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

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

9. Truckee Outreach, Engagement, and Liaison

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

10. Provide Services to Veterans and Their Family.

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

11. Provide Housing and Supportive Services to the Severely Mentally Ill Homeless

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

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

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

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

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

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

unit maintenance and upkeep, cooking, laundry, and money management); recreational and social activities; transportation planning and assistance for access to off-site services; educational services, including assessment, GED (General Education Diploma), school enrollment, assistance accessing higher education benefits and grants, and assistance in obtaining reasonable accommodations in the education process; and employment services, such as supported employment, job readiness, job skills training, job placement, and retention services, or programs promoting volunteer opportunities for those unable to work.

12. Training of Staff, Contactors, Community Stakeholders, Individuals with Lived Experience and Family Members

Provide education, training and workforce development programs and activities that contribute to developing and maintaining a culturally competent workforce, to include individuals with client and family member experience that are providing client- and family-driven services that promote wellness, recovery, and resiliency, leading to measurable, values-driven outcomes.

C. *Outreach and Engagement*

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

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

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

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

Training is available to Peer Support Staff and individuals that seek to empower themselves to work with their peers, media, potential employers, community agencies, community members, and family members. Participants learn how to, but not limited to:

- **a.** Provide Peer Support/Mentoring services
- **b.** Increase their life skills
- **c.** Use a computer or increase their computer skills
- **d.** Improve overall health/well being
- **e.** Access community resources

D. *Program Expenditures*

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

E. *Future Programs*

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

F. *CSS Program Costs and Cost per Person*

The estimated cost for CSS programs based on the number of individuals served in FY 16/17: 1) FSP programs is $2,020,000, 2) General System Development programs is $1,600,000, 3) Outreach and Engagement Programs and activities is $175,000, and 4) Administration cost is $540,000. The estimated total cost is $4,335,000. The average estimated cost per person involved in a CSS activity will be $302. This is the estimated cost of FSP, General System Development, Outreach and Engagement activities, and Administrative costs divided by the number of individuals served in FY 16/17 with CSS

funds (14,350). We estimate serving during a given year 428 children, 705 TAY, 1,696 adults, 541 older adults and 10,980 individual's ages may not be known.

Estimated Cost by Age by CSS Program:

Age	# Served in FSP	% of the Total	Est. FSP cost/age	# Served in GSD	% of the Total	Est. GSD cost/age	# Served in O&E	% of the Total	Est. O&E cost/age
Unknown Age	0	0	$0	10	0	$0	10,970	.94	$164,500
Children	134	.39	$787,800	293	.13	$208,000	1	0	$0
TAY	90	.26	$525,200	473	.21	$336,000	142	.01	$1,750
Adults	97	.28	$565,600	1,207	.52	$832,000	392	.03	$5,250
Older Adults	25	.07	$141,400	321	.14	$224,000	195	.02	$3,500
Total	346	1	$2,020,000	2,304	1	$1,600,000	11,700	1	$175,000

Note: These costs by age and CSS programs are only estimates, actual costs may vary greatly, and do not include County administration charges.

G. *Prudent Reserve*

NCBHD started to fund the Prudent Reserve with Unapproved FY 2005/2006 Estimate Funds in the amount of $158,857. In the Three Year Plan Update for FY 2008/2009 Nevada County directed $751,800 of FY 2006/2007 CSS Unapproved Planning Estimates into the Prudent Reserve. Additionally, in the FY 2008/2009 Three Year Plan Update Nevada County directed $118,493 of FY 2007/2008 CSS Unapproved Planning Estimates to the Prudent Reserve for a total of $870,293. Lastly, NCBHD requested to have FY 2007/2008 PEI Unspent Funds of $100,000 to be directed to the Prudent Reserve. In FY 18/19 $14,200 will be transferred into the Prudent Reserve from CSS. This latest transfer will bring the total amount Nevada County has dedicated to the Prudent Reserve is $1,143,350.

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

H. *MHSA CSS Administration*

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

administrative cost in the original CSS plan and subsequent Updates are applicable expenses.

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

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

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

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

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

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

III. *Prevention and Early Intervention (PEI)*

A. *PEI Project Name: Early Intervention Programs*

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

a. Identification of the Target Population:

i. **Demographics:** Youth age 8-15, transitional age youth 16-25. Services will be provided to all gender and sexual orientation. Services are provided in Eastern and Western Nevada County. Program participants will be referred to as youth in this section.

ii. **Mental illness for which there is early onset:** Services will be provided for mental illness that is presented, including serious emotional disturbance, depression, anxiety, self-harm, suicidality, bi-polar disorder.

iii. **Brief description of how each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began. Program referrals typically come from families, school psychologists or therapists in the community.

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

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

participants make and connect to their community. The therapeutic guides-to-youth participants are 1-3.

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

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

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

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

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

i. Community Collaboration: Staff work closely with family members, school counselors and psychologists, private referring therapists, Family Resource Centers, and County behavioral health staff. Staff provides case management support when program participants are engaged with a multi-agency teams.

ii. Cultural Competence: The program and staff are completely youth focused. Staff have extensive experience working in alternative education settings, providing adventure activities and creative expression opportunities for young people. The program hires passionate, vibrant, embodied people who prior to their therapeutic work, came from the fields of education, ski coaching, youth development. Youth respond to staff authenticity and that staff truly respect and value who they are. The program has success in working with youth from the Latino Community, Latino therapeutic guides have been hired who also assist other staff who are working with Latino families. In addition, the program is part of a cohort of grantees from Youth Outside, which is working to increase Cultural Competence, equity and inclusion amongst outdoor education leadership to better serve youth of color. The director and key staff are involved in extensive trainings to improve these skills in Cultural Competence.

iii. Program Participant Driven: Youth program participants choose to participate in treatment programs; in most cases they report greater satisfaction in services, and greater and easier access to service provider

personnel than is found in traditional treatment systems. Youth program participants participate in the development of treatment plans and program evaluations.

iv. **Family Driven:** The program staff works closely with program participant families. In a Wraparound setting the therapeutic guides participate in Family Team Meetings. Families are usually involved in the development of treatment plans.

v. **Wellness, Recovery, and Resilience Focused:** The core concept of the treatment methods, within the framework of longer session times, creates the likelihood for an increase in wellness, recovery and resilience for program participants. Program staff are able to build a relationship, creating the space and conditions for the likelihood of increased self-awareness to develop, leading to behavioral change. Improvements in exercise habits, diet, reductions in reactivity and greater engagement with other resiliency building resources, are the hallmark of the program.

vi. **Integrated Service Experience for Program Participants and Their Families:** Services are integrated within the existing system of care, as well as school counselors, psychologists, teachers and resource staff. The program staff stay in close contact with referring therapists and often provide support for program participants as they access psychiatric care. Program staff help program participants navigate to other resources as needed.

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

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

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

i. Explain how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory: The program provides an increased session time, the relationship that is formed between therapeutic guides and program participant youths, and the self-efficacy building focus of the treatment methods, help

program participants understand their symptoms in a broader and more supportive context, thus reducing their feelings and fears of stigmatization. Staff have a lot of experience in working with youth with a wide range of backgrounds, ethnicities, and sexual and gender orientations, staff members are very sensitive and supportive of all youth and their families.

j. Estimate Number of Children, Transition Age Youth, Adults and Seniors Served Per Year- 12 youth and their families will be served per year

k. The Estimated Cost Per Person: $1,667 ($20,000/12 youth) per program participant.

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2. **Project Name:** Bi-lingual Therapy

a. Identification of the Target Population:

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

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

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

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

d. Describe the MHSA negative outcomes that the program is expected to affect: Because the program sees all age groups and each person may have different needs, any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. It is anticipated that prolonged suffering will be decreased in all individuals served.

i. **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** Because the program sees all age groups and each person may have different needs, it is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.

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

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

i. **Community Collaboration:** This whole program is built on Community Collaboration. Multiple community based organizations, MHSA stakeholders, including program participants and their family are working together to provide a process that Spanish speaking individuals can receive therapy for needed mental health conditions.

ii. **Cultural Competence:** This program provides mental health treatment in the language of the individuals needing services. Therapist are collaborating and working with community based Promotoras. When mental health services are located at the County office Promotoras are bringing program participant's to the first appointments to ensure that they feel comfortable, and that a relationship is developed. Therapists are located at Family Resource Centers and schools, where individuals are already connected to and feel comfortable.

iii. **Program Participant Driven:** The program participant's chooses to participate in services and determines the treatment that they receive and participates in the creation of the Treatment Plan and the goals of the Treatment Plan. They determine if they want other family members to be involved in their treatment plan.

iv. **Family Driven:** Adults who want their spouse or other family members involved in their Treatment Plan are encouraged and supported to include them. Parents of children and youth have the primary decision-making role in the care of their children which includes determining the services and supports that would be most effective and helpful for their child(ren).

v. **Wellness, Recovery, and Resilience Focused:** The program utilized Promotoras to help support the individual who wants to get help for their mental health needs. The program reflects the cultural, ethnic, and racial

diversity of the population being served. The treatment services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. Each Treatment Plan is based on the individual's needs and goals.

vi. **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community based organizations, non-profits, and schools. Individuals and their families can enter the program from one of many doors. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

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

g. **The intended setting(s) and why the settings enhance access for specific, designated underserved populations:** This therapy occurs at the Behavioral Health Department, at the Family Resource Centers, schools, or at a location in the community that the individual chooses.

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

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

i. **Estimate Number of Children, Transition Age Youth, Adults and Seniors Served Per Year-** 27 individuals

j. **The Estimated Cost Per Person:** $2,481 ($67,000/27 individuals) per program participant

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

a. **Identification of the Target Population:**
   i. **Demographics:** Services in this program can be provided to children and youth of all ages: birth to 25. Services in this program can also be provided to pregnant women and postpartum women who have a child in the home under the age of five or gave birth within the last year.
   ii. **Mental illness or illness for which there is early onset:** Services will be provided for any mental illness that is presented that short term therapy is appropriate and that NCBHD or contracted agencies have the capacity to treat. This includes screening and assessing pregnant women and postpartum women for depression.
   iii. **Brief description of how each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began.

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

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

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

d. **Describe the MHSA negative outcomes that the program is expected to affect:** Because the program sees children, youth, pregnant and postpartum

woman and their families each person may have different needs, any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. It is anticipated that prolonged suffering will be decreased in all individuals served.

i. **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** Because the program sees all age groups and each person may have different needs, it is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.

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

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

i. **Community Collaboration:** The County is working with program participants, family members, schools, community based organizations and other service providers to plan and implement this program. Referrals for this program can come from any organization or individual that supports or serves the target population.

ii. **Cultural Competence:** The therapists are located out in the community and at the County. The Moving Beyond Depression program therapists provide services in the homes of the program participants. Spanish speaking participants are served through the Bi-lingual program and the Moving Beyond Depression program has hired a bi-lingual therapist. The County is creating a "no wrong door" approach to children and youth who are showing early signs of a mental illness.

iii. **Program Participant Driven:** The program participant chooses to participate in services and determines the treatment that they receive and participates in the creation of the Treatment Plan and the goals of the Treatment Plan. They determine if they want other family members to be involved in their treatment plan.

iv. **Family Driven:** Pregnant and postpartum women who want their spouse or other family members involved in their Treatment Plan are encouraged and supported to include them. Parents of children and youth have the primary decision-making role in the care of their children which includes determining the services and supports that would be most effective and helpful for their child(ren).

v. **Wellness, Recovery, and Resilience Focused:** The programs utilized therapist who have been trained to provide services to children, youth, pregnant and postpartum women to help support the individual who wants to get help for their mental health needs. The program reflects the

cultural, ethnic, and racial diversity of the population the program is serving. The treatment services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. Each Treatment Plan is based on the individual's needs and goals.

vi. **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community based organizations, non-profits, other County departments, service providers and schools. Individuals and their families can enter the program from one of many doors. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

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

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

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

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

therapy services in schools, in homes, and in the community. Lastly, the Behavioral Health Department hires Spanish speaking therapist in both their children's and adult programs when they have qualified applicants. Some contractors have also hired Spanish speaking therapist. Evaluation forms are provided in Spanish and English.

j. Estimate Number Served Per Year: 80 individuals

k. The Cost Per Person: $2,281 ($182,500/80 individuals) per program participant

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4. **Project Name:** Homeless Outreach and Therapy

a. Identification of the Target Population:

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

ii. Mental illness or illness for which there is early onset: Services will be provided for any mental illness that is presented that short term therapy and case management is appropriate and that the program has the capacity to treat.

iii. Brief description of how each participant's early onset of mental illness will be determined: All referred individuals and families are assessed and a treatment plan is created for individuals who receive treatment. Part of the assessment will be to ask the individual or their family members when the mental illness began.

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

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

c. The activities to be included in the program that are intended to bring about mental health and related functional outcomes: The activities in this program are to hire, train and supervise a therapist, case manager and outreach workers to conduct outreach and engagement services, assessments, therapy and referrals to homeless individuals out in the community and at Hospitality House. Some of the duties/ positions are listed here and in other PEI components: Prevention: HAP and Access and Linkage: Homeless Outreach.

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

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

d. Describe the MHSA negative outcomes that the program is expected to affect: Each homeless individual may have different needs, any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. It is anticipated that prolonged suffering will be decreased in all individuals served. It is anticipated that homelessness will decrease in some of the individuals served.

i. **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** Because the program sees all age groups and each person may have different needs, it is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.

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

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

i. **Community Collaboration:** The County is working with program participants, family members, schools, community based organizations and other service providers to plan and implement this program. Referrals for this program can come from any organization or individual that supports or serves the homeless population. Multiple organizations provide a variety of services depending on the need of the homeless individual.

ii. **Cultural Competence:** The program was planned and establish with the assistance of the homeless community. The Homeless Outreach Therapist's office is located at a homeless shelter. Case Managers and Outreach Worker goes to where the need is in the community.

iii. **Program Participant Driven:** The program participant chooses to participate in services and determines the treatment that they receive and participates in the creation of the Treatment Plan and the goals of the Treatment Plan. They determine if they want other family members to be involved in their treatment plan. Additionally, the program participants determine what other types of supportive serves they need to address their current needs and to help them move out of homelessness.

iv. **Family Driven:** Adults who want their spouse or other family members involved in their Treatment Plan are encouraged and supported to include them. Parents of children and youth have the primary decision-making role in the care of their children which includes determining the services and supports that would be most effective and helpful for their child(ren).

v. **Wellness, Recovery, and Resilience Focused:** The program utilizes a therapist who collaborates with a Homeless Outreach Care Coordinator to help support the individual who wants to get help for their mental health needs. The program reflects the cultural, ethnic, and racial diversity of the population being served. The treatment services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. Each Treatment Plan is based on the individual's needs and goals.

vi. **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community

based organizations, non-profits, other County departments, service providers and schools. Individuals and their families can enter the program from one of many avenues. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

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

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

h. Explain how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory: The Behavioral Health Department is collaborating and coordinating with other County departments, school based partners, and community based partners who serve the homeless population. The Department is training community partners to increase and improve their knowledge, skills and attitudes around mental illness, so that community members will refer homeless individuals to treatment services. The Behavior Health Department provides therapy and supportive services at their offices, Hospitality House Emergency shelter, and in the field. Evaluation forms are available in both English and Spanish.

i. Estimate Number of Children, Transition Age Youth, Adults and Seniors Served Per Year- 540 individuals

j. The Estimated Cost Per Person: $59 ($32,000/540 individuals) per program participant

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

1. **Program Name:** First Responder Training

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

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

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

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

ii. **Suicide Prevention Training:** The Suicide Prevention Intervention (SPI) Coordinator is working with the Suicide Prevention Task Force, Nevada County, schools, community based organizations, businesses, and service providers to bring training to the community to create a more "suicide aware community." Trainings occur out in the community at service provider sites, community meetings, schools, faith based community programs, health sites, etc. The trainings provided include, but is not limited to: Living Works, Mental Health First Aid, Know the Signs, and other evidence based curriculum as they become available.

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

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

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

i. **Community Collaboration:** The County is working with program participants, family members, schools, law enforcement, courts, faith based organizations, community based organizations and other service

providers to plan and implement this program. When trainings occur, consumers and family members are usually part of the trainings to provide consumer and family member perspective and feedback.

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

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

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

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

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

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

e. For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations. Trainings in general are not located at the Behavioral Health Department. The program is providing trainings in the community. Depending on who is being trained, the training is occurring at their organization or at a community meeting room. This is done to increase the number of individuals trained, to lesson transportation costs for the First Responders and to have the trainings where people are most comfortable.

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

g. An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory: Multiple different strategies are used depending on who the First Responders are:

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

h. Estimated number of Children, TAY, Adults, and Seniors to be served: 100 individuals will received First Responder training in the year

i. The Cost Per Person: $400 ($40,000/100 individuals) per program participant

C. *PEI Project Name: Prevention Programs*

1. **The Program Name:** Housing Assistance Program (HAP)

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

- **i. Participants' risk of a potentially serious mental illness:** Participants in this program have a higher than average risk of serious mental illness due to inadequate living environments. The mere fact of living on the streets is a traumatic event. The longer an individual/family is on the streets the more vulnerable they become to physical and mental health issues. Many homeless individuals/families do not have the resources readily available to receive physical/mental health services and this population has shown to be at an elevated risk of Emergency Room visits and/or hospital stays.
- **ii. How the risk of a potentially serious mental illness will be defined and determined:** The risk of a potentially serious mental illness will start to be determined through informal observations by program staff which may include: Outreach Workers, Monitors, Social Workers, Therapists, and/or Case Managers. In-house referrals will be made to on-site Therapist and volunteer (licensed) Behavioral Health workers within the organization. The program will also receive referrals from Turning Point, Nevada County Behavioral Health, Sierra Nevada Memorial Hospital (SNMH), Western Sierra Medical Clinic (WSMC), Chapa-De and other community medical providers. Program participants will be assessed using appropriate tools used for measuring and screening for mental health disorders.

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

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

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

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

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

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

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

ii. Increase protective factors/life skills, such as, but not limited to:
- ♦ Job training
- ♦ Resume creation
- ♦ Job searching
- ♦ Securing financial benefits the individual/family is entitled to receive
- ♦ Housing searching
- ♦ Family financing and budgeting skills

- ♦ Education/General Education Development (GED)
- ♦ Daily life skills
- ♦ Parenting skills

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

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

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

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

c. Specify any MHSA negative outcomes as a consequence of untreated mental illness that the program is expected to affect, including reduction of prolonged suffering. Without adequate treatment, the consequences of untreated mental health could include:

- **i.** Advance to more severe condition resulting from further decline in mental health
- **ii.** Lowered capacity to recognize physical health issues

iii. Increased urgent care/first responder/emergency room costs
iv. Increased use of resources- Fire Department, Emergency Medical Treatment, Law Enforcement, etc.
v. Increase crime
vi. Increased problems with tobacco, alcohol, and other drugs
vii. Missed work or school, or problems related to work or school
viii. Legal and/or financial problems
ix. Self-harm or harm to others
x. Weakened immune system leading to lower resistance to infections
xi. Heart disease/other medical conditions
xii. Poverty/Homelessness
xiii. Social isolation
xiv. Family conflicts
xv. Depression and fatigue
xvi. Abnormalities in areas of the brain, particularly areas associated with memory
xvii. Lack of impulse control
xviii. Fear and anxiety

d. List the mental health indicators that the County will use to measure reduction of prolonged suffering: A reduction of prolonged suffering may be measured through evidence of an increase in program participant's quality of life. This may include: a decrease in ER/Hospital stays, a decline of criminal activity, the ability to obtain housing and an income source, the ability to maintain stable housing and employment, improvement of personal relationships, etc. An evaluation tool will be created to measure increase in protective factors and/or a decrease in individual/family risk factors.

e. Explain the evaluation methodology, including how the evaluation will reflect cultural competence: Program participants will be given an assessment upon program entry. An onsite licensed behavioral health clinician along with the program participant will determine the needs of the program participant, along with identifying potential referrals, and case management service needs. Program participants will be provided with case management on a regular basis, and further behavioral health evaluations may be administered as needed. These evaluations may be conducted at the shelter, or in locations the individual feels most comfortable.

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

i. Community Collaboration: The Housing Assistance Program (HAP) will use every available resource and community partner to deliver services through referrals, agency collaboration and participation within the Continuum of Care (CoC) to End Homelessness.

ii. Cultural Competence: Program staff will employ and maintain the awareness and consciousness of personal reaction to those who are different, including staff members' own cultural bias and beliefs, so as to avoid incorporating those qualities in delivery of the program services.

iii. Program Participant Driven: The HAP will employ case management service that empowers program participants to participants in all services

delivered and to lead the process. A person-centered case plan approach that is consistent with the individual's culture and everyday lifestyle. Program personnel will be non-judgmental, recognizing that, with appropriate and adequate support, individuals living with chronic illnesses, behavioral health disorders and addictions are competent and capable of making life changes. Program participants will create their own goals and housing plans with the support of program staff.

iv. **Family Driven:** Program staff will assess the needs of the family as a whole, as well as the individual needs of each family member. Based on the needs assessment, staff in collaboration with the program participant will identify and prioritize support services that will enable the individual/family to obtain and remain in their home and/or community. The Case Manager will assure that the individuals and families have choice and control. A person-centered case plan approach will be consistent with the family's culture and everyday lifestyle. Staff will do the following to assist each individual within a family:

- ♦ Assess needs and desired outcomes of each individual
- ♦ Develop individual case plans with program participants, program participant's family, and community partners who will be chosen by the program participant to be part of the service team
- ♦ Provide or locate support services identified in the case plan which will meet the needs stated by the program participant
- ♦ Provide or connect the program participant/family with the requested services
- ♦ Coordinate support services with the family
- ♦ Meet regularly with the program participant to assess case plan progression
- ♦ Ensure that eligibility for funding stays current
- ♦ Advocate for needed support and services

v. **Wellness, Recovery, and Resilience Focused:** Staff will empower program participants by allowing them to develop their own case plan and will respect the choices made by youth/families/individuals in transition. In any case where family members are in need of education regarding an individual's disabilities, referrals to appropriate service providers or resources will be provided by the staff. HAP Staff will implement an assessment tool to identify and detect the presence of co-occurring substance/mental health issues and/or physical health issues to be referred to clinicians as deemed necessary, as well as continually informing program participants of their rights and responsibilities. Lastly, staff will be in collaboration with other service providers so as to ensure continuity of care.

vi. **Integrated Service Experiences for Program Participants and Their Families:** The HAP will partner with community providers to include support to stabilize housing, reduce hospitalizations and incarcerations, conduct risk assessments, provide 24/7 crisis, medication management services, agency referrals, counseling and group therapy, SSI and Medi-Cal advocacy, home visits and assistance with doctor appointments, and employment services referrals.

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

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

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

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

k. **Estimate Number Served Per Year:** 55 individuals

l. **The Cost Per Person:** $1,318 ($72,500/55 individuals) per program participant

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

a. **Identification of the target population for the specific program, including:**
   i. **Participants' risk of a potentially serious mental illness:** The participants in the program have a higher than average risk of a serious illness due to their age, disabilities, isolation and lack of services,

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

ii. **How the risk of a potentially serious mental illness will be defined and determined:** Screening and referrals for this population is being done by nurses, social workers, service providers, family members and program participants (self-referral). Home Visiting Nurses/Social Workers and/or Volunteers, and/or other health workers are screening for depression by using the Beck's Depression scale or a similar tool.

iii. **Demographics:** This program is available to all individuals in the County that are homebound due to age and/or disability. All age groups, racial, ethnic and cultural populations are served.

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

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

d. List the mental health indicators that the County will use to measure reduction of prolonged suffering: The BHD department will be looking to decrease depression and anxiety and to improve the quality of life in the target population of homebound due to age and/or disability. For the program volunteers the BHD is looking to see that the volunteer's quality of life is improved and that they feel more comfortable to talk directly about depression, anxiety, and depression to the individual they are supporting.

e. Explain the evaluation methodology, including how the evaluation will reflect cultural competence: The evaluations at a minimum will be done at program entry and annually and/or at program exit. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or have it read to them. The evaluation can be conducted in person, by mail or by phone.

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

i. **Community Collaboration:** This program is the results of multiple organizations working together with consumers and family members to bring services into the home of isolated elderly and/or disabled individuals. This program collaborates intimately with Home Visiting

nurses/social workers. Home visiting nurses/social workers are conducting a mental health screening with all individuals they visit along with physical health and fall prevention screening. The nurses/social workeres refer individuals that score high on the depression screening tool to physicians, mental health providers, community based organizations, family members and to the Home Visitor program.

ii. **Cultural Competence:** The program works to match volunteers with program participants that can connect at multiple levels, including at a cultural level.

iii. **Program Participant Driven*:*** The volunteers communicate and work with the program participants to determine when and how they want to interact and the activities to engage in.

iv. **Family Driven:** The volunteer includes family members, when appropriate, when planning and implementing program services.

v. **Wellness, Recovery, and Resilience Focused:** The volunteer services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. The volunteers bring hope to the program participants. The program participants have someone to look forward to seeing and to share their stories with. The volunteers connect the program participants with community events, activities and service providers.

vi. **Integrated Service Experiences for Program Participants and Their Families:** This program is the result of multiple organizations coordinating together to provide services in the home of isolated elderly and/or disabled individuals. Referrals from the community are received. Volunteers from the community are recruited**.** The volunteers also refer the program participants to community based organizations as appropriate. These referrals may include: SPIRIT Peer Empowerment Center, NAMI, Nevada County Behavioral Health Department, PEI SPI Coordinator, primary care physicians, and other appropriate staff contracted or hired with PEI funds

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

h. For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations: The setting for this program is elderly and/or disabled individual's homes. Because this population is isolated and have limited capacity or ability to drive or utilize public transportation, services are brought to them. Another reason this program is delivered in the home is because individuals in this population can be

so ill that it is not healthy for them to go out into the community for fear of picking up a communal infection.

i. **Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (g) and, if so, what outcomes(s) and how will it be measured, including timeframes for measurement.** Using a depression screening tool/survey program participants will be evaluated at intake and annually to monitor levels of depression and to determine reduction of prolonged suffers by measuring a reduction in risk factors, indicators, and/or increased protective factors that will lead to improved mental emotional, and relational functioning.

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

k. **Estimate Number Served Per Year:** 50 individuals

l. **The Cost Per Person:** $760 ($38,000/50 individuals) per program participant

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

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

a. **Identification of the target population for the specific program, including:**
   i. **Participants' risk of a potentially serious mental illness, either based on individual risk or membership in a group or population with greater than average risk of a serious mental illness:** Wellness Centers are for individuals with a mental illness that are seeking support from Peers and/or for individuals who are in crisis or having trouble with a life function (school, employment, relationship, housing, friends, family, drugs, law enforcement, mental health, etc**.).**

ii. **How the risk of a potentially serious mental illness will be defined and determined:** The program participants are utilizing the program on a voluntary basis. They want to improve in at least one domain of their life and are participating in the Wellness Center to engage in self-improving activities.

iii. **Demographics relevant to the intended target population for the specific program: T**he Wellness Center programs target individuals with mental health conditions and/or emerging mental health issues, and/or individuals who want to decrease the prolong suffering they are experiencing. The BHD currently have two Wellness Centers, one for adults 18 and over and one for high school students in the Tahoe Truckee area. These Wellness Centers are open to all individuals' regardless of race/ethnicity, gender, sexual orientation, language used and military status.

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

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

d. List the <u>mental health indicators</u> that the County will use to measure reduction of prolonged suffering and/or decrease in school failure or dropout: Because the program sees all age groups and each person may have different needs, it is anticipated that surveys will be used to measure the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program strategy, program participant and their specific goals and individual needs.

e. Explain the evaluation methodology, including, how the evaluation will reflect cultural competence: Depending on the program strategy evaluations will occur per community event/training or at program entry and annual and/or program exit. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or have it read to them.

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

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

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

The Adult Wellness Center provides Peer Support services, this may include, but is not limited to: one-on-one peer counseling, support groups, theme-specific peer support/self-help groups, outreach training to Peer Support staff and individuals

that seek to empower themselves and to help end the stigma of mental illness. Program participants may be unable or unwilling to access traditional services or cannot otherwise afford counseling or psychotherapy. These programs help to build skills, encourage and support individuals to seek mental health treatment. Peer Supporters refer and conduct warm handoffs to individuals seeking mental health treatment.

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

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

i. An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory: The strategies being used in this program that make it non-stigmatizing and non-discriminatory are:

- **i.** The program is located and delivered on school sites and in the community.
- **ii.** Youth and adults with mental health needs are involved in all aspects of the program-planning, implementation and evaluation.
- **iii.** Youth orientated organizations volunteer at school sites.
- **iv.** Wellness Centers welcome people to come as they are.

j. Estimate Number Served Per Year: 2,349 individuals

k. The Cost Per Person: $92 ($215,000/2,349 individuals) per program participant

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

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

i. Participants' risk of a potentially serious mental illness: Students/children at schools have a potential of serious mental illness for a variety of reasons:

- ♦ Exposed to violence at school
- ♦ Exposed to individuals who are not tolerant of differences,
- ♦ Some students are emotionally fragile,
- ♦ Bullying in the schools,
- ♦ Children with mental health issues who became the target of negative behavior**.**

ii. **How the risk of a potentially serious mental illness will be defined and determined:** For this program all children enrolled in preschool to high school have a potential for a serious mental illness.

iii. **Demographics:** Program participants will be all children and youth enrolled in a participating school/ preschool/ Child Care facility.

b. Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities: At community meetings people spoke about the need for more screening and services for children and youth. Many Nevada County residents told us in the meetings that they thought students in the schools should be educated about mental health, social skills and violence prevention. Most thought this should start at an early age and continue through their school years. They thought education about mental health would reduce stigma, decrease bullying and make it easier for children to learn in school. They were concerned that children were not tolerant of differences or students who were emotionally fragile and those children with mental health issues often became the target of bullying. The school administrators also voiced the above concerns. They said that they would like to include in their curriculum teaching social skills, emotional management, problem solving and cooperation. All hoped teaching pro-social skills would make the classroom a better place to learn and that the teachers would have to spend less time on discipline. It was also believed that if children were given the tools to handle conflict and emotions they would be less violence, see less violence and school disruption throughout the child's school life would decrease and the children would more likely succeed in school.

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

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

community as well as providers of other services. The SECOND STEP trainers train their teachers on accessing resources in the community.

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

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

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

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

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

- **i. Community Collaboration:** This program is being implemented in both the Tahoe-Truckee and the Nevada County school districts**.** School personnel are collaborating with Nevada County Behavioral Health Department and other service providers in the community.
- **ii. Cultural Competence:** Second Step kits are provided in English and Spanish. Teachers are utilizing kits and trainings that are appropriate for the age of the student.
- **iii. Program Participant Driven:** When a child or family requests or is identified as needing mental health services, the trainers' work with the family and refers these children and families to County Behavioral Health, community service provider or to a private sector service provider.
- **iv. Family Driven:** In Truckee "Parent Nights" are held to provide information and engage parents in supporting curriculum at home and Truckee started a Second Step Community blog so that parents would talk to each other and ask counselors questions.

v. **Wellness, Recovery, and Resilience Focused:** The Second Step Program provides age appropriated training to build protective factors in students across the school spectrum. The prevention programs support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. The Second Step program is designed to build protective factors in preschool to high school students so that students can have mental health wellbeing.

vi. **Integrated Service Experiences for Program Participant and Their Families*: :*** In the Tahoe-Truckee school district not only are the teachers and school councilors trained in Second Step, but paraprofessional staff, food service workers, bus drivers, office workers and other school staff are also trained on the concepts and vocabulary of Second Step. The whole culture of the school is in step with the program.

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

h. For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations. The setting for the Second Step program is preschool and schools. The setting enhances access to the program because all students are required to attend school. The students are learning the same protective factor skills from preschool to high school. And, the parents are reinforcing and continuing the education at home.

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

i. Training as many school personnel as funds will allow and parents that interact with the youth so that the lessons and skills being taught are uniform and consistent.

ii. All youth are being taught the same lessons, no children are singled out, all youth are learning together. This allows the youth to practice and use the skills that they have been taught.

j. Estimate of Number Served per Year: 1,722 individuals

k. The Cost Per Person: $26 ($45,000/1,722 individuals) per program participant

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5. **The Program Name:** Child and Youth Mentoring

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

i. Participants' risk of a potentially serious mental illness: The population served by the mentoring program will be youth that are at risk of failing or falling behind in school. These youth will be referred to the program by a parent, teacher, school counselor or community member.

These youth will have a risk factor occurring in their life that is or most likely will interfere with their ability to perform well in school.

ii. **How the risk of a potentially serious mental illness will be defined and determined:** Youth will be referred to the program by a parent, teacher, school counselor or community member. These youth will have a risk factor occurring in their life that is or most likely will interfere with their ability to perform well in school. This could be a trauma, illness, economic or social change that has occurred to the youth or their family that is affecting the child's ability to perform at school.

iii. **Demographics relevant to the intended target population for the specific program:** This program will be available to school age youth of all races and ethnicities.

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

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

d. List the mental health indicators that the County will use to measure reduction of prolonged suffering: The Children's Behavioral Health Department, community members, schools and mentoring agencies wanted to increase at risk youths school performance, create relationships with peers and parents/adults; decrease risky behaviors, and improve social-emotional competence.

e. Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence: Approaches to collect data may include but is not limited to: surveys, that may include, Strength of Relationship

at the beginning and end of the program year, interviews on an on-going basis with teachers, parents, mentor and mentees, screening tools and other program documents.

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

- **i. Community Collaboration:** The Mentoring project is a collaboration project between the schools, community based organizations, community-based service organizations and the Behavioral Health Department**.**
- **ii. Cultural Competence:** Each youth who is assigned a mentor is matched with an individual who has shared interests. These interests may be based on racial/ethnic, cultural or community interests.
- **iii. Program Participant Driven:** The youth receiving mentoring services get to decide who their mentor will be, what they will do during their mentoring time, and switch mentors if needed.
- **iv. Family Driven:** Family members provide information on the situation that the youth is going through, provides feedback on how the mentoring match is going, and provides recommendations on activities that may help their child.
- ***v.*** **Wellness, Recovery, and Resilience Focused:** Mentoring programs help to increase children's self-esteem, the sense of community and connectedness. School based mentoring works to reduce school absenteeism, gives young children a reason to attend school and a better chance to perform in school.
- **vi. Integrated Service Experiences for Program Participant and Their Families:** The Mentoring program is administered by a community based program at school sites**.** Youth who need additional support beyond mentoring services receive services from school staff, community service providers and community-based service providers.

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

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

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

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

j. Estimate Number Served Per Year: 21 children and 21 youth mentors

k. The Cost Per Person: $490 ($20,600/42 individuals) per program participant

D. *PEI Project Name: Access and Linkage to Treatment Programs*

1. **Program Name:** 211 Nevada County

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

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

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

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

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

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

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

- **i. Community Collaboration:** Establishing and maintaining a 211 system has been a community wide endeavor. Community members are collaboratively funding the program and all service providers have to communicate any changes to their program as they happen.
- **ii. Cultural Competence:** The 211 call center has access to many languages by being connected to a language service that has approximately one hundred and fifty different languages available. Caller's identification is kept confidential.
- **iii. Program Participant Driven:** Callers tell the 211 Referral Call Specialists what services they need. 211 Referral Call Specialists ask callers if they would like follow-up services or "warm-hand-off" services. The caller determines how many and the type of referrals they need.
- **iv. Family Driven:** It is common for family members that are trying to help out their loved ones to call 211. The 211 Referral Call Specialists will provide referrals based on the information received.
- ***v.* Wellness, Recovery, and Resilience Focused:** The 211 Call Center supports the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination by allowing callers to determine what they need referrals too and the amount of support they need.
- **vi. Integrated Service Experiences for Program Participant and Their Families:** Nevada County was the first rural county in California to have a 211 Call Center. Nevada County was able to do this due to all of the community based and community service providers working together to have one centralized location where people could go to receive referrals for services.

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

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

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

i. **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** Some of the strategies used are:
   - **i.** Centralized location- community only needs to call one number to get referrals for their service needs and service providers only need to communicate with one organization when they have a change of information.
   - **ii.** The service is available by phone or computer.
   - **iii.** The service is available 24/7, 365 days a year.
   - **iv.** The 211 call center has access to a language service that has approximately one hundred and fifty different languages available.

j. **Estimate Number Served Per Year:** 5,616 callers, with an additional 16,480 web searches conducted from unique IP addresses by individuals for whom no demographic information is available

k. **The Cost Per Person:** $3.56 ($20,000/5,616 callers) per call

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

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

b. Explain how individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention program: Individuals for the program may self-refer, be referred by a family member, service provider, community member, at special events, and program staff will outreach and engage specific subpopulations. Examples:

- **i.** A Forensic Liaison is trained and working with jail, law enforcement personal, community members and family members. When the jail has an inmate who is going to be released from the jail and there is concerned about the mental health of the individual the Forensic Liaison will go to the jail and build a relationship with the individual and assess them for what level of service they will need upon release.
- **ii.** For the homeless population program staff works with homeless individuals and families at homeless camps, at shelters and food giveaways.
- **iii.** For the senior, disabled, and isolated population Nurses/Social Workers or other trained individuals go to the homes of these individuals and utilizing a depression screening tool along with other physical health and fall prevention screening tools.
- **iv.** For Veterans the Veteran Services Office staff is connecting with veterans that come into their office and may not be eligible to Veteran's benefits or need to travel so far to receive services that they cannot obtain them.
- **v.** For youth a screening program has been developed that occurs at all of the local public high schools. The screening occurs on all youth that signed a permission slip along with their parents. The target population is youth in the 9^{th} and 10^{th} grade.

c. Explain how individuals, and, as applicable, their parents, caregivers, or other family members, will be linked to county mental health services, a primary care provider, or other mental health treatment.: Depending on the individual being screened and referred will depend on where they ae referred. Referrals can be done by email, program referral form, phone, fax and in person. Program staff members provide care coordination services to the individual and family. This service includes driving the person to their appointment(s), helping to arrange rides to appointments, and showing the individual how to utilize transportation through their medical care provider.

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

e. Indicate if the County intends to measure outcome(s): Each program will track:

- **i.** The number of referrals to treatment and the number of individuals who follow through on the referral and engage in treatment.
- **ii.** The duration of untreated mental illness of individuals who are referred to treatment and who have not previously received treatment.
- **iii.** The interval between the referral and engagement in treatment

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

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

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

h. For each program, the County shall indicate the intended setting(s): Each program is delivered in a setting that accommodates the program participants:

i. **Social Outreach-** provides services in the homes of seniors, disabled and isolated individuals.
ii. **Homeless Outreach Worker-**provides services at emergency shelters, food giveaway programs, on the streets, in parks, at homeless camps (homeless individuals homes), anywhere homeless individuals gather.
iii. **Forensic Liaison-**provides services in the jail, at homes, in the community, at county offices, schools, anywhere the program participant is comfortable at engaging in services.
iv. **Youth Outreach-** provides services at school sites.
v. **Veterans Outreach-**provides services at the Veterans Service Office, Veteran's Stand Down, community events, at community based organizations, schools, and at service providers organizations.

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

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

j. **Estimate Number Served Per Year:** 1,044 individuals

k. **The Cost Per Person:** $297 ($310,000/1,044 individuals) per program participant

E. *PEI Project Name: Stigma and Discrimination Reduction Programs*

1. The Program Name: Latino Outreach

a. **Identify whom the program intends to influence:** Nevada County will outreach and engage the Latino population.

b. **Specify the methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness and/or seeking mental health services:** Nevada County will serve the Latino population by expanding existing "Promotoras" programs. Nevada County has two small Promotoras programs in the Truckee and Grass Valley areas. Traditionally Promotoras are "community health workers" who are lay members of the community who usually share ethnicity, language,

socioeconomic status, and life experiences with the community members they serve. Promotoras in Nevada County are Spanish speaking bi-cultural and/or bi-lingual paraprofessionals who help Latino families connect to resources mostly for physical health care in the community. Promotoras offer interpretation and translation services, provide culturally appropriate physical health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individuals and community health needs. The BHD funds the Promotoras to expand the services they provide to include mental health education, support and advocacy. The Promotoras conduct outreach and conduct psycho-educational groups for Latino families in Spanish about mental health care. Psycho-education groups will educate people about mental health issues to decrease stigma about reaching out for help for mental health issues. By decreasing stigma about mental health conditions the program will promote, maintain, and improve individual and community mental health. Childcare may be offered at mental health education classes. In the Latino Outreach Project the Promotoras link individuals and families that they serve to needed services in the community which includes mental health services and when necessary accompany individuals to their first appointment for a warm handoff to the mental health professional.

c. Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:

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

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

i. Community Collaboration: This whole program is built on Community Collaboration. The Family Resource Centers, community based organizations, MHSA stakeholders, County government, representatives from the Latino community are working together to provide outreach, advocacy, support, education and training to the Spanish speaking individuals in the community so that mental health stigma to access and receive treatment is decreased.

ii. Cultural Competence: This program provides training, education, and support in the language of the individuals needing mental health services. Local bi-lingual and/or bi-cultural Promotoras are implementing the

program. When mental health services are located at the County office Promotoras are bringing program participant's to the first appointments to ensure that the program participant feels comfortable, and that a relationship is developed between the program participant and service provider. Therapists are located at Family Resource Centers where the target population are already connected too and feel comfortable.

iii. **Program Participant Driven:** The program has been developed with the input of the Latino population, they have influenced the way outreach, implementation and evaluation of the program is conducted.

iv. **Family Driven:** Parents of children and youth who have the primary decision-making role in the care of their children continue to be involved in the planning, implementation and evaluation of the program.

v. **Wellness, Recovery, and Resilience Focused:** The program utilized Promotoras to help support the individual(s) and families who want to learn about mental health needs so that they can break the tradition of not talking or speaking about mental health and not accessing treatment services. The program reflects the cultural, ethnic, and racial diversity of the population being served. The trainings, education and support provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

vi. **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community based organizations, non-profits, schools, government agencies, families and consumers. Individuals and their families can participate in multiple training and education opportunities offered at different locations in the community. Multiple entities that are funded by a variety of funding sources are providing services and supports in a coordinated comprehensive manner to individual and their family.

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

f. **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** This program improves access to services by addressing stigma about mental illness in the Latino population. This program is decreasing stigma pertaining to seeking and

receiving mental health services by educating individuals on what mental illness is, signs, symptoms and resources to get support and treatment and how mental illness relates to overall health. The Promotoras are partnering with the Behavioral Health Department so that they have a therapist on site or available at the County to refer individuals for screening, assessment and treatment.

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

h. Indicate if the County intends to measure outcomes: The programs will track:

i. Demographic information of individuals served.
ii. Changes in attitudes, knowledge, and/or behavior related to mental illness.
iii. Changes in attitudes, knowledge, and/or behavior related to seeking mental health services.
iv. Referrals to community and mental health services.
v. Type of service provided: community outreach, education on mental health issues, referrals, and care coordination/support.

i. The approaches to collect data may include, but is not limited to:

i. Participants receive written pre and post-tests at meeting with a single theme or a series of meetings on the same theme; which indicate not only increase of knowledge, but also opportunity for a review of the topic.

ii. The Promotoras use an informal testing model based on conversation, which provides for honest narrative through a means that is not daunting to the program participant. The Promotoras complete a pre-workshop evaluation that consists of a group conversation in which questions are allowed to be asked and discussion is encouraged. Through this initial evaluation, the Promotoras gain a sense of the knowledge base that each participant holds; areas of interest and gaps in knowledge can be identified and addressed. At the end of each workshop, the Promotoras conduct an evaluation through informal small group discussions. The purpose of the discussion format is to provide a comfortable atmosphere for participants to express the knowledge that they have gained from the workshop. The Promotoras use a template of questions to gauge the increase in knowledge of their participants. The pre and post tests are directly correlated and allow the Promotoras and contracted staff to determine the levels of increased knowledge and awareness. Detailed narratives of the discussion allow for a qualitative analysis of results.

iii. Written and verbal feedback from program participants and the Promotoras plays an important role in understanding the impact of workshops for the workshop participants.

iv. Additionally, the number of people who opened up and asked for help and referrals to Behavioral Health is tracked.

j. What Strategies that are Non-stigmatizing and Non-Discriminatory will be utilized:

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

k. Estimated Number Served Per Year: 395 individuals

l. The cost per person: $194 ($76,500/395 individuals) per program participant

F. *PEI Project Name: Suicide Prevention Programs*

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

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

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

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

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

i. Community Collaboration: Nevada County has formed a Suicide Prevention Task Force. The Nevada County Suicide Prevention Task Force has created a Community Action Plan based on the California Strategic Plan on Suicide Prevention 2008. Membership of the Task Force reflects a broad range of local stakeholders with expertise and experience with diverse at-risk groups. The SPI Coordinator is collaborating with Family Resource Centers, community based organizations, MHSA stakeholders, County government, and representatives from the Latino community, schools, faith based organizations and others.

ii. Cultural Competence: This program provides training, education, and support in in Spanish to individuals needing suicide prevention and intervention services. Local bi-lingual and/or bi-cultural Promotoras are

trained in suicide prevention, early identification, referral, intervention and follow-up services.

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

iv. **Program Participant Driven:** The program has been developed, implemented and evaluated with the input of survivors of suicide attempts.

v. **Family Driven:** The program has been developed, implemented and evaluated with the input of family members of individuals who committed suicide and/or survived a suicide attempt.

vi. **Wellness, Recovery, and Resilience Focused:** Nevada County is creating a more "suicide aware community." To create a more "suicide aware community" the program is: 1) Raising awareness that suicide is preventable; 2) Reducing stigma around suicide and mental illness; 3) Promoting help seeking behaviors; and 4) Implementing suicide prevention & intervention training programs. The trainings, education and support provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

vii. **Integrated Service Experience for Program Participants and Their Families:** This program is part of an integrated program with community based organizations, non-profits, schools, government agencies, families and consumers. Individuals and their families can participate in multiple training and education opportunities offered at different locations in the community. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

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

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

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

Additionally, consumers and family members are a part of the program so that their perspective is a part of the training.

g. Evaluation Process:

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

h. Estimate of Number Served per Year: 111 individuals

i. Cost per Person: $1,694 ($188,000/111 individuals) per program participant

G. *PEI Funding Expenditures*

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

H. *PEI Program Costs and Cost per Person*

The estimated cost for 1) Early Intervention programs is $301,500, 2) Outreach programs is $40,000, 3) Prevention Programs is $391,100, 4)Access & Linkage Programs is $330,000, 5) Stigma and Discrimination Programs is $76,500, 6) Suicide Prevention Program is $188,000, 7) PEI Assigned Funds is $10,000 and, 8) Administration $75,000. The estimated total PEI program costs are $1,412,100. Using an estimate number based

partially on the number of individuals served in FY 16/17 (12,143 individuals), it is estimated the average cost per person involved in a PEI activity will be $115 ($1,402,100 /12,143). This is the average cost of individuals involved in all PEI Projects. This does not include PEI Assigned Funds.

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

I. *PEI Future Funded Activities*

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

J. *MHSA PEI Administration*

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

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

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

trainings, community events, community education, media outreach and engagement events, and stigma awareness and reduction campaigns.

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

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

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

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

IV. *Innovation (INN)*

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

V. *Workforce Education and Training (WET):*

Nevada County has utilized all of the original allotment of Workforce Education and Training (WET) funds.

VI. *Technological Needs:*

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

VII. *Capital Facilities*

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

VIII. *Assembly Bill (AB) 114 Plan*

AB 114 became effective July 10, 2017. The bill amended certain Welfare and Institution Code (WIC) Sections related to the reversion of MHSA funds.

AB 114 implemented provisions concerning funds subject to reversion as of July 1, 2017. Funds subject to reversion as of July 1, 2017, are deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1(a)). Funds that could be subject to reversion as of July 1, 2017, were distributed to counties from Fiscal Year (FY) 2005/2006 through FY 2014-15. By July 1, 2018, counties are required to have a plan to spend those funds by July 1, 2020 (WIC Section 5892.1(c)).

Every county must develop a plan to spend its reallocated funds and post it to the county's website. The county must submit a link to the plan to DHCS (Department of Health Care Services) by July 1, 2018. Each county's Board of Supervisors (BOS) must adopt a final plan within 90 days of the county posting the plan to the county's website. Each county must submit its final plan to DHCS and the MHSOAC (Mental health Services Oversight and Accountability Commission) within 30 days of adoption by the county's BOS. A county may not spend funds that are deemed reverted and reallocated to the county until the county's BOS has adopted a plan to spend those funds.

In addition, each county must comply with the following:

- The expenditure plan must account for the total amount of reverted and reallocated funds for all impacted FYs
- The county must include the plan in the County's Three-Year program and Expenditure Plan or Annual Update, or as a separate update to the County's Three-Year Program and Expenditure Plan, and comply with WIC Section 5847 (a);
- Reallocated funds must be expended on the component for which they were originally allocated to the county;
- If reallocated funds were originally allocated to the INN component, the funds are subject to the requirements of California Code of Regulations, Article 9, sections 3900-3935;
- The county must follow the stakeholder process identified in WIC Section 5848 when determining the use of reallocated funds; and
- The county must report expenditures of reallocated funds, by component, on its Annual MHSA Revenue and Expenditure Report.

A county may expend reallocated funds for an already approved program/project or use the reallocated funds to expand an already approved program/project provided the program/project is the same component as the component for which the funds were originally allocated to the county, which must be in compliance with applicable MHSA statutes and regulations.

If a county fails to prepare a plan and submit a link to the plan by the required deadlines, the county will be substantially out of compliance with the MHSA. Per WIC Section 5899(e), DHCS will work with the SCO (State Controller's Office) to develop a process to withhold 25% of the county's monthly allocations from the MHF (Mental Health Fund) until the county submits a link to the plan.

AB 114 MHSA Funds Subject to Reversion by Fiscal Year by Component

Nevada County	CSS	PEI	INN	Total
FY 2005-06	$80,061			$80,061
FY 2006-07	$0			$0
FY 2007-08	$0	$0		$0
FY 2008-09	$0	$0	$133,693	$133,693
FY 2009-10	$0	$0	$61,421	$61,421
FY 2010-11	$0	$0	$84,612	$84,621
FY 2011-12	$0	$0	$0	$0
FY 2012-13				
FY 2013-14				
FY 2014-15				
Total	$80,061	$0	$279,726	$359,787

	No Funds Subject to Reversion
	Annual Revenue and Expenditure Report Data if Not Complete

Nevada County Plans to spend reallocated funds:

CSS (Community Services and Supports) - Any reallocated funds from past years will be utilized on existing CSS programs that are in Nevada County's approved MHSA Three Year Plan. The reallocated funds will be the first funds spent. Per our existing approved MHSA Three Year Plan: any CSS funds that may revert in any year will be transferred to the Prudent Reserve to avoid reversion of those funds.

INN (Innovation) - Any reallocated funds from past years will be utilized on our next or current Innovation Plan that is approved by the MHSOAC. Nevada County worked on an Innovation Plan for two years and the Innovation Plan was denied by the MHSOAC. Nevada County is currently working on a new Innovation Plan. Nevada County anticipates that the new Innovation Plan will be presented to the MHSOAC in FY 18/19. The new Innovation Plan will utilize the Innovation reallocated funds.

PEI (Prevention and Early Intervention)- NCBHD is late in turning in Revenue and Expense Report to the DHCS so NCBHD does not know if the State is going to revert and reallocate PEI funds to NCBHD. If funds are reverted and reallocated to NCBHD the plan is to use the reallocated funds first on programs that are approved in the Nevada County MHSA Three Year Plan. The reallocated funds will be the first funds spent.

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

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

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

1. Nevada County Recommendations of Needed Mental Health Service

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Truckee Recommendations of Needed Mental Health Service

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

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

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

Current programs that need to be maintained:

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

Current Priorities for expansion of services:

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

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

Current programs that need to be maintained:

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

Current Priorities for expansion of services:

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

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

Current programs that need to be maintained:

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

Current Priorities for expansion of services:

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

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

Current programs that need to be maintained:

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

- Improve functioning of 5150 process

Current Priorities for expansion of services:

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

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

Current programs that need to be maintained:

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

Current Priorities for expansion of services:

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

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

Current programs that need to be maintained:

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

Current Priorities for expansion of services:

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

Nevada County Mental Health Services Act (MHSA) Annual Progress Report for Fiscal Year 2016/2017

Overall Implementation Progress Report on Fiscal Year (FY) 2016/2017 Activities

General Nevada County Information:

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

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

Notes:

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

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

MHSA Program Updates:

Community Services and Supports (CSS)

Full Service Partners:

VICTOR COMMUNITY SUPPORT SERVICES' (VCSS)

Program Description

Program Overview

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

During fiscal year 16/17 Victor reduced their management structure to a .5 FTE Director and two clinical supervisors. There were no other significant changes in the program.

Target Population

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

Evaluation Activities and Outcomes

- In FY 16/17 124 individuals were served by Victor.
- **Housing**: During fiscal year 16/17, 96% of the 124 individuals served remained in a community living situation and avoided a higher level of residential care.
- **Employment and education**: VCSS achieved its contractual goal of ensuring at least 80% of parents report youth maintained a C average or improved on their academic performance, as

94% of parents surveyed reported their child maintained a C average or saw improvement in their child's academic performance. Additionally, based on the Comprehensive Child and Adolescent Needs and Strengths (CANS) item "Academic Achievement," 85% of individuals were maintaining at least a C average and were not failing any classes at discharge.

VCSS achieved its contractual goal of ensuring at least 75% of youth maintain regular school attendance or improve their school attendance, as 93% 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 admit and discharge; 84% of youth did not experience a suspension or expulsion in fiscal year 16/17.

- **Criminal Justice involvement:** VCSS achieved its contractual goal of ensuring at least 70% of youth have no new legal involvement (arrests/violations of probation/citations) between admission and discharge. In FY 16/17, 96% of individuals had no new legal involvement while receiving services.
- **Acute Care Use**: Ninety-eight percent (98%) of youth served did not experience a psychiatric hospitalization during the fiscal year.
- **Emotional and Physical Well Being**: Throughout the 2016/2017 fiscal year, VCSS Grass Valley successfully supported the strengthening and development of youth, caregiver, and family members' emotional and physical well-being.

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

  VCSS achieved its contractual goal of at least 80% of parents/caregivers report an increase in their parenting skills. In FY 16/17, 94% of surveyed caregivers reported they learned additional strategies to address behaviors at home.

  VCSS achieved its contractual goal of ensuring at least 75% of caregivers report maintaining or increasing connection to natural supports. Ninety-four percent of surveyed caregivers reported maintaining natural supports and 86% reported increased connections in the community.

  VCSS achieved its contractual goal of ensuring at least 80% of youth improve their scores on the CANS instrument between intake and discharge. During FY 16/17, 84% of youth with a planned discharge improved in at least one of the following CANS domains: Life Functioning, Mental Health/Behavioral/Emotional Needs, Risk Behaviors, and Educational Needs. CANS outcomes for FY16/17 planned discharges were strong, with 81% improving in Life Functioning, 78% improving in Mental Health/Behavioral/ Emotional Needs, 74% improving in Risk Behaviors, and 71% improving in Educational Needs.
- **Stigma and Discrimination:** Victor provided Mental Health First Aid trainings to law enforcement and other community members to increase awareness and decrease stigma related to mental illness.

- **Service Access and Timeliness**: Excluding transfers between reporting units, there were a total of 57 discharges in this fiscal year. For the 2016/2017 fiscal year, the average length of service (ALOS) for the discharge population was 13.2 months, similar to the ALOS of the previous fiscal year.

  VCSS has a contractual goal of attempting initial contact with referrals within three (3) business days of receipt of referral. While initial contact was attempted for all individuals within three days, initial contact was successfully made with 70% of referrals in this period.

  VCSS achieved its contractual goal of making face-to-face contact with 60% of referrals within ten (10) business days of receiving the referral, serving 75% of referrals within ten days.
- Outreach and Engagement was provided to 12 potential partners throughout FY 16/17.

Challenges, Solutions, and Upcoming Changes

A change that was made during fiscal year 16/17 was that Victor shifted their management structure from .5 Full Time Equivalent (FTE) Director and 2 FTE Clinical Supervisors to 1 FTE Director and 1 FTE Clinical Supervisor to meet program need.

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

Program Participant Story

When Victor began working with this child and his father they were recently re-unified and had an open Child Protective Services (CPS) case after the child had been removed from the home. While at Victor the child received individual therapy services, the father and son received Parent- Child Interaction Therapy services, and the father was able to work with a Victor parent-partner to help support him in his parenting skills. At that time they were living in shared housing, the father had recently recovered from homelessness, and the son was having some difficulty managing anger in the classroom. The father remained very engaged in the son's treatment and eventually the CPS case was closed. The son was able to learn coping skills needed to manage his anger and was able to remain in a mainstream classroom. In addition, the father began taking classes at a local college to further his career. Since discharge from Victor Community Support Services, the father has obtained independent housing and he and his son have maintained stability in the community.

Full Service Partners:

UPLIFT FAMILY SERVICES

Program Description

Program Overview

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

Target Population

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

Evaluation Activities and Outcomes

Eighty-eight unduplicated individuals were served by this program in FY 16/17.

- **Length of Stay -** Since inception, the average length of stay, for the 259 youth who were enrolled for 60 days or more, is 15.4 months. For youth discharged in FY 16/17, 27 had a length of stay of 60 days or more, and had an average length of stay of 17.57 months.
- **Youth will Improve Functioning** - Since 2011, 115 matched pairs first completed/discharge Child and Adolescent Needs and Strengths (CANS) tool were available to analyze. Seventy-nine percent of youth (n=91) improved in at least one domain based on the Reliable Change Index (RCI). In FY 16/17, paired data for 17 youth were available and 88% of youth (n=15) improved in at least one domain based on the RCI.
- **Youth will Identify at least One Lifelong Contact -** Since 2011, 97% of youth (n=112) maintained or increased lifelong contacts. In FY 16/17, 94% of youth (n=16) maintained their lifelong contacts.

- **Caregivers will Maintain or Increase Connections to Natural Supports** - Since 2011, 94% of caregivers (n=89) maintained or increased their connections to natural supports. In FY 16/17, 100% of caregivers (n=16) maintained or increased their connections to natural supports.
- **Youth will be Stabilized at Home or in Foster Care** - Since inception, 86% of youth (n=101) who participated in the Nevada Wraparound Program for at least 60 days were stabilized at home or in foster care at discharge. In FY 16/17, 93% of youth (n=25) were stabilized at home or in foster care at discharge.
- **Youth Will Attend School Regularly** - Since 2011, 92% of discharged youth (n=101) maintained regular school attendance or improved their school attendance. In FY 16/17, 81% (n=13) maintained or improved their school attendance.
- **Youth Will Improve Academic Performance** - Since inception, 74% of discharged youth (n=80) maintained their academic performance or improved their school achievement during participation in the Nevada County Wraparound Program. In FY 16/17, 67% of youth (n=10) maintained or improved their school achievement.
- **Youth Will Be Out of Legal Trouble** - Since 2011, 91% of discharged youth (n=76) maintained zero arrests, probation violations, or days spent in custody in the six months prior to discharge. Thirty-five percent of youth (n=8) with a history of juvenile justice involvement reduced their involvement from admit to discharge. In FY 16/17, 93% of youth (n=13) remained out of trouble.
- **Reason for Discharge** - Since inception, 55% of youth (n=143) with a length of stay of 60 days or more, discharged from the program because they met their treatment goals. For the 27 youth who discharged in FY 16/17, and had a length of stay of 60 days or more, 56% (n=15) were discharged because they met their treatment goals.
- **Percent of Youth and Families Satisfied** - Since inception, 77% of caregivers (n=177), 59% of youth (n=85), and 100% of adult youth (n=5) indicated satisfaction with the program. In FY 16/17, 85% of caregivers (n=39), 62% of youth (n=18), and 100% of adult youth (n=3) indicated satisfaction with the program. Satisfaction is defined by an average total score of 4.0 or higher.

Goals	Measures	FY 16/17 Actual Outcome
80% of youth will improve functioning.	CANS Score – RCI; paired admit & discharge CANS	88% (n=15/17)
60% of youth will have a face-to-face contact with the agency within 10 working days of receiving the referral.	TIER	52% (n=14/27)
65% of youth will be able to identify at least one lifelong contact.	CANS LDF Relationship Permanence Item – rating of 0-2; paired admit & discharge CANS	94% (n=16/17)
75% of caregivers will report maintain or increase connections to natural supports.	CANS CGSN Social Resources – rating of 0-2; paired admit & discharge CANS	100% (n=16/16)
80% of youth will be stabilized at home.	Master-client Living Situation, CEDE – *Home is defined as Bio/Adopt, foster care, ILP, guardianship, kinship, and family friend;* Paired admit & discharge CEDE	93% (n=25/27)
75% of youth will maintain regular school attendance or improve their school attendance.	CANS LDF School Attendance Item; paired admit & discharge CANS	81% (n=13/16)
70% of youth with a history of suspensions or expulsions will have no new occurrences.	CEDE School Suspensions & School Expulsions; paired admit & discharge CEDE	100% (n=2/2)
80% of parents will report youth will maintain a C average or improve their academic performance	CANS LDF School Achievement; paired admit & discharge CANS	67% (n= 10/15)
70% of youth with history of legal involvement will have no new legal involvement (arrests/violations of probation/citations).	CEDE Arrests, Sustained Offenses, Probation Violations, Days in custody items - paired admit & discharge CEDE	0% (n=0/3)
80% of parents will report an increase in their parenting skills.	CANS CGSN Domain – RCI; paired admit & discharge CANS	31% (n= 5/17)
80% of youth and families will be satisfied with services.	YSS, YSS-F (% satisfied = mean score of 4.0 or higher on Total Satisfaction)	YSSF: 85% (n= 39/46) YSS: 62% (n=18/29) Adult Survey: 100% (n=3/3)

- Outreach and Engagement was provided to 88 potential partners throughout FY 16/17.

Challenges, Solutions, and Upcoming Changes

Uplift Family Service's Nevada County Wraparound program experienced significant staff turnover in FY 16/17. This presented challenges in maintaining staff morale and ongoing engagement with families. Despite the staff turnover, the program was able to maintain its contracted census throughout the fiscal year. UFS completed a market analysis to support salary adjustments, offered hiring incentives, and provided moral building and training activities for staff due to the turnover rate.

UFS closed their Nevada City offices in June, 2017. Fiscal year 16/17 is the last annual progress report for this program.

Program Participant Story

For pre-teen, Scarlett (name changed to protect confidentiality), everything changed too quickly. The stable home she knew was no longer one she could rely on. She was transitioned from a mother she loved and trusted, to a father of mere acquaintance. It seemed that her life was in the hands of others, and would never be the same.

When Scarlett and her siblings were referred to UFS Wraparound program a year ago, the family was heavily involved in the reunification process through Child Protective Services (CPS) and the court system. Scarlett's spare time was characterized by CPS mandated meetings and unpredictable schedules. To accommodate appointments, Scarlett would endure a two hour commute on a windy narrow road, frequently leading to motion sickness, nausea, and headaches. Throughout the process, she displayed consistent anger towards adults; voicing her hatred and disgust with every new adult professional introduced to 'help' her. Her reluctance to engage with Wraparound staff and continued aggression towards her siblings escalated as the family reunification was extended. Scarlett's witness to domestic violence and alcohol abuse, combined with a family history of mental health issues increased staff awareness of her need for supportive care. Her antisocial behavior, withdrawal, and aggression with siblings further enhanced her candidacy for court mandated therapy and her need for psychiatric consultation.

Wraparound services implemented consistent collateral and parenting guidance with Scarlett's parents, providing education on mental health, substance abuse and parenting skills. Wraparound assisted both parents in participating in community support programs in addition to helping with financial and transportation needs. Scarlett received a personal behavior specialist whom visited on a weekly basis. As Scarlett's new school year began, a more consistent schedule of time spent with her father and reunification with her mother was developed. Scarlett's behavior specialist was able to meet with her in the home, where Scarlett became more active in building skills to decrease and cope with negative emotions, manage stress, and increase empathy with others. Scarlett's need for court mandated therapy and medication management decreased as her strengths and skills continued to build. Her teacher's initial reports of withdrawal and antisocial behavior became notices of positive interactions, increased

empathy, improved quality of work, and establishment of friends. Currently, Scarlett is fully reunified with her mother, participating in a community group, taking a leadership role in a school club, and showing her strengths as a participant in school sports. Her overall resiliency and progress since her case opened a year ago is demonstrated by her ability to engage with adults and Wraparound staff, her increase in self-esteem and awareness, and the positive relationship she's built with her siblings.

Full Service Partners:

TURNING POINT COMMUNITY PROGRAMS
Providence Center

Program Description

Program Overview

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

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

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

Target Population

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

Included in AACT services are individuals who may also meet criteria for Assisted Outpatient Treatment (AOT), designed for members who, in addition to having a severe psychiatric disability, may have committed an act of violence or made a serious threat of violence (within 48 months of the AOT referral) due to untreated mental illness.

Evaluation Activities and Outcomes

- **AACT:**

  OUTCOMES OF DISCHARGED INDIVIDUALS
  - Total # of Discharges during reporting period
    - 34 Discharges
  - Discharge Settings (top 2)
    - 29.4% Lower Level of Care
    - 23.5% No Longer Requiring Services - Client's Choice

  DOMAIN OUTCOMES

  Psychiatric Hospital Days
  - Total Psychiatric Hospital Days for reporting period
    - 639 Days
  - Number of Individuals Accruing Psychiatric Hospital Days
    - 17.6% of Individuals
  - Number of Individuals Accruing Zero Psychiatric Hospital Days
    - 82.4% of Individuals

  Although there was a slight increase in the total psychiatric hospital days from FY 15/16 to FY 16/17, it is important to note the following. Of the 16 individuals who accrued psychiatric hospital days in the 15/16 fiscal year, 14 continued to receive services through the Providence Center in the 16/17 fiscal year. Of those 14, 12 (85.7%) either had a decrease in days accrued (n=6, 50.0%) or no longer accrued any days (n=6, 50.0%) in the 16/17 fiscal year.

  Yet another positive outcome is that the vast majority of individuals served in the 16/17 fiscal year did not accrue any psychiatric hospital days throughout the entire year (n=98, 82.4%).

  Jail Days
  - Total Jail Days for reporting period
    - 467 Days
  - Number of Individuals Accruing Jail Days
    - 10.9% of Individuals
  - Number of Individuals Accruing Zero Jail Days

- 89.1% of Individuals

Homeless days
• Total Homeless Days for reporting period
  - 855 Days
• Number of Individuals Accruing Homeless Days
  - 14.3% of Individuals
• Number of Individuals Accruing Zero Homeless Days
  - 85.7% of Individuals

Supported Housing
Supported housing includes the use of a board and care, room and board, living with biological parents, living independently or with a roommate in a house, apartment, group living homes, sober living homes, etc.

Due to individuals moving into different residencies throughout the year, the total occurrences of supported housing per year will exceed the number of individuals served.

In the 15/16 fiscal year, there were 219 total occurrences of utilization of supported housing. In the 16/17 fiscal year, there were 245 total occurrences of utilization of supported housing suggesting an increase in their use.

Emergency Interventions
• Total Emergency Interventions for reporting period
  - 107 Emergency Interventions
• Number of Individuals Accruing Emergency Interventions
  - 33.6% of Individuals
• Number of Individuals Accruing Zero Emergency Interventions
  - 66.4% of Individuals

Although there was an increase in the number of Emergency Interventions (EI) from FY 15/16 to FY 16/17, it is important to note the following. Of the 28 individuals who originally accrued EIs in the 16/17 fiscal year, 82.1% either had a decrease in the number of EIs accrued (21.7%) or no longer accrued any EIs in FY 16/17 (78.3%). Additionally, 51.4% of these EIs were accrued by newly enrolled individuals. This could suggest that these participants had a higher level of acuity, but had not been receiving ACT services for a long enough period to see results yet.

Another positive outcome is that the majority of individuals served in 16/17 did not accrue any EIs (66.4%).

Employment
• Total Individuals Employed
  - 5.6% competitive employment
  - 3.4% supported employment
  - 1.1% paid in-house work
  - 7.9% volunteer

- 1.1% other employment

Between FY 15/16 and FY 16/17, two (2) individuals became employed who had not been in the previous fiscal year. Eleven (11) individuals maintained employment between the two fiscal years.

Utilization of lMD (Institute of Mental Disease)

- Total IMD Days in the 16/17 Fiscal Year
  - 139 Days (124.2% increase from previous fiscal year)
- Number of Individuals Accruing IMD Days in 16/17 Fiscal Year
  - 1.7%
- Number of Individuals Accruing Zero IMD Days in 16/17 Fiscal Year
  - 98.3%

Although there was an increase in IMD days from one fiscal year to the next, it is important to note the following. The individuals who had originally accrued IMD days in the FY 15/16 continued to receive services through the Providence Center in FY 16/17. They no longer accrued any IMD days in the 16/17 fiscal year. This is a positive outcome. Additionally, 77.7% of the IMD days were accrued by one person who was new to the Providence Center in FY 16/17. This suggests that person may have been at a higher level of acuity and required higher level services.

A very positive outcome is that the vast majority of those served in the 16/17 fiscal year did not accrue any IMD days (98.3%).

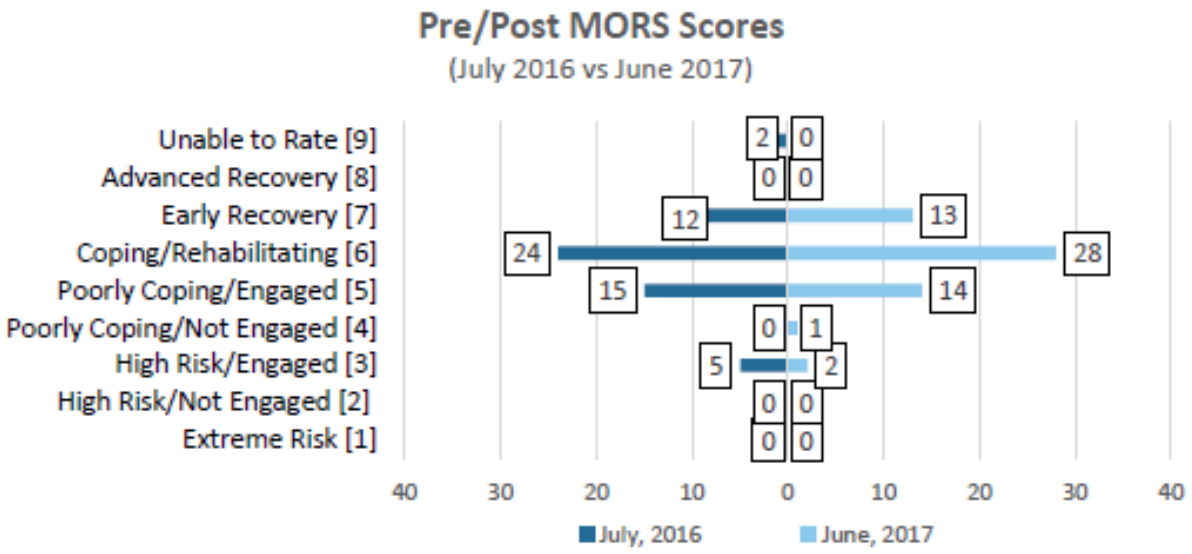
Families and Caregivers Support

Turning Point (TP) has offered a Family Support Group on Wednesday Evenings at Providence Center for participant's loved ones as well as loved ones of community members not enrolled in TP. The Family Support group had low attendance and has been paused as of June 1, 2017 to reevaluate the needs and start again when needed. Turning Point offers Family Team Meetings facilitated by a mental health professional to help individuals within their natural support systems and to assist the people who are supporting the FSP participant. There is a need to educate and aid the support systems of our partners so that the whole family system can function at a healthy level.

Supervisors and staff are available at all times to listen to the concerns of loved ones and to support them (when/if the participant has allowed TP to speak to them). Recently a TP participant was supported with a master leased home so that she and her daughter could have a clean, safe living environment.

MILESTONE OF RECOVERY SCALE (MORS)

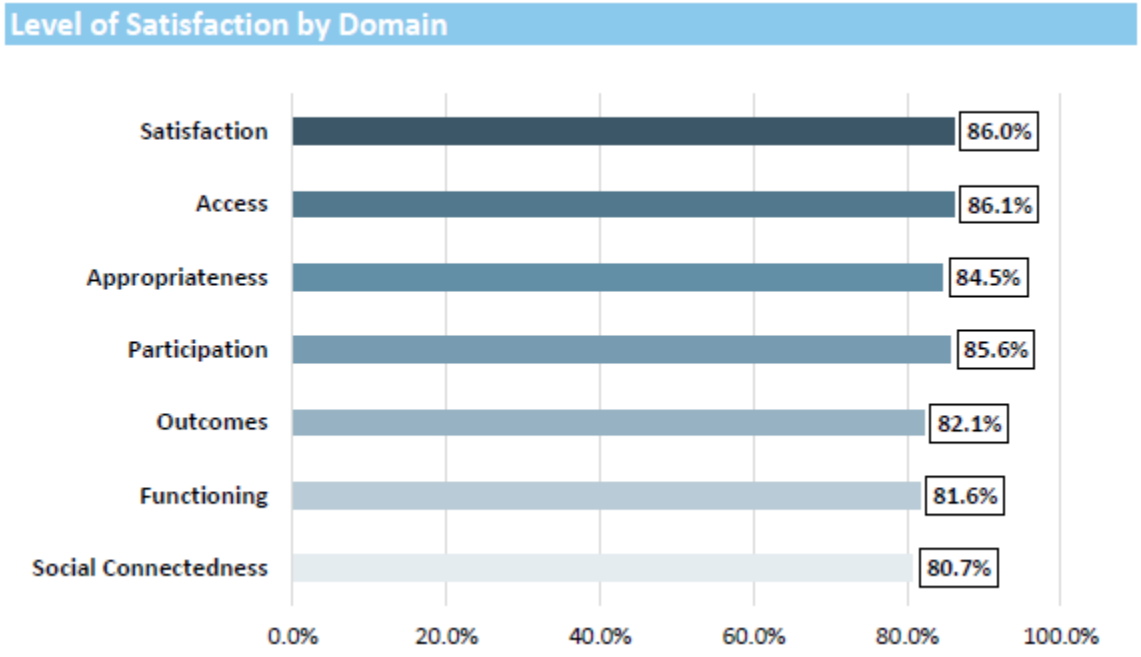
Of the 119 unduplicated individuals served within the 16/17 fiscal year, 48.7% received a MORS score in both July 2016 and June 2017.



The 58 clients served in the reporting period who had a MORS score in both July 2016 and June 2017 were included within the graph above. Forty-one (41) clients were excluded due to not having scores in July 2016 and 33 clients were excluded due to being discharged prior to the end of the reporting period.

CONSUMER SATISFACTION SURVEY

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



Between July 2016 and June of 2017 a total of 86 surveys were administered. Of the 86 surveys administered, 57% completed the survey. The remaining 43% declined to participate.

All domains were at or above the 80% threshold set, which suggests that individuals are satisfied with Providence Center's services. The highest rated domain was the Access Domain (86.1%). The Providence Center program received an overall satisfaction rate of 83.7%.

- Outreach and Engagement was provided to 176 potential partners throughout FY 16/17.

- **AOT:**

DOMAIN OUTCOMES

Psychiatric Hospital Days

Between May, 2015 and April, 2016, a total of 291 psychiatric hospital days were accrued by seven individuals or 63.6% of the total 11 individuals observed. Four individuals did not accrue any psychiatric hospital days in the reporting period.

# of Days Accrued by Those Who Volunteered to Receive Services	86 (30%)
# of Days Accrued by Those Who Were Court Ordered	205 (70%)

Jail Days

Between May, 2015 and April, 2016, no jail days were accrued by the 11 individuals observed.

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

Homeless Days

Between May, 2015 and April, 2016, a total of 6 homeless days were accrued by one individual or 9% of the total 11 individuals observed. The rest of the individuals (91%) did not accrue any homeless days in the reporting period.

# of Days Accrued by Those Who Volunteered to Receive Services	0 (0%)
# of Days Accrued by Those Who Were Court Ordered	6 (100%)

Emergency Interventions

Between May, 2015 and April, 2016, a total of 25 emergency interventions (EIs) were accrued by seven individuals or 63.6% of the total 11 individuals observed.

# of Days Accrued by Those Who Volunteered to Receive Services	4 (16%)
# of Days Accrued by Those Who Were Court Ordered	21 (84%)

MILESTONE OF RECOVERY SCALE (MORS)

Out of 12 individuals served between May, 2016 and April, 2017, seven have been included in the following analysis (five clients were excluded due to insufficient data points). Each client's first MORS score following their referral date has been compared to their most recent MORS score. Some clients have been discharged within the time frame; however, the

majority had their most recent score given within the month of March, 2017 (April scores are not entered until mid-May).

On average, at the time the first MORS score was assigned, the majority of individuals were at Poorly Coping/Engaged (a score of five) (63.6%, n=seven). At the time of their most current MORS score assignment the majority were Poorly Coping/Engaged with staff (a score of five) (45.5%, n=five). Overall, six (54.5%) of the 11 individuals included in the analysis had an increase between their initial to their most current MORS score, ranging from 1 to 3 score levels. This is a very positive outcome showing that progress was made towards recovery once the Providence Center began providing services.

Court Ordered AOT MORS:

- All but one individual demonstrated significant gains on the MORS. Five individuals started with a rating of one or extreme risk, two others were high risk/not engaged. Only one had a pre-AOT score of five (poorly coping/engaged) which may be explained by the amount of time in AOT treatment when the MORS was first scored.
- Following the AOT treatment order, six individuals scored in the succeeding range of five or above, with two in the coping/rehabilitating & early recovery range.
- During the AOT review period, increased participation in treatment and, related social actively were demonstrated among all participants, through the MORS. This engagement ranged from High Risk/Engaged to Coping/Rehabilitating during the treatment period, with most of the participants achieving greater levels of engagement in treatment with MORS scores reflecting success and greater satisfaction with their lives.

CONSUMER SATISFACTION SURVEY

Between May, 2016 and April, 2017, of the 12 individuals served, a total of 13 (100.0%) surveys were administered. Of the 13 surveys administered, nine (69.2%) completed the survey. The remaining four (30.8%) declined to participate.

All seven domains were at or above the favorable 80% threshold set for all Turning Point programs, which suggests that individuals are satisfied with the services that they received. The highest rated domain was the Access Domain (88.1%). Overall, Providence Center AOT received a favorable satisfaction rate of 85.3%.

Court Ordered AOT Consumer Satisfaction Survey:

When counting only the seven individuals who were court ordered, Providence Center AOT received a favorable satisfaction rate of 85.7%.

Challenges, Solutions, and Upcoming Changes

Challenges: For the 2016-2017 Fiscal Year, Turning Point went through several staffing changes and had an influx of clients who were in need of more intensive services. The management team lost a Program Director in October, then gained a new one at the end of December. The program also lost a Clinical Team Leader in April and did not replace that position. Additionally, Turning

Point was down to only one licensed Mental Health (MH) professional, who had to complete all of the AOT petitions and updates. In March the program lost a Personal Service Coordinator (PSC) and did not replace that position because of upcoming budget cuts. The therapist, Certified Drug & Alcohol Counselor (CADC) specialist/court liaison, and the management staff took on supporting program participants which stretched the staff more than normal. Turning Point continued to operate on a budget that did not allow for raises this fiscal year.

Solutions: As always, the Providence Center team was able to think outside of the box and be flexible through all these challenges. Turning Point increased their reliance on Community Partners, and looked at supporting program participants with independent transportation plans so that PSCs were not spending all their time driving clients from place to place. Turning Point hired a previous Providence Center Team Leader as the Program Director and she was able to jump right into the team with little training. The MH professional still provided oversight and support of the AOT process and trained the Program Director to take over this role when she is officially licensed as a Clinical Social Worker.

Upcoming Changes: Turning Point had a significant budget cut for the upcoming fiscal years and again, don't have the budget to provide raises to staff. The program is working on getting more "on-call" staff that can cover sick & vacation days at the Catherine Lane and Insight Respite facilities. With the new staff hired for Catherine Lane or Insight Respite, Turning Point plans to cross train them for both sites. This will relieve the overtime of the PSCs from the Providence Center that fill shifts at Catherine Lane and should reduce burnout. Turning Point is currently waiting to hear if the county has been awarded a grant from Substance Abuse and Mental Health Services Administration to support a homeless outreach and housing program that Turning Point will be contracted to provide.

Program Participant Story

Turning Point has served this particular middle aged gentleman since 2012. He has been homeless for most of his life. This individual has a history of chronic alcohol and drug use and was only able to stay off substances when in jail for short stints. The Providence Center team supported him with a variety of transitional and permanent housing opportunities, including a staffed home, to support his independence in living safely in the community. He struggled in the different housing situations, all of which he was unable to maintain at the time; sometimes he simply left. He became homeless again. Only his PSC was allowed to go to his camp, no one else had seen it. Due to the severity of his mental illness and alcohol use, this gentleman was unable to manage his bodily functions, creating a camp "home" that was virtually uninhabitable by any humane standard of living. Due to his delusions and paranoia he did not have the capacity (or the interest) to stop his use of alcohol and drugs. At the beginning of the year, he was released from jail and went to live at a transitional home. He was accepted into Mental Health Court and began to follow his court ordered treatment plan. With the support of his long term PSC, the Treatment Team and Mental Health Court Team, this gentleman will soon celebrate a year of sobriety. He is following his program down to a "T" and is a model participant in both Mental Health Court and Turning Point Providence Center. Best of all, he is

happy, he is housed, he has hope and he is recovering. He demonstrates what is possible when humanity is emphasized and hope is not abandoned.

Full Service Partners:

NEW DIRECTIONS

Program Description

Program Overview

The New Directions Program in the Nevada County Behavioral Health Department is a lite Adult Assertive Community Treatment (AACT) program, which serves individuals with severe, persistent mental health issues and accompanying challenges to daily living. The program facilitates consumers transitioning from county services to independence and community living. The New Directions team maintains a strong commitment to providing services which include Supported Independent Living, Supported Employment, educational and therapy groups, individual therapy and WRAP (Wellness Recovery Action Plans).

Target population

New Directions participants are identified as the most severely impaired by mental illness in our community. These individuals need at least weekly case management, and sometimes daily support, to function in the community. Consumers aged 16 and above are served by this program.

Service Intensity

During the FY 16/17 service intensity varied by individual for the 15 participants served. The focus of increased services across all age categories is to decrease hospitalization by utilizing intense case management, temporary placement at Odyssey House transitional home, medication caddy services, and nightly calls to the most high risk consumers.

Program Options

Housing:

- *Self-Sufficient Support (S^3)* - Residents who are successfully capable of living independently with minimal support are classified as "self-sufficient." These participants receive support on an "as needed" basis from Personal Service Coordinators (PSC). The residents are able to handle and problem solve most basic daily situations of independent living. Three Full Service Partners were supported in this program
- *Supported Independent Living (SIL)* - Residents need regularly scheduled support to remain successful in independent living. Identified shared houses are supported by Nevada County Behavioral Health in the following manner:
    - Deposits are paid by MHSA flex funds.

- If a room is vacant, MHSA funds are used to pay the monthly rent to maintain stability of the house until residents can locate a new housemate.
- A "basic needs" list for residents is created by staff and obtained by either residents' resources, donations and/or MHSA flex funds.
- PSCs provide support with medication, housemate conflict resolution, money management skills, paying bills, meal planning, budget planning, shopping, leisure skill planning and other daily living skills.
- PSCs work with landlords to ensure support for both the resident and the landlord.

New Directions continued supporting two Full Service Partners within the SIL (Supported Independent Living) houses in FY 16/17.

- Housing was provided for four homeless adults or previously homeless adults who struggled with severe and persistent mental illness using subsidies from the Housing and Urban Development (HUD) Supported Housing Program grants. This included *Winters' Haven* house and scattered sites in the *Summer's Haven* and *Home Anew* Projects. See MHSA Housing section of this report for more details.
- *The Catherine Lane House (a joint venture with Turning Point)* - The Catherine Lane House offers 24/7 support services to residents with independent living skills challenges. This permanent supportive house includes a focus on single room occupancy that facilitates residents in achieving their maximum level of independence. This house enables residents to live independently and keep their current community support network intact. In FY 16/17 the New Directions Program has two participants living at the Catherine Lane House.
- *The Willo House* - The Willo House is a program which provides intensive support services for participants who are on conservatorship or in need of one or more staff contacts per day. This setting provides participants an opportunity to live in the community with greater independence than an IMD (Institute for Mental Disease) or Board and Care facility. The Willo House is a three bedroom unit. In FY 16/17 the New Directions Program housed two participants in Willo House.

Employment/Volunteer Employment:

- *Snack Shack* - Vocational training is available through the Snack Shack program. The Snack Shack program is a collaborative effort between the National Alliance for the Mentally Ill (NAMI), the Behavioral Health Department (both adult services and children's) and Consumers. It is a consumer driven retail program providing vocational skills and structure. Participants learn customer service, cash register skills and team building. Management of the program is provided by consumers and a consumer with bookkeeping experience balances the receipts. In FY 16/17 there were five managers and 17 participants that volunteered to work in the Snack Shack program. None of these workers were FSP participants, but this program remains a valuable volunteer option for Full Service Partners.
- *Peer Support Training* - Peer Support Training is an eight month program where consumers develop skills to counsel and support peers. The goal of the support services is to promote self-empowerment, independence and interdependence, facilitating consumers functioning and thriving in their community. Training requirements are no more than four missed sessions and completion of a mock peer support session. The training offers two outcomes: 1) a certificate of graduation or 2) a certificate of participation. Of the 19 training participants in FY 16/17 who completed Peer Support Training, one was a Full Service Partner. Within the graduates of the program:

- Seven participants took the training for personal enrichment.
- Thirteen participants graduated with diplomas.
- Six participants were still in training at the end of the fiscal year.

After graduation, consumers are then introduced to volunteer opportunities in the community. At the end of FY 16/17:

- Two graduates worked at Behavioral Health,
- One graduate taught a depression group at Tuning Point,
- One graduate was employed at Insight Respite Center and Turning Point.

Supportive Services:

- *Weekly Groups:*
  - Healthy Living - Healthy Living courses provide education to consumers and healthy options for independent living. Choices include coping and time management skills; nutrition, social and budgeting skills; leisure and development of Wellness Recovery Action Plans (WRAP) and social activities based in the community. This program served 23 individuals in FY 16/17, one of whom was a Full Service Partner.
  - Saturday Adventure Outings - Saturday Adventure Outings serve high risk consumers who have a history of being isolated on weekends. The goal of the program is to engage these individuals socially with other peers that result in decreased symptoms of mental health issues and increased quality of life. The consumers organize the adventure and determine the activities each week. Two peer staff members provide transportation utilizing Behavioral Health vehicles. The staff also provides support and referral services during the program. This creative solution has enabled individuals to access social interactions through activities they determine. In FY 16/17, two of the seven participants in the Saturday Adventure Outings program were New Directions, Full Service Partners. The lead therapist/program team coordinator provided qualitative data in collaboration with the larger Behavioral Health clinical team indicating that this program had a direct role in reduction of symptoms and the need for more intensive services for program participants.
  - Art Therapy is the application of the visual arts and the creative process within a therapeutic relationship, to support, maintain, and improve the psychosocial, physical, cognitive and spiritual health of individuals. It is based on current and emerging research that art making is a health-enhancing practice that positively impacts quality of life by improving concentration and attention. New Directions art-based groups support, maintain, and improve overall health, physical, emotional and cognitive functioning, interpersonal skills, and personal development. In FY 16/17 the Art Therapy group served 31 participants, including six Full Service Partners.
- *Therapy Support and Service Coordination:*
  - Therapy services are provided by interns through the intern program. The program offers an opportunity for interns to be trained in the mental health field while offering services to individuals who might otherwise wait or not receive individual therapy. The long term benefit is quality services for the consumer and training for a new generation of clinicians who have developed skills which they will bring to a variety of community based settings.

  - The Interns are individuals in the process of completing or who have completed their Master's degree in psychology, sociology or a related field. Supervision is provided by a licensed therapist with the New Directions Program.
  - Program treatment options range from service coordination to providing mental health rehabilitation, including medication delivery.
  - Individual and group therapy provides participants the opportunity to further their goals of developing healthy life options, including choosing the abstinence or harm reduction model for recovery from substance use disorders as a component of their co-occurring disorder.
- *After Hour Services* - Nevada County is a small county and resource availability within the Behavioral Health Department is limited, given budget constraints. In order to meet the criteria of 24 hour/seven day a week services, the following adjunct supports have been developed for holidays, weekends and overnight coverage. Individuals have use of the 24 hour crisis line of Nevada County Behavioral Health as a contact resource. They have the further option of requesting contact with the program team coordinator or designee alternate for support in managing critical issues through the crisis line. For participants in New Directions utilizing daily medication deliveries, service coordinators from Behavioral Health make weekday morning deliveries.

Evaluation Activities and Outcomes

Notable community impact is reflected by these program outcomes.

- Independent Living was maintained or increased which reduces the impact on community based homeless resources.
- Out of the 15 program participants prior to actively engaging in FSP treatment, three had a previous history of eviction and 10 had a history of evictions *and* were chronically homeless. Twelve out of 15 were successfully living in independent living locations in 16/17. Two of the participants were supported in finding housing but did not remain housed during this time period.
- Comparing the year before partnership to the second year of receiving services through New Directions, the number of Homeless days decreased from to 149 to 119 days.
- Out of the 15 participants, prior to actively engaging in FSP treatment three had a previous history of hospitalizations. Decreased hospitalizations were recorded. Comparing the year before partnership to the second year of receiving services through New Directions, the number of individuals in a Psychiatric Hospital decreased from five to four.
- Fourteen out of the 15 participants had a history of *multiple* hospitalizations, and during FY 16/17 six of them were not hospitalized. The number of Independent Living days for these individuals increased from 1,161 to 1,306 days.
- There was a decrease in legal issues (six individuals with arrests prior to partnership, decreased to four partners with arrests during the first year of service).
- There was a decrease in homelessness (12 out of 15 participants were successfully living in independent living throughout 16/17).

- Comparing the year before partnership to the second year of receiving services through New Directions, the number of individuals in Residential Placement remained the same at five and the number of Supervised participants decreased from five to three.
- Programs focused on medication adherence, nutrition and physical health reduced utilization of emergency room services (10 individuals with emergency room visits before partnership, decreased to five partners during the first year of partnership).
- Comparing the year before partnership to the second year of receiving services through New Directions, the number of participants in an Emergency Shelter decreased from two to one.
- The employment program provided enrolled consumers with additional resources which they spent locally and thereby became financially contributing members of the local community.

Challenges, Solutions, and Upcoming Changes

- It is difficult to find landlords for the chronically homeless who are willing to lease, rent, or master lease to New Directions.
- There is a chronic shortage of hospital beds in California which puts the beds in the local Crisis Stabilization Unit and Odyssey House in shortage when New Directions needs them for somebody.
- The Supported Housing component of the New Directions program continues to have challenges related to staffing restrictions. These restrictions limit the number of units which can be adequately developed and managed to meet the participant's needs.
- Peer support challenges continue. As peer support continues to expand, so does the need to find paid or volunteer community placements for program graduates. Ongoing outreach to community based agencies and groups is continually needed to provide options for graduates to utilize their skills. Additionally, once a Peer counselor has a paid or volunteer position in the community they typically need intermittent support. Staff schedule an alumni meeting once a month to provide support for the individuals working in the community. Staff also facilitate visits to other agencies to foster knowledge of future referral resources, as well as meet prospective employers.

Program Participant Story

In 2016 Hospitality House identified a young man who had been homeless on and off for over a year. He was psychiatrically hospitalized for "grave disability" and was an inpatient for three weeks. Behavioral health staff at Hospitality House provided an assessment for this young man upon his release from the hospital. He stated that he suffered from overwhelming anxiety, did not do well in social situations and had no friends. He had been a program participant at Behavioral Health (BH) Children's services and had been prescribed a medication which he said caused him to "wander and visualize." He had recently been fired from a job for drug use.

This young man was amenable and polite during the assessment but stated that it was very difficult for him to ask for help. He said he was not sure what kind of help he needed. He said that his goals were to find housing and a job, but he had no idea how to go about getting either

one of those. This young man said that it was his understanding that his mom used cocaine while pregnant with him and that she had also been diagnosed with a mental illness, but was untreated. He said that he never knew his father.

At the time of his assessment he had been clean from drugs and alcohol for two weeks. He suffered from some medical issues as he spent most of his days outdoors in the elements. He would often report that he was confused and did not know what he was supposed to do.

He was scheduled to see the BH psychiatrist and was prescribed medications for his mental illness. He was offered a room in a BH Supervised, independent living house which he accepted. A year later, this young man has enrolled in school at a Community College and attended outpatient substance use groups. Most recently he has obtained part time employment and has been working for more than six months at this job. He has been clean and sober for a year. He continues to live in BH supported housing.

General System Development:

NEVADA COUNTY ADULT & CHILDREN'S SYSTEM OF CARE
Intern Program Expansion

Program Description

Program Overview

In FY 16/17 Intern Program Expansion added service capacity, increased access, and broadened services in Nevada County. Interns and their clinical supervision were funded through CSS GSD. In FY 2016/2017 14 interns provided 12,609 hours of services to 168 individuals (4,192 hours) through the Adult System of Care and 210 individuals (8,417 hours) through the Children's System of Care. Additionally, 123 hours of intern supervision were funded by MHSA CSS GSD.

Target Population

Nevada County Behavioral Health (NCBH) program participants who work with clinical staff interns. All age groups are served by this program.

Evaluation Activities and Outcomes

Of the 168 adult program participants, 48 had completed a baseline and annual Basis 24 outcome measure survey. The Basis 24 is scored on a five point Likert Scale where zero represents "No Difficulty" and four represents "Extreme Difficulty". Results are shown below.

Basis 24 Domain	Overall	Depression/ Functioning	Relationships	Self-Harm	Emotional Lability	Psychosis	Substance Abuse
# of Participants	37	44	48	41	45	48	48
% of Participants who improved or stayed the same	59%	55%	69%	83%	58%	60%	65%

The NCBH Children's System of Care is in the process of implementing Electronic Behavioral Health Solutions (eBHS), a software and support product that will facilitate efficient quantitative data-gathering and aggregation of outcome measures including the Achenbach Child Behavior Checklist (for children/youth). The Children's team collects this data now, but there is no way to aggregate it for overall reporting. It is expected that in the next six months there will be quick access to aggregate outcome data. Until that time there are no reportable outcomes.

Challenges, Solutions, and Upcoming Changes

Finding a system that will collect, collate and summarize outcome data for NCBH has been a challenge. With the implementation of the eBHS software, staff, supervisors and management will be able to pull reports using a wide range of filters to better understand the data that is being collected. This will enable the programs to report out on participants' progress and improvements due to treatment they have received.

General System Development:

NEVADA COUNTY BEHAVIORAL HEALTH
Network Providers

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) has licensed therapists, Network Providers, who work in the community at private offices. They see children, Transition Aged Youth (TAY), adults and older adults referred to them by NCBH. Nevada County Behavioral Health refers program participants with less acute needs to the Network therapists. These are individuals who do not appear to need medication or significant case management. Network providers help to serve additional individuals and offer partners and families a variety of specialties and locations that NCBH would not be able to offer otherwise. Network providers are funded under both the Adult and Children's programs within CSS. In FY 16/17 76 unduplicated participants were served. This includes 66 individuals served in the Children's System of Care and 10 individuals served in the Adult System of Care.

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 are individuals who do not appear to need medication or significant case management.

Evaluation Activities and Outcomes

The Children's System of Care has just started collecting outcome data in earnest for Network Providers and do not yet have baseline and mid-treatment data analyzed to report. This data should be available next fiscal year.

In the Adult System of Care, individuals seeing Network Provider are given the Basis 24 Outcome Measures Survey annually. Of the 10 adults that were served in this program, six

completed a baseline and annual Basis 24 outcome measure survey. The Basis 24 is scored on a five point Likert Scale where zero represents "No Difficulty" and four represents "Extreme Difficulty". Results are shown below. However, the small number of consumers who had data available for this program does not represent a statistically significant sample size.

Basis 24 Domain	Overall	Depression/ Functioning	Relationships	Self-Harm	Emotional Lability	Psychosis	Substance Abuse
# of Participants	2	3	6	5	5	6	6
% of Participants who improved or stayed the same	0%	0%	67%	80%	20%	50%	83%

Challenges, Solutions, and Upcoming Changes

There has been a decrease in the number of Network Providers for Adult consumers. This has caused a reduction in our overall totals for this program.

General System Development:

NEVADA COUNTY ADULT & CHILDREN'S SYSTEM OF CARE
Expand Psychiatric Services

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) Children's Services provided Expanded Psychiatric services to 14 children with MHSA CSS funds in FY 2016/2017. Some of the children were being wrapped with Full Service Partner (FSP) providers. Some of these children continue to see the NCBH doctor individually and work with the WRAP team.

Nevada County Behavioral Health Adult Services provided Expanded Psychiatry to Case Management/Auxiliary program participants using General System Development funds. These funds payed for 29 individuals in FY 16/17. Expansion of psychiatry services and expansion of behavioral health services within the Adult System of Care included the same individuals. All Integrated Service Team program participants received both psychiatric and case management services.

Target Population

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

Evaluation Activities and Outcomes

Of the 29 adult program participants, 10 had completed a baseline and annual Basis 24 outcome measure survey. The Basis 24 is scored on a five point Likert Scale where zero represents "No Difficulty" and four represents "Extreme Difficulty". Results are shown below. However, the small number of consumers who had data available for this program does not represent a statistically significant sample size.

Basis 24 Domain	Overall	Depression/ Functioning	Relationships	Self-Harm	Emotional Lability	Psychosis	Substance Abuse
# of Participants	6	8	10	9	9	10	10
% of Participants who improved or stayed the same	17%	13%	60%	78%	33%	40%	80%

The NCBH Children's System of Care is in the process of implementing Electronic Behavioral Health Solutions (eBHS), a software and support product that will facilitate efficient quantitative data-gathering and aggregation of outcome measures including the Achenbach Child Behavior Checklist (for children/youth). The Children's team collects this data now, but there is no way to aggregate it for overall reporting. It is expected that in the next six months there will be quick access to aggregate outcome data. Until that time there are no reportable outcomes.

Challenges, Solutions, and Upcoming Changes

Finding a system that will collect, collate and summarize outcome data for NCBH has been a challenge. With the implementation of the eBHS software, staff, supervisors and management will be able to pull reports using a wide range of filters to better understand the data that is being collected. This will enable the programs to report out on participants' progress and improvements due to treatment they have received.

General System Development:

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

Program Description

Program Overview

Community Recovery Resources (CoRR): Co-Occurring Disorders (COD) Program, Adolescent Services and Co-Occurring Disorders (COD) Program Adult Services provide services to people

struggling with concurrent issues of substance use and mental illness, with program components for both adults and adolescents. The adolescent component also specializes in services to youth in YES Court (Youth Empowerment System, formerly known as Juvenile Drug Court). Co-Occurring Disorders services are an integration of both mental health and substance use treatment. Services are recovery-oriented and driven by the unique needs and strengths of individuals. They are community based, family-centered and culturally relevant. Services include case management, an individualized myriad of rehabilitative life skills development and therapeutic interventions such as mood management and trauma work. The program is based on a COD best-practices model within a recovery-oriented system of care and employs evidenced-based approaches in an integrated manner within COD specific treatment stages to address and promote mental health and substance use disorders recovery. All COD program services are provided by a multidisciplinary, integrated treatment team that functions within a framework of intensive provider collaboration both internally (within CoRR) and externally (within the greater system of care including Uplift Family Services, Victor Services, Behavioral Health, Probation, Courts, Child Protective Services, etc.).

Target Population

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

Evaluation Activities and Outcomes

Tracking of demographic information and treatment outcomes impact community goals such as number of emergency room visits, hospitalizations, homelessness, increases in work or volunteerism, decreases in arrests, reduction in number of individuals on probation, drug of choice, increase in participation in community based self-help or support, and reconnection to family. This data is gathered per participant self-report (URICA Change Assessment Scale), QOL (Quality of Life Scale), clinical observation and progress reporting.

Adult Program Outcomes:
Adults complete the BASIS-24 for evaluation of clinical outcomes, and participation in a satisfaction survey twice per year.

The COD Adult program served 32 unduplicated adults. Of the 32 Adults, 16 remain enrolled, six successfully completed the program, two were transferred to other services (one because she lost her Medi-Cal), two returned to prison and six withdrew from services. This is a 19% completion rate over the course of the year. CoRR believes this low completion rate is due to the increase in individuals in the program with complex backgrounds and histories, including multiple incarcerations and probation for chronic offending. Fifteen individuals began the

program on probation, one successfully terminated probation. Eight individuals had return incarcerations while in the program, the result of sanctions from Adult Drug Court or other probation violations. However, there were no new offenses.

The program saw 46% of participants able to move from the pre-contemplative stage to contemplative and/or into action stages/readiness for change (URICA Scale), and to achieve a period of stability that included abstinence. Fifty percent of those individuals experienced relapse and the other 50% continued clean and sober in the program. Enrolled individuals have also increased their access to and utilization of Primary Care, due to satellite medical services onsite in the clinic. The program tracked data that demonstrated increases in employment/volunteerism, reported stable living environments, self-help/social support networks and personal connection for individuals in the COD program. A primary focus of COD services trauma informed interventions, 94% of enrolled adults reported a history of trauma. Of those, 81% reported a decrease in individualized symptomology related to trauma (treatment team tracking, progress notes, assessments and BASIS-24). Additionally these individuals demonstrated improvements in daily functioning, feeling better in social situations, and reduction in a variety of symptoms of psychological distress from initial enrollment.

Child Program Outcomes:
Youth participants and parents complete appropriate versions of the complete Youth Outcomes Questionnaire (parent version YOQ and youth version YOQ Self Report) for evaluation of clinical outcomes, and they complete a services satisfaction survey.

The COD program served 10 unduplicated youth, with a 60% completion rate over the course of the year. Of these youth, 100% were misusing substances upon enrollment, and 50% became abstinent while in the program. Out of the 10 youth, 20% chose to adopt a formal, community supported program of recovery to support achieving and sustaining abstinence, and 36% successfully participated in an individualized harm reduction goal and reduced their use of substances while in the program. All participants reported an increased awareness of the role and impact of substances on their lives, particularly within their families and living environments. In the fiscal year 90% of youth joined the program while on probation, and 50% of those successfully completed probation. There were no episodes of homelessness or emergency room visits/hospitalizations. Four youth became gainfully employed, and 30% reported an increase in supportive connections. (Results from interviews, treatment team tracking, progress notes, and participant self-assessments).

Of the 10 enrolled youth, 90% reported significant traumatic events with resulting behavioral symptoms, and 28% of those demonstrated a reduction in a variety of symptoms related to trauma (YOQ).

In the fiscal year, 25% of youth enrolled had their parents involved in some way in their services. Of the families that identified their own substance use history as having an impact on their children, all of them were themselves well connected to the recovery community.

Challenges, Solutions, and Upcoming Changes

The program incorporates harm reduction as an individualized approach when indicated. This presents challenges in a social recovery model based environment for those adopting abstinence, and makes it more difficult for participants to build social recovery meetings into their support network/strategy, when Dual Recovery Anonymous groups are not available. It can be a confusing message in a recovery based environment. Access to psychiatric services became an increased barrier this year, regardless of the program's efforts in linkage to this resource. The youth program has been cut for next year due to budget constraints.

Program Participant Story

Adult Story:
Mandi (name changed to protect confidentiality) is an older widow who came to CoRR upon referral from an emergency shelter program. She had a 14-year history of addiction to opiates. Mandi was diagnosed with a co-occurring disorder of Posttraumatic Stress Disorder. After over a decade of living in sobriety, she relapsed on pain pills, and later, returned to Heroin use. She eventually lost her job, her housing, and all of her support systems with the exception of her adult children. Mandi achieved abstinence in the residential facility. She was admitted to the COD program for mental health and substance use disorders services and to CoRR's Transitional Housing Program.

Mandi made a strong connection almost immediately with her COD therapist and rehab specialist. She worked on a relapse prevention plan which she continues to use today. Mandi was an active participant in her treatment. She used her relapse prevention plan, community-based self-help groups, and Cognitive Behavioral Therapy skills to address her goals. At one point, Mandi appeared to become increasingly lethargic, with notable memory loss and inability to manage some aspects of daily living. One day she collapsed, and was taken to the emergency room. She was admitted for her medical conditions. Mandi eventually transferred to a Skilled Nursing Facility. COD staff continued to meet with her on a weekly basis for counseling and support. Mandi remained substance-free, and after three months moved back to the long term shelter she is comfortable with. Mandi regained her strength, and without the constant thought processes about her past, began to focus on the present. She developed an interest in health care needs of older adults and began to research the topic. With support from COD staff, Mandi located a volunteer position in a local agency. She now works two days per week there, and attributes her ability to do so, to her work in the COD program. Mandi will soon move into her adult daughter's home, and for the first time in 17 years will have a home again. Mandi continues to receive services in the COD program as she is now ready to work on childhood trauma issues revealed in recent months. She has been completely abstinent from all substances for over 2 years.

Child Story:

Theo (name changed to protect confidentiality), an 18 year old adolescent male in a diverse ethnic group, came to CoRR at age 17 in June 2016 after being referred by Juvenile Probation. Before even starting services at CoRR, he had a five year history of addiction to both marijuana and alcohol. He had been using both substances daily and sometimes went to school under the influence. He had a close call with alcohol poisoning a couple of times when he was age 17 where he blacked out and became violently ill. Theo was diagnosed with a co-occurring disorder with Posttraumatic Stress Disorder; related to abuse and neglect he suffered in his earlier childhood. Theo said he used drugs on a daily basis "for fun sometimes" and would also "numb" his feelings related to anxiety and depression. The daily use of drugs resulted in his grades dropping drastically due to extensive absences, tardiness, getting in trouble for disruptive behavioral issues/defiance, and not being able to pay attention in class. Prior to his drug and alcohol dependence he was an A student, very engaged in school, and had excellent behavior. Theo also had relational issues with his adoptive parents and would rebel against his adoptive father, shut down and not communicate with his adoptive mother. He reported feeling hopeless at times, self-harming, being reckless in different ways, and feeling anxiety on a daily basis. He reported traumatic memories from his entire life until he was adopted out to his adoptive parents. He also reported some grief and loss issues related to losing his mom.

Theo was a very open communicative person with his therapist from the beginning. Working with this clinician, he was able to build coping skills and reduce his anxiety and depression. He went from having a fairly flat affect and limited expression of feelings, to beginning to discover, name and express an increased range of emotion openly. He participated in grief work related to his losses, traumas and the abuse and neglect he and his siblings suffered. He processed feelings and demonstrated empathy and forgiveness to his biological mother and also to his adoptive parents for various circumstances. He was able to forgive himself. As a result of services he began attending school, clean and sober, on a regular basis and remained abstinent from substances in general. He also found healthier clean and sober friends, practiced coping skills, started to play his guitar again and successfully graduated school with a high GPA. He completed Probation and because he did everything required and more, he does not have a criminal record that will follow him (his past legal issues are sealed with the court). In addition, Theo experienced the benefit of working on himself, and maintains participation in a men's group catering to the ethnicity with which he identifies, to continue personal work related to drugs/alcohol, family, trauma, etc. Theo now considers his future to be very bright.

General System Development:

NEVADA COUNTY ADULT & CHILDREN'S SYSTEM OF CARE
Expand Mental Health Services

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) Children's Services provided Expanded Mental Health services to 45 children with MHSA CSS funds in FY 2016/2017. Some of the children

were being wrapped with Full Service Partner (FSP) providers. Some of these children continue to see NCBH staff individually and work with the WRAP team. This data excludes services provided by interns. Intern services are funded separately.

Nevada County Behavioral Health Adult Services provided Expanded Mental Health services to Case Management/Auxiliary program participants using General System Development funds. These funds payed for 29 individuals in FY 16/17. Expansion of psychiatry services and expansion of mental health services within the Adult System of Care included the same individuals. All Integrated Service Team program participants received both psychiatric and case management services. This data excludes services provided by interns. Intern services are funded separately.

Target Population

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

Evaluation Activities and Outcomes

Of the 29 adult program participants, 10 had completed a baseline and annual Basis 24 outcome measure survey. The Basis 24 is scored on a five point Likert Scale where zero represents "No Difficulty" and four represents "Extreme Difficulty". Results are shown below. However, the small number of consumers who had data available for this program does not represent a statistically significant sample size.

Basis 24 Domain	Overall	Depression/ Functioning	Relationships	Self-Harm	Emotional Lability	Psychosis	Substance Abuse
# of Participants	6	8	10	9	9	10	10
% of Participants who improved or stayed the same	17%	13%	60%	78%	33%	40%	80%

The NCBH Children's System of Care is in the process of implementing Electronic Behavioral Health Solutions (eBHS), a software and support product that will facilitate efficient quantitative data-gathering and aggregation of outcome measures including the Achenbach Child Behavior Checklist (for children/youth). The Children's team collects this data now, but there is no way to aggregate it for overall reporting. It is expected that in the next six months there will be quick access to aggregate outcome data. Until that time there are no reportable outcomes.

Challenges, Solutions, and Upcoming Changes

Finding a system that will collect, collate and summarize outcome data for NCBH has been a challenge. With the implementation of the eBHS software, staff, supervisors and management will be able to pull reports using a wide range of filters to better understand the data that is being

collected. This will enable the programs to report out on participants' progress and improvements due to treatment they have received.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Crisis Workers, Crisis Support Team

Program Description

Program Overview

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

The crisis workers provided direct crisis intervention services to program participants by phone contact and face-to-face evaluation. Crisis staff also responded to other locations as required including Sierra Nevada Memorial Hospital, Wayne Brown Correctional facility, and juvenile hall. Workers collaborated with other human service providers and law enforcement to determine whether hospitalization was required and what resources for referral were appropriate.

The location of the Crisis worker in the CSU at SNMH offers an integrated service where people being held on a 5150 can, if appropriate, be moved from the hectic atmosphere of the local emergency room to a higher and more appropriate level of care at the CSU. It also offers a place where individuals experiencing a crisis can stay for 23 hours on a voluntary basis with therapeutic help, and perhaps, eliminate the need for a 5150 hold.

Target Population

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

Evaluation Activities and Outcomes

In FY 16-17 the targeted goal was for Crisis Workers to serve 1,000 individuals. The result was 928 unduplicated people served, representing 92.8% of the goal. A total of 1,740 contacts occurred; many of the above individuals were seen two or more times throughout the year.

Reports from the community have been anecdotally provided by the hospital medical staff and by law enforcement. The physical presence of crisis staff on the hospital campus 24/7 has increased immediate access and shortened response time.

Consumers have also expressed satisfaction with the immediate service and additional resources as crisis workers are able to provide quicker crisis stabilization with the CSU right next to the Crisis office. With the new walk-in policy, consumers get immediate crisis response without having to go through the Emergency room.

The requirement to have a qualified Crisis Worker in service at all times has been met.

Challenges, Solutions, and Upcoming Changes

There is a shortage of Crisis staff.

Two consumer categories are particularly challenging: The highly acute, potentially violent client, and the minor who is in need of acute care placement. Planning is now occurring for improved staffing in regards to security measures and specially trained staff for high acuity consumers.

Program Participant Story

Recently, a minor, from another county, who had been placed on 5150 holds on repeated occasions, was brought again to the Emergency Room (ER). For five days, crisis workers searched in vain for placement for him while he remained in the ER. Placement was continuously blocked by acute care facilities refusing to accept him, for various stated reasons, including his Foster Care designation. The crisis worker provided extensive consultation and outreach to the facility to aid them in providing treatment, and closely coordinated with them on a safety plan for this child to return to their facility. This extensive intervention ended his stay in the ER, returned him to his familiar and appropriate living situation, and provided new tools and strategies to his caregivers to help de-escalate and possibly prevent further 5150 episodes.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Crisis Stabilization Unit (CSU)

Program Description

Program Overview

Sierra Mental Wellness Group's Crisis Stabilization Unit (CSU) opened on December 14, 2015 to better serve Nevada County residents experiencing a mental health emergency. The facility is a four bed, unlocked unit, staffed by a mental health professional and a medical professional on-

site at all times. Psychiatrists are on-call 24/7. Individuals may be admitted while awaiting placement on a 5150 hold or voluntarily. Since opening, the CSU has served 508 unduplicated individuals with 808 total admissions. In FY 16/17 the CSU served 389 unduplicated individuals.

Per Medi-Cal requirements, individuals are allowed to stay up to 24 hours in the CSU. During that time the individuals are assessed by the medical professional for medical issues that may be contributing to their crisis. Current medication interactions are investigated. A "wellness and recovery" plan is developed by the mental health professional in conjunction with the participant. The plan explores the participant's strengths and support systems to help resolve their crisis and improve their coping mechanisms. Specific referrals to meet the individual's needs are offered and, where possible, warm-handoffs are provided. The local respite center has received 17 documented warm handoffs from the CSU. Many more CSU participants could have used the service, were beds available. Many avenues are explored for individuals with drug and alcohol issues e.g. Behavioral Health Drug and Alcohol Treatment, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and local outpatient programs. Spirit Peer support staff provide services to individuals residing in the CSU daily.

The participant's family and support system are included in their care wherever possible. Arrangements are made for family meetings with a mental health professional, or contact is made by telephone. The staff make an effort to get participant permission to make contact their family and/or support system with 100% of the individuals residing in the CSU, and/or staff support the individual in making that contact themselves. The success rate of arranging contact is not available; however anecdotal information suggests that it is successful well over 60% of the time.

The CSU program reduces the stigma of mental illness while providing the participant a safe, therapeutic, pleasant environment with staff trained to serve the special needs of individuals experiencing a mental health emergency. Additionally, the program reduces the burden in the local hospital emergency room which is located on the same grounds about 70 feet from the CSU door.

Target Population

A CSU is 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 5150 hold whose crisis can be relieved by a 24 hour stay in the CSU with therapeutic and medical intervention, is the primary goal of the program. The program serves uninsured, and privately insured individuals 18 years old and older.

Evaluation Activities and Outcomes

The CSU program has resulted in the rescinding of 84 of the 257 individuals who resided in the CSU while on a 5150. The availability of the CSU offers the crisis staff an additional resource

as part of the participant's safety plan. For the participant, it is a safe haven away from the stressors that are often catalysts to their crisis.

The CSU has been a huge success with the community. Participants report 95% satisfaction with the treatment they received and the progress they made while in residence, per the satisfaction survey. Those that were unfortunate enough to have mental health emergencies prior to the CSU being built are particularly appreciative of the services provided and the compassionate, therapeutic nature of the care.

Sierra Nevada Memorial Hospital (SNMH) is also appreciative of the CSU. The emergency room boarding time has decreased 50% since the CSU doors opened. This data is collected and shared by SNMH Community Health Outreach Specialist, Stephanie Krieter. Participants evaluated in the emergency room (individuals must be 18 years or older, medically stable, and not violent) are presented to the CSU staff and transferred to the CSU as quickly as possible. With only 18 beds in the emergency room, freeing up beds for medical patients is vital. The cooperative relationship with the hospital is functioning well with ongoing meetings between Nevada County Behavioral Health, CSU, and hospital administrations, along with community stakeholders.

To lessen the impact of overcrowding on the emergency room, and the impact of the emergency room on the participants, a 12-hour window from 10 a.m. to 10 p.m. was established for walk-in evaluations at the CSU. Since September 2016, when the walk-in policy began, the Crisis Team has evaluated 173 walk-ins, and 109 were admitted to the CSU. The numbers may be underestimated due to procedural changes with the new policy. Now, clients are relieved of lengthy delays and frustration while awaiting treatment in the emergency room triage area. The service has also benefitted other community stakeholders such as law enforcement. They now bring individuals directly to the CSU, give the crisis staff a report, and return to duty. The county jail, local homeless shelter, FREED Center for Independent Living, and local clinics often refer directly to the CSU. A working relationship has been established with these stakeholders to communicate with crisis and CSU staff regarding participant care.

Arrangements have been made for two neighboring counties to admit their clients to the Nevada County CSU.

The impact of the CSU cannot be overstated. It is lauded at community meetings on a frequent basis.

Challenges, Solutions, and Upcoming Changes

The CSU was underutilized during startup and into the first year the facility was open. The census is increasing as both clients and community stakeholders are made aware of the services offered e.g. in the second quarter of 2016 the CSU had 54 admissions, in the same quarter of 2017 the CSU had 201 admissions, a 272% increase. Outreach and education about how to access the CSU is helping to build census, but more needs to be done. The focus of the outreach has been to referral sources e.g. Turning Point, Spirit Center, Western Sierra Medical Center, law

enforcement, etc. Approximately 200 people have received information on the CSU services and accessibility since the CSU opened.

A brochure was created with the availability of walk-in service and description of CSU services. Copies are available at locations with community access e.g. Spirit Center, Turning Point, Western Sierra Medical Clinic, and Sierra Nevada Memorial Hospital. Local referral sources for CSU admissions continue to be contacted by CSU and Nevada County Behavioral Health. Staff meetings with referral source staff are attended and information about the CSU is shared. Local stakeholder meetings e.g. Forensic Task Force, 5150, substance abuse, and many more, are attended on a regular basis and include updated information and reports on the CSU operations.

Originally, there was a learning curve for administration, the crisis team and the CSU staff as to who was appropriate for a CSU admission. Individuals who were thought to be too violent or an Absent without Leave (AWOL) risk, when admitted, have responded well to therapeutic, compassionate treatment, and pleasant surroundings. Few problems have occurred in the year and a half of operation, and those that did were resolved without major incidents. This has increased staff and administration willingness to admit individuals previously thought to be a risk and, thereby, increased census.

The 12-hour walk-in policy has also helped to increase census and educate staff, participants, and the community as to who can benefit from CSU admission. Speed of access to evaluation and admission to the CSU has increased. Space to do evaluations is an issue as the number of walk-ins rises. Rethinking how the available rooms can be utilized is being assessed.

Some clients report being bored when not interacting with staff on the unit. A television with DVDs is available. Though reading material is provided, many clients who experience hallucinations or intrusive thoughts cannot focus well enough to read. Therapeutic art materials were added. Originally, participants were not allowed to use their electronics. A change of policy which allows electronics has improved participant satisfaction. Arrangements have also been made to provide smoking breaks which has been well received. Family and support persons are encouraged to visit, along with Spirit Peer Support and AA/NA representatives.

Program Participant Story

A long-term behavioral health participant experienced a psychotic break exacerbated by the use of alcohol and drugs. The individual is a large male with a tendency to fight and react violently when confined or threatened. Because of his past behaviors, he stayed in the emergency room for days awaiting placement in a psychiatric facility. He AWOLed several times due to anxiety and frustration with being confined and the inability to smoke. The AWOLs delayed his treatment and recovery, and increased the wait for psychiatric placement. Eventually, it was decided that confining him in the emergency room was not a successful strategy. A clear agreement was made with the individual regarding his behavior. Boundaries were set, and smoking breaks were agreed upon. While he waited for a hospital bed, staff worked with him regarding his health (weight and medical issues) and behavioral issues. They built a relationship with him and his self-esteem improved. He adapted well and made an excellent recovery.

Months later, after stabilization on medication, he frequently drops by the CSU. The staff greet him fondly and give him positive reinforcement for the changes he's made. He is clean and sober, taking care of his medical issues, exercising and eating more appropriately. He is taking his medication and his psychosis is under control. He was able to return home and enjoy his extended family.

General System Development:

TURNING POINT
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 as a whole. The approach is based on the core values of mutual respect and mutual learning. It's about guests connecting with someone in a way that supports each in learning, growing and healing.

In collaboration with SPIRIT Peer Empowerment Center and Nevada County Behavioral Health, the IRC is committed to providing guests an environment and connections that help individuals move toward their desired goals. Located in a lovely rural setting, "Insight" offers an alternative resource for eligible adults that may prevent the need for hospitalization. Peer supporters, trained in trauma informed models, are available 24 hours a day, offering hope, compassion and understanding in a stigma-free environment.

After leaving Insight Respite Center, guests are offered a number of additional services, including a 24/7 "warm line" manned by peer supporters, follow up phone calls from peers at two weeks and two months; regular alumni lunches, and visiting hours.

Target Population

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

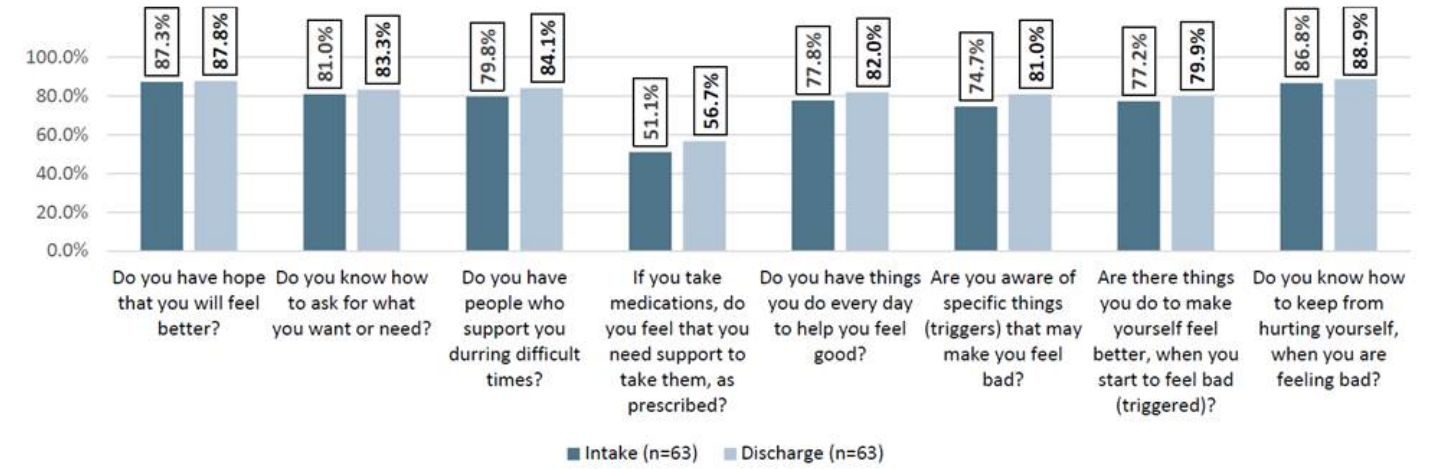
Evaluation Activities and Outcomes

- A total of 77 guests were served at IRC in FY 16/17.
- Demographic data is gathered on all guests served.
- Insight Respite Center is 87% peer staffed.
- Insight Respite Center guests received 128 linkages to community services during their stay.
- At discharge, 61.3% of guests met their goals.
- Prior to admission, 9.8% of guests had an inpatient psychiatric hospitalization in the previous six (6) months; in the months following discharge, 5.4% of guests had an inpatient psychiatric hospitalization, for a decrease of 4.4%.
- Prior to admission, 0.9% of guests had Institutions for Mental Disease (IMD) or other hospitalization in the previous six (6) months; in the months following discharge, there were no IMD or other hospitalizations reported.
- Outreach for the first quarter included an article on Insight Respite that was in the newspaper. The Circulation of The Union Newspaper was 10,172 people.
- Based on data from pre and post outcome surveys given at intake and discharge, guests showed an increase in each of the eight areas measured:

As part of the guest's intake and discharge process, they are asked to fill out a Pre/Post Outcome Survey. Eight items are measured as a pre/post comparison between intake and discharge. Participants answer the following items using a 3-point Likert scale (Rarely, Some of the Time, Most of the Time):

Pre/Post Outcomes

For those served within the reporting period, a total of 63 duplicated individuals completed both a Pre (intake) and Post (discharge) Outcomes Survey. Only those 63 individuals were included in the analysis below.



- The data below includes all the Insight Respite Center Admissions in FY 16/17 (not unduplicated). The data shows that 9.8% of admissions were hospitalized before their Respite stay, but only 5.4% were hospitalized after going to Respite. Additionally, .9% of admissions were in an IMD before their Respite stay, but none were in an IMD after going to Respite.

Number and Percent of IRC Admissions,
by Inpatient Hospitalization Before* IRC Admission

	# IRC Admissions	% IRC Admissions
Inpatient Before IRC	11	9.8%
No Inpatient	101	90.2%
Total	112	100.0%

Number and Percent of IRC Admissions,
by Inpatient Hospitalization After* IRC Discharge

	# IRC Admissions	% IRC Admissions
Inpatient After IRC	6	5.4%
No Inpatient	106	94.6%
Total	112	100.0%

Number and Percent of IRC Admissions,
by IMD/Other Hospitalization Before* IRC Admission

	# IRC Admissions	% IRC Admissions
IMD/Other Before IRC	1	0.9%
No IMD/Other	111	99.1%
Total	112	100.0%

Number and Percent of IRC Admissions,
by IMD/Other Hospitalization After* IRC Discharge

	# IRC Admissions	% IRC Admissions
IMD/Other After IRC	0	0.0%
No IMD/Other	112	100.0%
Total	112	100.0%

* Data was analyzed on hospitalizations 6 months before IRC admission through 6 months after IRC discharge.

Challenges, Solutions, and Upcoming Changes

Barriers/Challenges: Accommodating staff needs for frequent scheduling adjustments due to self-care/vacations, and hiring staff who identify as peers who will work on an "on-call" basis are challenges faced at the Insight Respite Center.

Finding additional funding sources for the impending end of the SB 82 grant in 2018, to keep Respite as a thriving and viable option for the community is also a challenge.

Solutions to Barriers: Respite is advocating for staff pay increases in FY 2017/2018 to maintain the current staff levels and as an attraction for future hires. Insight Respite is working with Nevada County Behavioral Health to implement Medi-Cal billing as a funding source beginning in January 2018. Outreach efforts to community partners are ongoing to promote awareness of the services Insight Respite Center offers.

Program Participant Story

Written by a former guest

"Well, as I arrived as a guest here at Respite, I was having a lot of distorted thinking. The stay here and support of PSS (Peer Support) staff provided a good sounding board (of people) who could relate. I was able to calm down, think things out, use the pros and cons to weigh out and balance the issues I had when I arrived. I've been able to observe the peer supporters in their positions to see how guests are cared for to help with returning home. All I can say is 'thank you all', but thanks can't be enough. What I've learned confirms the things I learned in Sue Haddon's class, that when I've put myself stable, I will submit an application to return and help someone else with the issues they are experiencing. Respite is, and should be expanded worldwide. A pit stop on the track of life. I am on a path with fresh tires and a full tank of fuel! I see the green light. Thanks to all."

General System Development:

SPIRIT
Emergency Department (ED)
Crisis Peer Support Program

Program Description

Program Overview

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

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

Target Population

The SPIRIT ED program targets individuals in crisis in the Emergency Department (ED). Anyone over 18 who walks into the Emergency Department/Crisis Stabilization Unit in crisis that indicates that they would like support is served.

Evaluation Activities and Outcomes

The total number of unduplicated people served in FY 16/17 was 262. Of those, 118 people became SPIRIT participants. There were 179 Action Plans developed. Stress Reduction Techniques were discussed with 205 participants and 114 participants put the techniques to use. There were 755 referrals made and of those, 145 were able to be tracked to completion.

Challenges, Solutions, and Upcoming Changes

Accurate Demographic Data is challenging to acquire. Collecting most demographic information other than name and age is difficult from folks who are in crises at the emergency department and Crisis Stabilization Unit (CSU).

Going forward, staff will be collecting the demographic information at the SPIRIT Center when a person comes in to register for services. There will be a place on the form for participants to state whether they were seen in the emergency department and also a box to check for "decline to state". This should make a huge improvement on the data able to be collected. However, it is still a struggle to get folks to come to the SPIRIT Center after meeting with them at the CSU.

Program Participant Story

My name is Mary (name has been changed) and I'd like to tell you about my story of being in crisis, and the services that were provided to me at the hospital. I was feeling very anxious, and I decided to drive myself to the hospital. Once arriving, and walking through the doors of the trailers located near the Emergency Room, I was immediately comforted. The staff asked if I'd like to see a Peer Supporter, and I quickly said yes. We had a wonderful chat, and the Peer Supporter was very professional and understanding. One thing she suggested was the SPIRIT Center. After a few days of rest, I decided to try her suggestion. I'm very glad that I did, as I now have a support group that I enjoy, and a new group of friends!

General System Development:

SIERRA MENTAL WELLNESS GROUP
Truckee Outreach & Engagement Liaison

Program Description

Program Overview

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

Target Population

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

Evaluation Activities and Outcomes

Four individuals were served by this program in under CSS funding in FY 16/17 between 7/1/2016 and 8/26/2016. On 8/26/2016 the program moved from CSS to Innovation funding. The data for the rest of the fiscal year can be found in the Innovation section of this report. Due to staff turn-over and the short time this program was funded under CSS, there was not enough activity to develop or collect evaluation or outcomes data.

Challenges, Solutions, and Upcoming Changes

Due to housing costs in Truckee and some other factors, it has been difficult to keep this program staffed.

This program changed to an Innovation project as of 8/26/2016.

Program Participant Story

Due to staff turnover, no individual story was available.

General System Development:

WELCOME HOME VETS

Program Description

Program Overview

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

ongoing treatment, thus ensuring that some Veterans who are at a high risk for suicide, involvement with the legal system, divorce and psychiatric hospitalization received the help they needed.

Welcome Home Vets (WHV) received its 501 (c)(3) certification in 2010. The program provides a continuum of psychotherapy to veterans and their families who are afflicted with PTSD and other diagnoses related to psychological trauma incurred in the military, as well as collaborative referrals to other services which will help the veteran adjust to civilian life. To date several hundred vets have participated in the vets-only programs.

Target Population

The Welcome Home Vets program targets the veteran population of Nevada County and their families who are afflicted with PTSD and other diagnoses related to psychological trauma incurred in the military.

Evaluation Activities and Outcomes

During the 16/17 fiscal year, 60 individuals were served by this program. WHV delivered 46 group sessions and 412 individual sessions by Licensed Marriage & Family Therapists (LMFT).

FY 16/17 BASIS-24 OUTCOMES:

- Contract Goal: Less than 5% of veterans will be incarcerated in jail or prison during the time of treatment. Basis-24 FY 16/17 outcomes showed 14% of veterans were incarcerated in jail or prison during the time of treatment. WHV did not meet the contract requirement for this goal.
- Contract Goal: 95% of veterans in treatment will report thinking about ending their life only a little or none of the time. Basis-24 FY 16/17 outcomes showed 50% of veterans in treatment reported thinking about ending their life only a little or none of the time. WHV did not meet the contract requirement for this goal.
- Contract Goal: 90% or more of veterans in treatment will not be hospitalized in a psychiatric hospital during the treatment period. Basis-24 FY 16/17 outcomes showed 100% of veterans in treatment were not hospitalized in a psychiatric hospital during the treatment period. WHV met the contract requirement for this goal.
- Contract Goal: 15% or less of veterans in treatment will report being in a shelter or homeless on the street more than one time during treatment. Basis-24 FY 16/17 outcomes showed 10% of veterans in treatment reported being in a shelter or homeless on the street more than one time during treatment. WHV met the contract requirement for this goal.
- Contract Goal: 70% of veterans in treatment will report feeling short-tempered less during a week. Basis-24 FY 16/17 outcomes showed 45% of veterans in treatment reported feeling short-tempered less during a week. WHV did not meet the contract requirement for this goal.
- Contract Goal: 70% of veterans will report that they got along well in social situations half the time or more during a week. Basis-24 FY 16/17 outcomes showed 59% of

veterans reported that they got along well in social situations half the time or more during a week. WHV did not meet the contract requirement for this goal.

Challenges, Solutions, and Upcoming Changes

Therapist provided pro bono services for 13 group sessions and 124 individual sessions. In February, the WHV Board of Directors voted to increase funding for the therapists from WHV's general funds. The amount of this additional funding is 20% of the CSS contract value but it is highly dependent on WHV's financial position. WHV therapists were very pleased with the Board of Directors decision to provide additional funding. The program has also seen an increase in donations, has received several grants, and has conducted/participated in a number of fund raisers.

In addition, WHV has been gradually transitioning many of their longer-term clients to a recovery model which features peer-facilitated support groups in place of therapist-led support. This model fits the needs of the chronically disabled population quite well. As participants begin to achieve some of the goals that they set, especially goals in the area of relationships with others, they become less dependent on the paid therapist and are able to engage in more social activities with peers; something many have not done since leaving the military. This model also allows WHV to allocate scarce resources to newer clients who need therapist-led treatment.

Several grants have been received from the Sierra Health Foundation and the Elks which will supplement the WHV general funding.

Program Participant Story

Welcome Home Vets (WHV) organized a Quilting Event in December 2016. The idea was to introduce ten quilters who donated quilts to the veterans who would receive them. These veterans would receive the quilts at the event. The tables were set up such that the quilters were at the same table as the veteran who would receive their quilt, but neither one knew that. The event was a huge success! One veteran, a pilot, received a quilt with a rotor blade pattern.

A veteran's mom, representing her son, received a quilt on his behalf. Her son spent several years in the military, including a year in Iraq, before returning home. "He hasn't been the same since, but he is improving thanks to work with outside organizations including WHV. He just wasn't adapting coming home. He just wasn't well. It's been a long difficult journey for the family and for my son. We couldn't do it without outside help; without these people here. He's getting better. There are still a lot of challenges but the WHV volunteer, and other people in the community helped us navigate through the VA system to get my son a disability rating so he could at least pay his bills and not be homeless."

General System Development:

NEVADA COUNTY HOUSING DEVELOPMENT CORPORATION (NCHDC)
Housing & Support Services,
MHSA Housing

Program Description

Program Overview

The MHSA Housing program provides housing and supportive services to severely mentally ill (SMI) homeless individuals and families.

Behavioral Health and Nevada County Housing Development Corporation (NCHDC) partner to provide housing and supportive services for individuals with mental illness who are potentially homeless, are homeless, or are chronically homeless. NCHDC provides property management, maintenance and repairs for the two homes they own as well as the ones they master lease. NCHDC closed on a second Mental Health Services Act home in August 2016. Behavioral Health and Turning Point provide Case Management support for the tenants.

NCHDC assists tenants with their rental applications, lease agreements and general living skills to maintain their housing. NCHDC also assists with grant applications, grant reviews and grant evaluation reports as needed. NCHDC meets weekly with County and contract housing personnel: Case Managers/Personal Service Coordinators, Program Managers, Supervisors and others. Lines of communications are kept open with tenants' family members and all owners to address any concerns and to provide services to keep the tenants housed. Tenant information is entered into HMIS (Homeless Management Information System), and quarterly meetings are held with County Accounting personnel to review expenses and income regarding the properties and the grant funding requirements.

Summer's Haven Program

Behavioral Health received a renewal grant from Housing and Urban Development (HUD) Continuum of Care (COC) for $110,841 to house a minimum of thirteen individuals. There are 16 sites that house 21 tenants.

Home Anew

Behavioral Health was awarded a renewal grant for $20,270 from HUD in FY 16/17. These funds subsidize the rent for three units that house 4 tenants.

Winters' Haven

Behavioral Health received a renewal grant from HUD for $38,840 for the Winters' Haven Program. The Winters' Haven Program provides project-based vouchers for five bedrooms in the first home purchased with MHSA Housing funds. New in FY 16/17 is the expansion of the project-based voucher to an additional housing unit, so a total of 6 units are supported by the program.

Catherine Lane - Second MHSA funded House
NCHDC closed escrow in August 2016 on a six-bedroom house. There are six tenants housed there. A House Manager is present during the day and House Monitors spend the night. The tenants need this level of care to remain housed. The home is currently being upgraded including a new roof, deck replacements, bathroom fixtures, ceiling fans and new flooring.

Target Population

The target population for these programs are individuals with mental illness who are potentially homeless, are homeless or are chronically homeless.

Evaluation Activities and Outcomes

NCHDC meets with tenants and their supportive staff to help tenants maintain their housing. The program provides as much assistance as possible, including payment plans if individuals have financial difficulties paying their rent. Assistance with donations of furniture and other household items is given.

A total of 42 individuals were housed through NCHDC in FY 16/17. This included two tenants that have remained housed for over four years, and twelve tenants who are in their third year being housed. Seven tenants left the program and of those, five secured independent housing.

The success of NCHDC is keeping tenants housed long term and having tenants who have been able to move onto independent living. Of the seven tenants who moved, five obtained permanent housing. Those who left the program in FY 16/17 had an average length of stay of 16 months. The remaining tenants in FY 16/17 have an average length of stay of 18 months. One tenant had no income at program entry, and now has Social Security Income. Eighty-three percent of tenants maintained their income level in FY 16/17. Seventeen percent increased their income level during this fiscal year.

Challenges, Solutions, and Upcoming Changes

There is always a challenge to find landlords willing to rent to no income or low income individuals with poor rental histories, and to find units that meet the NCHDC funding requirements. The program has negotiated with owners to accept the Fair Market Value that NCHDC can pay.

NCHDC, due to the Executive Director retiring, is merging with another Non-Profit Housing agency.

Program Participant Story

NCHDC reports a tenant who now has their own single-family house, and another tenant who obtained their own shared apartment. These are true success stories.

Outreach and Engagement:

FULL SERVICE PARTNERSHIP AGENCIES AND OTHER CONTRACT CSS SERVICE PROVIDERS

Program Description

Program Overview

Full Service Partnership Agencies and Other Contract CSS Service Providers conducted outreach and engagement services throughout the fiscal year. These services were done for individuals, families, and other stakeholders through Turning Point, New Directions, Victor, Uplift Family Services, Insight Respite Center, and the Crisis Stabilization Unit. Outreach and engagement activities were provided to 10,845 individuals under these programs in FY 16/17. This number does not include services provided by the individual programs listed separately in this section of the report.

Outreach and Engagement:

SIERRA FAMILY MEDICAL CLINIC

Program Description

Program Overview

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

Target Population

SFMC targets the low income unserved and underserved segment of the County's population with mental health needs, primarily individuals in the North San Juan Ridge Area. Two thirds of SFMC patients are low income: 40% are on Medi-Cal and 26% are on Medicare/Medi-Cal. Additionally, 26% are on Medicare, with a significant number without a secondary insurance plan.

Evaluation Activities and Outcomes

A total of 81 unduplicated individuals were served by SFMC in FY 16/17. Consistent with clinic practice, warm-handoffs from medical providers resulted in approximately 90% of participants connecting and continuing with behavioral health services. Eighty percent of individuals engaged in referred services within 90 days. Participants were referred to Hospitality House, LogistiCare transportation, Medi-Cal, CalFresh, Family Resource Centers, Alta Regional Center, Domestic Violence and Sexual Assault Coalition, SPIRIT Center, Common Goals, Nevada County Behavioral Health, FREED, Community Legal, Workforce Development, Connecting Point, Interfaith Food Ministry, Salvation Army, North San Juan Senior Center, and community therapists. There were an unusually high number of participants in the second quarter of the fiscal year as SFMC actively engaged individuals in enrolling for the Housing Choice Voucher program; a team of staff assisted participants in completing and submitting the forms.

Challenges, Solutions, and Upcoming Changes

The greatest challenge for SFMC is transportation. There is no public transportation in this large rural area, including no transportation to Nevada City/Grass Valley. Although managed care Medi-Cal patients can access transportation now for medical appointments, it can be limited and does not support obtaining prescriptions or ancillary needs. Participants have expressed that sometimes there are challenges with the medical taxis picking them up after the medical visit, if the visit is long.

Participants have cancelled appointments due to lack of gas for their cars. Individuals' cars break down, but cannot be fixed due to lack of funds. The ability to receive assistance for food and social support can also be impeded due to lack of public transportation in the area.
Participants have challenges getting to town for specialty medical appointments due to transportation barriers. Some individuals have to choose between gasoline and food in order to attend cancer treatment appointments, physical therapy, and other multi-appointment treatments.

This issue needs attention beyond the clinic. Staff encourages carpooling and participant connections, but there are not enough resources to address this problem.

In addition to transportation, housing continues to be a major need. Rentals are hard to find let alone affordable housing and temporary housing for participants who are not eligible for current community programs; some individuals continue to live in substandard housing and crowded conditions.

Finally, clinic primary care providers are not able to address participants with complex psychiatric needs. At present tele-psychiatry is only available to individuals on Anthem Blue Cross managed care Medi-Cal. It is nearly impossible to find psychiatry for participants with California Health and Wellness coverage.

Program Participant Story

A SFMC participant in his thirties with intellectual disabilities, anxiety, depression and general medical problems lost his job and faced homelessness. He had no family support. SFMC was able to support him in treatment for his health conditions and helped him strengthen socialization skills. Additionally, SFMC facilitated successful connections with Alta Regional Center and FREED which resulted in a successful application with Social Security Income (SSI). This individual now is a Regional Center participant, receiving SSI and is no longer homeless. He also has a part-time job.

Outreach and Engagement:

SPIRIT
SPIRIT Peer Empowerment Center

Program Description

Program Overview

The SPIRIT Center is a local non-profit centrally located in a comfortable home-like setting on five acres with a garden. The program offers Individual Peer Support, Weekly Support Groups, and Referrals to Community Services, computer access, an organic garden, Saturday brunch, and access to showers and laundry. SPIRIT Center offers Educational Training classes like Advanced Peer Support 101, Recovery, Goals and Life Skills, WRAP (Wellness Recovery Action Plan) and Yoga WRAP.

Target Population

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

Evaluation Activities and Outcomes

- During FY 16/17 SPIRIT had 6,745 visits by 774 unduplicated visitors. SPIRIT's volunteers contributed 5,042 hours that resulted in a savings of $89,243 in potential wages. These volunteers engage in helping SPIRIT to grow and thrive. Some of their jobs entail front desk, property maintenance, one-on-one peer support, group facilitation, Peer Support Interning and other things to help the center run on a daily basis.
- SPIRIT provided 565 one-on-one peer support sessions during the year. SPIRIT's support group attendance was 1,248. SPIRIT provided 809 showers; 253 loads of laundry were also done. SPIRIT also assisted its participants with access and linkage to other community resources, provided assistance with completing applications to receive

services from other agencies, and assisted with locating housing and jobs for participants. The program continues to provide food that is donated from The Food Bank of Nevada County. In FY 16/17 SPIRIT supplied 903 bags of food to participants.

- SPIRIT offered six Social activities per week, in addition to the regularly offered support groups and educational classes. The attendance for FY 16/17, to all of the Social Activities (Music and Movement, Restorative Yoga, Garden Project, Brunch, Beading for Wellness and Creative Expressions) was 1,584.
- Of the folks that completed surveys, everyone was extremely complimentary regarding SPIRIT's services. One hundred percent of the surveys indicated that SPIRIT had made a positive improvement in participants' lives. Most common were the improvements in life-coping skills and prolonged suffering. About 65% of participants can still use help with Housing and Employment. These are issues SPIRIT will focus on going forward.
- Additional statistics from FY 16/17 are below:

SPIRIT Center Stats For FY 16/17	**Year End Total 16/17**
Empower peers to engage in the highest level of work or productive activity appropriate as measured by:	
Number of peers who obtained gainful employment	35
Peer Support training hours	1,009
Services offered to peers to optimize opportunities for productive activity (list hours for each service):	
- Front Desk	1,285
- Property Maintenance	1,285
- One-on-one Peer Support	1,285
- Group Facilitation	24
- Peer Support Interning	1,285
Reduce isolation of persons with mental illness as measured by:	
Support Groups per Quarter	325
Social Activities per Quarter	287
Improve quality of life of homeless individuals as measured by:	
Number of homeless participants who obtained housing	12
Survey Results-Number of participants who improved in each area. Note: 200 Surveys were completed.	
Housing	78
Education/Life Skills/Coping Skills	120
Hospitalizations	75
Incarcerations	5
Employment	95
Prolonged Suffering	151
Number of people attending a SPIRIT educational class:	
- Peer Support (PS-101)	12
- Yoga WRAP	25
- Holiday WRAP	2
- Group Facilitation	8
- WRAP	5
Other Data to be collected:	
New Participants	310
-New Participants that came to SPIRIT from the ED program	118
Fundraising efforts (Holiday Letter, donation jar, random donations)	$8,096.40
- Fundraising dates and number of attendees	11/2016 - 35, 5/2017 - 100 attendees
Stomp out Stigma efforts	8
Number of participants in the weekly Co-Occurring Diagnosis Group	98
Hours the Center was open	1,285

Challenges, Solutions, and Upcoming Changes

Finances continue to be the largest challenge SPIRIT faces; specifically, the inability to hire more Peer Supporters. A large percentage of participants (currently 50%) are homeless. The homeless participants take quite a bit more staffing resources than those participants that are housed. SPIRIT struggles because of lack of staff to handle the needs of both housed and un-housed participants in an effective way. SPIRIT continues to try to maximize their volunteer effort to fill the gaps in staffing.

Program Participant Story

Written by a SPIRIT participant:
I first became involved with SPIRIT when I enrolled in their Peer Support Specialist Training. I quickly experienced the warm, welcoming environment that SPIRIT provides and knew this was a place where I wanted to spend more time. This was during a period in my life in which I had a great desire to help others, while at the same time, I was still in need of support in continuing on my own path of wellness. At SPIRIT, I was able to do both; receive support and empowerment from my peers while also lending support to others. SPIRIT helped me beyond measure during a critical, transitional period in my life. It is the many aspects of SPIRIT that not only make the center unique, but also helped me to be successful in my own personal well-being. SPIRIT provides a home-like setting that is equipped with basic essentials such as a kitchen full of food, laundry access, and showers. There are several support groups available as well as one-on-one peer support with staff that is patient, compassionate, and open to sharing their own life experiences. I often felt there were no challenges I couldn't share with my peers at SPIRIT. In addition, it was wonderful to see other participants and volunteers thrive as I did, as a result of the SPIRIT center's services. Now, as I move on to attend a university and earn my degree, I am very grateful for the opportunities that were afforded me through SPIRIT. And I know that I am always welcome, as a volunteer, a participant, or to simply drop in and say hello. Thank you SPIRIT, I am eternally grateful.

Prevention and Early Intervention (PEI)

PEI Project Name: Early Intervention Program

UPLIFT FAMILY SERVICES
Nevada County School Therapeutic Services

Program Description

Program Overview

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

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

Target Population

Uplift Family Services serves children and TAY ages 5-22.

Evaluation Activities and Outcomes

Uplift collects evaluation activities for MHSA including demographic information on each individual receiving services. In addition, information on the type, date, location, and duration of the service is collected. The Child and Adolescent Needs and Strengths (CANS) and information on living situation, school suspensions, legal involvement, etc. is collected at admission, periodically, and at discharge. Information on referrals to community services is also collected. When Uplift closed the local offices in 2017, they referred all participants to Nevada County Behavioral Health to be served or placed in other local programs

During FY 2016-17, Uplift Family Services served 19 youth for a total of 489 hours, averaging 25.7 hours per youth. A total of 17 individuals had family involvement in their services. A table of outcomes from Uplift is below:

Goals and Objectives Outcomes	Percent
Youth reporting improved functioning on at least one CANS domain (*N=12*)	**58.3%**
Parents reporting an increase in parenting skills (*N=12*)	**33.3%**
Youth able to identify at least one lifelong contact (*N=12*)	**83.3%**
Caregivers reporting same or increased connections to natural supports (*N=12*)	**66.7%**
Youth stabilized at home (*N=16*)	**93.8%**
Youth maintaining regular or improving school attendance (*N=11*)	**100%**
Youth maintaining or improving school behavior (*N=11*)	**90.9%**
Parents reporting youth maintaining a C average or improving their academic performance (*N=11*)	**81.8%**
Youth with a history of suspensions or expulsions who have no new occurrences (*N=1*)	**100%**
Youth maintaining or improving job functioning (*N=4*)	**100%**
Youth with history of legal involvement who have no new legal involvement (arrests/violations of probation/citations) (*N=3*)	**33.3%**

Of the individuals served by this program the Duration of Untreated Mental Illness (DUMI) for 16% was one month, 26% was two to six months, 5% was seven to twelve months, 16% was one to four years, 21% was over five years, 5% was other, and for 11% the DUMI was unknown.

Challenges, Solutions and Upcoming Changes

It is often a challenge to maintain consistency of participation in therapy from week to week due to school holidays, school closures (weather, etc.) and schedule changes. In response to such challenges, the Uplift Therapist scheduled sessions at other community locations and at the youth's home whenever possible. Maintaining contact with and collateral support of parents/ caregivers also helped resolve scheduling challenges.

The most significant upcoming change is the planned closure of the Uplift School Therapy program in August 2017. The program is set to be taken over by Nevada County Behavioral Health staff.

Program Participant Story

A young woman, Ella (name changed to protect confidentiality), was referred to Uplift's TTUSD Therapist. Her parents, teachers, and peers were worried about her as she had lost interest in things she used to look forward to and was isolating herself frequently. Ella and the therapist completed a strengths-based assessment, a safety plan that utilized Ella's strengths to support coping skills, and developed service plan goals that included improving her relationships and increasing her self-esteem. Ella engaged in therapy for approximately nine (9) months. She

consistently attended therapy as scheduled and her parents engaged in collateral work to support Ella's treatment goals. Ella reports that she can identify several personal strengths and has learned better communication skills. Her parents report an increased understanding of Ella's diagnosis as well as improved parenting skills.

Ella was referred to Uplift due to the Therapists' outreach efforts, which included fostering relationships and communication with school personnel. These relationships help school personnel feel confident in referring students like Ella and supporting students' progress toward improved behavioral health.

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Gateway Mountain Center

Program Description

Program Overview

Gateway Mountain Center provides adjunctive mental health rehabilitation support to youth for improved outcomes including: decreased incidents of mental health crisis, increased positive socialization, and increased engagement within one's community. Gateway's method and theory of change can be described overall within four (4) tenets: 1. Authentic Relationship; 2. Time immersed in Nature. 3. Embodied peak experience; 4. Helping Others - Connection to community through service.

The program serves youth in the Truckee Tahoe and Grass Valley/Nevada City region who have symptoms of mental illness, serious emotional disturbance, and co-occurring substance use disorders. Services include developing a one-on-one personal connection, life-enriching experiences, exercise, proper nutrition, nature-connection, learning new things, and personal reflection.

Youth are seen by their assigned therapeutic staff once a week, on average, for a session that lasts for three (3) to five (5) hours. Sessions are typically provided in the field. Locations of outings vary and include trails, rock climbing areas, ski areas, or lakes (for kayaking activities). Sometimes, if weather is bad or energy levels are low, sessions will take place at a café, or the Gateway office, with a focus on doing artwork. During sessions, mindfulness practices, and techniques from therapeutic modalities, such as Dialectical Behavior Therapy and Acceptance and Commitment Therapy, may be utilized. Volunteer time with other community organizations is also common.

When children or youth are in need of higher levels of care, they are referred accordingly.

Target Population

The program serves youth in the Truckee Tahoe and Grass Valley/Nevada City region who have symptoms of mental illness, serious emotional disturbance, and co-occurring substance use disorders.

Evaluation Activities and Outcomes

Gateway Mountain Center collects evaluation activities for MHSA including demographic information for each individual person receiving services. In addition, the Youth Outcomes Questionnaire (YOQ) is administered at the beginning and end of services. Information on referrals to community services is also collected.

Gateway Mountain Center began its contract with Nevada County in March, 2017. Given the late start, the program served four (4) unduplicated participants (three of whom had family involvement) with a total of 148 service hours by the close of the fiscal year. This is an average of 37 hours per participant.

The YOQ was administered to all participants at the start of the program. However, due to the short time the program was up and running in FY 2016-17, there were no participants who completed the program and no post-test data available for outcome analysis this year. Also, due to the short time the program was running, no referrals to outside agencies were made in FY 2016-17.

With the population Gateway serves, outcomes will vary, and often the long-term view is necessary. Direct participant evaluation consists of close contact and feedback from the participants' families, communication with the therapeutic service provider counselors, and Gateway's own Clinical Supervisor.

Of the individuals served by this program the Duration of Untreated Mental Illness (DUMI) for 25% was over five years, 50% the participants preferred not to report their DUMI, and for 25% the DUMI was unknown.

Challenges, Solutions, and Upcoming Changes

A major challenge is full involvement from participants, as well as parents, in the Wraparound process. This process requires a great deal of engagement with families to participate in services. The Gateway Method is also unique in that participants are worked with during long sessions, three (3) to four (4) hour sessions weekly, over a long period of time to develop an authentic connection, with real and lasting results – which is not the traditional Medi-Cal model.

Gateway is attempting to reach more at-risk youth by hiring at all levels to provide direct services to participants, support for counselors, and to meet, or exceed, the highest level of professional protocols for the program.

Program Participant Story

Sean (name has been changed) suffered from a mental illness, and joined Gateway soon after his return from over a year in an out-of-home placement. Upon starting the Gateway program, he was very shut down in his communication, in poor physical condition, and prone to violent outbursts. In the first few months, he quickly established a rapport with his mentor, but was still struggling with a lack of social-emotional coping skills, especially at school and in relation to his guardians. Sean was willing to try some new outdoor athletic challenges, and over time he grew significantly in his physical confidence and skill level. As time went on, he started trusting his mentor and was willing to participate in role-playing activities and rehabilitative skill-building exercises, and he became more self-aware and able to manage his anger. Now he sees and values his time in nature as a resource, is much more in-tune with his body, and his triggering outbursts are far less frequent. He switched to a different school, which included a work internship, where he thrived. He continues to improve with growing self-awareness, improved physical skill, more confidence, an increased ability to self-regulate, and a greater ability to process and reflect on conflicts within his family, including an increased ability to take responsibility for his own actions.

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH (NCBH)
Bilingual Early Intervention

Program Description

Program Overview

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

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

NCBH maintains good communication with these community agencies by:

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

Target Population

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

Evaluation Activities and Outcomes

The Bilingual Early Intervention Program collects demographic and service-level data through NCBH's Electronic Health Record, Cerner. NCBH is in the process of implementing Electronic Behavioral Health Solutions (eBHS), a software and support product that will facilitate efficient quantitative data-gathering and aggregation of outcome measures including the Achenbach Child Behavior Checklist (for children/ youth) and Basis 24 (for adults). It is expected that in the next six months NCBH will have quick access to aggregate outcome data.

The NCBH Bilingual Early Intervention program served 27 Spanish-speaking individuals with 182 services in FY 2016-17. Of the 27 participants, 55.6% had their families involved in services. No referrals to outside agencies were reported.

All 27 direct service participants reported having experienced untreated mental health symptoms for more than one month (see table below).

Duration of Untreated Mental Illness	
Duration	**% Participants**
1 month ago	14.8%
2 - 6 months ago	11.1%
7 - 12 months ago	33.3%
1 - 4 years ago	40.7%

Anecdotal outcomes from the therapists come from a hand count of client treatment goals and results (see table below).

Treatment Goals:	Percent Improvement	Percent No Improvement	Unknown
Reduce Anger	100%	0%	0%
Reduce Conflicts	100%	0%	0%
Increase Compliance	100%	0%	0%
Reduce Intrusive Memories	100%	0%	0%
Reduce Psychological Reactivity	100%	0%	0%
Reduce Guilt	100%	0%	0%
Increase Interest in Activities	100%	0%	0%
Increase Energy	100%	0%	0%
Reduce Hearing Voices	100%	0%	0%
Increase Sleep	100%	0%	0%
Reduce sadness/ depressed mood	83%	6%	11%
Reduced Anxiety/ Worry	82%	0%	18%
Reduced Panic Attacks	80%	0%	20%
Reduce Guarding for Danger	75%	0%	25%

Challenges, Solutions, and Upcoming Changes

One major challenge is cultural beliefs and stigma about therapy in the Latino community that prevent individuals from accessing treatment. For example, many Mexican fathers are more reluctant than mothers to seek therapy for themselves or their children, or families may come from rural areas of Mexico, where parenting practices including yelling and corporal punishment are acceptable, while mental health therapy is not acceptable. In many Mexican families, grandparents and other extended family members who tend to have traditional beliefs regarding mental health, have more influence in decision-making about accessing mental health services for their children and grandchildren. These factors present a barrier to accessing services in the Latino community. Another challenge in Nevada County is that the Latino population here often work lower-paying jobs with long hours, so there is less flexibility to take time off to participate in mental health services. Furthermore, some participants served by the program do not drive due to financial circumstances or cognitive difficulties.

These barriers to access are addressed in several ways by the therapists. To engage Latino families in mental health services, the therapists conduct warm outreach and have flexible hours and availability for home visits. To help engage Latino fathers, the therapists practice Structural Family Therapy (which has a focus on father engagement), affirm the great value in the fathers' perspectives on their children and their children's emotional needs, and affirm the father's willingness to work hard as a provider for their family. In addition, therapists use Family Systems Therapy which promotes talking to parents about considering alternative disciplinary measures and changes in perspective. Direct, live coaching with parents is provided through Parent–Child Interaction Therapy (PCIT).

Therapists also make connections and maintain close communication with community agencies, such as Tahoe SAFE Alliance and the FRC of Truckee. These agencies have a history of building trust with families by providing direct services. NCBH maintains good communication by funding programs at the FRC, including the Bilingual Peer-Counseling Program. The therapists regularly schedule one-hour weekly sessions there, and have provided training on basic counseling techniques and motivational interviewing to the peer counselors. NCBH provides a flexible work schedule to offer sessions as late as 5:00 pm to accommodate family member work schedules. Structural Family Therapy can be used to address strategies and identify opportunities to strengthen families. These obstacles can often be predicted and planned during case formulation, and can often be addressed proactively with family members. To address transportation barriers, therapists often see participants at schools and at home, as needed.

Therapists promote connection with other Spanish-speaking agency partners using face-to-face introductions and by attending initial sessions. Although therapists are required to respond to requests for services within ten (10) working days, providers work to respond within one (1) or two (2) days. Quick, supportive contact is especially valuable for those who have recently arrived in the USA, particularly in a time of fear and distrust.

Program Participant Story

A program participant had suffered several traumatic assaults by the time the individual was first seen as a youth by NCBH. The participant was extremely hesitant to disclose the assaults.

Initially the individual had suicidal thoughts, and was diagnosed with Major Depressive Disorder and Post-Traumatic Stress Disorder. An NCBH therapist provided Trauma-Focused CBT. As part of the treatment, the therapist coached the individual's parents on how they could provide more emotional support. When parental coaching was unsuccessful, the participant believed the assaults were their own fault. The therapist then provided psycho-education on trauma and trained the parents to listen with compassion.

This individual's symptoms of anxiety and depression improved through treatment and the individual was able to confront the traumatic memories, talk about them, and gradually accept that the assaults were not their fault. With these breakthroughs, the anxiety and depression lessened, and the relationships with the participant's family improved.

PEI Project Name: Early Intervention Program

NEVADA COUNTY PUBLIC HEALTH
Moving Beyond Depression - Every Child Succeeds

Program Description

Program Overview

Moving Beyond Depression is a voluntary, evidenced-based program for women experiencing prenatal or postpartum depression (i.e., perinatal depression; PND) who are enrolled in a home-visitation program. Moving Beyond Depression offers In Home-Cognitive Behavioral Therapy (IH-CBT) in 15 weekly sessions and a one (1) month follow-up booster session. Therapy is provided by two (2) licensed therapists and supervised by a psychologist.

Currently, two (2) therapists work from western Nevada County to provide the in-home services. One (1) of them is bilingual / bicultural and is able to offer limited (seasonal) services to qualifying clients on the eastern side of Nevada County.

Moving Beyond Depression is in partnership with home visitation programs in Nevada County: Foothills-Truckee Healthy Babies (FTHB), Early Head Start, the Adolescent Family Life Program (AFLP) of the Nevada Joint Union High School District, the STEPP Program of the Tahoe Truckee Unified School District (TTUSD), and the Nevada County Maternal-Child Public Health Nurses.

Target Population

This program is designed to meet the needs of low-income, underserved women who are enrolled in a home visitation program in Nevada County and who are experiencing PND.

Evaluation Activities and Outcomes

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

electronic data capture tools hosted at Nevada County Behavioral Health (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 2016-17, Moving Beyond Depression provided services for 17 unduplicated participants for a total of 243 sessions, with an average of 14.3 sessions per participant. All participants had their families involved in services. No referrals to outside agencies were recorded.

All of the participants reported experiencing mental health symptoms for more than a month (see table below).

Duration of Untreated Mental Illness	**% Participants**
1 month ago	41.2%
2 - 6 months ago	29.4%
1 - 4 years ago	17.6%
5 years ago or longer	11.8%

Responses indicated that all participants who completed the EPDS two (2) or more times felt less depression and half of the participants who completed the ISEL-SF two (2) times perceived better social support after services (see tables below).

	% Improved N=17*
Edinburgh Postnatal Depression Scale (EPDS) Improvement, Pre to Post	100.00%

*Note: Seventeen (17) participants were assessed two (2) or more times.

	% Improved N=4**
Interpersonal Support Evaluation List - Short Form (ISEL-SF) Improvement, Pre to Post	50.00%

**Note: Four (4) participants were assessed two (2) times.

[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 Apr;42(2):377-81.

In addition, participants who completed the Participant Perception of Care survey indicated better social functioning at discharge from the program (see table below).

Participant Perception of Care					
	Agree	Neutral	Disagree	Total %	N
I am getting along better with my family.	100.0%	-	-	100.0%	3
I do better in school and/or work.	-	100.0%	-	100.0%	2
My housing situation has improved.	33.3%	66.7%	-	100.0%	3
I am better able to do things that I want to do.	100.0%	-	-	100.0%	3
I am better able to deal with crisis.	100.0%	-	-	100.0%	3
I do better in social situations.	66.7%	33.3%	-	100.0%	3
I have people with whom I can do positive things.	100.0%	-	-	100.0%	3
I do things that are more meaningful to me.	100.0%	-	-	100.0%	3
I have learned to use coping mechanisms other than alcohol and/or other drugs.	100.0%	-	-	100.0%	3
In a crisis, I would have the support I need from family or friends.	66.7%	-	33.3%	100.0%	3
Staff welcome me and treat me with respect.	100.0%	-	-	100.0%	3
Staff are sensitive to my cultural background.	33.3%	66.7%	-	100.0%	3
Average (All Responses)	**75.0%**	**19.4%**	**2.8%**	**100.0%**	**3**

Challenges, Solutions, and Upcoming Changes

A huge challenge that the program experienced was the unexpected loss of the primary therapist in the Truckee region. This bilingual therapist served the eastern part of the region, where there is a large Spanish-speaking population. The departure of the bilingual therapist created a hardship for access to services for the mothers in the region. Referrals to county Behavioral Health are necessary in order to accommodate the community's needs.

Another ongoing challenge is the continued MBD education to community partners and medical professionals regarding the scope of the program and the parameters for referral, especially the necessary participant involvement in a home visitation program.

In addition, an ongoing discussion regarding sustainability of the program may depend upon the implementation of Medi-Cal billing via the county's electronic health record system, for therapists' services starting in FY 2017-18.

An additional challenge was the retirement of the MBD program coordinator which created a break in the continuity of the program. While a new coordinator was hired in October 2017, the limited engagement in the MBD program created difficulties in obtaining needed REDCap data, submission of invoices, and communicating with MBD staff.

Program Participant Story

Susan (name has been changed) was referred by her home visitor after her screening session; her EPDS score was very high. She had a history of depression and anxiety, but currently was also presenting with grief and loss from a recent incident. Susan had difficulty making decisions, fearful she would make a wrong decision, leading to an irreversible tragedy. She often blamed herself if something didn't go as planned, experiencing feelings of guilt. Susan exhibited negative self-talk, with intrusive thoughts. One of her biggest fears was that her depression was never going to end. Susan was diagnosed with mental illness.

Treatment followed Cognitive Behavioral Therapy (CBT) interventions as per the Moving Beyond Depression model and fidelity checklist. Initial sessions focused on increasing pleasurable activities, completing a daily schedule, identifying treatment goals, and building a therapeutic relationship with Susan. Over the course of several weeks, treatment addressed unhelpful thinking styles, negative thoughts, core beliefs, mindfulness to decrease symptoms of anxiety, and weekly goals. On session fourteen, Susan's EPDS score had significantly decreased. Using the flexibility of the program and the option of providing additional sessions to mothers who would benefit from continued services, sessions continued every other week for three additional sessions; her score continued to drop. In a post-assessment testing session, Susan no longer qualified for the mental illness diagnosis.

Upon exiting from the MBD program, Susan presented with a bright mood, smiled often, engaged happily with her baby, and talked about future plans. She was exercising, meeting with friends, and even stated she was considering doing a speaking engagement about postpartum depression. Susan was able to identify negative thoughts, find alternative thoughts, and assess the validity of her thoughts (e.g., by asking, "are these thoughts true?"). Susan used exercise and mindfulness to decrease anxiety. At the end of treatment Susan, reported that she had learned: "Postpartum depression and anxiety can get better with counseling and medication; Exercise, food (eating regular meals) and rest helps; That it felt overwhelming being a mom, but now being a mom is fun; I don't have to be afraid to be sad."

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Homeless Early Intervention Services

Program Description

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

Target Population
NCBH Homeless Early Intervention serves homeless guests at Hospitality House Homeless Shelter and homeless individuals and families that seek outreach services at Hospitality House.

Evaluation Activities and Outcomes

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

Staff delivered direct services to 98 unduplicated participants during FY 2016-17. A total of 423.7 hours of direct services were recorded, for an average of 4.3 hours per participant. Staff made 157 outreach visits at the Hospitality House shelter, for a total of 442 contacts with Shelter Guests. Referrals to outside agencies were made 22 times, with 6 (27.3%) successfully connecting. Referrals that connected included agencies such as NCBH, Crisis Stabilization Unit, SPIRIT, and private therapists or psychiatrists. Of the 98 direct service participants, two (2) had their families involved in services.

Of the 98 direct service participants, 77 (78.6%) reported having experienced untreated mental health symptoms for more than one month (see table below).

Duration of Untreated Mental Illness	
Duration	**% Participants**
1 month ago	1.0%
2 - 6 months ago	6.1%
7 - 12 months ago	1.0%
1 - 4 years ago	20.4%
5 years ago or longer	50.0%
Unknown	21.4%

Challenges, Solutions, and Upcoming Changes

Challenges include continuity of services, unknown outcomes, and tracking reduction in symptoms and suffering. These difficulties are mainly due to the transient population. Other challenges include drug and alcohol issues for many of the participants, resulting in more varied outcomes, difficulty with participant follow-through, instability, and difficulties in ability to make use of services offered.

Some solutions include networking and keeping up on agencies, therapists, and psychiatrists who provide mental health treatment and use of brief assessment tools to track emotional stability and outcomes more regularly.

Program Participant Story

Madison (name has been changed) is a divorced mother who has been diagnosed with a mental health disorder. Through a series of circumstances, she found herself homeless with her children and no support system - she was in crisis. Madison attempted to overdose, was hospitalized, and lost custody of her children to their father. She came to the shelter in a very vulnerable state. She was harming herself, using drugs, and not making progress to become safer. With the assistance of the Early Intervention Program, Madison received treatment. She became stable on the appropriate medications, stopped harming herself, and attended therapy with the Early Intervention therapist (sometimes a few times a week plus check-ins). With the Early Intervention program and Hospitality House, she had daily support, encouragement, and assistance. Madison eventually secured employment. With several months of progress and stability, she petitioned the court and was awarded visitation with her children. Madison also secured housing and continues to be stable in her housing and employment. She continues weekly therapy and is taking her medication regularly. She recently started dating, has had continuous and lengthy visits with her children, and is looking forward to her future.

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

NEVADA COUNTY BEHAVIORAL HEALTH
Mental Health First Aid

Program Description

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

Participants learn a five (5) step action plan encompassing the skills, resources, and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care. Nationally, 25% of adults, 20% of youth, and 30% of soldiers returning from war are affected by mental illness. Aside from accidents, suicide is the leading cause of death among youth. Developing skills and strategies for community members to combat this is therefore a national priority.

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

Evaluation Activities and Outcomes

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

MHFA provided two (2) trainings during FY 2016-17, with a total of 54 unduplicated participants attending the sessions. One session was on youth MHFA and was attended by 25 individuals, and the other session was on adult MHFA and was attended by 29 individuals. Of the 54 participants, 13 (24.1%) reported not having experienced untreated mental health symptoms and 41 (75.9%) were unknown. No participants reported having their families present for training activities. No referrals to outside agencies were made during FY 2016-17.

Participants who completed the post-training evaluation indicated that they felt more confident that they would be able to attend to individuals exhibiting mental health problems effectively (see table below).

MHFA Post-Training Evaluation Items	**Percent Agree/ Strongly Agree (N=23)**
I feel more confident that I can recognize the signs that someone may be dealing with a mental health problem/challenge or crisis.	**100.0%**
I feel more confident that I can reach out to someone/a youth who may be dealing with a mental health problem/challenge or crisis.	**95.7%**
I feel more confident that I can ask a person/young person whether s/he is considering killing her/himself.	**100.0%**
I feel more confident that I can actively and compassionately listen to someone/a young person in distress.	**100.0%**
I feel more confident that I can offer a distressed person/young person basic "first aid" level information and reassurance about mental health problems.	**95.7%**
I feel more confident that I can assist a person who may be dealing with a mental health problem or crisis to seek professional help.	**100.0%**
I feel more confident that I can assist a person/young person who may be dealing with a mental health problem or crisis to connect with community, peer, and personal supports.	**100.0%**
I feel more confident that I can be aware of my own views and feelings about mental health problems and disorders.	**95.7%**

Challenges, Solutions, and Upcoming Changes

Challenges for this program include the expectations of MHFA–USA for their instructors and the county. The requirement is for each instructor to conduct a minimum of three (3) workshops per year. Each workshop is led by a maximum of two (2) instructors. When the county has two (2) instructors, then three (3) workshops are offered per year. However, in FY 2016-17, the county had four (4) instructors, and thus, MHFA was expected to offer six (6) workshops. In addition, the most cost-effective way to run workshops is to have attendance near or at capacity (30 participants), which also allows for effective group interaction. However, meeting this base standard, while running workshops at capacity is especially challenging for rural communities who have a smaller participant market to draw from. In addition, MHFA–USA instructor support is extremely limited.

For now, Nevada County Behavioral Health (NCBH) has met these challenges by recruiting non-county instructors, but this is not a permanent solution. In the future NCBH may add the MHFA training component to an existing NCBH contractor's scope of service. Discussions are currently in progress.

Program Participant Story

Participant comments about the training:

- "Recommend to all!"
- "Lots of good practical knowledge"
- "I really feel like I was given good tools to help me work with someone who might have mental health illness"
- "It helped me learn strategies to approach someone in crisis"
- "I'm very glad that I took this class. I feel more comfortable helping my students"
- "The scenario's helped to reinforce ALGEE" (a five-step action plan)
- "When creating an action plan for helping people with mental illness challenges it is important to encourage self-help and other support strategies as well as encourage appropriate professional help" (from a participant with lived mental health experience)

PEI Project Name: Prevention Program

Homeless Rapid Rehousing (RRH) Program

Program Description

Program Overview
Program deferred to FY 17/18.

PEI Project Name: Prevention Program

FREED
Friendly Visitor Program

Program Description

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

The Friendly Visitor Coordinator meets with the 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 trainings and volunteer support groups. Volunteers are expected to spend a minimum of one hour per week visiting with their matched participant, but many volunteers spend several hours more than the minimum.

In addition to providing community contact, the FREED Friendly Visitor Program complements other mental health programs, and connects individuals to other necessary mental health services. The program is administered by FREED Center for Independent Living, an organization that provides a 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

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

The FREED Friendly Visitor Program provided services to 30 individuals during FY 2016-17. FREED exceeded its goal of recruiting 10 new volunteers by four (4) and maintained a pool of at least 30 volunteers. Due to a particularly harsh winter and difficulty traveling to Truckee with the snowfall, only one (1) match was made in Truckee, though the goal was two (2). FREED volunteers visited participants 745 times, made 111 phone calls, and spent a total of 1,222 hours visiting participants (see table below). Volunteers referred participants to outside agencies such as Sierra Nevada Memorial Hospital, Adult Protective Services, In-Home Support Services, Legal Services and 2-1-1, a total of 14 times in FY 16/17.

Number of Hours, Participants, and Average Hours per Participant	
Total Number of Hours	**1,222**
Total Number of Participants	**30**
Average Hours/Participant	**40.7**

Number of Visits, Participants, and Average Visits per Participant	
Total Number of Visits	**745**
Total Number of Participants	**30**
Average Visits/Participant	**24.8**

An annual survey was conducted of all participants. Of all participants, 25% responded to the survey. Of those who responded, 100% felt less down, depressed, or lonely; less anxious, worried, or nervous; and their quality of life had improved. Regarding suicidal thoughts, 33% had had thoughts of suicide and felt comfortable talking to their visitor or their minister about it; 66% reported that they had not had thoughts of suicide.

There were six (6) training and support groups for volunteers. Six (6) volunteers attended those throughout the year. There were a total of 12 hours of training provided in a group setting and 14 hours of one-on-one orientation training with new volunteers. A year-end survey was conducted of all volunteers, with 50% of the current volunteers responding to the survey. Forty percent (40%) of the volunteers visited their participant at least one (1) time a week for one (1) hour, while 60% of the volunteers met more than one (1) hour and/or more than once a week. All (100%) of those who responded knew what the signs of depression and anxiety were and felt comfortable discussing them with the person they visited. If they saw signs of suicidal thoughts, 100% felt comfortable talking directly with the person or contacting the Program Coordinator to discuss their concerns.

The FREED Friendly Visitor Program conducted 28 outreach events with an estimated attendance of 1,315 individuals during FY 2016-17. In addition, brochures with information about the Program were distributed to various locations.

Of the individuals served by this program the Duration of Untreated Mental Illness (DUMI) for 3% was seven to twelve months, for another 3% the DUMI was five years or longer, and for 93% the DUMI was unknown.

Challenges, Solutions, and Upcoming Changes

The challenge to find committed volunteers is ongoing. FREED met this challenge by doing constant outreach in different ways to increase the number of potential volunteers reached. By sharing the need for volunteers through networking with other service providers, distributing fliers in locations where potential volunteers may acquire them, and staffing tables at community events, FREED is getting the word out about the program's volunteering opportunities and services available. The program continues to work closely with the Retired & Senior Volunteer Program (RSVP) for referrals of volunteers.

It was a challenge this year to begin using a new internal data base to track participant activity. Also, the new requirements of gathering and tracking extensive data on program activities was a challenge that took time to learn and fully implement.

The upcoming changes include aligning the new data base more efficiently with the requirements of MHSA data collection. This will make semi-annual and annual reporting more efficient. It will prevent FREED from duplicating data collection and reporting efforts and allow for more focus on providing services to community members.

The Program Coordinator was on medical leave during the first and fourth quarters of the year. As a result, the number of referrals for both participants and volunteers were lower than expected. Although there was coverage during this time by other FREED staff, the relationships that develop among community service staff often rely on the specific coordinator they are accustomed to working with. RSVP has a pool of new volunteers, which they have held onto while awaiting the Program Coordinator's return. With her return and the new volunteers, an increase in referrals from service providers is anticipated.

Program Participant Story

A volunteer who had been a friendly visitor for some time approached FREED staff regarding concerns she had about a woman who was living with the person she visits. The arrangement was that in exchange for help around the house and light cooking, the woman would not pay

rent. As time went on, this live-in helper did less and less around the house, and brought more and more visitors and friends into the house. Also, there were some safety issues regarding the woman's son.

The volunteer shared her concerns with the Friendly Visitor Coordinator, who reached out to the participant to talk about the concerns. The participant indicated feeling frustrated and taken advantage of. She requested help to remove this person from her home and acquire alternative in-home services. The coordinator worked with the participant and collaborated with other service organizations to address the issues. Working with Adult Protective Services, In Home Supported Services, Senior Outreach Nurse, the Sheriff's Department and Community legal services, we were able to secure safety measures for the participant before having the live-in helper evicted. The live-in helper did return to the property one time after the eviction, but the participant was prepared and called the police to have her removed. The participant is feeling much safer in her home and is working with FREED to secure some personal assistance services.

PEI Project Name: Prevention Program

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
Wellness Program

Program Description

Program Overview

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

The TTUSD Wellness Program has Wellness Centers at North Tahoe High School and Truckee High School. The Wellness Centers provide a comfortable setting for students to drop-in during their breaks to ask questions, get support, or just relax. The Centers are furnished with cozy chairs and couches, artwork, music, games, art supplies, and healthy snacks to make it a fun place for students to hang out. The program also partners with Gateway Mountain Center to create an integrated Wellness Curriculum at Sierra High School and Placer County Community School that provides individualized supports and tools for students to develop sustainable wellness practices.

Key Focus Areas include:

Youth Voice- The TTUSD Wellness Program facilitates a Peer Mentor Program that trains students to become Peer Mentors and teaches them skills to better support themselves and their peers. The Wellness Centers also provide leadership opportunities for students to have an authentic voice in shaping school and community initiatives, such as: Sources of Strength Club, Pride Club, youth leadership workshops, 9th grade Challenge Days and participation in Community Collaborative and County meetings.

Support- TTUSD Wellness Centers provide trained staff and volunteers to listen to, support, and connect students to community health and wellness resources. The Wellness Centers offer a variety of empowerment and peer support groups (coping skills, social skills, girls and boys groups) to build stronger connections with students and provide ongoing social emotional supports. The Wellness Program also collaborates with school and county partners to provide additional mental health resources for students on campus, such as: Coordinated Care Teams, school-based therapists and the What's Up Wellness Program.

Education- The TTUSD Wellness Program offers a variety of wellness workshops to provide students with practical tools to improve their overall health. Topics cover the range of social, emotional, mental, and physically healthy choices and lifestyle tools, such as: Healthy ways to deal with stress, Heart Math, Know the Signs, Mindfulness, and 9th grade Challenge Days.

The TTUSD Wellness Centers offer three types of programming:

1. **Group Services:** TTUSD Wellness Centers offers several ongoing groups that bring students together to discuss their experiences, share ideas, and provide emotional support for one another.
2. **Drop-In:** The Wellness Center is open for students to drop-in at any time to receive support, be connected to resources, socialize, or just take a break when needed.
3. **Outreach:** The TTUSD Wellness Centers outreach to students by hosting workshops, leadership development days, presentations in the health classes and Wellness Days at Sierra High and the Community School.

Wellness Center Locations and Hours:

- North Tahoe High – The Wellness Center is located in Room 217 and is open Monday-Thursday: 7:30-2:30, Friday: 10:30-12:30
- Truckee High – The Wellness Center is located in Room M1 Monday-Friday: 9-2:30

Target Population

The TTUSD Wellness Centers program primarily serves high school students, ages 14-18 years, but it also provides peer mentor supports, wellness workshops, and Sources of Strength (SOS) trainings to middle school students, ages 11-13 years. Most of the high school students served seek out Wellness Center programming on their own, but the program also receives referrals from the counselors, psychologists, school administrators, and teachers.

Evaluation Activities and Outcomes

Note: The following data show the youth from both Placer and Nevada County who attended the Tahoe Wellness Centers' TTUSD Wellness Program.

TTUSD collects evaluation activities for MHSA including collecting demographic information on each individual person receiving services. In addition, information on the type, date, location, and duration of the service is collected for group services. Perception of Care surveys are collected annually. Information on referrals to community services is also collected.

TTUSD Wellness Centers provided 10 unique types of groups/classes/workshops to 121 unduplicated participants during FY 2016-17, for a total of 189 meetings and an average attendance of 11.6 per meeting. Types of groups/classes/workshops included:

- Body Image Group
- Empowerment Group
- Girls Relationship
- Middle School Boys Group
- One Another Project
- Peer Mentors
- PRIDE
- Sexual and Gender Acceptance
- Teens Offer Peer Support (TOPS)
- Thursday Girls Group

In addition, the Drop-In center was open for 168 days across the two locations, with over 7,000 attendee sign-ins (see table below; drop-ins are a duplicated count).

Average Attendees* per Day

North Tahoe High	# Attendees	3,340
	# Days Available	149
	Average Attendees/Day	22
Truckee High	# Attendees	3,939
	# Days Available	125
	Avg. Attendees/Day	32
Both Schools	**# Attendees**	**7,279**
	# Days Available	**168**
	Average Attendees/Day	**43**

*Attendees are a duplicated number of drop-in contacts

TTUSD Wellness Centers made 91 referrals to outside agencies such as Mental Health, Adventure Risk Challenge, Tahoe SAFE Alliance, Therapists, and Child Welfare Services, with

71 (78%) eventually connecting with the agency. Not all connections reported dates of appointments, but for the 44 that did, the average number of days from referral to appointment was 7.9.

Outreach activities consisted of 31 events with an estimated 2,228 attendees.

TTUSD recently began administering the Social Emotional Assets and Resiliency Scale (SEARS) to participants. As it is a new addition, only 18 participants had a pre and a post measure for the SEARS. Of those 18 participants, 13 (72.2%) showed improvement.

The Peer Mentor Training collected surveys assessing attitudes toward mental health. Overall, peer mentors had a more positive attitude toward mental health after their training (see table below).

Peer Mentor Training Attitude Survey Items	**% Pre Agree**	**% Post Agree**
People who have a mental illness experience high levels of prejudice and discrimination (Pre N=29) (Post N=28)	82.8%	78.6%
I plan to take action to prevent discrimination against people who have a mental illness (Pre N=29) (Post N=28)	69.0%	92.9%
I know how to support a person who has a mental illness (Pre N=29) (Post N=28)	24.1%	78.6%
I believe that a person who has a mental illness can eventually recover (Pre N=28) (Post N=28)	75.0%	75.0%
	% Pre Disagree	**% Post Disagree**
People who have had a mental illness are never going to be able to contribute to society (Pre N=29) (Post N=28)	89.7%	96.4%
I believe that a person who has a mental illness is a danger to others (Pre N=29) (Post N=28)	69.0%	71.4%
	% Pre Always	**% Post Always**
If you had a mental illness, would you seek professional help? (Pre N=29) (Post N=29)	55.2%	85.7%
	% Pre Never	**% Post Never**
If someone in your family had a mental illness, would you feel ashamed if people knew about it? (Pre N=29) (Post N=29)	55.2%	75.0%

Participant Perception of Care surveys indicated that, overall, participants reported better functioning as a result of attending classes or workshops at the TTUSD Wellness Centers (see table below).

Participant Perception of Care Survey Items	Agree	Neutral	Disagree	Total	N
I am getting along better with my family.	43.5%	43.5%	13.0%	100.0%	46
I do better in school and/or work.	54.0%	44.0%	2.0%	100.0%	50
My housing situation has improved.	37.2%	55.8%	7.0%	100.0%	43
I am better able to do things that I want to do.	82.4%	15.7%	2.0%	100.0%	51
I am better able to deal with crisis.	82.7%	15.4%	1.9%	100.0%	52
I do better in social situations.	75.0%	21.2%	3.8%	100.0%	52
I have people with whom I can do positive things.	88.7%	9.4%	1.9%	100.0%	53
I do things that are more meaningful to me.	78.0%	18.0%	4.0%	100.0%	50
I have learned to use coping mechanisms other than alcohol and/or other drugs.	65.1%	27.9%	7.0%	100.0%	43
In a crisis, I would have the support I need from family or friends.	70.6%	23.5%	5.9%	100.0%	51
Staff welcome me and treat me with respect.	86.8%	11.3%	1.9%	100.0%	53
Staff are sensitive to my cultural background.	89.6%	8.3%	2.1%	100.0%	48
Average (All Responses)	**67.0%**	**22.2%**	**3.9%**	**100.0%**	**49**

Of the individuals served by this program the Duration of Untreated Mental Illness (DUMI) for 3% was one to four years, and for 81% the DUMI was unknown.

Challenges, Solutions, and Upcoming Changes

The biggest challenge continues to be working within the school schedule so as not to take students out of class too much. It is hard to provide support to some of the high-need students while still keeping them in class so they don't fall behind in their school work. The nature of offering programming during school hours is that there is very limited time to meet with students. This year, staff worked closely with the Coordinated Care Teams to create plans for students that needed additional supports, and aligned the support groups and training schedules with the academic school day. As a result, the program has increased communication between the Wellness Center, Counseling Department, Administration, and teachers so all are informed and on the same page. This has helped strengthen relationships, build trust, and create more consistent supports to help students succeed both academically and emotionally.

Program Participant Story

Maricela (name has been changed) was first referred to the Wellness Center when a concerned teacher noticed that she had been missing class and became worried about her. Our Wellness Liaison met with Maricela and discovered that she had been missing school because she had been helping her mom with work. Maricela was very stressed about her family's finances. Our Wellness Liaison provided a supportive listening ear and offered to help Maricela's family get connected to supportive resources. They worked with the school counselor to set up a meeting with Maricela's mom, referring her to the Family Resource Center and offering counseling support to Maricela. Unfortunately, Maricela's mother was not open to receiving support. Our Wellness Liaison continued to meet with Maricela regularly to offer emotional support.

Sadly, the following year things got worse. Maricela's family was evicted from their home and her mother moved in with a new boyfriend who Maricela didn't like. With the support of community partners, Maricela's decided to move in with another relative. This environment ended up being much more supportive for Maricela and she finally felt some of the weight of her previous responsibilities being lifted. She started coming to school more consistently and became a Wellness Center regular. Our Wellness Liaison then invited her to join one of the groups to get additional support. She loved being in the group and was also a support to a few of the other participants. Through the group, she was able to open up about her struggles, which led to our Wellness Liaison offering to help get her connected to a therapist. Our Wellness Liaison helped her process the paperwork and get Maricela into the school therapist once a week. Her confidence continued to grow so much that she asked to become a Peer Mentor. It was inspiring to see her come out of her shell and step into a leadership role. It was a very special moment when she came into the Wellness Center this spring to ask for help decorating her graduation cap. Our Wellness Liaison helped her create a beautifully decorated cap and proudly watched her walk with her graduating class in June.

PEI Project Name: Prevention Program

NEVADA COUNTY SUPER INTENDENT OF SCHOOLS
Second Step for Early Learning

Program Description

Program Overview

The Nevada County Superintendent of Schools (NCSOS) brings the Second Step Curriculum into preschools and transitional kindergartens of the Western Nevada County Region as a component of the County's MHSA Prevention and Early Intervention (PEI) Program.

Second Step is a research-based curriculum that teaches social and emotional learning for children. The Collaborative for Academic, Social and Emotional Learning (CASEL) recently

published findings of the largest, most scientifically rigorous review of research ever done of school-based intervention programs (Durlak, Weissberg, Taylor, & Dymnicki). The findings indicate that "…students receiving school-based Social Emotional Learning (SEL) scored 11 percentile points higher on academic achievement tests than their peers who did not receive SEL."

Goals for the Second Step program are for children to develop self-regulation skills, learn to manage their emotions, treat others with compassion, solve problems without anger, and develop strong bonds to school. The curriculum is implemented by the classroom teacher each day in several short segments. The teacher uses scripted lesson cards with photographs, boy and girl puppets, music, and skills practice activities that lead to role playing and discussions. Parents are sent weekly Home Link letters to inform them of what their children have learned and to give them ideas for supporting these concepts at home.

Target Population

The target population for NCSOS Second Step is preschool teachers in Western Nevada County and their students.

Evaluation Activities and Outcomes

NCSOS collects evaluation activities for MHSA including demographic information on each preschool teacher that implements the program. The Desired Results Developmental Profile (DRDP) is collected at the beginning and end of the year to measure the impact of the program on the student's behavior. Information on referrals to community services is also collected.

At the beginning of the year, the Second Step trainer connected with 32 previously active classrooms and found that 24 were continuing, three were not currently participating/on hiatus, and five had new lead teachers.

The trainer provided seven (7) on-site trainings for 26 adults. The trainer worked in five (5) different classrooms that had new lead teachers, modeling the first two (2) weeks of daily lessons with their students and providing guidance on working the program into their existing schedule. This included two special education (SDC) classrooms: one (1) preschool and one (1) kindergarten through 3rd grade. All of these classrooms were using the program previously but required retraining because of the staff turnover. In the five (5) classrooms with new lead teachers that received the full training and classroom modeling, 89 children participated in the Second Step program. In the 24 classrooms continuing to use Second Step at some level, 384 children participated. The students in the continuing classrooms combined with the students in the new classrooms brings the grand total of children experiencing Second Step in FY 2016-17 to 473.

The trainer met with all new teachers at the end of each unit to check in, provide support, and deliver curriculum story books from the Second Step library. In the case of the special education

classrooms, where the children move through the lessons at a much slower rate, meetings were held every four (4) to six (6) weeks. No referrals to outside agencies were made for students or teachers during FY 2016-17.

The trainer provided on-site training, guidance, support meetings, and curriculum story books from the Second Step library from mid-year on for the teacher that took over in a 'continuing' classroom when the original teacher left.

The DRDP assesses nine measures of growth in self-regulation and social-emotional competence. Pre-assessments and post-assessments were collected on the children in the classrooms with new teachers. The results indicate that most students showed some growth. Students whose growth score remained the same, scored higher in the critical area of 'Self-Control of Feelings and Behaviors' allowing them to safely spend more time in class interacting with other students.

Teachers surveyed regarding the implementation of Second Step in their classrooms were enthusiastic. Teachers concurred with the DRDP results, reporting that they observed social and emotional growth in their students. All of the teachers responded, "Yes" to the question: "Do you feel Second Step is beneficial to the mental health of your students and teachers?" All new teachers indicated that they will be using the program next year, some responded with as many as three exclamation points!

Across the two (2) types of classrooms with new teachers, there was a 63% reduction in behavior problems since the beginning of the year (82% in mainstream classrooms and 35% in special education classrooms), according to teacher reports.

Challenges, Solutions, and Upcoming Changes

A wonderful challenge was working in the county special education classrooms with complex children, many of whom are nonverbal and have severe behavioral issues. For these classrooms, more than the normal amount of time was dedicated. Additional hours of classroom observation time were included, spanning multiple days, before coming in to teach and work with the children. This was a crucial step in being prepared to work effectively with the particular children in the classroom. There was also additional time spent at the beginning, and during the year, brainstorming ways to modify the curriculum. The curriculum is not written for special education students, so the NCSOS Second Step staff developed ways to work it into their unique schedules.

Program continuity was an extra challenge in the K-3 special education classroom. The new teacher in that classroom had no experience working with young children. There were also a number of staff changes with the assistant teachers requiring long term use of multiple substitutes. Again, extra time and attention were required to get the program back on track and

find different ways through the year to deliver the program elements to students as effectively as possible.

One (1) classroom had a teacher with self-described ADD. This made program follow-through and consistency difficult. After brainstorming with the lead teacher, it was decided to have one very organized assistant take over teaching the Second Step lessons. NCSOS Second Step staff, the teacher, and assistant worked together to create a new plan with consistently scheduled times for Second Step. Although they got off track a couple times and fell behind in the program, Second Step staff was able to provide a detailed schedule plan to the assistant, that was approved by the lead teacher, to get them back on track. The end results showed wonderful growth in the children.

This year, more time was required for administrative tasks such as working back into the previous years to provide information for the new reporting requirements and for keeping up with the number of changes throughout the year to know exactly what to collect and the forms to be used. Second Step program funding is for a single person with a limited number of hours, so changes were necessary. NCSOS Second Step is no longer collecting pre-assessments, post-assessments or demographics for the continuing schools that use the DRDP, from which the assessment is derived. These growth assessments are now only collected on the students in new classrooms receiving full training during the grant year.

Teacher Success Stories

From the mainstream classrooms:

- "Joe (name changed to protect confidentiality) used to scream and yell when things upset him. Today he was being left out of a game and got upset. Instead of screaming, he separated himself and did calm-down breathing. He remained separated until he regrouped successfully."
- "At the beginning of the year John (name changed to protect confidentiality) could only attend for ½ hour. Then he would get angry and start throwing things. Now, he does pretty well the whole day – a Second Step success."
- "I found this program really helpful with my [special needs] children. It gave them a frame to use to solve their problems. Fred (name changed to protect confidentiality) has gotten really good at naming his feelings and calming himself down. Then he could deal with his feelings. For example, one day (mid-year) when he heard, 'Time for clean-up,' he started screaming. When asked, 'Do you have a strong feeling?' he put his hand on his tummy and said, 'Stop' and did the calm-down belly breathing. He then said, 'Angry.' When asked, 'What can you do?' he said, 'I'm going to count (backpacks around the room),' and so he did. Shortly thereafter he was doing his job."
- "One child stands out the most. He was very angry and would almost always become aggressive if in a conflict with another child. He would use his hands to solve a problem (hitting). By using this program, we have been able to help him use his words and learn how to control his anger. He now uses this at home and his parents comment on how well he's doing at home too!"

From the Special Education classrooms:

- "Some of the children now recognize that they need to 'take a break' or calm down and know where to go in the room to do that. For example, Sam (name changed to protect confidentiality) says, "Break please," instead of hitting. He says "Hi," to staff and visiting adults."
- "The children want to play with each other (showing more interest). Some say hello to each other."
- "Child A showed concern and a desire to help Child B feel better when 'B' fell down and got hurt. 'A' wanted to, and did, hold ice on the back of the injured child's head."

PEI Project Name: Prevention Program

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT (TTUSD)
Second Step for Early Learning

Program Description

Program Overview

Second Step is a research-based curriculum that teaches social and emotional learning for children. The Collaborative for Academic, Social and Emotional Learning (CASEL), recently published findings of the largest, most scientifically rigorous review of research ever done of school-based intervention programs (Durlak, Weissberg, Taylor, & Dymnicki). The findings indicate that "…students receiving school-based Social Emotional Learning (SEL) scored 11 percentile points higher on academic achievement tests than their peers who did not receive SEL."

Goals for the Second Step program are for children to develop self-regulation skills, learn to manage their emotions, treat others with compassion, solve problems without anger, and develop strong bonds to school. The curriculum is implemented by the classroom teacher each day in several short segments. The teacher uses scripted lesson cards with photographs, boy and girl puppets, music, and skills practice activities that lead to role playing and discussions. Parents are sent weekly Home Link letters to inform them of what their children have learned and to give them ideas for supporting these concepts at home.

TTUSD is entering its seventh year of implementation of the Second Step curriculum in preschool to 8th grade. The Second Step kits were purchased, and training has been ongoing for teachers, newly hired staff, bus drivers, support staff, and employees of the Boys and Girls Club at Truckee Elementary School.

Target Population

The target population is teachers of preschool to 8th grade in the Tahoe Truckee Unified School District and their students.

Evaluation Activities and Outcomes

TTUSD Second Step collects evaluation activities for MHSA including demographic information on each teacher that implements the program. The Desired Results Developmental Profile (DRDP) is collected at the beginning and end of the year to measure the impact of the program on the student's behavior. Information on referrals to community services is also collected.

TTUSD Second Step trained six (6) teachers/staff during FY 2016-17. A total of 1,598 students are in schools where TTUSD Second Step has been implemented.

Trainings took place at Glenshire and Truckee Elementary schools for new support staff and teachers. A bus driver training and a training at the Boys and Girls Club afterschool program were also offered. The bus driver training did not happen due to scheduling conflicts. Kits were offered to the Boys and Girls Clubs. They did not request any further training at this time.

Training and outreach was offered for preschools, but no new trainings took place due to scheduling conflicts. TTUSD will continue offering this training to all new staff and new pre-schools in order to give the students a good foundation when moving into Transitional Kindergarten and Kindergarten in the local schools.

Mind Yeti licenses were purchased to facilitate the new mindfulness part of the Second Step program. Mind Yeti is a tool for teachers and parents to teach mindfulness to students in grades preschool - 8th grade. Mindfulness practice helps students with managing their emotions, self-regulation, making transitions, empathy-building, anxiety, and more. At each school, teachers, counselors, and principals were given access to the Mind Yeti application. Mind Yeti will also be offered to parents on an as-needed basis to use in the home. These licenses are good through next September and will then be purchased again for any teacher that would like to renew.

Both Glenshire and Truckee Elementary have implemented the School-Wide Information System (SWIS) for tracking office referrals. TTUSD has asked the schools to continue to track office referrals every day for each month in the 2017-2018 school year.

Challenges, Solutions, and Upcoming Changes

In order to monitor teachers' use of the Second Step curriculum, surveys will be administered at the beginning and at the end of the school year. These surveys will also assess outcomes of the program and its benefits for social emotional growth of the students. Evaluating the program going forward: TTUSD will put in place the Implementation Preparedness Survey and the

Lesson-Completion Checklists. In addition, the Devereux Early Childhood assessment for Preschoolers will be an option for pre-schools, if they choose to use it.

Referrals to outside agencies can be hard to track, so TTUSD has discussed with each site the tracking and recording of referrals to the student study team for students who are referred for social emotional issues. This information will help track and monitor the support that is given to the student.

A fun and necessary challenge is the fact that the Second Step program is continually updating. TTUSD monitors updates and purchases new kits / licenses, as needed. For example, the Second Step Middle school program was restructured to a digital and more user-friendly format. New, all-digital kits, will be needed to replace the kits that use DVDs.

The District Goal this year is the "Power of Connections." This goal complements the Social Emotional basis of the Second Step Program. All students learn and thrive when they feel safe and connected to their school or an adult in their lives (e.g., a teacher, counselor, custodian, secretary, parent, coach, etc.).

Mindfulness is the newest addition to the Second Step program. Students are taught skills in self-regulation, ease-in-transitions, dealing with strong emotions, becoming more empathetic, tools for dealing with anxiety, and so much more. Mindfulness training is a great step on the continuum of fostering emotional well-being in the students.

Program Participant Story

A counselor at Donner Trail Elementary School has been implementing and re-teaching the Second Step program each year. She often asks the students about what they remember the most from last year's Second Step program. Approximately 80-90% of students mention taking three (3) deep breaths for a calming down technique and using self-talk. They say that they use it often when solving conflicts or when they have strong emotions. Second Step is going beyond the school, as well, with at least one student reported having taught his mom about taking three (3) deep breaths.

PEI Project Name: Prevention Program

BIG BROTHERS, BIG SISTERS
Pal Program

Program Description

Program Overview

The Big Brothers, Big Sisters Pal Program serves at-risk elementary and middle school youth, called Little Pals, by providing them with a high school mentor, or Big Pal. The Big Pals help the Little Pals develop the skills to manage the trials of growing up, while also providing academic support.

High School juniors and seniors are matched with elementary and middle school students, Grades 3 - 7, for a weekly mentoring meeting. All meetings are held on the school campus. Students are referred by administrators/teachers from one of four schools: Scotten, Lymon Gilmore – Grass Valley School District, Deer Creek, and Seven Hills – Nevada City School District. High School Big Pals are recruited from the following schools: Nevada Union High School, Forest Charter School, and Bitney Prep Charter. The Pal Program Coordinator recruits, screens, trains, and matches all children and teens, conducts match support meetings on a bi-monthly basis, and works closely with the schools and teachers to set goals and review progress towards those goals throughout the school year.

Target Population

The Pal Program serves at-risk elementary and middle school youth, Grades 3 - 7.

Evaluation Activities and Outcomes

Big Brothers, Big Sisters collects evaluation activities for MHSA including demographic information on each individual person receiving services. In addition, information on the number of meetings between Big and Little Pals is collected. Information on referrals to community services is also collected.

There were 21 matches this year, but two (2) pals moved so their matches were closed, leaving 19 matches for the full year. Matches met a total of 315 times for one-hour sessions over the course of the year.

At the end of the year, 12 matches closed due to the Bigs graduating high school. Seven (7) matches will continue during the next school year. This is significantly higher than the number of returning matches that the program had at the beginning of this school year. Of the matches continuing, five (5) are 5th grade, one (1) is 6th grade, and one (1) is a 7th grade match.

Big Brothers, Big Sisters of Nevada County and North Lake Tahoe have been conducting effective mentoring programs for at-risk youth for the past 35 years. Two surveys are used to assess the quality of the relationships between the Big Pals and the Little Pals and the impact of the Program on the children served: the Strength of Relationship (SoR) survey and the Youth Outcomes Survey (YOS).

Each child and mentor completes the SoR survey after three (3) months of being matched, to establish a baseline. Thereafter, they both complete the SoR annually on their anniversary. This survey assesses the quality of the relationship between the child and the mentor by looking at

how close they feel to one another, how much they trust one another, and how important the relationship is to them. The end-of-year SoR surveys showed that, overall, Littles felt close to their Bigs. On average, 86% to 100% of Littles reported that their Big was helpful on a number of dimensions of the SoR (e.g., the Big Pal guided the Little Pal in problem-solving).

The YOS is given to youth in the program before they are matched, then annually on their match anniversary. This measures the impact of the mentoring relationship on the child's self-confidence, school performance, healthy behaviors, and interpersonal relationships. The end-of-year YOS showed that, overall, the Pal Program had a positive impact on the Littles, with 75% showing stable or improved school absences, 81% reporting having a positive adult in their lives, and no Littles reporting having been arrested.

Big Brothers, Big Sisters also measures program impact by the length of the mentoring relationship. Big Brothers, Big Sisters expects a one-year minimum commitment from mentoring matches because research has shown that matches that remain together for one year or longer demonstrate higher relationship quality and more positive outcomes for the children being mentored.

The Pal Program will potentially include the Grass Valley Charter School this next school year. One of the counselors at the school has children she wants to refer to the program. She has a location for the matches to meet, should those students get matched with a Big Pal. Colfax elementary and high school are possible additions for next year, as well.

No referrals to outside agencies were made during Fiscal Year 2016-17.

Challenges, Solutions, and Upcoming Changes

As seen before, challenges with scheduling made it difficult to make matches. It seems that some teachers feel that once a week is too much class time to miss. The high school has also changed their policy about students leaving during lunch time, so the interested high school students who wanted to meet during their lunch period were unable to. Talking with the high school teachers helps them to understand the importance of the program and that once a week is something their students can keep up with. In the next year, the Pal Program should contact the Principal of the high school to see if there is something that can be done about allowing students to leave during their lunch time to visit with Little Pals.

This year the program had to work with some Little Pals on their behavior. However, the most common challenge was keeping up with changing addresses and phone numbers of parents and guardians. In order to keep in contact with parents of Little Pals, the Pal Program will sometimes have to get in contact with the school to see if there has been a change of address or phone number reported. Schools are willing to help the Pal Program keep in touch with the family of the Little Pals.

Program Participant Story

A story from a Big Pal: When I was in third grade, a few of my friends had teenagers who would come visit them once a week and pull them out of class to hang out. Initially, I did not understand why some kids got these "Big Pals." I soon discovered it was because my friends were considered at-risk of developing harmful mindsets. For this reason, they were enrolled in the Pal Program and the teenagers who would visit them were there in order to provide a kind ear and help them through any struggles they were experiencing. Since I was not considered at-risk, I could not have a Big Pal, but from that moment I decided that when I was in High School I would be a Big Pal and I would be a mentor to a student in need to help them through their hardships. Fast forward to a few years later: I have been in the Pal Program for two years and I am organizing the Pal projects. Being a Big Pal has truly been one of the most rewarding experiences I have ever had, and I will never forget the smiles and laughs I have shared with my Little Pal. Over these two years my Little Pal not only became my friend, but my family. We always got along perfectly. Although I was the mentor, there to lend an ear to the struggles, my Little Pal also made an impact on my life and I will always be grateful. As we both take the next steps in our lives, I will not get to see them every week anymore. Fortunately, my Little Pal and I grew so close, I feel that there is a bond between us that will never be broken, and I know that we will keep in touch throughout the years. My Little Pal knows they can always come to me whenever they are having a hard time or just need someone to talk to, and I will always be grateful to have such a sweet and wonderful person in my life to call family.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA-SIERRA CONNECTING POINT PUBLIC AUTHORITY
2-1-1 Nevada County

Program Description

Program Overview
2-1-1 Nevada County is a resource and information phone hub that connects people with community, health, and disaster services through a free, 24/7, confidential phone service and searchable online database. By dialing 2-1-1, Nevada County residents can access health information, community services, and disaster services throughout Nevada County. This program offers assistance in multiple languages, and is accessible to people with disabilities. Trained information and referral specialists give personalized attention to each caller by utilizing a comprehensive computerized database of more than 1,200 nonprofit and public agencies at 1,700 different locations in Nevada County. Specialists refer callers to a variety of services to best meet their needs.

Target Population
2-1-1 Nevada County serves the entire population of Nevada County and anyone calling the 2-1-1 Line seeking information about community resources.

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on each caller, the number of referrals to community resources, and the number of follow-up calls.

Of the 10,324 total calls handled:

- 1,807 were follow-up calls
- 1,849 calls ended with a “warm referral” direct connection to resources
- 73 callers were warm transferred to Nevada County Behavioral Health

The 111,193 searches and web resource page views conducted on the 2-1-1 Nevada County website were from 16,480 unique IP addresses.

Outcome Measures Tracked:

- 5,616 unduplicated callers
- 10,211 referrals provided to callers
- 271 referrals to mental health services

No caller identifying suicidal ideation was let off the line without a referral to a suicide prevention specialist. Suicide-related calls handled included:

- Caller was concerned about her friend who was threatening suicide. Though she was already connected with a suicide prevention agency and was at a safe location, her friends and family couldn't reach her. As she had an address, the caller was advised to contact the sheriff and ask them to do a welfare check.
- Caller whose son in Sacramento was threatening suicide was referred to the Behavioral Health Crisis line for the caller and 2-1-1 Sacramento for the son and/or his girlfriend.
- Caller who was grieving and depressed with thoughts of suicide daily was referred to SPIRIT Center and Anew Day for additional counseling, as he was already getting counseling through his managed Medi-Cal plan.

Staff attended the California Alliance of Information and Referral Services Conference, and trainings in Compassion Fatigue, Motivational Interviewing, CA Department of Aging, Security Awareness Training, Quality Assurance for Information and Assistance Specialists, and in-house educational presentations from local resource providers.

Challenges, Solutions, and Upcoming Changes

Requests for resources for affordable housing, both emergency and long-term, continue to present challenges to call agents when referral inventory in Nevada County is inadequate.

By implementing the Coordinated Entry System in conjunction with the Continuum of Care in Nevada County, 2-1-1 is able to systematically collect valuable data on service needs for homeless individuals and report gaps to decision makers in the county.

Program Participant Story

A caller expressed serious concerns regarding her current situation. She was interested in getting help dealing with her anger, and expressed feeling that she was "at the end of her rope." She didn't feel that she was necessarily a danger to herself or others, but she wanted to be proactive to get the support she needed to help her more successfully navigate through her various issues before they became unmanageable. Due to information gathered in prior calls, staff were, at the time of this call, aware that the caller had various mental health concerns, substance abuse issues, and was currently taking prescription medications. After listening carefully and providing a "safe space" for the caller to speak her mind, the call agent provided several referrals to local agencies that could assist her in getting connected with both group and individualized therapy and support sessions related to her needs, but, most especially, anger management. Four local resources were provided for this support. The caller said she was already working with two additional local agencies. The caller was warm-transferred to a local provider, and a follow-up call was scheduled.

Four (4) days later, the agreed upon follow-up call was placed. The agent ascertained that the caller had gotten her specific and primary needs met directly through one of the referrals made in the warm-transfer. She signed up for a support group, and she also enrolled herself in some physical movement classes, which she believed would help her manage her stress levels more effectively. The caller then reported that she was "doing much better" at the time of the follow-up, and that she was thankful for the assistance 2-1-1 had provided.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY ADULT SERVICES
Social Outreach Nurse

Program Description

Program Overview

The Social Outreach Nurse program provides a Registered Nurse (RN) to make home visits to older adults and adults with disabilities. The Social Outreach Nurse assesses for depression, anxiety, and risk of falling while building rapport with the individuals. The nurse also provides support by listening, advocating, and making referrals to various public and private services.

The number of visits and phone contacts varies with each person, based on need. Follow-up "check-in" calls are frequently conducted, and the participants are always encouraged to call if a need arises. At times, consumers call after several months when they need assistance, circumstances change, or they need someone to talk to for support.

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

Target Population

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

Evaluation Activities and Outcomes

The Social Outreach Nurse program collects information on each person who receives a home visit. This information includes demographic details, date of the outreach, location, and number

of services. The program also collects the number of referrals made to community agencies. A Depression Screening Tool is used at the beginning of services.

A total of 51 unduplicated participants were served and 33 individuals reported family involvement in services in FY 2016-17. Of those 35 were new consumers and 16 were continuing from the previous year. Services were delivered to participants for a total of 272.5 hours with an average of 5.3 hours spent with each participant. Depression screenings were administered to the 35 new participants, resulting in ten (10) manifesting moderate to severe symptoms. A total of 78 referrals to outside agencies such as FREED, Therapists, Clinics, In-Home Support Services, and 211 were delivered to participants. Of these referrals 34 (43.6%) successfully connected with the agency.

Another parameter for evaluation of the Social Outreach Nurse is the timing of participant visits to a primary care provider/physician (PCP) within the previous twelve months. Of the 35 new participants, all but three (3) had seen their PCP during the previous year. Two (2) participants stated that they did not have a PCP and one relied on a neurologist for medical direction.

The Social Outreach Nurse performed outreach to the community at two (2) events with approximately 95 older adults in attendance. The events were the Salvation Army's Teens Offer Peer Support (TOPS) Group and the Ponderosa Pines Mobile Home Park.

Of the individuals served by this program the Duration of Untreated Mental Illness (DUMI) for 4% was one month, 18% was two to six months, 12% was seven to 12 months, 31% was one to four years, 28% was over five years, and for 8% the DUMI was unknown.

Challenges, Solutions, and Upcoming Changes

One minor challenge this year was that the Social Outreach Nurse had no alcohol and other drug (AOD) screen to use with participants. This issue was resolved quickly by finding, adopting, and implementing an AOD screening tool: the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool. The SBIRT is now administered at each new client's first home visit with the RN. The tool was adopted later in the year and it took some time for the nurse to become familiar with the tool, thus only a few AOD screenings were administered and no summary data is available to report here.

Outreach to Truckee participants (Eastern Nevada County) remains a challenge, but the nurse has progressed to having home visits in this area at least once a month and occasionally more often, depending on client need. However, the winter months also remain a challenge with the inclement weather. One solution to this challenge is the nurse increasing supportive phone calls to clients. Another challenge in serving Truckee is providing clients with a home visit from a Licensed Clinical Social Worker (LCSW). A possible solution would be for one of the Western Nevada County LCSWs to consider travel to Truckee.

Program Participant Story

The Social Outreach Nurse worked with a person in an apartment complex. The person was no longer able to drive, was experiencing chronic depression, and over the last several years had become reclusive to the point of experiencing mild agoraphobia. The individual had also begun feeling paranoid, especially regarding neighbors – suggesting they were "talking about me and spreading rumors." This individual was aware that these thoughts were likely "paranoia" and at times, during conversations with the Social Outreach Nurse, would laugh about these paranoid feelings.

This individual has a grown child who visits often. Even so, the individual often verbalized, and was occasionally tearful about, feeling lonely – saying things like, "my children are busy with their own lives." The individual accepted daily meal deliveries, but was leery of talking to "strangers."

The Social Outreach Nurse discussed having the individual ask a Primary Care Physician for antidepressants or see a therapist, but the individual refused both suggestions. Therefore, the focus of the nurse, over several home visits was to build a trusting relationship with the individual and eventually convince the individual to follow through on referrals to two local agencies. After the individual accepted these referrals, allowing these new people in, the individual eventually verbalized an improvement in loneliness. The individual's quality of life was enhanced by the Social Outreach Nurse and the referrals to these two vital Nevada County outreach services.

PEI Project Name: Access and Linkage to Treatment Program

HOSPITALITY HOUSE

Program Description

Program Overview

Hospitality House is a nonprofit community shelter for people who are homeless in Nevada County. Hospitality House is committed to ending homelessness by providing intensive case management services to all of its guests. Hospitality House also offers outreach services including rapid rehousing, Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) application assistance, birth certificate and California ID fee waiver assistance, referral services, transportation, clothing and clothing vouchers, food and drink, and camping gear. Hospitality House strives to empower people who are homeless and help them develop the skills they need to overcome the barriers that prevent them from successfully obtaining and maintaining stable housing. The mission of Hospitality House is to bring homeless people in Nevada County into a circle of community caring that offers shelter,

sustenance, medical care, advocacy, opportunity, dignity, and hope as they are assisted in transitioning from homelessness to housing.

Target Population

Hospitality House serves individuals who are homeless in Nevada County.

Evaluation Activities and Outcomes

Hospitality House collects evaluation activities for MHSA including demographic information on each individual person receiving services. In addition, information on outreach and referrals to outside agencies is collected.

During FY 2016-17, Hospitality House Outreach case managers made contact with 175 unduplicated individuals. Outreach case managers made a total of 46 referrals to outside agencies such as Mental Health Services, SPIRIT, Hospitality House, and Social Services Agency. Of these referrals, 31 (67.4%) connected to the outside agency. A summary of the number of times each participant was contacted by the case manager is below.

Number of Service Contacts*

	1 Contact	2 - 4 Contacts	5 - 7 Contacts	8+ Contacts	Unduplicated Total
# Participants	99	52	13	11	175
% Participants	56.6%	29.7%	7.4%	6.3%	100.0%

* Total number of contacts each participant received in FY 2016-17

Challenges, Solutions, and Upcoming Changes

The biggest challenges are finding affordable housing and being able to keep track of transient individuals. Many individuals show up briefly and leave before staff are able to connect them to services, or get any demographic information on them. Hospitality House is working to connect individuals to 2-1-1 to get applicable demographic information entered into the Homeless Management Information System (HMIS). The opening of the HMIS system will allow Outreach case managers to discover other services guests might be using. This would aid in the ability to track transient guests' comings and goings and eventually connect them to services.

Program Participant Story

An individual had been living independently since he was a teenager. As a teen, he was involved in a severe accident in which he received multiple injuries. The injuries resulting from the accident made it difficult for him to navigate daily life. In particular, his social skills and his ability to maintain steady full-time employment have been hindered. His life from the accident forward was one of isolation and minimal survival. In addition, he had emotional problems, most prominent of which was a low threshold for anger. For a while, he experienced issues with substance abuse. These circumstances kept him from sheltering, as he did not have the capacity to cope with the various personalities and sensory stimulation common to the shelter environment.

After a couple of recent additional injuries as well as the increasing difficulty of isolated camping and maneuvering the rugged landscape, the individual finally reached out. He began coming to Hospitality House occasionally for supplies, including food, clothing, etc. After the first few meetings the shelter case manager was able to develop a trusting relationship with the individual. It became apparent to the case manager that this individual would likely meet the requirements for government benefits. He was assisted with the necessary online and paper applications. He was also encouraged to attend a workshop at Hospitality House, and there, he was assisted in completing a housing application. In addition, he was connected to medical and psychological treatment, establishing a primary care physician. This connection led to treatment, and connection with additional specialty health care services.

Within ten (10) months of coming to Hospitality House, this individual was awarded government benefits, connected to the medical resources he needed, and is currently on the waitlist for housing. He continues to be homeless, but accepts minimal outreach supplies and is saving his retroactive benefit dollars for housing. He still visits about once a month to check in and has maintained a relationship with the outreach case manager.

PEI Project Name: Access and Linkage to Treatment Program

PROJECT MANA
Truckee Homeless Outreach, Access, and Linkage to Treatment Program

Program Description

Program Overview

The Truckee Homeless Outreach Program provides outreach, access, and linkage services for homeless individuals in the Truckee area. One goal of the program is to engage with homeless individuals in order to reduce the risk of harm and enhance safety. The Homeless Outreach Coordinator works with homeless individuals to connect them to benefits, jobs, housing, services, and treatment. The Homeless Outreach Coordinator also supports and assists individuals to utilize warming shelters, when available.

In addition, the program provides essential items to homeless individuals including socks, sleeping bags, jackets, blankets, clothes, personal hygiene items, etc.

Target Population

The Truckee Homeless Outreach Program serves individuals who are homeless or at risk of homelessness in the Truckee area.

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on the people served, the location of services, and number of persons referred to community resources, including housing.

The Truckee Homeless Outreach Program provided direct services to seven (7) unduplicated participants in Nevada County during FY 2016-17. Staff engaged in targeted outreach to potential participants 72 times for a total of 105.7 hours, averaging 1.5 hours per targeted outreach contact.

Project Mana delivered outreach and education to 187 unduplicated individuals. Staff provided 72 referrals to participants such as Mental Health Services, Hospitality House, CoRR, Common Goals, physicians, Food Bank, Human Services Benefits, Legal Services, Family Resource Center and Financial Assistance. Of these, five (6.9%) successfully connected. Other support provided by staff included:

- Supplied a sleeping bag to three (3) individual participants.
- Supplied a blanket to one (1) participant.
- Supplied clothes to four (4) individual participants.
- Supplied bus ticket for participant to get to a court Appointment.
- Worked with one (1) participant to obtain food assistance.
- Worked with one (1) participant to obtain a Social Security card.
- Wrote proof of occupancy letter for one (1) participant to obtain a California I.D.
- Supplied two (2) participants with $5 food cards.
- Assisted one (1) participant in moving out of county.
- Talked to one (1) participant about the benefits of taking medication on a regular basis.
- Promoted participants to go to rehab for drug and alcohol use.
- Formed strong relationships with many participants in town.

Challenges, Solutions, and Upcoming Changes

An ongoing challenge is the lack of resources for homeless individuals in the Truckee area, including a lack of permanent shelters and a lack of transitional housing.

To address some of the challenges, Project Mana continues to train staff and to learn about new skills such as **t**rauma-informed care, action planning, and small county wellness. In addition, the program provides Life Skills and Personal Life-Enhancing Activities/Plans, Housing Readiness

Workshops, and Job Readiness Workshops. An exciting upcoming change is the opening of the Western Sierra Medical Center, a Federally Qualified Health Center (FQHC).

Program Participant Story

An individual was referred to Project MANA Homeless Outreach, who had experienced homelessness on-and-off over a long period of time. This individual had a challenge with his memory, problem-solving skills and mobility. Therefore, he had limited ability to work. While in Truckee, he was working at a part-time job that would end when the season ended. He was staying on a friend's couch, but did not know how long he would be able to stay there. The individual stated that he was interested in moving out of the county, back to a place he had lived before.

The individual had lost his driver's license. The Outreach staff advised him of the steps he could take to reinstate his driver's license, which the individual intends to do after he moves.

The individual did not have any current connections to the place where he wanted to move. The Outreach staff supported him in researching resources in the area and calling relevant agencies for help. The individual was able to connect with a local center that would work with him when he moved. The Outreach staff also assisted him in researching and finding housing in the area. The individual was also able to contact an employment agency that was able to work with him and find him suitable employment.

After the individual contacted the employment agency, received information on housing, and talked to the local center, he decided to move. He moved his belongings into storage with the help of additional Truckee resources.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY BEHAVIORAL HEALTH
Forensic Outreach

Program Description

Program Overview

Forensic Specialist Services aims to prevent and decrease law enforcement contact and incarceration for individuals experiencing mental health conditions. The program provides assessment of needs and obstacles, referrals to community resources, support accessing substance use disorder treatment, consultation, and direct counseling interventions. The Forensic Specialist engages with numerous community resources including Law Enforcement, Mental

Health Court, Public Defender, Behavioral Health, Adult Protective Services, Hospitality House, Community Recovery Resources (CoRR), Common Goals, National Alliance for the Mentally Ill (NAMI), SPIRIT Peer Empowerment Center, and other social service providers.

Target Population

Forensic Outreach provides services for persons who are, or have been, incarcerated and who are ready to be, or have been, released. 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.

Forensic Outreach provided services to 18 unduplicated participants during FY 2016-17. The program provided 32 referrals to participants, sending individuals to agencies such as, Nevada County Behavioral Health, Hospitality House, SPIRIT Center, Crisis Stabilization Unit, FREED, and Human Services (Benefits).

Challenges, Solutions, and Upcoming Changes

One challenge of the program is having a single point of contact for both local police departments, and having no point of contact in the Sheriff's Department. Officers in the field do not appear to always get information or ask for help from the Forensic case manager, nor from the assigned "mental health officer." Additionally, the officer for Nevada City Police Department was on leave for a significant part of the year. Although, the point of contact is a good idea for disseminating information to officers, the Forensic Specialist is also reaching out to individual officers in the field to create more referrals and solidify the training that was provided last year.

Program Participant Story

A long-time homeless individual in the community with substance use issues was diagnosed with a serious medical condition. One day, the condition progressed to the point in which he was unable to live without supportive medical services. Working with a local homeless advocacy group and a recently re-united family connection, the Forensic Mental Health specialist was able to use a small amount of grant funds to place the individual in temporary housing while they completed paperwork and agreements to place him in a local supportive care facility. He

continues to deal with the chronic health condition but is no longer homeless, has been able to maintain sobriety, and has improved his quality of life.

PEI Project Name: Access and Linkage to Treatment Program

WHAT'S UP? WELLNESS CHECK UPS

Program Description

Program Overview

The What's Up? Wellness Checkups (WUWC) program screens high school students in the Nevada Joint Union High School District (NJUHSD) and Tahoe Truckee Unified School District (TTUSD) for suicide risk, depression, anxiety, and other emotional health issues. Students privately take a brief, computerized diagnostic questionnaire, followed by a one-on-one interview with program staff, who then connect students with community resources, in-school supports, and/or case management and crisis support as needed. In the case of a necessary, immediate connection or referral, WUWC staff serve as one of the primary support systems for the student's family, providing both in-person and phone-based crisis intervention and referrals to local crisis agencies. WUWC identifies and helps youth at-risk, promotes wellness, increases peer support systems, and strengthens family connectedness.

WUWC recruits, trains, and supervises screening volunteers and group facilitators. The program collaborated with the Domestic Violence and Sexual Assault Coalition (DVSAC) and Nevada County Public Health to provide in-school groups, like the Boys Groups and Mindfulness Skills Groups at Nevada Union (NU) and Bear River High schools. WUWC also created ongoing, up-to-date referral guides for case management.

WUWC coordinates with district officials, school administration, and staff to find on-campus screening sites and provide student follow-ups. The program supports community awareness via newspaper, radio (including the National Public Radio station in Reno), social media, website, school, community, and fundraising events. WUWC attended local collaboratives and agency meetings, including the Suicide Prevention Task Force, MHSA, and Nevada County Behavioral Health (NCBH). The program shared resources, coordinated services, and participated in events with a local youth-serving organization, New Events & Opportunities (NEO).

Parent consent forms were integrated into the online enrollment for FY 2016-17. Parent follow-up notifications are sent regarding students who are not able to be screened due to refusal, absence, graduation, or having transferred out of the district.

Ongoing translation and interpretation services are provided by the WUWC Translator/ Promotora, and local Family Resource Centers (FRC) as needed. In FY 2016-17, WUWC's Translator/ Promotora as well as the Grass Valley FRC Promotora provided support and outreach to students/ families. Staff have continued to develop systems to ensure that Spanish-speaking families are receiving outreach, case management, and follow-up services.

Target Population

WUWC targets high school students at the NJUHSD and TTUSD schools, including Bear River, Ghidotti, Nevada Union, Nevada Union Tech, Silver Springs, Northpoint Academy, North Tahoe, Truckee, and Sierra high schools. WUWC also conducted screenings this year at Western Sierra Youth Build and Earl Jamieson high schools. WUWC focuses outreach on incoming freshmen for prevention, as Grade 10 has the highest national suicide completion rate.

Evaluation Activities and Outcomes

WUWC collects evaluation activities for MHSA including demographic information for each individual receiving referrals. In addition, information on the type, date, location, and duration of the service is collected for group services. Information on referrals to community services is also collected.

WUWC screened a total of 366 students for mental health issues during FY 2016-17. Of those students, 113 (31%) screened positive for mental health issues and out of those students, 82 (73%) were provided case management services. WUWC provided group services to an additional 82 participants.

Group services included groups like mindfulness training and boys' groups. There were a total of 53 meetings of these groups with total (duplicated) attendance of 310, for an average of 5.8 participants per group meeting.

WUWC provided 132 referrals to school-based or outside agencies with 99 (75%) of those referrals eventually connecting. Students were referred to agencies such as Mental Health, Anew Day, Culturally-Specific Services, CoRR, Physician/MD, Private Therapist, Hospital/Clinic, Benefits Help, Family Resource Center, 2-1-1, Tahoe SAFE Alliance and School-Based Services to name a few.

A Group Evaluation Survey was administered to group participants. The survey indicated that most students felt the group improved their stress-coping skills (see table below).

Group Evaluation Survey Items	**% Pre Agree**	**% Post Agree**
I have replaced negative coping skills with positive coping skills (Pre N=26) (Post N=25)	26.9%	64.0%

I am able to use positive coping skills to deal with my stress (Pre N=26) (Post N=25)	30.8%	68.0%
I am aware of how I respond to stress (Pre N=25) (Post N=24)	28.0%	70.8%
I am aware of how stressed I am (Pre N=26) (Post N=25)	69.2%	80.0%
I view stress as a manageable part of my life (Pre N=26) (Post N=25)	30.8%	48.0%

Of the individuals served by this program the Duration of Untreated Mental Illness (DUMI) for 1% was less than six months, 3% was six to twelve months, 25% was one to four years, 10% was over five years, and for 10% the DUMI was unknown.

Challenges, Solutions, and Upcoming Changes

One challenge was the limited screening access to Northpoint students despite ongoing coordination attempts and on campus WUWC staff presence. The independent study schedule causes student attendance to be minimal and sporadic. Another challenge was the decrease in parent consent return rate at NJUHSD, from 74% in FY 2015-16 to 51% in FY 2016-17. This decrease is possibly due to access issues as this year there was increased emphasis on online enrollment rather than hardcopy enrollment packets. The consistently low TTUSD parent consent return rate is an ongoing challenge.

To address the challenge at Northpoint, WUWC staff is collaborating with Northpoint administration to provide comprehensive outreach in FY 2017-18, including scheduling a full screening week as part of the school schedule in both Fall and Spring semesters. With NJUHSD, WUWC offered three (3) additional Nevada County schools WUWC screening services. And, with TTUSD, WUWC staff actively pursued a new classroom-integrated outreach plan that successfully increased TTUSD consent return rate to 60% in FY 2016-17, from 4% in FY 2015-16. In addition, staff integrated WUWC screenings and presentations into health classes as part of their mental health week.

Program Participant Story

A non-English-speaking student, referred to WUWC by school staff, was screened and found to be in crisis. Crisis protocols were immediately enacted and coordinated by WUWC staff. The student and family were directly linked by WUWC to bilingual treatment at Nevada County Children's Behavioral Health. WUWC's interpreter provided cultural support and psychoeducation regarding suicide risk and mental health awareness to the family.

In the following weeks, WUWC staff provided ongoing check-ins, psychoeducational materials, and resource information to the student and family. WUWC also consulted with the treatment provider and school staff. However, after a month, the student was back in crisis and

hospitalized. The family called the WUWC interpreter who went to the hospital, coordinating with WUWC staff to provide information to the family, as needed throughout the hospitalization. Prior to the student being released from the hospital, WUWC staff consulted with a Suicide Prevention Coordinator to help facilitate the student's sensitive re-entry to school. The Family Resource Center staff was also brought in by WUWC to help with the family's reintegration of their child into the home environment.

The student is now stable and doing much better. Recently, the parent of this student told the WUWC interpreter, "thanks to your intervention, (my child is) alive and receiving support. The whole situation has helped our family to be more open to talk about mental health issues." For WUWC, this crisis also helped spur the awareness of the need for a collaborative effort of integrating Nevada County bilingual services more efficiently and thoroughly. It helped WUWC staff to develop a more extensive crisis protocol within the school system with the myriad of partners involved, as well as uncover a hidden need within the non-English-speaking teen community for connection, and the need to address issues of isolation within that community.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY ADULT SERVICES
Veterans Service Office Outreach and Linkage

Program Description

Program Overview

The Veterans Service Office (VSO) promotes the interest and welfare of veterans, their dependents, and their survivors by enhancing their quality of life through counseling, education, benefit assistance, and advocacy. Veterans Service Representatives meet with veterans and/or their dependents to assist them with access to benefits and resources. The Representatives conduct regular follow-up meetings or phone calls with the veterans and their dependents to ensure timely and reliable access to resources.

Target Population

The target population for the Veterans Service Office is Nevada County's veterans and their dependents. There are approximately 9,500 veterans in the county.

Evaluation Activities and Outcomes

The Veterans Outreach and Linkage program collects evaluation activities for MHSA including demographic information for each individual person receiving referrals. Information on referrals to community services is also collected.

A total of 20 veterans and/or their dependents were served in FY 2016-17. Veterans Service Representatives delivered a total of 24 referrals to community services such as the Crisis Stabilization Unit, Welcome Home Vets, and Adult Protective Services. Of these referrals, 22 (91.7%) were successfully connected by the end of FY 2016-17. The program also engaged in outreach to the community. There were a total of seven (7) outreach events with at least 335 in attendance across all events. These events included: College Night, Sierra College Vets Outreach, KNCO Radio - Veteran's Benefit Information, Nevada County Leadership Meeting, Crisis Intervention Training, Department of Social Services - All Staff Meeting, and a Veteran Services Event.

Of the individuals served by this program the Duration of Untreated Mental Illness (DUMI) for 5% was one to four years, 5% was over five years, and for 85% the DUMI was unknown.

Challenges, Solutions, and Upcoming Changes

A major challenge for VSO staff is the limited amount of time to complete the data collection forms. The Veterans Service Representatives' calendars typically consist of back-to-back appointments, which leads to delays in getting paperwork completed. Staff are referring veterans to other services, however the documentation from the Veterans Service Office does not reflect all of the referrals made. To address this challenge, staff meetings explaining the required documentation for MHSA have been held and data collection form submissions are now required weekly.

Program Participant Story

A Truckee veteran came to the Veterans Service Office to file a claim and expressed his need to see a counselor to help with his mental health issues. The Veterans Service Representative submitted the referral to a local Vet Center. In addition, the Representative called to discuss the Vet Center processing his referral while the Representative tried to get a copy of the vet's discharge papers to verify his service. After some time with no success connecting with the Vet Center, the veteran told the Representative that he felt he really needed to speak with someone soon, as he was "on the edge." The Representative contacted Truckee Social Services to see if they had a counselor that might be able to see him until he could connect with the Vet Center. They agreed to see him. The veteran said, "It's the perfect fit," and is happy.

PEI Project Name: Stigma and Discrimination Reduction Programs

FAMILY RESOURCE CENTER OF TRUCKEE
Promotora Program - Latino Outreach Services

Program Description

Program Overview

The Family Resource Center of Truckee (FRCoT) has a Promotora Program, which utilizes paraprofessionals to help Latino families connect to health resources and offers health education.

Traditionally, Promotoras are "community health workers" who are lay members of the community and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Promotoras in Nevada County are Spanish-speaking, bi-cultural, and/or bi-lingual paraprofessionals who help Latino families connect to resources in the community. Promotoras offer interpreter services, provide culturally appropriate physical health education and information, assist people in receiving the care they need, give informal support and guidance on health behaviors, and advocate for individuals and community health needs.

Promotoras participate in capacity-building trainings based on physical health and mental health outreach and education. They also conduct outreach and psycho-educational groups for Latino families in Spanish about mental health care. Psycho-education groups educate people about mental health issues to decrease stigma about reaching out for help for mental health issues. By decreasing stigma about mental health conditions, the program promotes, maintains, and improves individual and community mental health.

The Promotoras link individuals and families that they serve to needed services in the community, which include mental health services, and when necessary, they accompany individuals to their first appointment for a warm handoff to the mental health professional. Promotoras can refer individuals and families to Nevada County Behavioral Health (NCBH) Spanish-speaking therapists in Truckee. The therapists provide services to individuals, or if the consumer is a child, services are provided to the child and their family.

Target Population

The Family Resource Center of Truckee Promotora Program primarily serves Latino families who could benefit from supportive services and assistance to link them to needed services in the community.

Evaluation Activities and Outcomes

FRCoT collects evaluation activities for MHSA including demographic information on each individual receiving services. In addition, information on the Family Room group services, outreach, and referrals to outside agencies is collected. Direct service information includes date, location, and duration of the service.

The Promotora team delivered individual direct services and/or group activities to a total of 120 unduplicated participants in FY 2016-17. In addition, the Promotora team made 32 referrals to outside agencies during the year, of which 12 (37.5%) successfully connected. Referrals were made to agencies and individuals such as mental health service providers, physicians, and the Social Services Agency. Of the 120 direct service participants, 17 (14.2%) had their families involved in services.

The Promotora team for FY 2016-17 consisted of three (3) Promotoras and a Program Coordinator. Workshops were given in teams of two (2) Promotoras. Promotoras received support and guidance from their Program Coordinator and the FRCoT staff. The FRCoT Promotora team worked in close collaboration with the North Tahoe Promotora team, meeting regularly, sharing resources, trainings, and working to strengthen a regional force of Promotoras. The Promotora team also participated in network building efforts with Latino Leadership of Auburn, University of Reno's community health program, and the nation-wide organization of Promotoras - Vision y Compromiso; two members of the FRCoT Promotora team attended the annual Vision y Compromiso Conference in Ontario, CA, where they met other Promotora leaders and attended workshops on community health outreach work.

Outreach and workshops included the following:

- En Mi Familia Empieza el Mundo
- Las Posadas Community Events
- Salud y Visuteria
- Visuteria y Salud Mental
- World Class Communication
- Chronic Disease Self-Management
- Manualidad y Charla
- Grupo Apoyo
- Mental Health First Aid

Promotora activities included the following:

- Promotora Development
- Regional Promotora Meetings
- Latino Leadership Liaison Meeting
- Vision y Conmpromiso Annual Conference

Summaries of the group and individual services are in the tables below.

Number of Group Activities, Attendance, and Average Attendance per Group		
Promotora/Latino Outreach *Unduplicated N=105*	Number of Group Activities	**82**
	Attendance	**568**
	Average Attendance/Group	**6.9**

Number of Direct Individual Service Hours, Participants, and Average Hours per Participant		
Promotora/Latino Outreach *Unduplicated N=20*	Number of Direct Service Hours	**52.0**
	Number of Unduplicated Participants	**20**
	Average Hours/Participant	**2.6**

Of the 120 direct service participants, 5.8% reported having experienced untreated mental health symptoms for more than one month (see table below).

Duration of Untreated Mental Illness	
Duration	**% Participants**
2 - 6 months ago	0.8%
7 - 12 months ago	0.8%
1 - 4 years ago	1.7%
5 years ago or longer	2.5%
Other	0.8%
Unknown	90.0%

Challenges, Solutions, and Upcoming Changes

FRCoT has a strong presence in certain areas of town where the FRCoT programs are well known, but has a tougher time garnering attendance in neighborhoods where the Promotora Program is less well known. In the next year, FRCoT will target neighborhoods that have not had a strong Promotora presence in the past (e.g., Donner Creek Mobile Home Park and Truckee Pines Apartments).

This year there was a continued struggle with data collection and evaluation. It has been a challenge for the Promotora team to keep track of the different data sheets for Placer and Nevada Counties and to keep up with the changes in the data collection. There is still participant resistance to the quantity of paperwork and frequently paperwork is left incomplete. In the next year, the plan is to continue to work to become familiar with the proper forms, to stick to the

forms that are currently used and to get into the habit of asking for forms to be completed by every participant. In order to facilitate the collection of evaluation forms and demographic sheets and to communicate the level of importance of the forms, the FRCoT plans to send an FRCoT staff member at the beginning and the end of the workshops to help with data collection and evaluation implementation.

Program Participant Story

A few years ago, a mother with a chronic health condition gave birth to a premature baby in the Truckee area. Her baby needed a lot of care after they returned home from the hospital. Truckee Healthy Babies sent a worker to regularly visit mom and baby. The worker recognized that mom was struggling. She referred mom to mental health care practitioners, but mom refused, saying that she didn't need it and she wasn't 'crazy;' that she was just overwhelmed. The worker was able to offer her own peer counseling services. The worker visited every day for two months. Slowly, mom and baby got healthier. At the end of the two months of visitation, the worker suggested that mom check out the Promotora Program at the FRCoT, encouraging her to participate in one of their programs.

Mom started to come to the workshops. She was engaged and a great asset to the group. Over time, mom started to attend other Promotora Programs and build a support network amongst her peers and the Promotoras. The first workshop that she attended was approachable for mom, since it was craft-based and seemed less serious than other mental health workshops. It was at that workshop that mom first talked about mental health with her own peers. She couldn't believe how comfortably the Promotoras discussed depression or how open her peers were about their experiences. She started to see that she was not alone in her difficult emotions. For the first time, she used the words herself about her own experience. Mom now wants to share the education that she received with others.

PEI Project Name: Stigma and Discrimination Reduction Program

NEVADA COUNTY SUPERINTENDENT OF SCHOOLS
Promotora/ Latino Outreach

Program Description

Program Overview

The NCSOS Promotora/Latino Outreach Program consists of Mental Health Outreach and Engagement groups for the Latino Community. The goal of these groups is to educate individuals and to decrease stigma and fear about mental health issues in the Latino Population.

These groups are conducted in Spanish and childcare is always available during group meetings. Meetings take place at the Family Resource Center (FRC) and the Grass Valley Charter School, facilities of the Nevada County Superintendent of Schools (NCSOS).

Traditionally, Promotoras are "community health workers" who are lay members of the community and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Promotoras in Nevada County are Spanish speaking bi-lingual and/or bi-cultural paraprofessionals who help Latino families connect to resources for health care in the community. Promotoras offer interpretation and translation services, provide culturally appropriate physical health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, and advocate for individuals and community health needs. Promotoras also link individuals and families that they serve to needed services in the community, which include mental health services. When necessary, Promotoras accompany individuals to their first appointment for a warm handoff to the mental health professional.

Target Population

NCSOS Promotora/Latino Outreach serves the Latino population in the Grass Valley area. This program serves children, transition age youth (TAY), adults, and older adults.

Evaluation Activities and Outcomes

The NCSOS Promotora/Latino Outreach Program collects evaluation activities for MHSA including demographic information on each person receiving services and/or being trained. In addition, information on individual and outreach services is collected. An attitude survey is collected at the end of services. Information on referrals to community services is also collected.

The NCSOS Promotora/Latino Outreach Program provided services to 275 unduplicated individuals in collaboration with Chapa-De, local Gynecologists, Dentists, Western Sierra Medical Clinic, Sierra Nevada Memorial Hospital (SNMH) Emergency, Imaging and billing, Domestic Violence and Sexual Assault Coalition (DVSAC), Foothill Healthy Babies, Suicide Prevention Task Force, Community Health Improvement Plan (CHIP) Steering Committee, CoRR, Behavioral Health, Drug and Alcohol Services, Child Protective Services, school districts Individualized Education Program (IEP) translations, Affordable Care Act, employment, and housing. Staff made 11 referrals to outside agencies such as Mental Health and Family Resource Center, of which seven (63.6%) successfully connected.

There were 11 educational meetings and one (1) traditional event with 200 in attendance across all meetings. All attending received information regarding mental health services. These meetings included:

- Emergency Preparedness by Fire Chief M. Buttron and Emergency Services J. Gulserian
- Six Keys to Physical and Mental Health by Dr. Vassar
- Uncertainties by Attorney Sara Coppin with Q&A session
- Kings Day Traditional Event

- Less Stress for Better Health
- Know Yourself
- Yoga Breathing to Destress by Spec. Sari Pinto
- Personalities … Weakness Overcome by Strengths by Meg Luce, LMFP
- WRAP Presentation to FRC Staff by N. Mead.

Due to language and literacy challenges, and cultural competency, the Promotora conducts many surveys verbally instead of on paper. Verbal surveys of participants at the FRC resulted in open conversations about mental health, including conversations about suicide prevention, thus reducing the strength of the cultural taboo. Distribution of SanaMente ribbons and cards in three (3) market cashier booths resulted in awareness and conversations on the spot. Twelve individuals verbally reported a deeper understanding of the "Know the Signs" materials for suicide awareness.

After a series of three (3) stress-reduction meetings, participants were verbally surveyed. About 40% reported a reduction in their stress levels, felt they learned how to manage stress better, and felt they would sleep better. Over 90% of those attending the meetings increased their knowledge of mental health illnesses and are aware of available resources.

The Attitude Survey pre and posttests added to the program mid-year were completed by four individuals. The survey results showed an improved knowledge and understanding of mental illness and the associated stigma.

Eleven individuals made WRAP plans in one to three hour sessions.

Challenges, Solutions, and Upcoming Changes

Attracting an audience is an ongoing challenge met with new ideas; however this year has been particularly challenging due to the population's fear of raids by authorities. Promotoras helped to assuage some of the fear by delivering information to prepare families in the case of an emergency through events with a local immigration attorney and local law enforcement, and by handing out Sierra College Forum materials. The information was well received. However, one of the suggestions was to only leave home when necessary as a precautionary measure, which significantly lowered the attendance of meetings this year.

The new reporting forms have been a challenge but offer an opportunity to tune up data collection. Their use will ultimately become part of a welcome routine.

Program Participant Story

A teenager who accessed services with the Promotoras is happily smiling now, experiencing success in school, and living in a stable location. Her current situation is in stark contrast to her

previous depressed countenance and forced smile. When she first came to the Promotoras, she was experiencing depression, feeling caged, and she had already attempted suicide several times. Her parents were given materials to help them understand mental health issues and to help her access the help she needed. In collaboration with What's Up? Wellness Checkups, a Behavioral Health therapist, Nevada County Behavioral Health Suicide Prevention, and the participant's parents, the Promotora Program was able to guide this participant to mental health resources leading to her current, stable state.

And, a quote from a WRAP participant: "I found learning about WRAP and the steps involved to be very helpful. It helped me think about triggers (mine and some other people in my life) and the things that personally help recharge and sustain me. I even shared some with my family. Thanks!"

PEI Project Name: Suicide Prevention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Suicide Prevention and Intervention

Program Description

Program Overview

The Suicide Prevention and Intervention (SPI) Program was developed to create a more "suicide aware community." An SPI Coordinator organizes and leads the implementation of this program. The SPI Coordinator works with consumers, individuals, families, support groups, task forces, community-based organizations, local and state governments, schools, crisis lines, and health clinics. The goals of the program are to raise awareness that suicide is preventable, reduce stigma around suicide and mental illness, promote help-seeking behaviors, and implement suicide prevention and intervention training programs.

The SPI Coordinator uses an evidence-based curriculum, such as safeTALK, and other evidence-based practices to conduct outreach in the community, build community capacity, and provide linkage to services. The Coordinator provides these services in schools, faith-based organizations, business communities, county offices, public health sites, city offices, and to individuals and organizations that request assistance. The SPI Coordinator reaches people in the community who ordinarily would not be aware of mental health resources or how to access them.

The SPI Coordinator collaborates with a number of community organizations, including, the Suicide Prevention Task Force (SPTF), the Tahoe Truckee Suicide Prevention Coalition, the Fall Prevention Coalition (FPC), the Elder Care Providers Coalition (ECPC), Parents and Families of Lesbians and Gays (PFLAG), the Hope and Heal Fund, Tahoe Truckee Unified School District (TTUSD), and Tahoe SAFE Alliance, among others.

Target Population

The SPI program serves the entire population of Nevada County.

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on each participant in the training. In addition, a survey is collected at the end of training to provide information on the perception of the training.

SPI provided five (5) Know the Signs trainings and four (4) safeTALK trainings to 111 unduplicated participants during FY 2016-17. The safeTALK post-training evaluation showed

that all participants felt more prepared to speak openly with someone who is reporting suicidal thoughts (see table below).

safeTALK Feedback Questionnaire	**Percent Responses: Mostly/Well Prepared (N=43)**
How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide?	**100.0%**

Of the individuals served by this program the Duration of Untreated Mental Illness (DUMI) for .9% was one to four years, 3% was over five years, .9% was other, and for 82% the DUMI was unknown.

Challenges, Solutions, and Upcoming Changes

Despite strong programming efforts, the county experienced a number of suicides within a short period of time. The community members' hearts were heavy and spirits low, as the community grappled with the gravity of the situation and searched for solutions. Two (2) guides were made available to the community: "After Rural Suicide: A Guide for Coordinated Community Postvention Response in Tahoe Truckee" and "Loss Survivors Brochure." These protocols were engaged as outlined, and overall, proved to be a helpful tool to unify the community response.

Program Participant Story

A video created in collaboration with Inner Rhythms Dance, Truckee-Tahoe Suicide Prevention Coalition, Tahoe-Truckee Community Fund, and TTUSD which raises awareness of youth suicide prevention can be found at this link:
https://www.youtube.com/watch?v=GDwEpBOkyFU&sns=em
To the county's knowledge, no county mental health program participants were filmed in the link above.

CALMHSA STATEWIDE PEI PROJECT

Program Description

Program Overview

In FY 2016-17, 41 counties collectively pooled local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the Statewide PEI Project. The Statewide PEI Project is publicly known as Each Mind Matters: California's Mental Health Movement, which represents an umbrella name and vision to amplify individual efforts from the county and other organizations that are taking place across California under a united movement to reduce stigma and discrimination and prevent suicides.

In FY 2016-17, funding to the Statewide PEI Project supported programs such as maintaining and expanding public awareness and education campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to county agencies, schools and community based organizations, providing mental health/stigma reduction trainings to diverse audiences, engaging youth through the Directing Change program, and building the capacities of schools to address mental health, stigma reduction and suicide prevention.

Target Population

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

Evaluation Activities and Outcomes

The agencies, schools, and organizations that were reached with Statewide PEI Programs included Nevada County Children's Behavioral Health, Sierra College, John Muir Charter School, and Tahoe Truckee Unified School District.

Through the Statewide PEI Project during FY 2016-17, Nevada County agencies received:

- Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, as a platform for judging submitted Directing Change videos.
- Discounted rate to receive the Send Silence Packing exhibit, which publicly displays backpacks on campus grounds representing youth suicide deaths to begin a conversation about suicide prevention.
- E-Newsletters created specifically for service providers that provide information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.
- Technical assistance:
    - Providing support to staff on how to do a general suicide prevention presentation to local staff, local employers and community based organizations (CBOs).

    - Providing additional Know the Signs suicide prevention materials to Tahoe Forest Health System Wellness Neighborhood and helping them navigate other available resources under the Each Mind Matters.
- A total of 8,839 physical, hardcopy materials for Each Mind Matters programs and initiatives. In addition, county contacts received numerous emails to access and share resources electronically via the Each Mind Matters Resource Center (www.emmresourcecenter.org).
    - Each Mind Matters Promotional Items: 690
    - Each Mind Matters Educational Materials: 1,200
    - SanaMente Materials: 521
    - Know the Signs/El Suicidio Es Prevenible Educational Materials: 6,423
    - Directing Change Materials: 5

The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of Each Mind Matters is critical for creating a culture of mental health and wellness regardless of where individuals live, work or play. Key statewide achievements of the Statewide PEI Project in FY 2016-17 include:

- Reaching the milestone of disseminating over 1 million lime green ribbons
- Over 1 million hardcopy materials were disseminated in counties, schools, and CBOs
- Over 450 people attended the inaugural Each Mind Matters webinar series
- Over $250,000 in mini-grant funds were provided to CBOs, National Alliance for the Mentally Ill affiliates, Active Minds Chapters and Community Colleges to host community outreach events utilizing Each Mind Matters resources and messaging
- The Directing Change Program received over 480 videos submissions from over 100 schools across California, engaging over 1,300 students
- Over 25 new Each Mind Matters culturally adapted resources were developed
- Over 70 news broadcasts, news articles and radio reports discussed programs implemented by the Statewide PEI Project
- Nearly 700 county agencies, schools, local and statewide organizations across California were touched by programs implemented by the Statewide PEI Project

Workforce Education and Training (WET)

Nevada County's WET plan was approved on June 17, 2009. Implementation is proceeding as outlined in the plan in several areas. These include Workforce Staffing Support, Training & Technical Assistance, Mental Health Career Pathways and Expansion of the Internship Program when funds are available.

NEVADA COUNTY BEHAVIORAL HEALTH
Workforce Staffing Support

Program Description

Program Overview

The Mental Health Services Act (MHSA) Coordinator worked on the implementation of the plan including providing updates as required to the Mental Health Board and the MHSA Steering Committee. The MHSA Coordinator participated in the state-wide WET conference calls and meetings, and provided leadership for ongoing trainings, WET activities and development. Clerical staff supported the ongoing administration for the MHSA Coordinator, Behavioral Health staff, contractors, program participants and families as related to WET implementation. A total of 280.75 hours were billed to Workforce Staffing Support in FY 16/17.

NEVADA COUNTY BEHAVIORAL HEALTH
Training and Technical Assistance

Program Description

Program Overview

Numerous training events have been offered by the County for staff, service providers, and stakeholders, including program participants and family members. When appropriate, Mental Health Services Act (MHSA) Prevention & Early Intervention (PEI) and Workforce Education & Training (WET) funds were utilized for training opportunities. For FY 16/17 events/ conferences/ trainings included: Two Day Intensive Assertive Community Treatment (ACT) Training/Commitment Therapy, A Toolkit for Suicide Prevention Webinar, ACT Acceptance & Commitment Therapy, Adapting Dialectical Behavior Therapy, Adolescent Addiction Training, Assisted Living Facility (ALF) Wellness Recovery Action Plans (WRAP) Training, Assist and SafeTalk Summit, Bridges Out of Poverty Training, Business Writing for Results, California Disaster Behavioral Health, California Quality Improvement Conference (CalQIC), Child Sex Trafficking: Training for Professionals Assisting Children and Adolescents, California Institute for Behavioral Health Studies (CIBHS) Drug Medi-Cal Continuum of Care, CIBHS Leadership Institute, Clinical Supervision: Essentials of Reflective Supervision, Clinical Supervision: Pitfalls of Supervision, Clinical Supervision: Supervising the difficult Supervisee, California

Mental Health Advocates for Children and Youth (CMHACY), Coordinated Community Response Strategy Session-Training for Commercial Sexual Exploitation of Children, Crisis Management, California State Association of Counties (CSAC)-20 Things to know about Medi-Cal 2020, Community Services and Supports (CSS) Evaluation Toolkit Presentation, Cultural Competence Summit, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) Overview, DSM-5 Training, Effective Use of Social Media, Elder Abuse, Eye Movement Desensitization and Reprocessing (EMDR) - 3 Day Intensive Training on Post Traumatic Stress Disorder (PTSD), Ethical Decision-Making, Housing Choice Vouchers Workshop, Human Resources Supervisory Training, Integrating Primary Care with Behavioral Healthcare, Juveniles Who Sexually Offend Training, Know the Signs, Law & Ethics Training, Lifeguard Training Recertification, Mental Health First Aid-Youth, Mental Health First Aid Training, Mindfulness, Healing, and Transformation: The Pain and the Promise of Befriending the Full Catastrophe, Motivational Interviewing Advanced, National Behavioral Health Information Management Conference, New Trauma Treatment Approaches, Open Minds California Best Practices Conference, Overcoming Trauma-Related Shame and Self-Loathing with Janina Fisher, Ph.D., Peer Provider Core Competency Training, Parents & Family of Lesbian and Gay-When we rise-Cleve Jones, Practical Mental Health Recovery Model, Professional Ethics for Psychologists, Psychopharmacology-Psychiatric Medication Review, SafeTALK, Strengths, Opportunities, Aspirations & Results (SOAR) Planning Forum-Social Security Disability (SSD) SOAR Development, Suicide to Hope -Train the Trainer, Superior Region Peer Provider Core Competency Training, Transition Aged Youth: A Primer on First/Early Episode Psychosis, Trauma Focused-Cognitive Behavioral Therapy-Introductory Training, Ultimate Peer Employment Symposium, Working with Young People with Mental Illness, WRAP Around the World, and Wrong to Strong: Using Positive Psychotherapy.

Purchases continue to be made to expand the training library. Staff and providers are welcome to check materials out and use these resources as it fits their schedules. Continuing Education Units (CEU) are available for some of the materials.

In October, 2016 50 My WRAP and 50 WRAP Workbooks were purchased. In February, 2017 100 My WRAP Crisis Plan and 100 WRAP Workbooks were purchased.

A total of 518 duplicated and 418 unduplicated individuals attended a training, conference or event in FY 16/17. Of those, 59 were service providers, seven provided support services, 38 were community members and 314 were of unknown affiliation.

NEVADA COUNTY BEHAVIORAL HEALTH
Mental Health Career Pathway Programs

Program Description

Program Overview
Mental Health Career Pathway – WRAP funding was depleted on May 12, 2016. There was no funding spent under this category in FY 16/17.

NEVADA COUNTY BEHAVIORAL HEALTH
Expansion of Nevada County's Internship Program

Program Description

Program Overview
This program was primarily funded under CSS in FY 16/17. See CSS section above for details.

NEVADA COUNTY BEHAVIORAL HEALTH
Financial Incentives

Program Description

Program Overview
Nevada County Behavioral Health WET funds are no longer used for this program.

Innovation (INN)

Innovation Project Name: Integration of Rural Mental Health Services to Improve Outcomes

NEVADA COUNTY BEHAVIORAL HEALTH
Innovation Case Manager

Program Description

Program Overview
Both Nevada and Placer County are located in the Tahoe Truckee Community, a remote, rural community with some unique challenges. MHSA stakeholders from both counties identified the Tahoe Truckee area as a high priority for MHSA Innovation funding and services, and indicated that more collaboration was necessary across counties in the area. The goal of this Innovation Project is to learn how to develop and implement a coordinated, interagency, cross-county service delivery system to meet the needs of clients living in the Tahoe Truckee area, regardless of the county of residence. This coordination will reduce barriers to services; reduce inefficiency and duplication of services; and create accessible services to meet individuals' needs regardless of their county of residence. Through this Innovation project, the counties will learn how to develop interagency partnerships, and share services and resources to better meet the needs of the community.

This collaboration is facilitated and coordinated by the Innovation Case Manager, an individual who is employed half-time by Placer County via Sierra Mental Wellness Group (SMWG) and half-time by Nevada County Behavioral Health (NCBH). In addition, hours of services from the Family Resource Center of Truckee (FRCoT) are expanded to provide additional bilingual, bicultural services to this community.

Training is available to support staff from both counties to develop and strengthen skills in Motivational Interviewing; wellness and recovery; mental health support services; and Wellness Recovery Action Plans (WRAP). Training is also available to the community, including Mental Health First Aid.

Target Population
The Innovation Project targets unserved and underserved Tahoe Truckee residents, with an emphasis on including the Latino population and older adults.

Evaluation Activities and Outcomes

Unfortunately, the Innovation Case Manager position has experienced a lot of turnover. There have been three (3) different people hired for this position in the past two (2) years. As a result, it has been difficult to consistently collect data for this project and data is only available for May through August, 2017 (see Challenges, Solutions, and Upcoming Changes for more detail). During this time period, the Case Manager served 16 unduplicated participants, eight (8) Placer and eight (8) Nevada County residents. The Case Manager delivered individual direct services for a total of 81.1 hours, averaging 5.1 hours per participant.

The Case Manager made a total of eight (8) referrals, of which six (6) were successfully connected. Of those that connected, the average time from referral to appointment was 15.3 days. Referrals were made to agencies such as CalWORKs, Family Resource Centers, legal services, physicians, and Western Sierra Medical Clinic. Three (3) participants were referred to the Case Manager by NCBH Adult Mental Health and three (3) by Placer County Adult Mental Health. Two (2) did not indicate where they were referred from. The Case Manager also conducted targeted outreach two (2) times to three (3) individuals, disseminating information regarding SMWG and mental health programs.

Of the 16 participants, six (6) indicated that they either were not experiencing mental health symptoms, or they had previously received services for their mental health symptoms. The remaining ten (10) did not indicate whether or for how long they were experiencing mental health symptoms. Three (3) of the 16 participants' families were involved in services.

A part-time, bicultural Innovation Promotora is employed at the FRCoT to support the Innovation Case Manager. Data for this position is available for the period of April through November, 2017. During this time period, the Promotora delivered individual direct services to four (4) unduplicated participants for a total of 16.8 hours, averaging 4.2 hours per participant.

The Promotora made one (1) referral for benefits (e.g., food bank, financial). The individual successfully connected 13 days after being referred. One (1) participant was referred to the Promotora by NCBH Children's System of Care. Three (3) did not indicate from where they were referred. The Promotora also conducted targeted outreach visits two (2) times to three (3) individuals, disseminating information regarding FRCoT and mental health programs.

None of the four (4) participants indicated whether or for how long they were experiencing mental health symptoms. Of the four (4) participants, one (1) of the families was involved in services.

A survey was conducted in August, 2017 to assess the levels of collaboration between agencies in the Tahoe Truckee area. The highest levels of collaboration were reported with Tahoe SAFE Alliance, North Tahoe FRC, and FRCoT. The lowest levels of collaboration were reported with Right Hand Auburn, Insight Respite Center, and SPIRIT. This survey will be distributed every six (6) months to assess and monitor changes in levels of collaboration across agencies in the

Tahoe Truckee area. Improvements in collaboration across all agencies assessed in the Tahoe Truckee region is expected.

Challenges, Solutions, and Upcoming Changes

The biggest challenge for the Innovation Project is hiring and retaining a person in the position of Innovation Case Manager. The Tahoe Truckee area has only a few job openings or housing opportunities and the pay for the Case Manager position is relatively low. As a result, it has been difficult to hire and retain a person in this position. As an example of these hardships, the previous Case Manager was not able to find housing in the Tahoe Truckee area and decided to live in a neighboring county. The Case Manager's commute was roughly 90 minutes each way, during the summer. Looking forward to the winter and seeing how much money he was spending on gas, the Case Manager realized this commute was impractical, found a job closer to home, and quit the Innovation position within about three months.

Hiring a person currently living in the area should help secure a more permanent Case Manager. The current Innovation Case Manager has lived in the area for many years and is expected to remain in the area and the position long-term.

Program Participant Story

Due to staff turnover, no program participant story was available.