# Nevada County

# Mental Health Services Act

## FY 2016/2017 Annual Update

## Three Year Program and Expenditure Plan

## And

## Annual Progress Report
## FY 2014/2015

January 2017

**Nevada County**
**Mental Health Services Act Plan Update**
**FY 2014/2015 to FY 2016/2017**

**Table of Contents**

Exhibit A

# MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Nevada County

☐ Three-Year Program and Expenditure Plan
☑ Annual Update

| Acting Local Mental Health Director | Program Lead |
|---|---|
| Name: Jill Blake, MPA | Name: Michele Violett |
| Telephone Number: (530) 265-1732 | Telephone Number: (530) 265-1790 |
| E-mail: Jill.Blake@co.nevda.ca.us | E-mail: Michele.Violett@co.nevada.ca.us |

Local Mental Health Mailing Address:

500 Crown Point Circle, STE 120
Grass Valley, CA 95919

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

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

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

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

Jill Blake, MPA

_____ _____
Acting 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

| Acting Local Mental Health Director | County Auditor-Controller / City Financial Officer |
|---|---|
| Name: Jill Blake | Name: Marcia Salter |
| Telephone Number: (530) 265-1732 | Telephone Number: (530) 265-1251 |
| E-mail: Jill.Blake@co.nevada.ca.us | E-mail: Marcia.Salter@co.nevada.ca.us |
| Local Mental Health Mailing Address:<br>500 Crown Point Circle, STE 120<br>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.

Jill Blake, MPA

_____ _____ _____

Acting Local Mental Health Director (PRINT) Signature Date

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

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

Marcia Salter

_____ _____ _____

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

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

## FY 2016/17 Mental Health Services Act Annual Update

**EXHIBIT C**

### Funding Summary

County: Nevada

Date: 12/29/16

| | 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 2016/17 Funding** | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | 808,400 | 1,402,339 | 504,230 | 118,290 | | |
| 2. Estimated New FY 2016/17 Funding | 3,750,000 | 940,000 | 250,000 | | | |
| 3. Transfer in FY 2016/17[a/] | 0 | | | | | |
| 4. Access Local Prudent Reserve in FY 2016/17 | | | | | | 0 |
| 5. Estimated Available Funding for FY 2016/17 | 4,558,400 | 2,342,339 | 754,230 | 118,290 | 0 | |
| **B. Estimated FY 2016/17 MHSA Expenditures** | 4,193,065 | 1,830,844 | 0 | 99,543 | 0 | |
| **G. Estimated FY 2016/17 Unspent Fund Balance** | 365,335 | 511,495 | 754,230 | 18,747 | 0 | |

| **H. Estimated Local Prudent Reserve Balance** | |
|---|---|
| 1. Estimated Local Prudent Reserve Balance on June 30, 2016 | 1,129,150 |
| 2. Contributions to the Local Prudent Reserve in FY 2016/17 | 0 |
| 3. Distributions from the Local Prudent Reserve in FY 2016/17 | 0 |
| 4. Estimated Local Prudent Reserve Balance on June 30, 2017 | 1,129,150 |

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

**FY 2016/17 Mental Health Services Act Annual Update** **EXHIBIT C**

**Community Services and Supports (CSS) Funding**

County: Nevada Date: 12/29/16

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | 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 | 3,625,000 | 650,000 | 1,450,000 | | 1,200,000 | 325,000 |
| 2. Assertive Community Treatment (ACT) | 3,025,000 | 1,700,000 | 1,242,000 | 75,000 | | 8,000 |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| 8. | 0 | | | | | |
| 9. | 0 | | | | | |
| 10. | 0 | | | | | |
| 11. | 0 | | | | | |
| 12. | 0 | | | | | |
| 13. | 0 | | | | | |
| 14. | 0 | | | | | |
| 15. | 0 | | | | | |
| 16. | 0 | | | | | |
| 17. | 0 | | | | | |
| 18. | 0 | | | | | |
| 19. | 0 | | | | | |
| **Non-FSP Programs** | | | | | | |
| 1. General System Development | 3,118,065 | 1,093,065 | 725,000 | 500,000 | 350,000 | 450,000 |
| 2. Outreach and Engagement | 225,000 | 225,000 | | | | |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| 8. | 0 | | | | | |
| 9. | 0 | | | | | |
| 10. | 0 | | | | | |
| 11. | 0 | | | | | |
| 12. | 0 | | | | | |
| 13. | 0 | | | | | |
| 14. | 0 | | | | | |
| 15. | 0 | | | | | |
| 16. | 0 | | | | | |
| 17. | 0 | | | | | |
| 18. | 0 | | | | | |
| 19. | 0 | | | | | |
| **CSS Administration** | 525,000 | 525,000 | | | | |
| **CSS MHSA Housing Program Assigned Funds** | 0 | | | | | |
| **Total CSS Program Estimated Expenditures** | 10,518,065 | 4,193,065 | 3,417,000 | 575,000 | 1,550,000 | 783,000 |
| **FSP Programs as Percent of Total** | 158.6% | | | | | |

**FY 2016/17 Mental Health Services Act Annual Update** **EXHIBIT C**

**Prevention and Early Intervention (PEI) Funding**

County: Nevada Date: 12/29/16

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | 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 | 43,000 | 43,000 | | | | |
| 2. Wellness Center: Peer Support & Outreach | 215,000 | 215,000 | | | | |
| 3. Child & Youth Mentoring | 50,000 | 50,000 | | | | |
| 4. Teaching Pro-Social Skills in the Schools | 55,000 | 55,000 | | | | |
| 5. Homeless Rapid Rehousing | 165,000 | 90,000 | 75,000 | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| 8. | 0 | | | | | |
| 9. | 0 | | | | | |
| 10. | 0 | | | | | |
| **PEI Programs - Early Intervention** | | | | | | |
| 11. Alternative EI for Youth & Young Adults | 201,500 | 40,000 | 85,000 | | 76,500 | |
| 12. Homeless Outreach & Therapy | 40,000 | 35,000 | 5,000 | | | |
| 13. Bilingual Therapy | 137,000 | 75,000 | 35,000 | | 27,000 | |
| 14. Early Intervention for Referred | 152,000 | 100,000 | 20,000 | | 32,000 | |
| **PEI Programs - Early Intervention** | | | | | | |
| 15. Access & Linkage | 280,500 | 258,000 | 5,000 | | 500 | 17,000 |
| 16. Outreach: First Responder Training | 50,000 | 50,000 | | | | |
| 17. Stigma & Discrimination Reduction | 85,000 | 85,000 | | | | |
| 18. Suicide Prevention | 165,000 | 165,000 | | | | |
| 19. | 0 | | | | | |
| 20. | 0 | | | | | |
| **PEI Administration** | 564,844 | 564,844 | | | | |
| **PEI Assigned Funds** | 5,000 | 5,000 | | | | |
| **Total PEI Program Estimated Expenditures** | 2,208,844 | 1,830,844 | 225,000 | 0 | 136,000 | 17,000 |

**FY 2016/17 Mental Health Services Act Annual Update** **EXHIBIT C**

**Innovations (INN) Funding**

County: Nevada Date: 12/29/16

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | 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 | 0 | | | | | |
| 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** | 0 | | | | | |
| **Total INN Program Estimated Expenditures** | 0 | 0 | 0 | 0 | 0 | 0 |

**FY 2016/17 Mental Health Services Act Annual Update** **EXHIBIT C**

**Workforce, Education and Training (WET) Funding**

County: Nevada Date: 12/29/16

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | 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 | 25,000 | 25,000 | | | | |
| 2. Training and Technical Assisstance | 50,000 | 50,000 | | | | |
| 3. Residency, Internship Programs | 9,543 | 9,543 | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| 8. | 0 | | | | | |
| 9. | 0 | | | | | |
| 10. | 0 | | | | | |
| 11. | 0 | | | | | |
| 12. | 0 | | | | | |
| 13. | 0 | | | | | |
| 14. | 0 | | | | | |
| 15. | 0 | | | | | |
| 16. | 0 | | | | | |
| 17. | 0 | | | | | |
| 18. | 0 | | | | | |
| 19. | 0 | | | | | |
| 20. | 0 | | | | | |
| **WET Administration** | 15,000 | 15,000 | | | | |
| **Total WET Program Estimated Expenditures** | 99,543 | 99,543 | 0 | 0 | 0 | 0 |

**FY 2016/17 Mental Health Services Act Annual Update** **EXHIBIT C**

**Capital Facilities/Technological Needs (CFTN) Funding**

County: Nevada Date: 12/29/16

| | Fiscal Year 2016/17 | | | | | |
|---|---|---|---|---|---|---|
| | 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 |

**THREE-YEAR PROGRAM AND EXPENDITURE FOR FY 2014/15 THROUGH 16/17**

**COMMUNITY STAKEHOLDER PLANNING PROCESS AND LOCAL REVIEW PROCESS**

**County:** Nevada **30-day Public Comment Period Dates:** January 3, 2017 through February 2, 2017

**Date:** January 3, 2017 **Date of Public Hearing:** February 3, 2017

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

| **Community Program Planning** |
|---|
| 1. A description of the local stakeholder process including date(s) of the meeting(s) and any other planning activities conducted. Description of how stakeholder involvement was meaningful. |
| In September 2005 a MHSA Steering Committee 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 Steering Committee 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 we have stakeholders from service providers, contract providers, program participant/family advocates, program participants, family members, County employees and interested community members attend our Steering Committee meetings. Any member of the public is welcome to attend any of our meetings and to provide input.<br><br>The Steering Committee had meetings on the following dates in FY 15/16: 08/10/2015, 11/09/2015, 4/15/2016, and 6/10/2016. To date in FY 16/17 we had one meeting on 9/15/2016.<br><br>Our Workforce and Employment Training (WET) Subcommittee had been meeting monthly since July 2007. In May 2011 the WET Subcommittee started to meet bi-monthly. As of November 2012 the WET Subcommittee joined the County's Cultural Competency Work Group and the Quality Improvement Committee. In FY 14/15 due to staff shortages the WET Subcommittee stopped meeting separately and became part of the MHSA Steering Committee.<br><br>The MHSA Coordinator attended the Truckee "Youth Café" public meeting on 11/3/15 to hear from youth what the local strengths and gaps in services are and solutions, from the perspectives of youth.<br><br>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.<br><br>Nevada County has employed subcommittees to address specific components of the MHSA. In April of 2008 Capital Facility and Technology Need (CF/TN) was added to our CSS Subcommittee. In March 2010 Housing was added to our CSS/CF/TN Subcommittee. In May 2010 a Prevention and Early Intervention (PEI)/Innovation (INN) Subcommittee was formed. These groups met on a quarterly or on as-needed bases |

through December 2012. As of January 2013 these subcommittees are no longer meeting on a regular basis due to the fact that the people attending were also the people attending the MHSA Steering Committee meeting. It was determined to form ad hoc committees as needed.

One ad hoc group that continued to meet in one form or another was for SB 82 funds to support expansion of Crisis Workers at the Hospital, to expand Peer Counselors hours at the Emergency Department, to create a Respite Center in the community and a Crisis Stabilization Unit (CSU) at our local hospital in Grass Valley. The meeting dates for these in FY 13/14 were: 3/18/13, 4/29/13, 6/10/13, 10/24/13, 10/30/13, 11/18/2013, 12/17/13, 1/7/2014, 1/13/2014, 2/18/14, 2/25/14, 3/4/14, 3/18/14, 3/25/14, 4/1/14, 4/8/14, 4/15/13, 4/22/14, 4/29/14, 4/29/14, 5/6/14, and 5/13/14. In FY 14/15 and 15/16 the number of meetings were too numerous to document. As the County got closer to implementation the number and kind of meetings increased. The County had meetings with Sierra Nevada Memorial Hospital, program participants, family members and other stakeholders. The Respite Center opened in July 2015 and the CSU opened in December 2015.

Another ad hoc group that was created to work on a Community MHSA Mental Health Services Survey and Recommendations of Needed Mental Health Services for FY 2014-2017. A group of individuals meet to work to create the survey and plan on how and where to distribute the survey (3/6/13 & 3/15/13). The survey was provided in hard copy and through Survey Monkey. All completed hard copy surveys were hand entered into Survey Monkey by a Behavioral Health Staff member. The survey was available in Spanish and English. The survey was provided to the following organizations and they shared with participants in their programs, posted on their websites or in newsletters or social network page: Nevada County National Alliance on Mental Illness (NAMI) (4/25/13 meeting presentation), Mental Health Board (5/3/13 meeting presentation), Continuum of Care to End Homelessness (5/3/13 meeting presentation and 5/10/13 email), SPIRIT (5/24/13 meeting presentation and Face Book page), Community Support Network (Newsletter), Network Therapist (email), Nevada County Health and Human Services Agency (Newsletter 5/9/13), Community Collaborative of Tahoe Truckee (5/7/13 meeting presentation and 5/15/13 Newsletter), Nevada County Superintendent of Schools Family Resource Center (5/20/13 meeting presentation), MHSA Steering Committee (5/23/13 meeting presentation), Forensic Task Force Meeting ( June 28, 2013 meeting presentation), Hospitality House (5/29/13 meeting presentation), and California Aging and Disability Resource Connection (ADRC) (Newsletter 6/17/13). We had 200 individuals respond to the survey. The survey results were shared with stakeholders and the Recommendation of Needed Mental Health Services for FY 2014-2017 document was created with input proved by the Quality Assurance Meeting group (12/16/13) and two small workgroup meetings on 1/16/2014 and 1/27/14. The Recommendation of Needed Mental Health Services for FY 2014-2017 document was shared and supported by the MHSA Steering Committee and the Mental Health Board.

In FY 14/15 we conducted four Innovation Community Meetings. The dates of the meetings were: 2/20/15, 3/4/15, 3/17/15 and 3/30/15. Additionally, we had additional meetings with different targeted stakeholders on 2/9/15, 4/17/15, and 4/23/15. More detailed information is included as part of the Innovation Plans that are approved outside of this plan.

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 and implementation
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 is not limited to: County Behavioral Health Directors Association, Medi-Cal Policy Committee Meetings, County Behavioral Health Fiscal Leadership Institute, Department of Health Care Services Behavioral Health Forum, External Quality Review Organization Audit, Emergency Solutions Grant Redesign, Homeless Resource Council of the Sierras, Information Systems Annual National Behavioral Health Information Management Conference, Mental Health Board, MHSA Steering Committee, Mental Health Services Oversight and Accountability Commission (MHSOAC), Northern California Homeless Roundtable, PFLAG-Transgender Day of Remembrance and LGBT Support Groups, Quality Improvement Committee, substance Abuse Prevention and Treatment, Superior Region Workforce and Education and Training, and Transgender Support Group.

In FY 15/16 Nevada County started to provide demographic forms to individuals attending these meetings. The results we got for Unduplicated Ages were: one Transition Age Youth, 42 adults, 24 older adults, two declined to respond and 34 unknown. For Race the results were: 61 white, three indicated more than one race, four declined to answer, and 34 are unknown. For Ethnicity the results were: three Mexican, one other and one unknown. For Non-Hispanic the results were: two Eastern European, 9 European, 10 other, one was more than one, six declined to answer, and 39 unknown. Primary Language results were: 62 English, two Spanish, two other, and 35 unknown. Sexual Orientation results were: one gay, 22 straight, 1 queer, 1 decline and 80 unknown. Gender results were: 25 male, 44 female and 46 unknown. The results for Gender Identity were: three male, 21 females, one decline to answer and 80 unknown. Veteran Status results were: four served, four were family members, 17 did not serve, 77 unknown, and one declined to answer. The Disability results were: two mental disabilities, two physical disabilities, four health disabilities, 18 no disabilities, 80 unknown. The results for Affiliation were: 39 service, one support, three family, one program participant, and 55 unknown.

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

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

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

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

**THREE-YEAR PROGRAM AND EXPENDITURE FOR FY 2014/15 THROUGH 16/17**

**COMMUNITY STAKEHOLDER PLANNING PROCESS AND LOCAL REVIEW PROCESS**

presented to the Board of Supervisors.

The 30-day review and comment period was January 3, 2017 through February 2, 2017 which served as the opportunity for the public to provide additional input to this update of our MHSA Annual Plan and Annual Progress Report for FY 2014/2015.

The MHSA Annual Plan Update and Annual Progress Report Public Hearing was held at our local Mental Health Board on February 3, 2017.

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

The stakeholders involved in the Community Program Planning Process included:

1. Family members from eastern and western Nevada County
2. Program participants
3. Nevada County Behavioral Health Contract providers:
    a. Uplift Family Services formally known as EMQ FamiliesFirst
    b. Victor Community Support Services, Inc.
    c. Turning Point Providence Center
    d. SPIRIT Peer Empowerment Center
    e. Community Recovery Resources
    f. Sierra Forever Families
    g. Nevada County National Alliance on Mental Illness (NAMI)
    h. Common Goals
    i. Sierra Mental Wellness Group
    j. Network Providers
    k. Welcome Home Vets
    l. 2-1-1 Nevada County
    m. FREED
    n. Truckee Family Resource Center
    o. Big Brothers Big Sisters
    p. Hospitality House
    q. Project MANA
    r. Tahoe Truckee Unified School District
    s. Nevada County Superintendent of Schools
    t. Sierra Family Medical Clinic
    u. Nevada County Housing Development Corporation
    v. Shellee Anne Sepko
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

**THREE-YEAR PROGRAM AND EXPENDITURE FOR FY 2014/15 THROUGH 16/17**

**COMMUNITY STAKEHOLDER PLANNING PROCESS AND LOCAL REVIEW PROCESS**

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

**Local Review Process**

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

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

**THREE-YEAR PROGRAM AND EXPENDITURE FOR FY 2014/15 THROUGH 16/17**

**COMMUNITY STAKEHOLDER PLANNING PROCESS AND LOCAL REVIEW PROCESS**

| |
|---|
| 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. |
| No substantive comments were received. |

# *General Nevada County Information:*

Nevada County is a small, rural, mountain community, home to an estimated 98,893 (2014 US Census Bureau estimate) individuals. According to the 2014 US Census estimate a little over 93% of the Nevada County residents identified their race as White, while over 3% of residents identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander combined. Additionally, 3% identified themselves by two or more races. In regards to ethnicity, an estimated 85.6% of the population identified as Non-Hispanic or Latino and 9.2% of the population of Nevada County identified themselves as Hispanic or Latino. Therefore, Nevada County's one threshold language is Spanish.

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

# *I. Community Services and Supports (CSS)*

## *A) Full Service Partnerships (FSP)*

1) **Plan I: Children's Full Service Partnership (FSP)**
   a) **Target Population**
      (i) The targeted population served in Plan I are children (age 0-17) who are seriously emotionally disturbed or seriously mentally ill. These individuals who because of their mental health diagnosis will:
      - Be at serious risk of or have a history of psychiatric hospitalization, residential care, or out of home placement
      - Children who are homeless or at risk of becoming homeless
      - Be at risk of aging out of the juvenile justice system or foster care with no care or support
      - Be at risk for dropping out of school, experiencing academic failure or school disciplinary problems
      - Be at risk of involvement with the criminal justice system

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

   c) **Services and Supports**

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

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

d) **Wraparound Treatment Teams**

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

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

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

Nevada County has Wraparound service providers that support both the western and eastern parts of the county. The Wraparound service providers provide for and/or arrange for all necessary services as indicated by individual needs. Substance abuse 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 have bi-lingual and bi-cultural staff that works with families. 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 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 will 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).

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** 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.

8) **Emergency Department Outreach and Engagement, includes Respite Care and Crisis Stabilization facility supports**
   a) In an effort to increase the quality of care for patients utilizing the Emergency Department (ED) for mental health needs and to reduce ED visits, an ED support and a follow-up service has been designed and is being implemented.
   b) This service provides ED support, ED 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/Counselors build relationships with individuals and then provide warm handoffs to appropriate community service providers. The ED service support staff work in collaboration with the ACT Team, Peer Counseling Agency, NCBHD staff, Crisis support staff and other involved agencies. One-to-one follow-up by a Peer Counselor is offered to individuals experiencing the symptoms of serious mental illness within 72 hours of ED release. These individuals receive a phone "check in call" and an offer of support by a Peer Counselor trained in Peer counseling 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 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 in Nevada County 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 psychotherapy services to veterans who have mental health needs related to service in the military. This continuum of services includes individual and group psychotherapy, 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 psychotherapy will be provided under contract with licensed therapists who are experienced in working with veterans and their families. In addition to the psychotherapy 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 will 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, 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.

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 capable of providing client- and family-driven services that promote wellness, recovery, and resiliency, leading to measurable, values-driven outcomes.

## *C) Outreach and Engagement*

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

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

3) Wellness Centers provide Peer Support services, this may include, but is not limited to: one-on-one peer counseling, 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 Counselors, a Peer Counselor, community volunteer and/or a trainee and will cover various topics such as, but not limited to: Dual Diagnosis issues, Gay and Lesbian, Transitional Age Youth issues, Men's Group, Women's Group, Spirituality Group, and WRAP Plans.

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

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

## *D) Program Expenditures*

Expenditures for this work plan may include all expenditures identified in the Original three-Year Plan (for FY 2005/2006 through 2007/2008), subsequent Annual Updates, and items on the MHSA Recommendations of Needed Mental Health Services FY 2014-2017 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, 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 2014-2017 document, including, but not limited to: homeless outreach, support and engagement services; other Latino outreach and engagement services; additional North San Juan Ridge and Truckee services; additional or enhanced services to court involved families; additional or enhanced jail services for inmates within six months of release from jail or juvenile wards at juvenile hall; foster youth care children; additional support for at risk youth in the school system and/or community; additional wellness centers; additional services to serve unserved, underserved and inappropriate served populations: consultation to clinics and Primary Care Physicians and other health care providers; additional contract services; services to Veterans and their families, use of Interns; expansion or additional contract services; expansion of crisis services including crisis residential, crisis stabilization units and Respite Care; expansion of services for treatment for Co-occurring disorders; additional 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 14/15: 1) FSP programs is $2,350,000, 2) General System Development programs is $1,093,065, 3) Outreach and Engagement Programs and activities is $225,000, and 4) Administration cost is $525,000. The estimated total cost is $4,193,065. The average estimated cost per person involved in a CSS activity will be $906.02. 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 14/15 with CSS funds (4,628). We estimate serving during a given year 425 children, 426 TAY, 2,071 adults, 1,048 older adults and 658 individual's ages will not be known.

Estimated CSS Cost per Year by Age:

| Age | Est. # Served/Year | % of the Total | Est. Cost/Age |
|---|---|---|---|
| Unknown age | 658 | .14 | $596,162 |
| Children | 425 | .09 | $385,059 |
| TAY | 426 | .09 | $385,965 |
| Adults | 2,071 | .45 | $1,876,369 |
| Older Adults | 1,048 | .23 | $949,510 |
| Total | 4,628 | 1 | $4,193,065 |

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 | 387 | .17 | $218,115 | 271 | .13 | $33,705 |
| Children | 112 | .33 | $877,175 | 313 | .14 | $176,408 | 0 | .00 | $0 |
| TAY | 76 | .22 | $595,226 | 308 | .14 | $173,590 | 42 | .02 | $5,224 |
| Adults | 119 | .35 | $931,999 | 902 | .41 | $508,372 | 1050 | .51 | $130,592 |
| Older Adults | 36 | .10 | $281,949 | 307 | .14 | $173,027 | 705 | .34 | $87,683 |
| Total | 343 | 1 | $2,686,349 | 2,217 | 1 | $1,249,512 | 2,068 | 1 | $257,204 |

Note: These costs by age and CSS programs are only estimates, actual costs may vary greatly. These costs only reflect first year budget and will change with each new FY's budget.

## *G) Prudent Reserve*

NCBHD started to fund the Prudent Reserve with Unapproved FY 2005/2006 Estimate Funds in the amount of $158,857. In the Three Year Plan Update for FY 2008/2009 Nevada County directed $751,800 of FY 2006/2007 CSS Unapproved Planning Estimates into the Prudent

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

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

## *H) MHSA CSS Administration*

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

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

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

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

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

enhanced and/or increased space needs related to services, and other administration expenses associate with the services in this plan.

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

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

# II. Prevention and Early Intervention (PEI)

## A) PEI Project Name: Early Intervention Programs

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

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

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

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

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

community service opportunities which help program participants make and connect to their community. The therapeutic guides-to-youth participants are 1-3.

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

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

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

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

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

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

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

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

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

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

i) **Estimate Number of Children, Transition Age Youth, Adults and Seniors Served Per Year-** It is estimated that five children and five Transition Age Youth per year will be served. A total of 10 individuals served per year.

j) **The Estimated Cost Per Person:** Estimated Average Cost per youth and transition age youth served per year: $57,917/10 = $5,792

## 2) Project Name: Bi-lingual Therapy

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

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

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

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

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

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** Because the program sees all age groups and each person may have different needs, it is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.
- **Explain the evaluation methodology, including, how the evaluation will reflect cultural competence.** The evaluations at a minimum will be done at the beginning of therapy and at program exit. Spanish speaking therapist administer the evaluation. Evaluation forms are offered in Spanish. Program participants are offered the option of filling out the evaluation themselves or have it read to them.

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

and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

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

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

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

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

i) **Estimate Number of Children, Transition Age Youth, Adults and Seniors Served Per Year-** It is estimated that 40 children, 10 transition age youth, 25 adults and 5 older adults will be served per year. A total of 80 individuals.

j) **The Estimated Cost Per Person:** $108,595 /80 individuals for a total of $1,357 per person

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

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

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

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

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

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

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** Because the program sees all age groups and each person may have different needs, it is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.
- **Explain the evaluation methodology, including, how the evaluation will reflect cultural competence.** The evaluations at a minimum will be done at the beginning of therapy and at program exit. Spanish and English speaking therapists administer the evaluation. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or have it read to them.

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

doors. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

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

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

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

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

i) **Estimate Number Served Per Year:** It is estimated that 50 individuals will receive direct services. These individuals will represent 35 families.

j) The Cost Per Person: $2,896 ($144,793/50)

## 4) **Project Name:** Homeless Outreach and Therapy

a) **Identification of the Target Population:**
- **Demographics:** Homeless population: can be of any age, sex and ethnicity. The majority of the homeless are white (91%) and non-Hispanic (94%).
- **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 program has the capacity to treat.
- **Brief description of how each participant's early onset of mental illness will be determined:** All referred individuals and families are assessed and a treatment plan is created. Part of the assessment will be to ask the individual or their family members when the mental illness began.

b) **Identification of the type of problems and needs for which the program intended to address:** Nevada County homeless frequently live in the woods or by one of the many rivers and lakes located in Nevada County. Per the January 2015 Homeless Point-in-Time Count, on any given day in Nevada County there are 279 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 279 homeless individuals, 43% identified as having a serious mental illness, 37% identified as having a substance use disorder, and 33% 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 to conduct outreach and engagement services, assessments, therapy and referrals to homeless individuals out in the community.

Therapy will be provided to the target population. Therapy services 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 will conduct outreach and engagement services, assessments and refer homeless individuals to needed community services. 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:** Each homeless individual may have different needs, any one or several of the seven negative outcomes may be affected: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from the home. It is anticipated that prolonged suffering will be decreased in all individuals served. It is anticipated that homelessness will decrease in some of the individuals served.

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** Because the program sees all age groups and each person may have different needs, it is anticipated that for adults Basis-24 and CANS for children and youth will be utilized to evaluate the reduction of prolonged suffering, however, if appropriate other instruments or evaluation tools may be used. The mental health indicator that will be used will be determined by the program participant and their specific goals and treatment plan.
- **Explain the evaluation methodology, including, how the evaluation will reflect cultural competence.** The evaluations at a minimum will be done at the beginning of therapy and at program exit. Evaluation forms are offered in Spanish and English. Program participants are offered the option of filling out the evaluation themselves or have it read to them.

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

- **Community Collaboration:** The County is working with program participants, family members, schools, community based organizations and other service providers to plan and implement this program. Referrals for this program can come from any organization or individual that supports or serves the homeless population. Multiple organizations provide a variety of services depending on the need of the homeless individual.
- **Cultural Competence:** The program was planned and establish with the assistance of the homeless community. The Homeless Outreach Therapist's office is located at a homeless shelter and goes to where the need is in the community.
- **Program Participant Driven:** The program participant chooses to participate in services and determines the treatment that they receive and participates in the creation of the Treatment Plan and the goals of the Treatment Plan. They determine if they want other family members to be involved in their treatment plan. Additionally, the program participants determine what other types of supportive serves they need to address their current needs and to help them move out of homelessness.
- **Family Driven: :** Adults who want their spouse or other family members involved in their Treatment Plan are encouraged and supported to include them. Parents of children and youth have the primary decision-making role in the care of their children which includes determining the services and supports that would be most effective and helpful for their child(ren).
- **Wellness, Recovery, and Resilience Focused:** The program utilizes a therapist who collaborates with a Homeless Outreach Care Coordinator to help support the individual who wants to get help for their mental health needs. The program reflects the cultural, ethnic, and racial diversity of the population being served.

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

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

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

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

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

i) **Estimate Number of Children, Transition Age Youth, Adults and Seniors Served Per Year-** It is estimated that 50 individuals will receive direct services.

j) **The Estimated Cost Per Person**: $1,014 ($50,678/50)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f) **The County intends to measure what outcomes and when?** The County may, but is not limited to measuring: number of individuals' trained, demographic info on those trained, pre and post-test on what the First Responder learned from the training

and other indicators as directed by the training curriculum used. Outcomes will be collected at the beginning and/or end of trainings, as appropriate.

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

h) **Estimated number of Children, TAY, Adults, and Seniors to be served:** It is estimated that 150 individuals will received First Responder training in the year

i) **The Cost Per Person:** $483 ($72,397/150 individuals)

## *C) PEI Project Name: Prevention Programs*

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

assessed using appropriate tools used for measuring and screening for mental health disorders.

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

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

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

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

Social Workers 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 Social Worker 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 Social Worker will assess program participants using screening and brief intervention techniques for referral purposes.

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

- Decrease risk factors that may limit housing opportunities, such as, but not limited to:
  (i) Untreated substance use
  (ii) Untreated physical and/or mental health issues
- Increase protective factors/life skills, such as, but not limited to:
  (i) Job training
  (ii) Resume creation
  (iii)Job searching
  (iv)Securing financial benefits the individual/family is entitled to receive
  (v) Housing searching

(vi)Family financing and budgeting skills
(vii) Education/General Education Development (GED)
(viii) Daily life skills
(ix)Parenting skills

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

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

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

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

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

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** A reduction of prolonged suffering may be

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

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

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

- **Community Collaboration:** The Homeless Rapid Rehousing Program (HRRP) will use every available resource and community partner to deliver services through referrals, agency collaboration and participation within the Continuum of Care (CoC) to End Homelessness.
- **Cultural Competence:** Program staff will employ and maintain the awareness and consciousness of personal reaction to those who are different, including staff members' own cultural bias and beliefs, so as to avoid incorporating those qualities in delivery of the program services.
- **Program Participant Driven:** The HRRP Program will employ case management service that empowers program participants to participants in all services delivered and to lead the process. A person-centered case plan approach that is consistent with the individual's culture and everyday lifestyle. Program personnel will be non-judgmental, recognizing that, with appropriate and adequate support, individuals living with chronic illnesses, behavioral health disorders and addictions are competent and capable of making life changes. Program participants will create their own goals and housing plans with the support of program staff.
- **Family Driven:** Program staff will assess the needs of the family as a whole, as well as the individual needs of each family member. Based on the needs assessment, staff in collaboration with the program participant will identify and prioritize support services that will enable the individual/family to obtain and remain in their home and/or community. The Case Manager will assure that the individuals and families have choice and control. A person-centered case plan approach will be consistent with the family's culture and everyday lifestyle. Staff will do the following to assist each individual within a family:
  (i) Assess needs and desired outcomes of each individual
  (ii) Develop individual case plans with program participants, program participant's family, and community partners who will be chosen by the program participant to be part of the service team
  (iii) Provide or locate support services identified in the case plan which will meet the needs stated by the program participant

(iv) Provide or connect the program participant/family with the requested services
(v) Coordinate support services with the family
(vi) Meet regularly with the program participant to assess case plan progression
(vii) Ensure that eligibility for funding stays current
(viii) Advocate for needed support and services

- **Wellness, Recovery, and Resilience Focused:** Staff will empower program participants by allowing them to develop their own case plan and will respect the choices made by youth/families/individuals in transition. In any case where family members are in need of education regarding an individual's disabilities, referrals to appropriate service providers or resources will be provided by the staff. Rapid Rehousing Staff will implement an assessment tool to identify and detect the presence of co-occurring substance/mental health issues and/or physical health issues to be referred to clinicians as deemed necessary, as well as continually informing program participants of their rights and responsibilities. Lastly, staff will be in collaboration with other service providers so as to ensure continuity of care.
- **Integrated Service Experiences for Program Participants and Their Families:** The Homeless Rapid Rehousing Program will partner with community providers to include support to stabilize housing, reduce hospitalizations and incarcerations, conduct risk assessments, provide 24/7 crisis, medication management services, agency referrals, counseling and group therapy, SSI and Medi-Cal advocacy, home visits and assistance with doctor appointments, and employment services referrals.

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

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

g) **Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (g) and, if so, what outcomes(s) and how will it be measured, including timeframes for measurement.** The program will collect and summarize information on an ongoing basis, determining the activities to continue, grow, modify, or improve. Periodically, program participants will be assessed to determine any change in his/her quality of life (i.e. decreased untreated mental illness,

decreased urgent care or emergency room visits, decreased police/911 fire department calls, etc.). In addition, Management will identify staff and volunteer training needs, as it relates to the program.

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

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

j) **The Cost Per Person:** $2,369 ($130,314/55) /program participant (Housing Stabilization Services & Rental Assistance)

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

a) **Identification of the target population for the specific program, including:**
- **Participants' risk of a potentially serious mental illness:** The participants in the program have a higher than average risk of a serious illness due to their age, disabilities, isolation and lack of services, transportation and support. Additionally, the senior population has a lack of awareness of depression due to their generation having stigma on mental health needs.
- **How the risk of a potentially serious mental illness will be defined and determined:** Screening and referrals for this population is being done by nurses, social workers, service providers, family members and program participants (self-referral). Home Visiting Nurses and/or Volunteers, and/or other health workers are screening for depression by using the Beck's Depression scale or a similar tool.
- **Demographics:** This program is available to all individuals in the County that are homebound due to age and/or disability. All age groups, racial, ethnic and cultural populations are served.

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

assigned a program participant and visit program participates in person and/or by phone on a regular basis.

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

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

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

- **Community Collaboration:** This program is the results of multiple organizations working together with consumers and family members to bring services into the home of isolated elderly and/or disabled individuals. This program collaborates intimately with Home Visiting nurses. Home visiting nurses are conducting a mental health screening with all individuals they visit along with physical health and fall prevention screening. The nurses refer individuals that score high on the depression screening tool to physicians, mental health providers, community based organizations, family members and to the Home Visitor program.
- **Cultural Competence:** The program works to match volunteers with program participants that can connect at multiple levels, including at a cultural level.
- **Program Participant Driven:** The volunteers communicate and work with the program participants to determine when and how they want to interact and the activities to engage in.
- **Family Driven:** The volunteer includes family members, when appropriate, when planning and implementing program services.
- **Wellness, Recovery, and Resilience Focused:** The volunteer services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. The volunteers bring hope to the program participants. The program participants have someone to look forward to seeing and to share their stories with. The volunteers connect the program participants with community events, activities and service providers.
- **Integrated Service Experiences for Program Participants and Their Families:** This program is the result of multiple organizations coordinating

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

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

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

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

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

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

j) **The Cost Per Person:** $1,384 ($62,261/45)

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

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

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

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

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

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

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

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

- **Integrated Service Experiences for Program Participant and Their Families:** Wellness Center staff work with community adult volunteers and Youth Peer Mentors to improve the social, emotional and mental health of program participants and to connect program participants to community resources.

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

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

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

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

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

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

h) **Estimate Number Served Per Year:** 1,000: 700 Children (7th-10th grades), 300 TAY (11th & 12th grades)

j) **The Cost Per Person:** $311 ($311,306/1,000)

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

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

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

This Prevention activity increases the SECOND STEP program in schools and preschools. SECOND STEP has been implemented in the pre-schools to middle schools and is in the SAMHSA National Registry of Evidence-based Programs and Practices. It is a classroom based social skill program that teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models

integrated with social learning theory, empathy research and social information processing theories. Each preschool and elementary school curriculum contains teaching kits that build sequentially and cover empathy, impulse control and anger management in developmentally and age appropriate ways. The Second Step Middle School Program aims to prevent or reduce aggression, violence and substance abuse through the promotion of attitudes and social and problem solving skills that are linked to interpersonal and academic success. The design draws on theory and research about adolescent development and utilizes a risk and protective factors framework. Risk factors include: inappropriate classroom behavior; favorable attitudes toward problem behavior; friendships with others who engage in problem behavior; early initiation of problem behavior; peer rewards for antisocial behavior; and peer rejection and impulsiveness. Protective factors include social skills, school connectedness, and adoption of conventional norms about substance abuse.

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

This program will be implemented from pre-schools through high school as funds will allow. Implementation began with preschoolers and elementary schools and was expanded to middle school. In FY 15/16 it will be expanded to high schools.

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

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** The Second Step curriculum which works to strengthen protective factors and helps children develop self-regulation skills, manage their emotions, treat others with compassion and solve problems without anger. The Second Step program evaluates the child's ability to identify emotions, brainstorm alternative solutions to problems, and generate pro-social responses to problems, and a reduction in disciplinary issues.
- **Explain the evaluation methodology, including, and how the evaluation will reflect cultural competence:** Approaches to collect data and determine results may include, but is not limited utilizing School-Wide Information System data, referrals, pre and post testing using 12 measures of the Desired Results Developmental Profile from the Self and Social Development Domains that support the protective factors completed at the beginning of the program and at the end of the school year, and teacher feedback surveys.

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

- **Community Collaboration:** This program is being implemented in both the Tahoe-Truckee and the Nevada County school districts. School personnel

are collaborating with Nevada County Behavioral Health Department and other service providers in the community.

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

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

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

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

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

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

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

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

**i) The Cost Per Person:**

- Grass Valley: The cost per person for the direct services to individuals/groups is approximately $82 ($42,251/515) per person.
- Truckee: The cost per person for direct services to individuals/groups is approximately $24 ($37,385/1,555) per person.

## 5) The Program Name: Child and Youth Mentoring

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

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

**b) Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities to be included in the program:** The community spoke about the need to mentor children and youth. The community is concerned about children who have a number of risk factors in their life and do not have an adult in their live that can help to build protective factors. In Nevada County there are a number of different mentoring programs; in some of these programs the mentoring take place in the community and in others the mentoring takes place in the schools. The school based mentoring programs connect older teens to mentor young children in the schools or have a trained aid that connects with the child. Individuals in the

community want to continue and expand mentoring programs; because these programs help children build resilience, feel safe and connected at school. Mentoring gives young children in rural communities a connection in the community which helps to breakdown isolation risk factors. School based mentoring works to reduce school absenteeism, gives young children a reason to attend school and a better chance to perform in school.

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

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

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

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

g) **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory:** Nevada County mentoring programs are a well-accepted part of the community and the community's goals have been to expand these programs. The strategies to be used are:
- Mentoring programs connect a teen with an elementary school child or they connect a caring adult with the child. The mentoring programs that use adolescents as mentors have the same result for the adolescent mentor. These children and youth will be more successful with their school work with this connection.
- The teen mentors and the mentoring coordinators receive training in mental health issues.
- Services are provided at the mentees schools where they are familiar with their surroundings and feel safe.

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

i) **The Cost Per Person:** $905 ($72,397/80)

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

### 1) Program Name: 211 Nevada County

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

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

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

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

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

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

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

community based and community service providers working together to have one centralized location where people could go to receive referrals for services.

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

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

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

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

j) **Estimate Number Served Per Year:** 7,200 callers, with an additional 116,000 web searches conducted by individuals for whom no demographic information is available.

k) **The Cost Per Person:** $4 ($26,063/7,200)

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

a) **An explanation of how the program and strategy within each program will create Access and Linkage to Treatment for individuals with serious mental illness:** Each program will:

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

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

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

the person to their appointment(s), helping to arrange rides to appointments, and showing the individual how to utilize transportation through their medical care provider.

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

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

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

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

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

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

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

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

i) **What Strategies that are Non-stigmatizing and Non-Discriminatory will be used:** Some examples are:

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

a) **Estimate Number Served Per Year:** 750 individuals served per year

b) **The Cost Per Person:** $463 ($347,504/750)

# *E) PEI Project Name: Stigma and Discrimination Reduction Programs*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**j) Estimated Number Served Per Year:**

- Grass Valley- Approximately 230 individuals will be served: 105 children (0-15), 20 TAY (16-24), 100 adults (25-59) and 5 seniors (60+). The number of families served will be approximately 85either directly or indirectly.
- Truckee-Approximately 40 individuals will receive direct services: 15 children (0-18), 15 adults, and 10 seniors. The program hopes to serve 20 families.

k) **The cost per person:**
- Grass Valley: the cost per person is approximately $330 ($75,976/230) per person
- Truckee: the cost per person is approximately $1,177 ($47,098/40) per person

## *F) PEI Project Name: Suicide Prevention Programs*

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

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

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

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

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

- **Cultural Competence:** This program provides training, education, and support in in Spanish to individuals needing suicide prevention and intervention services. Local bi-lingual and/or bi-cultural Promotoras are trained in suicide prevention, early identification, referral, intervention and follow-up services.

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

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

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

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

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

connection or relationship with the population being served. Additionally, consumers and family members are a part of the program so that their perspective is a part of the training.

g) **Estimate of Number Served per Year:** It is estimated that the program will serve 50 children (0-15), 650 transition age youth (16-25), 900 adults (26-59), and 150 Older Adults (60+) for a total of 1,750 individuals.

h) **Cost per Person:** $137 ($238,909/1,750)

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

## *G) PEI Funding Expenditures*

PEI funding for all programs listed above may be used to fund expenditures for all expenditures identified in the Original Three-Year Plan and the subsequent Annual Updates, or for activities listed in the MHSA Recommendations of Needed Mental Health Services FY 2014-2017 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 $250,000, 2) Outreach programs is $50,000, 3) Prevention Programs is $453,000, 4)Access & Linkage Programs is $258,000, 5) Stigma and Discrimination Programs is $85,000, 6) Suicide Prevention Program is $165,000, 7)

PEI Assigned Funds is $5,000 and, 8) Administration $564,844. The estimated total PEI program costs are $1,830,844. Using an estimate number based partially on the number served in FY 14/15, it is estimated that 13,560 individuals will receive PEI services and the average cost per person involved in a PEI activity will be $135 ($1,825,844/13,560). 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) Future Funded Activities*

Activities for the PEI Plan, may include, but not limited to: the expansion of any activities approved in the original PEI Plan and subsequent Annual Updates, including, but not limited to additional Latino outreach; additional homeless outreach, 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.

## *H)MHSA PEI Administration*

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

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

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

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

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

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

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

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

# *III) Workforce Education and Training (WET):*

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

## A. *Workforce Staffing Support-*

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

2. Budget Information:
   a. Salary and benefits for the MHSA Program Coordinator/NCBH Management staff/Evaluator and clerical support at $25,000.

      Nevada County is requesting $25,000 in WET funding to support the continued operation of this Action per year through the end of Fiscal Year 2016/2017. These funds may be used for salaries, benefits, contracted staff time, stipends, travel, mileage, supplies, materials and any other stakeholder needs to implement this activity. Nevada County intends to provide ongoing support of the WET Component though the MHSA Integrated Three-Year Plan beginning in Fiscal Year 2014/2015. This support will continue until funds are exhausted.

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

## *B. Training and Technical Assistance-*

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

2. Budget justification:
   a. Training and technical assistance for trainers, materials, consultant fees and conference space. This may include the purchase of curriculum, rental of training facilities, and fees for trainers/content experts. Trainers/content experts are budgeted for training, facility rental, supplies, copying and curriculum.
   b. Teleseminars/webinar including the cost of the copies and general supplies for each session.
   c. Library materials, including books, audio materials, DVD and computerized software.
   d. Total Annual Cost: $50,000
      Nevada County is requesting $50,000 in WET funding to support the continued operation of this Action through the end of Fiscal Year 2016/2017. The cost may include travel, food, lodging, training and technical assistance for trainers, training materials, consultant fees, conference space, incentives, stipends, the purchase of curriculum, rental of training facilities, child care fees, fees for trainers/content experts, cost for teleseminars/webinars, copies, general office supplies to support training needs, library materials which may include books, audio materials, DVD, computers, projectors, computer software, furniture and any other supplies needed to conduct a training or support the lending Library. WET Training and Technical funds may be used to support or in combination with CSS, PEI and Innovation funds.

Nevada County intends to provide ongoing support for the WET Component though the MHSA Integrated Plan beginning in Fiscal Year 2014/2015- 2016/2017. This support will continue until funds are exhausted.

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

## C. *Mental Health Career Pathway Programs*

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

## *D. Residency, Internship Programs-*

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

2. Budget justification:
   a) Salary and benefits for a clinical supervisor to supervise interns and manage the program.
   b) Stipends to pay interns.
   c) Total Annual Cost: $9,543
   d) Nevada County is requesting $9,543 in WET funding to support the operation of this Action through the end of Fiscal Year 2016/2017. Funds may be used to fund clinical supervisors to supervise interns and manage the program and to pay stipends to interns and the related costs for interns to work in an office. Nevada County intends to provide ongoing support for the WET Component though the MHSA Integrated Plan beginning in Fiscal Year 2014/2015-2016/2017. This support will continue until funds are exhausted.

## *E. Financial Incentive Programs-*

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

**F. Cost per Person**

The number of individuals served in FY 2014/15 (234 individuals) is being used to estimate the average cost per person involved in a WET activity will be $425 ($99,543/234). This is the average cost of individuals involved in all five WET Projects: Workforce Staffing Support, Training and Technical Assistance, Mental Health Career Pathway Programs, Residency and Internship Programs, and Financial Incentive Programs. This also includes administration costs of $15,000.

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

## *G. WET Funding Expenditures*

WET funding in Action #1-5 may be used to fund expenditures for all expenditures identified in the Original Three-Year Plan and the past Annual Updates or for activities listed in the MHSA Recommendations of Needed Mental Health Services FY 2014-2017 document, including but not limited to: staffing, professional services, stipends, operating expenses (office supplies, travel and transportation, client vouchers, translation and interpreter services, rent, utilities and equipment, etc.), tele/video psychiatry equipment, office furniture, capital purchases, training and education, food and incentives for meetings, trainings, and the cost of improving the functionality of information systems used to collect and report client and program information. Capital purchases for staff and contractors may include the cost of vehicles, the cost of equipping new employees or contractors with all necessary technology (cellular telephones, computer hardware and software, projectors, etc.), the cost of enhanced and/or increased space needs related to services and other expenses associated with activities in this plan.

# *Innovation (INN)*

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

# *V) Technological Needs:*

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

# *VI) Capital Facilities*

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

# Nevada County Mental Health Services Act (MHSA) Annual Progress Report for Fiscal Year 2014/2015

## Overall Implementation Progress Report on Fiscal Year (FY) 2014/2015 Activities

***General Nevada County Information:***

Nevada County is a small, rural, mountain community, home to an estimated 98,893 (2014 US Census Bureau estimate) individuals. According to the 2014 US Census estimate a little over 93% of the Nevada County residents identified their race as White, while over 3% of residents identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander combined. Additionally, 3% identified themselves by two or more races. In regards to ethnicity, an estimated 85.6% of the population identified as Non-Hispanic or Latino and 9.2% 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.

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***MHSA Program Updates:***

## *Community Services and Supports (CSS):*

**Full Service Partners:**

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

1. **Victor Community Support Services' (VCSS)** Intensive Treatment Services Program in Grass Valley serves children diagnosed with a serious emotional disturbance or mental illness and their families through three modalities. The Assertive Community Treatment 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. 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.

   **Demographics:** In fiscal year 2014/2015, VCSS Grass Valley served 101 program participants representing 96 unduplicated individuals. Most program participants were white (78%), with others reporting Multi-cultural (11%), American Indian or Alaska Native (5%), other (3%), Black or African American (1%) and Native Hawaiian or other Pacific Islander (1%). Non-Hispanics (90%) accounted for the main ethnicity of program participants, along with the male

gender (55%), and age range of 0-15/Children & Youth (60%). All program participants reported English as their primary language. Ten percent of individuals reported being Latino/Hispanic, nine percent were listed as Homeless, another nine percent were tied into the Criminal/Legal System, and three percent identified as LGBTQ.

**Referrals:** During this fiscal year 2014/2015, there were 39 referrals made, with 37 program participants opening (95%), one individual remaining pending at the end of the fiscal year, and one referral being denied. Three referrals pending from the previous fiscal year opened to services, bringing the total number of intakes to 40, excluding transfers between reporting units.

**Barriers/Challenges:** A major barrier to service was the difficulty of communicating with program participants. Individuals in the program and those being referred frequently lacked a phone or available phone-minutes, and cell phone service could be limited in rural areas. As a result, it could be hard to establish and maintain contact with referred individuals and program participants. To ensure program participants received service and support, VCSS occasionally provided reloadable cell phones for individuals in need.

**Outcomes/Successes:**

- Housing: During this reporting period, 93% of program participants remained in a community living situation and avoided a higher level of care. Seven individuals experienced a group home placement. Please note this does not include temporary juvenile hall placements, which are addressed below.
- 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. During this reporting period, 80% of parents surveyed reported they saw improvement in their child's academic performance. Additionally, based on the CANS item "Academic Achievement," 86% of program participants were maintaining at least a C average and were not failing any classes.
  - VCSS achieved its contractual goal of ensuring at least 75% of youth maintain regular school attendance or improve their school attendance, as 81% of discharged program participants 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; 75% of program participants did not experience a suspension or expulsion in this fiscal year.
- 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 this reporting period, 90% of program participants had no new legal involvement while receiving services.
- Acute Care Use: Ninety-two percent (92%) of program participants served did not experience a psychiatric hospitalization during this fiscal year.
- Emotional and Physical Well Being:
  - Throughout the 2014/2015 fiscal year, VCSS Grass Valley successfully supported the strengthening and development of program participant, caregiver, and family members' emotional and physical well beings.
  - VCSS achieved its contractual goal of ensuring at least 65% of children were able to identify at least one lifelong contact. Based on the CANS item, "Relationship

Permanence," 97% of program participants served were able to identify at least one lifelong contact.
  - VCSS achieved its contractual goal of at least 80% of parents/caregivers reporting an increase in their parenting skills. In this fiscal year, 93% 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 maintained or increased connection to natural supports, with 89% of surveyed caregivers reporting increased connections in the community.
  - VCSS achieved its contractual goal of ensuring at least 80% of program participants improved their scores on the Comprehensive Child and Adolescent Needs and Strengths (CANS) instrument between intake and discharge. During this fiscal year, 84% of program participants with a planned discharge improved in at least one of the following CANS domains: Life Functioning, Mental Health/Behavioral/Emotional Needs, Risk Behaviors, or Educational Needs. CANS outcomes for FY 14/15 planned discharges were strong, with 72% improving in Life Functioning, 68% improving in Mental Health/Behavioral/Emotional Needs, 45% improving in Risk Behaviors, and 56% improving in Educational Needs.
- Service Access and Timeliness:
  - Excluding transfers between reporting units, there were a total of 35 discharges in this fiscal year. For this time period, the average length of service (ALOS) for the discharge population was 14.5 months.
  - 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 program participants within three days, initial contact was successfully made with 65% 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.

2. **EMQ FamiliesFirst (EMQ FF)** wraparound/full service partnership program 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.

   **Demographics:** Two-hundred and seventy-five youth have been admitted to EMQFF's Nevada County Wraparound Program since inception. More than half of these youth have been male (60%), between the ages of 12 and 17 at intake (60%), and predominantly Caucasian (76%). The most common diagnoses at intake were Adjustment Disorder (18%) and Post-Traumatic Stress Disorder (17%), and most youth (78%) were living with an adoptive or birth parent at admission.

   There were 80 youth served during the July 2014 to June 2015 timeframe, a majority of who were male (64%), between the ages of 12 and 17 (60%) at admission, and Caucasian (72%). The most common diagnoses at intake were Disruptive Behavior Disorder (24%) or Depressive

Disorder (20%), and most youth were living with an adoptive or birth parent (80%) at admission.

**Service Intensity:** For the 275 youth served since the inception of the Nevada County Wraparound Program, 251 youth were unduplicated and received an average of 16 service hours per youth, per month. For the 80 youth served during the July 2014 to June 2015 timeframe, 73 youth were unduplicated and received an average of 9.5 service hours per youth, per month was provided.

**Community Responsiveness:** For the July 2014 to June 2015 timeframe, 72% of youth and families received an initial contact within three business days of receipt of the referral. Forty-eight percent received face-to-face contact within ten business days of receipt of the referral.

**Outcomes/Successes:**

- **Length of Stay** - Since inception, the average length of stay, for the 202 youth who were enrolled for 60 days or more, is 14 months. For youth discharged during the July 2014 to June 2015 timeframe, 23 had a length of stay of 60 days or more, and had an average length of stay of 21 months.
- **Pro-social Behavior** - Since 2011, 99 matched pairs first completed/discharge Child and Adolescent Needs and Strengths (CANS) tool were available to analyze. Fifty percent of actionable items improved compared to non-actionable items on youth clinical condition and quality of life. During the July 2014 to June 2015 timeframe, 20 matched pairs first completed/discharge CANS tool were available to analyze. Forty-six percent of actionable items improved to non-actionable items on youth clinical condition and quality of life.
- **In Home or Foster Care** - Since inception, 83% of youth who participated in the Nevada Wraparound Program for at least 60 days were stabilized at home or in foster care at discharge. During the July 2014 to June 2015 timeframe, 79% of youth were stabilized at home or in foster care at discharge.
- **School Attendence** - During the July 2014 to June 2015 timeframe, 94% of youth maintained regular school attendance during participation in the Nevada County Wraparound Program.
- **School Behavior** - During the July 2014 to June 2015 timeframe, 92% of youth maintained no suspensions or expulsions in the three months prior to discharging.
- **Academic Performance** - In the July 2014 to June 2015 timeframe, 78% of youth with a history of academic problems improved their academic performance.
- **Legal Trouble** - During the July 2014 to June 2015 timeframe, 87% of discharged youth maintained zero arrests, probation violations, or days spent in custody in the three months prior to discharging. Twenty-five percent of discharged youth with prior legal involvement improved to have no new legal involvement at discharge.
- **Relationship** - During the July 2014 to June 2015 timeframe, 25% of youth established, reestablished or reinforced lifelong relationships with a caring adult while participating in the Nevada Wraparound Program.
- **Caregiver Self-confidence in Parenting** - During the July 2014 to June 2015 timeframe, 50% of caregivers reported an increase in their parenting skills at discharge that they learned while participating in the program.
- **Families Connecting to Natural Supports** – Fifty percent of youth and families maintained or improved natural supports during the July 2014 to June 2015 timeframe.

- **Discharge** - Since inception, 58% of youth with a length of stay of 60 days or more, discharged from the program because they met their treatment goals. For the 23 youth who discharged during the July 2014 to June 2015 timeframe, and had a length of stay of 60 days or more, 59% were discharged because they met their treatment goals.
- **Satisfaction** - Since inception, 76% of caregivers and 54% of youth indicated satisfaction with the program. During the July to June 2015 timeframe, 81% of caregivers and 44% of youth indicated satisfaction with the program.

**Summary and Conclusions:** Based on the outcomes of the youth discharged thus far, youth served in the Nevada County Wraparound Program are primarily being maintained in their homes or reunified. Many youth are attending school regularly, improving their academic performance and establishing lifelong relationships with a caring adult. Additionally, youth and families are meeting their treatment goals and lengths of stay are not excessive. These results indicate that the program is on the right track to helping youth and families effectively achieve their goals.

**Plan II: Adult Full Service Partnership (FSP)**

1. **Turning Point 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. Included in AACT services are individuals who may also meet criteria for Assisted Outpatient Treatment, 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. Services are grounded in a culturally responsive, respectful manner that fosters independence, self-determination and community integration.

   **Demographics:** In fiscal year (FY) 2014/15 a total of 118 individuals were enrolled in the Providence Center program. Of this total, age ranges were broken out into Transition Age Youth, ages 18 to 25 (8.5%, n=10); Adults, ages 26 to 59 (73.7%, n=87); and Older Adults, ages 60 plus (17.8%, n=21). The races served were Caucasian (92.4%, n=109); Native American/Eskimo (1.7%, n=2) and African American, Asian, and other (.8%, n=1 each). Program participants were predominantly English speaking (97.5%, n=115) with a small percentage of Spanish speakers (2.5%, n=3). Schizophrenia was the primary diagnosis of the majority of individuals served (46.3%) with Schizoaffective DO (28.1%) the second highest incident of primary diagnosis. Additionally, the highest frequency of individuals served resided in Grass Valley (69.4%), the next highest frequency lived in Nevada City (18.2%), followed by Penn Valley (3.3%), Truckee (2.5%) and North San Juan (1.7%). Program participants reported having a variety of cultures including: LGBTQ (n=4), Veterans (n=1), HIV/AIDS (n=2), Homeless (n=14), Latino/Hispanic (n=5) and Criminal/Legal Issues (n=48).

   **Outcomes/Successes:**

- Program Discharge: A total of 45 individuals were discharged in FY 14/15. The top two discharge settings were Lower Level of Care at 44.4%, n=20; and Program Participants Discontinued Services at 24.4%, n=11.
- Psychiatric Hospital Days: A total of 417 Psychiatric Hospital Days were reported for 17 individuals (14% of total individuals) in FY 14/15.
  - This represents a decrease of 156 days from the 573 psychiatric hospital days accrued by 18 individuals in the 2013/2014 fiscal year.
  - Overall, 86.0% (n=104) of the individuals served within the 14/15 fiscal year accrued zero psychiatric hospital days.
- Jail Days: Jail Days were reported as 1,077 (a 156 day increase from FY 13/14) for 23 individuals (19% of total individuals). Ninety-eight individuals (81%) accrued zero Jail Days.
- Homeless Days: Twenty-eight individuals (23%) accrued a total of 2,578 Homeless Days (665 days increase from FY 13/14). Ninety-three individuals accrued zero Homeless Days (77%).
  - Of the 20 individuals who had accrued homeless days within FY 13/14, 18 (90%) continued to receive services at Providence Center in the FY 14/15. Thirteen (72.2%) of those 18 individuals were reported as having a decrease in the total number of homeless days accrued. Additionally, 10 of those 13 individuals (76.9%) no longer accrued any homeless days in FY 14/15. The remaining three individuals showing a decrease in days accrued 112 (4.3%) of the 2,578 homeless days in FY 14/15. The remaining 2,466 days were accrued by individuals who had either accrued fewer homeless days in FY 13/14 or were new to Providence Center entirely.
  - Note that nine individuals alone accrued 2,053 (79.6%) of the total 2,578 days in FY 14/15; suggesting the presence of outliers.
- Emergency Interventions: Eighty-one Emergency Interventions were performed on 34 individuals (28%). This represents a slight increase of eight days from the 73 Emergency Interventions accrued by 32 individuals in FY 13/14.
- Milestones of Recovery (MORS): Scores of five (Poorly Coping/Engaged) (38.2%, n≈35.7) made up the majority of those scored across the past 12 months. Scores of six (Coping/Rehabilitating) made up the second highest frequency (27.3%, n≈25.5). A score of six is a favorable threshold of the MORS.
- Consumer Satisfaction Survey: Overall, the Providence Center program received a satisfaction rating of 84.1% on a scale from 0% – 100%. All seven domains had satisfaction rates above the favorable 80% threshold.
- Assisted Outpatient Treatment (AOT) Outcomes: The following outcomes are from data submitted to DHCS for the 26 individuals who were served by AOT in FY 14/15.
  *AOT Hospital Days:*
  - A total of 296 psychiatric hospital days were accrued by five individuals or 19.2% of the total 26 individuals observed. The majority of individuals (80.8%, n=21) did not accrue any psychiatric hospital days in the reporting period.
  - There was a decrease of 417 days or 64.6% post referral versus pre-referral. Ten of the 14 individuals (71.4%) who had accrued hospital days prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Eight of those 10 individuals (80.0%) no longer accrued any further hospital days post-referral.
  - In comparing the pre and post-referral data, there was a reported decrease of 207 days or 65.5%. Five individuals accrued the 316 psychiatric hospital days prior to their AOT referral. All five (100%) were reported as having a decrease in total days accrued post-

referral. Four of the five (80.0%) no longer accrued any psychiatric hospital days after their referral.

*AOT Incarceration Days:*

- During the reporting period a total of 243 incarceration days were accrued by four individuals or 15.4% of the total 26 individuals observed. The majority of individuals (84.6%, n=22) did not accrue any incarceration days in the reporting period. Additionally, one individual accrued 143, or 58.8%, of the total 243 incarceration days suggesting the presence of outliers.
- There was a decrease of 303 days or 61.0% post referral versus pre-referral. All 3 (100.0%) of the individuals who had accrued incarceration days prior to their AOT referral no longer accrued any further incarceration days post-referral.
- In comparing the pre and post-referral data, there was a reported decrease of 32 days or 14.3%. Two individuals accrued the 224 incarceration days prior to their AOT referral and both no longer accrued any days within the 12 months after their referral.

*AOT Homeless Days:*

- During the reporting period, a total of 29 homeless days were accrued by five individuals or 19.2% of the total 26 individuals observed. The majority of individuals (80.8%, n=21) did not accrue any homeless days in the reporting period.
- There was a decrease of 649 days or 78.6% post referral versus pre-referral. Six (85.7%) of the seven individuals who had accrued homeless days prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Four of those six individuals (66.7%) no longer accrued any further homeless days post-referral.
- In comparing the pre and post-referral data, there was a reported decrease of 81 days or 97.6%. Of the two individuals who were court ordered and had accrued homeless days prior to their AOT referral, both (100%) no longer accrued any homeless days post-referral.

*AOT Emergency Interventions:*

- During the reporting period, a total of 24 emergency interventions were accrued by nine individuals or 34.6% of the total 26 individuals observed. The majority of individuals (65.4%, n=17) did not accrue any emergency interventions in the reporting period.
- There was a slight increase of three days, or 9.1%, post referral versus pre-referral. Despite this increase seven (43.8%) of the 16 individuals who had accrued emergency interventions prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Six (85.7%) of those seven no longer accrued any emergency interventions in post referral. One individual continued to accrue the emergency interventions both pre-referral (12.1%, n=4) and the majority post referral (41.7%, n=15) suggesting the presence of an outlier.
- Just as there was for the entire AOT population observed, those who were court ordered also showed a very slight increase in the number of emergency interventions accrued pre referral in comparison to post referral (-12 days, 85.7%). Four of the six individuals (66.7%) who had accrued emergency interventions prior to their AOT referral date were reported as having a decrease in days accrued. Three of the four (75.0%) no longer accrued any emergency interventions.

*AOT Milestones of Recovery (MORS):*

- On average, at the time the first MORS score is assigned, the majority of program participants were at extreme risk (a score of 1) (42.4%, n=14). At the time of their most current MORS score assignment the majority were poorly coping but engaged with staff (a score of 5) (51.5%, n=17). Overall, 22 (66.7%) of the 33 individuals included in the analysis had an increase between their initial and most current MORS score.

- On average, program participants increased by approximately 2 scores between their initial and most current MORS score assignment. This shows that progress was made towards recovery once the Providence Center began providing services.

*AOT Consumer Satisfaction Survey:*

- Overall, the AOT program received a satisfaction rating of 79.1% on a scale from 0% – 100%. Four of the seven domains had satisfaction rates above the favorable 80% threshold. The other three domains had scores in the mid to high 70% range.

2. The **New Directions Program** in Nevada County Behavioral Health Department is a lite AACT program, which serves individuals with severe, persistent mental health issues and accompanying challenges to daily living. The program facilitates program participants transitioning from county services to independence and community living. Program participants in the following age categories were served in FY 14/15: two Transitional Aged Youth (16-25 years), 32 Adults (26-59) and 15 Older Adults (60 years and above). The New Directions team maintains a strong commitment to providing services which include Supported Independent Living, Supported Employment, educational and therapy groups, individual therapy and WRAP (Wellness Recovery Action Plans). During FY 14/15 New Directions provided services to 49 program participants across the three age categories.

**Demographics**: Of the 49 participants served in FY 14/15, 49% were female and 51% were male. Of the total 84% were Caucasian, 2% were Asian, 2% were Native American, 4% cited multiple races and 8% did not report their race. Participants reported 78% Not Hispanic ethnicity and 11% Unknown. The primary language of all participants was English.

**Service Intensity**: During the FY 14/15 service intensity varied by individual for the 49 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 daily delivery support in partnership with Turning Point, and nightly calls to the most high risk program participants. Comparing the year before partnership to the second year of receiving services through New Directions, the number of program participants in a Psychiatric Hospital decreased from six to three. The number of participants in an Emergency Shelter decreased from three to one. The number of individuals in Residential Placement decreased from six to four and the number of participants Supervised (in Congregate Placement or Community Care) decreased from four to three.

**Program Options:**

***Housing:***

- *Self-Sufficient Support ($S^3$)* - Residents who are successfully capable of living independently with minimal support are classified as "self-sufficient." These participants receive support on an "as needed" basis from Personal Service Coordinators (PSC). The residents are able to handle and problem solve most basic daily situations of independent living. Comparing the year before partnership to the first year of receiving services through New Directions, the number of Independent Living days increased from 5,530 to 6,376 days. Also, comparing the year before partnership to the second year of receiving services through New Directions, the number of Homeless days decreased from 423 to 234 days.
- *Supported Independent Living (SIL)* - Residents need regularly scheduled support to remain successful in independent living. Identified shared houses are supported by Nevada County Behavioral Health in the following manner:
  - Deposits are paid by MHSA flex funds.

  - If a room is vacant, MHSA funds are used to pay the monthly rent to maintain stability of the house until residents can locate a new housemate.
  - A "basic needs" list for residents is created by staff and obtained by program participants' resources, donations and/or MHSA flex funds.
  - PSCs provide support with medication, housemate conflict resolution, money management skills, paying bills, meal planning, budget planning, shopping, leisure skill planning and other daily living skills.
  - PSCs work with landlords to ensure support for both the resident and the landlord.
- New Directions continued support for the six SIL (Supported Independent Living) houses, housing 14people.
- Housing was provided for 35 homeless adults or previously homeless adults who struggled with severe and persistent mental illness using subsidies from the HUD Supported Housing Program grants. This included Winters' Haven house and scattered sites in the Summer's Haven and Home Anew Projects. See MHSA Housing section of this report for more details.
- *The Catherine Lane House (a joint venture with Turning Point)* - The Catherine Lane House offers 24/7 support services to residents with independent living skills challenges. This non-licensed 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 14/15 the New Directions Program did not have any 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 14/15 the New Directions Program housed five participants in Willo House.

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

***Employment/Volunteer Employment:***

- *Snack Shack* - Vocational training is available through the Snack Shack program. The Snack Shack program is a collaborative effort between NAMI, the Behavioral Health Department and Program participants. It is an individual 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 program participants and an individual with bookkeeping experience balances the receipts. In FY 14/15, 14 participants volunteered to work in the Snack Shack program for a total of 1,697 hours.
- *Peer Support Training* - Peer Support Training is an eight to ten month program where program participants develop skills to counsel and support peers. The goal of the support services is to promote self-empowerment, independence and interdependence, facilitating individuals 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. Program participants are then introduced to volunteer opportunities in the community. In FY 14/15, ten participants completed Peer Support Training and within the graduates of the program:
  - Two participants took the training for personal enrichment.

- One participant is volunteering at the Behavioral Health Department.
- Two participants are working for Respite Center positions.

Peer support challenges continue. As peer support continues to expand, so does the need to find paid or volunteer community placements for program graduates. Ongoing outreach to community based agencies and groups is continually needed to provide options for graduates to utilize their skills. Additionally, once a Peer Supporter 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.

***Supportive Services:***

- *Weekly Groups:*
  - Healthy Living - Healthy Living courses provide education to program participants and healthy options for independent living. Choices include coping and time management skills; nutrition, social and budgeting skills; leisure and development of Wellness Recovery Action Plans (WRAP) and social activities based in the community.
  - Saturday Adventure Outings - Saturday Adventure Outings serve high risk program participants 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 program participants organize the adventure and determine the activities each week. A peer staff member and an MFT intern trainee 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 14/15 the New Directions Program had 20 participants in the Saturday Adventure Outings program. The lead therapist/program team coordinator provided qualitative data in collaboration with the larger Behavioral Health clinical team indicating that this program had a direct role in reduction of symptoms and the need for more intensive services for program participants.
- *Therapy Support and Service Coordination:*
  - Therapy services are provided by interns through the intern program. The program offers an opportunity for interns to be trained in the mental health field while offering services to individuals who might otherwise wait or not receive individual therapy services. The long term benefit is quality services for the program participants 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. Through a partnership with Turning Point Providence Center, medication delivery services are provided at night, on weekends and holidays. During FY 14/15, nine individuals received daily medication caddie deliveries in collaboration with Turning Point for night and weekend coverage.

**Outcomes:** Notable community impact is reflected by these program outcomes.

- Decreased hospitalizations (listed above) were recorded.
- There was a decrease in legal issues (10 individuals with arrests prior to partnership, decreased to five partners with arrests during the first year of service).
- Independent Living was maintained or increased (listed above) which reduces the impact on community based homeless resources (decreased homelessness listed above).
- Programs focused on medication compliance, nutrition and physical health reduced utilization of emergency room services (17 individuals with emergency room visits before partnership, decreased to five partners during the first year of partnership).
- The employment program provided enrolled program participants with additional resources which they spent locally and thereby became financially contributing members of the local community.

## *General System Development:*

1. In FY 14/15 **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 2014/2015 eleven interns provided 9,510 hours of services for Nevada County citizens. The interns provided services in both adults' and children's systems of care (3,657 hours for adults and 5,853 hours for children). Additionally, two individuals provided supervision to the interns. Of the total hours of supervision provided, 149 hours were funded by MHSA CSS GSD.

2. 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 lower needs to the Network therapists. These are individuals who do not appear to need medication or a lot of case management. Network providers help to serve additional individuals and offer individuals and families a variety of specialties and locations that NCBH would not be able to offer otherwise. Network providers are funded under both the Adult and Children's programs within CSS.

   **Demographics:** These therapists provided services to 238 individuals in FY 14/15. One hundred and fifteen individuals under age 16, 38 Transition Aged Youth between 16 and 25 years old, 76 adults, and nine older adults - over age 60. This included 26 Hispanics, 198 Non-Hispanics and 14 individuals of unknown ethnicity. The predominant race served was Caucasian (n=194) followed by individuals with multiple races (n=19), African Americans (n=5),

American Indians and Asians (n=2 each), and 16 individuals whose race was unknown. Most of those served spoke English as their primary language (n=234), while two spoke Spanish. Females accounted for 130 of those served while 108 were male. Three veterans, five homeless, and 37 individuals with disabilities were served.

3. **Expand Adult and Child Psychiatric Services**

*Nevada County Behavioral Health (NCBH) Children's Services* provided Psychiatric services to 27 children with MHSA CSS funds in FY 2014/2015. 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.

**Demographics:** Twenty-one of the children seen in FY 14/15 were ages 0-15, and six of the children were Transition Aged Youth (TAY), ages 16-25. There were 11 females and 16 males. Twenty-two of the children were Caucasian, with one Asian, one African American, two with multiple races, and one whose race was listed as "other". Six Hispanics/Latinos were served, including three Mexican/Mexican-American/Chicanos and three Other Hispanic/Latinos, while twenty Non-Hispanic/Latinos and one individual of unknown ethnicity were also served. The primary language spoken by all program participants was English. Three of the children were reported to have disabilities, while one was said to be in the criminal/legal system.

*Nevada County Behavioral Health Adult Services* provided Psychiatry to Case Management/ Auxiliary, New Directions and Healthy Outcomes Integration Team (HOIT) program participants using General System Development funds. Expansion of psychiatry services and expansion of behavioral health services within the Adult System of Care included the same individuals. All Auxiliary, New Directions and HOIT program participants received both psychiatric and case management services.

**Demographics:** The program served 43 individuals including three Transition Aged Youth (ages 16-25), 25 Adults (ages 26-59), 13 Older Adults (aged 60+) and two people with age unknown. Thirty-four parties were Non-Hispanic and nine did not list an ethnicity. Thirty-four Caucasians, three multi-racial individuals, one Asian, one African American and four individuals of unknown race were served. The primary language of 41 of these program participants was English, while two listed their primary language as unknown. Females accounted for 19 of those served while another 19 were male; five individuals did not specify their gender identity. Three veterans, three homeless, and 15 individuals with disabilities were served.

4. The **Sierra Family Medical Clinic (SFMC)** provides therapy one day a week to underserved children, adolescents, adults and older adults. Therapy includes solution-focused, cognitive behavioral therapy, and other modalities that are evidenced-based/promising practices utilizing motivational enhancement/motivational interviewing counseling styles and techniques. Care coordination services are provided to high-need behavioral health patients to assure that care is patient-centered. Individuals with mental health conditions can have challenges prioritizing concerns when seeing a medical provider due to focusing and concentration difficulties. Providers may have a limited amount of time to address concerns in one appointment. The BH care coordinator meets with individuals to assist with this process and develop a multi-visit plan so that the program participants feel heard and valued. Connection with other community

services is continually developed and supported so that program participants can access services in accordance with their abilities.

**Demographics:** In fiscal year 14/15, 163 unduplicated individuals were served by SFMC. One child/youth (ages 0-15), six transition aged youth (ages 16-24), 77 adults (ages 25-59) and 79 older adults (ages 60 plus) were served. Most individuals were Caucasian (n=156), however, four Native Americans and three multi-ethnic individuals were also served. All but one individual spoke English as their primary language, and the other person spoke Spanish. Alternative cultures such as: Lesbian, Gay, Bi-sexual, Transgender, Queer (n=12); Veterans (n=12); Homeless (n=12); Disabled (n=122); and Criminal/Legal System (n=18) were seen through SFMC as well. Additionally, the program provided Outreach and Engagement services to 149 individuals.

**Barriers/Challenges:** Challenges were primarily addressing the needs of individuals with serious mental health conditions who required more intensive support than is possible through the clinic. Primary care providers were not able to address patients with complex psychiatric needs; tele-psychiatry was limited. Some individuals had chronic mental health conditions that could be debilitating at times and sufficient care management was not available.

Although managed care Medi-Cal recipients had transportation charges for medical appointments covered, it was sometimes limited and did not support obtaining prescriptions. The ability to receive assistance for food and social supports was also impeded due to lack of public transportation in the area.

A recurring challenge continues to be finding affordable housing and temporary housing for people who were not eligible for the current programs; some people continued to live in substandard housing and crowded conditions.

SFMC continues to problem-solve with Nevada County Behavioral Health to obtain treatment for individuals with psychiatric needs. The program also continues to collaborate with other community stakeholders on these issues.

**Outcomes/Successes:**

- Approximately 80% of individuals who entered treatment with suicide ideation were no longer experiencing suicidal thoughts after a course of treatment.
- Approximately 80% of individuals desiring reconciliation/re-connection with family members and personal supports experienced increased confidence and the ability to successfully repair relationships.
- These measures reduced the need for emergency department visits.
- Consistent with clinical practices, warm-handoffs from medical providers resulted in over 85% of patients continuing with behavioral health services.
- Anecdotal evidence included a person disabled by depression and anxiety unifying with his wife/children and obtaining employment; a young person who had been disabled by anxiety and depression was now able to go to school part-time.

5. **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 EMQFF, Victor Services, Behavioral Health, Probation, Courts, Child Protective Services, etc.).

**Demographics:** Forty-six adults and children were served in FY 2014/2015, including eight children (ages 0-15), 14 Transition Aged Youth (TAY) (ages 16-24) and 24 adults (ages 25-59). The most predominant race of individuals served was white (n=43), followed by Black/African American (n=2), with one program participant's race unknown. Everyone served spoke English as their primary language. Several other cultural factors were represented among those served including 46 people with substance use issues, 35 suffering from trauma, 17 involved in the criminal/legal system, four homeless individuals, three with disabilities, two who identified as LGBTQ and one Latino/Hispanic.

**Barriers/Challenges:**

- The number of youth referrals to the COD program was quite low this year. Other community youth services such as Probation and YES! Court also reported low youth referral numbers. In an already small program, this translates into less group services (group therapy, skill/rehab groups and parent group) for enrolled youth, and a shift to a primary emphasis on individual modalities. The same holds true in the adult services; gender specific group services suffer. Group services overall will be even more difficult next year, as the program has been cut by 50%. This means enrollments will be low making it challenging to offer robust groups with appropriate milieu match, beyond gender specific.
- This population experiences difficulty maintaining eligibility of their Medi-Cal benefits. In FY 14/15 there appeared to be an increase in a variety of issues for COD enrolled individuals (both adults and youth). This resulted in interruptions or discontinuations of their Medi-Cal benefits, which is the only funding the program can accept. On the bright side, CoRR now has greater access to a Medi-Cal eligibility worker resource.
- Access to psychiatric services continues to be a barrier. This service type is limited in Nevada County.

**Outcomes/Successes:**

- The COD program served 25 unduplicated adults and 21 unduplicated youth. This is above the contractually required minimum of 26 people. Of the youth enrollment, five remain enrolled, four were successful completions, six were transferred to other services/levels of care, two moved out of the area, three withdrew, and one lost their Medi-Cal funding. Of the 25 Adults, eight remain enrolled, four successfully completed the program, four were transferred, two lost their Medi-Cal funding, two moved out of the area, and five withdrew. The evidenced based practice (EBP) model of COD treatment implemented by the program is designed to meet individuals with COD 'where they are', and services are not time

limited, therefore, a 75% completion rate (achievement of treatment goals within one year) is not in alignment with the implemented COD EBP model of care.

- The program did see an increase in the speed at which some individuals moved from the pre-contemplative stage to contemplative and action stages. This improvement of individuals moving more rapidly than expected from their initial stage of change, we believe is due to the influence of the environment within which most services are delivered, and the effective level of integration with staff. The service delivery setting has been primarily a specialty substance misuse/dependence treatment facility with a continuum of treatment programs. It has increasingly become a facility fully integrated with both substance use and mental health services and a treatment philosophy that integrates mental health and wellness in addition to medical care. All services accessed onsite.
- The program tracked data that demonstrated decreases in homelessness and increases in employment and volunteerism for individuals in the COD program. Out of three adults and one youth reporting homelessness upon intake, all ended up with housing. Three youth became employed and one started a volunteer position. Five adults became employed and one obtained a volunteer position.
- In the adult population, there were 0% incarcerations for new offenses for anyone during their enrollment in services, and only one new offense (5%) for youth. Eight youth (38%) participated in either gainful employment, volunteer work or completed community service hours. Half of the adults (50%) served during their enrollment, either became gainfully employed, did volunteer work or completed community service.
- Additionally, 18 of the 25 adults served (72%) and six of the 21 youth (29%) participated in 12 step or self-help non-treatment groups in the community during enrollment in COD. For adults and children combined, 90% reported an increase in supportive connections. Some of those supportive connections resulted in safer and more stable living environments in the community, as well as employment opportunities.
- Ninety percent of enrolled adults either reduced the use of their drug of choice or were successful in adopting a program of recovery, understanding the need for abstinence from substances. The most prevalent drugs of choice for adults were alcohol and methamphetamine. Seventy percent of youth reduced their use of substances. For those meeting the criteria for addiction, 50% were able to adopt a program of recovery and achieve abstinence. The overwhelming drug of choice for the youth population was cannabis, while alcohol was the drug associated with the highest risk factors and addiction criteria for youth.
- Families engaged in services reported anecdotally improvements in family communication, increased parenting skills, improved ability to make and follow through with parenting/family decisions that resulted in increased problem solving and stability, and changes in family configurations done proactively.

6. **Expand Adult and Child Mental Health Services**

*Nevada County Behavioral Health (NCBH) Children's Services* provided Mental Health services to 55 children with MHSA CSS funds in FY 2014/2015. 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.

**Demographics:** Thirty-six of the children seen in FY 14/15 were ages 0-15, 19 of the children were Transition Aged Youth (TAY), ages 16-25. There were 26 females and 29 males. Forty-two of the children were Caucasian, with three American Indians, one African American, seven with multiple races, and two whose race was listed as "other". Eight Hispanics/Latinos were

served, five Mexican/Mexican-American/Chicanos and three Other Hispanic/Latinos, while forty-one Non-Hispanic/Latinos and six individuals of unknown ethnicity were also served. The primary language spoken by all program participants was English. Twelve of the children were reported to have disabilities, while one was said to be in the criminal/legal system.

*Nevada County Behavioral Health Adult Services* were expanded in FY 14/15, to provide Case Management to Auxiliary, New Directions and Healthy Outcomes Integration Team (HOIT) program participants using General System Development funds. Expansion of psychiatry services and expansion of behavioral health services within the Adult System of Care included the same individuals. All Auxiliary, New Directions and HOIT program participants received both psychiatric and case management services.

**Demographics:** The program served 43 individuals including three Transition Aged Youth (ages 16-25), 25 Adults (ages 26-59), 13 Older Adults (aged 60+) and two people with age unknown. Thirty-four parties were Non-Hispanic and nine did not list an ethnicity. Thirty-four Caucasians, three multi-racial individuals, one Asian, one African American and four individuals of unknown race were served. The primary language of 41 of these program participants was English, while two listed their primary language as unknown. Females accounted for 19 of those served while another 19 were male; five individuals did not specify their gender identity. Three veterans, three homeless, and 15 individuals with disabilities were served.

7. MHSA funding provides a **Crisis Worker Position and Crisis Support Team** onsite at the Behavioral Health office from 8am to 5pm during normal weekday hours. Also provided is a crisis support position for afterhours including weekends and holidays, and a crisis worker position to staff the local hospital's emergency department 24 hours a day, seven days a week. These services are exclusive to western Nevada County. Funding sources used to support these Crisis Services included Medi-Cal, Senate Bill 82 Triage Grant, 1991 Realignment funds, MHSA-CSS funds.

   Crisis services are provided on location at Nevada County Behavioral Health's, Crown Point facility. The crisis workers provide 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 collaborate with other human service providers and law enforcement to determine whether hospitalization is required and what resources for referral may be appropriate.

   **Demographics:** In FY 14/15 MHSA Crisis Workers served 851 unduplicated individuals. Children aged 0-15 comprised 1.4% of those served, while 9.6% were transitional aged youth (16-25 years old), 33.7% were adults aged 26-59, 10.2% were older adults (60+ years old) and 45% were anonymous or of an unknown age. Females comprised 28.6% of program participants, males accounted for 27.4%, and 44% did not specify a gender. Ethnically speaking, 17.4% of individuals served were Non-Hispanic, 1.2% were Hispanic or Latino, and 81.4% were anonymous or of an unknown ethnicity. The majority of individuals served were Caucasian (16%), with .6% multi-racial, .5% American Indian or Alaska Natives, .2% Black or African American, .1% Asian, and 83% anonymous or of an unknown race. Only one person spoke Spanish as a primary language while 459 spoke English and 391 did not identify their primary language. A variety of cultural groups were ministered to including seven veterans, 20

homeless, and 63 disabled. **Note: the demographic numbers for FY 13/14 were duplicated totals.*

**Barriers/Challenges:**
The main barriers faced in this program were lack of acute care services for program participants requiring hospitalization, and lack of follow-up services for individuals needing outpatient and other supportive care. Persistent efforts were made to access resources from other agencies, and crisis workers continued follow-up services until the crisis events were fully stabilized.

**Outcomes/Successes:**
- Service provision to program participants and families resulted in referrals to other agencies or hospitalization.
- Approximately 20% of program participant evaluations resulted in hospitalization.
- Contact was maintained with individuals until the crisis was stabilized.
- Services were provided to all age groups.
- Services included brief crisis intervention to resolution.
- Services provided on site at the Crown Point facility included: Crisis Intervention; 5150 Assessment; Collateral Support; and collaboration with families, behavioral health staff, and other support providers. Consultation with law enforcement, hospital staff, and community service providers also occurred.
- Many services were provided by phone including: brief crisis support, assessment and linkage and referral services.

8. **Truckee Outreach, Engagement and Liaison** is funded under other CSS and PEI (Prevention and Early Intervention) programs.

9. **Emergency Department Crisis Peer Counselor Program (SPIRIT ED)**, has Crisis Peer Counselors (CPCs) available for 10 hours a day, 7 days a week at the Sierra Nevada Memorial Hospital Emergency Department. Providing Crisis Peer Support in the hospital emergency department (ED), following up with individuals served in the ED, supporting community members in crisis to get connected with local resources and offering continued peer support to empower individuals to reach their wellness and recovery goals are the main services provided by this program. The overall goal of the program is to reduce the number of people going to the ED in crisis, and to reduce the number of recurring ED visits. Crisis Peer Counselors and Team Leaders coordinate and collaborate closely to support each other and community members in crisis.

**Demographics:** The SPIRIT ED Program served 304 people in FY 14/15. Of those, 51 were transition aged youth (TAY) aged 16-25, 209 were adults aged 26-59, and 44 were older adults aged 60 plus. All those served were English speakers. Caucasians comprised the majority race with 286 individuals, while three people were Native American and 15 listed their race as "other". The program served three Lesbian, Gay, Bi-sexual, Transgender, Questioning (LGBTQ) individuals, 10 veterans, 40 homeless people and 65 individuals with disabilities.

**Barriers/Challenges:**
- Many of those served by SPIRIT do not have a phone for staff follow up calls, or the number is disconnected. When a person with no phone shows up at the SPIRIT Center, they are connected with the Free Government Phone application.

- Frequently individuals are unsure where they will live once they are released from the hospital, as their current home environment is not supporting them. Nevada County now has a peer centered Respite Center where guests can take time to collect themselves and access resources to help them on their path to recovery.
- Transportation is regularly a challenge in getting individuals to doctor's appointments and to the SPIRIT office. SPIRIT gives out bus passes for those needing transportation to important appointments.
- At this time SPIRIT does not have a tool for outcome measures, however they are being trained and attending webinars that will help them measure outcomes in the future.

**Outcomes/Successes:**

- There were 55 requests to follow up with program participants from Crisis Workers and 248 requests to follow up with program participants from CPCs in FY 14/15.
- Completed follow ups numbered 116 for the year with 40 still pending at year end. Other follow up statistics included 48 people who refused contact, 44 who would not give permission to follow up, 46 who were contacted but did not return calls and 62 who were not available by phone.
- In FY 14/15 CPC's working with individuals developed 58 Action Plans, discussed Stress Reduction Techniques with 60 people, tracked Stress Reduction Techniques used by 40 people, made 513 referrals and provided resources to 38 individuals.
- The members of the ED Team, along with SPIRIT staff and community members, were trained by Lauren Spiro in Emotional CPR (eCPR). This was a public health education program designed to teach people to assist others through an emotional crisis by three simple steps: C = Connecting, P = emPowering, and R = Revitalizing.

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

**Demographics:** In FY 14/15, WHV served 50 veterans and family members including eighteen Adults (26-59 years old) and 32 Older Adults (60+ years old). Of those individuals, the primary Race was Caucasian (43 individuals) and the primary language was English. Thirty-two of the individuals served were Veterans.

**Barriers/Challenges:**

- Those Veterans being treated under VA funding may now remain under that funding umbrella with their local provider. However, WHV has also determined that there are a number of Veterans in Nevada County whose trauma, although incurred in the military, was not related to being in combat. Those Veterans were, and still are, not eligible for treatment in the county through VA funding. Yet they are often just as disabled by their PTSD and other diagnoses as the combat Veteran. WHV has been adding those Veterans to the target

population as funding has been available, either through pro bono services, donations, fundraising or other short-term grants. With the renewal of the MHSA/CSS contract, WHV can use some of those funds to serve those non-combat Veterans now that the VA is continuing to fund treatment for combat Veterans within the county.

- There is still a pressing need to continue treatment of families of those Veterans who have PTSD, a need which has been met in the past by the MHSA/INN contract. That contract expired last year, and is not renewable, nor is there MHSA funding in another category with which to continue this program. Fortunately, NCBH has allowed a slight change in the wording of the CSS contract which has allowed family members as well as Veterans to be treated. Even though combat Veterans are now funded through the VA, the current amount of the CSS contract is not sufficient to fully cover treatment of families and of non-combat Veterans. Several WHV therapists are currently providing up to 40% of covered therapy on a pro bono basis. WHV continues to seek other funding sources to cover this population, and are grateful for the County's investment in the mental health of Veterans and their families.
- As the WHV outreach numbers grow, the need for fundraising/new grants grows as well, since costs to provide services increase accordingly.

**Outcomes/Successes:**

- WHV provided a total of 117 group therapy sessions paid for by CSS funds. Therapists provided a further 51 sessions to WHV program participants on a pro bono basis. WHV Licensed Clinical Psychologists (LCP) provided 127 individual sessions funded by CSS, as well as donating 41 pro bono individual sessions. WHV Licensed Marriage and Family Therapists (LMFT) provided 143 individual therapy sessions funded by CSS, as well as donating 107 pro bono sessions. This emphasis on individual therapy reflects their ongoing attempt to move program participants to peer-led group sessions where feasible and appropriate, allowing WHV to focus resources on the most urgently needed services.
- WHV has been successful in reaching more Veterans in FY 14/15 than in the previous year.
- In addition, WHV has been gradually transitioning many of their longer-term program participants to a recovery model which features peer-facilitated support groups in place of therapist-led support. This model fits the needs of this chronically disabled population quite well. As program participants begin to achieve some of the goals 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 program participants who need therapist-led treatment.
- The year from July 2014 through June 2015 was WHV's first full year of Outreach & Engagement. The Outreach Coordinator reported almost 900 new contacts with Veterans throughout the year. Many of these Veterans are helped by WHV in ways additional to therapy, for example; help processing claims with the Department of Veteran's Affairs, referring Veterans to other agencies to help in locating the services they need, and even help with mundane issues such as a new appliance. During the year, relationships have been established with all local law enforcement agencies, local community agencies, Sierra College, and most local non-profits that work with Veterans. As a result of these collaborations, Welcome Home Vets has been able to exchange referrals with these agencies on behalf of mutual populations.

11. **Housing and Supportive Services to the Severely Mentally Ill Homeless** was provided through the MHSA Housing program, the Roseville/Rocklin/Placer-Nevada Continuum of Care;

the lead agency identified as administrator is the Homeless Resource Council of the Sierras (HRCS) and the Nevada County Coordinating Council (NCCC) to End Homelessness.

**MHSA Housing** includes:
**Housing Choice Vouchers (HCV) (formally known as Section 8):** The Housing Choice Vouchers list opened last fiscal year. The Personal Service Coordinators from Behavioral Health and contracted service providers helped program participants complete the HCV Pre-Application form. Many of Behavioral Health and contracted service providers program participants were placed on the Housing Choice Voucher wait list. During FY 14/15 Personal Service Coordinators assisted individuals on the wait list to secure additional required documents to verify what they had put on the HCV Pre-Application form, complete the rest of the HCV Application, look for and secured housing that could be used by a voucher and move into their new homes.

**Second MHSA House:** Nevada County Housing Development Corporation (NCHDC) entered into escrow for a second MHSA funded house. Escrow was to close in August 2014, but due to NIMBY (Not in My Back Yard) issues with 46 neighbors, the escrow did not close and the home was not purchased.

**Nevada County Housing Development Corporation (NCHDC):** A landlord that remodeled a large Victorian home into nine apartments approached the County to master lease the whole building from him. The County has partnered with NCHDC, to master lease the building and sub-lease the apartments to Behavioral Health program participants.

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

For FY 14/15 there were six tenants in the house. One person left the house mid-year for another permanent supported housing opportunity and another person moved in. All six tenants were male. Ages of tenants varied: one was Transitional Age Youth ages 18-24, four were adults ages 25-50 and one was an older adult age 60+. All tenants were non-Hispanic while five were White and one was Black or African-American. Three individuals came from Emergency Shelters; two came from a place not meant for habitation and one person transferred over from another housing program. All six tenants had a source of income at the end of the fiscal year, including four with SSI and two with General Assistance. Lastly, all six tenants were housed for six months or longer.

Winters' Haven had its second California Housing Finance Agency (CalHFA) housing inspection and the inspection resulted in no negative findings.

**Summer's Haven Project/Supportive Housing Project (SHP):** The Behavioral Health Department applied for a renewal of their SHP. They received a renewal grant from Housing and Urban Development (HUD) Continuum of Care (CoC) in the amount of $108,803. This grant is meant to provide permanent supportive housing to a minimum of 13 individuals with severe mental illness enrolled in the MHSA Full Service Partnerships.

In FY 14/15 the SHP vouchers were utilized by 18 households consisting of 21 individuals. There were ten adult males and adult females enrolled in the program and one male child. The

ages of the individuals in the program were: one individual under the age of five and the rest ranged in age from 25 to over 62 years old. All individuals except one were non-Hispanic. The race of the tenants was: 17 white, one Black or African-American, one American Indian or Alaska native, and two multiple races. Most of the tenants had physical or mental health conditions: 19 had mental illness, one had alcohol use issues, four had drug use issues, and five had a physical disability. The Residence prior to program entry varied: four from emergency shelters, 14 from a place not meant for habitation, and two from another permanent supportive housing program. One program participant served in the military. All households had a source of income except three. Sources of income included earned income, SSI, SSDI and General Assistance. The only individual to leave the program passed away during the fiscal year. The average length of stay for the tenants was 541 days. Of the 21 adult program participants 20 were enrolled in the program for at least 6 months (housing stability measure).

The largest barrier to implementing this program is finding landlords that will master lease to Nevada County Housing Development Corporation.

**Home Anew:** The Behavioral Health Department submitted an application to HUD for three additional Permanent Supportive Housing grant vouchers for chronically homeless individuals with a serious mental health condition in FY 13/14. The Behavioral Health Department was awarded the grant for $20,270 for two vouchers in FY 14/15.

In FY 14/15 the Home Anew vouchers were utilized by two households consisting of one individual each; one adult male and one adult female. One individual was between the ages of 25-59 and the other was over the age of 60. Both individuals were non-Hispanic and both were white. Both tenants had a mental health condition and one additionally had developmental and physical disabilities. One residence came from an emergency shelter and the other from a psychiatric facility. Both tenants had SSI as a source of income. The program started less than six months ago so cannot measure housing stability yet.

**Homeless Count January 26, 2015:** A Homeless Count was conducted on the night of January 26, 2015 for individuals in Emergency shelters (sheltered) and people living outside, in cars, and in places not meant for human habitation (unsheltered). A Homeless Connect Event happened on January 27th. At the Homeless Connect Event the homeless participants were surveys on where they slept on the night of January 26th. At the Homeless Connect Event food, warm clothing, entertainment, and support from local businesses and community based organizations were provided. A street count was also conducted and individuals who did not come to the Homeless Connect Event were asked to complete the survey.

Below are some of the results of the survey:

- A total of 279 individuals were homeless, 101 were in shelters and 178 were unsheltered.
  - Two hundred and eleven households were homeless, 71 were in shelters and 140 were unsheltered.
  - Forty-two children under the age of 18 were homeless, 25 were in shelters and 17 were unsheltered.
  - Thirty-one young adults (18-24) were homeless, six were in shelters and 25 were unsheltered.
  - Twenty-one people 60 years or older were homeless, eight were in shelters and 13 were unsheltered.

  - One hundred and eighty-five individuals were between the ages of 25-59, 62 of these were sheltered and 123 were unsheltered.
- Ninety-two females (33%) were homeless and 187 (67%) males were homeless.
- Length of time in Nevada County: More than five years = 59.9%; 1-5 years = 15.6%; and less than a year = 24.5%.
- What is the main reason you live here: have family or friends here = 46.4%; originally from here/grew up in the area = 24.6%; job opportunities/employment 7.7%; attended school here = 3.3%; all other responses (other, just passing through, better social services, legal issues) = 17.9%.
- Chronically Homeless individuals (homeless for a year or longer or homeless four times in three years) = 109, 33 sheltered and 76 unsheltered.
- Homeless Veterans = 22: three were females and 19 were males; eight sheltered and 14 unsheltered; 14 were chronically homeless veterans.
- Disabilities (individuals self-identified whether they had a disabling condition and if it severely interfered with their life): Individuals could mark that they had more than one condition.
  - Chronic Depression, Post-Traumatic Stress Disorder and Serious Mental Health Issues = 50.6%; Substance Use = 28.5%; Development Disability = 11%, Traumatic brain injury = 9.3%, Chronic health condition = 22.8%, Physical Disability = 19%.
- Ninety-one adults or 38.4% of participants said they had experienced dangerous or violent situations (including domestic violence, sexual assault, stalking, or dating violence) at some time in their life.
- Twenty-four adults or 10% said of participants said they had lived in a foster home or a group home.
- 50.3% of households reported no income; 15.2% reported Social Security income; 10% reported CalWORKs; 9.3 % reported General Assistance income; and Other Sources (other, family and friends, unemployment and Child Support) were reported by 17.9%.
- Un-obtained Service Needs (individuals could make more than one service need request): Supported Housing/vouchers = 58.1%; Dental/vision = 41.9%; Transportation = 41.9%; Financial Assistance = 39.5%; Mental Health services/counselling = 33.7%; Emergency shelter = 31.4%; Food = 25.6%; Legal = 20.9%; Job Training = 20.9%; Drug and alcohol services = 14%.

In order to apply for and receive Homeless Continuum of Care (CoC) funding, the United States Department of Housing and Urban Development (HUD) requires that a community establish an effective Homeless Continuum of Care. Nevada County is a member of the **Roseville/Rocklin/Placer-Nevada Continuum of Care;** the lead agency identified as administrator is the **Homeless Resource Council of the Sierras (HRCS).** The **Nevada County Coordinating Council (NCCC) to End Homelessness** is one of three regional groups that provide feedback, support and information to the HRCS for planning and collaboration purposes. The other two regional groups are located in Tahoe-Truckee and in western Placer County. The Behavioral Health Department is an active member of the HRCS and the NCCC.

**Outcomes/Successes:** MHSA funds were used to help fund the HRCS Coordinator position. The HRCS Coordinator in FY 14/15 completed the following:

- Developed the HUD Homeless Assistance applications that were submitted to HUD in October 2014. The Coordinator assisted the Nevada County project applicants in the development of their applications.

  - Summer's Haven: This permanent supportive housing program is funded annually at $110,841 to provide 13 housing units for individuals with severe mental illness enrolled in an MHSA Full Service Partnership program.
  - Homelessness Management Information System (HMIS): The HMIS Lead Agency and The Salvation Army Grass Valley Corps submitted two proposals to fund a full-time HMIS Systems Operator for the HRCS and to purchase user licenses. An applicant must be using HMIS to receive HUD Homeless Assistance funds or Emergency Solutions Grant funds.
- Coordinated the application, evaluation and Annual Progress Report process for the HRCS's 14 HUD grants that annually total $1,200,571.
- For the December 2014 round of Emergency Solution Grant (ESG) funding, the California Department of Housing and Community Development required that the CoCs assign up to 100 Need Points to each applicant. However, the points assigned to each application needed to be at least five points apart. The Coordinator facilitated the process to develop an unbiased HRCS Committee to review the ESG applications and assign points. Five Nevada County ESG applications were reviewed. Four applications from Nevada County were funded:
  - Hospitality House was awarded two grants for a total of $400,000.
  - The Salvation Army was awarded two grants for a total of $190,515.
- Conducted the January 2015 Sheltered and Unsheltered Homeless Count and Housing Inventory Chart.
- Facilitated the following HRCS-wide committees/task forces:
  - Nevada-Placer Governance Committee
  - Grant Evaluation Committee
  - Homeless Count Coordinating Committees
  - Coordinated Assessment

## *Outreach and Engagement:*

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

   **Demographics:** NAMI served 97 individuals in FY14/15. The majority of these people were older adults (n=53) ages 60+, while 42 were adults ages 26-59 and two were Transition Aged Youth (TAY) ages 16-25. Ethnicity was broken out as 93 Non-Hispanics and four Hispanics, while race was primarily white (n=93) with a few multi-racial (n=2), American Indian (n=1) and Pacific Islander (n=1). All but one of the participants were English speakers. Other cultures served were comprised of Lesbian, Bi-sexual, Gay, Transgender, Questioning (LBGTQ) (n=2), veterans (n=2), disabilities (n=5) and people tied into the criminal/legal system (n=3).

**Barriers/Challenges:** The Peer-to-Peer and NAMI Basics programs were not offered due to instructor issues.

**Outcomes/Successes:**

- In FY 14/15 NAMI provided educational information regarding their resources to members of the Unitarian Universalist Community of the Mountains Church (UUCC). This set the foundation for building a relationship which resulted in bringing the Inside Mental Illness program to the church in the subsequent fiscal year. NAMI members are members of the UUCC congregation, so in working with the UUCC leadership, NAMI was granted access to the congregation. The leadership was welcoming and open to this collaboration.
- Inside Mental Illness training with Community Legal Inc. resulted in NAMI being asked to formalize a community partnership agreement to provide quarterly trainings to Community Legal's constituency. Community Legal training was attended by attorneys and mediators. This session included information about mental illnesses, communication strategies to use when individuals are struggling, Our Voices Matter perspectives and linkage to community resources. The training was presented on June 23, 2015 by four program participants/family members and addressed personal experiences as well as providing information to 24 attendees.
- NAMI Family to Family Educational (evidenced based) program comprised of 12 weekly sessions for family members of individuals with mental illnesses was provided. The class filled quickly after conducting outreach through NAMI membership, support programs and The Union Newspaper. The Family to Family program was held from January 15, 2015 through April 2, 2015 and 17 people were enrolled for the 12 week course.

2. **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, EMQ, Welcome Home Vets and Sierra Family Medical Center. Outreach and engagement activities were provided to 1,741 individuals in FY 14/15. This number does not include services provided by the individual programs listed separately in this section of the report.

3. **SPIRIT Peer Empowerment Center (SPIRIT)** serves visitors 18 years and older. The program serves people with severe, moderate and mild mental illness including the homeless population, offering 13 different support groups. These groups cover topics such as: Dual Diagnoses, WRAP (Wellness Recovery Action Plan), Bi-polar Group, Men's Group, Women's Group, LGBTQ Group, Peer Support, Group Facilitation and Basic Computer 101 Group.

   **Demographics:** In FY 14/15, SPIRIT Center served 696 individuals including 25 Transition Aged Youth (16-25 years old), 621 Adults (26-59 years old) and 50 Older Adults (60+ years old). Of those individuals the primary ethnicity was Non-Hispanic (n=691), while five Hispanics were also treated. The race most commonly seen was Caucasian (690 individuals) with three each American Indian and African American. The primary language for all individuals was English. Five LGBTQ, five veterans, 200 homeless, five people with disabilities and 30 people in the criminal/legal system were also served.

   **Barriers/Challenges:** It has been difficult to penetrate the community with the SPIRIT message. SPIRIT is getting more articles in the newspaper and is planning a campaign to work with doctors in the community showing them how SPIRIT can be a resource for their patients.

At this time SPIRIT does not have a tool that is used for outcome measurement, however staff are attending trainings and webinars that will help them to measure outcomes in the future.

**Outcomes/Successes:**

- In FY 14/15 SPIRIT Center provided a total of 5,301 services.
- SPIRIT Center provided Peer Counseling in the isolated community of North San Juan (NSJ). Peers either met individuals at the Resource Center in NSJ or at the individual's home. Six unduplicated program participants were served in NSJ in FY 14/15. This service was provided by two of SPIRIT's NSJ local Peer Counselors. They are husband and wife and have lived in the community for years so they know the culture in NSJ well. A SPIRIT board member does additional outreach in NSJ.
- Offering group support and one-on-one peer support has helped individuals to get well and reach out for support to other community resources. SPIRIT provided 696 unduplicated services in FY 14/15 including 655 Peer Support visits. SPIRIT groups were accessed 1,280 times in the year.
- SPIRIT supports the homeless population by supplying showers and laundry facilities. This enables the homeless to be presentable when they go out and look for employment. Showers were accessed 244 times and the laundry facility was used 99 times in FY 14/15.
- Serving a hot lunch on Saturdays has helped individuals socialize and break free from their isolation. SPIRIT provided 806 bags of food and 1,040 Saturday brunches in FY 14/15.
- SPIRIT tracked 5,662 volunteer hours and were open a total of 1,309.50 hours in FY 14/15.
- SPIRIT Center is an active participant in the MHSA Steering Committee and Innovation Subcommittee, CoC, Cultural Competency/WET as well as, NAMI, Forensic Task Force, Suicide Prevention Task Force and Mental Health Board.

# *Prevention and Early Intervention (PEI): Access to Services*

## Activity 1: Suicide Prevention Intervention (SPI) Program

**Suicide Prevention Intervention (SPI) Program** was created to make a more "suicide aware community." An SPI Coordinator organizes and leads the implementation of this program. The Coordinator works with a cadre of concerned citizens, comprised of program participants, individuals, families, support groups, task forces, community based organizations, local & state governments, including schools, crisis lines & health clinics. These citizens have all contributed towards the shared goal of creating a more "suicide aware community." The goals of the program are to: 1) Raise awareness that suicide is preventable, 2) Reduce stigma around suicide & mental illness, 3) Promote help-seeking behaviors, and 4) Implement suicide prevention & intervention training programs. Programs provided include the following:

- Gay-Straight Alliance (GSA) Leadership Summit: Sponsored by Parents and Family of Lesbian and Gay (PFLAG) of Grass Valley, this event is an opportunity for high school and college students and staff to meet, network, and participate in workshops designed to help everyone better understand and advocate for Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) students
- Sources of Strength (SoS) Peer Leaders
- Tahoe Truckee Suicide Prevention Coalition (TTSPC) Steering Committee
- Know The Signs (KTS) Media Forum: Responsible suicide reporting and do no harm media messaging. 5,000 by 2015! Campaign.
- Youth Mental Health First Aid (YMHFA) Train-the-Trainer Workshops: Certified Instructor Workshops.
- Applied Suicide Intervention Skills Training (ASIST) Workshop: Two days
- Crisis Response (Tahoe Truckee)
  - Multi-County Health Officer Health Alert Letter – Formal announcement to heighten health care providers awareness of vulnerable patients seeking help services – Lake Region (El Dorado, Tahoe & Truckee).
  - Tahoe – In March & April, several suicide deaths occurred within a small geographical area. The lake community was stunned and grief stricken.
  - Greif Workshop / Parent & Community Forum – North Tahoe

**Demographics:** In FY 14/15 the SPI Program served 1,750 individuals. Of those, 50 were Children ages 0-15, 625 were Transition Aged Youth ages 16-25, 900 were Adults ages 26-59 and 175 were Older Adults ages 60 plus. Hispanic/Latinos accounted for 90 program participants while five Eastern Europeans, two Europeans and 1,653 people of unknown ethnicity were helped. Caucasians made up the majority of individuals with 1,690, while 30 multi-racial parties, seven Asians, five African Americans, three American Indians and 15 individuals of unknown race were also served. The Primary Language of 1,658 participants was English, while 75 spoke Spanish, one spoke Russian, six spoke other languages and ten did not identify their primary language. SPI served the following types of individuals: 170 Lesbian, 90 Gay, 15 bi-sexual, seven transgender, 20 questioning their sexual identity, 88 veterans, 42 with HIV/AIDS, five homeless, ten with disabilities, two within the criminal/legal system, 225 claiming substance use and five dealing with domestic violence. Those who identified as female numbered 1,133, while 610 identified as male, five identified as trans-female and two identified as trans-male.

**Barriers/Challenges:**

- MHFA Workshops: Several adult workshops were canceled due to low registration numbers. Staffing changes impacted promotion efforts. Slight variations between MHFA & YMHFA may cannibalize the limited market for this workshop. Maintaining instructors is cumbersome especially when workshops do not fill and classes are cancelled.
- Multiple suicides weigh heavily on the community and community leaders. Grief, fears of contagion and clusters, as well as feelings of overwhelm, exhaustion and caregiver fatigue are present among stakeholders.

**Solutions to Barriers:**

- MHFA Workshops: Secure training space a year in advance. Develop MHFA/YMHFA workshop flyer for dissemination. Announce workshops many months in advance via NCBH e-list serves. Consult with MHFA-USA about difficulties maintaining dual training statuses in MHFA & YMHFA.
- Multiple suicides: Outreach to KTS State Representatives for rural community response strategies. Strengthen bi-county ties and promote self-care for the Tahoe Truckee community and especially for the TTSPC steering committee members.

**Outcomes/Successes:**

- GSA Leadership Summit: Forty LGBTQ regional youth attended, ages 18-24.
- Sources of Strength Peer Leaders promoted connectivity, school bonding, peer-adult partnerships, and help-seeking behaviors.
- Tahoe Truckee Suicide Prevention Coalition hired an Outreach Facilitator (10 hrs. /wk.) with areas of focus, 1. Awareness, 2. Access to Care, 3. Stigma Reduction, 4. Advocate & Disseminate Healthy Supports.
    - Maintained email contact data base for Youth Suicide Prevention Coalition.
    - Supported monthly Youth Suicide Prevention Task Force Steering Committee meetings.
    - Spearheaded the Know the Signs Campaign and provided related training to local community groups.
    - Assisted with planning and advertising quarterly Youth Suicide Prevention Coalition Meetings.
    - Developed Tahoe Truckee Suicide Prevention page on the Truckee Tahoe Unified School District website.
    - Established a relationship with the Sierra Sun newspaper to submit monthly articles for publication, focusing on stigma reduction and mental health and wellness.
- KTS endeavored to reach 5,000 people by 2015 (5,000 by 2015!). Over 4,000 received a face-to-face KTS in-service training in Truckee.
- Approximately 120 Nevada Joint Union High School District Non-Classified Staff were trained in YMHFA.
- Approximately 92 people were trained in MHFA including Sierra Community College.
- ASIST workshops were provided in Grass Valley and Tahoe Truckee. Forty-five people were trained in suicide intervention skills, including Nevada County Crisis workers.
- SoS Bear River High School (BRHS) SuicideTALK gave an hour and a half presentation to SoS Peer Leaders. SuicideTALK encourages open and direct talk about suicide.
- SoS BRHS and BRHS GSA co-sponsored an educational performance at a school assembly called "Dis/Connected" by New Conservatory Theater. "Dis/Connected" looks at the dynamics of friendship, peer pressure, diversity, labeling, stereotypes, harassment, and growing up in this highly technological age. (200 students)

- Community Outreach, Counseling, Support and Education in Tahoe Truckee: Community meetings, a multi-county Public Health Officer letter, media stories of resiliency, letters to the editor about living with mental health illness - especially depression, guest speakers on suicide, death, and grief, how to talk to your kids, and the psychology of happiness and resiliency are some of the topics that were covered in FY 14/15.
- Greif Workshop/Parent & Community Forum in North Tahoe: Supporting Ourselves and Our Children in Difficult Times, a community discussion about mental health and community resources was held. Speakers addressed topics ranging from how to talk to your children about suicide to depression, to self-care during grief and sadness. The workshop featured Dr. Kim Bateman, Jackie Hurt-Coppola and a panel of community mental health experts. (200 people attended)
- Mental Health in the Mountains: A six session educational series on mental health was held in Tahoe Truckee. Sponsors included Youth Suicide Prevention Coalition, Tahoe Forest Health System's Wellness Neighborhood, North Tahoe Family Resource Center, Family Resource Center of Truckee, Tahoe Truckee Unified School District, UC Davis Tahoe Environmental Research Center, Sierra College and the Community Collaborative of Tahoe Truckee. The first session, held in Tahoe City was on The Science of Happiness and included a lecture, Q&A, and a Screening of the film "Happy". This program focused on positive psychology and building up resiliency.
- Crisis Response (Tahoe): A regional approach to working closely with local governments and Health Officers in El Dorado, Placer and Nevada counties was provided. This activity was provided to alert, without alarming, health care providers, including mental health professionals, about supporting our most vulnerable community members.

**Activity 2: Integrated Behavioral Health (IBH) Training for Primary Medical Care Providers** – No activity in FY 14/15. Plans are being made to remove this from the plan.

**Activity 3: First Responder Training**

**Mental Health First Aid (MHFA) Training** is an evidence based, community proven training provided to first responders. "First Responders" may respond to an individual in crisis in their home, on the streets, at school, on the job, at church, etc. "First Responders" are often the facilitators of mental health services for people in the community. The MHFA Training provided increased first responder's ability to care for and properly refer individuals who may not otherwise receive mental health services. In fiscal year 2014/2015 two Law Enforcement and two Adult focused Mental Health First Aid Trainings were held. A total of 52 individuals were trained.

**First Responder Training - Crisis Intervention Training (CIT)** is provided to patrol officers, correctional staff and juvenile hall staff who may work with mentally ill individuals in crisis. The intent is to increase knowledge and skill levels in this area. During fiscal year 2014/2015, eight separate Crisis Intervention Trainings were provided to 117 attendees in Nevada County.

Trainings focus on understanding and working with high risk program participants who encounter law enforcement frequently or during intense events, while incarcerated or on the street. Emphasis is on effective response to deescalating agitation and reducing risk of injury to individuals and first responders. Other focal points in the training are on conducting more accurate field evaluations of suicide risk and identifying acute symptoms. Resources and referral options are also provided to trainees. Trainings are conducted by a licensed mental health

professional, teamed with a law enforcement instructor. Peace Officer Standards and Training (POST) hours are provided to the sworn officers.

**Demographics:** All 117 individuals served were Adults (ages 26-59), who spoke English as a Primary Language. Trainings were provided to 25 juvenile hall and correctional staff. Other trainings were provided to 92 sheriff's department patrol and correctional staff.

**Barriers/Challenges:** Organizing training times to meet law enforcement shift work and mandatory existing training schedules was challenging. Arranging and accessing training facilities and preparing materials and presentations to meet specific training requests was also at times demanding.

**Solutions to Barriers**: Working with training providers, law enforcement administration and training officers was helpful in overcoming barriers. Providing consistent efforts to interject Crisis Intervention Training into administrative scheduling, as well as allowing adequate time for training preparation has also been beneficial.

**Outcomes/Successes:**

- The program reduced fear and anxiousness and increased knowledge and skills for training participants.
- Participants learned the basics of mental illness.
- Individuals trained have more skills in de-escalating a crisis.
- Participants learned how to avoid injuries to themselves and others.
- Trainees learned to recognize the signs of mental health distress.
- Training results in avoidance of participant deaths (suicide prevention).
- Staff were trained about referrals and how to link mentally ill individuals to appropriate resources.
- Further requests for additional trainings were received.
- Training was provided to over 100 individuals in formal training events.
- Training plans for future first responder events were established.

**Activity 4: Nevada County 2-1-1**

**2-1-1 Nevada County** is a resource and information hub that connects people with community, health and disaster services through a free, 24/7 confidential phone service and searchable online database. 2-1-1 Nevada County serves the entire population of Nevada County. 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. Utilizing a comprehensive computerized database of more than 1,282 nonprofit and public agencies at 1,739 different locations in Nevada County, trained information and referral specialists give personalized attention to each caller. Specialists can refer callers to a variety of services to best meet their needs.

On July 1, 2014 2-1-1 Nevada County began taking calls locally on a 24-hours-a-day, 365-days-a-year basis. Prior to that date, 2-1-1 Nevada County contracted with 2-1-1 Sacramento to handle calls after regular business hours. During this fiscal year, total call volume increased by 76% over the prior year. Increased call volume can also be attributed to specialized programs such as screening callers for emergency assistance services and providing CalFresh outreach

and education. 2-1-1 Nevada County's 2014/15 web search totals were up more than 44% from the prior year. People in search of resources can also contact 2-1-1 Nevada County through instant messaging on the website or by texting their zip code to TXT211.

**Demographics:** Of the 7,292 calls answered, 43%, were from individuals between the ages of 26-59, while 25% were from individuals 60 years or older, 5% were from Transition Aged Youth between 16-25 years old, .04% were from Children under age 16, and 28% were from people of unknown ages. Of these program participant contacts, 99% were of unknown ethnicity, while .8% were Latino/Hispanic. The racial breakdown of callers was 24% White, .4% American Indian, .2% African American, .1% Asian, .1% multi-racial, .3% other races and 75% of unknown race. All participants spoke English as their primary language, except four whose primary language was Spanish. The participants included 66 Veterans, 1,502 Homeless, and 868 with Disabilities. Sixty-seven percent of callers were Female, 28% were Male and 8% were of unknown gender.

**Barriers/Challenges:** Callers experiencing homelessness or on the verge of homelessness report high levels of stress, anxiety and agitation. A lack of sufficient affordable housing, both emergency and long-term, frequently presents challenges to call agents when they are unable to provide referrals to assist individuals with fulfilling this basic need.

Call agents are sometimes challenged with serving the needs of callers who may appear to be in need of behavioral health services, but aren't specifically seeking this type of referral. Instead they may be seeking other solutions to a web of problems they report. Although 2-1-1 Nevada County doesn't receive many suicidal callers, such calls do have the potential for raising the stress level for call agents during these brief, emotionally intense calls.

**Solutions to Barriers:** Training for call agents is being secured to better prepare them for handling behavioral health crisis calls, including suicidal callers. This will increase call agents' confidence in handling these calls and reduce their stress levels. The call center manager attended QPR (Question, Persuade, Refer) training and has been a resource to agents on this subject. The Resource Specialist recently attended Mental Health First Aid training. In addition, staff will be attending the safeTALK training in August and future offerings of Mental Health First Aid.

**Outcomes/Successes:**

- The total number of service calls as they relate to MHSA Prevention and Early Intervention in FY 14/15 were 7,292.
- In addition 105,555 web searches were conducted by individuals on the 2-1-1 Nevada County website.
- A total of 11,673 behavioral health resources were accessed by callers and web users during this period.
- At the conclusion of each call, the call agent requests that the caller call back if the referral(s) received doesn't work out for him or her, so additional referrals may be made.
- A warm hand-off option was instituted this year and is routinely offered to callers to directly connect them with the resources needed. Behavioral health crisis calls are always warm transferred to a crisis line. Non-crisis callers appreciate the ease of connection this affords. Those who struggle to navigate automated phone menu options also appreciate the additional customer service received from 2-1-1 through the warm transfer option. During the past year, callers accepted offers of warm transfers 697 times.

- Because there is no charge to dial 2-1-1 from a pay phone, callers are able to access 2-1-1 and can then request transfer directly to county Social Services or Behavioral Health.
- Call Agents made 84 follow up calls to individuals this year.
- Through telephone calls, web searches on 211nevadacounty.org, instant messaging and texting, 2-1-1 Nevada County program participants and agencies seeking services for individuals received referrals to behavioral health services at any time, day or night, 365 days a year.
- The primary resources most searched for by 2-1-1 Nevada County users during the year were Housing & Shelter (1,343 calls and 20,869 web searches), Aging & Disability Resources (722 calls and 16,199 web searches), and Medical Services (740 calls and 12,088 web searches).
- 2-1-1 Nevada County provided a total of 11,673 resources to individuals requesting Behavioral Health services as follows:
    - Counseling Services – 3,840 referrals
    - Substance Use – 3,041 referrals
    - Support Groups – 2,936 referrals
    - Domestic Violence Services – 1,463 referrals
    - Crisis Hotline – 393 referrals
- Healthcare referrals provided by 2-1-1 in FY 14/15 were as follows:
    - Clinics & Hospitals – 6,419
    - Personal Care – 1,924
    - Pharmacy – 1,525
    - Physician – 1,245
    - Public Health – 817
    - Insurance – 763
    - Vision – 683

# *Prevention and Early Intervention: Outreach Projects*

### Activity 1: Social Outreach (Disabled and Older Adult Outreach)

The **Social Outreach (Disabled and Older Adult Outreach) Program** is funded by the Mental Health Services Act, working with the Falls Prevention Coalition as a component of the Prevention and Early Intervention (PEI) Program.

***Friendly Visitor Program*:** This program is designed to provide prevention and early intervention, mental health services by reducing isolation in seniors and people with disabilities. Isolation can be geographical or social and lead to depression, anxiety, and other health issues. By intervening and providing community contact, this program increases the mental and physical health of individuals who are at risk.

Friendly Visitor volunteers are matched with program participants and provide peer support and community engagement primarily through weekly home visits and phone calls to isolated individuals. The program is administered by FREED Center for Independent Living, an organization that provides a program participants driven, peer support model of services to people with any type of disability in the community, including mental health.

The Friendly Visitor Program impacts the community in three distinct ways: 1) It brings members of the community to an individual, reducing isolation and improving mental health; 2) It mitigates and prevents, in many instances, the reliance on more costly services and complements other mental health programs such as the Senior Outreach Nurse by providing social contact and; 3) It connects individuals who are isolated and at risk of depression, anxiety, and suicide to other mental health and community services so that they can remain living safely in the community.

Referrals are received through a variety of agencies and family members. The Friendly Visitor Coordinator meets with the program participants in their home and gets to know their needs and interests, and then matches them with an available volunteer. All volunteers have completed applications, interviews, back-ground and reference checks and are expected to spend a minimum of an hour a week visiting with their matched program participants. Many volunteers spend several more hours each week then is mandated. Volunteers attend an orientation on consumer-centered services as well as regular monthly trainings and volunteer support groups.

**Demographics:** In fiscal year 2014/2015, 43 unduplicated c program participants received services. Females comprised 72% of participants, while 28% were male. All of them identified as having at least one disability. Ninety-five percent were older, Caucasian adults who spoke English. Two percent were Japanese and 7% of the program participants were Veterans.

**Barriers/Challenges:** Monthly volunteer support groups and trainings were poorly attended.

**Solutions to Barriers:** Monthly meeting going forward will be held on a regular day and time based high attendance last year, the fourth Tuesday of each month. This should help reduce scheduling conflicts.

**Outcomes/Successes:**

*Program participants:*

- There were 43 volunteer- program participants matches made.
- There were 76 individuals served.
- There were 957 home visits made.
- There were 118 phone calls made.
- There were 1,430 hours of in-home visitation.
- The consumer survey reported:
  - 85% of program participants contacted, participated in the survey.
  - 100% of respondents felt their quality of life had improved because of the visits.
  - 100% indicated that they felt less depressed due to receiving visits.
  - 95% said that they felt less anxiety because of the weekly visits.

*Volunteers and Volunteer Training:*

- Volunteers are interviewed and have reference and background checks and are given orientation training.
- This year, 46 active volunteers participated in the program.
- There were six volunteers in the Truckee area, but no program participant referrals for the program in Truckee. Some of the Truckee area program participants may live in Placer County and be receiving services there, while others may require a Spanish speaking volunteer. Some Truckee area volunteers are willing to be matched with western Nevada County program participants.

- Monthly Volunteer Support Group Meetings were held.
- FREED provided four group trainings to volunteers in FY 14/15. Topics covered included:
  - Companioning Skills
  - Depression Among Older Adults
  - Older Adults and Substance Use
  - Hoarding
  - Suicide Prevention
  - Honoring Memories
  - Workshop on serving people with disabilities, seniors and the low- income population.
  - Workshop on the new managed care Medi-Cal Program.
- The volunteer survey reported:
  - 66% of volunteers contacted, participated in the survey. Rate was low due to several pre-scheduled vacations.
  - 95% of volunteers felt that the quality of their life improved by participating in the program.
  - 95% of volunteers felt comfortable talking directly about depression with the person they visited.
  - 100% of volunteers felt comfortable talking directly about anxiety with the person they visited.
  - 90% of volunteers felt comfortable talking directly about suicide with the person they visited.

**Focus for Fiscal Year 2015-2016:**

- The Friendly Visitor program would like to shift focus to younger people who have disabilities and are socially isolated. Staff is working closely with John Pillsbury at Sierra College and Special Ed teachers at the high school level who have students who are at least 18 years old.
- Another goal is to successfully provide support groups and ongoing training for volunteers, rotating on different days/times to accommodate different schedules.
- The program would like to offer more Peer Support groups for program participants at FREED.

***Social Outreach Nurse Program*:** This program is funded by the Mental Health Services Act, working with the Falls Prevention Coalition as a component of the Prevention and Early Intervention (PEI) Program. The program is in its sixth year and continues to be recognized as an important resource that benefits the senior and disabled populations in the local community.

The Social Outreach Nurses do a Mental Health/PEI Screening on all new program participants unless the individual has dementia. They also visit seniors and disabled adults primarily in their homes, where the vast majority live alone. Some of the many challenges they are dealing with are: isolation, loss of independence, grief, declining health issues, limited financial resources and family conflicts.

The Social Outreach Nurse assesses for depression, anxiety, and fall risk while building rapport with the individuals. Part of the depression assessment may include a Geriatric Depression Scale (Yesavage). The nurse provides support by listening, advocating and making referrals to various public and private services. The number of visits and phone contacts vary with each person based on need. Follow up "check in" calls are frequently done and the participants are always

encouraged to call if any needs arise. Program participants sometimes call after several months when they need assistance, circumstances change or they need someone to talk to.

An integral part of this program is Outreach. This happens through networking with other individuals and organizations. This year the Social Outreach Program initiated a monthly presentation at a senior apartment complex. Each month a different topic, chosen by the residents, was presented by various guest speakers. Topics included, Aging - What to Expect and Resources Available, Advance Directives, Assisted Living and Caregiver Options, and next month's presentation will be on the In-Home Supportive Services (IHSS) and Adult Protective Services (APS) programs presented by County Social Workers. These Presentations have been very well received as they not only provide valuable information and opportunities for questions and answers, but they also bring neighbors together.

As part of the on-going Outreach and Education the Social Outreach Nurses attend meetings, trainings, seminars and workshops.

- Meetings: Falls Prevention Coalition, Adult Services Unit Meetings, Social Outreach Nurse's Meeting, Elder Care Provider's Coalition (ECPC), Community Networking Meetings, MHSA Steering Committee, Truckee Community Collaborative Meetings.
- Presentations: Grass Valley Ladies Relief Luncheon, Beginning in the 40, conducted monthly Presentations at a Low Income, Apartment Building for residents on various topics around aging and resources available.
- In-services/Classes Attended: HIPAA Training, Child Abuse Mandatory Training, Hospice Liaison Donna Brown, Healing Journey's at Sierra Nevada Memorial Hospital, Six Week Stress Management class with Marge Kaiser MA CHT through IHSS.
- Seminars/Trainings: SBIRT - Screening, Brief Intervention and Referral for Treatment and Motivational Interviewing, ASIST - Applied Suicide Intervention Skills Training, PESI - Hoarding Disorder, ECPC The Caregiver's Journey Continues … Alzheimer Conference.
- Online Trainings: UC Davis Extension: Civil Rights Division 21- Nevada County 2015.

**Demographics:** In fiscal year 2014/2015 the Social Outreach Nurse Program served 70 people. Of those, 10 were Adults ages 25-59 and 60 were Older Adults ages 60 plus. Fifty-six were female and 14 were male. Sixty-nine individuals were Caucasian and one was African American. All individuals reported English as their primary language. Thirteen people reported having Disabilities, four were Veterans, three had HIV/AIDS and one was gay.

**Barriers/Challenges:** The lack of available psychiatrists in the local area is a challenge.

**Solutions to Barriers:** This program utilizes Licensed Clinical Social Workers who, in some cases are able to make home visits. This is a tremendous benefit that reaches program participants that would not have access to therapeutic services otherwise.

**Outcomes/Successes:**

- There were 70 individuals served in FY 14/15.
- This fiscal year the nurses screened 137 program participants and referred 21 to the Social Outreach Program. Other referrals came from Adult Protective Services, Social Workers from Sierra Nevada Memorial Hospital and Home Care Agencies, FREED, In Home Supportive Services, Public Authority, as well as families and individuals themselves.
- 100% of the individuals served were under the care of a primary physician and were seen within the past year. Many were being followed by specialists as well.

- There were 26 Geriatric Depression Scale (Yesavage) screenings done;
  - Two of the participants were within the normal range; four indicated moderate to severe depression and the remaining had mild depression.
  - Two who indicated moderate to severe depression, with increased socialization and counseling were later screened again and indicated mild depression.
  - One participant continues to have moderate depression as a result of numerous challenges. She is currently responding to counseling and making changes in her life.
  - The fourth person who indicated moderate to severe depression did not have a follow up screening but did verbalize that he is doing better and declined various referrals.
- Most of the program participants whose general well-being improved were utilizing various resources, including counseling, Friendly Visitor Program, and/or Caregivers.
- Improvement was also seen in individuals who were working on family relationships and who had increased socialization.
- The response from the six participant surveys returned indicated:
  - 100% benefited emotionally from the social visit
  - 100% looked forward to the visits
  - 100% would recommend the program to a friend
  - The referrals that program participants said they benefited from included: counseling, Social Outreach Nurse, Friendly Visitor, Falls Prevention Event, IHSS, Meals on Wheels (MOW), Domestic Violence and Sexual Assault Coalition (DVSAC), and Primary Care Physician.

**Activity 2: Latino Outreach**

**Latino Outreach:**

In **Western Nevada County** the Latino population is growing. In accessing Spanish speaking resources, Behavioral Health believes that this population is underserved, especially with mental health services. The Grass Valley Family Resource Center serves the Latino population in the area. The Family Resource Center's Promotora Program conducts 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. Meetings take place at the Family Resource Center and the Grass Valley Charter School, facilities of the Nevada County Superintendent of Schools (NCSOS).

In FY 14/15 the program conducted psycho-educational meetings to increase knowledge and reduce stigma related to mental health. Family Resource Center Promotora staff facilitates the use of appropriate community resources by helping with translation, scheduling appointments, and initiating referrals. Staff collaborated with local community agencies to translate services for participants.

Also, part of this program are NCBH Spanish speaking therapists in Grass Valley to which the Promotora can refer individuals and families. The therapists provide services to individuals or if the program participant is a child, services are provided to the child and their family.

**Western County Demographics:** In FY 14/15 NCBH's Latino Outreach therapists served 19 people in Grass Valley. Nine individuals were female, eight were male and two did not specify their gender. Seven of these individuals were Children, ages 0-15; one was TAY, age 16-25; and 11 were adults, ages 26-59. The ethnic breakdown of these individuals was: nine Mexican-

American, seven other Hispanic/Latino, one Non-Hispanic and two of unknown ethnicity. One individual categorized themselves as Caucasian, five were of unknown race and 13 individuals were of other races. Fourteen people spoke Spanish as their primary language, while two spoke English and three did not specify a language. Three of those served had disabilities.

In FY 14/15 NCSOS's Latino Outreach program served 234 individuals. Of these individuals 112 were Children ages 0-15; 18 were TAY, ages 16-25; 99 were adults, ages 26-59; and five were Older Adults, ages 60 plus. The genders reported were 88 female, 33 male, one trans-female and 112 of unknown gender. The Race and Ethnicity breakdown of these individuals was: 227 Mexican-American, four South American, three Central American, and all were Caucasian. All of the program participants spoke Spanish as their Primary Language (n=234). One individual reported being gay and three reported having disabilities.

**Barriers/Challenges:**

- There is still a language barrier for participants to access and integrate into the educational and health care systems. Mental health still has a negative cultural connotation.
- Many participants don't know about health care resources, and those that do may have difficulty accessing resources.
- Outreaching to new audiences, as well as gathering and maintaining the interest in discussing mental health disorders with the existing audience is challenging.

**Solutions to Barriers:**

- Staff make the psycho-educational meetings attractive by addressing how lifestyle impacts mental health. i.e., diabetes and mood, exercise and depression, or they present the meetings as a prescription for wellness.
- The program finds Spanish speaking professionals to present mental health topics.
- The team stays up-to-date on trends in healthy lifestyle and pairs them with mental health.
- Staff serve the community through translation, applications, information, and referrals.

**Western County Outcomes/Successes:**

- The Exercise Club is self-sustaining, meeting bi-weekly with five to ten members. The Promotora met with the club six times in "Sanamente Conversation Starters" in FY 14/15.
- The Latino community rallied to collect food for two refugee families not eligible for any aid.
- The Partners Family Resource Center provided 177 services this year.
- Psycho-educational meetings were held 26 times with a total attendance of 206, excluding children. Sixteen participants in the groups or individually made WRAP plans in three sessions, meeting 13 times.
- Knowledge of the symptoms of depression, anxiety and mania were increased. A meeting on Food and Mood dealt with depression, nutrition and diabetes. Several meetings dealt with anxiety and stress reduction through the practice of Yoga. Another meeting dealt with stress and anxiety relating to child abuse. Not only did these meetings increase the participants' knowledge, but also their comfort level in speaking and sharing their concerns about these issues. A post-test response from one participant in the Yoga meeting was: "This has helped me relax and reduce back pain due to stress." Another said: "I can sleep better".
- There was an increase in knowledge of substance use and treatment resources available in Nevada County. During the meetings there is time for announcements when the availability of treatment and resources is advertised. At large meetings, a resources sheet and blank

cards are passed out. Requests for referrals are left in a slotted box for discretion. People feel comfortable to share their concerns about alcohol abuse in the community and/or in their families with the Promotora. One person felt so comfortable and supported that she referred her mother for detox.

- Participants demonstrated a knowledge of mental health treatment resources available in Truckee and Nevada County. The Nevada County Emergency Resource Numbers sheet was available and given out at all the meetings. On one occasion, since the sheet did not include the 1-888 number for Spanish Suicide Prevention, the number was added by the participants to the sheet using a memory game to aid in memorization.
- There was increased comfort in talking about depression, anxiety and mania. For example a "Conversation Starters" in Spanish from "Each Mind Matters" was used in the Exercise Club. This facilitated a lively discussion where stigma of mental illness disappeared and comfort in speaking about these disorders increased.
- The level of comfort in talking about suicide was enhanced. "Know the Signs" materials were used to outline the warning signs, find the words, and reach out to find help for those with suicidal thoughts. Thirteen people attended and felt comfortable enough to open up and talk about their own experiences with relatives and others. They even stayed past the time of the meeting dismissal.
- Ten Spanish Speaking referrals were made to a Nevada County Mental Health Bilingual professionals for treatment in FY 14/15. Some individuals were transported and accompanied to their first appointment as a warm hand-off, while others received help in making their first appointment. Additionally, with the education and information shared during meetings, some people felt comfortable self-referring, setting aside the stigma of mental health and reaching out for help.
- One hundred and twenty-two individuals received mental health education and/or resources through the many meetings held during the year.

In **Eastern Nevada County** the Family Resource Center of Truckee (FRCoT) Promotoras continued to see success in their outreach and education work in the Latino Community during the 2014/2015 fiscal year. The Promotoras are all dedicated to, and passionate about, serving the local Latino community. The program provides mental health education/stigma reduction workshops. Promotoras participate in capacity building trainings based on health and mental health outreach and education, including Chronic Disease Self-Management and Crisis Intervention. Latino Outreach promotes and supports the Family Room as a place to build networks of peer support and to break out of the isolation of parenting. The FRCoT provides referrals for community members to local mental health providers and the Family Advocates of the FRCoT.

Also, part of this program are NCBH Spanish speaking therapists in Truckee to which the Promotoras can refer individuals and families. The therapists provide services to individuals or if the program participant is a child, services are provided to the child and their family.

**Eastern County Demographics:** In FY 14/15 NCBH's Latino Outreach therapist in Truckee served 53 program participants. Thirty-four of these individuals were children ages 0-15; six were TAY, ages 16-25; 12 were adults, ages 26-59; and one was an older adult 60 years old or above. Of the participants 29 were female, 15 were male and there were nine of unknown gender. The Race and Ethnicity breakdown of these program participants was: 51 Mexican-Americans, one other Hispanic/Latino, and one Non-Hispanic/Non-Latino, 24 Caucasians, eight reported other races and 21 were of unknown race. Eighteen people spoke English as their

primary language, 15 spoke Spanish and 20 did not list their primary language. Nine of the individuals reported having a disability.

In FY 14/15 FRCoT's Latino Outreach program served 41 individuals. Fourteen of these were children, ages 0-15; eight were TAY, ages 16-25; 16 were adults, ages 26-59; and three were Older Adults, ages 60 plus. All 41 individuals reported Mexican/Mexican-American/Chicano as their Ethnicity, unknown as their race, female as their gender and Spanish as their Primary Language. One participant reported having a disability.

**Barriers/Challenges:**

- There is little local access to diverse mental health resources.
- Transportation is an ongoing challenge.
- Cultural barriers and differences keep individuals from seeking treatment and/or opening up.
- Promotoras are not always available when needed.

**Solutions to Barriers:**

- Referrals were made to a local community parenting consultant and home visitor with Truckee-Tahoe Healthy Babies for peer counseling.
- NCBH staff provided bilingual services at the FRCoT.
- Public transportation programs were utilized as much as possible.
- Promotoras divided up their tasks to help cover for one another.

**Eastern County Outcomes/Successes:**

- Four mental health education/stigma reduction workshops were provided to a total of 41 participants.
- Increased knowledge of mental health issues in the Latino Community: The Promotoras evaluate the success of their workshops by assessing program participants' knowledge of mental health and local resources before and after the Promotora Workshop. By using an informal testing model based on conversation, the Promotoras are able to gain an honest narrative through a means that is not intimidating or daunting. 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, staff gains 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 result of this fiscal year's pre and post workshop conversations was that 100% of regular participants (who came to three or more sessions) increased their knowledge of mental health issues.
    - Throughout the duration of each workshop, group participants write down questions, issues, concerns or recommendations and submit them anonymously at the end of each session. This method helps the Promotoras to assess group needs and participant understanding of topics covered. The Promotoras in conjunction with FRCoT staff use the information gathered through these anonymous questions and those raised during discussions to determine indicators and select outcomes.

- Increased networks of peer support and increased confidence and ability: Family Room – Final evaluations at the end of the year reflected that all participants felt more connected to peers, other families and resources through their participation in the Family Room.
- Consumer Satisfaction Surveys showed 58% of individuals specifically mentioned new friends as the greatest benefit of the workshop.
- 100% of participants present for the post-workshop conversation reported feeling more confident, able, and connected.
- Narrative reports provided by the Promotoras from program participants reflect the benefits of a peer network of support. They speak to alleviating the isolation of parenthood for many community members and the increase in comfort maneuvering within the Truckee community and utilizing the resources available to them.
- Increased capacity of Promotoras:
  - Three Promotoras completed five days of Crisis Intervention Training with Tahoe Safe Alliance.
  - Four Promotoras completed six sessions of the Chronic Disease Self-Management Program in Spanish, Tomando Control de su Salud. They will be trained as leaders this September. There is a chronic mental health component to the Program.
  - Three Promotoras completed the Paraprofessional Development Series as a part of the North Tahoe Family Resource Center (NTFRC)/FRCoT and Tahoe Forest Hospital regional Promotora project.
- The program continues to grow and stabilize as its structure and capacity improves with the Promotoras.
  - One new Promotora was brought on-board.
  - Two additional new Promotoras are in the contract process.
  - There is increased participation and increased involvement in the Family Room.
  - Expansion of Promotora programs have been offered, including additional health workshops and community programs.
  - Collaboration and partnership with NTFRC, Tahoe Forest Health District (TFHD), and Placer PEI.

**Activity 3: Homeless Outreach**

The **Homeless Outreach Program** provided by Hospitality House Homeless Shelter (HH) also known as Utah's Place serves unsheltered individuals through many routes of engagement; social networking at food banks, bus stops, homeless camps, libraries and public parks, word of mouth referrals, law enforcement referrals, shelter guests and community referrals. This Access and Linkage Program utilizes an Outreach Coordinator to go where the homeless are to engage with them in order to reduce their risk of harm and enhance safety (e.g., provide sleeping bags on cold nights); to stabilize acute mental health symptoms via crisis intervention; and to offer other referrals as needed.

**Demographics:**
HH provided services to 249 individuals in FY 14/15. Of those, 11 were Children ages 0-15, 72 were TAY ages 16-25, 114 were Adults ages 26-59 and 52 were Older Adults ages 60+. Fifty-one females and 198 males were served. The Race and Ethnicity of these individuals was broken down as follows: 229 Caucasians, six Latino/Hispanic, four Native Hawaiian/Pacific Islanders, two African American, two Native American, and six of "other" races and six of unknown race. The primary language spoken by 245 of those served was English, while Spanish was the primary language of four individuals. Many unique cultures were served by Homeless

Outreach including: 10 veterans, 82 individuals with disabilities, 14 people with substance use, 27 with criminal/legal system issues and two dealing with domestic violence. The number of homeless individuals and families served in Western Nevada County was 248. The number served in Eastern Nevada County was one. Of these, 181 were chronically homeless.

**Barriers/Challenges:**
Hospitality House received a number of calls/complaints regarding homeless encampments located on both public and private lands. It continues to be a challenge to manage these calls as most reporting parties are motivated by a desire to evict and convict the campers, which is not a role that HH Outreach is available to play.

**Solutions to Barriers:**
The willingness of the Outreach Coordinator to respond quickly to these calls does a lot to minimize the fears and concerns of the community at large.

**Outcomes/Successes:**
- In FY 14/15 2,300 contacts were made with homeless on the streets or in the camps.
- Transportation was provided 524 times in the form of bus passes and/or rides to needed appointments.
- There were a total of 195 referrals made to individuals and families including:
  - Salvation Army - 34
  - Public Defender - 27
  - Hospitality House Housing Program - 21
  - Western Sierra Medical Clinic/Sierra Nevada Memorial Hospital - 17
  - Behavioral Health - 14
  - Social Services - 14
  - Other - 12 (outside substance use recovery centers)
  - Common Goals - 10
  - CoRR - 8
  - DMV - 8
  - Spirit Center - 6
  - Social Security Administration - 4
  - Veteran's Services - 1
- 100% of individuals received services from the referred agency: 195.
- 60% of chronically and severely mentally ill individuals received psychiatric services: 14 out of 23.
- 25% of homeless individuals and families found stable permanent housing: 48.
- 95% of chronically and severely mentally ill were assisted with Social Security applications by the Outreach Coordinator (those not already receiving benefits).
- 80% of those with a drug problem were offered drug treatment services.

**Activity 4: Forensic Outreach**

**Forensic Specialist Services** aim to prevent and decrease law enforcement contact and incarceration for individuals experiencing mental health conditions. Services provided are assessment of needs and obstacles, referrals to community resources, support accessing drug and alcohol 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, CoRR, Common Goals, NAMI, SPIRIT and other social service providers.

**Demographics:** During FY 14/15 there were 46 people served under this program. Men comprised 21 of the individuals, 13 were female and twelve were of unknown gender. Twenty-eight were adults (ages 26-59), two were TAY (ages 16-25), eight were older adults (60+) and eight were of unknown age. The Race/Ethnicity of these individuals was mostly Caucasian (n=26), with many (n=18) Unknown, and one Latino/Hispanic. Almost all (n=37) were English speakers, with one Spanish speaker and eight unknown. There were eight homeless individuals, four Veterans and 15 with disabilities.

**Outcomes/Successes:**

- There were a total of 23 referrals in FY 14/15.
- Of all individuals seen this year:
    - Ten were assessed for services
    - Two were ineligible for services
    - Three engaged in services
    - Twelve refused, declined or did not call back
    - Three had medical treatment
    - Four had mental health treatment
    - Two received help with Social Security
    - Eleven received substance use treatment
    - Thirteen were given help with housing
    - Three received warm handoffs
    - There were a total of 29 follow-ups made by Forensic staff

**Activity 5: Wellness Center: Peer Support and Outreach Services**

**Wellness Center – Truckee Tahoe Unified School District (TTUSD)** provides Peer Support & Outreach. The TTUSD Wellness Program is a collaborative project between the TTUSD, Placer and Nevada Counties, Community Collaborative of Tahoe Truckee partners and youth designed to help high school students build protective factors, reduce risk factors/behaviors and increase access to a broad spectrum of mental health services. The program is financially supported by both Nevada County and Placer County and is comprised of Wellness Centers at Truckee High School and North Tahoe High School and individualized wellness programming at Sierra High School. The Centers serve as hubs for high school students to talk with caring adults, connect to community resources and learn new skills to develop sustainable wellness practices.

Key Services include:
1. YOUTH VOICE: a peer mentor program at the three high school sites provides students with skills to better support themselves and their peers. This service gives students an authentic voice in shaping school and community initiatives.
2. SUPPORT: trained Wellness staff and volunteers from community agencies listen to, support and connect students to community health and wellness resources.
3. EDUCATION: Wellness Workshops provide students with practical tools to improve their overall health. Topics cover the range of social, emotional, mental and physical healthy choices and lifestyle tools, such as: Healthy ways to deal with stress, Heart Math, Suicide Prevention Training, Being the Change, and Bullying Prevention.

The Sources of Strength Program (SOS) helps prepare adolescent, peer leaders to change school norms, and connects suicidal youth to capable adults at school and within their community. Trained "peer leaders" change student norms regarding the acceptability of suicide throughout these Truckee schools. The program enables help-seeking and youth-adult communication by conducting a set of well-defined messaging activities with ongoing adult mentoring. Trainings and weekly clubs are facilitated where students get together to organize meaningful activities that educate and support their peers.

**Demographics:** In fiscal year 2014/2015 TTUSD's Wellness Program at the Wellness Center served 1,098 students. Of those, 807 were Children between 0-15 years old and 291 were Transitional Aged Youth between 16-25 years old. Most were Caucasian and spoke English as a Primary Language (n=677), while many were Latino/Hispanic and spoke Spanish as a Primary Language (n=421). The gender split was 587 females vs. 511 males. Eight of the students identified as bi-sexual.

**Barriers/Challenges:**
The primary barrier was receiving referrals and staying in close communication with some of the school counselors. Counselors were very busy and did not have a lot of time to meet with Wellness Staff to coordinate services and communicate about students. At times, the Wellness Center felt disconnected from the rest of the school.

There were some scheduling challenges for the SOS trainers to present to students. It was a struggle to find dates that worked well for the trainers and the students. At Truckee High School, an SOS training was scheduled, but unfortunately not enough students returned their permission slips so the training had to be cancelled.

**Solutions to Barriers:**
Student Care Coordination Teams have been created to improve communication between Wellness Staff, School Counselors, School Psychologists and relevant community service providers, such as Nevada County's What's Up? Wellness Checkups Program. The plan is to meet regularly to case manage and provide a continuum of support for the highest need students. This is part of a new initiative to expand the Wellness Centers into Wellness Hubs to truly create a single access point for students to connect with peer mentors, health screening, school-based behavioral health, health coverage, primary care and reproductive health services. This initiative is being spearheaded by Tahoe Forest Hospital and is closely linked with Nevada County and Placer County Behavioral Health Services. The overall goal is to expand current Wellness Programming to make it more integrated in the school and community health systems.

Next year, all of the SOS training dates will be scheduled ahead of time so the trainers will have them calendared and can appropriately plan for them.

**Outcomes/Successes:**
- OUTCOME #1 - YOUTH: The program surpassed the contractual goal of training 50 youth. A total of 76 youth were trained in peer mentoring and leadership skills to better support themselves and their peers, as well as have authentic voices in shaping school and community initiatives. Activities included:
  - Creating opportunities for 21 youth to speak/share their voice at county and community meetings.

- Training 44 youth in peer mentoring and helping skills.
- Training 73 youth in leadership skills at the Youth Leadership Summit.
- Supporting students in designing and leading their own projects, such as 9th Grade Peer Mentor Groups and Pathways presentations.

- OUTCOME #2 - SUPPORT: The program again, surpassed the contractual goal of linking 50 youth to community resources. New connections and/or support was given to 540 students at Truckee High, North Tahoe High, Sierra High and Community School through assemblies, workshops, groups, clubs, peer mentoring, tutoring and lunch time socialization.
  - In-depth work was done with 53 students to listen to, support and help them improve their social, emotional and mental health.
  - Linkage to outside community resources was provided to 18 students including referrals to: EMQ FamiliesFirst therapy, Nevada County Behavioral Health, Child Protective Services, Teen Clinic, What's Up? Wellness Checkups, Adventure Risk Challenge (ARC), Family Resource Center and Boys and Girls Club.
- OUTCOME #3 - EDUCATION: The program successfully surpassed the contractual goal of teaching practical tools to improve overall health and well-being to at least 200 youth. Thirty-five educational presentations were offered to 329 youth and adults on the following topics: Heart Math, Mindfulness/Stress Reduction, Self-Empowerment, Know the Signs (of Suicide), Healthy Kids Survey, and LGBTQ.
- The SOS program served 558 individuals in FY 14/15.
  - At Truckee High and North Tahoe High:
    - Staff trained 29 Truckee High and 22 North Tahoe High students in peer helping skills.
    - Staff trained 13 students in the Middle School SOS curriculum.
    - Ten SOS students attended the Community Collaborative Youth Café and engaged in meaningful conversations with community leaders about mental health and substance use issues for youth.
    - SOS students launched a school-wide Love Campaign to promote the message of treating each other with respect and kindness.
    - SOS students organized a Positive Messaging Campaign during Valentine's Week.
    - Seventeen students attended the REACH Leadership Conference in Chico, Ca. The students spent three days learning about themselves and how to be leaders.
    - SOS students helped design the Youth Leadership Summit and recruit students to attend. Students also participated in a follow-up group to determine next steps and generate ideas for next year.
    - SOS students designed and launched a new website where students can anonymously ask questions. Many conversations revealed that young people don't always feel safe asking for help face to face. It was felt that more students might seek help if they could ask for it online and anonymously.
    - Students created signs about "Asking for Help" and "Not Being Alone" with a link to the new website. The signs were posted all over the school.
  - At Sierra High:
    - The SOS club focused on creating a positive school climate. The group met at least twice monthly throughout the quarter, more often if a particular event was happening. Club members checked-in regarding: status, atmosphere at school and any concerns. Members brainstormed about how to keep school cohesive, safe and fun.
    - Fifteen students were trained in SOS.
    - A positive messaging Holiday Party and Easter celebration were held.

- At North Tahoe School:
  - The SOS group met every other month. The students discussed school culture and ways to better support their friends. Instead of organizing school-wide activities, the group focused on having thought provoking conversations and providing individual support for its members.
  - Twenty students were trained in SOS and engaged in meaningful conversations.
- At Alder Creek Middle School:
  - The SOS students focused on spreading the message of SOS school-wide and building a stronger, more supportive school community.
  - Twenty-five students were trained in SOS.
  - An SOS booth was organized and run at the Wellness Fair.
  - Students supported Kindness Week by organizing fun kindness activities and getting the word out to their peers.
  - Students organized a school-wide Movie Night for 58 kids to build and strengthen the school community.
  - An end of the year party was held.

- Cumulative Retrospective Survey Results (Surveys conducted at the end of 4th Quarter - 58 students):
  - 72% of students reported that they have an improved sense of safety and well-being from having the Wellness Centers on campus.
    28% of students reported that they had an improved sense of safety and well-being at certain times but not always.
  - 72% of students reported have improved feelings of self-worth by participating in Wellness Program activities.
    23% of students reported having improved feelings of self-worth at certain times by participating in Wellness Program activities.
  - 78% of students were able to meet new people and make new social connections through the Wellness Center.
    17% of students were able to make new social connections at certain times but not always.
  - 72% felt like they have more support in their life as a result of the Wellness Center.
    24% felt like they had more support at certain times.
  - When asked what is your biggest Sources of Strength:
    70% said Healthy Activities
    33% said Friends
    20% said Family
    9% said School
    4% said Other (computer, internet, myself)
  - 100% of students experienced a positive environment when they were in the Wellness Center.
  - 97% of students felt like the Wellness Center staff listened to them and treated them with respect.
  - 74% of students reported that they felt the Wellness Centers provided them with appropriate outside resources.
  - 26% of students felt this was not applicable to them.

## *Prevention and Early Intervention for at Risk Children, Youth, and Families*

**Activity 1: Teaching Pro-Social Skills in the Schools**

The **Nevada County Superintendent of Schools** brings the **Second Step** Curriculum into preschools of the Western Nevada County Region as a component of the County's MHSA Prevention and Early Intervention (PEI) Plan. This program brings Second Step social and emotional learning curriculum to preschools and transitional kindergartens.

**Demographics:** In FY 14/15, 540 children, ages 0-15 and 15 adults (teachers), ages 26-59 participated in Second Step at both new and continuing schools. Of those, 270 were female and 285 were male. Forty-nine were Hispanic or Latino including: one Central American, one South American and 47 Mexican/Mexican-American/Chicano. Non-Hispanic/Non-Latinos accounted for 506 participants including: one each Chinese, Japanese, Korean, and Middle Eastern, three each Eastern European and Filipino, five Africans, 469 Europeans and 22 other non-Hispanic/Non-Latinos. Races listed were three Native Hawaiian/other Pacific Islander, five each American Indian/Alaskan Native and Black/African American, nine multi-racial, ten Asian, 522 Caucasian and one other. The Primary Language of 516 of the participants was English, while 34 spoke Spanish, one each spoke Cantonese and Tagalog, and three spoke other languages.

**Barriers/Challenges:**
The first challenge is getting the initial commitment from schools to participate. Another challenge is scheduling the training sessions since preschool teachers, especially those at private centers, can have incredibly long days and often there is no extra money to pay for time beyond the normal schedule. The high teacher turnover rate in early learning presents another challenge to the program.

**Solutions to Barriers:**
Second Step staff met in person with prospective participants to present the program in such a way that they understood its incredible value and importance. Staff also showed how it is possible to add another piece into teachers' already very busy day. Trainings are held on site and at whatever times work with the teachers' schedules. Sometimes multiple trainings are held at the same site in order to reach everyone. Second Step also returns to retrain new teachers at schools where there has been teacher turnover.

**Outcomes/Successes:**
- In FY 14/15 540 children in 28 early learning classrooms, both new and continuing, participated in Second Step.
- Second Step curriculum was brought into seven new classrooms through teacher training and program modeling.
  - There were nine on-site trainings given to a total of fifteen teachers.
  - Second Step staff delivered the first two weeks of daily lessons in each of the seven classrooms. The teacher(s) were present so staff could model the program in the teacher's classroom with their children, working with their schedule.
  - Second Step staff met with the teachers at the end of each unit to support them, check-in with their progress and deliver curriculum-recommended storybooks for upcoming lessons.
- Second Step met at least twice with the twenty-one continuing sites started in past years.
- Second Step also meet with sites that were on hiatus (for various reasons) from the program.

- 99% of the children showed some growth in the social-emotional and self-regulation areas measured on the knowledge assessments.
- As a whole, improvement on the twelve knowledge assessment measures ranged from 66% to 86%.
- Of the teachers who could quantify a percentage, disciplinary issues were reduced by 48%.
- On a scale of 1 to 5, teachers rated the children's overall self-regulation growth as 4.1 and their social-emotional growth as 4.1. The second Step program overall was rated at 5.

**Tahoe Truckee Unified School District (TTUSD)** is entering its fifth year of implementation of the updated Early Learning-5 **Second Step** Curriculum, a curriculum that teaches social and emotional learning for children from preschool to 5th grade that was introduced in FY 10/11 into Eastern Nevada County elementary schools. With significant outcomes in FY 12/13 at Glenshire Elementary, the first elementary school to implement Second Step, this contract will continue to support all teachers, school staff and students at all elementary schools with the goal of full implementation in Early Learning-5 classrooms.

In FY 13/14 TTUSD piloted the Second Step Middle School Curriculum, "Student Success through Prevention," in two classrooms at the 6th, 7th and 8th grade levels at Alder Creek Middle School with the goal of full implementation of the middle school curriculum in succeeding years. Leveraging the familiar Second Step concepts and vocabulary that students experienced in elementary school provided a familiar framework and smooth transition for middle school students who, research shows, are especially challenged in the realms of social change and pressure. During these years, students witness and take part in more problem social behaviors than at any other time in their educational careers.

The Second Step Middle School Program aims to prevent or reduce aggression, violence and substance use 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 use.

The five themes in the middle school curriculum include: empathy and communication; bullying prevention; emotional management; action steps for problem solving, decision making and goal setting; and substance use prevention. The universal classroom-based program uses high-interest, interactive lessons to addresses the core competencies and problematic behaviors that have been shown to affect students' success in school and throughout their lives.

Early Adolescence is a key time for school staff to structure students' opportunities to think and talk with peers about social behavior. Research suggests that this may also be a good time to affect norms and values related to behavior. Evaluation of a previous version of the Second Step middle school program showed that Second Step lessons were associated with changes in student attitudes about aggression. Specifically, students who received these lessons were less tolerant of aggression than students who did not, and it was easier for them to use social emotional skills than students in the comparison group.

Outreach to the local pre-schools continues to occur at a slow but steady pace, with 75 pre-school students receiving the benefits of this program weekly. TTUSD's Transitional Kindergartens (TK) are seeing the benefit of this early social-emotional learning. The students enter already knowing about empathy, self-regulation, problem-solving and skills for learning, which help them deal with the higher behavioral expectations that are expected in the TK year.

Alder Creek Middle School (ACMS) implemented the Second Step Curriculum with the entire student body, beginning in September of 2014. A whole school staff training was given in August of 2014. The teachers were enthusiastic and excited about the program. They could see the benefits of having these social-emotional conversations with their students. The TTUSD trainer also went to a staff meeting in October in order to answer questions that staff had after teaching the program for one month. Additionally, another training was held for the Latino parents at one of their scheduled English Language nights, and the parents felt the program would help them with many of the parenting issues that were occurring in the home environment.

The decision was made to have every teacher take a small group of students for an advisory once a week and teach the program. This included music, PE, Spanish, etc. teachers as well. ACMS found that the bond between a student and a teacher that a student did not have for their regular curriculum was limited and this factor affected the impact of the program. Therefore, next FY 2015/16 the student's advisory teacher will also be one of their regular teachers in the day. The goal being that the connection with the teacher will enhance the material being taught, and allow the students to take it more seriously. The staff will all be wearing lanyards next year with "How to cope with stress," and "Staying in control." The staff decided these were the two most important Second Step concepts the students could benefit from at this time.

Transitional-Kindergarten through fifth grade continue to benefit from the Second Step Program. Both Glenshire Elementary School and Truckee Elementary School have 100% of teachers teaching the program. There was a refresher training for all teachers in August of 2014 and a new teacher training in September of 2014. Additionally, a refresher training was held for all paraprofessionals in June of 2015.

**Demographics:** In FY 14/15, TTUSD Second Step served 1,612 children. Of those, 942 were Caucasian, 590 were Latino/Hispanic, 21 were multi-racial, 13 were Asian, 11 were African American, six were American Indian/Alaska Native, three were Native Hawaiian/other Pacific Islanders, and 22 listed other races. The Primary Language for 1,194 individuals was English, while 411 spoke Spanish, two spoke Russian, one spoke Vietnamese and four listed other languages. Over half of the children were males (n=840), and the rest were female (n=772). Twenty children reported being Homeless and 198 had Disabilities.

**Barriers/ Challenges:**

- There was high teacher turn over.
- The Project Coordinator changed from the beginning of the program year in 2014 to the end of reporting period in 2015.
- Few preschools are participating.
- The counselor had limited work hours.
- The counselor was not familiar with or involved in writing the original grant.
- The new Project Coordinator was not familiar with the preschools in the area.

- The person in charge of Early Childhood Education no longer works with this grant.

**Solutions to barriers:**

- Staying connected to schools and being informed about staff changes.
- Simplify data collection.
- Someone who works in a preschool can train the preschool teachers and do the follow up.
- Have more flexibility in counselor's schedule for site visits when the timing is best for each site; to complete as many as possible before October.
- Continue to train new teachers, bus personnel, and Boys and Girls club personnel.
- Replace materials as needed.
- Buy new materials for new teachers.
- Continue to keep teachers informed of changes to website. Have the Committee for Children continue to update the website and offer new things for teachers and individuals teaching the program.
- Continue training new teachers in early September.

**Outcomes/Successes:**

- 100% of K-5 classroom teachers at Glenshire Elementary fully implemented the curriculum in FY 14/15.
- 85% of K-5 classroom teachers at Truckee Elementary fully implemented the curriculum in FY 14/15.
- 85% of 6-8 grade classroom teachers at Alder Creek Middle School fully implemented the curriculum in FY 14/15.
- Teachers and school staff demonstrated they felt supported by ongoing training, support and technical assistance from the Counselor/Facilitator, Early Childhood Educators and the Early Learning Trainer.
- Second Step Curriculum Kits and supplies were ordered as needed.
- TTUSD explored high school social-emotional curriculum/programs for 9-12 grade.
- TTUSD collaborated with the Boys and Girls Club on implementation of Second Step in their afternoon child care program.

**Activity 2: Mental Health Screening in the Schools**

The **What's Up? Wellness Checkups** (WUWC) program, is modeled after the Columbia University's TeenScreen program. The program screens Nevada County high school students for suicide risk, depression, anxiety and other emotional health issues. WUWC screens students at the Nevada Joint Union High School (NJUHSD) and Tahoe Truckee Unified School Districts (TTUSD). Students privately take a brief computerized diagnostic questionnaire with a follow up provided as a one-on-one interview with program staff. Staff then connects students with treatment referrals, community resources and case management as needed.

This program came out of a long-standing collaboration between Nevada County Behavioral Health, the Tahoe Truckee Unified School District, the Nevada Joint Union High School District and the county Suicide Prevention Task Force. It identifies and helps youth at risk, promotes teen wellness, increases peer support systems and strengthens family connectedness. As in many rural areas, the suicide rate in Nevada County has been higher than the state average over the past years. Prior to WUWC, Nevada County high school students were not universally screened for emotional health issues.

WUWC screenings have taken place at the NJUHSD schools including Bear River, Ghidotti, Nevada Union (NU), Park Avenue Campus, and Northpoint Academy high schools. Screening at the TTUSD schools includes North Tahoe, Truckee, and Sierra high schools. WUWC targets sophomore students for outreach, as tenth grade has the highest national suicide completion rate.

Translation and interpretation services are provided by the Truckee and Grass Valley Family Resource Centers (FRCs). Staff has continued to develop systems to ensure that the Spanish-speaking families are receiving follow-up services. The Grass Valley Promotora has been integrally involved in the team, including engaging with families in crisis.

Case management services included referrals to local counseling centers, private therapists, medical providers, Placer and Nevada County Behavioral Health, school counselors, school-based student assistance programs, advocacy organizations, school nurses, National Alliance on Mental Illness (NAMI), Domestic Violence and Sexual Assault Coalition (DVSAC), Tahoe Safe Alliance, faith-based organizations, and a local mentoring program. Staff send screening results to the providers, and follow-up to ensure that each student meets with their provider at least three times.

WUWC staff and Promotoras provided crisis management for some program participants. Because of the need for an immediate connection or referral, the WUWC staff serve as one of the primary, if not the only, support system for the student's family, providing both in-person and phone-based crisis intervention and referrals to local crisis agencies.

**Demographics:** In FY 14/15 WUWC served 342 individuals including 235 ages 0-15 and 107 ages 16-25. Of these, 30 were Hispanic/Latino including 15 Mexican/Mexican-American/Chicano, one Central American and 14 other Hispanic/Latinos. There were 268 Caucasian students served along with 26 multi-racial, ten American Indian/Alaska Native, three Asians, two Native Hawaiian/other Pacific Islanders, one Black/African American and 32 of unknown race. All but one student spoke English as their primary language, and the other student spoke Spanish. Fifteen students reported being bi-sexual, five were lesbian, three were gay, two were transgender and two were questioning their sexual orientation. The gender breakdown was 176 females and 166 males. WUWC screened 92 children or family members of veterans, three homeless, 15 with disabilities, 15 with substance use issues and three experiencing domestic violence.

**Barriers/Challenges:**

- Significant numbers of students were unable to be screened. Consent forms were provided for students no longer in the NJUHSD or TTUSD districts or were consistently absent when requested for screening.
- TTUSD had lower consent rates this year resulting in lower numbers of students screened.
- Lack of available resources for students at "mild to moderate risk" for ongoing mental health support was a continuing challenge.

**Solutions to Barriers:**

- Staff worked with districts to locate missing students and determine whether they were eligible for screening. Letters were sent to those still in the district with consent forms for next year's screenings.

- WUWC worked with TTUSD on a plan for the 2015/16 school year to integrate consent forms into their enrollment packets, and to increase screenings from just 10th grade to both 9th and 10th graders.
- Additional group resources were created through the STARS program by offering Mindfulness Skills Groups at both NU and Bear River, and additional group offerings are being planned for the 2015/16 school year.

**Outcomes/Successes:**

- A total of 342 high school students were screened in Nevada County. This represents a 62% increase from the prior year.
- There was a 20% increase in returned parent consents from over the prior year.
- In-depth clinical interviews were provided to 105 students to assess the need for further evaluation/treatment.
- Referrals/ WUWC case-management services were provided to 70 students and their families.
- Seventeen students at Bear River and NU high schools participated in a Mindfulness Skills Group founded and designed by WUWC in response to the need for more support groups in the NJUHSD high schools.
- A new WUWC training structure was developed for current and future volunteers/interns.
- Outreach and education on the WUWC program and mental health issues were provided to approximately 85 people through fundraising events, youth groups and health fairs.
- With NAMI support, WUWC created a mental health stigma reduction presentation for high school classrooms.

| Schools | Consent Forms Out | Consent Forms Returned | Yes Consent | Students Screened | Screened Positive | Case Management Provided | Screening Refusals |
|---|---|---|---|---|---|---|---|
| Bear River | 600 | 186 | 82 | 62 | 15 | 12 | 9 |
| Nevada Union | 700 | 532 | 328 | 205 | 60 | 41 | 16 |
| Silver Springs | 150 | 46 | 43 | 12 | 5 | 3 | - |
| Ghidotti | 120 | 42 | 23 | 25 | 6 | 3 | - |
| Northpoint | 100 | 65 | 19 | 3 | - | - | - |
| | | | | | | | |
| Truckee High | 182 | 45 | 38 | 23 | 11 | 6 | - |
| Sierra High | 7 | 10* | 10 | 5 | 5 | 4 | - |
| North Tahoe | 96 | 14 | 11 | 7 | 6 | 1 | 1 |
| **TOTAL** | **1,955** | **940** | **554** | **342** | **108** | **70** | **26** |

*Consent forms can be obtained from other sources, so it is possible to have more forms returned than are sent out.

**Activity 3: Child and Youth Mentoring:**

The **Big Pal Program** has a long history of serving at-risk elementary and middle school youth, called Little Pals, by providing them with a Big Pal, or high school mentor, who helps them

navigate the sometimes stormy path of growing up while also providing academic support. The program began in the Nevada City School District and was expanded by Big Brothers Big Sisters of Nevada County (BBBSNC) to the Grass Valley School District in the fall of 2009 with funding from the U.S. Office of Juvenile Justice and Delinquency Prevention. With the lack of funding from the Nevada City School District to support the program along with the retirement of their long-time Coordinator, BBBSNC consolidated the program and operated it for both school districts in the 2010-2011 school year. BBBSNC now operates the program exclusively.

High School juniors and seniors are matched with elementary and middle school students, grades three through seven, for a weekly mentoring meeting 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 bases and works closely with the schools and teachers to set goals and review progress towards those goals throughout the school year. For the school year 2014/2015 39 matches were successfully completed.

**Demographics:** In fiscal year 14/15 39 children ages 0-15 were served. Four of them were Mexican/Mexican-American/Chicano and 35 were European. Twenty-eight were Caucasian, three were American Indian/Alaska Natives, and four were multi-racial. All but three children spoke English as a Primary Language, while the remaining three spoke Spanish. Females comprised 18 of those served and 21 were male.

**Barriers/Challenges:** The main challenges are recruiting enough High School students (especially males) to volunteer as "Bigs". There are many more "Littles" referred to this program from the schools, than Bigs who volunteer.

**Solutions to Barriers:** This year, the Big recruitment efforts were expanded to include the alternative High Schools (Bitney Charter and Forest Charter). These students have greater flexibility and are new to the program so they are excited about the opportunity to serve the community. This will be an ongoing effort, as it was very well received by both High Schools and the word has spread. In addition there is support from the administration and encouragement from the teachers for students to participate.

**Outcomes/Successes:**

- Based on the Youth Outcome survey, the following progress was reported by the Littles at the end of the 2014/2015 school year:
  - 20% more of the students are now very sure they will graduate from high school.
  - 50% more of the students are very sure they will go on to college and graduate from college.
  - 10% more of the students believe it is not okay to skip school without permission.
  - 70% more of the students improved their grades in school.
  - 30% more of the students believe it is not okay to engage in risky behaviors (tobacco, drug or alcohol use).
  - 10% more of the students have a better relationship with their parents.

**Activity 4: Early Intervention for Referred Children and Youth**

In FY 14/15 no children were served through this funding stream.

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# *Innovation (INN):*

**Work Plan #1 - Veterans' Family Wellness – FINAL REPORT:**

- **Innovation Project Name: Welcome Home Vets (WHV) or Veterans' Family Wellness Project**

- **Brief Summary of the Priority Issues related to Mental Illness**
  This project was designed to create and deliver a continuum of mental health care specifically geared to family members of veterans who are afflicted with Military-Related Psychological Trauma (MRPT), such as Post Traumatic Stress Disorder (PTSD), Major Depression, etc. Several diagnoses may result from traumatic experience, with PTSD being the most common. Although studies have demonstrated that family members of veterans who suffer from PTSD have a higher incidence of mental health and social problems than the families of veterans without PTSD, there are few resources dedicated to their unique mental health needs. When these family members are offered treatment, it is generally not delivered any differently than for the general population, usually meaning individual therapy in a therapist's office without interaction with others who have similar issues and with a therapist who may not be competent in military culture. However, treatment with veterans who have PTSD in a continuum of care consisting of individual therapy, group therapy and adjunctive social activities has been demonstrated to be very effective. Therefore, this project will demonstrate the effectiveness of a continuum of care for family members. Furthermore, this project will demonstrate the value of input from multiple sources in creating program design, including the prospective program participant. In order to design a continuum of care for family members, input from veterans, family members and professionals who treat veterans with PTSD was integrated into a conceptual programmatic whole. Their input, through focus groups, was a moving force behind the final design.

- **Description of Any Changes**
  *Change #1:*

  -As a result of the information gathered from focus groups in Phase I, an educational component was added to the proposed continuum of care, with funding re-allocated from Therapy to the Educational component. This curriculum was divided into four classes meeting weekly for four weeks, open to veterans and spouses. The cost of $1,500 to create the curriculum and $450/month to implement was transferred from funds originally allocated to psychotherapy. The resulting curriculum was well received by new program participants, both veterans and family members, and helped them understand the problems they were experiencing, according to class evaluations.

  -The Initial period of authorization for individual therapy for new program participants was reduced from 6 sessions to 3 sessions. This was an encouragement to therapists to move program participants into group therapy early in treatment, and justification for not entering group therapy was required of therapists. This was felt to be important based on feedback from the focus groups. Most therapists complied with the idea of getting program participants into group as soon as possible.

  -A requirement was adopted that the Vet and family member were to come together for a couples or family session every 3-6 months at a minimum. This proved difficult to enforce, as vets and family members were usually assigned different therapists and setting up joint meetings for contracted therapists in private practice was generally unsuccessful. Monitoring compliance was also extremely difficult.

-The Flanagan Quality of Life scale was adopted as an evaluation tool, to be used in addition to the BASIS-24 required by the contract. This was done in order to assess which instrument was best for reflecting change in family members.

*Change #2:*

-Due to several obstacles in completing Phase I of the project in a timely manner, $19,082 allocated to Year One was not spent. As implementation of actual treatment proceeded in Year Two, it became evident that Year Three would exceed budgeted expectations in terms of numbers of program participants to be served. Therefore, the unspent funds from Year One were re-allocated to Year Three.

- **Program Information collected during the Reporting Period**
  Quarterly and annual reports were collected which included: the unduplicated number of program participants served by month, individual's age and services provided by month (Individual, Group, Couple's/Family Therapy). Also, collected were the number of individuals served by age, race and ethnicity, primary language, and culture on an annual basis.

- **Final Evaluation Results**
  - **Description of the evaluation methodology.**
    Upon admission, every program participant was administered the BASIS-24 (Behavior and Symptom Identification Scale) and the Flanagan Quality of Life Scale. Attempts were made to obtain these measures again at the end of treatment, but generally it was found that there was no formal end to treatment in most cases; the program participants just stopped coming when they felt like they are done. Mailings to all program participants of these questionnaires, along with a Consumer Satisfaction Survey, resulted in only fourteen (14) program participants returning the completed packet, although they were sent to each of the sixty-seven (67) program participants who had participated in the program.
  - **Outcomes of the Innovative Project including those related to the selected primary purpose, with a focus on whatever was new or changed compared to established mental health practices.**
    - Areas of Individual Improvement on BASIS-24:
      There were improvements on every item of the BASIS-24, but only two items received a number of responses that approached significance:
      Item #1: "During the past week, how much difficulty did you have managing your day-to-day life? 36% showed improvement.
      Item #2: "During the past week, how much difficulty did you have coping with problems in your life? 36% showed improvement.
    - Areas of Individual Improvement on Flanagan Quality of Life Scale:
      There were improvements on several items on the Quality of Life Scale, but only four items received a number of responses that approached significance:
      Item #3: "Relationships with parents, siblings & other relatives – communicating, visiting, helping." 21% showed improvement.
      Item #5: "Close relationships with spouse or significant other." 21% showed improvement.
      Item #11: "Work – job or home." 14% showed improvement.
      Item #13: "Socializing – Meeting other people, doing things, parties, etc." 14% showed improvement.
    - Significant comments from Consumer Satisfaction Survey:

- The Four Introductory Classes:
  -"Enjoyed the classes very much."
  -"Awesome! Difficult to bear, but very well done presentation."
  -"The classes were very helpful."
  -"Excellent classes – more detail is far always useful."
  -"Very informative."
  -"(Instructor) did an awesome, thorough and interesting presentation for each class."
- The individual therapist:
  -"It means a lot to be able to talk to her about my feelings."
  -"She has been a real life saver and the best counselor I've ever experienced."
  -"Being in therapy has helped me on so many levels. It has been a huge part of getting me through hard parts of dealing with issues dealing with getting through life after a vet with PTSD."
  -"Very insightful and has a very caring and has a profound effect on my well-being."
  -"He really makes you think and open up!"
  -"She is a life saver! I have experienced lots of emotional growth and healing due to her skill and guidance. So thankful for her wisdom!"
  -"Very little attention paid to what I had to say, though my son was helped by being heard at the VA hospital."
  -"(Therapist) listened and counseled me with kindness and understanding."
  -"(Therapist) has been an enormous support, a wise guide, a nurturing presence in my life. I am ever grateful for her and for Welcome Home Vets."
- Group Therapy:
  -"I still feel uncomfortable in group setting. I don't enjoy or look forward to it. But hope it will be doing me some good."
  -"Going to group with women who understand what I've been through has been a big part of helping me."
  -"Very cohesive group, we care deeply about each other, and are close."
  -"Even with different styles, both (therapists) ran excellent groups."
  -"Some sessions better than others."
  -"Sometimes don't feel safe to share. Don't know if it's me or what makes it so unpleasant. Do not look forward to it like others seem to do."
  -"Therapist allowed one person to do all the talking. I requested help with grief as my husband was dying but she never addressed it! I felt frustrated."
- Overall Satisfaction with the Family Wellness Program:
  Participants were asked to rate the program on a scale of 1 to 5, with 1 being totally dissatisfied and 5 being extremely satisfied.
  Results: 5 = 45%; 4=36%; 3=9%; 2=9%, with 1% not rating the program.
  Significant Comments:
  -"I am so thankful for this program, especially the individual counseling."
  -"I feel I have most benefitted from the classes and the personal/individual counseling. Also my husband has better coping skills and support system in place."
- Those no longer participating in the Family Wellness Program and comments:
  36% of the respondents indicated that they were no longer participating in the Family Wellness Program. Reasons included:
  -"I felt that I had received the max."

-"Group therapy too difficult emotionally; do better in individual therapy."
-"No improvement."
-"Therapist quit." (Referring to one therapist who left as a provider; her program participants were offered the opportunity to see another program provider.)

- **Any variation in outcomes based on demographics of participants, if applicable.**
  The only significant variation in demographics of participants has to do with age. Most (78%) of those who responded to the evaluation tools were spouses of Vietnam-era veterans. This group also tended to remain in treatment for longer periods of time than younger spouses. One spouse of an Iraq war veteran actually enrolled in the program twice but never attended a program activity; like many of the younger participants, she only sought help when there was an acute issue, but when that issue resolved, she did not follow through with getting help.
- **Assessment of which activities or elements of the Innovative Project contributed to successful outcomes.**
  Contracted therapists were unanimous in their feeling that all components of the program (education, individual therapy, group therapy, couples/family therapy) were important in contributing to success. However, they acknowledged that group therapy was not for all program participants for various reasons. A small percentage of program participants reported that group therapy was not comfortable for them.
- **Explanation of how the evaluation was culturally competent.**
  All contracted therapists were required to demonstrate competence in military culture through experience or completion of an on-line or in person course on military culture. Military culture was one of the classes that family members enrolled in the program were required to take, and their input through both written evaluation tools and a consumer satisfaction survey was the primary source of information for the evaluation process.
- **Explanation of how stakeholders contributed to the evaluation.**
  Contracted therapists gave verbal feedback on their evaluation of the program. Program participants completed the BASIS-24, Flanagan Quality of Life Scale, and a Consumer Satisfaction Survey.

- **Sustainability of the Innovative Project**
  Due to funding constraints, the County was not able to continue the Innovative Project. However, an existing contract through MHSA/CSS for treating veterans was expanded in scope to include family members, but no additional funds were provided. The contractor, Welcome Home Vets, is attempting to continue serving families with a full continuum of treatment through billing insurance when available.

- **Key Outcomes and Lessons Learned**
  Expected Outcomes:
  - *Specific needs of veterans' families and loved ones in Nevada County will be formulated through focus groups of veterans, family members and loved ones.*
    This outcome was successfully accomplished, with additional input from professionals who worked with veterans and family members, meeting twice as a group to help design the program and to offer focused responses to the needs of family members. There were then five focus groups conducted with veterans and family members in separate homogeneous groups.

- *The target program participants will be introduced to psychotherapy for themselves in group, individual, couples, child and/or family therapy as deemed clinically appropriate after assessment by a licensed psychotherapist.*
  This outcome was also successfully accomplished, aided by a requirement that therapists begin to justify keeping a program participant in individual therapy alone after three treatment sessions. Although the therapists in this project were aware of the benefit of group therapy for this cohort of program participants, there was an early tendency to maintain them solely in individual therapy for an extended period of time. (It needs to be noted that there is a financial incentive to do so, as individual therapy is billed at a higher rate than group therapy; the effect of this factor on actual practice is undeterminable within the context of this project).
- *Through the process of psychotherapy, potential peer counselors and support group leaders will be identified. Those who desire further involvement will be trained, in conjunction with NAMI training programs or other appropriate training resources.*
  This anticipated outcome was never fully realized. Three different individuals, all spouses of veterans, were identified as potential peer group facilitators at different times, but all dropped out of the training due to personal issues unrelated to the project.
- *Once peer counseling and support groups are in place, veterans' families and their loved ones in the program will be referred to those modalities as clinically appropriate.*
  This anticipated outcome was never realized, due to lack of trained peer group facilitators/counselors as stated in #3 above.
- *An evaluation of program participant functioning using a standardized instrument, will be accomplished at admission to the project, at discharge from a modality or transfer to a new modality, and annually in the support group setting.*
  Partially met; all were administered the BASIS-24 and the Quality of Life (QOL) scale upon admission to the project. However, the reality of operations made this goal unrealistic as far as administering those instruments at changes of modality, especially with only three sessions of the individual therapy modality required before entering into the group therapy modality. This brief period of time did not realistically allow for any significant changes to take place in the program participants. Other modalities, such as couples or family therapy, were integrated into the individual and group phases of treatment in such a way as to make any "change of modality" artificial. The instruments were administered at the end of one year in treatment and/or at discharge, but the reality was that program participants rarely were "discharged" by their therapist, they just stopped coming when they felt done. Therefore, all follow-up assessments through these instruments was sought via mailing to the former program participant, with a very low rate of return.
- *Results of the project will be reported through MHSA channels and published in an appropriate clinical journal.*
  All quarterly and annual reports have been submitted through MHSA channels as required. Unfortunately, a realistic appraisal of the clinical outcomes, due to low rate of return of the instruments of evaluation, make final results of this project inappropriate for publication in a journal.
- *There will be no divorces during the time program participants are in treatment.*
  Perhaps the most important goal in terms of program participant centered outcomes, and a goal that was met. There were no divorces of anyone in the program during their time in treatment.

- Summary of what was learned:

  A continuum of care which includes education, individual therapy, group therapy and couples/family therapy when appropriate is beneficial for family members of veterans who suffer from MRPT. However, there needs to be some flexibility in terms of treatment modality, particularly group therapy, which was not appropriate for everyone.

  Managing provision of care through contracted therapists in private practice is difficult, both in terms of consistency of quality and in compliance with program requirements. For example, instead of being able to gather information for program evaluation at the time of discharge, contractors rarely formally discharged anyone; the program participant usually just stopped coming with no follow-up by the therapist as to why or to get the evaluation tools completed.

- **Dissemination of Results**
  Locally, the Veterans' Family Wellness Project outcome data was shared at MHSA Steering Committee meetings and at Mental Health Board meetings. Information about the Veterans' Family Wellness Project outcomes was included in MHSA Annual Progress Reports. In addition, the results of Veterans' Family Wellness Project are available to the public on the Nevada County Behavioral Health Website and by contacting the Behavioral Health Director, Rebecca Slade, at Rebecca.Slade@co.nevada.ca.us, (530) 470-2784.

- **Additional Relevant Data**
  None

**Work Plan #2- Rehabilitation and Behavioral Health Collaborative – FINAL REPORT:**

- **Innovation Project Name: Department of Rehabilitation (DOR) and Nevada County Behavioral Health (NCBH) Collaborative:**

- **Brief Summary of the Priority Issue Related to Mental Illness**
  This program supported counseling services from Nevada County Behavioral Health (NCBH) for Department of Rehabilitation (DOR) clients, all of whom were Nevada County residents and Transition Aged Youth (TAY) who were attending Sierra College's Truckee campus. Individuals served by this program voluntarily participated in individual counseling services provided by NCBH and were referred by the Department of Rehabilitation's Senior Vocational Rehabilitation Counselor (SVRC) for the Truckee/Tahoe area.

  The SVRC identified and informed all eligible TAY of this program at intake. Eligible individuals who expressed an interest in counseling were then referred to the Adult Therapists at NCBH. Individuals being referred signed an appropriate release of information form and the therapist was provided with a referral form, a copy of the individual's Rehabilitation Plan and the release. Participants set up their own appointments with the Adult Therapist. The Adult Therapists and the SVRC coordinated services, monitoring individual participation in the counseling program. Nevada County residents who fit the TAY criteria could be referred at any time they were attending Sierra College's Truckee campus with DOR's support. Referrals were made throughout the year, not just when school was in session. Counseling services were provided at the NCBH offices in Truckee.

The counseling funded by this program was provided by NCBH and was part of a larger collaboration between DOR and Sierra College's Truckee campus staff. DOR provided additional support to TAY in their transition to college by funding an Individual Service Provider (ISP) who provided problem-solving assistance and support. DOR clients met individually with the ISP weekly. The ISP and SVRC also assisted the Sierra College staff with any disability-related issues and serve individuals referred by the school. Through this collaboration, DOR was been able to identify clients/students who could benefit from counseling. This program was intended to augment the support services provided at the college, filling the need to address significant psychiatric issues for this population through therapy. This created a "safety net" for TAY coming out of high school that provided the support, array of adult services, and problem-solving assistance that was beneficial during their transition to the adult world. Many TAY had significant psychiatric issues that required therapy and these programs worked together to provide effective services as a part of a more comprehensive network of support.

- **Description of Any Changes or Program Challenges**
  - It was unfortunate that the counseling services provided by this grant could not take place at Sierra College. Services were meant to be provided on the college campus, but were not allowed by the school. To keep the program going, staff had to scramble to move the services to the NCBH offices. While the NCBH office is not far from the college, a number of potential referrals did not drive and could not get to their counseling appointments from the college. This change in location was not ideal.
  - Providing appropriate personal support for TAY clients who may be transitioning out of their parent's home, affected by economic pressures, forming new relationships, dealing with emotional issues, and facing significantly greater demands at school in this phase of their life was a challenge in itself. The support services provided through this collaborative appeared to aid the clients in maintaining their emotional stability.
  - The TAY who had to work and who were required to devote significant time at home to assist their family with childcare or other duties had a unique set of challenges. They could be caught between the needs of their family, their desire to pursue their education, and their need for mental health services. These issues may have be related to the individual's culture at home and could be barriers to the TAY's need to fully participate in all of the support services that were available to them.
  - Coordinating this program was difficult for the SVRC because of the multiple demands of their position, a large caseload, and the resulting minimal time that was mutually available for meetings with the Adult Therapist. Setting up case-staffing and meetings for referral purposes was difficult.
  - Many young people had unrealistic goals coming out of high school, making reaching the necessary agreement for an appropriate rehabilitation plan difficult for the SVRC. The therapist was a welcome extra layer of support for the client during the difficult adjustment process when personal goals were in the process of changing.
  - There is a dramatic need for low cost counseling in Placer County. While the counseling services contained in this program were very beneficial to Nevada County participants, having no such option to offer the youth of Placer County constituted a gap in the support system. Additional collaborations were sought to add this important piece to the safety net.
  - Because of the limited time available for NCBH staff to attend to the coordination of services, contracting with a local counseling agency may have led to more effective collaboration.

- There was a lack of vocational training options in the Truckee area. It was hoped that the collaborations would provide a stronger voice to advocate for the development of additional programs that could benefit the programs' mutual clients.

- **Program Information Collected During the Reporting Period**
  The program served 10 individuals in its entirety. Nine of these individuals were ages 16-25 years old, while one was over 25. Seven were Caucasian, one was Native American, one was Non-White/Other and one was unreported. Seven were Not Hispanic and three were Other Hispanic/Latino. Eight spoke English as their primary language, one spoke Spanish and one had an unknown primary language. One client was a veteran and two were disabled.

- **Final Evaluation Results and Lessons Learned**
  Counseling was recommended for a number of students who appeared to be able to benefit from these services, but many were resistant to therapy. It was thought that the program would be utilized by a greater number of DOR clients. In some cases, TAY disregarded the agreement contained in their Rehabilitation Plan to continue with counseling. There is a dramatic drop-off of services available to TAY once they leave high school. Effectively connecting TAY to adult services was one of the challenges of this collaborative. Because the focus was on the TAY population in Truckee, there was more awareness of the multiple stressors and challenges they face. The benefits of individual therapy were continually seen for those that participated in this program. In some cases a history of emotional trauma was not diagnosed by the school system because of that system's focus on learning problems. However, the emotional problems that come out of childhood emotional trauma constitute a major barrier to success for these individuals and this program was successful in addressing these issues.

- **Sustainability and Key Outcomes**
  The DOR/Sierra College collaboration, augmented by this program, continues to provide quality support for increasing numbers of DOR clients attending Sierra College's Truckee campus. Clients in the program receive an increased level of support than would be available without this partnership. Throughout this collaboration, all of the clients/students stayed connected to DOR following their separation from the college. This is a significant finding compared to the high level of DOR-sponsored TAY who stopped communicating after failing to succeed in other schools. The extra layer of support provided by this collaboration fills a service gap by offering more personal support than is available through disability resource departments alone. This finding illustrates the need for more support services that can address the psychological needs of the TAY population.

- **Additional Relevant Data**
  None

**Work Plan #3 - Primary Care Mental Health Integration – FINAL REPORT:**

- **Innovation Project Name: <u>Integrating Primary Care and Behavioral Health Services or Healthy Outcomes Integration Team (HOIT)</u>**

- **Brief Summary of the Priority Issue Related to Mental Illness**
  The vision of the Nevada County Behavioral Health (NCBH) Innovation Project was to

build and support healthy futures in people with a Serious Mental Illness (SMI). To assist individuals to achieve wellness and recovery, strategies were developed for integrating health care services with mental health and substance use treatment services. To achieve this vision, local mental health, primary care, and substance use treatment providers, community partners, program participants, and family members formed a consortium and developed a collaborative system of care for adults with an SMI. This collaboration created the ability to develop an integrated health care system.

This MHSA-funded project was expanded and strengthened with a three-year Health Resources and Services Administration (HRSA) grant to fully develop the Healthy Outcomes Integration Team (HOIT). HOIT was comprised of a Registered Nurse (RN) and three part-time Service Coordinators, as well as staff from each of the consortium agencies. HOIT staff identified and linked program participants to services and worked collaboratively with consortium agencies to achieve the goals of the project.

The organizations in the consortium who were actively involved in implementing HOIT included NCBH as the lead agency; Western Sierra Medical Clinic, a Federally Qualified Health Center (FQHC); and Sierra Family Medical Clinic, an FQHC Look-Alike. In addition, two agencies, Community Recovery Resources (CoRR) and Common Goals, Inc., offered substance use treatment services to HOIT program participants who had co-occurring substance use disorders. This integrated team delivered coordinated services to SMI adults, with an emphasis on improving access to health care, identifying chronic health conditions, and improving health outcomes.

The priority focus of the Innovation Project was to create a supportive environment to help program participants access primary health care services; identify chronic health conditions; and develop a support system to help program participants effectively manage their chronic health conditions and improve their health outcomes. The second priority was to develop and enhance collaboration and coordination of services across partner agencies to improve services and improve program participant outcomes. This enhancement included developing the capacity to reconcile medications across agencies; coordinate treatment; and develop shared goals to support each person's wellness and recovery.

HOIT also provided leadership to improve system outcomes including bi-directional, co-location of primary care at the Behavioral Health (BH) clinic. This strategy helped to improve access to health care services for program participants who were reluctant to see a primary care provider. Subsequently, program participants experienced improved health indicators. HOIT was instrumental in developing strategies to coordinate services across providers through the development of a shared Multi-Party Agreement. This collaborative document formalized this consortium of providers through clear identification of roles and responsibilities.

Individuals with an SMI who were served by HOIT had access to a range of effective health services, supports, and resources to promote wellness, manage chronic health conditions, and improve overall health outcomes. The HOIT RN coordinated services with the Primary Care Physician and RN from the FQHCs to reconcile medications for program participants, identify any discrepancies in health care, and developed an Individual Treatment Plan (ITP) to promote health and wellness. To further integrate health care services, one FQHC brought their mobile van to the BH outpatient clinic one day a week to deliver primary care services

to the BH program participants. The FQHC medical staff met with BH staff and the BH Psychiatrist prior to seeing the program participants. This strategy created the opportunity to discuss complex situations, fully coordinate care, and identify any specialized needs of each individual.

The collaboration between HOIT, BH staff, and the FQHC primary care providers created important outcomes for program participants. These outcomes included linking all individuals with a primary care provider and developing a person-centered health care home. This approach helped to reconcile medications for shared program participants and improve coordination and continuity of care for these high-risk individuals. HOIT activities also improved participants' health outcomes, including blood pressure, Body Mass Index (BMI), breath Carbon Monoxide (CO), fasting glucose, Hemoglobin A1C (diabetes), Triglycerides, and cholesterol. Participants learned how to manage their chronic health conditions, through exercise, improved diet, and healthy choices in meal preparation. This model has been effective at improving continuity of care, and other Behavioral Health systems are highly encouraged to develop an integrated service delivery model to support positive health and wellness outcomes for program participants.

- **Description of Any Changes**
  It was originally planned to have the two FQHCs identify a primary care physician who would deliver integrated primary and behavioral health care services at the NCBH outpatient clinic to adult participants. However, in order for the FQHC to be reimbursed for their primary care services at the FQHC rate, an extensive application process with HRSA and the Center for Medicaid and Medicare Services needed to be completed, including a change of scope and certification. This application process would have taken between one and two years to complete, based upon similar applications for other FQHCs. The FQHC began looking at alternative opportunities to this co-location model.

  Western Sierra Medical Clinic (WSMC) determined that they could utilize their existing mobile van to deliver the needed primary care services outside of the NCBH outpatient clinic. This strategy would allow program participants to conveniently receive primary care services on the grounds (in the parking lot) of the BH outpatient clinic, and the FQHC could be reimbursed for all primary care services delivered to the BH program participants. This approach created the capacity to obtain reimbursement for services without submitting 1-2 years of paperwork in order to be paid for the primary care services delivered at NCBH.

  This change in service model, using the mobile van, allowed NCBH to bring primary care services to our adult program participants, in a location that was comfortable to them. Program participants appreciated having a primary care provider and being able to see the physician on the same day as their scheduled mental health services.

- **Program Information Collected During the Reporting Period**
  The evaluation team collected information on a number of different key health indicators to track health status improvement as a result of integrated services. The selected indicators were consistent with the Federal Healthy People 2020 initiative, including reduced weight for overweight individuals; reduced chronic pain; reduced number of suicide attempts; reduced number of persons who smoke; improved access to treatment for co-occurring disorders; and improved access to primary care.

The RN and Service Coordinator worked together to complete an intake assessment for each individual upon enrollment in HOIT and periodically throughout the project. In addition, each participant enrolled had lab work completed at intake and periodically. Each participant's health data was analyzed, graphically displayed, and shared with the individual and staff in an easy-to-understand format. This format provided information on each health indicator, the "normal" range for each measure, and whether the individual's information was at risk for becoming a chronic health condition (e.g., pre-diabetic; high blood pressure; high cholesterol).

The evaluation team also utilized the county's Electronic Health Record (EHR) to collect information on participant demographic and service utilization data. This information was used to evaluate the amount of services delivered to each participant.

- **Final Evaluation Results**

Individuals with an SMI who were served by HOIT had access to a range of effective health services, supports, and resources to promote wellness, manage illnesses, and improve overall health outcomes. The HOIT RN coordinated services with the Primary Care Physician and Registered Nurse from the FQHC and FQHC Look-Alike to reconcile medications for program participants; identify any discrepancies in health care; and developed an ITP to promote health and wellness. To further integrate health care services, the FQHC brought their mobile van to the Behavioral Health (BH) Outpatient Clinic one day a week to deliver primary care services to the BH participants. The MD and RN met with BH staff and the BH psychiatrist each morning, prior to seeing the BH participants. This strategy created the opportunity to discuss complex situations, fully coordinate care, and identify any specialized needs of the individual.

This integrated model supported both staff and program participants to improve management of chronic health conditions as well as reinforce positive outcomes. In addition, the HOIT RN and Service Coordinators offered a number of different classes to individuals, to help them develop skills in managing their chronic health conditions, lose weight, stop smoking, and manage their stress. A number of individuals were managing their chronic pain by taking prescription medications. Utilizing a coordinate team approach, many of these individuals were able to manage their pain without medications and utilized relaxation and medication to reduce their dependence on pain medications.

National data was used to identify the need for integrating physical health and mental health care for NCBH program participants. Research has shown that individuals with an SMI face an increased risk of having chronic medical conditions and die, on average, 25 years earlier than other Americans, largely due to treatable medical conditions. Data shows that some of the most common health issues for adults with an SMI are diabetes, hypertension, depression, obesity, heart disease, autoimmune disorders, and high cholesterol. Older adults are also at risk of having depression, arthritis, chronic pain, and limited mobility. Substance use is more common for adults with an SMI, including alcohol addictions and inappropriate use of prescription medications. In addition, many individuals smoke cigarettes, which increases the probability of developing heart disease, asthma, and/or certain types of cancer. Some individuals also have a chronic cough and/or chronic obstructive pulmonary disease (COPD) as a result of smoking, or living with a person who smokes.

A number of different key health indicators were selected to help track program participant's

improvement in health status as a result of these integrated services. The selected indicators are also consistent with the Federal Healthy People 2020 initiative.

Several different data collection instruments were used to collect data on each program participant enrolled in HOIT. An RN interviewed each individual at baseline, every six months, and at discharge. The RN also collected the individual's blood pressure; height and weight to calculate the Body Mass Index (BMI); and waist circumference. The RN used a Breath Carbon Monoxide (CO) monitor to measure the impact of smoking on the program participant's lungs. Breath CO monitoring provides an easy and low cost method of determining smoking status without relying on an individual's self-report alone to determine whether or not they smoke.

In addition, each program participant had lab work completed at baseline and annually. The lab work provided values on Fasting Plasma Glucose; Hemoglobin A1C (diabetes); Total Cholesterol, and Triglycerides.

The Service Coordinators (Case Managers), some of whom are persons with lived experience, also collected data for the project, including demographic at baseline and mental health and substance use information from each program participant at baseline, every six months, and at discharge. This information provided data on each individual's education, employment, and functioning, and was collected through an interview process with the individual.

Data sources included lab reports at baseline and annually. The RN collected key health information at baseline, every six months, and at discharge. This information was included in the "Nurse Packet" to report blood pressure, BMI, waist circumference, and CO level. The Service Coordinator collected information at baseline, every six months, and at discharge. The "Service Coordinator Packet" was collected through an interview with the participant. In addition, Nevada County Behavioral Health routinely collects participant demographic and service-level information on each individual through the EHR. This service-level data was utilized to support the evaluation activities.

The data process and analysis included several different strategies. The Evaluator analyzed the data from the EHR, lab work, Nurse Packet, and Service Coordinator Packet to report data on the national Performance Indicators Measures (PIMS). In addition, the Evaluator collected information on each individual's progress on improving a number of different health conditions, and analyzed the data to produce an Individual Wellness Report (IWR) for each participant at baseline and every six months. The IWR was developed to provide ongoing information to participants and staff regarding the identified core health indicators. A number of different measures were analyzed for persons at risk for the following health conditions: Blood Pressure, BMI, Breath CO, Fasting Plasma Glucose, Hemoglobin A1C, Total Cholesterol, and Triglycerides. The IWR was generated at baseline, and data was added every six months to reflect new information over time. This strategy allowed the program participant and staff to see areas of improvement on each health indicator, celebrate success, and identify new goals for those conditions showing "at risk" indicators. The EHR data was also used to provide information on program participant demographics and service utilization. This information was analyzed to determine access and linkage to services.

Collecting lab work was the most complex component of the evaluation. Program

participants were asked to fast eight (8) hours prior to visiting the lab. Some individuals forgot to fast, so the individual and Service Coordinator needed to reschedule a time to draw labs. In addition, many of the program participants did not like needles and were reluctant to get their blood work drawn. The Service Coordinators were creative in developing incentives when participants completed their lab work. Otherwise, there were no limitations to the data.

The Innovation Project achieved excellent outcomes on a number of measures over the period of the project. Data follows:

- The Project served 84 individuals. Participants were ages 18 and older: Fifteen (15) of these program participants were ages 18-34 (17.9%), 51 were ages 35-59 (60.7%), and 18 were 60 years and older (21.4%). There were more females (61.9%) than males (38.1%). The majority were Caucasian (75%). Other race/ethnicity groups included Hispanic (4.8%), Black/African American (3.6%), Asian (2.4%), Native American (8.3%), and other (6%).
- Nearly 75% of the participants stayed in the project for at least six months. There were 23.8% who stayed 6-11 months, 31% who were in the project for 1-2 years, and 17.9% who were in the project for over 2 years.
- Participants showed an improvement in their identified health indicators (e.g., diabetes, depression, hypertension, cholesterol, etc.). Data was analyzed by identifying individuals who were "at risk" at baseline, and determining the number and percent who showed improvement while in the project. The key outcome data is shown below:
  - *Measurement: The number of overweight HOIT participants who improved their Body Mass Index during the grant period.*
  - Outcome: Of the 42 participants who had a Body Mass Index above 25, 14 (33.3%) showed improvement.
  - *Measurement: The number of HOIT participants who had a Breath CO above 6 and showed improvement during the grant period.*
  - Outcome: Of the 22 participants who smoked and were at risk as measured by the Breath CO, 19 (86.4%) showed improvement.
  - *Measurement: The number of HOIT participants who had an 'at risk' Systolic Blood Pressure at baseline and showed an improvement (decrease) in Systolic Blood Pressure during the grant period.*
  - Outcome: Of the eight participants who had an 'at risk' Systolic Blood Pressure measurement at baseline, six (75%) showed improvement during the grant.
  - *Measurement: The number of HOIT participants who had an 'at risk' Diastolic Blood Pressure at baseline and showed an improvement (decrease) in Diastolic Blood Pressure during the grant period.*
  - Outcome: Of the seven participants who had an 'at risk' Diastolic Blood Pressure measurement at baseline, six (85.7%) showed improvement during the grant.
  - *Measurement: The number of HOIT participants who had an 'at risk' Fasting Plasma Glucose at baseline and showed an improvement in Fasting Plasma Glucose during the grant period.*
  - Outcome: Of the 25 participants who had an 'at risk' Fasting Plasma Glucose measurement at baseline, 10 (40%) showed improvement during the grant.
  - *Measurement: The number of HOIT participants who had an 'at risk' Total Cholesterol at baseline and showed an improvement in Total Cholesterol during the grant period.*

- Outcome: Of the 12 participants who had an 'at risk' Total Cholesterol measurement at baseline, eight (66.7%) showed improvement during the grant.
- *Measurement: The number of HOIT participants who had an 'at risk' Triglycerides at baseline and showed an improvement in Triglycerides during the grant period.*
- Outcome: Of the 16 participants who had an "at risk" Triglycerides measurement at baseline, 10 (62.5%) showed improvement during the grant.
- *Measurement: The number and percent of HOIT participants who received services from a primary care provider.*
- Outcome: Of the 84 participants served, all 84 were enrolled and received services with a primary care provider (100%).
- *Measurement: The number and percent of HOIT participants with diabetes whose condition has been diagnosed.*
- Outcome: Of the 84 participants served, 25 were diagnosed with Diabetes (30%).
- *The number and percent of HOIT participants who participated in local health and wellness programs.*
- Outcome: Of the 84 participants served, all 84 increased their access to health and wellness programs (100%).
- *The number and percent of HOIT participants who set goals to enhance health outcomes.*
- Outcome: Of the 84 participants served, all 84 set goals and showed an improvement in their health outcomes (100%).
- *The number and percent of HOIT participants who remain living in the community and are not admitted to a psychiatric inpatient hospital.*
- Outcome: Of the 84 participants served (all with a serious mental illness), only three participants (3.6%) were hospitalized while enrolled in HOIT. Of the 46 participants discharged from HOIT, only one participant (2.2%) has been hospitalized.

Individuals were successfully engaged in coordinated services. The Service Coordinators supported participants to attend a range of activities (e.g., nutrition groups, teaching how to cook healthy meals, walking groups, meditation and relaxation) to help improve their health indicators. In addition, individuals enrolled in HOIT were given memberships to the local gym. These memberships were paid for as long as the individual visited the gym at least 10 times per month. This incentive was a powerful one for participants who maintained this level of involvement. These individuals experienced improved health outcomes, as a result.

Participants reported excellent satisfaction with services. They were pleased to see their progress on improving their health indicators, reduced hospitalization, and stability in their daily lives (e.g., stable housing, improved social supports). Participants also reported satisfaction with having a Primary Care Physician and visited regularly with their providers. They also reported satisfaction in receiving services from the FQHC mobile van that came to the Behavioral Health Outpatient Clinic to deliver primary care services.

- **Sustainability of the Innovation Project**
  It is planned to continue this project by funding the positions through CSS.

- **Key Outcomes and Lessons Learned**
  The HOIT project was extremely successful. Individuals enrolled in the project were adults ages 18 and older who had an SMI. Initially, many of these individuals did not have a primary care physician and/or did not access primary care services. Similarly, the

Behavioral Health program did not collaborate on a daily basis with the local FQHCs to coordinate services for the SMI program participants. Initially, both Behavioral Health and FQHC staff did not feel that they had the time to participate in weekly calls to discuss shared program participants, reconcile medications, and coordinate care. However, within a few short weeks, staff from these agencies realized that, at times, program participants were being prescribed duplicate medications, family members were sharing medications, and medications were not being taken as prescribed. Through frequent phone calls and meetings to coordinate medications and services, participant's health conditions were greatly improved. As a result, a strong, collaborative, trusting relationship was developed across these agencies. As a result, staff initiated phone calls and consulted on shared program participants, as needed and on a daily basis.

The collaboration between the HOIT team, Behavioral Health staff, and the FQHC primary care providers created important outcomes for program participants. These outcomes included linking all individuals with a primary care provider and developing a person-centered health care home. This approach helped to reconcile medications for shared program participants and improve coordination and continuity of care for these high-risk individuals. HOIT activities also improved participants' health outcomes, including blood pressure, BMI, Breath CO, fasting glucose, A1C, and Cholesterol. Participants learned how to manage their chronic health conditions, through exercise, improved diet, and healthy choices in meal preparation.

HOIT also provided leadership to improve system outcomes including bi-directional, co-location of primary care at the Behavioral Health clinic. This strategy helped to improve access to health care services for program participants who were reluctant to see a primary care provider. Subsequently, participants experienced improved health indicators and learned how to manage their chronic health conditions. HOIT was also instrumental in developing strategies to coordinate services across providers through the development of a shared Multi-Party Agreement. This collaborative document helped to formalize this consortium of providers through clear identification of roles and responsibilities and delivery of bi-directional, integrated health care services by co-locating primary care services at the NCBH clinic and similarly co-locating behavioral health services at the primary care clinics in the community to meet the needs of program participants. This strategy also created a continuous Quality Improvement process that developed the capacity to share information across programs to improve program participant care and services over time.

Individuals with an SMI who were served by HOIT had access to a range of effective health services, supports, and resources to promote wellness, manage illnesses, and improve overall health outcomes. The HOIT RN coordinated services with the Primary Care Physician and Registered Nurse from the FQHC and FQHC Look-Alike to reconcile medications for program participants, identify any discrepancies in health care, and developed an ITP to promote health and wellness. To further integrate health care services, the FQHC brought their mobile van to the Behavioral Health (BH) Outpatient Clinic one day a week to deliver primary care services to the BH program participants. The MD and RN met with BH staff and the BH psychiatrist each morning, prior to seeing the BH program participants. This strategy created the opportunity to discuss complex situations, fully coordinate care, and identify any specialized needs of the individual.

This integrated model supported both staff and program participants to improve management of chronic health conditions as well as reinforce positive outcomes. In addition, the HOIT RN and Service Coordinators offered a number of different classes to individuals, to help them develop skills in managing their chronic health conditions, lose weight, stop smoking, and manage their stress. A number of individuals were managing their chronic pain by taking prescription medications. Utilizing a coordinate team approach, many of these individuals were able to manage their pain without medications and utilized relaxation and medication to reduce their dependence on pain medications.

- **Dissemination of Results**
  Locally, the HOIT outcome data was shared at MHSA Steering Committee meetings and at Mental Health Board meetings. Information about the HOIT project outcomes was included in MHSA Annual Progress Reports. In addition, the results of the HOIT Project are available to the public on the Nevada County Behavioral Health Website and by contacting the Behavioral Health Director, Rebecca Slade, at Rebecca.Slade@co.nevada.ca.us, (530) 470-2784. In addition, the Behavioral Health Director has provided information on the results of this project at state meetings and conferences.

  Due to the positive impact of the HOIT project, which was funded by both federal grants and state MHSA allocations, NCBH has been nominated to be added to the HRSA Rural Health Models and Innovations Hub located on the Rural Community Health Gateway (https://www.raconline.org/communityhealth). The Rural Community Health Gateway showcases programs that can help other organizations who are interested in building effective community health programs. This website is an excellent opportunity to disseminate the HOIT strategies and successes.

- **Conclusion**
  The success of the HOIT project created the foundation for NCBH to obtain two California MHSA-funded grants. One grant expands the NCBH crisis services to be co-located 24/7 at the Emergency Department (ED) of the local hospital. It also expands the number of hours for Crisis Peer Counselors, who are program participants and family members employed by SPIRIT Peer Empowerment Center, to go to the ED and support program participants and family members while experiencing a crisis. This grant also funded the development of a four-bed Peer-Run Respite Center, to help support program participants to resolve their crisis in a community setting and/or provide additional support following a crisis or psychiatric inpatient hospitalization. A second CA MHSA grant funded the development of a Crisis Stabilization Unit on the grounds of the local hospital. Both of these MHSA grants support the development of an exemplary crisis continuum of care in Nevada County to help program participants to remain in the community, whenever possible.

  The integration of primary care and behavioral health has a significant impact on the health and well-being of persons with a Serious Mental Illness. Many individuals do not access primary care and/or know how to manage their chronic health conditions. Similarly, Behavioral Health staff do not typically understand chronic health conditions or have the skills needed to help program participants improve their health functioning. Through coordinated, integrated health, behavioral health, and substance use treatment services, program participants can improve their health conditions and achieve positive outcomes. This model has been effective at improving continuity of care and other behavioral health systems are highly encouraged to develop an integrated service delivery model to support

positive health and wellness outcomes for program participants.

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***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 Staff Support, Training & Technical Assistance, Mental Health Career Pathways and Expansion of the Internship Program.

1. **Workforce Staffing Support:** The MHSA Coordinator worked on the implementation of the plan including providing updates as required to the Mental Health Board and the MHSA Steering Committee. The MHSA Coordinator participated in the state-wide WET conference calls and meetings, and provided leadership for ongoing trainings, WET activities and development. Clerical staff supported the ongoing administration for the MHSA Coordinator, Behavioral Health staff, contractors, program participants and families as related to WET implementation. A total of 239.25 hours was billed to Workforce Staffing Support in FY 14/15.

2. **Training and Technical Assistance:** Numerous training events have been offered by the County for staff, service providers, and stakeholders, including program participants and family members. When appropriate, MHSA PEI and WET funds were utilized for training opportunities. For FY 14/15 events/conferences/trainings included: Adult Behavioral Health (BH) Training, Advanced Applications in Cognitive Therapy, Advancing Behavioral Health Care in your Hospital, California (CA) BH Policy Forum, CA Hospital Association, County Behavioral Health Directors Association of California (CBHDA) Meetings, Child Abuse & Incest Reporting Laws & Treatment, California State Association of Counties (CSAC) Institute - Managing Conflict, CSAC Yearly Registration, Data Collection and Reporting (DCR) System Training, Emergency Mental Health - Crisis Assessment & Treatment, Full Service Partnership (FSP) Enhanced Partner-level Data (EPLD) Template Training, Governing Board Strategic Planning Meeting, Hoarding Disorder Training, Integrating Substance Use with Mental Health and Primary Care, Know the Signs - Suicide is Preventable, Law & Ethics Training, Living Works Training, Making Sense of Anxiety Training, Mental Health First Aid, Mental Health First Aid for Law Enforcement, Mental Health America (MHA) Recovery Oriented Practice Training (Immersion), MHA Recovery Training, MHSA WET Mental Health Board Training, Motivational Interviewing to Facilitate Family Change, PsychCeli.com Courses, Risk Assessment and Treating Clients in Crisis, Superior Region WET Meeting, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Booster Training, and Understanding & Using Acceptance and Commitment Therapy (ACT) in the Treatment of Eating Disorders.

   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.

   **Demographics:** A total of 234 individuals attended a training conference or event in FY 14/15. Of those receiving training, 19 were adults, two were older adults and the rest were of unknown age. Thirty trainees were white and the rest were of unknown race. One trainee was Mexican, seven were European, two were of other ethnicities and the rest were of unknown ethnicity. Thirty-two individuals spoke English as their primary language, while one spoke Spanish and one spoke another language; the rest were unknown. Ten participants were male, 20 were female and the rest were of unknown gender. The instances of unknown statistics are based on participants not completing demographic questionnaires. Participants included service providers, service supporters, family members and individuals with lived experience.

3. **Mental Health Career Pathway Programs:** In FY 11/12, it was decided to utilize $15,000 in Mental Health Career Pathway funds to further support the Wellness Recovery Action Plan (WRAP) Facilitators in Nevada County. Eighteen individuals were either trained to be a WRAP Facilitator or had a booster training. These individuals were representatives of a wide range of organizations/groups. Individuals from SPIRIT Peer Empowerment Center, The Alliance for Wellbeing, Grass Valley PARTNER Family Resource Center, Family Resource Center of Truckee, Community Recovery Resources, Women of Worth, Domestic Violence and Sexual Assault Coalition, and New Directions (a Nevada County Behavioral Health Full Service Partner provider) participated in the training. These individuals included: program participants, peer support specialists, young adult peer supporters, Promotores, drug and alcohol counselors, domestic violence counselors/employees, and therapists. The County continues to support the WRAP Facilitators by providing training, meeting space and materials to conduct WRAP Facilitator Support Meetings. WET funds are also used to provide WRAP Facilitation Group implementation materials. In FY 14/15 the county purchased these additional resources for the ongoing program using WET funds: 30 WRAP books, 20 WRAP For Addictions books, 70 My WRAP books, 35 Wrap for Veterans and People in the Military books, and one WRAP for Veterans & People in the Military DVD set.

4. **Expansion of Nevada County's Internship Program:** This program was primarily funded under CSS in FY 14/15. See CSS section above for details.

5. **Financial Incentives:** Our Voices Matter (OVM) continues to be an essential program participants/family-run speaker's bureau that provides the opportunity for program participants/family members to give voice to their experiences living with mental health conditions. Telling stories can be very effective in addressing the stigma and discrimination that individuals with mental health conditions face. The program is actively supported by NAMI Nevada County and SPIRIT Peer Empowerment Center, however Nevada County Behavioral Health WET funds are no longer used for this program.

# Individuals Served by MHSA in FY 2014-15

**Program:** MHSA Totals

| Age Group | # of individuals |
|---|---|
| Children & Youth (0-15) | 3890 |
| TAY (16-25) | 1893 |
| Adults (26-59) | 6572 |
| Older Adults (60+) | 3265 |
| Unknown | 2939 |
| **Total** | **18559** |

| Ethnicity | # of individuals |
|---|---|
| ***Hispanic or Latino as follows:*** | |
| Caribbean | 0 |
| Central America | 5 |
| Mexican/Mexican-American/Chicano | 1552 |
| Puerto Rican | 0 |
| South America | 5 |
| Other Hispanic/Latino | 143 |
| Unknown | 21 |
| **Hispanic or Latino Subtotal:** | **1726** |
| ***Non-Hispanic or Non-Latino as follows:*** | |
| African | 14 |
| Asian Indian/South Asian | 2 |
| Cambodian | 1 |
| Chinese | 2 |
| Eastern European | 8 |
| European | 1190 |
| Filipino | 8 |
| Japanese | 2 |
| Korean | 1 |
| Middle Eastern | 1 |
| Vietnamese | 0 |
| Other Non-Hispanic/Non-Latino | 1640 |
| Unknown | 583 |
| **Non-Hispanic/Non-LatinoSubtotal:** | **3452** |
| More than one ethnicity | 0 |
| Ethnicity Unknown | 13381 |
| **Total** | **18559** |

| Race | # of individuals |
|---|---|
| American Indian or Alaska Native | 100 |
| Asian | 56 |
| Black of African American | 69 |
| Native Hawaiian or other Pacific Islander | 15 |
| White | 9230 |
| Other | 543 |
| More than one race | 192 |
| Unknown | 8354 |
| **Total** | **18559** |

| Primary Language | # of individuals |
|---|---|
| English | 15354 |
| Spanish | 1274 |
| Arabic | 1 |
| Cambodian | 0 |
| Cantonese | 1 |
| Farsi | 0 |
| Hmong | 0 |
| Mandarin | 0 |
| Russian | 3 |
| Tagalog | 1 |
| Vietnamese | 1 |
| Other | 15 |
| Unknown | 1909 |
| **Total** | **18559** |

| Sexual Orientation | # of individuals |
|---|---|
| Lesbian | 175 |
| Gay | 96 |
| Bi-sexual | 39 |
| Transgender | 10 |
| Questioning | 22 |
| Unknown | 0 |
| **Total** | **342** |

| Gender Identity | # of individuals |
|---|---|
| Female | 8903 |
| Male | 5526 |
| Trans-Female | 6 |
| Trans-Male | 2 |
| Both | 0 |
| Neutral | 0 |
| Unknown | 4122 |
| **Total** | **18559** |

| Culture | # of individuals |
|---|---|
| Veterans | 1234 |
| HIV/AIDS | 47 |
| Homeless | 2146 |
| Disabilities | 1854 |
| Criminal/Legal System | 193 |
| Latino/Hispanic | 1608 |
| Substance Abuse | 300 |
| Domestic Violence | 10 |
| Other: | 35 |
| **Total** | **7427** |

# Individuals Served by MHSA in FY 2014-15

**Organization:** Adult System of Care

**Program:** Community Services and Supports

| Age Group | # of individuals |
|---|---|
| Children & Youth (0-15) | 22 |
| TAY (16-25) | 242 |
| Adults (26-59) | 2071 |
| Older Adults (60+) | 1048 |
| Unknown | 387 |
| **Total** | **3770** |

| Ethnicity | # of individuals |
|---|---|
| ***Hispanic or Latino as follows:*** | |
| Caribbean | 0 |
| Central America | 0 |
| Mexican/Mexican-American/Chicano | 16 |
| Puerto Rican | 0 |
| South America | 0 |
| Other Hispanic/Latino | 32 |
| Unknown | 11 |
| **Hispanic or Latino Subtotal:** | **59** |
| ***Non-Hispanic or Non-Latino as follows:*** | |
| African | 6 |
| Asian Indian/South Asian | 2 |
| Cambodian | 1 |
| Chinese | 0 |
| Eastern European | 0 |
| European | 0 |
| Filipino | 4 |
| Japanese | 0 |
| Korean | 0 |
| Middle Eastern | 0 |
| Vietnamese | 0 |
| Other Non-Hispanic/Non-Latino | 630 |
| Unknown | 294 |
| **Non-Hispanic/Non-LatinoSubtotal:** | **937** |
| More than one ethnicity | 0 |
| Ethnicity Unknown | 2774 |
| **Total** | **3770** |

| Race | # of individuals |
|---|---|
| American Indian or Alaska Native | 20 |
| Asian | 12 |
| Black of African American | 19 |
| Native Hawaiian or other Pacific Islander | 2 |
| White | 2047 |
| Other | 31 |
| More than one race | 46 |
| Unknown | 1593 |
| **Total** | **3770** |

| Primary Language | # of individuals |
|---|---|
| English | 2455 |
| Spanish | 11 |
| Arabic | 0 |
| Cambodian | 0 |
| Cantonese | 0 |
| Farsi | 0 |
| Hmong | 0 |
| Mandarin | 0 |
| Russian | 0 |
| Tagalog | 0 |
| Vietnamese | 0 |
| Other | 1 |
| Unknown | 1303 |
| **Total** | **3770** |

| Sexual Orientation | # of individuals |
|---|---|
| Lesbian | 0 |
| Gay | 1 |
| Bi-sexual | 1 |
| Transgender | 0 |
| Questioning | 0 |
| Unknown | 0 |
| **Total** | **2** |

| Gender Identity | # of individuals |
|---|---|
| Female | 469 |
| Male | 415 |
| Trans-Female | 0 |
| Trans-Male | 0 |
| Both | 0 |
| Neutral | 0 |
| Unknown | 2886 |
| **Total** | **3770** |

| Culture | # of individuals |
|---|---|
| Veterans | 963 |
| HIV/AIDS | 2 |
| Homeless | 346 |
| Disabilities | 505 |
| Criminal/Legal System | 151 |
| Latino/Hispanic | 59 |
| Substance Abuse | 46 |
| Domestic Violence | 0 |
| Other: | 35 |
| **Total** | **2107** |

# Individuals Served by MHSA in FY 2014-15

**Organization:** Children's System of Care

**Program:** Community Services and Supports

| Age Group | # of individuals |
|---|---|
| Children & Youth (0-15) | 403 |
| TAY (16-25) | 184 |
| Adults (26-59) | 0 |
| Older Adults (60+) | 0 |
| Unknown | 271 |
| **Total** | **858** |

| Ethnicity | # of individuals |
|---|---|
| ***Hispanic or Latino as follows:*** | |
| Caribbean | 0 |
| Central America | 0 |
| Mexican/Mexican-American/Chicano | 34 |
| Puerto Rican | 0 |
| South America | 0 |
| Other Hispanic/Latino | 29 |
| Unknown | 10 |
| **Hispanic or Latino Subtotal:** | **73** |
| ***Non-Hispanic or Non-Latino as follows:*** | |
| African | 2 |
| Asian Indian/South Asian | 0 |
| Cambodian | 0 |
| Chinese | 1 |
| Eastern European | 0 |
| European | 0 |
| Filipino | 0 |
| Japanese | 0 |
| Korean | 0 |
| Middle Eastern | 0 |
| Vietnamese | 0 |
| Other Non-Hispanic/Non-Latino | 359 |
| Unknown | 129 |
| **Non-Hispanic/Non-LatinoSubtotal:** | **491** |
| More than one ethnicity | 0 |
| Ethnicity Unknown | 294 |
| **Total** | **858** |

| Race | # of individuals |
|---|---|
| American Indian or Alaska Native | 18 |
| Asian | 3 |
| Black of African American | 11 |
| Native Hawaiian or other Pacific Islander | 1 |
| White | 467 |
| Other | 19 |
| More than one race | 47 |
| Unknown | 292 |
| **Total** | **858** |

| Primary Language | # of individuals |
|---|---|
| English | 581 |
| Spanish | 4 |
| Arabic | 0 |
| Cambodian | 0 |
| Cantonese | 0 |
| Farsi | 0 |
| Hmong | 0 |
| Mandarin | 0 |
| Russian | 0 |
| Tagalog | 0 |
| Vietnamese | 0 |
| Other | 0 |
| Unknown | 273 |
| **Total** | **858** |

| Sexual Orientation | # of individuals |
|---|---|
| Lesbian | 0 |
| Gay | 0 |
| Bi-sexual | 0 |
| Transgender | 0 |
| Questioning | 0 |
| Unknown | 0 |
| **Total** | **0** |

| Gender Identity | # of individuals |
|---|---|
| Female | 264 |
| Male | 323 |
| Trans-Female | 0 |
| Trans-Male | 0 |
| Both | 0 |
| Neutral | 0 |
| Unknown | 271 |
| **Total** | **858** |

| Culture | # of individuals |
|---|---|
| Veterans | 1 |
| HIV/AIDS | 0 |
| Homeless | 10 |
| Disabilities | 72 |
| Criminal/Legal System | 13 |
| Latino/Hispanic | 73 |
| Substance Abuse | 0 |
| Domestic Violence | 0 |
| Other: | 0 |
| **Total** | **169** |

# Individuals Served by MHSA in FY 2014-15

**Organization:** Outreach Projects

**Program:** Prevention & Early Intervention

| Age Group | # of individuals |
|---|---|
| Children & Youth (0-15) | 986 |
| TAY (16-25) | 399 |
| Adults (26-59) | 290 |
| Older Adults (60+) | 170 |
| Unknown | 8 |
| **Total** | **1853** |

| Ethnicity | # of individuals |
|---|---|
| ***Hispanic or Latino as follows:*** | |
| Caribbean | 0 |
| Central America | 3 |
| Mexican/Mexican-American/Chicano | 755 |
| Puerto Rican | 0 |
| South America | 4 |
| Other Hispanic/Latino | 9 |
| Unknown | 0 |
| **Hispanic or Latino Subtotal:** | **771** |
| ***Non-Hispanic or Non-Latino as follows:*** | |
| African | 1 |
| Asian Indian/South Asian | 0 |
| Cambodian | 0 |
| Chinese | 0 |
| Eastern European | 0 |
| European | 677 |
| Filipino | 0 |
| Japanese | 1 |
| Korean | 0 |
| Middle Eastern | 0 |
| Vietnamese | 0 |
| Other Non-Hispanic/Non-Latino | 315 |
| Unknown | 2 |
| **Non-Hispanic/Non-LatinoSubtotal:** | **996** |
| More than one ethnicity | 0 |
| Ethnicity Unknown | 86 |
| **Total** | **1853** |

| Race | # of individuals |
|---|---|
| American Indian or Alaska Native | 3 |
| Asian | 1 |
| Black of African American | 3 |
| Native Hawaiian or other Pacific Islander | 4 |
| White | 1302 |
| Other | 448 |
| More than one race | 1 |
| Unknown | 91 |
| **Total** | **1853** |

| Primary Language | # of individuals |
|---|---|
| English | 1091 |
| Spanish | 730 |
| Arabic | 0 |
| Cambodian | 0 |
| Cantonese | 0 |
| Farsi | 0 |
| Hmong | 0 |
| Mandarin | 0 |
| Russian | 0 |
| Tagalog | 0 |
| Vietnamese | 0 |
| Other | 1 |
| Unknown | 31 |
| **Total** | **1853** |

| Sexual Orientation | # of individuals |
|---|---|
| Lesbian | 0 |
| Gay | 2 |
| Bi-sexual | 8 |
| Transgender | 1 |
| Questioning | 0 |
| Unknown | 0 |
| **Total** | **11** |

| Gender Identity | # of individuals |
|---|---|
| Female | 905 |
| Male | 812 |
| Trans-Female | 1 |
| Trans-Male | 0 |
| Both | 0 |
| Neutral | 0 |
| Unknown | 135 |
| **Total** | **1853** |

| Culture | # of individuals |
|---|---|
| Veterans | 21 |
| HIV/AIDS | 3 |
| Homeless | 257 |
| Disabilities | 169 |
| Criminal/Legal System | 27 |
| Latino/Hispanic | 702 |
| Substance Abuse | 14 |
| Domestic Violence | 2 |
| Other: | 0 |
| **Total** | **1195** |

# Individuals Served by MHSA in FY 2014-15

**Organization:** Access to Services

**Program:** Prevention & Early Intervention

| Age Group | # of individuals |
|---|---|
| Children & Youth (0-15) | 53 |
| TAY (16-25) | 954 |
| Adults (26-59) | 4140 |
| Older Adults (60+) | 2006 |
| Unknown | 2058 |
| **Total** | **9211** |

| Ethnicity | # of individuals |
|---|---|
| ***Hispanic or Latino as follows:*** | |
| Caribbean | 0 |
| Central America | 0 |
| Mexican/Mexican-American/Chicano | 90 |
| Puerto Rican | 0 |
| South America | 0 |
| Other Hispanic/Latino | 59 |
| Unknown | 0 |
| **Hispanic or Latino Subtotal:** | **149** |
| ***Non-Hispanic or Non-Latino as follows:*** | |
| African | 0 |
| Asian Indian/South Asian | 0 |
| Cambodian | 0 |
| Chinese | 0 |
| Eastern European | 5 |
| European | 2 |
| Filipino | 0 |
| Japanese | 0 |
| Korean | 0 |
| Middle Eastern | 0 |
| Vietnamese | 0 |
| Other Non-Hispanic/Non-Latino | 0 |
| Unknown | 117 |
| **Non-Hispanic/Non-LatinoSubtotal:** | **124** |
| More than one ethnicity | 0 |
| Ethnicity Unknown | 8938 |
| **Total** | **9211** |

| Race | # of individuals |
|---|---|
| American Indian or Alaska Native | 35 |
| Asian | 13 |
| Black of African American | 18 |
| Native Hawaiian or other Pacific Islander | 0 |
| White | 3586 |
| Other | 21 |
| More than one race | 35 |
| Unknown | 5503 |
| **Total** | **9211** |

| Primary Language | # of individuals |
|---|---|
| English | 9063 |
| Spanish | 79 |
| Arabic | 0 |
| Cambodian | 0 |
| Cantonese | 0 |
| Farsi | 0 |
| Hmong | 0 |
| Mandarin | 0 |
| Russian | 1 |
| Tagalog | 0 |
| Vietnamese | 0 |
| Other | 6 |
| Unknown | 62 |
| **Total** | **9211** |

| Sexual Orientation | # of individuals |
|---|---|
| Lesbian | 170 |
| Gay | 90 |
| Bi-sexual | 15 |
| Transgender | 7 |
| Questioning | 20 |
| Unknown | 0 |
| **Total** | **302** |

| Gender Identity | # of individuals |
|---|---|
| Female | 5987 |
| Male | 2634 |
| Trans-Female | 5 |
| Trans-Male | 2 |
| Both | 0 |
| Neutral | 0 |
| Unknown | 583 |
| **Total** | **9211** |

| Culture | # of individuals |
|---|---|
| Veterans | 154 |
| HIV/AIDS | 42 |
| Homeless | 1507 |
| Disabilities | 878 |
| Criminal/Legal System | 2 |
| Latino/Hispanic | 149 |
| Substance Abuse | 225 |
| Domestic Violence | 5 |
| Other: | 0 |
| **Total** | **2962** |

# Individuals Served by MHSA in FY 2014-15

**Organization:** Child, Youth & Families at Risk

**Program:** Prevention & Early Intervention

| Age Group | # of individuals |
|---|---|
| Children & Youth (0-15) | 2426 |
| TAY (16-25) | 107 |
| Adults (26-59) | 15 |
| Older Adults (60+) | 0 |
| Unknown | 0 |
| **Total** | **2548** |

| Ethnicity | # of individuals |
|---|---|
| ***Hispanic or Latino as follows:*** | |
| Caribbean | 0 |
| Central America | 2 |
| Mexican/Mexican-American/Chicano | 656 |
| Puerto Rican | 0 |
| South America | 1 |
| Other Hispanic/Latino | 14 |
| Unknown | 0 |
| **Hispanic or Latino Subtotal:** | **673** |
| ***Non-Hispanic or Non-Latino as follows:*** | |
| African | 5 |
| Asian Indian/South Asian | 0 |
| Cambodian | 0 |
| Chinese | 1 |
| Eastern European | 3 |
| European | 504 |
| Filipino | 3 |
| Japanese | 1 |
| Korean | 1 |
| Middle Eastern | 1 |
| Vietnamese | 0 |
| Other Non-Hispanic/Non-Latino | 334 |
| Unknown | 0 |
| **Non-Hispanic/Non-LatinoSubtotal:** | **853** |
| More than one ethnicity | 0 |
| Ethnicity Unknown | 1022 |
| **Total** | **2548** |

| Race | # of individuals |
|---|---|
| American Indian or Alaska Native | 24 |
| Asian | 26 |
| Black of African American | 17 |
| Native Hawaiian or other Pacific Islander | 8 |
| White | 1760 |
| Other | 23 |
| More than one race | 60 |
| Unknown | 630 |
| **Total** | **2548** |

| Primary Language | # of individuals |
|---|---|
| English | 2087 |
| Spanish | 449 |
| Arabic | 0 |
| Cambodian | 0 |
| Cantonese | 1 |
| Farsi | 0 |
| Hmong | 0 |
| Mandarin | 0 |
| Russian | 2 |
| Tagalog | 1 |
| Vietnamese | 1 |
| Other | 7 |
| Unknown | 0 |
| **Total** | **2548** |

| Sexual Orientation | # of individuals |
|---|---|
| Lesbian | 5 |
| Gay | 3 |
| Bi-sexual | 15 |
| Transgender | 2 |
| Questioning | 2 |
| Unknown | 0 |
| **Total** | **27** |

| Gender Identity | # of individuals |
|---|---|
| Female | 1236 |
| Male | 1312 |
| Trans-Female | 0 |
| Trans-Male | 0 |
| Both | 0 |
| Neutral | 0 |
| Unknown | 0 |
| **Total** | **2548** |

| Culture | # of individuals |
|---|---|
| Veterans | 92 |
| HIV/AIDS | 0 |
| Homeless | 23 |
| Disabilities | 213 |
| Criminal/Legal System | 0 |
| Latino/Hispanic | 624 |
| Substance Abuse | 15 |
| Domestic Violence | 3 |
| Other: | 0 |
| **Total** | **970** |

# Individuals Served by MHSA in FY 2014-15

**Program:** Innovation

| Age Group | # of individuals |
|---|---|
| Children & Youth (0-15) | 0 |
| TAY (16-25) | 7 |
| Adults (26-59) | 37 |
| Older Adults (60+) | 39 |
| Unknown | 2 |
| **Total** | **85** |

| Ethnicity | # of individuals |
|---|---|
| ***Hispanic or Latino as follows:*** | |
| Caribbean | 0 |
| Central America | 0 |
| Mexican/Mexican-American/Chicano | 0 |
| Puerto Rican | 0 |
| South America | 0 |
| Other Hispanic/Latino | 0 |
| Unknown | 0 |
| **Hispanic or Latino Subtotal:** | **0** |
| ***Non-Hispanic or Non-Latino as follows:*** | |
| African | 0 |
| Asian Indian/South Asian | 0 |
| Cambodian | 0 |
| Chinese | 0 |
| Eastern European | 0 |
| European | 0 |
| Filipino | 1 |
| Japanese | 0 |
| Korean | 0 |
| Middle Eastern | 0 |
| Vietnamese | 0 |
| Other Non-Hispanic/Non-Latino | 0 |
| Unknown | 37 |
| **Non-Hispanic/Non-LatinoSubtotal:** | **38** |
| More than one ethnicity | 0 |
| Ethnicity Unknown | 47 |
| **Total** | **85** |

| Race | # of individuals |
|---|---|
| American Indian or Alaska Native | 0 |
| Asian | 1 |
| Black of African American | 1 |
| Native Hawaiian or other Pacific Islander | 0 |
| White | 38 |
| Other | 1 |
| More than one race | 3 |
| Unknown | 41 |
| **Total** | **85** |

| Primary Language | # of individuals |
|---|---|
| English | 45 |
| Spanish | 0 |
| Arabic | 0 |
| Cambodian | 0 |
| Cantonese | 0 |
| Farsi | 0 |
| Hmong | 0 |
| Mandarin | 0 |
| Russian | 0 |
| Tagalog | 0 |
| Vietnamese | 0 |
| Other | 0 |
| Unknown | 40 |
| **Total** | **85** |

| Sexual Orientation | # of individuals |
|---|---|
| Lesbian | 0 |
| Gay | 0 |
| Bi-sexual | 0 |
| Transgender | 0 |
| Questioning | 0 |
| Unknown | 0 |
| **Total** | **0** |

| Gender Identity | # of individuals |
|---|---|
| Female | 22 |
| Male | 20 |
| Trans-Female | 0 |
| Trans-Male | 0 |
| Both | 0 |
| Neutral | 0 |
| Unknown | 43 |
| **Total** | **85** |

| Culture | # of individuals |
|---|---|
| Veterans | 3 |
| HIV/AIDS | 0 |
| Homeless | 3 |
| Disabilities | 17 |
| Criminal/Legal System | 0 |
| Latino/Hispanic | 0 |
| Substance Abuse | 0 |
| Domestic Violence | 0 |
| Other: | 0 |
| **Total** | **23** |

# Individuals Served by MHSA in FY 2014-15

**Organization:** Training & Technical Assistance

**Program:** Workforce Education & Training

| Age Group | # of individuals |
|---|---|
| Children & Youth (0-15) | 0 |
| TAY (16-25) | 0 |
| Adults (26-59) | 19 |
| Older Adults (60+) | 2 |
| Unknown | 213 |
| **Total** | **234** |

| Ethnicity | # of individuals |
|---|---|
| ***Hispanic or Latino as follows:*** | |
| Caribbean | 0 |
| Central America | 0 |
| Mexican/Mexican-American/Chicano | 1 |
| Puerto Rican | 0 |
| South America | 0 |
| Other Hispanic/Latino | 0 |
| Unknown | 0 |
| **Hispanic or Latino Subtotal:** | **1** |
| ***Non-Hispanic or Non-Latino as follows:*** | |
| African | 0 |
| Asian Indian/South Asian | 0 |
| Cambodian | 0 |
| Chinese | 0 |
| Eastern European | 0 |
| European | 7 |
| Filipino | 0 |
| Japanese | 0 |
| Korean | 0 |
| Middle Eastern | 0 |
| Vietnamese | 0 |
| Other Non-Hispanic/Non-Latino | 2 |
| Unknown | 4 |
| **Non-Hispanic/Non-LatinoSubtotal:** | **13** |
| More than one ethnicity | 0 |
| Ethnicity Unknown | 220 |
| **Total** | **234** |

| Race | # of individuals |
|---|---|
| American Indian or Alaska Native | 0 |
| Asian | 0 |
| Black of African American | 0 |
| Native Hawaiian or other Pacific Islander | 0 |
| White | 30 |
| Other | 0 |
| More than one race | 0 |
| Unknown | 204 |
| **Total** | **234** |

| Primary Language | # of individuals |
|---|---|
| English | 32 |
| Spanish | 1 |
| Arabic | 1 |
| Cambodian | 0 |
| Cantonese | 0 |
| Farsi | 0 |
| Hmong | 0 |
| Mandarin | 0 |
| Russian | 0 |
| Tagalog | 0 |
| Vietnamese | 0 |
| Other | 0 |
| Unknown | 200 |
| **Total** | **234** |

| Sexual Orientation | # of individuals |
|---|---|
| Lesbian | 0 |
| Gay | 0 |
| Bi-sexual | 0 |
| Transgender | 0 |
| Questioning | 0 |
| Unknown | 0 |
| **Total** | **0** |

| Gender Identity | # of individuals |
|---|---|
| Female | 20 |
| Male | 10 |
| Trans-Female | 0 |
| Trans-Male | 0 |
| Both | 0 |
| Neutral | 0 |
| Unknown | 204 |
| **Total** | **234** |

| Culture | # of individuals |
|---|---|
| Veterans | 0 |
| HIV/AIDS | 0 |
| Homeless | 0 |
| Disabilities | 0 |
| Criminal/Legal System | 0 |
| Latino/Hispanic | 1 |
| Substance Abuse | 0 |
| Domestic Violence | 0 |
| Other: | 0 |
| **Total** | **1** |