Nevada County Mental Health Services Act (MHSA) Annual Progress Report for Fiscal Year 2018/2019

Overall Implementation Progress Report on Fiscal Year (FY) 18/19 Activities

General Nevada County Information:

Nevada County is a small, rural, mountain community, home to an estimated 99,696 (2018 US Census Bureau estimate https://www.census.gov/quickfacts/) individuals. According to the 2018 US Census estimate over 93% of the Nevada County residents identified their race as White, while over 3% of residents combined identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander. Additionally, 3% identified themselves by two or more races. In regards to ethnicity, an estimated 85% of the population identified as Non-Hispanic or Latino and 9.7% of the population of Nevada County identified themselves as Hispanic or Latino. Nevada County's one threshold language is Spanish.

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

Notes:

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

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

ADULT FULL SERVICE PARTNERSHIP

JULY 2018 – JUNE 2019

Full Service Partnerships are supported with Nevada County Behavioral Health Mental Health Services Act (MHSA) funding. The majority of MHSA funding is dedicated towards Full Service Partnership programs.

Adult Full Services Partnership (FSP) programs are designed for individuals 18+ years old who have been diagnosed with a severe mental illness and would benefit from a more intensive outpatient program. In Fiscal Year 2018/2019, **Turning Point Community Programs** was the primary Adult FSP provider in Nevada County.

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

Nevada County Behavioral Health also operates a small FSP program, serving 9 individuals in FY 18/19. Outcomes for these clients can be found in the full annual progress report.

CHILDREN'S FULL SERVICE PARTNERSHIP

JULY 2018 – JUNE 2019

Full Service Partnerships are supported with Nevada County Behavioral Health Mental Health Services Act (MHSA) funding. The majority of MHSA funding is dedicated towards Full Service Partnership programs.

Children's Full Service Partnership (FSP) programs are intensive mental health treatment programs for children under age 21 diagnosed with a serious emotional disturbance or mental illness and their families. In Fiscal Year 2018/19, **Victor Community Support Services (VCSS)** was the primary Children's FSP provider in Nevada County.

Victor Community Support Services (VCSS) clinicians and staff create individualized service plans for each youth and family, and work to build upon each family's unique strengths, needs, and existing community supports. Almost all services are delivered within the homes, schools, and communities of the youth and families served.

114 YOUTH SERVED

> *I am so grateful and at peace with this service. Victor's changed our lives.*

97% SUCCESSFULLY REMAINED HOUSED

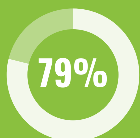
98% AVOIDED PSYCHIATRIC HOSPITALIZATION

AVOIDED NEW LEGAL INVOLVEMENT

ACADEMIC PERFORMANCE

- **96%** of youth maintained a C average or improved their academic performance
- **89%** of youth did not experience a suspension or expulsion
- **86%** of discharged youth reported regular school attendance or improvement in school attendance

CAREGIVERS



of caregivers reported increased connections in the community

of caregivers reported their parenting skills increased or improved

> *Our team at Victor was amazing. They tried very hard to assist our family with all our needs and work with our schedule.*

MHSA Program Updates:

Community Services and Supports (CSS)

Full Service Partners:

VICTOR COMMUNITY SUPPORT SERVICES (VCSS)

Program Description

Program Overview

Victor Community Support Services (VCSS) is an intensive treatment program in Grass Valley that serves children diagnosed with a serious emotional disturbance or mental illness and their families. In FY 18/19 three different treatment modalities were used. The Victor Less Intensive Treatment model, which provides mental health services, case management, medication support and crisis intervention; Therapeutic Behavioral Services (TBS); and Family Vision Wraparound, which provides high fidelity wraparound services, including case planning and therapeutic services. This report covers outcomes for children and youth served through any of these modalities. Victor Community Support Services (VCSS) clinicians and staff create individualized service plans for each youth and family, and work to build upon each family's unique strengths, needs, and existing community supports. Almost all services are delivered within the homes, schools, and communities of the youth and families served.

Target Population

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

Individuals are referred to Victor from SMART (Special Multi-Agency Resource Team), Children's Behavioral Health, Child Protective Services, Probation, or school districts, including youth qualifying for Medi-Cal, Educationally Related Mental Health Services, and/or Katie A services.

Evaluation Activities and Outcomes

- In FY 18/19, VCSS Grass Valley provided 114 youth with mental health and/or Wraparound services. Of those, 27 were served in the Less Intensive Treatment program, with 10 being

served *only* in the Less Intensive Treatment program and 17 being served in *both* the Less Intensive and main Victor MHSA program. There was outreach to an additional five (5) prospective participants throughout the year. The goals of these services are to reduce hospitalizations and recidivism for juvenile offenders, improve school performance, improve targeted behaviors, increase community connections, and provide effective services to ensure the most efficient, least restrictive, and most appropriate level of care for youth and their families.

- **Housing**: During FY 18/19, 97% of the 114 individuals served remained in a community living situation and avoided a higher level of residential care. There were two changes in foster care placement, and two incidents of temporary homelessness, but no individuals required group home placement.
- **Employment and education**: VCSS achieved its contractual goal of ensuring at least 80% of parents report youth maintained a C average or improved on their academic performance, as 96% of parents surveyed reported their child maintained a C average or saw improvement in their child's academic performance. Additionally, based on the Child and Adolescent Needs and Strengths Assessment (CANS) item "Academic Achievement," 81% of discharged youth 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 86% of discharged youth reported regular school attendance or improvement in school attendance (based on the CANS item "School Attendance").

  VCSS achieved its contractual goal of ensuring that at least 70% of youth have no new suspensions or expulsions between admit and discharge; 89% of youth did not experience a suspension or expulsion in this fiscal year.
- **Criminal Justice involvement:** VCSS achieved its contractual goal that at least 70% of youth have no new legal involvement (arrests/violations of probation/citations) between admission and discharge. In FY 18/19, 97% of individuals had no new legal involvement while receiving services.
- **Acute Care Use**: Ninety-eight percent (98%) of youth served did not experience a psychiatric hospitalization during the fiscal year.
- **Emotional and Physical Well Being**: VCSS Grass Valley successfully supported the strengthening and development of youth, caregivers, and family members' emotional and physical well-being throughout the fiscal year. A new line of less-intensive support was established to further assist individuals as they transition out of the Wraparound program.

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

  VCSS achieved its contractual goal of at least 80% of parents/caregivers reporting that there was an increase in their parenting skills. In FY 18/19, 92% of surveyed caregivers reported their parenting skills increased or improved.

VCSS achieved its contractual goal of ensuring that at least 75% of caregivers report maintaining or increasing connections to natural supports, with 92% of surveyed caregivers reporting maintaining natural supports and 79% reporting increased connections in the community.

Victor achieved its contractual goal of ensuring that at least 80% of individuals improved their scores on the Comprehensive Child and Adolescent Needs and Strengths (CANS) instrument between intake and discharge. During FY 18/19, 84% of individuals with a planned discharge improved in at least one of the following CANS domains: Life Functioning, Mental Health/Behavioral/Emotional Needs, Risk Behaviors, and/or Educational Needs.

- **Stigma and Discrimination:** Victor provided Mental Health First Aid trainings to community members to increase awareness and decrease stigma related to mental illness.
- **Service Access and Timeliness**: Excluding transfers between reporting units, there were 70 discharges this year. For FY 18/19, the average length of service (ALOS) for the discharged population was 10.2 months.

VCSS achieved its contractual goal of attempting initial contact with referrals within three (3) business days of receipt of referral. Initial contact was *attempted* for all individuals within three business days, and initial contact was *successfully made* with 83% of referrals in this period.

VCSS achieved its contractual goal of offering an appointment for face-to-face contact with 80% of children and families within 10 business days of receiving the referral, as 82% of eligible referrals were *offered* an appointment date in this time frame. Additionally, 82% of referrals received a face-to-face contact within 10 business days of contact made.

Challenges, Solutions, and Upcoming Changes

During FY 17/18, Victor adopted a high-fidelity wraparound model. This required new staffing of parent partners and facilitators, and a new management structure of one director, one clinical supervisor, and one Community Services Supervisor, which is a new position for the Grass Valley team. Extensive training on the model was provided to all staff in July of 2017, and there have been on-going trainings and in-service coaching provided throughout the past year.

In the past year, Victor has further refined this model, adding more groups and community building activities and events, and further integrating the wraparound philosophy and teaming into the practice. It has been determined that the Less Intensive Treatment model does not add significant value to the array of services and will be discontinued in the next fiscal year. VCSS will serve all youth referred to the program utilizing Full Service Partnership (FSP) and wraparound principles according to their individualized needs, strengths, and treatment plan goals. Length and intensity of services will be determined by assessment and current need. The anticipated length of stay will remain 8-10 months on average.

Staffing remains one of Victor's primary challenges, with the clinician position being the most difficult to recruit.

Program Participant Story

VCSS began working with a young boy that was referred through a school district with reports of out of control behaviors, oppositional behaviors towards authority, “intentional” feces smearing and running away. The child had already moved into many different schools in his short academic career, and his current school placement was at risk. He had been assessed by various professionals with a range of psychological diagnoses, and a medical diagnosis.

The youth’s mother was exhausted by his severe aggressive and argumentative behaviors and was in need of respite. The youth engaged in aggressive and high risk behaviors 10 times daily. There was significant conflict in the home between the child and his siblings. His mother believed that he was a danger to his siblings. Respite was difficult to find due to the youth’s reputation with local agencies and history of being expelled from after-care programs, summer camps, and enrichment activities. Treatment happened primarily in the office due to the boy’s inability to stay safe in the community or home.

The primary focus of services was helping the family meet his medical and safety needs, stabilizing a school placement, and supporting family functioning. Psychiatric treatment was instrumental in identifying an accurate diagnosis, creating and monitoring an appropriate medication plan, and assisting the doctor, the parent, and the wraparound team in targeting and addressing his behaviors. When therapy first began, the boy would run from therapy, refuse to engage, and behave aggressively toward the therapist. Due to the extreme challenges, VCSS offered the family Therapeutic Behavioral Services (TBS) in an effort to address specific behavioral needs in the home. The Family Parent Partner worked with the boy’s mother to address school concerns through the request of an Individualized Education Plan (IEP) and help her connect to natural supports and engage in more self-care. Extensive collaboration with a frustrated school system ultimately resulted in a non-public school setting better equipped to manage his behaviors and facilitate his success, while offering some respite and relief to his mother.

With proper diagnosis, medication, consistent therapy, skill building with the whole family, Communication Focused Therapies (CFTs), and extensive support from the Victor team, the boy’s behaviors steadily improved. He no longer elopes, his food perseveration has reduced to manageable levels, and he is able to manage his anger without engaging in destructive behaviors. The youth is able to engage appropriately for long periods, he maintains safe behaviors in public, and he was accepted into a long-term respite program to support management of his medical treatments. He has become personable, friendly and engaging. Long-term behavioral support solutions such as Applied Behavior Analysis (ABA) were put into place, providing in home assistance 10-20 hours a week to improve interactions and family functioning. The boy was transferred to a local placement, to be monitored for a potential return to his school district. At the time of closure, his mother reported confidence in her ability to manage the boy’s behaviors and keep all of the children safe at home. There was a strong network of support in place, and there had been significant healing and repair both within the family and between the family and the system (schools, care providers, community resources).

Full Service Partners:

TURNING POINT COMMUNITY PROGRAMS
Providence Center

Program Description

Program Overview
Turning Point Community Programs (TPCP) - Providence Center promotes wellness and recovery, partnering with individuals 18 and older living with severe and persistent psychiatric disabilities. Participants are referred for individualized, locally based outpatient treatment. Assertive Community Treatment (ACT) and Assisted Outpatient Treatment (AOT) support individuals in achieving and maintaining a higher level of independence and quality of life within the community.

Services strengthen community integration, mental and physical well-being, vocational and educational opportunities, healthy relationships and sense of independence.

Target Population
The AACT target population consists of individuals 18 years old and over with severe mental illness (SMI).

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

Evaluation Activities and Outcomes

AACT:
In FY 18/19, the Providence Center FSP served 91 individuals. One individual has been excluded from the analysis below due to being incarcerated at time of referral.

- **Housing:** *Goals – show a decrease in homelessness, decrease in number of days homeless, emergency shelter use, increase in independent living, decrease in out of home placement for children, and/or residential status for children.*
    - During FY 18/19, 71 (79%) individuals successfully remained housed in either temporary or permanent housing; avoiding homelessness. The remaining 19 (21%) individuals accrued a total of 1,295 homeless days.
    - A total of 75 individuals carried over from FY 17/18 and continued to accrue services in FY 18/19. Of those 75 individuals, 63 (84%) either continued to avoid homelessness or decreased in the number of homeless days accrued.

- **Employment and Education:** *Goal – show an increase in employment, paid or unpaid, school attendance, and/or grades in school improve.*
  - **Employment:** Of the 91 individuals served within FY 18/19, employment information was provided for 74 participants. Of those 74, at the completion of FY 18/19, a total of nine (12%) individuals were reported as having some form of employment (paid or unpaid). When comparing to the Partnership Assessment Form (PAF), all nine individuals who were reported as being employed at the end of the fiscal year had been unemployed prior to their enrollment at the Providence Center.
  - **Education:** In FY 18/19 a total of 17 individuals were reported as having spent at least one day in school since enrollment. Seven (41%) of those 17 had not attended school prior to enrollment.

- **Criminal Justice Involvement:** *Goal – show arrest decrease, and/or days and times incarcerated decrease.*
  - During FY 18/19, 78 (87%) of the 90 individuals with available data avoided incarcerations or the accrual of jail days. The remaining 12 (13%) individuals accrued a total of 677 jail days.
  - Of the 75 individuals who carried over from FY 17/18 and continued to receive services through the Providence Center in FY 18/19, 69 (92%) avoided the accrual of incarceration days while only six (8%) accrued jail days.
  - With regards to arrests, during FY 18/19, 77 (86%) individuals avoided arrests. The remaining 13 (14%) accrued a total of 35 arrests amongst them. Between FY 17/18 and FY 18/19, two individuals were reported as having accrued arrests in both fiscal years. One of the two individuals was reported as having a decrease in the number of arrests.

- **Acute Care Use:** *Goal – show a decrease in time and number of days in Psychiatric Hospital, and/or decrease in mental health emergency events.*
  - **Psychiatric Hospitalizations:** Within FY 18/19, 80 (89%) individuals avoided psychiatric hospitalizations. The remaining 10 (11%) accrued a total of 559 psychiatric hospital days. A positive outcome is that of the 75 individuals who carried over from FY 17/18 and continued to receive services, 67 (89%) either continued to avoid psychiatric hospitalizations completely (n=56) or had a reduction in their accrual of psychiatric hospital days (n=11).
  - **Emergency Interventions:** Within FY 18/19, 57 (63%) individuals avoided the need for an emergency intervention. The remaining 33 (37%) accrued a total of 88 emergency interventions. A positive outcome is that of the 75 individuals who carried over from FY 17/18 and continued to receive services, 50 (67%) either continued to avoid emergency interventions completely (n=26) or had a reduction in their accrual of emergency interventions (n=24).

- **Discharges**
  - During FY 18/19, a total of 20 discharges occurred. Of those 20, the majority (11, 55%) returned to County Behavioral Health. Of those 11, four (36%) were due to positive reasons such as the participant having met his or her goals at the Providence Center.

- **Productivity**
  - **Objective A:** Minimum productivity standard of 65% of billable time for hours worked
    - In-depth tracking on productivity for the Providence Center began in October of 2018. In the nine months between October 2018 and June 2019, despite onboarding new Personal Service Coordinators which tends to lower productivity, the Providence Center had an average productivity of 73%.
  - **Objective B:** 90% of all participants are Medi-Cal eligible
    - 100% of the beneficiaries served at the Providence Center in FY 18/19 were Medi-Cal eligible.
  - **Objective C:** 5% denial rate for billed and audited services
    - Turning Point, Providence Center maintained a denial rate of only 1% for FY 18/19, meeting their contractual goal to keep denials less than 5%.
  - **Objective D:** Each Medi-Cal service provided must meet medical necessity guidelines and meet Medi-Cal requirements as described by service and activity/procedure code.
    - All Medi-Cal services provided in FY 18/19 met medical necessity guidelines as well as Medi-Cal requirements as described by the service and activity/procedure code.
  - **Objective E:** Contractor shall document and maintain all beneficiaries' records to comply with all Medi-Cal regulations.
    - Providence Center staff documented and maintained all beneficiaries' records in order to comply with Medi-Cal regulations.

- **Emotional and Physical Well Being**: *Goal – to show reduction in mental health symptoms, decrease in depression, decrease in trauma, Recovery/Quality of Life improvement, reduction in substance and/other drug use, and/or improvement in physical health.*

  Turning Point's current attention to trauma informed practice is supporting participant's work toward recovery and quality of life improvement. As an agency, Turning Point has put a focus on trainings and discussions around moving all care toward trauma informed practice. TPCP's RISE (Rapid Integrated Support and Engagement) program has been a successful addition to the Nevada County program over this last year. It serves not only Turning Point members, but also Nevada County Behavioral Health participants. RISE gives those who struggle with both severe mental illness and substance use issues a place to feel welcome and comfortable as they work through recovery.

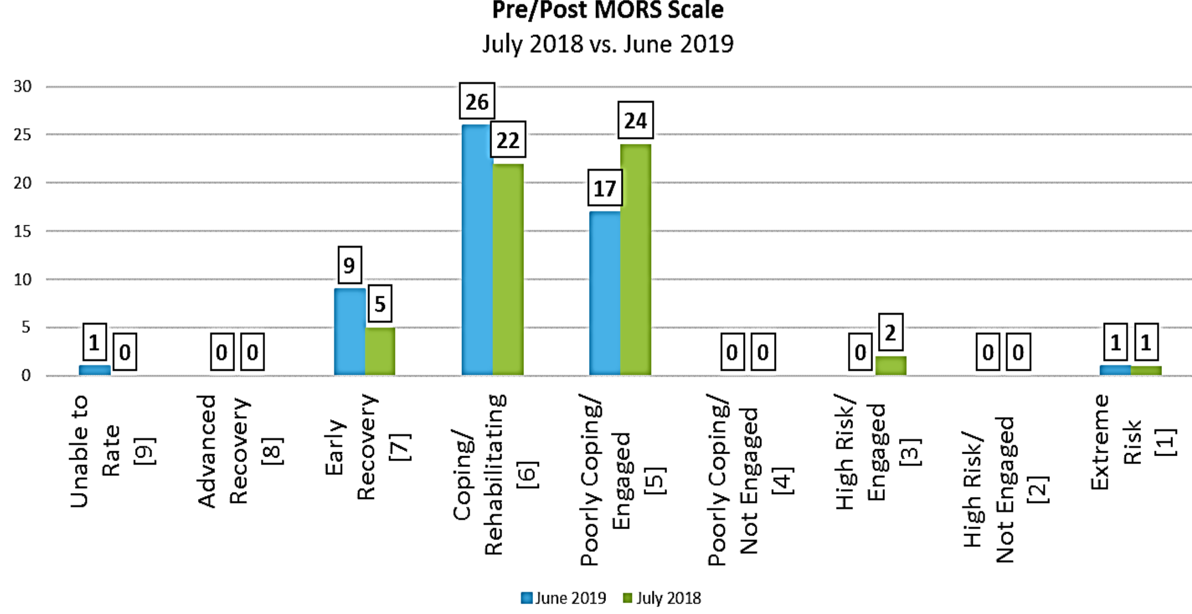
- **Stigma and Discrimination:** *Goal – to show the level or degree of stigma of mental illness, either at the individual or community level is decreased.*

  A marked reduction in stigma has been seen over the last year within community partners. Collaboration continues with local law enforcement, Hospitality House Homeless Shelter, local motels, the courts, medical clinics, Social Services and more. Turning Point participants report navigating the community with less struggle and road blocks than before.

- **Service Access and Timeliness:** *Goal – to show the percentage of non-urgent mental health service appointments offered within 10-15 business days of the initial request for appointment, number and percent of acute psychiatric discharge episodes that are followed by a psychiatric readmission within 30 days during a one-year calendar period, and/or percent of acute (psychiatric inpatient and psychiatric health facility) discharges that receive a follow up outpatient contact or Institution for Mental Diseases (IMD) admission within seven days of discharge.*
    - One hundred percent of non-urgent mental health service appointments were offered within 10-15 business days of initial request.
    - Only two people released from acute psychiatric hospitals were readmitted within 30 days.
    - Of all the acute discharges, 100% received a follow up appointment within seven days of discharge.

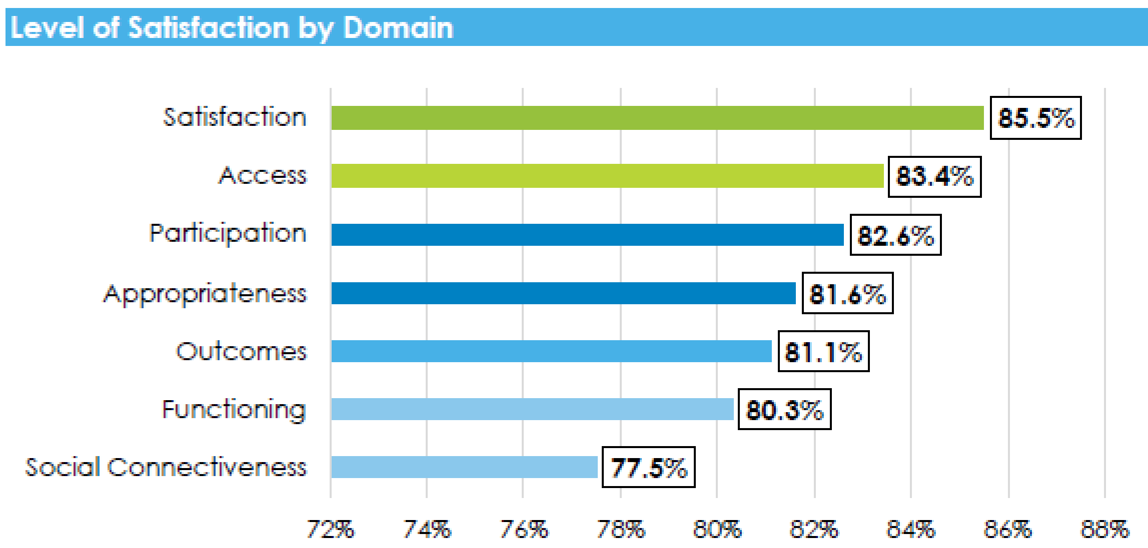
- **Outreach and Engagement** was provided to 58 potential partners throughout FY 18/19.

- **Milestone of Recovery Scale (MORS)**
  The Milestone of Recovery Scale (MORS) is both a clinical and administrative tool. It allows clinicians to measure where individuals are in their journey of recovery and produce data that describes the journey of recovery over time.



A total of 54 individuals were scored at both the beginning and the end of the fiscal year. When comparing scores from the beginning of FY 18/19 (July 2018) with scores from the end of the fiscal year (June 2019), a total of 15 (28%) individuals had a higher MORS score suggesting movement towards recovery including a lower level of risk, an increase in the level of skills and supports beyond program services, and an increase in the individual's level of engagement with program staff. Thirty-six (67%) individuals remained at the same score, two (4%) had a lower MORS score at the end of the fiscal year, and one (2%) was unable to rate.

- **Consumer Satisfaction Survey**
  Between July of 2018 and June of 2019, 74 surveys were administered: 42 (56.8%) individuals completed the survey, and 32 (43.2%) declined to participate. Six of the seven domains were at or above the 80% threshold. This suggests that individuals are generally satisfied with Providence Center's services. The highest rated domain was the Satisfaction Domain (86%). Overall, the Providence Center received a favorable satisfaction rate of 82%.



AOT:

- **Individuals served (5/1/2018 – 4/30/2019):** While nine individuals (unduplicated) were enrolled in AACT/AOT services & supports during this review period, five individuals were ineligible for AOT for various reasons. The remainder of this report data focuses on four people served through the AOT Court Process during the FY 18/19 reporting period.

  AOT OUTCOMES:
  - Beneficiary #1 decreased to zero jails days after entering for treatment.
  - Although Beneficiary #2 had slight increases in psychiatric hospital days and emergency interventions, there was a significant decrease in the number of jail days and homeless days after entering for treatment.
  - Beneficiary #3 decreased to zero emergency interventions after entering treatment.
  - Although there was a slight increase in psychiatric hospital days and emergency interventions, Beneficiary #4 did not accrue jail and homeless days after entering treatment.

Challenges, Solutions, and Upcoming Changes

Turning Point continues to experience challenges in finding and keeping educated and skilled staff, which makes the work more difficult. TPCP has worked very hard on the Career Exploration program and has empowered and trained several former partners to move into employment within

Turning Point. This has been a viable solution to the staffing issues. However, Turning Point still struggles to find and maintain licensed eligible staff. This is likely due to Turning Point's salary structure. Turning Point has just begun a new contract, allowing the hiring of three new employees for the Homeless Outreach and Medical Engagement (HOME) team in collaboration with Nevada County Behavioral Health and Hospitality House Homeless Shelter. There are potential additional Turning Point contracts in the upcoming fiscal year.

Program Participant Story

A Turning Point partner received services on and off for several years with periods of using multiple services across the Nevada County System of Care. Last year this person gained employment. They worked a few hours per week and really began to shine. Their path to recovery escalated, and they became proud of their job and themselves. This person learned new skills that could be applied to many other jobs and gained self-confidence and a sense of purpose. By the end of the year, this individual had met their goals and was discharged from services.

Full Service Partners:

NEVADA COUNTY BEHAVIORAL HEALTH
Full Service Partners

Program Description

Program Overview

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

Target population

NCBH FSP participants are identified as the most severely impaired by mental illness in the community. These individuals need at least weekly case management, and sometimes daily support, to function in society. Consumers aged 18 and above are served by this program. During FY 18/19 service intensity varied by individual for the nine participants served. The focus of increased services across all age groups is to decrease hospitalizations, homelessness and incarcerations by utilizing intense case management, temporary placement at a local transitional home, medication caddy services, and nightly calls to the most high-risk consumers.

Evaluation Activities and Outcomes

Housing - Of the nine Full Service Partner participants identified in FY 18/19, all have a history of homelessness. Six have lived in transitional housing in the past. The local transitional housing has 24-hour staff and is intended as a step down for individuals released from IMD's (Institute for Mental Disease). Residents may stay at transitional housing for up to 18 months while learning independent living skills, medication management and community resources. Residents also focus on housing readiness to enable them to move to a lower level of care and live semi-independently.

Of the nine Full Service Partner participants identified, seven currently live in some level of supported housing. Three currently live in Supervised Independent Living (SIL) housing. Service coordinators facilitate house meetings in the SIL's to ameliorate conflict and provide support to all residents. One partner needed a higher level of care for health reasons and currently lives in a board and care facility outside of Nevada County, as there are no board and care facilities in this county. One partner lives in a Harm Reduction House, which is part of the Bridge Housing program, and is supported by NCBH service coordinators. Two Full Service Partner participants continue to reside at Odyssey House in FY 18/19.

Employment and education – One of the Full Service Partner participants is working toward attaining their General Education Degree. Another Full Service Partner participant is seeking volunteer work in the community.

Criminal Justice involvement - No information was recorded for 18/19 in this area.

Acute Care Use - Of the nine participants, seven had a combined total of 340 days in psychiatric hospitals in FY 17/18 and none had psychiatric hospitalizations in FY 18/19.

Emotional and Physical Well Being - Nevada County has purchased a new "Dashboard" program that will help to analyze program outcomes. Until the dashboard is up and running, the county is unable to analyze the Basis 24 data that has been collected. By FY 19/20 outcomes should be available.

Stigma and Discrimination - The program is increasing awareness of mental health needs especially among the homeless population in this community. The program has been able to work with a property owner on this.

Service Access and Timeliness - All partners in FY 18/19 were existing from the previous year, so timeliness form initial request to first service did not happen in FY 18/19. All partners (100%) received an appointment for follow up within seven days of discharge.

Challenges, Solutions, and Upcoming Changes

Transportation in a small rural county continues to be a challenge as does the stigma associated with mental illness. Many Full Service Partner participants continue to struggle with co-occurring disorders and tend to find connections with people who use drugs and who sell drugs. NCBH is working with a provider and Federally Qualified Health Center's Medication Assisted Treatment programs to help some of these participants remain "clean" from drugs while living in Supervised Independent Living situations.

Program Participant Story

This Full Service Partner participant was born into a home where drug use was the norm, and one or both parents had some level of mental illness. This partner was eventually removed from the home by Child Protective Services and placed in several foster care environments. This person dropped out of school, and quickly connected with what was most familiar, the drug culture. This partner came to NCBH as a Transitional Age Youth (TAY) and had many encounters with law enforcement. The participant was eventually hospitalized for a grave disability due to a first psychotic break and ongoing drug use. The participant had an extensive history of homelessness and was arrested for breaking into homes to find shelter.

This participant has been on conservatorship and in IMDs. Many medications were tried but the participant did not exhibit a significant reduction in psychotic symptoms. The participant was unsuccessful when placed at local transitional housing (step-down housing program) and had to return to the IMD.

This individual was released from the IMD on anti-psychotic medications but still reported symptoms, although not debilitating. The conservatorship was dropped, because the individual's symptoms were improving. However, the participant continued to cycle through the local transitional housing, homelessness, crisis services and was then conserved again due to drug use and psychotic symptoms.

This time, the individual was able to recognize the need for ongoing treatment and discontinuation of illicit drugs. Again, placed at transitional housing, the individual began to engage in activities, attend psychiatry appointments, attend a harm reduction group for co-occurring disorders, learn how to prepare meals and complete chores along with peers. This participant became a model for others struggling with addiction and mental illness. Working toward a GED, this individual has been able to live semi-independently off conservatorship. The participant continues to engage in services provided through NCBH, and is working toward a positive, meaningful life.

General System Development:

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

Program Description

Program Overview

In FY 18/19 Intern Program Expansion added service capacity, increased access, and broadened services in Nevada County. Interns and their clinical supervision were funded through Community Services and Supports (CSS), General System Development (GSD). In FY 18/19, 12 interns provided 9,221 hours of Mental Health services, treating 234 individuals. The Adult System of Care provided 5,742 hours, treating 138 individuals; The Children's System of Care provided 3,479 hours, treating 96 individuals. Additionally, 1,119 hours of intern supervision were funded by this source.

General System Development:

NEVADA COUNTY ADULT & CHILDREN'S SYSTEM OF CARE
Network Providers

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) has licensed therapists, Network Providers, who work in the community at private offices. They see children, Transition Aged Youth (TAY), adults and older adults referred to them by NCBH. Nevada County Behavioral Health refers program participants with less acute needs to the Network therapists. These individuals do not appear to need medication or significant case management. Network providers help to serve additional individuals and offer partners and families a variety of specialties and locations that NCBH would not be able to offer otherwise. Network providers are funded under both the Adult and Children's programs within CSS. In FY 18/19, 20 unduplicated participants were served. This includes 13 individuals served in the Children's System of Care and seven individuals served in the Adult System of Care.

Target Population

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

Evaluation Activities and Outcomes

Baseline and annual Basis 24 outcome measure surveys continue to be collected for individuals served by the Adult System of Care. Individual and aggregate reporting on outcomes will soon be available through the county's new Dashboard system provided by Kings View. However, aggregate reporting for this subset of program participants is not yet available through the Kings View Dashboard.

The NCBH Children's System of Care is collecting the Child and Adolescent Needs and Strengths Assessment (CANS) and the Pediatric Symptom Checklist 35 (PSC-35) outcome measures. As with the Basis 24, the CANS and the PSC-35 will soon be available through the county's new Dashboard system provided by Kings View. However, aggregate reporting for this subset of program participants is not yet available. The county hopes this functionality will be in place by next year's report.

Challenges, Solutions, and Upcoming Changes

There has been a decrease in the number of Network Providers contracted with the county. This has caused a reduction in the overall total of individuals served for this program in FY 18/19.

General System Development:

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

Program Description

Program Overview

The Nevada County Behavioral Health (NCBH) System of Care spent $223,585 for psychiatric services in FY 04/05. MHSA allows counties to expand the amount of psychiatric services provided to beneficiaries starting in FY 07/08, by paying for these services out of MHSA, Community Services and Supports, General System Development funds. Due to system changes at the county between 2005 and 2007, historic data from FY 06/07 was not available to use as a baseline. Thus, FY 04/05 became the baseline measurement for the Expanded Psychiatric Services program for NCBH and the county reports annually on the amount of MHSA funds used for psychiatric services. In FY 18/19 MHSA funds paid $639,326 for 3,516 Expanded Psychiatric services to 532 individuals.

Nevada County Behavioral Health (NCBH) Children's Services provided 695 Expanded Psychiatric services to 138 children with MHSA funds totaling $138,163 in FY 18/19. Some

children were being wrapped with Full-Service Partnership (FSP) providers. Some children continue to see the NCBH doctor individually and work with the WRAP team.

Nevada County Behavioral Health Adult Services provided 2,521 Expanded Psychiatric services to 394 adults with MHSA funds totaling $501,163 in FY 18/19.

General System Development:

SIERRA FAMILY MEDICAL CLINIC

Program Description

Program Overview

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

Target Population

SFMC targets the low income unserved and underserved segment of the County's population with mental health needs, primarily individuals in the North San Juan Ridge Area. Two thirds of SFMC participants are low income: 77% of visits are with individuals with Medi-Cal insurance. Additionally, 36% are on Medicare with a significant number either also with Medi-Cal, or without a secondary insurance plan.

Evaluation Activities and Outcomes

In FY 18/19 66 unduplicated individuals were served by this program. Consistent with Clinic practices, warm-handoffs from medical providers resulted in approximately 90% of individuals connecting and continuing with behavioral health services. Eighty percent of participants engaged in referral services within 90 days. Participants were referred to Hospitality House, LogistiCare transportation, Medi-Cal, CalFresh, Family Resource Centers (FRC) (especially the San Juan Ridge FRC), Alta Regional Center, Community Beyond Violence, SPIRIT Center, Granite Wellness Center, Common Goals, Nevada County Behavioral Health, FREED, Community Legal, Workforce Development, Connecting Point, Interfaith Food Ministry, Salvation Army, North San Juan Senior Center, and community therapists.

Challenges, Solutions, and Upcoming Changes

The greatest challenge continues to be transportation. Although public transportation is now available through a specialized "Route 7", the ability for participants to use it for appointments is minimal. SFMC provided the Transit Director the health center's hours of operation, but there are still concerns.

Arrival Concerns

- Bus arrives at the Center at 6:47a.m. The Center doesn't open and does not allow people inside until there is adequate staffing at 7:45 a.m., a gap of one hour.
- The Bus also arrives at 4:28p.m. which is limiting as the last appointment slot is at 4:30p.m.
- The Bus also arrives at the Center at 6:28pm when the Clinic is closed. Doors are locked between 5-5:30 pm.

Departure Concerns

- The closest bus stop is at Ananda, approximately a mile from the Clinic.
- Departing at 7:04 a.m. from Ananda – the Clinic is closed.
- Departing at 4:34 p.m.—if participants were to use this option, it's a mile walk which may not be feasible; alternatively, is there an option that a patient could stand at the bus stop by the Clinic and walk across the street which is not especially busy. There is a private wide driveway entrance across from the bus stop

Although Managed Care Medi-Cal beneficiaries can access transportation through LogistiCare services for medical appointments, there can be significant challenges. Sometimes a vehicle is not available resulting in missed appointments. Several times patients have experienced extended waits while the services find a vehicle that can come to pick the beneficiary up after an appointment; participants don't always wait.

Individuals not on Regular/Straight Medi-Cal do not have access to LogistiCare and have cancelled appointments due to the inability to pay for gas for their cars. Their cars break down but may not be able to be fixed due to lack of funds.

Consumers on regular Medi-Cal or Medicare have challenges getting to town for medical specialty appointments due to transportation barriers as well. The transportation issue needs attention beyond SFMC. SFMC staff encourage carpooling and consumer connection, but do not have the resources to address this concern.

Food scarcity is an increasing problem; transportation to obtain food can be crucial and not readily available to some consumers. Referrals to the FRC, food banks, and Interfaith Food Ministry are very helpful, but for consumers with transportations barriers, this continues to be a problem.

Secondly, housing continues to be a major need. Rentals are still hard to find, let alone affordable housing and temporary housing for individuals who are not eligible for current community programs; some people continue to live in substandard housing and crowded conditions. SFMC helps consumers sign up for Personal Choice Housing vouchers when available, but the housing issue continues to grow.

Program Participant Story

A wonderful outcome story features a new participant who initially presented with physical ailments, and wanted help getting state disability benefits. Staff worked with her, and as often is the case, behavioral health issues slowly came out as she felt more emotionally safe to share her feelings. Over time it became clear that she had co-occurring substance use, mental health, and physical health conditions. By aligning with her and working through stages of change, she engaged and completed a treatment program for her substance use. She maintains counseling and medical treatment for her co-occurring disorders in addition to utilizing other local Substance Use Disorder services. She is extremely grateful and feels she has her life back.

General System Development:

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

Program Description

Program Overview

Community Recovery Resources (CoRR) provides services to adult Medi-Cal beneficiaries experiencing concurrent issues of substance use and mental illness. Services are recovery-oriented and driven by the unique needs, strengths and natural supports 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 Co-Occurring Disorders (COD) best-practices model within a recovery-oriented system of care.

Target Population

CoRR treats individuals who have a moderate to severe substance abuse problem and moderate mental health problems. Individuals treated also meet Medi-Cal medical necessity, diagnostic and other criteria for Medi-Cal specialty mental health services.

Evaluation Activities and Outcomes

CoRR tracks demographic information, treatment outcomes, and community goals such as number of emergency room visits, hospitalizations, homelessness, increases in work or volunteerism, decreases in arrests, reduction in number of individuals on probation, drug of choice, increase in participation in community-based self-help or support, and reconnection to family. This data is gathered from participant’s self-report, URICA Change Assessment Scale scores, QOL (Quality

of Life Scale) scores, clinical observation and progress reporting. Adults complete the BASIS-24 for evaluation of clinical outcomes and participate in county Behavioral Health's satisfaction survey twice per year.

Program Outcomes:
The COD Adult program served 27 unduplicated adults in FY 18/19. Of the 27 adults, eight remain enrolled, seven were successfully completed, three were transferred to other services, and nine withdrew from services.

- Treatment goals: Approximately 72% of the population met their treatment goals measured by self and staff.
- Symptom reduction (Basis-24 items 10-20): Approximately 93% of enrolled adults reported history of trauma. Of those, 67% reported a decrease in individualized symptom reduction according to the Basis-24, (treatment team tracking, progress notes, assessments, individual BASIS-24 responses).
- Involvement with the law: Approximately 37% of the population began the program on probation, and 16% successfully terminated probation. Four percent of individuals had return incarcerations while in the program, the result of sanctions from Adult Drug Court or other probation violations.
- Substance Use: Approximately 63% of the population saw a decrease in substance use. The subcategories of the URICA-24; contemplation and action, saw the highest rates of increase (see chart below).
- Homelessness: There was no increase or decrease in homeless rate as measured by self and staff report.
- Emergency Department Visits: Less than 5% of the population experienced medical or psychiatric hospitalization.
- Employment: Approximately 66% of the population achieved volunteer and/or gainful employment as measured by self and staff report.
- Education: Approximately 6% of the population returned to school to further their education.
- Self-Help: 68% utilized community self-help groups.

Scores for the BASIS-24, the Quality of Life (QLS) and URICA-24 (Readiness for Change) were taken at the beginning, middle and end of treatment. A comparison was made between the scores taken at intake and the scores taken during the middle of treatment. The closing sample was not used in comparison due to low sample size.

BASIS-24- A difference was noted between the BASIS-24 overall mean scores of beneficiaries at admission (mean=1.72) and mean scores taken in the middle of treatment (mean=1.90). This finding denotes that beneficiary average scores increased by 0.18 which indicates a reduction in symptoms.

QLS-The total mean score at admission (mean=73.21) was compared to the total mean score at the middle of treatment at (mean=78). The overall findings of the Quality of Life Scale (QLS) indicate that the beneficiary average scores increased by 4.79. Higher scores on the QOL indicate a higher quality of life and an average score for a healthy population is 90. These findings indicate an improvement in beneficiary perception and emotions related to different areas of their life after treatment.

URICA-The readiness scores derived from the URICA-24 were used to indicate progress during treatment. The subscale scores represent attitudes and activities related to the stages of change. The subcategories include: pre-contemplation, contemplation, action and maintenance. Shifts in subscale scores are associated with the shifting people go through during the process of change, which is not a linear, single variable.

URICA-24	Pre-Contemplation	Contemplation	Action	Maintenance
Average Score at Admission	1.7	2.9	4.2	3.5
Average Mid-Tx Scores	1.2	4.4	4.5	3.3

Overall these findings indicate an increase in the average scores of contemplation and action subcategories and a decrease in pre-contemplation and maintenance. These results signify that participants saw an increase in examination of their alcohol or substance related problem/s as well as an increase in the engagement with more difficulty engaging in behaviors associated with pre-contemplation and maintaining their sobriety.

Challenges, Solutions, and Upcoming Changes

The program is driven by harm reduction as its primary approach. This presents challenges in a treatment and recovery-based model/environment for those who are best served adopting abstinence. Additionally, it makes it more difficult for participants better suited to a harm reduction model to utilize community 12 step social recovery meetings for their support network/strategy, when Dual Recovery Anonymous groups are not available. For example, when participants continue to smoke Marijuana, and present smelling of marijuana, that is often triggering for other group participants or those in the clinic, working on abstinence from Marijuana. This creates exclusion from the recovery community.

Program Participant Story

John (not the individual's real name) came to CoRR's Co-occurring Disorders (COD) Program in FY 18/19. At intake he was identified by the counselor to have potential co-occurring disorders based on his symptoms and history. He exhibited symptoms of anxiety and distress. At intake John revealed that he had been using alcohol regularly for years. He reported a long history of risk factors for COD. John immediately began attending therapy sessions, rehab sessions, and outpatient groups through CoRR in addition to outside Alcoholics Anonymous (AA) meetings.

John had excellent attendance at his appointments, groups and meetings. He was honest and sincere regarding his alcohol use and wanted to address the underlying issues contributing to his excessive drinking. John reported that his anxiety began to decrease when he joined CoRR's men's group, and a reduction in other symptoms as well. Within a month, John began to "open up" about his childhood in 1:1 therapy and in the group. He claimed that this is when he "started to turn

things around." In therapy he was drawn to DBT techniques – distress tolerance, mindfulness and emotional regulation.

John has been able to maintain sobriety and implement new coping skills in the face of several 'trigger' events in his recent life. John has since completed the men's group and continues to stay in contact with his recovery community. With encouragement from his therapist, John has agreed to begin attending events in the community to expand his social network with "like minded individuals." John is currently using the medium of art to process his trauma and pain from the past.

John shared with staff that the combination of individual services and the men's group enabled him to begin the process of "uncovering blocks and looking at childhood trauma" in a safe space with trusted individuals. He reported the group encouraged him to be vulnerable and that has improved his interpersonal effectiveness and communication skills. John continues to maintain abstinence from all substances. He no longer experiences debilitating periods of anxiety, and often uses DBT tools learned in treatment. John has successfully completed two out of his three treatment plan goals and he continues to attend therapy sessions with a plan to become "a sponsor for someone else in need" in his AA meetings. John stated recently, "I'm less afraid to talk to people that I don't know because I have more confidence in myself and my ability to connect authentically."

General System Development:

NEVADA COUNTY SYSTEM OF CARE
Expand Mental Health Services

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) provided Expanded Mental Health services to program participants using General System Development funds. These funds paid for 164 individuals in FY 18/19.

Target Population

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

Evaluation Activities and Outcomes

Employment and Education:

- Snack Shack – Vocational training is available through the Snack Shack program. The Snack Shack program had previously been a collaborative effort between the National Alliance for

the Mentally Ill (NAMI), the Nevada County Behavioral Health (NCBH) Department (both adult services and children's) and Consumers. In December 2017 NAMI left this partnership and was replaced by SPIRIT Peer Empowerment Center in collaboration with NCBH. The Snack Shack is a consumer driven retail program providing vocational skills and structure. Participants learn customer service, cash register skills and team building. Management of the program is provided by consumers and a consumer with bookkeeping experience balances the receipts. In FY 18/19 there were three managers and 18 participants that volunteered to work in the Snack Shack program.

- Peer Support Training - Peer Support Training is an eight-month program where consumers develop skills to counsel and support peers. The goal of the support services is to promote self-empowerment, independence and interdependence, facilitating consumers functioning and thriving in their community. Training requirements are no more than four missed sessions and completion of a mock peer support session. The training offers one of two outcomes: 1) a certificate of graduation or 2) a certificate of participation. Of the six training participants in FY 18/19 who completed Peer Support Training, none were a Full-Service Partner. Within the graduates of the program:
  - Three participants took the training for personal enrichment.
  - Three participants graduated with diplomas.

  After graduation, consumers are introduced to volunteer opportunities in the community. At the end of FY 18/19:
  - Two graduates volunteer as assistants in the Peer Support program at Behavioral Health
  - One participant is now employed full time locally.
  - One graduate is employed with and has been recently promoted within a local behavioral health agency.
  - One participant was hired as a bilingual teacher.

Supportive Services:

- Saturday Adventure Outings - Saturday Adventure Outings serve high risk consumers who have a history of being isolated on weekends. The goal of the program is to engage these individuals socially with other peers resulting in decreased symptoms of mental health issues and increased quality of life. The consumers organize the adventure and determine the activities each week. Two peer staff members provide transportation utilizing Behavioral Health vehicles. The staff also provides support and referral services during the program. This creative solution has enabled individuals to access social interactions through activities they determine. In FY 18/19 the New Directions Program had eight 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.
- Art Therapy: Art is the application of the visual arts and the creative process within a therapeutic relationship. It is designed to support, maintain, and improve the psychosocial, physical, cognitive, and spiritual health of individuals. It is based on current, and emerging research that art-making is a health-enhancing practice, that positively impacts quality of life. In FY 18/19 24 participants attended this group.
- Co-occurring disorders group is designed to address the needs of individuals with mental illness who are seeking support to maintain sobriety. The group provides useful techniques,

and social support in a clean, sober and nonjudgmental environment. Research demonstrates that treating these disorders concurrently tends to lead to higher levels of success than treating each individually. In FY 18/19 29 participants attended this group.
- Sierra Outreach Services (SOS): provides opportunities for socialization skill-building in the community. The group facilitator transports participants to various community events and activities to facilitate "real world" interactions between participants and the community where they live. The program provides opportunities to observe and practice appropriate social behaviors, foster connections in the community and reduce the stigma around mental illness. In FY 18/19 this program had 32 participants.

Program Participant Story

A participant in the Peer Support Training Program who is now employed at a local agency, was very reluctant to take the Peer support training. He was depressed and a bit belligerent. As the weeks went by, he started to trust the teacher and the other students, and he began to share the story of his life. Then, he had a death in the family, someone with whom he was very close. He came to the group for support and was met with kindness and compassion. This man, who was so closed off and angry, began to show his vulnerability. He completed the training and graduated. During the graduation ceremony he cried.

He applied for a job at a local agency but had to wait a month for clearance. He was not optimistic about getting the job. When he finally landed the position, it was winter time and the roads were icy. He did not think that his car would be able to handle the icy roads. With a lot of encouragement from staff and other students from the class, he was able to overcome his concerns and now he loves his job and is a true asset to the agency.

General System Development:

NEVADA COUNTY SYSTEM OF CARE
Expand Mental Health Services - Forensic Outreach

Program Description

Program Overview

Forensic Specialist Services aim to prevent and decrease law enforcement contact and incarceration for individuals experiencing mental health conditions. The program provides assessment of needs and obstacles, referrals to community resources, support accessing substance use disorder treatment, consultation, and direct counseling interventions. The Forensic Specialist engages with numerous community resources including Law Enforcement, Mental Health Court, Public Defender, Behavioral Health, Adult Protective Services, Hospitality House, Community Recovery Resources (CoRR), Common Goals, National Alliance for the Mentally Ill (NAMI), SPIRIT Peer Empowerment Center, and other social service providers.

Target Population

Forensic Outreach provides services for persons who are, or have been, incarcerated and who are ready to be, or have been, released back into the community. Many of the people referred to the program are homeless or at risk of homelessness.

Evaluation Activities and Outcomes

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

During FY 18/19, Forensic Outreach provided services to 163 unduplicated participants. The program provided 522 referrals to participants over the year, averaging 3.2 referrals per participant. See the table below for more detailed referral information.

Agency Referred To:	FY 18/19 # of Referrals
Nevada County Behavioral Health (NCBH)	206
Hospitality House/Homeless Shelter	81
Dial 2-1-1	43
CoRR	35
Sierra Nevada Memorial Hospital	25
Crisis Stabilization Unit	23
Physician/ MD	22
Western Sierra Medical Clinic	17
Other: AMI, Health Babies, Crisis, Odyssey House	17
Insight Respite House	14
SPIRIT Center	14
FREED Center for Independent Living	4
Chapa-De Indian Health	4
Social Services Agency	4
Veteran Services	3
Food Bank	2
Legal Services	2
Adult Protective Services	1
Financial Assistance	1
Family Resource Center	1
Faith-Based Organization	1
Domestic Violence Sexual Assault Coalition	1
Sierra Family Medical Clinic	1
Total # of Referrals in FY 18/19:	**522**
Average # of Referrals per Individual:	**3.2**

Challenges, Solutions, and Upcoming Changes

An overall lack of affordable housing in the community continues to be a challenge facing the target population. Bridge Houses and partnership with AMIH (Advocates for Mentally Ill Housing) have been able to provide additional beds but need continues to exceed supply. Addressing mental illness, addiction and recidivism are difficult tasks. Attempting to do so without sufficient housing resources is a cultural challenge. The Hospitality House Low Barrier shelter program continues to be a critical, first-step resource, allowing for individuals who had in the past not been eligible for shelter services, to access beds without sobriety or zero-tolerance for substance use requirements. Many consumers are able to access shelter, showers and meal services, while also creating relationships with shelter staff and other community service providers; a key component of any long-term, sustainable housing or treatment plan is the formation of such relationships. Community team meetings focused on homelessness, housing, partnerships with law enforcement officers and officers of the court, and other community providers also continue to bolster a community wide and unified approach to overcoming the social, cultural and economic impacts to this target population, and the greater community as a whole.

Program Participant Story

After two attempts at Bridge Housing and multiple periods of incarceration as a result of alcohol and homeless related misdemeanor crimes an older individual is thriving in supportive housing. With the stabilizing effects of housing and sobriety sustaining themselves this person has been able to address and coordinate care for a variety of physical ailments that have piled up as the result of years of hard living on the streets and in correctional facilities. Working in partnership with the Public Defender’s office, the office of the District Attorney, Nevada County Probation, Wayne Brown Correctional Facility medical staff, NCBH, AMIH, Grass Valley Police Department, Hospitality House homeless shelter and other community providers this one story exemplifies how a community can work together to promote increased quality of life and opportunity for its most vulnerable citizens. This individual found shelter at the Hospitality House through Low Barrier beds out of custody, transitioned to AMIH Bridge Housing, and remains housed through a multi-level cooperative community effort.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Crisis Workers, Crisis Support Team

Program Description

Program Overview

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

The Crisis Workers provide direct crisis intervention services to program participants by phone contact and face-to-face evaluation. Crisis staff also respond 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 are appropriate.

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

Target Population

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

Evaluation Activities and Outcomes

In FY 18/19 the targeted goal was for Crisis Specialist to serve 996 individuals. The result was 1,123 unduplicated people served, representing 113% of the goal. A total of 2,275 contacts occurred; many of the individuals were seen two or more times throughout the year. This is a substantial increase (7% increase) from the total contacts during the prior FY 17/18, where the Crisis Workers had a total of 2,219 contacts.

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

Consumers have also expressed satisfaction with the immediate service and additional resources. Crisis Specialists provide quicker crisis stabilization with the CSU in the same building as the Crisis office. With the walk-in policy from 10 am – 10 pm, consumers get immediate crisis response without having to go through the Emergency room during daytime hours.

The requirement to have a qualified Crisis Specialist in service at all times has been met, and there is often more than one Crisis Specialist available to support participants.

Challenges, Solutions, and Upcoming Changes

Hiring and training of qualified staff can be a long process. The nature of crisis work is detail-oriented and responsibilities are multi-faceted, requiring strong skills in multi-tasking, and organization. Hiring preemptively to account for unexpected staff changes has become a necessity. Training can take up to a month before a new staff member is ready to take a shift, followed by several months of close oversight and supervision. This is a system we are actively working on improving.

One consumer category is particularly challenging; the highly acute, potentially violent. This has been an ongoing process of improvement. Last year, the crisis office improved security measures by adding a security monitor and training staff on using emergency call buttons and codes. In FY 18/19, a new exit door was added to the crisis office. This offers an additional way out if there were an issue in the entryway, which was formerly the only route out of the office. Additionally, de-escalation trainings have been scheduled for all staff over the summer months.

Lastly, there has been a significant increase in the number of individuals seen per year since the CSU first opened. In FY 18/19 it became necessary to consider adding a 1.2 FTE position to increase Crisis Specialist support during day and weekend hours. These additional hours were approved and beginning July 1st, 2019 there has been an additional 40-hours of Crisis Specialist support on the floor during daytime hours, and an additional eight-hours of support by a Crisis Specialist during weekend evenings. This additional help provides an increased ability to respond to individuals in a timely manner, as well as provide additional support in finding timely placement and essential resources for consumers.

Program Participant Story

A consumer was brought from another county to the Crisis Stabilization Unit because she was a Nevada County resident. She was on a 5150-hold at the time she arrived. During her treatment at the CSU, she was supported in establishing resources, was able to stabilize, and have her 5150-hold lifted. After the hold was lifted, a friend arrived to pick her up and brought along the woman's child who had a bouquet of handpicked flowers for her. The reunion was sweet and a great reminder of how beneficial a few days of support and care can be for someone having a difficult psychological experience.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Crisis Stabilization Unit (CSU)

Program Description

Program Overview

The Crisis Stabilization Unit (CSU) serves Nevada County consumers experiencing a mental health crisis or emergency. It is a four-bed, unlocked unit, always staffed by a licensed mental health professional and a licensed medical professional on-site. Psychiatrists are on-call 24 hours a day, seven days a week. A new CSU Supervisor was hired in May 2019. The supervisor works in close partnership with the Crisis Response Team Supervisor and the Lead Clinician. Consumers may be admitted voluntarily for a maximum stay of 23 hours or while awaiting placement on a Welfare and Institutions (WIC) § 5150 hold. For FY 18/19 the CSU served 460 individuals with 811 total admissions.

Per Medi-Cal requirements, beneficiaries can stay up to 23 hours at the CSU. During that time, they are assessed by the licensed medical professional for medical issues that may be contributing to their crisis. Current medication interactions are investigated along with assisting beneficiaries in making appointments for any needed follow-up for medical concerns with their primary care doctor. Upon request the nurse will also help to establish a primary care doctor by assisting beneficiaries with new patient forms for local offices and clinics.

A personalized recovery plan is developed by the licensed mental health professional in conjunction with the beneficiary. It explores the individual's strengths and support system to help resolve their crisis and improve their coping skills. Specific referrals to meet the individual's needs are offered and, often, warm-handoffs are provided to local agencies / community resources for behavioral health and /or drug rehabilitation, medical services, housing referrals and more.

Target Population

The CSU was established with the intention of reducing the need for psychiatric hospitalization when someone is in crisis due to exacerbation of symptoms resulting from a mental illness, or as a reaction to life stressors, or both. Medi-Cal beneficiaries on a WIC § 5150 hold whose crisis can be relieved by a 23 hour stay in the CSU with therapeutic and medical intervention, are the target population for this program. The program also serves and voluntarily admits uninsured and privately insured individuals 18 years or older.

Evaluation Activities and Outcomes

The CSU program admitted 811 (duplicated) individuals in FY 18-19. This program has resulted in the rescinding of 113 out of 233 individuals placed there on a WIC § 5150 during FY 18/19 by stabilizing them and connecting them to local doctors and resources. That means 48% of the WIC § 5150 holds were rescinded or expired. Collaboration between therapists, beneficiaries and their loved ones, development of a personalized recovery/ safety plan and follow-up appointments made by the CSU staff, helped stabilize patrons enough to rescind their holds. The availability of the CSU offers the crisis staff an additional resource as part of the beneficiary's safety plan. For the patron, it is a safe haven away from the stressors that are often catalysts to their crisis and a way to be connected with a therapist, nurse and resources in the local community that can help.

The CSU is seen as a success by beneficiaries. Satisfaction surveys were completed by 18% of individuals that stayed in the CSU during FY 18/19. The surveys showed 97% satisfaction with the treatment received and the progress made during individuals' stay. Beneficiaries who were unfortunate enough to have mental health emergencies prior to the CSU being completed in 2015 are particularly appreciative of the services provided and the compassionate, therapeutic nature of the care.

Sierra Nevada Memorial Hospital (SNMH) is also appreciative of the CSU. The CSU provides a place for patients with a psychiatric need to receive care that is not traditionally provided in an emergency room setting. Beneficiaries evaluated in the emergency room, who meet CSU admissions criteria, are transferred to the CSU as quickly as possible.

The county jail, Hospitality House, FREED, and local clinics often refer people directly to the CSU. A working relationship has been established with these agencies to communicate with Crisis and CSU staff regarding beneficiary care. Arrangements have also been made for Placer and Sierra Counties to admit their beneficiaries to the Nevada County CSU when needed.

The impact of the CSU cannot be overstated, and it is lauded at community meetings on a frequent basis. In October of 2018 Sierra Mental Wellness Group was awarded with the 2018 Community Partner Award from the Health and Human Services Agency in Nevada County.

The local respite center received 17 documented warm handoffs from the CSU in FY 18/19. Many more CSU patrons could have used respite services, were beds available. Spirit Peer Support staff visit with CSU patrons daily, offering them follow-up support and referrals to groups offered at Spirit Center.

In the late summer and early fall of 2018 there were record high admissions to the CSU. There were 75 admissions in August, 78 in September and 76 in October.

Crisis Stabilization Unit
Summary by Fiscal Year

Fiscal Year	Admits	# of Medi-Cal/ Medi-Medi	# Other	% Medi-Cal or Medi-Medi	Average duration per admit (hrs.)	5150	# Rescind 5150
FY 18-19	811	632	179	78%	21.80	233	102
FY 17-18	767	627	140	82%	21.28	275	92

Challenges, Solutions, and Upcoming Changes

One challenge at the CSU is the often-long wait time for the SNMH ambulance to pick up beneficiaries and transfer them to psychiatric placement. A solution devised by CSU staff is to have Pro Transport on stand-by for when an SNMH ambulance is not available. Another challenge is getting beneficiaries signed up for Medi-Cal. It often takes a long time for Medi-Cal to process the applications. In working with GetixHealth at SNMH, CSU staff are now able to get

beneficiaries signed up for same-day HPE (Hospital Presumptive Eligibility) Medi-Cal. GetixHealth also helps beneficiaries fill out the application for permanent Medi-Cal.

Many CSU patrons deal with substance addictions, so CSU doctors have developed new protocols to use non-addictive medications. Trazodone, a non-addictive medication now replaces Ambien, a potentially addictive benzodiazepine, for related issues. The first drug of choice at the CSU for anxiety is now Vistaril, in place of Ativan, another benzodiazepine. Ativan can be used if the Vistaril is not effective, however approximately 70% of the time individuals who receive Vistaril for their anxiety experience relief of their symptoms.

The CSU has received multiple requests from local agencies for CSU staff to come and present to them about the CSU's services. There are still many agencies & people that are not aware of the services offered. This is a great opportunity to reach out and educate the community about the CSU.

Program Participant Story

An individual with a history of mental illness and substance abuse came to the CSU in a crisis on a WIC § 5150. This individual was connected with the CoRR Navigation counselor to begin the Substance Use Disorder treatment process and was referred to NCBH for approval of treatment funding. After the WIC § 5150 expired the individual went to CoRR, participated in inpatient treatment and then went into a Transitional House Program. This person is now employed, sober, seeing a psychiatrist regularly, taking medication and actively pursuing a peer training program.

In summary: The CSU serves beneficiaries with a mental health emergency in the most compassionate, therapeutic way possible while also serving all the stakeholders of the community and its residents.

General System Development:

TURNING POINT
Insight Peer Respite Center

Program Description

Program Overview

Turning Point's Insight Respite Center (IRC) is a peer-centered program where guests seeking relief from symptom distress are treated as equals on their path to recovery. Creating a bridge between health care providers, individuals, and the community is the essence of interdependence and serves to strengthen the community. The approach is based on the core values of mutual respect and mutual learning. It is about guests connecting with someone in a way that supports them in learning, growing and healing.

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

Services provided include the following:

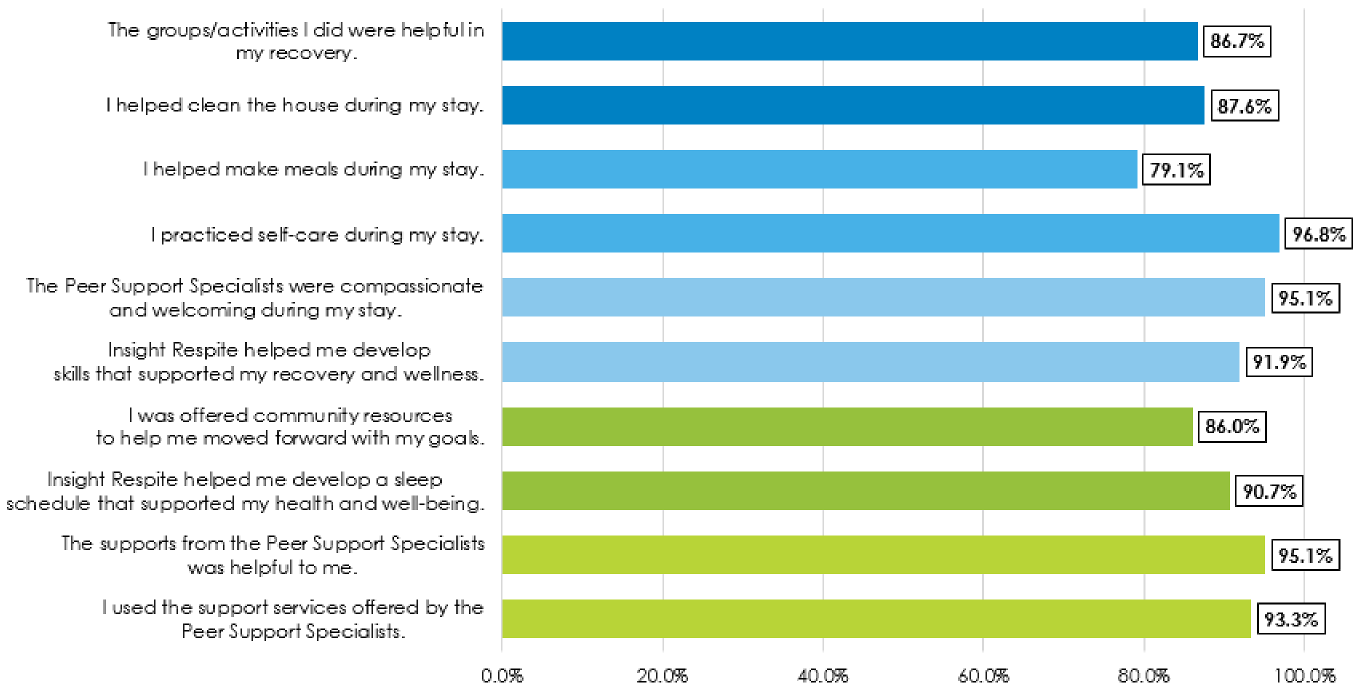
- Crisis intervention
- Rehabilitation
- Guest advocacy
- Life skills

Target Population

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

Evaluation Activities and Outcomes

- A total of 81 deduplicated guests were served at IRC in FY 18/19.
- The total number of duplicated service contacts for FY 18/19 was 185.
- Demographic data is gathered on all guests served.
- Insight Respite Center is 100% peer staffed.
- Insight Respite Center guests received 56 referrals to community services during their stay.
- At discharge, 71.1% of guests met their goals.
- In FY 18/19 five (4.2%) guests were referred to Insight Respite Center from the Crisis Stabilization Unit (CSU). Of the 114 discharges during FY 18/19, only one (0.9%) guest was discharged to an inpatient psychiatric hospital, Psychiatric Health Facility, or VA hospital.
- Based on data from the Satisfaction Survey below, guests are satisfied with the services they receive. Overall, guests gave IRC services a satisfaction rate of 90.2%.



Challenges, Solutions, and Upcoming Changes

With the conclusion of SB82 funding at the end of FY 17/18, IRC became Medi-Cal certified, launching billing services in FY 18/19. This funding stream has gone well, steadily increasing over the course of the fiscal year. IRC looks forward to continually progressing toward sustainability.

Program Participant Story

Written by a former guest:

> *"This wonderful, peaceful, positive and happy experience helped me feel safe and positive enough, and for long enough, with a lot of support for my medicine to begin working. I just started back on a medication a little less than 2 months ago and this environment really gave it a chance to work. I love that it is a clean & sober environment, because it just helps my recovery remain strong. With such love & support as Respite provides it makes one stronger as a mentally ill woman in recovery. Thank you for your staff and your services."*

General System Development:

SPIRIT
Emergency Department (ED)
Crisis Peer Support Program

Program Description

Program Overview

The SPIRIT Peer Empowerment Center (SPIRIT Center) has Crisis Peer Supporters to provide additional on-call support to individuals in crisis in the Emergency Department (ED). The trained and experienced SPIRIT Center Crisis Peer Supporters (CPS) are available to respond to a call from a Crisis Worker, and immediately come to the ED. CPSs are available from 10:00 a.m. until 8:00 p.m., seven days per week.

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

Target Population

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

Evaluation Activities and Outcomes

In FY 18/19 a total of 1,042 services were provided at the ED/CSU/ICU. The Emergency Department Program (EDP) Crisis Support Specialist work closely with the SPPIRIT Peer Empowerment Peer Support Specialist's (PSS) to offer ongoing support to ER/CSU beneficiaries by encouraging follow-up appointments, inviting them to join groups, receive ongoing peer counseling and access other services. The CPSs support people who have been seen in the ER/CSU when possible, to maintain the relationship and rapport established at the hospital. In FY 18/19 a total of 14 SPIRIT ED program participants have become SPIRIT Center participants.

The total number of unduplicated participants served in FY 18/19 is 225. There were 267 Action Plans discussed in the year, 248 Stress Reduction Techniques discussed, and 106 Stress Reduction Techniques were put into practice (based on follow-up calls). There were 822 referrals made over the year. Statistics include cumulative totals of people served in the SPIRIT ED program. All 164 individuals who received 5150 evaluations in FY 18/19 who have phones and gave permission for follow-up, were called by a CPS an average of two times in attempts to follow up. The CPSs

continue to see people served in the ED who have no phones but want follow-up through other methods such as mailing calendar updates or coordinating with the CSU.

The SPIRIT Director and SPIRIT ED staff meet monthly for ongoing training. SPIRIT ED continues to invite community partners to speak at the monthly meetings. FY 18/19's educational topics included: Nevada County Respite Services, Community Legal Resources, Free phones and IDs, the CPS's role in 5150s, and the importance of debriefing and follow-up one-on-ones. Future staff meeting topics will include: Community Legal Services and the Self-Help Legal Center, located in the Law Library in the Nevada County Courthouse.

Challenges, Solutions, and Upcoming Changes

Challenges and Changes: The one continual challenge for CPSs is reaching individuals who do not have phones. Staff continues to inform participants about the free phone programs.

Solutions and Successes: The EDP exceeded their annual target of 220 unduplicated individuals served in FY 18/19, by serving 225 individuals. This was a success considering the low number of individuals served in the first and second quarters of the year. The CPSs call or check in at the CSU and the ED during their shifts to see if any assistance is needed. This helps to increase the number of beneficiaries served. The number of individuals served went from 62 in the second quarter up to 113 in the third quarter and 107 in the fourth quarter. The goal for FY 19/20 is to double the number of individuals served in the SPIRIT EDP. This future goal will be supported by: learning about new and ongoing resources available, through consistent follow-up appointments with beneficiaries ween in the ED and CSU and collaborating with other programs that provide Crisis Support. The supervisor of the EDP is working with the supervisors for both the ED and the CSU, to continue toward better collaboration to better serve beneficiaries.

The EDP continues to invite the CSU staff to monthly staff meetings, which the CSU works hard to attend. The EDP is also working on developing a yearly gathering to include all available staff from the three organizations (EDP, CSU and ED) to continue helping staff become familiar with each other.

Program Participant Story

A Crisis Worker recently met with an individual in the ED who had just been released from a 5150 hold. The Crisis Peer Supporter reported how pleased the individual was to talk with a person that wasn't in such a hurry and could have an uninterrupted conversation. The CPS talked the individual into coming to the SPIRIT Center for a one-on-one follow-up.

General System Development:

WELCOME HOME VETS

Program Description

Program Overview

Welcome Home Vets (WHV) provides a portion of Nevada County's Veteran population with mental health services not provided by the Department of Veteran's Affairs (VA). This contract has been a major factor in funding ongoing treatment, ensuring that some Veterans who are at a high risk for suicide, involvement with the legal system, divorce and psychiatric hospitalization received the help they needed.

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

Target Population

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

Evaluation Activities and Outcomes

Welcome Home Vets Goals and Accomplishments:

- During FY 18/19, WHV delivered 183 group sessions; the contract calls for delivery of 50 group sessions.
- Welcome Home Vets delivered 180 individual sessions by Licensed Marriage and Family Therapists (LMFT) versus a goal of 100.
- The 251 individual therapy sessions by Licensed Clinical Psychologist (LCP) or LMFT exceeded the contract requirement of 225 sessions.
- Basis-24 Outcomes: Thirty-five respondents; the four that dropped out or moved are not included.
    - Goal: Less than 5% of veterans will be incarcerated in jail or prison during the time of treatment.
      Accomplishment: 0% incarcerations
    - Goal: 95% of veterans in treatment will report thinking about ending their life only a little or none of the time.
      Accomplishment: 94% were suicidal none or a little of the time.
    - Goal: 90% or less of veterans in treatment will not be hospitalized in a psychiatric hospital during the treatment period.
      Accomplishment: 88% were not hospitalized.
    - Goal: 15% of veterans in treatment will report being in a shelter or homeless on the street more than one time during treatment.

Accomplishment: 9% reported being in a shelter or homeless.
- Goal: 70% of veterans in treatment will report feeling short-tempered less during a week.
  Accomplishment: 74% were short-tempered less often.
- Goal: 70% of veterans will report that they got along well in family situations half the time or more during a week.
  Accomplishment: 75% got along well in family situations half the time or more.

Challenges, Solutions, and Upcoming Changes

Welcome Home Vets did not achieve the goal of serving 60 unduplicated individuals in FY 18/19; 39 served individuals were recorded. Welcome Home Vets is making every effort to recruit new participants; especially Vietnam Veterans.

Welcome Home Vets has also seen an increase in donations (e.g. $7,500 from Patriots Honor/LWW Injured Veteran Golf Tournament, $6,000 from Friends of the Nevada County Military, etc.) and has conducted/participated in a number of fund raisers. Through May 2019, $46,910 has been paid to therapists versus the contract amount of $30,000.

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

General System Development:

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

Program Description

Program Overview

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

Behavioral Health and Nevada County Housing Development Corporation (NCHDC) partner to provide housing and supportive services for individuals with mental illness who are potentially

homeless, are homeless, or are chronically homeless. NCHDC provides property management, maintenance and repairs, as well as supportive services for the two homes they own as well as the ones they master lease. Behavioral Health and Turning Point provide Case Management support for the tenants.

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

Summer's Haven Program:
Behavioral Health received a renewal grant from Housing and Urban Development (HUD) Continuum of Care (COC) for $113,958 to house a minimum of thirteen individuals. There are 15 sites that housed 26 tenants.

Home Anew:
Behavioral Health was awarded a renewal grant for $29,950 from HUD in FY 18/19. These funds subsidize the rent for three units that housed 5 tenants.

Winters' Haven:
Behavioral Health received a renewal grant from HUD for $40,580 for the Winters' Haven Program. The Winters' Haven Program provides project-based vouchers for five bedrooms in the first home purchased with MHSA Housing funds. In addition, Winter's Haven funds two additional units in the community. A total of eight tenants were housed.

Catherine Lane - Second MHSA funded House:
Catherine Lane is a six-bedroom house operated by Turning Point. There are six Full Service Partnership tenants housed there. A House Manager is present during the day and House Monitors spend the night. The tenants need this level of care to remain housed.

Target Population

The target population for these programs are individuals with significant and persistent mental illness who are chronically homeless.

Evaluation Activities and Outcomes

NCHDC meets with tenants and their supportive staff to help tenants maintain their housing.

The program provides as much assistance as possible, including payment plans if individuals have financial difficulties paying their rent. Assistance with donations of furniture and other household items is given.

A total of 46 individuals were housed through NCHDC in FY 18/19. This included ten tenants that have remained housed for over five years, and 16 tenants that have been housed for two to five years. Seven tenants left the program and of those, four have secured independent housing.

The success of NCHDC is keeping tenants housed long term and having tenants who have been able to move onto independent living. Those who left the program in FY 18/19 had an average length of stay of 28 months. The remaining tenants in FY 18/19 have an average length of stay of 42 months. Seven tenants had no income at program entry, and now six have been awarded either Supplemental Security Income or Social Security Disability Income, and four had earned income during the year.

Challenges, Solutions, and Upcoming Changes

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

Program Participant Story

NCHDC reports four tenants who are now employed in the community. These are true success stories.

Outreach and Engagement:

SPIRIT
SPIRIT Peer Empowerment Center

Program Description

Program Overview
The SPIRIT Center is a local non-profit centrally located in a comfortable home-like setting on five acres with a garden. The program offers Individual Peer Support, Weekly Support Groups, Referrals to Community Services, bilingual (Spanish) support, computer access, an organic garden, and access to showers and laundry. SPIRIT Center offers Educational Training classes like Advanced Peer Support 101, Recovery, Goals and Life Skills, WRAP (Wellness Recovery Action Plan) and Yoga WRAP. SPIRIT Center also offers opportunities for socialization through music groups and other creative activities such as beading and creative expressions.

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

Evaluation Activities and Outcomes

SPIRIT Center, Staffing, and Participant Updates:
- The SPIRIT Peer Empowerment Center provided 1,361 services to 976 unduplicated participants in FY 18/19.
- The Center partnered with Grass Valley Police Department (GVPD) to increase security at the vulnerable Center location, support concerted efforts to clean up the street outside of the SPIRIT Center (campers and loiterers) and tighten up on participants at the Center that are under the influence and/ or not participating. This has been a successful partnership and a welcomed support.
- SPIRIT implemented a daily Community Meeting where participants can have their voice heard and in an effort to team-build. Between 5-15 participants attend daily. The daily meetings developed a “Medical Emergency Response Team”. Each person has a task in the event of medical emergency.
- As of June 30th, 2019, SPIRIT Center is fully staffed. An Executive Director was hired in January 2019. A Program Coordinator and two Peer Support Service shifts started in March 2019.

Fundraising and Outreach Activities:
- SPIRIT’s Open House was a success with approximately 30 community members attending. The Yard Sale in May 2019 combined with all fund raising activities and the volunteer program

generated approximately $90,000 in funding for the SPIRIT Peer Empowerment Center programs.

- SPIRIT continues to notify the community about activities and events with daily radio spots on KNCO and KVMR Community Calendars. A new SPIRIT Center sign, brochure and a tri-fold Wish List, which is also available on the website, were created. The Briar Patch Co-op Community Fund, "Round up for a Cause" lists SPIRIT in 2020.
- Collaboration with Hospitality House homeless shelter and other agencies continues. SPIRIT management meets regularly with the Hospitality House case management team and the newly formed HOME Team (Homeless Outreach and Medical Engagement). An MOU (Memorandum of Understanding) was signed between the SPIRIT Board of Directors and Hospitality House for the upcoming collaborative Brunswick Shelter project.

Facilities:

- SPIRIT continues to maintain Gates Place and communicate with the surrounding property owners to maintain safe and clean facilities.
- The SPIRIT Center renovations are complete. The old carpet was removed, and beautiful hardwood floors were exposed underneath. The offices were completely repainted, and the carpets were replaced. Pictures and other decorations were added to the offices, and old furnishings and filing cabinets were replaced. Historic files/paperwork were properly archived. The only thing that still needs to be done is to replace the kitchen flooring.

Trainings:

- In January a 16-week Peer Support 101 course with 12 participants was completed.
- In February there was a WRAP 1 class with five attendees.
- An Advanced WRAP class was held in March with 12 participants.
- WRAP Recertification class was held in April with 15 participants.

SPIRIT Center Stats	**Year End Total 18/19**
FY 18/19	
Services	**1,361**
Empower peers to engage in the highest level of work or productive activity appropriate as measured by:	
# of peers who obtained gainful employment	**34**
Volunteer Hours spent maintaining the facility	**697**
Peer Support sessions	**399**
Peer Support training hours	**342**
Services offered to peers to optimize opportunities for productive activity (list hours for each service):	
- Front Desk	**1,489**
- Property Maintenance	**374**
- One-on-one Peer Support	**1,044**
- Group Facilitation	**688**
- Peer Support Interning	**598**

Reduce isolation of persons with mental illness as measured by:	
Duplicated Visits (Walk-ins)	**8,660**
Support Groups per Quarter	**328**
-Support Group's Attendance	**864**
Social Activities per Quarter	**236**
-Social Activity attendance	**847**
Improve quality of life of homeless individuals as measured by:	
# of Showers to homeless	**1,268**
# of Loads of Laundry to homeless	**608**
# of Bags of Food given to homeless	**1,301**
# of Homeless receiving basic services	**214**
# of homeless participants who obtained housing	**18**
Survey Results - # of participants who improved in each of these areas:	
Suicide	**7**
Housing	**26**
Education/Life Skills/Coping Skills	**52**
Hospitalizations	**6**
Court/Legal	**33**
Employment	**11**
Prolonged Suffering (depression)	**55**
# of people in SPIRIT sponsored structured educational class:	
- Advanced Peer Support	**36**
- Yoga WRAP	**116**
- WRAP	**21**
- Recovery, Goals and Life Skills	**115**
Other Data to be collected:	
New Participants	**976**
-New Participants that came to SPIRIT from the ED program	**19**
Fundraising efforts (Holiday Letter, donation jar, random donations)	**$3,570.12**
Number of bilingual PSS (phone)	**785**
Bus passes issued	**231**
Number of use sessions on public computer	**1,194**
Number of hours the Center was open	**1,554**

Challenges, Solutions, and Upcoming Changes

Increased demand on capacity:

- SPIRIT is seeing a noticeable increase in the number of homeless and substance using community members. This increases the number of participants attending SPIRIT day services, resulting in funding constraints. This is especially evident in the areas of Peer Support, Maintenance and Direct Services. There has also been an increase in utility costs. In an effort to provide effective services, SPIRIT needs four Peer Counselors on the floor to safely manage the 150-200 participants served each week. SPIRIT averages three volunteer Peer Counselors each day for a total volunteer contribution of $77,000 in Peer Support. For the next fiscal year, with continued volunteer support, fundraising, budget adjustments and the NCBH cost of living increase, SPIRIT foresees a tight budget for FY 19/20.
- Providing enough food for participants is a challenge. Since SPIRIT can no longer provide hot meals, they continue to provide packaged food from the Food Bank that participants can assemble.

Data Collection: Improvements in data collection protocols have been implemented to be more accurate. SPIRIT needs new computers including one laptop and two to three desktops.

Program Participant Story

About three years ago, after suffering mental illness and becoming homeless, a young woman came to the SPIRIT Peer Empowerment Center on the recommendation of another participant. She became involved in the Peer Training and joined several other weekly support groups offered at the Center. She is now a Peer Support Staff (PSS), runs the weekly group, volunteers and has taken on a few additional administrative projects. She has also found a “permanent” home and has learned several tools that assist her daily in her successful recovery.

This is the ‘Magic” of the SPIRIT Program; Peers supporting peers to create empowerment and self-sufficiency.

Prevention and Early Intervention (PEI)

PEI Project Name: Early Intervention Program

WHOLE HEARTS, MINDS AND BODIES
Gateway Mountain Center

Program Description

Program Overview

Gateway Mountain Center provides adjunctive mental health rehabilitation support to youth for improved outcomes including: decreased incidence of mental health crisis, increased positive socialization, and increased engagement within one's community. Gateway's method and theory of change can be described overall within four (4) tenets: 1. Authentic Relationship; 2. Time immersed in Nature; 3. Embodied peak experience; 4. Helping Others - Connection to community through service.

The program serves youth in the Truckee Tahoe and Nevada City region who have symptoms of mental illness, serious emotional disturbance, and co-occurring substance use disorders. Services include developing a one-on-one personal connection; life-enriching experiences; exercise; proper nutrition; nature-connection; learning new things; and personal reflection.

Their assigned mental health worker sees youth once a week, on average, for a session that lasts for three (3) to five (5) hours. Sessions are typically provided in the field. Locations of outings vary and include trails, rock climbing areas, ski areas, lakes (for kayaking activities), or the local climbing gym. Sometimes, if weather is bad or energy levels are low, sessions will take place at a café, or the Gateway office, with a focus on doing artwork. During sessions, mindfulness practices, and techniques from therapeutic modalities, such as Dialectical Behavior Therapy or Acceptance and Commitment Therapy may be utilized. Volunteer time with other community organizations is also common.

When children or youth are in need of higher levels of care, they are referred accordingly.

Target Population

The program serves youth in the Truckee Tahoe and Nevada City region who have symptoms of mental illness, serious emotional disturbance, and/or co-occurring substance use disorders.

Evaluation Activities and Outcomes

Gateway Mountain Center collects evaluation activities for MHSA including demographic information for each individual receiving services. In addition, the Youth Outcomes Questionnaire

(YOQ- SR 2.0) is administered at the beginning and end of services. Information on referrals to community services is also collected.

During FY 18/19, Gateway delivered 117 services to 14 participants.

The YOQ was administered to all participants at the start of the program. Gateway participants in FY 18/19 had baseline YOQ scores between 11 and 99 points. Only two participants completed a follow up YOQ in FY 18/19. Averaging these participants' pre and post scores showed an increase in presenting problems. Participants scores went up an average of nine points in the Intrapersonal Distress subscale; increased one point on the Somatic subscale; increased four points on the Interpersonal Relations subscale; increased two points on the Social Problems subscale; increased eight points on the Behavioral Dysfunction subscale; increased five points on the Critical Items subscale; and increased an average of 28 points for the total score. In addition, no referrals to outside agencies were made in FY 18/19.

With the population Gateway serves, outcomes will vary, and often the long-term view is necessary. Direct participant evaluation consists of close contact and feedback from the participants' families, communication with the therapeutic service provider counselors, and Gateway's own Clinical Supervisor.

Challenges, Solutions, and Upcoming Changes

Gateway's success also has created challenges. Referrals to the program have risen. Comparing March/April 2019 to April 2018 Gateway received five times more referrals in 2019 (from three to 15). This increase in referrals and the corresponding increases in participant load and Mental Health Rehab Specialist (MHRS) team members, is putting stress on the organizational and structural systems. To respond to this Gateway is increasing the case management and clinical supervision team and beginning to move data into a high-level data-management software program. This is requiring planning, increased time training new members and finding the best way to move data into the new system efficiently.

Within the Whole Hearts, Minds & Bodies (WHMB) program of Gateway Mountain Center, the following changes are being implemented:

Case Management Team:
Currently the cases are managed by the program director with the assistance of the clinical supervisors. WHMB is in the process of building a Case Management Team, with a lead Case Manager. Each team member will have his or her own cases to manage. The team will connect with each other and the clinical supervisors as needed to support each other. This will include meeting four times a year to review caseloads and discuss ways to support the overall program. This change will improve the consistency of care across the program and give case managers and therefore consumers a deeper level of support.

Training Manual Update:
Gateway is in the process of updating the training manual and training schedule to ensure the most relevant, state of the art and effective trainings are being offered to staff.

Data Management:
Gateway has begun the process of moving data management into an online software system such as SalesForce. This will help to manage cases more efficiently and effectively.

Program Participant Story

This participant is new to the Truckee/Tahoe area. The consumer was displaced from one parent's home and moved to their other parent's home in the Tahoe/Truckee area. This individual has been with the "Whole Hearts, Minds, & Bodies" (WHMB) program at Gateway Mountain Center for several months. Since the person's arrival in the program, they have been hospitalized multiple times. This is partly due to their mental health issues. The individual's WHMB Mental Health Worker "Cory" has been supporting the participant since they entered the program. This individual has responded well to their relationship with Cory and the activities they share. The person expresses to Cory often how beneficial the relationship is to their mental wellbeing. Cory has been able to respond quickly to the individual to avoid crisis. Cory is one of the first people this consumer will contact when they are in need of someone to talk to or hang out with when they are feeling sad. These sessions have helped the participant emotionally regulate themselves during stressful episodes and bring them back to a more balanced state of mind. The participant's parents have expressed deep gratitude toward Gateway Mountain Center for the work that Cory is doing with their child and the difference it is making in the participant's life.

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH (NCBH)
Bilingual Early Intervention

Program Description

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

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

NCBH maintains good communication with these community agencies by:

- coordinating care of mutual participants
- funding programs at Sierra Community House, including the Bilingual Peer-Counseling Program
- providing bilingual Case Management
- delivering quality treatment of participants referred from Sierra Community House

Target Population

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

Evaluation Activities and Outcomes

The Bilingual Early Intervention Program collects demographic and service-level data through NCBH's Electronic Health Record System (Cerner). During FY 18/19, the program served 24 deduplicated individuals; including 19 adults and five youth. At the Grass Valley Office 16 unique individuals were served, and at the Truckee Office, eight individuals were served. Throughout the fiscal year, the majority of services provided were Individual Therapy at 271 services or 73% of services. There were only two Crisis Intervention services provided. See the table below for more information on services.

Service Type	# of Services	% of Services
Individual Therapy	271	73%
Assessment - MH	35	9%
Case Management - MH	25	7%
Plan Development - MH	18	5%
Collateral - MH	13	3%
Group Rehab - MH	9	2%
Crisis Intervention	2	1%
Total # of Services:	**373**	**100%**

In FY 18/19, anecdotal outcomes from a hand count of treatment goals and results by the therapists showed that most, if not all, participants had reduced psychological reactivity, feelings of anger, panic attacks, and anxiety. In addition, participants had better psychological functioning, overall. See the table below for more information on treatment goals.

Qualitative Data:

Treatment Goals:	Individuals with Improvement	Individuals without Improvement	Total Individuals w/ symptom
Increase Interest in Activities	100%	0%	10
Reduce Psychological Reactivity	100%	0%	9
Managing day-to-day life	100%	0%	9
Coping with life problems	100%	0%	7
Reduce Conflicts	100%	0%	6
Increase Compliance	100%	0%	6
Increase Energy	100%	0%	6
Reduce Anger	100%	0%	4
Increase Sleep	100%	0%	4
Reduced Panic Attacks	100%	0%	2
Reduce Hearing Voices	100%	0%	1
Reduce sadness/ depressed mood	92%	8%	13
Reduced Anxiety/ Worry	90%	10%	10
Reduce Guarding for Danger	83%	17%	6
Reduce Intrusive Memories	83%	17%	6
Reduce Guilt	83%	17%	6
Think about ending your life	75%	25%	8

In FY 18/19, anecdotal outcomes from descriptions of treatment goals and progress by the therapists show that most participants who stay in the program are working towards their treatment goals: reducing negative thoughts and emotion, approaching situations that they previously would typically avoid, and sleeping regularly, among other specific goals.

Challenges, Solutions, and Upcoming Changes

A weakness in the data gathering, was getting pre and post-treatment results on the Basis 24 Outcome Measure. In the Truckee portfolio, pre and post-treatment results were available for just four of seven participants and in Grass Valley only three participants had pre-tests and no post-tests were collected. Therefore, the Basis 24 data is not shared here, but rather the qualitative outcomes relayed from the therapists are listed above for FY 18/19. The number of completed Basis 24 outcome questionnaires is much better in Truckee than in past years, but still needs to be improved. This data gathering is a priority for the County as it is difficult to judge program effectiveness with so much missing data. One of the solutions that might help to mitigate the problem would be to have the Basis 24 in the initial paperwork and have staff complete it as part of the intake. To gather information during mid-treatment staff could set up a remainder or even create a group for this community every other month to talk about their progress and other topics.

Three challenges in treating MHSA-funded participants have been identified:

- The high volume of requests for services; During the first half of FY 18/19, the Truckee office of NCBH experienced a high volume of requests for service for Medi-Cal funded mental health services. Individuals requesting services have to be screened, and, even if they are ultimately not treated by NCBH, NCBH therapists still facilitate the referral process. The time spent processing these service requests takes time away from treating participants, whether funded by MHSA or not.
- The case management needs of participants; The MHSA-funded individuals have extensive case management needs. These include help navigating the legal system, accessing medical care without health insurance, and finding housing. For example, during this funding period, one individual needed help in getting financial support from California's Victim Compensation Board. Another participant needed help communicating with Nevada County's Victim Witness Assistance Center to ensure that the District Attorney enforced specific victim rights for the person. Helping participants with these more concrete needs can build trust and rapport, but it takes time away from direct service work on mental health treatment goals.

  One solution for participants' case management needs is effective utilization of local community partners, especially the Sierra Community House. For one MHSA-funded individual, the Sierra Community House provided most of the case management, including emergency shelter, financial support, and later, help finding permanent housing. NCBH is increasing its case management capacity by partially funding the salary of a bilingual case manager at the Sierra Community House.
- The adverse childhood experiences of participants; A majority of adults treated by the Truckee office of NCBH have adverse childhood experiences (ACES), including neglect, emotional, physical, and/or sexual abuse. These experiences make treatment more lengthy, complex, and less likely to achieve full cessation of mental health symptoms. A comparison of MHSA funded individuals with and without ACES, illustrates this point. An MHSA funded adult without ACES suffered an assault as an adult, and treatment is advancing rapidly, steadily, with few setbacks, and the prognosis is very positive. Among other adults with ACES, one had a rapid, and successful outcome, but for others, the outcomes have been more mixed.

  A solution, or at least a helping factor in treating adults with ACES has been Trauma-Focused Cognitive Behavior Therapy (TF-CBT). NCBH has been providing extensive supervision support and training for therapists in TF-CBT. This effort has included outside training in TF-CBT, weekly group supervision, and monthly calls with a national-level expert in TF-CBT. TF-CBT is a treatment for children and teenagers, but expertise in it has provided a good foundation for treating trauma in adults.

Program Participant Story

A middle-aged, Hispanic, victim of domestic violence, was referred by a local community agency. The individual had been diagnosed with depression. The symptoms that presented at the beginning of therapy included feeling sad, struggles to set appropriate boundaries, and low self-esteem. The individual also had economic difficulties, was isolated, and felt powerless.

Treatment was based on a CBT approach. Through the process, the individual learned to identify and change cognitive distortions, improve coping skills and assertive communication skills and began relaxation exercises.

The participant was able to set strong limits, left the abusive relationship, and gained independence. This person also started to drive, work full time and engaged with other people. This resulted in the individual feeling happier and agreeing to terminating therapy.

PEI Project Name: Early Intervention Program

NEVADA COUNTY PUBLIC HEALTH
Moving Beyond Depression - Every Child Succeeds

Program Description

Program Overview

The Moving Beyond Depression (MBD) program is a voluntary, evidence-based, in-home cognitive behavioral therapy program for perinatal women experiencing perinatal mood disorder who are enrolled in a home visitation program. Treatment is comprised of 15 weekly in-home sessions, provided by a master's level therapist trained in the MBD model. A "booster" session is conducted one month post treatment. This program is provided in partnership with home visitation programs of Nevada County: Foothills Truckee Healthy Babies (FTHB), Early Head Start, the Young Parents Program of Nevada Joint Union High School District, the Sierra Teen Education & Parenting Program (STEPP) of Tahoe Truckee Unified School District, and the Maternal Child Adolescent Health (MCAH) Public Health Nurses.

This program works in unison with a home visiting program as findings indicate that efforts to address mental health needs of depressed mothers are more successful when treatment is provided in-home and in partnership with a home visitation program. Trained home visitors have an established relationship with the mother and aid in the identification of depression through multiple screenings of maternal depression through the course of the home visiting program. Maternal depression identified early, addressed, and treated through early intervention will help to reduce negative outcomes of untreated mental illness affecting the mother, thereby reducing the long-term negative effects on her children and family.

Target Population

Moving Beyond Depression targets Nevada County women experiencing depression in the prenatal and postpartum periods of pregnancy. The program is designed to meet the needs of low-income, underserved women, enrolled in a home visitation program in Nevada County.

Evaluation Activities and Outcomes

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

During FY 18/19, Moving Beyond Depression received referrals for 30 participants. Five participants were ineligible for services; four participants declined services; two participants started the program, but were transferred to other services after their seventh session; and two participants dropped out after their fifth session. Of the 21 participants who started the program, nine (9) completed the program. Four (4) participants are still progressing through the program. A total of 236 sessions were conducted with an average of 14 sessions per participant.

Of the 16 participants who completed six sessions or more, 93% of them showed an improved EPDS score. EPDS scores were improved by an average of 52%. Though the ISEL had incomplete data for half of the participants, 50% of the eight (8) who were scored showed an average increase of six (6) points in their score.

Two participants completed the Perception of Care survey and both indicated improvement on all survey questions.

Three participants were referred to Nevada County Behavioral Health (NCBH); however, one declined NCBH services, but was supported by staff at Tahoe Forest Hospital. One additional participant was referred to a local behavioral specialist. Of the participants referred for Mental Health services, three had not been previously treated for their current symptoms. These individuals did not know the duration of their untreated mental illnesses.

Challenges, Solutions, and Upcoming Changes

- The eastern side of the county (Truckee) was still underserved by the program due to not having a bilingual therapist. There was limited capacity to provide services to this region, especially during the winter months, as the Donner Summit/Interstate 80 area is often unpassable. During this time, Truckee moms were referred to alternate services for their mental health needs. Interviews are currently in process to find a local therapist for the position, though unfortunately it is difficult to identify one who is bilingual. Program leaders are feeling optimistic that services will be available in the next few months to support the moms in the Eastern region. If there is a need for a bilingual therapist, translation services will be used.

- Though MBD has had two therapists providing services to the western side of the county, the program was still at or exceeded capacity for most of the year. The program was able to accommodate some of the participants through another program called Project Launch. This program allowed participants to be assessed, and if appropriate, be seen for a limited number of therapy visits while participants waited for an opening in the MBD program. Unfortunately, Project Launch is no longer being funded and will be finishing at the end of September.
- REDCap data has been useful in determining trends. An example of this is a trend in incomplete cases noted particularly in the latter half of the year. Approximately half of the referrals for one therapist dropped out, declined treatment or were transferred to other services, indicating a 40% completion rate. The data in REDCap supported this trend, along with anecdotal reports from various home visitors stating participants were less receptive to services from this therapist. This was in contrast to an 80% completion rate for participants seen by the other therapist. At the end of the fiscal year, the therapist with the lower completion rate chose not to renew her contract.
- The Moving Beyond Depression program is gaining widespread popularity throughout the community, with many new referrals coming in from various agencies, health care providers, and residents. This program has had significant impact on many local mothers, who share their successes with their peers. This leads to additional self-referrals and an overall heightened awareness of the pervasiveness of perinatal mood and anxiety disorder.

Program Participant Story

Before enrolling in Moving Beyond Depression, a local Home Visitor agency was working with a mother who identified barriers that she wanted to work on (setting goals) but was unsure how to achieve. She wanted to get her kids on a regular schedule, did not know how to effectively parent them, and felt overwhelmed by life.

During home visits, it was witnessed that the mother had amazing empathy, appropriate and loving communication with her children, and spoke of regular outings and activities she had gone on with her kids. Yet she still felt she was not being a good or successful parent.

The Edinburgh Postnatal Depression Scale (EPDS) was administered and it showed that the mother had a very elevated score. While discussing specific areas of the depression tool with her, and through many tears, the mother reflected that she has been feeling symptoms of depression since her oldest child's birth three years prior. With her permission, the home visitor completed a referral to the Moving Beyond Depression in-home therapeutic program operated by Nevada County Public Health.

The MBD therapist had the Mom set specific goals; including working on her schedule with her children and getting more sleep for herself. After starting counseling with MBD, the Home Visitor noticed that during visits the mother began discussing her negative thought patterns, explaining how she was working on identifying, acknowledging, and then correcting these thoughts (cognitive behavioral therapy). During more recent visits, the Home Visitor has seen the Mom set more consistent boundaries for her children and enforce consequences for unwanted actions, and has

exuded more confidence in her parental decisions with her children. The mother recently became employed, which helps her feel better about herself as well as her family's financial situation.

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Homeless Early Intervention Services

Program Description

Program Overview

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

Target Population

NCBH Homeless Early Intervention serves guests experiencing homelessness at the Hospitality House shelter and individuals and families that seek outreach services at Hospitality House.

Evaluation Activities and Outcomes

Staff collect demographic information and service-level information on individuals who have had multiple contacts. In addition, information on referrals and linkage to community services is collected for each person referred. Staff also record outreach efforts at the Hospitality House Shelter.

- A total of 341 Individual/Family Therapy services with shelter guests were recorded for FY 18/19. Guests were seen within three business days of initial referral.
- Eighty-six unduplicated individuals were served by the Early Intervention Therapist.

	FY 18/19	
Number of Service Contacts	**Number Served**	**Percent of Served**
1 Contact	36	41.86%
2 – 4 Contacts	28	32.56%
5 – 7 Contacts	10	11.63%
8+ Contacts	12	13.95%
Unduplicated Total	**86**	**100.00%**

- Approximately 25 guests were referred to NCBH for services, of which 22 individuals followed through. Of those individuals who followed through, 12 met criteria for services at NCBH and 13 were referred to services in the community. Three individuals, who would have met criteria for NCBH, declined services.
- At least 26 individuals were referred to other Mental Health services though Chapa De Indian Health Center, Sierra Nevada Medical Center, Communities Beyond Violence, Crisis Stabilization Unit, and private providers who accept Medi-Cal. At least eight of these individuals followed through on these referrals.
- Twenty-one individuals were opened through NCBH assessments performed by the Early Intervention Therapist and received Case Management services by Turning Point Staff stationed at Hospitality House.
- There were no recorded referrals to NCBH for individuals with untreated mental illness.
- To evaluate the reduction of prolonged suffering and to measure reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning, the Behavioral Health Screening pre-test was given to 22 program participants in FY 18/19. Six participants were not able take the screening based on behavioral or substance use factors. For the remaining 16 participants, pre-test scores for Section 1 ranged from 0-18, with an average score of 9.7. A score of zero represents no behavioral health issues and a score of 21 represents severe behavioral health issues. Since these were all new participants, there were no post-tests administered and no outcome comparisons could be made.
- Staff makes outreach visits to the Hospitality House shelter regularly. Often it takes multiple contacts with the same individual before they agree to participate in the program or staff determines the individual is appropriate for the program. During FY 18/19, staff made 129 visits to the shelter in order to outreach to shelter guests. During these visits, staff made 340 contacts with guests.

Challenges, Solutions, and Upcoming Changes

Some of the challenges in this program remain the same as in previous reports; including unknown outcomes, lack of follow-through by participants and drug/alcohol issues due to the transient population and lifestyle of participants. With more county supports for the Substance Use Disorder (SUD) program, more participants are being offered and are receiving services. Hospitality House is now including the Behavioral Health Screening form in the intake process so that individuals experiencing symptoms of distress and/or mental illness can be identified and referred to the Early Intervention Therapist early on.

Other challenges have been adequate space for confidential sessions with guests. As the shelter has expanded to include a “low barrier” dormitory for individuals who cannot test negative to drug screening, the shelter space has had to be reconfigured. Office space was redistributed leaving the Early Intervention Therapist without a meeting space. With Turning Point personnel now providing Case Management at Hospitality House, space is even tighter. Finding space in which to meet with participants confidentially and privately is a struggle as there simply is not adequate space. Solutions have included utilizing dormitory space during non-operational hours for confidential meetings, as well as communicating and collaborating with Hospitality House and

NCBH staff regarding special needs. Additional space will continue to be a need as the program expands.

Upcoming changes affecting the Early Intervention program include the additional outreach staff in the form of the HOME Team (Homeless Outreach and Medication Engagement). The HOME Team provides more contacts, supports, services, referrals, collaboration and connection with Hospitality House, NCBH and with other government and community agencies.

Program Participant Story

"John," came to Hospitality House after being homeless for a few months. He had been using drugs and had stopped taking medication. John had recently been hospitalized and was not allowed to return to the place he had been living due to his disruptive behavior. John slept at various friend's houses and on the streets before coming to Hospitality House. He presented as very emotionally labile, impulsive, needy, and he had difficulty following rules. He spent many sessions with the Early Intervention Therapist at Hospitality House. He was initially against medication treatment and stated that he had been forced to take medications previously. The EI Therapist, John's Hospitality House Caseworker, and monitor staff supported him in his struggles and "met him where he was" without judgement. He eventually agreed to start back on his medications. John's journey is not without its ups and downs, however. He continued to struggle with his emotional problems after a traumatic personal experience. After another hospitalization, he was released to Hospitality House but was stable for a small amount of time before relapsing and getting arrested. Following his arrest, he asked for and received support and help from Hospitality House staff.

Through the next several months, John had the arrest charges dropped, enrolled in school, and became employed. John became compliant with his medications and made use of the services offered to him. He reconnected with family and became part of the Hospitality House community, utilizing the resources and supports available to him. He eventually moved into his own place. John is currently employed and has good relationships with family and a significant other. He is still stable and at last report stated, "I'm doing really well."

PEI Project Name: Early Intervention Program

SIERRA FOREVER FAMILIES

Program Description

Program Overview

Sierra Forever Families (SFF) provides comprehensive specialty mental health services for children and their families throughout Nevada County. There are three (3) specialized programs available to program participants: Destination Family (DF), which seeks to identify permanent connections to children in congregate care; Family Preservation (FP), which seeks to provide

family stability to families who have children who are at risk of removal from their home or at risk of Child Welfare or Probation involvement; and Therapeutic Support Services (TSS), which provides services to pre- and post-adoptive families. Specialty Mental Health Services provided are based on established medical necessity criteria for mental health services due to behavioral, emotional and functional impairments meeting Nevada County Behavioral Health (NCBH) Plan eligibility.

Target Population

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

Evaluation Activities and Outcomes

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

During FY 18/19, 104 youth received services, with an average of 44.3 services per participant. Most participants (89%) received eight (8) or more contacts during the fiscal year. See the tables below for more information.

	FY 18/19	
Number of Service Contacts	**# Participants**	**% Participants**
1 Contact	2	1.9%
2 – 4 Contacts	7	6.7%
5 – 7 Contacts	2	1.9%
8+ Contacts	93	89.4%
Unduplicated Total	**104**	**100.0%**

The following CANS scores are for youth served in FY 18/19. Sierra Forever Families served 99 unduplicated youth and their families. As data collection and reporting strategies progress, data outcomes for individual domains will be shown. This data will drive new areas of focus for SFF as it relates to needed training and/or additional supervision.

CANS Summary: 88% of individuals' CANS scores improved this fiscal year. The individuals whose scores did not improve were either moved to a higher level of care or had significant traumas and major life changes and are working through their issues with their current treatment teams.

Additional outcome results are collected quarterly and average scores for FY 18/19 are shown below. These outcomes include a focus on permanency, school performance, parenting skills

increase, legal involvement and placement disruption. Each goal was exceeded in FY 18/19. See table below.

Nine referrals were made by Sierra Forever Families to other county agencies throughout FY 18/19. These referrals were made to agencies like Big Brothers, Big Sisters, Adoption Support Group, A New Day, and Behavioral Health Services outside of Nevada County to meet the individuals' needs.

		FY 18/19
		N = 99
Goal	**Objective**	**Outcome**
To prevent and reduce out-of-home placements and placement disruptions to higher levels of care.	***80%*** *of children and youth served will be stabilized at home or in foster care*	**97%** of youth stabilized at home or in foster care
Youth will be out of legal trouble.	*At least* ***70%*** *of youth will have no new legal involvement between admission and discharge*	**100%** of youth had no new legal involved
Youth will improve academic performance.	*At least* ***80%*** *of parents will report youth maintained a C average or improved on their academic performance.*	**93%** maintained or improved academic performance
Youth will attend school regularly	*At least* ***75%*** *of youth will maintain regular school attendance or improve their school attendance.*	**94%** of youth maintained regular school attendance
Youth will improve school behavior	***70%*** *of youth will have no new suspensions or expulsions between admit and discharge.*	**88%** of youth had no new suspensions or expulsions
Caregivers with strengthen their parenting skills	*At least* ***80%*** *of parents will report an increase in their parenting skills.*	**89%** of parents increased parenting skills
Every child establishes, reestablishes, or reinforces a lifelong relationship with a caring adult.	*At least* ***65%*** *of children served will be able to identify at least one lifelong contact.*	**100%** of youth are able to identify one lifelong contact
Caregivers will improve connections to the community	*At least* ***75%*** *of caregivers will report maintaining or increasing connection to natural supports.*	**93%** maintained or increased connections to natural supports

Challenges, Solutions, and Upcoming Changes

Challenges continue in how data is being entered into the electronic health record systems (EHR). The move towards integration of all forms into Anasazi will be extremely helpful, as over the past

fiscal year SFF has entered CANS scores into three different EHR systems, causing disruptions to accurate data collection. Identifying a universal system that can accommodate all data reporting needs will be beneficial to the accuracy of data collection.

Sierra Forever Families, Nevada County mental health team continues to provide more intensive care to a greater number of youth and families than the contract was designed, and funded, to serve. Sierra Forever Families is pleased to be an essential part of the Nevada County Children's System of Care, however, the pace of the referrals and the time needed to meet the needs of the youth and families is demanding significant overtime commitments from the SFF team members. SFF continues to work with Nevada County leadership to address this concern in future contracts.

Program Participant Story

Sierra Forever Families received a referral for young twins who were recently removed from parental care and placed with their grandmother in Northern California. The twins were removed from the home due to the parent's neglect. Both children were born with positive toxicology screens. This out-of-home placement represents one of several removals and foster care placements for the twins, causing them distress in all areas of functioning. While the twins had a strong attachment with their grandmother, both felt abandoned and neglected, along with feeling grief and confusion by the frequent removals.

Services through Sierra Forever Families included individual therapy and rehabilitation. Collateral services with the grandmother were also provided to support this placement. Sierra Forever Families staff assisted by helping to reduce negative behaviors in the classroom.

Sierra Forever Families treatment team also aided in providing advocacy at school which resulted in check-ins with teacher and principal. The twins were able to check in with the principal as needed and received assistance from a 1:1 aide in the classroom. The twins' teacher was also receptive to trauma-informed psychoeducation from Sierra Forever Families staff along with behavioral modification strategies and encouraged other teachers and school staff to adopt similar strategic interventions. The grandmother was linked to the Nurtured Heart approach which was used successfully in the home to modify behavior. Sierra Forever Families staff helped the twins and their caregiver discover natural supports such as church, increased contact with extended family members, parenting support groups, and grandparent support groups. Sierra Forever Families staff encouraged extra-curricular activities to support social skills and continued development.

Through these interventions the children's behaviors and symptoms ameliorated. The twins were able to express their feelings, process trauma, increase tolerance to frustrations, become regulated and resolve feelings of grief. The grandmother ended up adopting both children, which contributed to the twins' feelings of stability and safety. The children are no longer fearful, and are able to academically perform, socially engage in positive manners and feel safe and secure in the home with their grandmother.

Both children met their treatment goals and are scheduled to be discharged from services. Their grandmother maintains care for the children, and they are now non-disruptive and safe in class. Their grandmother reports that both children are able to maintain safe behaviors, follow directives, and allow themselves to trust her as a parent figure, who is capable of providing them with a safe, loving family environment.

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

WHAT'S UP? WELLNESS CHECKUPS
Mental Health First Aid

Program Description

Program Overview

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

In FY 18/19, What's Up? Wellness Checkups began delivering Youth Mental Health First Aid trainings in addition to Adult Mental Health First Aid trainings. Youth Mental Health First Aid (MHFA) is an eight (8) hour training course designed to give members of the public key skills to help a youth developing a mental health problem or experiencing a mental health crisis. The evidence behind Youth Mental Health First Aid demonstrates that it helps people feel more comfortable managing crisis situations and builds mental health literacy — helping the public identify, understand and respond to signs of mental illness in youth.

Participants learn a five (5) step action plan encompassing the skills, resources, and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care. Nationally, 25% of adults, 20% of youth, and 30% of soldiers returning from war are affected by mental illness. Aside from accidents, suicide is the leading cause of death among youth. Developing skills and strategies for community members is therefore a national priority.

Target Population

The target population is any interested community member, which for example may include first responders, providers, and faith-based organizations.

Evaluation Activities and Outcomes

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

What's Up? Wellness Checkups delivered four total trainings in FY 18/19, two Adult Mental Health First Aid trainings and two Youth Mental Health First Aid trainings. In total, What's Up? Wellness trained a total of 78 individuals in FY 18/19.

Date	Training	Location	Participants
9/17/2018	Adult MHFA	Connecting Point	9
10/24/18 - 10/25/18	Adult MHFA	Unitarian Universalist Community of the Mountains	27
3/28/19 - 3/29/19	Youth MHFA	FREED	18
4/4/19 - 4/5/19	Youth MHFA	Nevada County Superintendent of Schools	24
Total			**78**

Participants who completed the post-training evaluation indicated that they felt more confident that they would be able to effectively identify and address individuals exhibiting mental health challenges, as demonstrated in the table below:

MHFA Post-Training Evaluation	Agree/Strongly Agree
I feel more confident that I can recognize the signs that someone may be dealing with a mental health problem/challenge or crisis.	100%
I feel more confident that I can reach out to someone/a youth who may be dealing with a mental health problem/challenge or crisis.	98%
I feel more confident that I can ask a person/young person whether s/he is considering killing her/himself.	95%
I feel more confident that I can actively and compassionately listen to someone/a young person in distress.	100%
I feel more confident that I can offer a distressed person/young person basic "first aid" level information and reassurance about mental health problems.	98%
I feel more confident that I can assist a person who may be dealing with a mental health problem or crisis to seek professional help.	97%
I feel more confident that I can assist a person/young person who may be dealing with a mental health problem or crisis to connect with community, peer, and personal supports.	95%
I feel more confident that I can be aware of my own views and feelings about mental health problems and disorders.	95%
I feel more confident that I can recognize and correct misconceptions about mental health and mental illness as I encounter them.	98%
Total Surveys Submitted	N= 67

Challenges, Solutions, and Upcoming Changes

The biggest challenge thus far in providing Mental Health First Aid trainings is how to adequately pace the presentation of curriculum material within the eight hours of training time. With the amount of information, depth of topics, community members' questions, as well as dialogue and integration of the material during presentations, trainers are left with less time for the final segments of curriculum. In order to reconcile these factors, the provider has consulted with Mental Health First Aid Trainers to explore new ways of reinforcing the boundaries of MHFA protocol (i.e. limiting questions until specific times during the training days). Another solution has been to add fifteen minutes to each day of trainings to allow time for breaks.

All Mental Health First Aid trainings filled up to capacity during their registration periods. However, in earlier trainings, the provider found that registrants would not show up for the trainings without providing advanced notice. As a result, the provider was not able to inform individuals on waiting lists. To overcome this challenge, the provider sent several email reminders prior to the trainings to request registrants to give advance notice if not able to attend. They also increased communication with individuals on waiting lists in case of last-minute openings. In addition, they have begun to "over" register– increasing the numbers of individuals in registration over maximum capacity foreseeing that some number of registrants may not show up. Thus far, the provider has been successful in resolving attendance issues and will continue to follow these helpful protocols.

In FY 19/20, What's Up? Wellness Checks will increase the total numbers trainings in Nevada County to a total of six total Youth and Adult of Mental Health First Aid trainings as compared to four total trainings in FY 18/19.

Program Participant Story

Mental Health First Aid training participant:
"Thanks for the wonderful informative and engaging MHFA training. Your subject knowledge was engaging, professional and compassionate. I was struck very often during the training, how a few kind words can make a mental health episode approachable."

PEI Project Name: Prevention Program

HOSPITALITY HOUSE & TURNING POINT COMMUNITY PROGRAMS
Housing Assistance Program

Program Description

Program Overview
The Housing Assistance Program (HAP) is a collaborative with Hospitality House and Turning Point Community Programs. The goal of the Housing Assistance Program is to deliver mental health services to participants of the Hospitality House shelter, rapid re-rehousing, and outreach programs. Two (2) Shelter Case Managers are responsible for assisting Hospitality House participants in meeting their expressed mental health-related goals, which may include specific assistance with medication management, housing, counseling, medical services, counseling, support, brokerage for other needed services, and advocacy. The Shelter Case Managers work directly under the supervision and direction of a Hospitality House Supervisor or Program Manager and Turning Point management.

The Housing Assistance Program began services in April 2018.

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

Evaluation Activities and Outcomes

Hospitality House and Turning Point Housing Assistance Program collected evaluation activities for MHSA including demographic information on everyone receiving services. In addition, information on individual services, referrals to outside agencies, outreach activities, and participant perception of care was collected.

The Housing Assistance Program served 228 unduplicated participants in FY 18/19. Of those participants, 205 received an individual service, such as Case Management/ Linkage or Housing Services. Participants received services for a total of 866 hours, for an average of 4.22 hours per participant. Most participants received between one (1) and four (4) services (72%). See the tables below for more information on individual services delivered.

Number of Service Contacts*	# Served	% Served
1 Contact	85	41.46%
2 – 4 Contacts	63	30.73%
5 – 7 Contacts	20	9.76%
8+ Contacts	37	18.05%
Unduplicated Participants	**205**	**100.00%**

Staff mostly provided Case Management/Linkage services to HAP participants with 845 services in FY 18/19. See below.

Service Category	# of Hours	# of Services	Average Hours per Service
Case Management/ Linkage	685.8	845	**0.8**
Housing Services	63.9	71	**0.9**
Crisis Intervention	28.3	28	**1.0**
Other	88.1	101	**0.9**
Total (All Services)	**866.0**	**1045**	**0.8**

Staff made 692 referrals to outside agencies. Of these referrals, 445 (64%) connected to the outside agency. Of those that connected, the average time from referral to date of appointment with the agency was 3.5 days. Ninety-one referrals were made to County Mental Health Services. Of those, 46 had not been previously treated for mental health symptoms. The duration of untreated mental illness for these individuals averaged four years, with a range of 0-20 years. See the table below for more referral information.

Agency	**# Referrals**	**# Connected**	**% Connected**	**Average Timeliness***
211	6	6	**100.00%**	**0.0**
Bread and Roses Thrift Store	86	68	**79.07%**	**8.0**
AMI	14	11	**78.57%**	**0.0**
Common Goals	15	4	**26.67%**	**1.0**
CoRR/Granite Wellness	39	19	**48.72%**	**1.6**
County Mental Health	91	52	**57.14%**	**2.9**
Crisis Stabilization Unit	23	14	**60.87%**	**0.4**
Employment/CalWORKs	14	6	**42.86%**	**0.0**
Eye Care	16	13	**81.25%**	**8.9**
Food Bank	14	10	**71.43%**	**0.0**
FREED	18	17	**94.44%**	**0.3**
Hospitality House/Homeless Shelter	18	7	**33.33%**	**4.0**
Human Services (Benefits)	18	14	**77.78%**	**21.8**
Legal Services	10	4	**40.00%**	**11.0**
One Stop	21	11	**52.38%**	**4.8**
Other Mental Health Provider	10	5	**50.00%**	**4.0**
Physical Health Care Provider	61	47	**77.05%**	**3.2**
Physician/ MD	20	14	**70.00%**	**4.3**
Social Security	11	9	**81.82%**	**9.1**
Social Services Agency	35	28	**80.00%**	**0.6**
SPIRIT	15	13	**86.67%**	**5.4**
Other	137	74	**54.01%**	**Unknown**
Total Referrals Connected	**692**	**445**	**64.31%**	**3.5**

**Timeliness refers to the number of days between referral to an agency and appointment at the agency. Unknown averages due to dates of referral and/or dates of appointment being unavailable. Average not applicable for referrals that did not connect.*

Participants who are discharged from the program are asked to complete a Participant Perception of Care survey. Forty-seven (47) discharged participants completed the survey, with a mostly positive response. Overall 85% of respondents agreed that the Housing Assistance Program had a positive impact on their lives and that the program staff was sensitive to their needs. See the table below for more detailed perception of care information.

Participant Perception of Care Survey	**Agree**	**Neutral**	**Disagree**	**N**
My housing situation has improved	89.4%	6.4%	4.3%	47
I am better able to do things that I want to do.	78.7%	14.9%	6.4%	47
I have people who I can go to for support.	89.4%	8.5%	2.1%	47
Staff welcome me and treat me with respect.	82.6%	15.2%	2.2%	46
Staff are sensitive to my cultural background.	84.8%	13.0%	2.2%	46
Average (All Responses) / Total Surveys Submitted	**85.0%**	**11.6%**	**3.4%**	**47**

At intake and discharge participants are asked to complete a Behavioral Health Screening to help determine if their mental health and/or substance use disorders have improved, and to see if participants could benefit from a referral to mental health or substance use disorder services. In FY 18/19, 16 participants completed the screening at intake. Of those who completed the intake screening, five were referred to the Behavioral Health Department. Only one participant completed a discharge screening during FY 18/19. Her responses on the intake and discharge screenings did not change much, except her thoughts of hurting herself decreased. This is a positive outcome.

Challenges, Solutions, and Upcoming Changes

One of the Shelter Case Managers moved on from his position, and he was hard to replace. To that end, the Case Management hours were reconfigured to reflect one full-time person, Monday through Friday and one part-time person, Friday through Sunday. While it was harder to recruit for a three-day position, finally having it covered has given HAP the opportunity to see the benefit of the change. Organizing the Full-Time Equivalents in this way allowed for better coverage at the shelter and improved treatment plan review on a regular basis. The second half of the fiscal year saw the completion of an Outreach Dormitory as well as a Recuperative Care Dormitory. These new program elements increased the number of individuals served by approximately 15 people nightly. Case Managers continue meeting the needs of these individuals, focusing on housing relationships and improving direct referrals.

Finding adequate housing is an ongoing challenge. The fixed income of most of the individuals served does not exceed $1,000 per month, and review of one-bedroom apartments sees rents between $800 and $1,200 per month. Rooms below that price require a tolerant landlord and roommates, and the individuals being served are often difficult to live with or have very high needs. This can be taxing on landlords and roommates. Additionally, the lack of housing for the highest need's individuals, who suffer from mental illness, substance abuse, and/or physical disabilities presents challenges. Ongoing relationship building with skilled nursing facilities has led to some success in placing these individuals, but beds open infrequently and there is not enough capacity to place all the people who have need.

HAP service rates and referral rates have seen a month over month increase, although continual data entry into two data bases (Homeless Management Information System, Anasazi Electronic Health Record System) requires time and eats into direct service hours. Both Case Managers are improving on their Medi-Cal billable hours, but ongoing training is still needed to ensure that the maximum is billed. The hiring of a Clinical Supervisor has been very helpful and appreciated. It is important to continue to have supervisorial assistance from Turning Point to ensure that any clinical tasks are being done with the highest level of integrity.

The addition of two embedded Turning Point Case Managers to the Hospitality House Team has really rounded out the services provided to the hundreds of guests served each year. The support and guidance offered by these Case Managers helps the clientele rebuild their social capital and prepare for the inevitable housing they will secure. Hopefully, this continued support is able to be maintained long term, as it takes a team to accomplish any task, and addressing homelessness is a task needing full support to have a real impact.

Program Participant Story

A homeless woman came to the shelter after fleeing a domestic violence situation in a nearby town. She spent nearly a year at the shelter getting back on her feet. Through case management she was connected to a primary care physician, a therapist and Supplemental Security Income (SSI) benefits through the SOAR (SSI/Social Security Disability Outreach, Access and Recovery) application. The woman had a long history of trauma, physical and sexual abuse and neglect throughout most of her life. Due to early childhood trauma, lack of stable housing or familial support, she had struggled with anxiety, post-traumatic stress and panic attacks since early adolescence. Due to debilitating anxiety, she had not been able to acquire gainful employment since her symptoms became uncontrollable about eight years prior. For five years she repeatedly applied for SSI and was denied. Trained as a SOAR representative, the case manager identified the woman as a prime applicant for the Housing Assistance Program. During the 6 months that her SOAR application was under review, the woman was referred to FREED's HDAP (Housing Development Assistance Program) which assists individuals with rent and utilities while they have a pending SOAR application. With the HDAP certificate of funds in hand she was turned down by landlords who did not want to rent to HDAP individuals. The rejection worsened her symptoms of mental illness. On multiple occasions she sought support at the Crisis Stabilization Unit to regain her mental stability. Finally, her SOAR application was approved, and she was awarded SSI benefits. In addition to her monthly allotment, the woman received back-pay for the time her application was under review. This money allowed her to pay for a down payment, and first and last month’s rent for an apartment nearby with her partner. After attaining benefits, it only took 11 days for her to be housed. This story demonstrates how difficult it is for people with mental illness to apply for and attain SSI benefits, but how fast an individual can find housing when they have first, last and deposit money in hand. Sadly, she remained housed for less than two months before returning to homelessness after experiencing issues with her live-in partner. Although she is unique, her story is not. Month after month the Housing Assistance Program sees housed participants return to homelessness due to lack of ongoing community support. Without a doubt,

post housing case management is the greatest gap in the work that HAP does. As "housing first" models suggest, case management needs to *begin* when people are housed, not *end* at that time.

PEI Project Name: Prevention Program

FREED
Friendly Visitor Program

Program Description

Program Overview

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

The Friendly Visitor Coordinator meets with participants in their home, gets to know their needs and interests, and matches them with an available volunteer. All volunteers have completed applications, interviews, background, and reference checks. Volunteers also attend an orientation on participant-centered services as well as regular monthly trainings and volunteer support groups. Volunteers are expected to spend a minimum of one (1) hour per week visiting with their matched participant, but many volunteers spend several hours more than the minimum.

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

Target Population

The FREED Friendly Visitor program serves individuals ages 60 and older, as well as persons with disabilities who are isolated in their homes.

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

Evaluation Activities and Outcomes

In FY 18/19, the FREED Friendly Visitor program served 42 unduplicated individuals. FREED made 38 new matches, with several volunteers meeting with more than one program participant. Two of the participants in FY 18/19 were served in Truckee. FREED recruited 16 new volunteers and held six training/support groups with a total of 32 volunteers in attendance. Topics included identifying signs of depression and anxiety, Know the Signs (suicide prevention), crisis counseling, communicating with people with dementia, community services, and CPR.

The FREED Friendly Visitor Program received 103 new referrals for services in FY 18/19 and had a waitlist of 63 people at the end of the fiscal year. FREED made 84 referrals to other community services, including to the Senior Outreach Nurse, Gold Country Lift, Gold Country Community Services for Firewood, Meals on Wheels, Hospice of the Foothills for grief counseling, and FREED for the Fix-It Program, Reuse Program and the Lending Library.

A year-end survey was given to volunteers by email or in paper form, to gather information about their ability and comfort level to identify and directly address the symptoms of depression, anxiety, and suicide ideation. There was a 50% response rate from the current volunteers. 100% of the volunteers who responded felt confident identifying symptoms of depression, anxiety and signs of suicidal ideation; 100% of the volunteers felt comfortable directly addressing the signs of depression and anxiety and 83% felt comfortable addressing suicidal ideation directly. One of the volunteers, who joined in June and had not attended previous trainings, said that she would need additional training to feel comfortable.

The program administered a year-end participant phone survey to gain information about the impact on participants' isolation and the ease and comfort level they have in sharing any feelings of depression, anxiety, or suicide ideation. Sixty percent (60%) of program participants responded to the survey. Of the respondents, 100% stated that felt less isolated, depressed, and anxious. Ninety-two percent (92%) stated that they would feel comfortable talking to their Friendly Visitor about thoughts of suicide. One person said that they had a wonderful life and would never think about suicide.

The FREED Friendly Visitor Program conducted 25 outreach events with an estimated attendance of 550 individuals during FY 18/19. In addition, outreach occurred via Facebook, the Connecting Point Volunteer Hub, the AARP Volunteer Website Createthegood.org, and the Nevada County 60+ Senior Guide.

Challenges, Solutions, and Upcoming Changes

It is a challenge to find new volunteers. This past year without RSVP recruiting volunteers for the program, the program has seen a decline in volunteer numbers. With a strong increase in consumer referrals, this has created a huge discrepancy between the need and the ability to meet those needs.

The Friendly Visitor Program will focus on outreach in FY 19/20. The Program Coordinator will work with Connecting Point to have a permanent volunteer opportunity listed on their Volunteer Website, as well as the AARP Website for community volunteers called Createthegood.org. The program will be advertising in The Union and the Senior Plus Guide. There will be monthly posts on the FREED Facebook Page and outreach booths at many community events. The Program Coordinator will focus on doing more outreach by giving presentations at local service clubs, organizations, and churches.

Program Participant Story

A participant was referred to the program by an employee from Meals on Wheels. The employee said that the participant was very lonely, and that the delivery person was the only contact she had. After the Friendly Visitor intake was done, the participant started receiving daily calls from the Phone Reassurance Program while she waited for a match. The volunteers reported that she was sounding much better and they even got her to laugh a little. After two months, a volunteer became available and visited the participant weekly. The volunteer was a faithful friend and made herself available to the participant on a regular weekly basis, and whenever the participant needed to talk. The program participant's anxiety level dropped, she was sleeping better at night, and she started going back to church when a ride was organized for her. When the participant was surveyed at the end of the year, she described at length how much happier and at peace she was now because she knew someone cared about her.

PEI Project Name: Prevention Program

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
Wellness Program

Program Description

Program Overview

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

The TTUSD Wellness Program has Wellness Centers at North Tahoe High and Truckee High. The Wellness Centers provide a comfortable setting for students to drop-in during their breaks to ask questions, get support, or just relax. The Centers are furnished with cozy chairs and couches, artwork, music, games, art supplies, and healthy snacks to make it a fun place for students to hang out. The program also partners with Gateway Mountain Center to create an integrated Wellness Curriculum at Sierra High and Placer County Community School that provides individualized supports and tools for students to develop sustainable wellness practices.

Key focus areas include:

1. **Youth Voice**- The TTUSD Wellness Program facilitates a Peer Mentor Program that trains students to become Peer Mentors and teaches them skills to better support themselves and their

peers. The Peer Mentors are trained as Link Leaders and offer support to 9th graders during their first year of high school. The Wellness Centers also provide leadership opportunities for students to have an authentic voice in shaping school and community initiatives, such as: Sources of Strength Club, Pride Club, GSA Club, youth leadership workshops, 9th grade Challenge Days and participation in Community Collaborative and County meetings.

2. **Support**- TTUSD Wellness Centers provide trained staff to listen to, support, and connect students to community health and wellness resources. The Wellness Centers offer a variety of empowerment and peer support groups (e.g., coping skills, social skills, girls and boys groups) to build stronger connections with students and provide ongoing social emotional supports. The Wellness Program also collaborates with school and county partners to provide additional mental health resources for students on campus, such as: Coordinated Care Teams, school-based therapists and the What's Up Wellness Program.
3. **Education**- The TTUSD Wellness Program offers a variety of wellness workshops to provide students with practical tools to improve their overall health. Topics cover the range of social, emotional, mental, and physically healthy choices and lifestyle tools, such as: Healthy ways to deal with stress, Heart Math, Know the Signs, Mindfulness, and Breaking Down the Walls Workshops.

The TTUSD Wellness Centers offer three types of programming.

1. **Group Services**: TTUSD Wellness Centers offers several ongoing groups that bring students together to discuss their experiences, share ideas, and provide emotional support for one another.
2. **Drop-In:** The Wellness Center is open for students to drop-in at any time to receive support, be connected to resources, socialize, or just take a break when needed.
3. **Outreach:** The TTUSD Wellness Centers outreach to students by hosting workshops, leadership development days, presentations in the health classes, and Wellness Days at Sierra High and the Community School.

Wellness Center Locations and Hours:

- North Tahoe High – The Wellness Center is located in Room 217 and is open Monday-Thursday: 7:30-3:00pm, Friday: 10:30-1:00pm
- Truckee High – The Wellness Center is located in Room 132 Monday-Friday: 8:00-3:00pm

Target Population

The TTUSD Wellness Centers program primarily serves high school students, ages 14-18 years, but it also provides peer mentor supports, wellness workshops, and Sources of Strength (SOS) trainings to middle school students, ages 11-13 years. Most of the high school students served seek out Wellness Center programming on their own, but the program also receives referrals from the counselors, psychologists, school administrators, and teachers.

**Note: The following data show the youth from both Placer and Nevada County who attended the Tahoe Wellness Centers' TTUSD Wellness Program.*

Evaluation Activities and Outcomes

TTUSD collects evaluation activities for MHSA including collecting demographic information on each individual person receiving services. In addition, information on the type, date, location, and duration of the service is collected for group services. Perception of Care surveys are collected annually. Information on referrals to community services is also collected.

GOAL #1 - YOUTH:

1. TTUSD trained 78 youth in Link Crew Peer Mentoring, SOS, gender/sexual identity stigma and leadership skills to better support themselves and their peers, as well as have authentic voices in shaping school and community initiatives.
   - 22 Truckee High Peer Mentors
   - 31 North Tahoe High Peer Mentors
   - 25 Sexual and Gender Acceptance Club members and 21 Pride Club members
2. TTUSD welcomed 297 incoming 9th graders to high school through fun, interactive, student-led Freshmen Orientation Days. Youth Leaders then followed up with 9th graders the first week of school and have been offering support and mentoring to them during their first year of high school.
3. TTUSD provided leadership opportunities for 15 alternative education youth from Sierra High and the Community School to participate in the annual Community Collaborative Youth Forum where they participated in a fishbowl conversation. The purpose of the forum was to educate and inform community leaders about the experiences, perspectives and needs our students who participate in our alternative education programs.

GOAL #2 - SUPPORT:

1. TTUSD supported approximately 950 students at Truckee High, North Tahoe High, Sierra High and Community School through workshops, groups, clubs, and Link Crew Peer Mentoring.
2. TTUSD linked 32 students to outside community referrals, such as: Tahoe Safe Alliance, Gateway Mountain Center, Nevada/Placer County Behavioral Health, Child Protective Services, ARC, Family Resource Centers and the Tahoe Forest Health Navigator.
3. TTUSD trained 18 community partners in skills to help them better support and connect youth to community health resources, such as: empowering young men, creating authentic relationships with youth who have experienced trauma, youth access to health care, supporting LGBTQ youth and connecting youth to mental health and youth substance abuse programs. TTUSD trained 42 Community Collaborative partners and 35 school district staff in Heart Math and stress reduction strategies. TTUSD also trained 45 school district staff in Restorative Practices to develop stronger school cultures, manage conflict and repair harm by building authentic and caring relationships with students.

GOAL #3 - EDUCATION:

The Wellness Center offered 91 educational outreach activities to over 5,641 attendees, 5,076 of whom were youth. Educational presentations covered the following topics: Heart Math, Mindfulness/Stress Reduction, Know the Signs/SOS, Link Crew, Transition to High School, Identity and Expression, Healthy Communication, Healthy Relationships and LGBTQ youth culture and Breaking Down the Walls. In addition to presentations, the Center provided education

and support for parents and caregivers of youth through Women's Groups, Men's Groups, Parenting Training, Leadership Training, and Wellness Day activities.

Additionally, the Wellness Center received funding mid-year to support local Suicide Prevention Coalition efforts. TTUSD contracted with Kim Honeywell to offer a Suicide Prevention Cultural Competency Training to 12 community providers and with Anara Guard to facilitate a Strategy Session with 11 core Coalition members to develop a plan for the Coalition structure and function. The Wellness Center also supported the On the Verge 35 Leadership program by facilitating 3 days of Leadership Trainings for 13 management staff from the newly formed Sierra Community House. The Sierra Community House is a collaborative effort between Tahoe Safe Alliance, North Tahoe Family Resource Center, Truckee Family Resource Center and Project MANA to consolidate organizations to maximize resources and to provide a more coordinated approach to serving families. Collectively the Sierra Community House will now be able to provide hunger relief, domestic violence and crisis intervention, legal counseling, immigration aid and other family strengthening programs. The "On the Verge" program is developing the leadership capacity of the core management team who supervise teams of staff who work directly with individuals in mental health crisis.

Over the years, TTUSD Wellness Centers have offered formal groups and informal clubs. The formal groups require more commitment on the part of the student to attend and to complete sign-ins and demographic forms. The unduplicated number of students who attended formal groups in FY 18/19 was 111. Clubs are less formal and only require a sign-in from students.

Some examples of groups are: Girls Empowerment, Boys Empowerment, and Link Crew. Some examples of clubs are: Body Image, Girls Relationship, One Another Project, Peer Mentors, PRIDE, Sexual and Gender Acceptance, and Teens Offer Peer Support (TOPS).

The Drop-In center was open for an average of 167 days in both high schools, with an average of 41 students per day in attendance in FY 18/19. The total number of drop-in student attendees throughout the year was 6,912. See the table below for more information.

		FY 16/17	**FY 17/18**	**FY 18/19**
North Tahoe High	# Attendees	3,340	3,848	4,412
	# Days Available	149	141	153
	Avg. Attendees/Day	22	27	29
Truckee High	# Attendees	3,939	8,907	2,500
	# Days Available	125	186	180
	Avg. Attendees/Day	32	48	14
Both Schools	**# Attendees**	**7,279**	**12,755**	**6,912**
	Avg. # Days Available	**137**	**193**	**167**
	Avg. Attendees/Day	**53**	**66**	**41**

Note: Attendees are a duplicated number of drop-in students.

During FY 18/19, TTUSD Wellness Centers made 32 referrals to outside agencies, with 31 successfully connecting, demonstrating the Center's dedication to supporting their students. See the table below for more information.

	FY 18/19		
Agencies	**# Referrals**	**# Connected**	**% Connected**
Adventure Risk Challenge	7	7	**100%**
Child Welfare Services (CWS/ CPS)	4	3	**75%**
Family Resource Center	2	2	**100%**
Gateway Mountain Center	2	2	**100%**
Tahoe Forrest Youth Health Navigator	8	8	**100%**
Tahoe SAFE Alliance	8	8	**100%**
Therapist/ Psychiatrist (Private)	1	1	**100%%**
Total Referrals Connected	**32**	**31**	**97%**

The Wellness Centers held 91 outreach events for the 18/19 fiscal year, reaching estimated audiences of 5,651 individuals during the year. The number of unduplicated individuals attending events was 2,582. This is an increase from the average of fiscal years 2015-2018 where an average of 48 events were held averaging an attendance of 2,731 individuals. See the table below for more information.

	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Number of Outreach Events	59	31	54	91
Estimated Attendance (All Ages)	3,786	2,228	2,180	5,641
Average Attendance per Event	**64**	**72**	**40**	**62**

Note: During FY 2016-17, six (6) Outreach activities were done in collaboration with Tahoe Forest Hospital District.

Link Crew Survey FY 18/19	**% Often or Always**
I am comfortable talking with and welcoming others who visit the Wellness Center.	96.3%
I am able to recognize when others are upset.	96.3%
I am comfortable with my ability to actively listen to others.	94.4%
I feel I have the skills to support other people when they need help.	98.1%
I feel comfortable taking a leadership role.	92.6%
I feel empowered to advocate for others.	92.6%
I am able to help others be their authentic/true self.	90.7%
I am respectful and accepting of others when they have different points of view.	96.3%
I feel that my voice is heard and valued at the Wellness Center.	92.6%
I feel that I can make a difference at my school.	79.6%
My interactions with friends and family have improved.	83.3%
Link Crew provided me with the support I needed to be a Peer Mentor.	92.6%
I felt that the Link Crew facilitator(s) respected me.	98.1%
Total Surveys Submitted N = 54	

Participant Perception of Care surveys were administered in FY 18/19. Responses indicated that, overall, participants reported better functioning as a result of attending groups or clubs at the TTUSD Wellness Centers. See the table below for more information.

Participant Perception of Care Survey Items	**FY 18/19**		
	% Agree	**% Neutral**	**Total**
I am getting along better with my family.	44.6%	38.3%	82.9%
I do better in school and/or work.	57.8%	33.7%	91.5%
My housing situation has improved.	37.3%	38.6%	75.9%
I am better able to do things that I want to do.	69.9%	21.7%	91.6%
I am better able to deal with crisis.	72.3%	25.3%	97.6%
I do better in social situations.	69.9%	25.3%	95.2%
I have people with whom I can do positive things.	79.5%	15.7%	91.2%
I do things that are more meaningful to me.	69.9%	26.5%	96.4%
I have learned to use coping mechanisms other than alcohol and/or other drugs.	61.5%	21.7%	83.2%
In a crisis, I would have the support I need from family or friends.	66.3%	25.3%	91.6%
Staff welcome me and treat me with respect.	84.3%	13.3%	97.6%
Staff are sensitive to my cultural background.	55.4%	22.9%	78.3%
Average (All Responses)	**62.7%**	**28.1%**	**96.4%**
Total Surveys Submitted	**83**		

Challenges, Solutions, and Upcoming Changes

Overall, the TTUSD Wellness Program is going strong. The program is continuing to support a range of students with mental, social and emotional needs through Wellness Center drop-ins, peer mentoring, support groups, club/DIY activities, wellness educational workshops, and referrals to wellness supports.

However, there is a need to provide more robust wellness supports for the alternative education students. The Sierra High Continuation School and Community School enrollment numbers have been steadily increasing over the last few years. This year, Sierra High had a challenging group of students who were very difficult to motivate and engage in learning. The Wellness Program is looking at changing the way wellness supports are offered so there can be a more consistent and regular presence at the alternative education school sites. The Program plans to increase the number of weekly support groups provided, train staff to strengthen their authentic relationships with students, and offer smaller and more consistent wellness workshops that tie into the school's curriculum. School staff are working to develop wellness programming that will better fit these students' needs. With that said, TTUSD would like to adjust its budget to dedicate additional funds to support school staff to provide more in-house wellness supports for students.

Another upcoming change is TTUSD's plan to implement Restorative Practices at all the secondary school sites next year. A two-day Restorative Practices training was offered at the school district this spring and there are plans to offer another training for more staff this fall. The goal is to train teams of administrators and teachers in Restorative Practices as a strategy to build stronger school and classroom communities, establish school culture norms, and resolve conflict. This approach uses a continuum of practices ranging from affective statements/questions to better understand people's feelings, to community building circles to build classroom connections, to formal conferences to respond to conflict in a collaborative and strengths-based way. It builds on the existing Character Education strategies: Touch Point Surveys, Second Step, Link Crew/WEB, Breaking Down the Walls, Alternatives to Suspension, Positive Behavioral Supports, and Mindfulness, by providing a language and approach to strengthen relationships between staff, students and parents. It teaches a practical framework to open up conversations with students instead of shutting them down. It is an easy approach that can be used by teachers, school support staff, counselors and administrators to engage students in collaborative conversations and to include them in the decision-making process. This framework will help deepen caring connections between staff and students and build a stronger school culture at each of the school sites.

The last challenge and change is that the Truckee High Wellness Liaison resigned at the end of the school year after one school year. TTUSD has since hired a new person who has been working at Truckee High as a Special Education Aide and are hopeful that she will be more invested in this position since she is already committed to staying at Truckee High and has strong relationships with students and staff.

Program Participant Story

One of the Wellness Center's most underserved student populations has been Latino high school boys. The center has struggled with how to engage this demographic in supportive services. Many of the boys have been resistant to talking to the counselors and joining any group. In particular, there is a group of sophomore and junior boys that have been very hard to reach. They regularly cut their classes and have gotten in trouble for using drugs and alcohol on campus. When we mandate them to attend an intervention program, they begrudgingly attend but don't participate. As a School Coordinated Care Team, after exhausting every school resource, TTUSD reached beyond our school resources for someone in the community who might be able to work with this group of boys. Gateway Mountain Center happily offered one of their Mentors, Juan, as the perfect person for to run a group for these boys. Juan is a young Latino adult male with a similar background to many of the high school boys. He overcame some significant hardships in his life to become a strong male role model for young men and boys in his community. Through coaching and training from Gateway Mountain Center, he has evolved into a dynamic, caring mentor, teacher and facilitator.

The Center's primary goal was to have Juan connect with the boys and create a safe environment where the boys felt like they could talk. They decided to offer it in the Wellness Center so the students made a connection with the space with the hope that they would eventually feel more comfortable accessing services in the future. As expected, the first meeting was tough. The boys tested Juan and didn't offer up much personal information. But Juan didn't push it and just let them sit there while he shared his story. The next group, a couple boys shared a little bit about themselves which broke the ice, and before he knew it, they were all sharing. The boys fully engaged in each group and even asked for the group to be extended longer than 8 weeks. They talked about what it was like to be a Latino male and the pressures they felt at home and school. From these conversations, staff was able to refer 3 boys to Gateway Mountain Center Whole Hearts Minds and Bodies Mentoring Program. They were able to get connected to caring mentors who continue to meet with them regularly. As a bonus, many of the boys started stopping in at the Wellness Center on their free time to talk to the Wellness Center Liaison. They were even able to recruit 2 boys to be Link Leaders. The Center realized the importance of finding the right person they could relate with to help build trust and bridge relationships with school staff. This scenario really reinforced the importance of building authentic relationships as the foundation for all that the Wellness Center does.

PEI Project Name: Prevention Program

NEVADA COUNTY SUPER INTENDENT OF SCHOOLS
Second Step for Early Learning

Program Description

Program Overview

The SECOND STEP Curriculum is part of Nevada County's MHSA Prevention and Early Intervention (PEI) Plan. In the FY 18/19 school year, the SECOND STEP Curriculum was brought

into preschools, a transitional kindergarten (TK), typical kindergarten, and a Special Day Class (SDC) kindergarten in the Western Nevada County Region.

SECOND STEP is a curriculum that teaches social and emotional learning for children from preschool to fifth grade. The curriculum grew out of a Safe Children program, where children were learning about red, yellow and green light touches, giving simple language to children, designed to alert adults to any physical or sexual abuse as early as possible. The SECOND STEP was designed to help children develop a sense of themselves and their own emotions through getting in touch with their breath and the feelings in their bodies as well as develop empathy and sensitivity to others.

The goals for the SECOND STEP program are for teachers to learn to support children with acquiring self-regulation skills, managing emotions big and small, treating others with kindness and empathy, and guiding children on how to problem solve while integrating all these social emotional skills. These important and fundamental skills help children develop strong bonds with classmates, teachers and school altogether.

Classroom teachers are trained in the SECOND STEP curriculum, which is comprised of picture, story cards that depict the lesson for the week, puppet shows (boy and girl) with a script to support the main lesson, music CDs with specially written songs, and skill-practice activities that encourage role playing and discussions. Parents are included through weekly Home Link letters that describe what their children have learned and offers ideas for supporting these concepts at home.

Target Population

In FY 18/19 the target population was preschool and transitional kindergarten (TK) students and teachers. It also included SDC kindergarten students and teachers as well as typical kindergarten students and teachers.

Evaluation Activities and Outcomes

In the classrooms that received the full training, classroom modeling, and year-long support, a total of 98 children and 26 educators participated in the SECOND STEP program for the 18/19 school year. To begin, 31 schools, of which 29 have been previously trained in Second Step, were contacted. Two of the schools had closed and one school began using the Center on the Social and Emotional Foundations for Early Learning curriculum, CSEFL (a more recent social-emotional learning program). Four schools did not respond. Sixteen schools reported they were still using some level of the SECOND STEP curriculum, reaching over 255 children. Eight classrooms agreed to accept more training for FY 18/19. One teacher received training in the fall of 2018 and lost her position, so the new replacement teacher received the training in the spring.

Training was provided to six special education preschool teachers, ten preschool teachers (three full inclusion preschool teachers), two TK teachers (one left mid-year, one started mid-year), and three kindergarten teachers.

Working in eight classrooms, the initial SECOND STEP teacher training and two weeks of modeling the daily lessons for teachers and their students was applied. Assistance was provided in creating ways to integrate SECOND STEP into already busy schedules. The special education teachers and the TK teachers were the only ones unfamiliar with the program.

At the end of each unit SECOND STEP, staff met with teachers to check in, provide support, and exchange books that correspond with upcoming lessons from the SECOND STEP library. With the special education classroom, meetings were more frequent to see how the program could be integrated, as it took much more time to make it through a unit.

The assessments looked at the following nine measures for growth in self-regulation and social-emotional competence. Using the Desired Results Developmental Profile (DRDP), pre-assessments and post-assessments were collected for the children in the classrooms, with the following results:

Percentage of children in Mainstream classrooms Showing Growth:

- Self-Control of Feelings and Behavior: 68%
- Shared Use of Space and Materials: 78%
- Identity of Self in Relation to Others: 74%
- Social and Emotional Understanding: 69%
- Relationships and Social Interactions with Familiar Adults: 66%
- Relationships and Social Interactions with Peers: 71%
- Conflict Negotiation: 80%
- Responsible Conduct as a Group Member: 71%
- Reciprocal Communication and Conversation: 78%
- 100% showed some growth

Percentage of Children in Special Education Kindergarten Showing Growth:

- Growth shown through DRDP measures for this class were lower than the mainstream classes. Overall, 50% of the children showed some growth. The measure on the DRDP that showed the most growth was “relationship and social interaction with peers.” This skill is very important for all children but can be even more difficult in a moderate to severe Special Education class.

Teacher Reporting:

- The teacher surveys revealed that 100% of the teachers felt SECOND STEP was … “beneficial to the mental health of your students and teachers.”

Teacher’s ratings of children’s growth and program on a scale of 1 to 5 with 5 being the highest:

- Self-regulation growth: five classrooms rated 5, three classrooms rated 4
- Social emotional growth: four classrooms rated 5, four classrooms rated 4
- Overall program rating: four classrooms rated 5, four classrooms rated 4

Reduction in behavior challenges since the beginning of the year:

- Mainstream: 45%
- Special Education: 20%

All teachers confirmed they will continue with SECOND STEP next year, while one teacher reported it would be only a modified version.

Other teacher comments included:

- “SECOND STEP helped my students be in charge of their behavior”.
- “I witness students using what they have learned to help with their day.”
- “SECOND STEP teaches great strategies for students to use to regulate their days.”
- “Teaching children social skills is very important!”
- “I do love the books that go with the program.”
- “SECOND STEP helps teachers support students in a calm and appropriate way, which in turn shows students calm ways to deal with emotional situations and self-regulate their behaviors.”

Challenges, Solutions, and Upcoming Changes

The primary challenge this year was finding classrooms that were enthusiastic to participate in this training, as many had received the training previously. Even at no cost financially, many teachers were not interested because of the time and energy commitment, including paperwork and meetings outside of class time. It would be good if there were some other incentives offered.

Some programs are already required to complete DRDP’s for each child, so for them it should have been very simple. However, there are two relevant DRDP measures that SECOND STEP requires, which the state no longer requires, giving even those teachers extra work. The TK teachers and Kindergarten teachers had big classes and they reported that doing the paperwork was challenging.

The other challenge was that the two-week classroom trainings should ideally happen early in the year, which several did. However, many of the classrooms have their circle time at the same time, and while occasionally it was possible to train two classrooms at a time, it was mostly one classroom at a time. This had the two-week modeling training pushed well into November, a bit of a late start for maximum results. Due to snow days, some of the lessons throughout the training were doubled up, which seemed to work well and keep the classes on track.

The other challenge was changing staff. The TK teacher lost her position in early October and the new teacher was not hired and trained in SECOND STEP until January. In the interim there were long term subs in a particularly high need class, not following SECOND STEP. These children had a restart with their new teacher, and the two-week training in the classroom was repeated, which appeared to be very helpful. While their DRDP assessments were somewhat close together as they were both completed by the new hire, the children still demonstrated good growth.

The Special Education Kindergarten got a new head teacher towards the latter part of the year. While the other teachers in the classroom implemented SECOND STEP, it is not clear if the low improvement displayed was a result of a different teacher assessing with the DRDP's and not knowing the children very long, or that this class, which had mostly children with minimal or no verbal language, thrives with other types of specific support instead.

Program Participant Story

"Two boys in the class really struggled at the beginning regarding waiting for a turn to ride the same bike. Because we discussed taking turns—fair ways to play—at circle time using Second Step, we were able to reference that discussion and remind the boys that we recognize it's hard to take turns and wait. We identified feelings and talked about setting a timer. We had to talk about these things several times, but they quickly realized that they could regulate emotion and wait for a turn using a timer successfully."

"As a group, using the deep breathing technique and the "Eyes are Watching" song, works to calm the group down every time!"

"The children have been more aware of saying 'sorry' if they accidentally hurt someone and checking on the hurt child to see if they are OK."

"'John' entered the program with a lot of anger. We used the emotions poster daily and had each child put a sticky note with their 'special letter' (first letter of their name) on the emotion they were feeling at the time. Everyday John put his on angry and he really did feel angry. During free choice time he would have a scrunched angry look on his face and would get easily angered about issues with other children or something not going the way he wanted. After several weeks of us using the emotions poster and talking about taking breaths when we feel angry and ways to calm our bodies, he gradually started to change to a calmer and happier person at school. I remember the day he chose 'happy' for his emotion with his sticky note. He has not gone back to angry since then and he plays with others so much better than in the beginning. His self-regulation skills have dramatically improved."

PEI Project Name: Prevention Program

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT (TTUSD)
Second Step for Early Learning

Program Description

Program Overview

Second Step is a research-based curriculum that teaches social and emotional learning for children. The Collaborative for Academic, Social and Emotional Learning (CASEL), recently published

findings of the largest, most scientifically rigorous review of research ever done of school-based intervention programs (Durlak, Weissberg, Taylor, & Dymnicki). The findings indicate "…students receiving school-based Social Emotional Learning (SEL) scored 11 percentile points higher on academic achievement tests than their peers who did not receive SEL."

Goals for the Second Step program are for children to develop self-regulation skills, learn to manage their emotions, treat others with compassion, solve problems without anger, and develop strong bonds to school. The curriculum is implemented by the classroom teacher each day in several short segments. The teacher uses scripted lesson cards with photographs, boy and girl puppets, music, and skills practice activities that lead to role-playing and discussions. Parents are sent weekly Home Link letters to inform them of what their children have learned and to give them ideas for supporting these concepts at home.

TTUSD is entering its ninth year of implementation of the Second Step curriculum in preschool to 8th grade. The Second Step kits were purchased, and training has been ongoing for teachers, newly hired staff, bus drivers, support staff, and employees of the Boys and Girls Club at Truckee Elementary School.

The district wide goal in FY 18/19 was "Power of Connections." All students learn and thrive when they feel safe and connected to their school, through their peers, teachers, school staff, parents, coaches, and others.

Target Population

The target population is teachers of preschool to 8th grade students in the Tahoe Truckee Unified School District and their students.

Evaluation Activities and Outcomes

TTUSD Second Step collects evaluation activities for MHSA including demographic information on each teacher that implements the program. In FY 18/19, 21 counselors, teachers and parents were trained in this program.

Trainings on Mind Yeti and/or Second Step took place at the elementary and middle school sites as needed. Training was offered to all the teachers and support staff at the pre-schools and schools in the TTUSD area. Staff training took place at Glenshire elementary school for new support staff and new teachers.

Training was offered to the Boys and Girls After School Programs at Truckee Elementary and Glenshire Elementary Schools. Three trainings were conducted in FY 18/19. On 10/1/2018 a Second Step Overview training was conducted at Tahoe Truckee Unified School District Office for School Counselors with seven counselors in attendance. On 10/2/2018 a Mindful Parenting class was held at Sierra High School with seven parents in attendance. On 12/17/2018 a Second Step Training was held at Glenshire Elementary School with another seven participants. At this

training pre and post evaluations were collected to understand the impact of the training on the teachers' ability to apply the principles of the Second Step training. Training evaluations returned showed a 42% increase in teachers' perceived ability to apply the principles after the training.

Training Performance Measures:

- 88% of Kindergarten through Fifth Grade classroom teachers at Glenshire have fully implemented the Second Step curriculum. Thus, 88% of the 539-student body, or 474 students were taught using these principles.
- 89% of Kindergarten through Fifth Grade classroom teachers at Truckee Elementary have fully implemented the Second Step curriculum. Thus, 89% of the 492-student body, or 383 students were taught using these principles.
- 40% of Sixth through Eighth Grade classroom teachers at Alder Creek Middle School have fully implemented the Second Step curriculum. Thus, 40% of the 537-student body, or 215 students were taught using these principles.
- Add Preschools and Transitional Kindergartens as room is available to an Early Learning cohort of seven sites. Data not available.
- California Healthy Kids Survey was given to students in 5th Grade, 9th Grade and 11th Grade. The areas that showed improvement from 5th Grade to 9th Grade were School Connectedness, Truancies, Meaningful Participation, and Facilities Upkeep. Regarding School Safety, the incidents of harassment, rumor spreading, and fights went down. Feelings of sadness decreased, and the number of e-cigarette smokers went down.

The areas that showed improvement from 5th Grade to 11th Grade were School Connectedness, Meaningful Participation, and Facilities Upkeep. Regarding School Safety, the incidents of harassment, rumor spreading, and fights went down. Results shown below.

ACMS/NTS Summary of Key Indicators California Healthy Kids Survey	Average of all 4 Elementary schools	Tahoe Truckee High	Change from 5th Grade to 9th Grade. Areas in green show Improvement	Tahoe Truckee High	Change from 5th Grade to 11th Grade Areas in green show Improvement
Grade:	5th	9th		11th	
Total # Surveyed:	260	148		109	
School Engagement Supports	%	%		%	
School connectedness (high)***	26	41	Improvement	46	Improvement
Academic motivation (high)	38	32		25	
Truant more than a few times*	8	3	Improvement	10	
Caring adult relationships (high)	37	26		31	
High expectations (high)	42	35		36	
Meaningful participation (high)	10	14	Improvement	14	Improvement
Facilities upkeep	19	62	Improvement	63	Improvement
School Safety and Substance Use					
School perceived as very safe or safe	73	67		66	
Experienced any harassment or bullying*	41	32	Improvement	34	Improvement
Had mean rumors or lies spread about you*	48	36	Improvement	40	Improvement
Been afraid of being beaten up*	18	10	Improvement	7	Improvement
Been in a physical fight*	35	7	Improvement	9	Improvement
Seen a weapon on campus*	11	14		12	
Been drunk or "high" on drugs at school, ever	1	8		17	
Mental and Physical Health					
Current alcohol or drug use*	18	19		39	
Current binge drinking*	2	4		27	
Current cigarette smoking**	0	4		10	
Experienced chronic sadness/hopelessness*	29	28	Improvement	35	
Current electronic cigarette use	6	5	Improvement	17	

Notes: Cells are empty if there are less than 25 respondents
*Past 12 months
**Past 30 days
***The data source in this category changed in 2018. This comparison is not reliable.

The End of Year Second Step Program Survey was completed by 84 teachers, administrators, counselors and support staff. Results showed that staff understood the Second Step program, believed that needy students at their school were receiving support and felt they needed more training on trauma informed practices.

Second Step Survey Evaluation (2018-2019 School Year)

	1. STRONGLY AGREE	2. AGREE	3. NEUTRAL	4. DISAGREE	5. STRONGLY DISAGREE	N/A	TOTAL	WEIGHTED AVERAGE
I understand the goals and objectives of the Second Step program.	53.57% 45	38.10% 32	4.76% 4	1.19% 1	2.38% 2	0.00% 0	84	1.61
I believe students who have experienced trauma or mental health needs or who lack social skills at my site are receiving support.	22.89% 19	57.83% 48	15.66% 13	2.41% 2	1.20% 1	0.00% 0	83	2.01
Our staff (teachers, admin, counselors, support staff) need more training on trauma informed practices.	30.12% 25	44.58% 37	19.28% 16	3.61% 3	2.41% 2	0.00% 0	83	2.04

In Transitional Kindergarten (TK) through 5th grades, Second Step Kits were purchased for all new teachers and any classrooms that needed a replacement. Replacement materials were purchased as needed for damaged or missing curriculum pieces.

The new Second Step streaming lessons were purchased for all 6th grade classes at Alder Creek Elementary School and all grades 6th through 8th at North Tahoe Middle School.

The new mindfulness part of the Second Step program, the Mind Yeti licenses were purchased for each school. Each teacher, counselor and principal were given access to the Mind Yeti application. Mind Yeti is a tool for teachers and parents to teach mindfulness to students in grades preschool through 8th grade. Mindfulness practice helps students with managing their emotions, self-regulation, making transitions, empathy building, anxiety and more. It will also be offered to parents on an as needed basis to use in the home. The licenses are good through next September and will then be purchased again in September 2019 for all the sites that would like access.

Information was collected for Student Study team referrals at Truckee Elementary School, Tahoe Lake Elementary School, Glenshire Elementary School, Alder Creek Middle School, North Tahoe Middle School and Kings Beach Elementary School. This tracks the students referred for mental health and social emotional issues and if the student was connected to a program or counselor within the school setting or outside services during the school year.

There were 62 referrals to the Study Team during FY 18/19, and 50 of those children were also referred to other services. Of those, 49 connected with the referral to which they were sent. Referrals were made for services such as; 504 assessments, behavioral strategies monitoring, boys/girls club, Cognitive Behavioral Therapy counseling, friendship group, full education evaluation, group counseling, growth mindset learning, Nevada County Behavioral Health, nurtured heart training, psychiatrist, Psycho-ed testing, reading intervention, school counseling, Special Friends, Tahoe Forest Hospital Psychologist and therapists.

Challenges, Solutions, and Upcoming Changes

One upcoming change is the use of surveys for the teachers. Surveys will be given the first few weeks of school to each teacher to monitor their use of the Second Step Curriculum and a survey will be given at the end of the year to show outcomes of the program and its benefits for social emotional growth. These surveys will be developed by the Second Step Coordinator.

We have discussed with each site tracking and recording the referrals to each school's student study team for students who are referred for social emotional issues. This will help monitor the support that will be given to each referred student.

The new Second Step program is continually updating with technology and ease of use for the teachers. Second Step will monitor this and purchase new kits and/or licenses as needed. The Second Step Middle School program was restructured to be used digitally. This was more user friendly for the teachers' advisory periods. New all-digital kits will be needed to replace the kits that use DVD's as the program changes and as new teachers are hired. Second Step will continue with new teacher training at all schools.

The District Goal this year is the "Power of Connections". This goes well with the social emotional basis of the Second Step Program. All students learn and thrive when they feel safe and connected to their school or an adult in their lives i.e. their teacher, counselor, custodian, secretary, parent, coach, etc.

The Mindfulness piece of the Second Step program or "Mind Yeti" licenses will be renewed for each elementary school site. Students are taught skills in self-regulation, ease in transitions, dealing with strong emotions, becoming more empathetic, and they are given tools for dealing with anxiety and so much more. This as a great step on the continuum of fostering emotional wellbeing in students.

Evaluating the program going forward, teachers will be asked to complete and put into place the Implementation Preparedness Survey and the Lesson-Completion Checklist. The California Healthy Kids survey will also be used as a tool for understanding the needs of students.

Program Participant Story

A quote from a Fourth-Grade teacher at Tahoe Lake School: Regarding the Second Step Curriculum in FY 18/19:

"The scenarios for the students that are portrayed on the Second Step videos are so timely and appropriate. It gives the teacher a teachable moment and opportunity that she would not necessarily have otherwise, to discuss the problem-solving steps, the emotion management skills, and empathy and compassion building skills. It shows what it takes for students to put themselves in other people's shoes. It teaches children how to calm down in tense and stressful situations and solve the problems that are typical for a fourth-grader in a peaceful way, in class and on the playground."

PEI Project Name: Prevention Program

BIG BROTHERS, BIG SISTERS
Pal Program

Program Description

Program Overview

The Big Brothers, Big Sisters Pal Program serves at-risk elementary and middle school youth, called Little Pals, by providing them with a high school mentor, or Big Pal. The Big Pals help the Little Pals develop the skills to manage the trials of growing up, while also providing academic support.

High School juniors and seniors are matched with elementary and middle school students, Grades 3 - 8, for a weekly mentoring meeting. In the Pal Program, Littles are referred for services through their school counselor and are identified as being at-risk for a variety of reasons. These children often struggle with social skills, bullying issues, and their academic performance, making them susceptible to future mental health challenges and concerns. Bigs are a mentor, tutor, and friend to their young mentees throughout the school year, meeting weekly during the school day for a period of 45 minutes. All meetings are held on the school campus. Students are referred by administrators/teachers from Grass Valley School District: Scotten Elementary, Lyman Gilmore Middle, and Grass Valley Charter; from Nevada City School District: Deer Creek Elementary and Seven Hills Middle; and from Pleasant Ridge School District: Cottage Hill Elementary. High School Big Pals are recruited from the following schools: Nevada Union High School, Bear River, North Point Academy, and Forest Charter School.

The Pal Program Coordinator recruits, screens, trains, and matches all children and teens, conducts match support meetings on a bi-monthly basis, and works closely with the schools and teachers to set goals and review progress towards those goals throughout the school year. As a prevention and early intervention strategy, Big Pals are trained to identify and report revelations to the Program Director concerning needed support with family struggles, substance abuse, domestic violence and emotional disturbance. The Director is in constant communication with the school counselor for any next level referrals such as Child Welfare, Mental Health Services, or Behavioral Health.

Target Population

The Pal Program targets at-risk children ages 6-13 at Lyman Gilmore, Scotten Elementary, Williams Ranch, Seven Hills, Grass Valley Charter, Cottage Hill and Magnolia Middle School. 52 littles were served from these Nevada County schools in the 18/19 school year.

Evaluation Activities and Outcomes

Big Brothers, Big Sisters collects evaluation activities for MHSA including demographic information on each individual person receiving services. In addition, information on the number of meetings between Big and Little Pals is collected. Information on referrals to community services is also collected.

In FY 18/19, the program experienced substantial growth. Matches of Big Brothers and Sisters to little brothers and sisters increased from 21 matches in the previous two fiscal years to 52 matches for FY 18/19. There was a total of 1,625 confirmed contacts and over 968 hours spent between mentors and their matches.

	FY 16/17		FY 17/18		FY 18/19	
Number of Service Contacts*	**Number of Matches**	**Percent of Matches**	**Number of Matches**	**Percent of Matches**	**Number of Matches**	**Percent of Matches**
1 Contact	-	-	-	-	1	2%
2 – 4 Contacts	2	9.5%	3	14.3%	3	6%
5 – 7 Contacts	-	-	2	9.5%	3	6%
8+ Contacts	19	90.5%	16	76.2%	47	86%
Unduplicated Total	**21**	**100.0%**	**21**	**100.0%**	**52**	**100%**

*Total number of direct service contacts each participant received in each Fiscal Year

Big Brothers, Big Sisters of Nevada County and North Lake Tahoe have been conducting effective mentoring programs for at-risk youth for the past 35 years. Two surveys are used to assess the quality of the relationships between the Big Pals and the Little Pals and the impact of the Program on the children served: the Strength of Relationship (SoR) survey and the Youth Outcomes Survey (YOS).

Each child and mentor complete the SoR survey after three (3) months of being matched, to establish a baseline. Thereafter, they both complete the SoR annually on their anniversary. This survey assesses the quality of the relationship between the child and the mentor by looking at how close they feel to one another, how much they trust one another, and how important the relationship is to them.

End of Year Strength of Relationship surveys were administered to 51 Littles at the end of the school year. Littles rated a series of questions related to the strength and quality of the mentoring relationship at the end of the school year, with 1 being the weakest rating and 5 being the strongest rating. According to the Littles, the average rating for the following relationship quality indicators was very strong:

- **Lack of Disappointment** in their relationship with their Big Pal (4.91)
- **Importance** of their relationship with their Big Pal (4.86)
- **Safety** in their relationship with their Big Pal (4.95)
- **Closeness** of their relationship with their Big Pal (4.76)
- How much their Big Pal helped them **Cope** with challenging situations (4.65)

The End-of-School-Year Youth Outcomes Surveys (YOS) were also administered to 13 Littles (the survey is only administered to children over 12 years of age). The YOS questions cover youth attitudes in three strategic outcome areas: educational success, avoidance of risky behaviors, and socio-emotional competence (which covers higher aspirations, greater confidence, and better relationships).

Improved Healthy Behaviors

- **97%** believe it is not okay to engage in risky behaviors, specifically: using tobacco, taking drugs that are not given to them by a doctor or parent, and drinking alcohol without their parent's knowledge
- **100%** have not been arrested for a crime, offense, and/or violation in the last 12 months

Improved School Performance

- **96%** believe it is not okay to skip school without permission
- **92%** believe it is not okay to break the school rules

Improved Interpersonal Relationships

- **91%** believe it is not okay to hit someone because they don't like what they say or do

No referrals to outside agencies were made during this fiscal year.

Challenges, Solutions, and Upcoming Changes

The biggest challenge to this program is having enough Bigs for all of the referred Littles. Constant recruitment has to happen throughout the year in order to provide services for all of county's needs. BBBS provided services for 94% of the referred children in the 18/19 school year, but the ultimate goal is to provide services for all referred children. One solution to this problem was to end the 2019 school year with a recruitment campaign to be ahead of recruitment needs for the 19/20 school year. Our goal this year is to provide services for 100% of our referred at-risk children.

Program Participant Story

A middle schooler was having many family struggles at the beginning of last year. The student's parents had both been deported last summer. She was living with a sister who was struggling financially to meet the family's needs. The counselor referred the student knowing she would need extra support as she was often times weepy at school missing her parents. The counselor felt strongly that the student needed someone who was Hispanic and could identify and relate to her struggles. The Program Coordinator met the middle schooler last September and was saddened by her story but also motivated to find her the right support. In what would seem like divine intervention, the Program Coordinator met a senior at one of her recruiting campaigns who was in fact Hispanic. This senior had recently experienced the deportation of her grandparents and was very eager to help the middle school student. The friendship was quick, and the impact was immediate. The student was no longer weepy at school and was able to navigate her rough year with the support of her empathetic, caring and diligent Big Sister. After a year of mentoring, the student's grades were good, her outlook positive and her counselor feels that she is no longer in need of intervention services.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA-SIERRA CONNECTING POINT PUBLIC AUTHORITY
2-1-1 Nevada County

Program Description

Program Overview
2-1-1 Nevada County is a resource and information phone hub that connects people with community, health, and disaster services through a free, 24/7, confidential phone service and searchable online database. By dialing 2-1-1, Nevada County residents can access health information, community services, and disaster services throughout Nevada County. This program offers assistance in multiple languages and is accessible to people with disabilities. Trained information and referral specialists give personalized attention to each caller by utilizing a comprehensive computerized database of more than 1,200 nonprofit and public agencies at 1,700 different locations in Nevada County. Specialists can refer callers to a variety of services to best meet their needs.

Target Population
2-1-1 Nevada County serves the entire population of Nevada County and anyone calling the 2-1-1 Line seeking information about community resources.

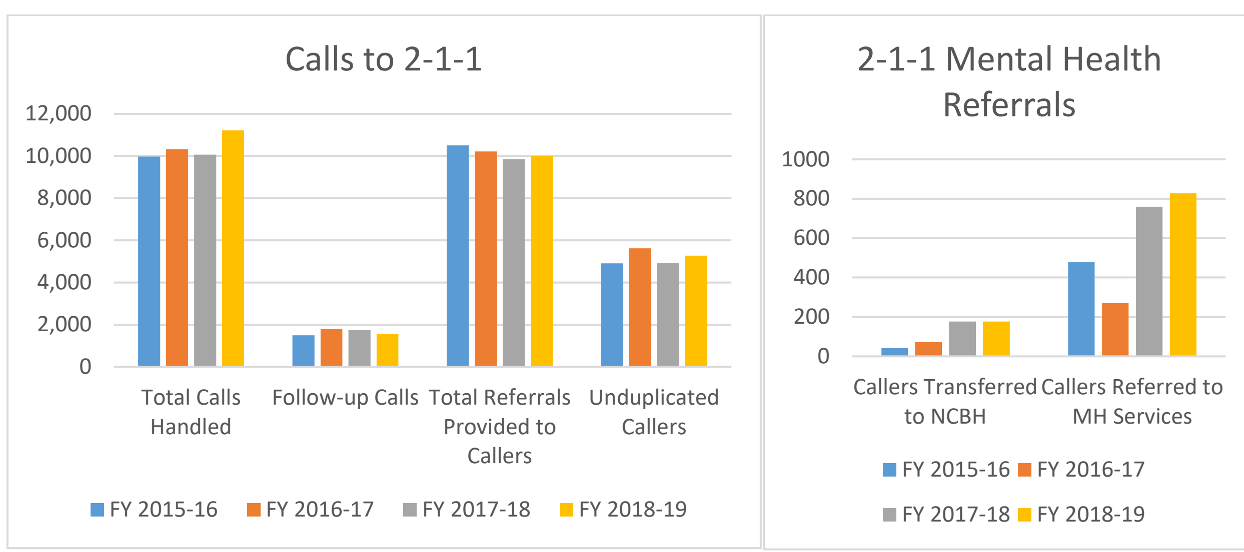
Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on each caller, the number of referrals to community resources, and the number of follow-up calls.

In FY 18/19, 2-1-1 staff handled 11,215 calls. This is an increase of 1,242 annual calls, or 12% from the FY 2015-16 data. There were 5,269 unduplicated callers in FY 18/19. Of the total number of annual callers, 89% of calls received a referral. See the tables below for information on calls to 2-1-1.

- Of the 11,215 total calls handled:
  - 1,573 were Follow Up Calls
  - 1,102 calls ended with a “warm referral” direct connection to resource
  - 176 callers were referred to Nevada County Behavioral Health
- Outcome Measures Tracked:
  - 10,004 referrals provided to callers
  - 5,269 unduplicated callers
  - 828 referrals to mental health services

Calls to 2-1-1	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Total Calls Handled	**9,973**	**10,324**	**10,065**	**11,215**
Follow-up Calls	1,503	1,807	1,740	1,573
"Warm" Referrals	873	1,849	1,530	1,102
Callers Transferred to NCBH	42	73	163	176
Callers Referred to MH Services	479	271	759	828
Total Referrals Provided to Callers	10,506	10,211	9,858	10,004
Unduplicated Callers	**4,907**	**5,616**	**4,921**	**5,269**



Additionally, 95,040 searches and web resource page views from 20,024 unique IP addresses were conducted on the 211 Nevada County website. This is an increase of 12,854 searches (16%) from an additional 5,818 unique IP addressed (41%) in FY 18/19 from the previous fiscal year.

2-1-1 Nevada County Website: 211connectingpoint.org	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Total Number of Searches	123,969	111,193	82,186	95,040
Searches from Unique IP Addresses	14,732	16,480	14,206	20,024

No participant identifying suicidal ideation was let off the line without a warm transfer to a suicide crisis line. Suicide-related calls handled included:

- Caller was very concerned about a friend who was released from the hospital about a month prior to calling. She says her friend is acting “strange” and had a past suicide attempt. The friend had just asked the caller to pick up 9 different “heavy” prescriptions for her. The caller wanted to know what she should do. The 211 Call Specialist advised the caller to call APS and local law enforcement. Caller accepted the contact information for APS.
- Caller was contemplating suicide. 211 Call Specialist offered local and national crisis line phone numbers and warm-transferred the caller to the local line.

- Caller was newly homeless and very distressed due to losing her job and losing her connection to her sister who had been helping her for several years. The caller had an appointment with her therapist later in the day but felt she couldn't make it until then and was feeling suicidal. Caller was warm-transferred to Behavioral Health.
- Caller was having thoughts of suicide. 211 Call Specialist attempted to implement newly created Suicide Risk Assessment, but caller declined, saying she was not comfortable doing the assessment, because she didn't want the police to be called on her. She was warm transferred to Behavioral Health.
- Caller was worried about her husband, who was having suicidal thoughts. He was also in a lot of physical pain due to health concerns. It was a holiday, and the family doctor's office was closed. Caller was currently with her husband, and she was transferred by the 211 Call Specialist to Behavioral Health Crisis Line. Follow up was set. Upon following up the next day, caller stated that her husband was feeling a bit better and that he had been able to reach his doctor to make an appointment for later in the week.
- Caller who was Spanish Speaking needed translation. The 211 Call Specialist contacted a Spanish Speaking translator through the Language Line. Through this translator, the Call Specialist learned that the caller was very depressed and needed help. His wife and children had moved out, and his wife had taken out a restraining order against him. He had 2 previous suicide attempts, both within the last 12 months. He was hospitalized after both attempts. His most recent therapist had discharged him, saying "he no longer needs therapy". He was currently without services. Several times he told the Call Specialist he wanted to disappear and die. The Call Specialist completed the Suicide Risk Assessment, and it was determined that he didn't have a clear plan or the means to carry it out at this time. He was warm transferred to The National Suicide Prevention Hotline to a Spanish Speaking counselor.
- Caller was calling about her friend, who is a senior in the process of being evicted from her home. The woman had shut herself in the house and told the caller she wants to die. She stopped eating. The caller was referred to Behavioral Health Crisis Line, National Suicide Prevention Lifeline, and the Nevada City Police Department.

During FY 18/19, 2-1-1 staff attended trainings in Diversity & Inclusion, Trauma Informed Care, Best Practices in Ageing & Disability Client Engagement and LGBTQ+ Transgender Diversity & Awareness and educational presentations from local resource providers.

2-1-1 also had in-house trainings on Handling Crisis Calls, Transportation Resources, Coordinated Entry, REACH and USDA Grant & Loan Resources.

Challenges, Solutions, and Upcoming Changes

The need for more intensive case management for Seniors in the community was identified. 211 will be working closely with our Senior Navigator to refer seniors who need personalized case management and resources. The Senior Navigator position is new and will be filled by Leslie Kerns.

Connecting Point also recently launched the Volunteer Hub, to help connect those looking for volunteer opportunities with local agencies and organizations in need of volunteer work.

An ongoing challenge for 2-1-1 has been in serving the homeless population in Nevada County. 2-1-1 currently provides these participants service through Coordinated Entry. They help people with emergency shelter and additional resources, however continue to see a need for additional long term and permanent housing options for homeless individuals.

Program Participant Story

Caller was homeless and went through Coordinated Entry to get into the Hospitality House. He was 2 weeks clean and sober and identified feeling suicidal. The call specialist completed a suicide risk assessment that identified a moderate suicide risk. He was warm-transferred to Nevada County Behavioral Health following his Coordinated Entry.

FOLLOW UP: The call specialist followed up with the caller to see how he was doing and if he was able to get the help he needed through Behavioral Health. The caller indicated that he was feeling better and he had scheduled an appointment at Behavioral Health for the following week. He had gotten a bed a Hospitality House.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY ADULT SERVICES
Social Outreach Program

Program Description

Program Overview

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

The number of visits and phone contacts varies with each person, based on need. Follow-up "check-in" calls are frequently conducted, and the participants are always encouraged to call if a need arises. At times, consumers call after several months when they need assistance, circumstances change, or they need someone to talk to for support, which allows additional opportunities to link participants to long-term supportive services.

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

Target Population

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

Evaluation Activities and Outcomes

The Social Outreach Program collected information on each person who received a home visit. This information includes demographic details, date of the contact, location, and number of services. The program also collected the number of referrals made to community agencies. A depression-screening tool and a drug/alcohol screening tool were completed at the beginning of services.

The Social Outreach Program delivered services to 66 unduplicated participants during FY 18/19. This is an increase from previous years where the totals were: 51 during FY 16/17, and 33 during FY 17/18. See table below.

In addition to serving double the number of participants from the previous year, the average number of hours spent with each participant increased this past fiscal year as well, from 3.4 hours in FY 17/18, to 14.3 hours in FY 18/19. The majority of services fell under the service category of assessment and screening, however the individuals serviced under the case management service category received substantially more average hours of service per individual (24.6 hours) than those receiving assessment and screening (4 hours). See table below.

	FY 16/17		FY 17/18		FY 18/19	
Number of Service Contacts	**Number Served**	**Percent of Served**	**Number Served**	**Percent of Served**	**Number Served**	**Percent of Served**
1 Contacts	14	27.5%	18	54.5%	12	18.2%
2 – 4 Contacts	22	43.1%	12	36.4%	42	63.6%
5 – 7 Contacts	8	15.7%	2	6.1%	10	15.2%
8+ Contacts	7	13.7%	1	3.0%	2	3.0%
Unduplicated Total	**51**	**100.0%**	**33**	**100.0%**	**66**	**100.0%**

	FY 16/17			FY 17/18			FY 18/19		
Service Category	**# of Hours**	**Number Served**	**Average Hours per Participant**	**# of Hours**	**Number Served**	**Average Hours per Participant**	**# of Hours**	**Number Served**	**Average Hours per Participant**
Assessment/ Screening	266.0	51	5.2	62.9	31	2.0	235.3	59	4.0
Case Management/ Linkage	1.0	1	1.0	48.2	7	6.9	169.8	7	24.6
Collateral	-	-	-	-	-	-	-	-	-
Family Team Meeting	-	-	-	-	-	-	-	-	-
Other	5.5	6	0.9	-	-	-	-	-	-
Total (All Services)	**272.5**	**51**	**8.3**	**111.1**	**33**	**3.4**	**405.1**	**66**	**14.3**

The Social Outreach Program Coordinator administered the short version of the Geriatric Depression Screening 116 times to 65 individuals over the course of FY 18/19.

	FY 18/19	
Geriatric Depression Screening	**Number Served**	**Percent of Served**
No Symptoms (0-4)	47	40.5%
Mild Symptoms (5-9)	44	37.9%
Moderate to Severe Symptoms (10-15)	25	21.6%
Total	**116**	**100.0%**

43 individuals completed a pre/post depression screening before and after receiving services from the Senior Outreach Program. Of those 43 individuals, 26 showed improvements in their depression screening score (average of -2.9 points), 6 screened with no changes, and 11 screened as showing an increase in depression symptoms (average +1.8 points). See the table below for more detailed depression screening information.

Geriatric Depression Screening	Number Screened	Percent of Individuals	Average Change in Score
Improvement in Symptoms	26	60.5%	2.9
No Changed	6	14.0%	0
Decline in Symptoms	11	25.6%	1.8
Total	**43**	**100.1%**	**-**

During FY 18/19, the Program Coordinator made 312 referrals to other agencies. Of these, 174 successfully connected with the agency. Referrals in the "other category" were primarily to the Friendship Line. Additional "other" referrals were for sobriety groups with CORR, Common Goals, and AA; transportation services; and PG&E. See the table below for more detailed referral information.

	FY 18/19		
Agencies	**# Referrals**	**# Connected**	**% Connected**
211	38	32	84.2%
A New Day	2	0	0%
Chapa De	-	-	-
Concern Aid	-	-	-
Faith-Based Organization	-	-	-
Financial Assistance	3	1	33.3%
Crisis Stabilization Unit	2	0	0%
Food Bank	8	8	100%
FREED	50	39	78%
Helping Hands	2	1	50%
In-Home Support Services (IHSS)	4	1	25%
Insight Respite House	-	-	-
Legal Services	2	1	50%
Mental Health	37	11	29.7%
Partner Agency	18	15	83.3%
Physician/ MD	3	1	33.3%
Sierra Nevada Memorial Hospital	-	-	-
Social Services Agency	13	13	100.0%
SPIRIT	4	1	25%
Therapist/ Psychiatrist (Private)	8	5	62.5%
Veteran Services	2	0	0%
Western Sierra Medical Clinic	1	1	100%
Other	115	44	38.3%
Total Referrals Connected/ Average	**312**	**174**	**55.8%**

During FY 18/19, the Program Coordinator performed a total of five (5) outreach presentations, including one in the Truckee area, with an estimated attendance across presentations of 105 attendees.

Challenges, Solutions, and Upcoming Changes

Outreach to the Truckee community (Eastern Nevada County) presents ongoing challenges regarding referrals as well as difficulty accessing the area during seasonal inclement weather. The Program Coordinator is continuing to work with community partners in the Truckee area to increase referrals to the Social Outreach Program and support for participants, including meeting at least quarterly with the Community Health Partnership. Additionally, the Program Coordinator collaborated with the Falls Prevention Coalition to present a workshop in Truckee on senior depression in Truckee in June 2019 with the intention of education as well as increasing the visibility and awareness of the Social Outreach Program as a resource in the area. Furthermore, phone appointments remain available in the case of inclement weather preventing in-person visits.

Another ongoing challenge is a deficiency of in-home therapy availability for participants. This creates a gap in service due to the characteristics of the population served by the Social Outreach Program. Many participants of the program have mobility issues, serious health conditions, chronic pain, anxiety, and memory impairment which, in many cases, make it difficult to attend appointments outside the home. The Program Coordinator has reached out to local therapists who accept Medicare and six of them have stated they will occasionally offer this service on a limited basis when they have availability. However, in practice, the therapists have full practices or have declined due to the participant being some distance from the therapist's office. Therefore, the Program Coordinator has been unable to connect any participants to these services in this fiscal year. The Program Coordinator continues to work with participants in accessing transportation through The Lift and other ride services to facilitate the ability to attend out of home therapy appointments. A community agency willing to develop and support a Senior Peer Counseling program offering in-home support, as is done in some other counties, could assist in addressing this challenge. Additionally, more local therapists willing to offer the service of in-home therapy could reduce the gap for Social Outreach participants obtaining needed mental health support.

Program Participant Story

The Social Outreach Coordinator worked with a participant who was experiencing chronic depression and suicidal ideation. Due to the symptoms of depression, the participant was having difficulty functioning and was isolating herself in her home. The individual had a supportive husband, but he often worked out of town leaving her alone for long periods of time and she had distanced herself from other friends and family members leading to isolation and loneliness.

The participant had received mental health services in the past but did not have a current therapist or psychiatrist working with her. The Social Outreach Coordinator was able to make referrals for a therapist as well as a psychiatrist for medication evaluation and management. With

encouragement, the individual was willing to follow through on the referrals and obtain regular, ongoing mental health support. The Social Outreach Coordinator also worked with the participant and her husband in creating a safety plan and provided appropriate referrals (Behavioral Health Crisis Line, Mental Health Urgent Care Center, and Insight Respite Center) to address the participant's suicidal ideation. As the individual participated in support services, she began reporting some relief from her depression symptoms. The individual was offered a referral to FREED Friendly Visitor program which she declined but with further encouragement from the Social Outreach Coordinator, she was able to begin attending some social functions outside the home and reaching out to friends and family she had previously been withdrawing from.

With encouragement and connection to services and supports, the participant's second depression screen showed a reduction in symptoms of depression. She also reported an increase in socialization and overall life satisfaction. Furthermore, the participant reported an appreciation for the support of the Social Outreach Program and stated she felt the program was vital to her progress and improved quality of life.

PEI Project Name: Access and Linkage to Treatment Program

HOSPITALITY HOUSE
Homeless Outreach

Program Description

Program Overview

Hospitality House is a nonprofit community shelter for people who are homeless in Nevada County. The mission of Hospitality House is to bring homeless people in Nevada County into a circle of community caring that offers shelter, sustenance, medical care, advocacy, opportunity, dignity, and hope as they are transitioning from homelessness to housing.

Hospitality House is committed to ending homelessness by providing intensive case management services to all of its guests. Hospitality House also offers outreach services including Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) application assistance, birth certificate and California ID fee waiver assistance, referral services, transportation, clothing and clothing vouchers, food and drink, and camping gear. Hospitality House Homeless Outreach staff works with social services, Public Health, Behavioral Health, churches, nonprofit organizations, service providers, family members, and other support systems of those who are homeless. Hospitality House strives to empower people who are homeless and help them develop the skills they need to overcome the barriers that prevent them from successfully obtaining and maintaining stable housing.

Target Population

Hospitality House serves individuals and families who are homeless in Nevada County.

Evaluation Activities and Outcomes

Hospitality House Homeless Outreach collected evaluation activities for MHSA including demographic information on each individual person receiving services. In addition, information on referrals to outside agencies and outreach activities was collected

During FY 18/19, Hospitality House Homeless Outreach case managers made contact with 107 unduplicated individuals. Of the 107 individuals served, 72 received referrals to 29 different agencies. Of the 72 receiving referrals 59 connected to a service, as defined by participating at least once in the program to which the person was referred.

Additionally, 42 referrals were made for mental health services, of which 37 engaged in treatment. This is a success rate of 88%.

FY 18/19 Goals and Outcome Measures:

Goal: 90% of homeless and severely mentally ill individuals with no social security income will be offered assistance with a referral to social security office and/or an application for benefits so that the individual can receive social security income.
Outcome: 100% of all income referrals were referred for benefits. Eleven referrals were made and connected.

Goal: 90% of homeless and severely mentally ill individuals will be referred to mental health services.
Outcome: Of the 34 referrals made to mental health services, 28 or 82%, were connected to services.

Goal: 70% of individuals with a drug problem will be referred to drug treatment services.
Outcome: 53% of all individuals reporting substance abuse in PEI were given a referral to treatment. Sixty-six individuals reported substance abuse issues (either drug and alcohol or both). Thirty-five individuals received referrals to treatment (drug counseling, detox, residential treatment). Three, or 97%, of those individuals referred accessed substance abuse services.

Goal: Refer a minimum of 10 individuals per year to mental health services.
Outcome: 34 referrals were made to mental health services.

Goal: 70% of individuals who are referred engage in the referred service, defined as participating at least once in the service.
Outcome: 76% of all referrals engaged in the referred service (542 referrals made and 414 engaged in services).

Goal: 25% of individuals and/or families served will secure stable housing.
Outcome: Of the 107 individuals served, 17% (19 individuals) exited to permanent destinations.

FY 18/19 saw substantial growth in homeless outreach as a result of the establishment and deployment of the Homeless Outreach and Medical Engagement (HOME) Team. The HOME Team serves the specific purpose of performing homeless outreach and linkage to services. The total number of outreach attempts increase by 650% from 38 in FY 2017-18 to 248 in FY 18/19. The number of individuals contacted increased by 577% rising from 375 in FY 2017-18 to 2,164 in FY 18/19. It should be noted that there will be some duplication between the HOME Team Innovation Report and the PEI Homeless Outreach Report, since the PEI Homeless Outreach Worker serves as a lead on the HOME team.

	FY 16/17	FY 17/18	FY 18/19
# Outreach Attempts	9	38	248
# Estimated Contacts	15	375	2164

Challenges, Solutions, and Upcoming Changes

From July 1, 2018 to June 30, 2019 Hospitality House served 107 individuals through its PEI program. Meeting outreach individuals "where they are at" poses certain challenges that are not found in sheltered guests. With no fixed address, and most not having cell phones, ongoing case management can be challenging. The expansion of services through the HOME Team and Hospitality House Outreach team is a step in the right in the right direction if more meaningful case management is to occur. While most of Hospitality House's outreach individuals have severe substance use or mental health issues, many of them are unwilling to engage in treatment or have engaged in the past and are unwilling to do so again. A lack of options in our community for super utilizers can create a "been there, done that" mentality from both providers and outreach individuals. Some individuals have voiced negative experiences with our local treatment options and encouraging engagement for those who have been disappointed with the outcome creates a barrier for case management. Ongoing relationship and rapport building as well as a willingness from agencies to reengage individuals is necessary for long term success in outreach.

Connecting individuals from the outreach cohort to housing poses a difficult challenge. Individuals who have lack of income, shortage of life skills, no rental history, and issues with authority are not seen as good candidates for potential landlords. Lack of funding to incentivize housing providers to take on higher risk renters has also been a barrier to getting outreach individuals housed. Finally, community backlash has prevented housing opportunities for master leasing as a "not in my backyard" mentality can be prevalent in this community. Compounding these issues are the unrealistic expectations from those experiencing homelessness in Nevada County. Most individuals don't want to share a room and would rather live alone. Individual units which are priced between $300-$600, in order accommodate a person living alone, do not exist.

While many challenges face the efforts of homeless outreach, moving forward the additional HOME team staffing and associated "flex" funding for housing, is a step in the right direction. The ability to master lease homes and give landlord incentives while also being able to meet individuals where they are at provides hope that we can begin to resolve some of these issues. However,

ongoing flexibility from service providers and embracing a "Housing First" model is necessary to keep these individuals in permanent housing.

Program Participant Story

For over a year the Outreach Team engaged with a chronically homeless individual who had been camping for a number of years. This individual was not at all interested in shelter, housing, or any other service that we had to offer. This person had suffered with multiple injuries and disabilities. At first building trust and rapport was difficult. Over time however, this person began engaging with the outreach team. Due to the combination of disabilities and living in a constant state of crisis, this individual had difficulty regulating his anger and emotions. The person eventually ended up in jail for an extended period of time. The outreach team continued to engage, and case manage the individual. Medications were prescribed to help the regulate his emotions and cope with his multiple injuries. Upon release from custody he was placed into a "Bridge House" for chronically homeless individuals. The outreach team collaborated with community partners to get full-service wrap around case management in place. This individual is now permanently housed and is thriving in his new environment.

PEI Project Name: Access and Linkage to Treatment Program

SIERRA COMMUNITY HOUSE
Truckee Homeless Outreach (formerly Project Mana)

Program Description

Program Overview

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

- Promote Safety: engage with individuals experiencing homelessness in order to reduce the risk of harm and enhance safety (e.g., provide sleeping bags on cold nights); and stabilize acute symptoms via crisis intervention.
- Form Relationships: engage with individuals in a manner that promotes trust, safety and autonomy, while developing relevant goals.
- Learn Common Language Construction: attempt to understand individuals by learning the meaning of his or her gestures, words, and actions; promote mutual understanding; and jointly define goals.
- Facilitate and Support Change: prepare individuals to achieve and maintain positive change; explore ambivalence, reinforce healthy behaviors, develop skills, and create needed supports; and utilize Change Model and Motivational Interviewing Principles.
- Form Cultural and Ecological Considerations: prepare and support individuals for a successful transition to new relationships, ideas, services, resources, treatment, etc.

The Homeless Outreach Coordinator also provides essential items, such as socks, sleeping bags, blankets, jackets, clothes, personal hygiene items, etc. to individuals. They support and assist individuals to utilize warming shelters, as they are available, and educate individuals experiencing homelessness about mental health and substance use issues and available resources.

If an individual experiencing homelessness is severely mentally ill, the Coordinator refers them to treatment and assists them in attending treatment services. The Coordinator supports the individual with their first appointment and/or until the individual is comfortable with the service provider. The Coordinator also assists individuals and/or families to connect to housing, to the CalWORKs One Stop Office, and/or apply for mainstream benefits (e.g., SSI, CalWORKs, CalFresh, Medi-Cal, General Assistance, etc.).

Target Population

The target population is individuals experiencing homelessness or those at risk of becoming homeless, in the Truckee and North Tahoe region.

Evaluation Activities and Outcomes

The Homeless Outreach Coordinator worked with 38 individuals providing 72 referrals to 29 different services and agencies. This includes 9 referrals to 211, 9 referrals to SSI, 5 referrals to Social Services, 6 referrals to Shelters, and 4 referrals to the Emergency Warming Center.

The Homeless Outreach Coordinator has provided transportation to Shelters in South Lake Tahoe, Grass Valley and Reno. The coordinator has also provided transport to SSI appointments in Auburn and South Lake Tahoe, as well as transportation to local resources as needed.

In FY 18/19, staff engaged in targeted outreach 165 times, averaging 1.7 hours per contact. See the table below for more detailed information.

Outreach	**FY 16/17**	**FY 17/18**	**FY 18/19**
# Hours	105.7	126.8	283.6
# Contacts	72	169	165
Avg. Hours/Contact	**1.5**	**0.8**	**1.7**

Staff has provided participants with many needed items, such as camping supplies, blankets, warm clothes, hygiene bags, food vouchers, gas vouchers, and local bus passes.

Staff has spent time with participants to educate them or assist them towards meaningful goals, such as:

- Obtaining Snap card, Social Security card, California I.D., SSI/SSDI Benefits
- Obtaining permanent housing or transitional housing, Section 8 vouchers
- Advocating for and assisting admittance into extended care unit at the hospital

- Giving safety talks on snow/cold weather, bear safety
- Transporting participants to various locations (e.g., Warming Room)
- Moving out of county
- Discussing benefits of taking prescribed medications on a regular basis
- Promoting participants to go to rehab for drug and alcohol abuse.
- Obtaining restraining order against abuser
- Forming strong relationships with many participants in town
- Organizing the Homeless Count in Truckee and North Lake Tahoe

Challenges, Solutions, and Upcoming Changes

Lack of available housing and lack of affordable, low income housing are the biggest barriers for the homeless in the Truckee/Tahoe region. Our community members who work part-time, low income jobs or are on SSI/SSDI simply cannot find housing in the area that they can afford. The need for good credit and rental histories are additional barriers that contribute to homeless individuals being unable to secure housing. There is also a lack of resources in the area. There are no transitional housing units for men with alcohol and drug problems, respite centers, or full-time shelters in the area. Many challenges the homeless face in the Truckee Tahoe region are made harder by the fact that to get help they must leave the region. The resources that are available in the Truckee Tahoe region are geographically spread apart. Outreach in Tahoe City and Kings Beach has been harder than outreach in Truckee. Many of the homeless find it a burden due to the distance, especially in the winter, to go to Truckee for the Emergency Warming Center (EWC) or the Food and Resource Center (FRSC). Even though outreach has been done consistently and transportation offered to get the homeless in Placer County over to the EWC and FRSC, the burden of getting the Tahoe City and Kings Beach populations over to Truckee resources has kept the homeless population more isolated than Truckee residents and less willing to receive help and resources. Snow and cold weather create dangerous situations where people can freeze to death and become stuck in their cars. Homeless who have campsites are sometimes hesitant to go to the EWC because a heavy snow can damage their tent and camp site. Extreme winter weather poses a constant threat to the homeless in the region.

There are no planned upcoming changes to the program.

Program Participant Story

In the summer of 2018, the Outreach Coordinator received a call about a community member in the Boca Campground who had been there for several weeks. The camp host contacted the coordinator because of concerns about the community member’s health. The community member would also have to move campgrounds soon as he had reached his limit of days at the campground he was at.

The coordinator came by the same day and talked to this community member. He was suffering from several health conditions including diabetes and asthma. He was out of medication and did not have a phone or a ride to town. He did have SSDI benefits. The Outreach Coordinator helped this community member obtain his medicine and a phone. He also gave him food and over the next few weeks helped him to move campsites and access resources in town such as the Food and Resource Support Center.

Over the next few weeks this community member came up with a plan. He stayed at the campground while he saved up money for a vehicle. We worked it out with the camp host to let him stay at an adjacent campground for a few weeks. His plan was to obtain a vehicle then get a job with a taxi company. He was able to complete both tasks and was soon driving for a taxi company in town. He worked at the company through the rest of fall and winter. His plan to get housing in the Truckee region did not come together as he could not make enough money as a taxi driver.

During the winter, the Outreach Coordinator encouraged him to stay at the Emergency Warming Center. The community member developed a strong relationship with the director there which further supported him in his goal. During the winter, he decided to move to Reno but had to wait for paperwork pertaining to his new car. During this time, his health suffered greatly, and he spent several stints in the hospital trying to manage an illness that was complicated by his diabetes and his asthma. As his health recovered, he was able to find a place in Reno. The EWC hosted a fundraiser which benefitted this community member, allowing him to pay move in costs for a one-bedroom apartment in Reno.

This community member has returned on occasion to the Food and Resource Support Center in Truckee to eat and update everyone on how he is doing. As of last update he was still housed and in good health. He was attempting to find work in Reno to supplement his income.

PEI Project Name: Access and Linkage to Treatment Program

WHAT'S UP? WELLNESS CHECK UPS

Program Description

Program Overview

The What's Up? Wellness Checkups (WUWC) program screens high school students in the Nevada Joint Union High School District (NJUHSD) and Tahoe Truckee Unified School District (TTUSD) for suicide risk, depression, anxiety, and other emotional health issues. Students privately take a brief, computerized questionnaire, followed by a one-on-one interview with program staff who assesses each student's support systems, coping skills, symptoms and impairments, then connect students with community resources, in-school supports, and/or case management and crisis support as needed. In the case of a necessary, immediate connection or referral, WUWC staff serve as one of the primary support systems for the student's family, providing both in-person and phone-based crisis intervention and referrals to local crisis agencies.

WUWC also facilitates evidence-based stress reduction groups for students on campus, as extra prevention support for those identified with mild to moderate symptoms. WUWC identifies and helps youth at-risk, promotes wellness, increases peer support systems, and strengthens family connections.

WUWC recruits, trains, and supervises screening volunteers and group facilitators. The program collaborated with Community Beyond Violence and Nevada County Public Health to provide their in-school groups, like the Boys Groups and Mindfulness Skills Groups at Nevada Union (NU) and Bear River High schools. WUWC also created ongoing, up-to-date referral guides for case management.

WUWC coordinates with district officials, school administration, and staff to find on-campus screening sites and provide student follow-ups. The program supports community awareness via the newspaper, radio (including the NPR station in Reno), social media, website, school, community, and fundraising events. WUWC attended local collaboratives and agency meetings, including the Suicide Prevention Task Force, MHSA, and NCBH. The program shared resources, coordinated services, and participated in events with a local youth-serving organization, New Events & Opportunities (NEO).

Ongoing translation and interpretation services are provided by the WUWC Translator/ Interpreter/ Promotora, and local Family Resource Centers as needed. Staff have continued to develop systems to ensure that Spanish-speaking families are receiving outreach, case management, and follow-up services.

Target Population

WUWC targets high school students at the NJUHSD and TTUSD schools, including Bear River, Ghidotti, Nevada Union, Nevada Union Tech, Silver Springs, Northpoint Academy, North Tahoe, Truckee, Sierra, Sierra Academy for Expeditionary Learning, and Earl Jamieson high schools. WUWC focuses outreach on incoming freshmen for prevention, as Grade 10 has the highest national suicide completion rate.

Evaluation Activities and Outcomes

During FY 18/19, 459 high school students were screened for mental health issues. Of those students, 145 students (32%) who screened positive received clinical interviews to assess the need for further evaluation or treatment. 81% of students who received clinical interviews received referrals and/or WUWC case management services.

WUWC made a total of 97 referrals to community services. 100% of students who accepted case management services received these services until they saw a mental health service provider at least once or declined further services. Once the appropriate consents were in place, 100% of students with untreated mental health symptoms were referred to a mental health service provider

at least once. Two students were referred to Nevada County Behavioral Health (NCBH), and 27 students were referred to other mental health providers.

WUWC conducted 83 prevention group meetings, serving 204 student participants. As a result of the prevention groups, participants reported decreases in suffering related to mental illness.

	FY 16/17	FY 17/18	FY 18/19
Number of Groups	53	35	83
Attendance	310	247	204
Avg. Attendance/Group	**5.8**	**7.1**	**2.5**

WUWC staff provided in-person follow up meetings with students, consultations with student's parents, and consultation with school staff on behalf of students.

Type of Follow Up	# of Meetings
Meeting w/Student	20
Parent Consultation	14
School Staff Consultation	11
Total	**45**

In addition to meeting and advocating for students, the WUWC provided referrals to school based and outside agencies for further support of students. During FY 18/19, WUWC provided 97 referrals to school-based or outside agencies with 78 (80%) of those referrals successfully connecting. See the tables below for more information.

FY 18/19 Referrals		
Agencies	**# Referrals**	**# Connected**
211	1	1
Academic Support	7	7
Behavioral Specialist	2	2
Counseling Center	1	0
Community Beyond Violence	1	0
Family Resource Center	0	0
Financial Assistance	0	0
Mental Health	17	10
In School Mental Health Support	29	26
Physician/ MD	0	0
Support Group	12	10
Therapist/ Psychiatrist (Private)	12	7
Wellness Center	2	2
Other	13	13
Total Referrals Connected	**97**	**78**

Throughout the year, WUWC put on 18 community engagement and awareness activities and presentations, reaching a total of 852 individuals. Additionally, WUWC provided media outreach through radio and newspapers, reaching up to 68,000 listeners and readers.

Challenges, Solutions, and Upcoming Changes

In FY 18/19 WUWC served the greatest number of students so far in its implementation – this year more students received both screenings and prevention group services than in any prior year. Even though WUWC has creatively addressed funding limitations in order to serve this number of students, one of the biggest ongoing challenges for WUWC has been the increasing need for its services. Greater numbers of parent consent, more complicated cases, higher risk students, as well as non-site schools and districts requesting services all point to the increasing need in our community for more WUWC mental health screenings and on-site prevention services for youth. In addressing this challenge in FY 18/19, WUWC collaborated with current sites for additional funding, thereby increasing program sustainability. WUWC had additional small contracts/agreements this year with TTUSD and Nevada Union that allowed a partial increase in screenings and prevention groups. Another solution this year was to encourage districts requesting WUWC services to communicate their needs to local funding sources and departments. Additionally, WUWC trained and supervised an MSW student who offered significant numbers of hours of program support. In order to address these needs next year, WUWC's upcoming changes include contracting with individual schools and districts when possible, recruiting an MSW student for the FY 19-20 school year, continuing to outreach to organizations for fundraising and collaboration (including Friendship Club as a possible fundraising partner), as well as increasing its services with additional funding from MHSA that has supplemented the FY 19-20 WUWC Volunteer Screening Stipend and Group Facilitation Services funds.

The confidentiality constraint of not being able to share WUWC's screening results with school staff due to HIPAA requirements has been an area of growth for WUWC. Without a release of information from parents (sometimes challenging to obtain post-screening) WUWC staff has not been able to share results that could benefit students' mental health or academic challenges. In order to address this barrier, releases of information were successfully integrated into WUWC's TTUSD Parent Consent forms in FY 18/19. WUWC collaborated further with TTUSD staff in FY 18/19 to work out more details around the sharing of information to identify the types of screening information that would best support student's mental health while at the same time respect their right to privacy. WUWC has included this same release of information form in the NJUHSD Parent Consent forms for the FY 19-20 school year. Many parents have so far signed these releases for NJUSHD, which will again help WUWC to share pertinent screening results with school staff. This upcoming change will be another opportunity for WUWC to collaborate with schools to provide more comprehensive support and advocacy to screened students.

Providing psychoeducation and mental health support to traditionally underserved Spanish speaking students and their families has been an ongoing goal for WUWC. Over the years, WUWC has addressed this challenge in numerous ways. In the fall 2018 the program tried something new and collaborated with NJUSHD, the Family Resource Center Promotora, and WUWC's Translator

and offered an evening support/psycho-education group for Spanish Speaking families on the Nevada Union high school campus. Knowing that attendance might be a challenge, WUWC presented at International Parents Night for outreach, polling families for relevant group topics to their community, provided weekly All Calls in Spanish to families inviting them to the group, as well as offered dinner, childcare, and raffles during the groups in order to entice more family participation. Attendance was small but potent and gave WUWC more insight into outreach that might help increase the inclusion of more families in the future – including possible collaboration with local churches. WUWC plans to further collaborate with the FRC and other partners to find new ways of outreaching and providing support to this community in need – with a particular focus in FY 19-20 on screened youth whose Spanish-speaking families are more challenged to access mental health services.

With access to services being a significant challenge for youth in Nevada County, one of WUWC's main priorities is to find ways for students who need mental health support to be able to receive it. In FY 19-20 WUWC seeks to collaborate with schools to increase accessible mental health supports for youth on campuses. WUWC plans to advocate for licensed mental health providers to provide services on campus, particularly for screened youth who are otherwise unable to receive mental health services in our rural community. WUWC also plans to increase Prevention Group services and has put part of its additional MHSA funds towards providing more groups. In terms of group challenges, participation and keeping group topics relevant to teens is essential, as well as including what school staff see as significant issues in their student body. WUWC addressed these challenges in FY 18/19 by managing ongoing coordination between group facilitators and school staff, increasing outreach through on campus media and teacher discussions, offering a mindfulness skills group taking place within a class (vs. separating students out from class), as well as offering a new type of prevention group - a social media support group. WUWC gave a mindfulness presentation in FY 18/19 open to any students on the Northpoint campus. WUWC also collaborated with Public Health's Tobacco Prevention program facilitating a focus group at Bear River of 30 mixed grade students investigating mental health and other teen needs, as well as their active use of coping skills to help inform future group services.

Reducing mental health stigma in the larger community is another ongoing goal for WUWC. In FY 18/19 WUWC staff participated in two community speaker panels – one being a live KVMR radio town hall on Suicide Prevention awareness, the other at an on-campus public event showing the film Angst, a documentary intended to increase public awareness of youth mental health. In FY 18/19 WUWC outreached to the Union newspaper, subsequently being included in three Union newspaper articles throughout the school year, as well as contributing an article on its suicide prevention program to YubaNet.com. As a way to normalize teen Wellness Checkups and increase program visibility within school communities, WUWC presented at two Parent Night orientations, at the Nevada County Superintendent of Schools as well as several teachers, staff, and school counselor meetings. In FY 18/19 WUWC staff provided a table with program information and resources at a community mental health fair at a Nevada County public library. WUWC staff met with The Friendship Club, Children's Behavioral Health, and Community Beyond Violence agencies to increase program collaboration. WUWC continues to add posts to social media pages and keeps up to date with latest WUWC news and statistics on its website. WUWC is an ongoing partner in Nevada County's Youth Collaborative to increase collaboration and outreach. In FY 18/19 WUWC also collaborated with the new County Suicide Prevention Coordinator on

supporting the Suicide Prevention Task Force in a smooth transition, as well as in content and initiative brainstorms to work toward a more collective approach to suicide prevention with youth in our community.

Program Participant Story

At times, WUWC case management services are more straightforward when referring screened students to a mental health provider – in these cases it might take several conversations with a family to determine types of insurance, find the right referral, and follow up to confirm a good treatment connection has been made. Often, however, cases are more complex. This is one such case:

A young high school student struggling with behavioral issues received a mental health screening that revealed significant mental health symptoms and impairments. During the clinical interview, this youth requested WUWC staff to connect them to mental health support, specifically to a past therapist who had moved locations. In years prior, this youth had received mental health services after their parent's sudden death. The absence of the therapist after the trauma of the parent's death was acutely difficult for this young teen. The student agreed for staff to contact their family and in turn, the family was relieved to obtain support through WUWC case management services since they had been unable to figure out how to obtain health insurance on their own. This family, who was already experiencing financial hardship, had lost their prior insurance and had been paying out of pocket for their health care needs. The case management services offered to this family included determining the youth's rightful guardianship in the family system, getting releases of information signed, then locating the prior therapist to see if that provider was an option for this youth. Staff then addressed the youth's lack of health insurance by researching the steps needed and subsequently coaching the family in how to obtain appropriate insurance. WUWC staff advocated for the youth with the insurance company which helped accelerate processing time. After the insurance was in place, it became clear that further adjustment was needed since the past therapist had returned to the area but currently only took certain types of insurance. WUWC offered support again in re-contacting the insurance company and helped the family to set up the correct type of insurance. Over a period of several months, WUWC staff worked closely with this family and eventually this youth was able to reconnect with the past therapist and receive services. In wrapping up this case, both the youth and therapist expressed to WUWC that treatment had resumed and was going well for the youth. Due to WUWC services, this youth not only has access to their preferred mental health provider, but now has insurance for their overall health needs reducing some of the stress on this youth and family.

PEI Project Name: Stigma and Discrimination Reduction Programs

FAMILY RESOURCE CENTER OF TRUCKEE
Promotora Program - Latino Outreach Services

Program Description

Program Overview

The Family Resource Center of Truckee (FRCoT) has a Promotora Program, which utilizes paraprofessionals to help Latino families connect to health resources and offer health education. The program is a collaboration between Nevada and Placer Counties, delivering services to participants from both counties.

Traditionally, Promotoras are "community health workers" who are lay members of the community and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. Promotoras in Nevada County are Spanish speaking, bi-cultural, and/or bi-lingual paraprofessionals who help Latino families connect to resources in the community. Promotoras offer interpreter services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal support and guidance on health behaviors, and advocate for individuals and community health needs.

The FRCoT Promotora Program provides peer-to-peer mental health education workshops that reduce the stigma and discrimination that result from misunderstandings of mental health issues. Promotoras participate in capacity-building trainings based on health and mental health outreach and education. Promotoras also conduct psycho-educational groups, which educate people about mental health issues to decrease stigma about reaching out for help when needed. By decreasing stigma about mental health conditions, the program promotes, maintains, and improves individual and community mental health.

Major goals of the Promotora program include: increasing knowledge within the Latino community about the symptoms of depression and anxiety; providing access to mental health support and services and normalizing open and honest discussions about mental health.

Through ongoing classes and programs based in neighborhoods, the Promotora Program aims to intervene early by engaging individuals prior to serious emotional/behavioral disorder or mental illness and preventing mental illnesses from becoming severe and disabling. The programs are focused on reducing negative feelings and perceptions related to mental health as well as reducing stigma related to accessing support and treatment for mental health.

Target Population

The Promotoras of the Family Resource Center of Truckee are bi-cultural and bi-lingual paraprofessionals that help connect Latino families to mental health resources and to promote the well-being of the Latino community in the Tahoe/ Truckee region.

Evaluation Activities and Outcomes

FRCoT collects evaluation activities for MHSA including demographic information on each individual receiving services. In addition, information on the Family Room group services, outreach, and referrals to outside agencies is collected. Direct service information includes date, location, and duration of the service. Throughout FY 18/19 the Family Resource Center of Truckee collected the demographic information of 135 individuals.

The Promotoras offered the following workshops in different neighborhoods in the Truckee region covering Placer and Nevada Counties:

- Arte y Salud Mental/ Mental health discussion and art - using art as an entry point for more difficult topics.
- Desestres-Arte - The mission of Arts in Wellness is to facilitate and promote personal and community health and harmony using art. The workshop is meant to encourage the participants who participate to express their emotions through art projects.
- Sonrisas en Otoño/ Zumba para Niños - Engagement workshop with art, exercise, and dance for kids age group 5 -10 years.
- Aerobics - We have offered on going aerobics classes in different neighborhoods. Exercise has been shown to increase your confidence, emotional stability, exercise is also one of the most effective ways to improve your mental health.
- Los Cuatro Acuerdos – Group participants learn about four life-changing commitments to help them increase resilience to life challenges that could lead to mental health issues.
- Empoderamiento de Mujeres - These community members are invited to have conversations about mental health issues while learning to love and enjoy the outdoors to help prevent isolation.
- Vida Sana – Facilitators cultivate an environment that supports healthy behaviors and lifelong wellness, including increased vegetable consumption, health screenings, and prevention of obesity.

Promotoras offered three, six-week chronic disease self-management workshops that offer support for those with chronic disease to be able to live their lives to the fullest and improve their general health.

- Dolor Cronico/ Chronic Pain
- Tomando Control de tu Salud/ Chronic Disease Self-Management
- Diabetes/ Diabetes

The Promotoras also offered 4 community events over FY 18/19:

- Neighborhood Health Fair at Sierra Village Apartments
- Community Swim Night and Health Fair in partnership with Truckee Donner Recreation and Park District
- Couples Workshop
- Housing workshop

The Promotoras participated in the following educational workshops to enrich their professional career: neurobiology of addiction, computer skills, and parenting classes, along with the completion of the nine-month Peer Support training.

The FRCoT Promotoras Program has grown over the fiscal years. During FY 15/16, FRCoT delivered services by means of the groups offered to 61 unduplicated individuals. During FY 16/17, that number increased to 105 unduplicated individuals. In FY 17/18, the number increased again to 129 unduplicated individuals and again increased to 135 individuals in FY 18/19.

Across the fiscal years, the number of groups offered and attendance at groups also increased, seeing the most substantial growth in FY 18/19. During FY 15/16, 34 groups were offered, and group attendance was recorded at 244 attendees throughout the year. 4 years later in FY 18/19, 151 groups were offered with group attendance reaching a high of 2,769 attendees, for an average of 18 attendees per group. All groups aimed to help destigmatize mental health by focusing on how mental and physical well-being are linked. See the table below for more detailed group service information.

	FY 15/16	**FY 16/17**	**FY 17/18**	**FY 18/19**
	Unduplicated N=61	*Unduplicated N=105*	*Unduplicated N=129*	*Unduplicated N=135*
Number of Groups	34	82	89	151
Attendance	244	568	740	2769
Average Attendance per Group	**7.2**	**6.9**	**8.3**	**18.3**

Referrals to outside agencies were recorded during FY 2018/19. Promotoras made 18 referrals, 12 of were made successful connections. See the table below for more detailed referral information.

	FY 18/19		
Agencies	**# Referrals**	**# Connected**	**% Connected**
Family Resource Center	3	3	**100%**
Legal Services	1	1	**100%**
Mental Health Service Provider	9	5	**56%**
Physician/ MD	2	2	**100%**
Tahoe SAFE Alliance	1	1	**100%**
Other	2	0	**0%**
Total Referrals Connected	**18**	**12**	**67%**

Promotoras administered a survey assessing attitudes toward mental health to attendees of the psycho-educational groups during FY 18/19. Results were positive with most respondents reporting a more positive and understanding attitude toward mental health issues after attending

the groups as compared to before attending. For example, 29.4% of respondents agreed with the statement, "I believe that a person who has a mental illness can eventually recover" before attending the group, whereas 58.8% agreed after attending. When asked, "Imagine that you had a problem that you needed to be treated by a mental health professional. Which of the following would you do? Would you delay seeking treatment for fear of letting others know about your mental illness?", 37.3% of respondents answered "Never" prior to the class. Following taking the class 74.5% of respondents identified that they would "never" delay seeking treatment for fear of others knowing about their mental illness. See the table below for more detailed attitude survey information.

Attitude Survey FY 18/19 51 surveys completed	**Before Attending**		**After Attending**		**Attitude Change**
	% Agree	**N**	**% Agree**	**N**	**%**
I believe that a person who has a mental illness can eventually recover.	29.4%	15	58.8%	30	**29.4%**
I know how to support a person who has a mental illness	3.9%	2	15.7%	8	**11.8%**
I plan to take action to prevent discrimination against people who have a mental illness	23.5%	12	49.0%	25	**25.5%**
People who have a mental illness experience high levels of prejudice and discrimination	25.5%	13	29.4%	15	**3.9%**
	% Disagree	**N**	**% Disagree**	**N**	**%**
People who have had a mental illness are never going to be able to contribute to society	13.7%	7	31.4%	16	**17.7%**
I believe that a person who has a mental illness is a danger to others.	17.6%	9	41.2%	21	**23.6%**
Imagine that you had a problem that you needed to be treated by a mental health professional. Which of the following would you do? Would you…	**% Never**	**N**	**% Never**	**N**	**%**
… deliberately conceal your mental illness from your friends or family?	27.5%	14	68.6%	35	**11.1%**
… deliberately conceal your mental illness from others?	3.9%	2	27.5%	14	**23.6%**
… delay seeking treatment for fear of letting others know about your mental illness?	37.3%	19	74.5%	38	**37.2%**
If someone in your family had a mental illness, would you feel ashamed if people knew about it?	41.2%	21	64.7%	33	**23.5%**
	% Always	**N**	**% Always**	**N**	**%**
If you had a mental illness, would you seek professional help?	43.1%	22	64.7%	33	**21.6%**

Challenges, Solutions, and Upcoming Changes

During the FY 18/19 fiscal year, one challenge the FRCoT Team has faced has been defining the specific responsibilities and boundaries of the roles within the agency including of the Program Coordinator and the Family Advocate. Additional challenges included limited funding resources.

In the upcoming fiscal year, The Family Resource Center of Truckee is merging with 3 local agencies: Tahoe SAFE Alliance, North Tahoe Family Resource Center, and Project MANA to become Sierra Community House (effective July 1, 2019). This collaboration will serve the joint mission to connect and empower the community through family strengthening, crisis intervention, hunger relief, and legal services and will be better equipped to serve the community through collective/common resources. With this consolidation, the innovation team will expand to 11 staff members throughout the eastern portions of both Placer and Nevada Counties. Moving forward, the team will include a full-time manager, full-time supervisor and a full-time coordinator, with eight part-time staff. This shift will provide the capacity to offer greater capacity for community services and have a specific focus on the Promotora program.

Program Participant Story

Irma*, a 37-year-old mother of two children, started attending “Desestres-Arte” with Karen*, her 15-year-old daughter. Karen was diagnosed with type 1 diabetes in 2012 when she was only 8 years old. The illness has had a huge impact on the family, and Irma reports that attending the art workshop gives them a period of time where they feel they can forget the difficult situation they face. The program provides a safe space where they feel encouraged to express their emotions through art and practice mindfulness as they focus on their crafts. Karen has been able to leave the isolation she has been living in due to feeling different from her age-group peers. It is a relief for Irma to see her daughter interact and have a good time. She is very grateful for the opportunity to have workshops like Desestres-Arte in their community.

**Name changed for privacy*

PEI Project Name: Stigma and Discrimination Reduction Program

NEVADA COUNTY SUPERINTENDENT OF SCHOOLS
Grass Valley Partners FRC Promotora/ Latino Outreach

Program Description

Program Overview

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

The Grass Valley FRC Promotora offers psycho-educational group meetings in order to decrease the stigma of mental health issues through evidence-based curriculum. The goal of these groups is to educate individuals and to decrease stigma and fear about mental health issues in the Latino community. These groups are conducted in Spanish and childcare is available as needed during group meetings.

Target Population

NCSOS Promotora/ Latino Outreach serves the Latino population in the Grass Valley area. This program serves children, transition age youth (TAY), adults, and older adults.

Evaluation Activities and Outcomes

The Promotora/ Latino Outreach Program collects evaluation activities for MHSA including: information on individual demographics, outreach and referrals to community resources on each person receiving services and/or being trained. In addition, an attitude survey is collected at the end of trainings.

Promotora staff provided varied services, such as: information regarding domestic violence, alcohol and drugs; assistance with medical and dental appointments, school issues, individualized education programs (IEPs), traffic violations, and immigration information; translation assistance with medical applications, housing applications, rental issues (e.g., eviction notices), and other documents. Staff also provided translation clinics, ESL tutors and parenting classes. Staff distributed mental health awareness pamphlets. Promotora staff also report that they have been able to connect each referral for mental health services to a provider regardless of their source of insurance.

Across the years, this program has collaborated with multiple other organizations including: ACA, Chapa-De, Child Protective Services (CPS), CHIP committee, Community Recovery Resources (CoRR), Dentists, Domestic Violence and Sexual Assault Coalition (DVSAC), Drug and Alcohol Services, Employment, Foothill Healthy Babies, Housing, Imaging and billing, local Gynecologists, Nevada County Behavioral Health, Nevada Union (NU) High School, School District Individual Education Plan (IEP) translations, Sierra Nevada Memorial Hospital (SNMH) Summer Institute, SNMH Emergency, Suicide Prevention Task Force, and Western Sierra Medical Clinic.

During FY 18/19, the program provided 226 occurrences of service delivery at the Partners Family Resource Center (FRC). Of these activities were:

- Four Atencion Plena Sessions at Grass Valley Charter School
- A Belaciones Saludables (Healthy Relationships) Class at Nevada Union High School
- Chair Yoga Classes at Partners Family Resource Center (FRC)
- Alcoholics Anonymous Groups in Spanish at FRC
- Kids Wellness and Recovery Action Plan (WRAP) Day Camp at FRC
- Kings Day Social Meeting at FRC
- Three Know the Signs workshops at NCSOS
- Five WRAP sessions at FRC

The program providing directed mailing to help increase awareness of their activities. Over FY 18/19 the program mailed out 393 postcards for 7 different events.

The Results of their survey showed regarding perception of mental illness, demonstrated that people felt comfortable seeking support for their own mental illness if needed. See table below.

NCSOS Promotora MOQA Survey Results	# Agree	%
As a direct result of this training I am MORE willing to:		
...live next door to someone with a serious mental illness.	7	50%
...socialize with someone who had a serious mental illness.	6	43%
...start working closely on a job with someone who had a serious mental illness.	5	36%
...take action to prevent discrimination against people with mental illness.	8	57%
...actively and compassionately listen to someone in distress.	11	79%
...seek support from a mental health professional if I thought I needed it.	12	86%
...talk to a friend or a family member if I was experiencing emotional distress.	12	86%
As a direct result of this training I am MORE likely to believe:		
...people with mental illness are different compared to everyone else in the general population.	3	21%
...people with mental illness are to blame for their problems.	1	7%
...people with mental illness can eventually recover.	8	57%
...people with mental illness are never going to be able to contribute much to society.	0	0%
...people with mental illness should be felt sorry for or pitied.	5	36%
...people with mental illness are dangerous to others.	3	21%
Please tell us how much you agree with the following statements:		
The presenters demonstrated knowledge of the subject matter.	10	71%
The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.).	10	71%
This training was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).	6	43%
TOTAL SURVEYED:	**14**	

Challenges, Solutions, and Upcoming Changes

Challenges:

- Motivating attendance to psychoeducational meetings will continue to be a challenge. Program staff report difficulty providing services with limited resources and feel that the application assistance and translation for housing needs has largely been unproductive.
- Reducing the time that new families take to integrate in the community in order to reduce gaps of service.

Solutions:

- Create new ideas to deliver health information by professionals in the medical field that attract an audience by providing needed service. Proactive presentations of health topics.
- Include the community in planning or designing social activities to meet isolated resident needs, i.e., a game night which will also give the opportunity to advertise and invite to Wellness and Recovery Action Plan (WRAP) meetings, one on one or in groups of children, youth, and adults with a personal approach.
- Visit Spanish Speaking providers to promote a goodwill contribution in their health field.
- Promote WRAP to help people learn how to care of for their own wellness and prevent crises.
- Increase utilization of electronic mail in order to communicate information with the community more expediently and efficiently.
- Promote internet safety for the whole family.

Upcoming Changes:

- The addition of a new Outreach Specialist will bring new talents and exciting contagious energy that will benefit the Program.
- Focus on conducting programs that address mental health stigma and discrimination in meetings that are designed to survey a positive change of attitude in the audience.
- The unknown impact of asylum immigrants finding work, needing housing, and health services.

Program Participant Story

The Bienestar Kids WRAP Camp was an exciting success. Ten children ages 9-12 attended. Their evaluations show they learned about themselves, their triggers, and what to do to not “go off” and keep themselves calm. One 17-year-old, a previous WRAP Camp attendant, visited the children and told them he wished he would have learned how to keep himself calm when he was younger like they are. He said when he was mad, he would punch the first kid he encountered and had to change schools. After WRAP he knew how to keep himself calm and stay out of trouble! His little brother praised him as his hero.

The Promotora advocated for the need of an Alcoholics Anonymous group in Grass Valley and looked for a leader for several years who was found this year. The group has been meeting

successfully several weeks now and the Promotora just received a call from a member who in the past called her in need of counselling for depression. She is having success, staying sober and now attending the group, she is very upbeat, and her voice is full of positive expressions; a change from night to day. She has a friend, and both encourage each other.

PEI Project Name: Suicide Prevention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Suicide Prevention and Intervention

Program Description

Program Overview

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

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

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

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

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

The SPP convenes the Suicide Prevention Task Force (SPTF) in Western Nevada County, supports the work of the Tahoe Truckee Suicide Prevention Coalition in Eastern Nevada County, and collaborates with a number of community organizations, including FREED, What's Up? Wellness, Parents and Families of Lesbians and Gays (PFLAG), Tahoe Truckee Unified School District (TTUSD), and others.

Target Population

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

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on each participant in the training. In addition, a survey is collected at the end of training to provide information on the perception of the training.

The Suicide Prevention Program provided 2 outreach activities at local Health Fairs in FY 18/19. These 2 outreach activities reached an estimated total of 355 attendees. SPP provided one (1) Know the Signs trainings to 15 unduplicated participants during FY 18/19. A Post-Training Evaluation Form following the training showed that training participants felt more equipped to recognize the signs of suicide risk and comfortable reaching out to individuals who are at risk of suicide (see table below).

Know the Signs Survey Results:

Survey Question	Strongly Agree	Agree
I am better able to recognize the signs, symptoms and risks of suicide.	12	3
I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide.	12	3
I am more willing to reach out and help someone if I think they may be at risk of suicide.	12	2
I know more about how to intervene (I've learned specific things I can do to help someone who is at risk of suicide).	12	3
I've learned how to better care for myself and seek help if I need it.	9	4
The presenters demonstrated knowledge of the subject matter.	12	3
The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.).	12	3
This training was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).	12	3
Total Surveyed: 15		

The limited number of outreach and trainings is the result of a transition in staff, which included the position being open for nine months (see Challenges, Solutions and Upcoming Changes for additional details). The new Health Education Coordinator received training as a trainer in safeTALK and ASIST in May and June 2019, respectively, so was not able to provide the trainings in those modalities in FY 18/19.

The Clinical Supervisor contacted and offered or provided support for all Nevada County suicide decedents' families and significant relations affected by suicide in Nevada County. The Clinical Supervisor also participated as a panelist on a suicide prevention town hall hosted by local public radio station KVMR on April 9. The town hall focused on raising awareness about suicide, including specific needs and risks in Nevada County, and was broadcast live on the radio and on the station's Facebook page.

Challenges, Solutions, and Upcoming Changes

Organizationally, the county experienced a major staff transition in its suicide prevention work. The previous coordinator had been in the position for six years prior to leaving. The previous coordinator was a certified trainer in many suicide prevention trainings and also coordinated both intervention and postvention services.

The staff transition provided an opportunity to reorganize the county's suicide prevention work. The previous Suicide Prevention Coordinator position was reclassified into two positions—suicide prevention through the Health Education Coordinator position at the Department of Public Health, and intervention and postvention support provided by the Clinical Supervisor at Behavioral Health. The reclassification process resulted in a gap of nine months between the previous coordinator's retirement and the positions being filled.

The new Health Education Coordinator did not come into the position with certification in suicide prevention trainings upon starting the position in February but has now been trained as a trainer in safeTALK and ASIST and has begun providing Know the Signs trainings. Their first safeTALK training is scheduled for September 2019 with additional trainings planned throughout the year.

The Clinical Supervisor had previously coordinated the county's crisis team, but suicide postvention is a new responsibility. The supervisor has experienced some challenges receiving necessary information to follow up with family members, including limited or no contact information on death certificates. The county is working with partners such as the Coroner to implement systems to make coordinating postvention services easier.

The change in staffing has also resulted in a change in facilitator of the county's Suicide Prevention Task Force. The county has used the change in leadership as an opportunity to engage task force members in a planning process to identify goals, strategies and outcomes it hopes to pursue over the coming years.

Program Participant Story

The Clinical Supervisor contacted the wife and daughter of a veteran who recently died by suicide to offer supports and empathy. This particular family is in the process to moving out of Nevada County and was overwhelmed with grief. The Clinical Supervisor contacted Veterans Services, County Behavioral Health, and other community supports in the county of the family's new

residence. The family expressed gratitude towards Nevada County for taking initiative in bridging supports as they begin the process of healing and dealing with loss and sadness.

CALMHSA STATEWIDE PEI PROJECT

Program Description

Program Overview
Counties collectively pooled local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the Statewide PEI Project. The Statewide PEI Project is publicly known as Each Mind Matters: California's Mental Health Movement, which represents an umbrella name and vision to amplify individual efforts from the county and other organizations that are taking place across California under a united movement to reduce stigma and discrimination and prevent suicides. In FY 18/19, more than 600 local county agencies were served by programs implemented under the Statewide PEI Project.

In FY 18/19, funding to the Statewide PEI Project supported programs such as maintaining and expanding public awareness and education campaigns, creating new outreach materials for diverse audiences, providing technical assistance to county agencies, schools and community based organizations, providing mental health/stigma reduction trainings to diverse audiences, engaging youth through the Directing Change program, and building the capacities of schools to address mental health, stigma reduction and suicide prevention.

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

Evaluation Activities and Outcomes

The agencies, schools, and organizations that were reached with Statewide PEI Programs included Nevada County Children's Behavioral Health, Tahoe Truckee Unified School District, The Reilly Group, and Nevada County Public Health.

The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of Each Mind Matters is critical for creating a culture of mental health and wellness regardless of where individuals live, work or play. Key statewide achievements of the Statewide PEI Project in FY 18/19 include:

- Over 1 million hardcopy materials were disseminated in counties, schools, and CBOs
- Over $94,000 in mini-grant funds were provided to various agencies to host community outreach events utilizing Each Mind Matters resources and messaging
- The Directing Change Program received over 1,000 videos submissions from over 150 schools across California, engaging over 3,600 students
- Nearly 10 new Each Mind Matters culturally adapted resources were developed
- 27 news broadcasts, news articles and radio reports discussed programs implemented by the Statewide PEI Project

Innovation (INN)

Innovation Project Name: Integration of Rural Mental Health Services to Improve Outcomes

NEVADA COUNTY BEHAVIORAL HEALTH & FAMILY RESOURCE CENTER OF TRUCKEE (FRCoT)

Program Description

Program Overview

Both Nevada and Placer Counties are located in the Tahoe Truckee Community, a remote, rural community with some unique challenges. MHSA stakeholders from both counties identified the Tahoe Truckee area as a high priority for MHSA Innovation funding and services and indicated that more collaboration was necessary across counties in the area. The goal of this Innovation Project is to learn how to develop and implement a coordinated, interagency, cross-county service delivery system to meet the needs of beneficiaries living in the Tahoe Truckee area, regardless of the county of residence. This coordination will reduce barriers to services; reduce inefficiency and duplication of services; and create accessible services to meet individuals' needs regardless of their county of residence. Through these Innovation funds, we will learn how to develop interagency partnerships, share services, and resources to better meet the needs of beneficiaries.

This collaboration is facilitated and coordinated by the Innovation Personal Services Coordinator, an individual who is employed half-time by Placer County via Sierra Mental Wellness Group (SMWG) and half-time by Nevada County Behavioral Health (NCBH). In addition, hours of services from the Family Resource Center of Truckee (FRCoT) are expanded, to provide additional bilingual, bicultural services to this community.

Training is available to support staff from both counties to develop and strengthen skills in Motivational Interviewing; wellness and recovery; mental health support services; and Wellness Recovery Action Plans (WRAP). Training is also available to the community, including Mental Health First Aid.

Through one-on-one appointments at the Family Resource Center of Truckee (FRCoT), home visits and outreach through FRCoT Promotora workshops, the FRCoT Family Advocate performed the activities under this Innovations project. This work was done with guidance from the bilingual Nevada County Behavioral Health therapist, Chris Mausolff. Activities included outreach to local Latino community members, linkage and access to services regardless of which county the community members live in, one-on-one support, referrals to bilingual therapist, and attending meetings with Nevada/Placer County and Promotoras.

Target Population

The Innovation Project targets unserved and underserved Tahoe Truckee residents, with an emphasis on including the Latino population and older adults.

Evaluation Activities and Outcomes

Family Resource Center of Truckee Family Advocate:
During FY 18/19, 14 individuals received one-on-one support and consultations from the Family Advocate to get connected with mental health services. The Family Advocate delivered a total of 80 hours and 55 minutes of individual direct services. The Family Advocate also made five referrals, four of which were successfully connected. Two referrals were for employment services, two for Project MANA, and one for legal services.

Sierra Mental Wellness Group Personal Services Coordinator (SMWG PSC):
During FY 18/19 the SMWG PSC performed 8 outreach activities specific to Nevada County totaling 17 hours and 33 shared events between Nevada and Placer County totaling 85 hours and 15 minutes. These outreach events including: homeless outreach, suicide prevention coalition, care coordination, youth health initiate, and Know the Signs trainings.

During FY 18/19 the SMWG PSC worked with 15 unduplicated individuals from Nevada County and an additional 15 from Placer County. The SMWG PSC provided individual case management services a total of 97 time and spent a total of 119 hours and 41 minutes providing direct individual case management services to Nevada County residents throughout the FY 18/19. The PSC also provided 32 referrals to those Nevada County residents receiving case management services. 28 of those referrals were connected to services. See table below.

Agency	# of Referrals	Connected?	% Connected
Adult Mental Health	1	0	0%
Adult Protective Services	1	0	0%
EDD	2	2	100%
Employment/One Stop	4	4	100%
Family Resource Center	1	1	100%
In Home Support Services	1	1	100%
Legal Services	3	2	67%
Other	4	4	100%
Project MANA	2	2	100%
Public Health	2	1	50%
Sierra Mental Wellness Group	2	2	100%
Social Services	2	2	100%
SSI/SSDI	4	4	100%
Tahoe Forrest Hospital	2	2	100%
Private Therapist/Psychiatrist	1	1	100%
TOTAL	32	28	88%

The innovation project encourages and tracks collaboration between agencies. Below is a chart identifying collaboration between agencies and across county lines as part of the integration of rural mental health services project. See table below for collaboration information.

Nevada County Innovation: Integration of Rural Mental Health Services
Collaboration Survey: Number of Respondents from Each Agency

Agency	# of Respondents August 2017	# of Respondents February 2018	# of Respondents August 2018	# of Respondents February 2019
Nevada County Child Behavioral Health	3	2	2	1
Nevada County Adult Behavioral Health	2	2	2	2
Nevada County Substance Use Treatment Services	-	1	1	-
Placer County Child System of Care	3	4	3	1
Placer County Adult System of Care	-	1	2	1
Placer County Substance Use Treatment Services	-	1	-	-
Nevada County Department of Social Services (Benefits)	2	1	1	2
Placer County Department of Social Services (Benefits)	-	1	-	-
Nevada County Veterans Services	-	1	-	-
Placer County Veterans Services	-	1	-	-
Nevada County Reproductive Health Services Clinics	2	1	1	-
Nevada County Teen Clinic	2	1	1	-
Nevada County Probation	-	1	-	-
Placer County Probation	-	1	-	-
Nevada County Sheriff	2	-	1	-
Placer County Sheriff	1	-	-	-
Nevada County Adult Protective Services (APS)	-	1	-	-
Placer County Adult Protective Services (APS)	-	1	-	-
Nevada County Public Health Nursing	1	1	-	-
Placer County Public Health Nursing	1	2	3	2
Nevada County Women, Infants, and Children (WIC)	1	1	-	-
Placer County Women, Infants, and Children (WIC)	-	1	-	-

Agency	# of Respondents August 2017	# of Respondents February 2018	# of Respondents August 2018	# of Respondents February 2019
Nevada County Child Welfare Services (CWS)	1	1	-	-
Placer County Child Welfare Services (CWS)	2	3	1	1
Nevada County In-Home Support Services (IHSS)	-	1	-	-
Placer County In-Home Support Services (IHSS)	-	1	-	-
Foothills/Truckee Healthy Babies	1	1	1	1
Sierra Teen Education Parenting Program	-	1	1	2
North Tahoe Family Resource Center	1	1	-	-
Family Resource Center of Truckee	3	3	1	1
TTUSD - Wellness Center	1	2	1	2
TTUSD - Counseling Services	1	1	-	1
TTUSD - Other	-	1	1	2
What's Up? Wellness Checkups	2	1	2	3
Tahoe Forest Hospital Wellness Center	2	2	3	3
Adventure Risk Challenge	1	1	1	1
Gateway Mountain Center	1	2	1	2
Big Brothers Big Sisters	1	-	-	1
Uplift Family Services	2	1	1	3
Aim High	-	1	-	-
SOS Outreach	1	1	-	1
Boys and Girls Club of North Lake Tahoe	-	1	1	-
Communities 4 Kids	1	1	1	-
Tahoe Truckee Reads	-	1	1	1
For Goodness Sake	1	-	-	-
United for Action	1	-	-	1
Sierra Senior Services	2	1	1	1
Tahoe SAFE Alliance	1	-	1	1
Moving Beyond Depression	-	1	1	-
Project MANA Homeless Outreach	2	2	2	2
Emergency Warming Center	2	2	-	2
Sierra Mental Wellness Group - Placer Outpatient	2	2	3	3
Dial 211 Nevada County	1	-	-	-
Future Without Drug Dependence	-	1	1	1

Agency	# of Respondents August 2017	# of Respondents February 2018	# of Respondents August 2018	# of Respondents February 2019
Crisis Stabilization Unit (CSU)	1	-	-	-
Crisis Assessment (Sierra Mental Wellness Group)	1	1	1	1
Tahoe Forest Hospital Emergency Department	2	2	2	1
Tahoe Forest Multi-Specialty Clinic	2	2	2	1
Tahoe Forest Primary Care (Occupational Health)	2	2	2	1
Other	1	3	2	1
Unduplicated Number of Persons Responding	**43**	**35**	**36**	**40**

Challenges, Solutions, and Upcoming Changes

During the FY 18/19 fiscal year, the FRCoT team continued to develop our understanding of the "Innovation Family Advocate" role in collaboration with Nevada County Behavioral Health and our in-house Promotora Program. One challenge has been defining the specific responsibilities and boundaries of the role. Our approach to these challenges has been to work through questions with partners as they arise and to document solutions.

The SWMG Personal Services Coordinator was tasked with following up with individuals who were placed on a 5150 hold at Tahoe Forrest Hospital following their discharge, with the goal of offering additional support and referral. One challenge with this additional task was the number of additional calls that needed to be made on top of other duties and overlap between the hospital and PSC on follow up. Additionally, a number of individuals required transportation to the greater Sacramento area for follow up appointments and referrals, and lack of available County car for the PSC was a barrier to providing this service.

In the upcoming fiscal year, The Family Resource Center of Truckee is merging with three local agencies: Tahoe SAFE Alliance, North Tahoe Family Resource Center, and Project MANA to become Sierra Community House (effective July 1, 2019). This collaboration will serve the joint mission to connect and empower the community through family strengthening, crisis intervention, hunger relief, and legal services and will be better equipped to serve the community through collective/common resources. With this consolidation, the innovation team will expand to 11 staff members throughout the eastern portions of both Placer and Nevada Counties. Moving forward, the team will include a full-time manager, full-time supervisor and a full-time coordinator, with eight part-time staff. This shift will provide the capacity to offer greater capacity for community services and have a specific focus on the Promotora program.

Program Participant Story

Personal Services Coordinator/Family Advocate:
Maria* was referred to the FRCoT by a Nevada County Department of Behavioral Health therapist. Maria's initial meetings with her Advocate were spent exploring different options for social services, including MediCal, CalFresh and disability. She and her Advocate set goals for where she wants to be a year from now and two years from now.

The FRCoT "Innovations" Family Advocate has developed a relationship with Maria in which she feels open to asking for help when she needs it – her Advocate notes that Maria will now call the FRCoT and ask for her by name when she needs to talk to someone. Our staff Advocate meets with Maria weekly and often accompanies her to doctor's appointments to be her support when facing language barriers. After working with Maria for several months, her Advocate notes that Maria has become more independent. Specifically, the Advocate helped Maria to gain comfort with taking the bus and the bus schedule, which laid the groundwork for her to be able to start a new job outside the home. Maria and her Advocate have also been able to work on steps for citizenship.
**Name changed for privacy*

Sierra Mental Wellness Group Personal Services Coordinator:
A beneficiary from Placer County had been seeing a Psychiatrist and a therapist at SMWG for about two years. This individual was feeling depressed but also felt that gaining benefits, even CalFresh, was abusing the system. He was in debt so he could not even pay his landlord rent before creditors would take the money from his account.

The SMWG Case Manager assisted this individual in finding things that brought joy to his life again. The beneficiary started riding his bike to meet friends that he used to hang out with to play chess. The Case Manager and the participant started volunteering at Project MANA so the beneficiary would see that it is okay to accept free food and that he could feel good about doing it by volunteering. The Case Manager assisted the beneficiary in filling out a benefits application and went through the motions of understanding the process and coping with rejections. The beneficiary was assisted in getting on CalFresh so he could afford to buy the foods that he wanted to eat. Finally, after one year of benefit rejections, the beneficiary was accepted for benefits.

The beneficiary had an appointment with a bankruptcy lawyer and is in the process of filing so he can keep his benefit money and pay his landlord rent on time.

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

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

Program Description

Program Overview

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

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

Target Population

The HOME Team's target population are chronically homeless residents of Nevada County. The Prevention and Early Intervention (PEI) Homeless Street Outreach Worker identifies and refers individuals to the HOME Team and has also joined the HOME team as the team lead due to his extensive experience with this population. As a result, the Innovation HOME Team program may serve individuals that are also counted in the PEI Homeless Street Outreach Program.

Evaluation Activities and Outcomes

The HOME Team officially launched in April 2019. The nursing position and some other positions took longer to fill. April through June 2019 served as a ramp-up period for the team, focused on getting to full staffing, training, and development of procedures.

The HOME Team conducted outreach through the personal service coordinators and peer specialist staff and started the process of receiving referrals through the Coordinated Entry System. It was not until July 2019 that the team started to collect target population data in the Homeless Management Information System (HMIS).

The HOME Team gave intakes and initial screenings to 20 individuals between April and June 2019. The Substance Abuse and Mental Health Services Administration (SAMHSA) Government Performance and Results Act (GPRA) Measurement Tool was used for screening these individuals. Results will be available in next year's report since this fiscal year was largely a ramp-up period.

Innovation Program Changes During the Reporting Period

As these were the first few months of the HOME Team program, no changes were identified or made in FY 18/19.

Challenges, Solutions, and Upcoming Changes

The main challenge for the HOME Team was recruiting and staffing the team. In April and May of 2019, recruitment for the personal services coordinators and peer specialist was completed with the initial staff beginning June 1st and 15th. The nurse was not hired until mid-July. Due to this incomplete staffing, no FY 18/19 data related to medical engagement objectives or activities was tracked.

Additional challenges included:

- Establishing the HOME Team program in the HMIS system
- Training staff on HMIS data entry
- Working through HIPAA regulations related to capturing medical engagement services in HMIS
- Amending current contracts and contract scopes to include MHSA/Innovation funds for staffing and housing acquisition

Program Participant Story

None in FY 18/19