# Nevada County

# Mental Health Services Act

## FY 2015/2016 Annual Update

## Three Year Program and Expenditure Plan

## And

## Annual Progress Report
## FY 2013/2014

December 2015

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

**Table of Contents**

Exhibit A

# MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Nevada County

☐ Three-Year Program and Expenditure Plan
☑ Annual Update

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

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

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

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

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

Rebecca Slade
_____
Local Mental Health Director (PRINT)

_____
Signature Date

# MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Nevada County

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

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

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

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

Rebecca Slade
Local Mental Health Director (PRINT)

_____ _____
Signature Date

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

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

Marcia Salter
County Auditor Controller / City Financial Officer (PRINT)

_____ _____
Signature Date

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

# FY 2015/16 Mental Health Services Act Annual Update
## Funding Summary

County: Nevada

Date: 10/27/15

| | MHSA Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Community Services and Supports | Prevention and Early Intervention | Innovation | Workforce Education and Training | Capital Facilities and Technological Needs | Prudent Reserve |
| **A. Estimated FY 2015/16 Funding** | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | 1,250,000 | 1,554,000 | 375,000 | 55,500 | 0 | |
| 2. Estimated New FY 2015/16 Funding | 2,888,000 | 722,000 | 190,000 | | | |
| 3. Transfer in FY 2015/16[a/] | 0 | | | 0 | 0 | 0 |
| 4. Access Local Prudent Reserve in FY 2015/16 | 0 | 0 | | | | 0 |
| 5. Estimated Available Funding for FY 2015/16 | 4,138,000 | 2,276,000 | 565,000 | 55,500 | 0 | |
| **B. Estimated FY 2015/16 MHSA Expenditures** | 4,050,000 | 1,001,000 | 0 | 55,500 | 0 | |
| **G. Estimated FY 2015/16 Unspent Fund Balance** | 88,000 | 1,275,000 | 565,000 | 0 | 0 | |

| **H. Estimated Local Prudent Reserve Balance** | |
|---|---|
| 1. Estimated Local Prudent Reserve Balance on June 30, 2015 | 1,129,150 |
| 2. Contributions to the Local Prudent Reserve in FY 2015/16 | 0 |
| 3. Distributions from the Local Prudent Reserve in FY 2015/16 | 0 |
| 4. Estimated Local Prudent Reserve Balance on June 30, 2016 | 1,129,150 |

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

# FY 2015/16 Mental Health Services Act Annual Update
## Community Services and Supports (CSS) Funding

County: Nevada Date: 10/27/15

| | Fiscal Year 2015/16 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **FSP Programs** | | | | | | |
| 1. Wraparound | 3,007,000 | 750,000 | 1,250,000 | 0 | 1,000,000 | 7,000 |
| 2. Assertive Community Treatment | 3,058,000 | 1,700,000 | 1,300,000 | 50,000 | 0 | 8,000 |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| 8. | 0 | | | | | |
| 9. | 0 | | | | | |
| 10. | 0 | | | | | |
| 11. | 0 | | | | | |
| 12. | 0 | | | | | |
| 13. | 0 | | | | | |
| 14. | 0 | | | | | |
| 15. | 0 | | | | | |
| 16. | 0 | | | | | |
| 17. | 0 | | | | | |
| 18. | 0 | | | | | |
| **Non-FSP Programs** | | | | | | |
| 1. General System Development | 2,760,000 | 900,000 | 900,000 | 110,000 | 500,000 | 350,000 |
| 2. Outreach and Engagement | 200,000 | 200,000 | | | | |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| 8. | 0 | | | | | |
| 9. | 0 | | | | | |
| 10. | 0 | | | | | |
| 11. | 0 | | | | | |
| 12. | 0 | | | | | |
| 13. | 0 | | | | | |
| 14. | 0 | | | | | |
| 15. | 0 | | | | | |
| 16. | 0 | | | | | |
| 17. | 0 | | | | | |
| 18. | 0 | | | | | |
| **CSS Administration** | 500,000 | 500,000 | | | | |
| **CSS MHSA Housing Program Assigned Funds** | 0 | | | | | |
| **Total CSS Program Estimated Expenditures** | 9,525,000 | 4,050,000 | 3,450,000 | 160,000 | 1,500,000 | 365,000 |
| **FSP Programs as Percent of Total** | 149.8% | | | | | |

# FY 2015/16 Mental Health Services Act Annual Update
## Prevention and Early Intervention (PEI) Funding

County: Nevada Date: 10/27/15

| | Fiscal Year 2015/16 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated PEI Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **PEI Programs - Prevention** | | | | | | |
| 1. Senior, Disabled & Isolated Home Visitor | 33,000 | 33,000 | | | | |
| 2. Wellness Center: Peer Support & Outreach Services | 205,000 | 205,000 | | | | |
| 3. Child & Youth Mentoring | 20,000 | 20,000 | | | | |
| 4. Teaching Pro-Social Skills in the Schools | 38,000 | 38,000 | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| **PEI Programs - Early Intervention** | | | | | | |
| 8. Homeless Outreach & Therapy | 35,000 | 35,000 | | | | |
| 9. Bilingual Therapy | 65,000 | 65,000 | | | | |
| 10. EI for Referred Children, Youth, Pregnant Women, Postpart | 57,500 | 57,500 | | | | |
| 11. | 0 | | | | | |
| 12. | 0 | | | | | |
| 13. | 0 | | | | | |
| 14. | 0 | | | | | |
| **PEI Programs - Other** | | | | | | |
| 15. Access & Linkage | 218,850 | 200,000 | 2,500 | | 250 | 16,100 |
| 16. Outreach: First Responder Training | 17,500 | 17,500 | | | | |
| 17. Stigma & Discrimination Reduction | 65,000 | 65,000 | | | | |
| 18. Suicide Prevention | 160,000 | 160,000 | | | | |
| 19. | 0 | | | | | |
| 20. | 0 | | | | | |
| **PEI Administration** | 100,000 | 100,000 | | | | |
| **PEI Assigned Funds** | 5,000 | 5,000 | | | | |
| **Total PEI Program Estimated Expenditures** | 1,019,850 | 1,001,000 | 2,500 | 0 | 250 | 16,100 |

# FY 2015/16 Mental Health Services Act Annual Update
## Innovations (INN) Funding

County: Nevada

Date: 10/27/15

| | Fiscal Year 2015/16 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated INN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **INN Programs** | | | | | | |
| 1. | 0 | | | | | |
| 2. | 0 | | | | | |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| 8. | 0 | | | | | |
| 9. | 0 | | | | | |
| 10. | 0 | | | | | |
| 11. | 0 | | | | | |
| 12. | 0 | | | | | |
| 13. | 0 | | | | | |
| 14. | 0 | | | | | |
| 15. | 0 | | | | | |
| 16. | 0 | | | | | |
| 17. | 0 | | | | | |
| 18. | 0 | | | | | |
| 19. | 0 | | | | | |
| 20. | 0 | | | | | |
| **INN Administration** | 0 | | | | | |
| **Total INN Program Estimated Expenditures** | 0 | 0 | 0 | 0 | 0 | 0 |

# FY 2015/16 Mental Health Services Act Annual Update
## Workforce, Education and Training (WET) Funding

County: Nevada

Date: 10/27/15

| | Fiscal Year 2015/16 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated WET Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **WET Programs** | | | | | | |
| 1. Training & Technical Assistance | 32,500 | 32,500 | | | | |
| 2. Mental Health Career Pathways Programs | 10,500 | 10,500 | | | | |
| 3. Financial Incentive Programs | 5,000 | 5,000 | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| 8. | 0 | | | | | |
| 9. | 0 | | | | | |
| 10. | 0 | | | | | |
| 11. | 0 | | | | | |
| 12. | 0 | | | | | |
| 13. | 0 | | | | | |
| 14. | 0 | | | | | |
| 15. | 0 | | | | | |
| 16. | 0 | | | | | |
| 17. | 0 | | | | | |
| 18. | 0 | | | | | |
| 19. | 0 | | | | | |
| 20. | 0 | | | | | |
| **WET Administration** | 7,500 | 7,500 | | | | |
| **Total WET Program Estimated Expenditures** | 55,500 | 55,500 | 0 | 0 | 0 | 0 |

# FY 2015/16 Mental Health Services Act Annual Update
## Capital Facilities/Technological Needs (CFTN) Funding

County: Nevada Date: 10/27/15

| | Fiscal Year 2015/16 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CFTN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **CFTN Programs - Capital Facilities Projects** | | | | | | |
| 1. | 0 | | | | | |
| 2. | 0 | | | | | |
| 3. | 0 | | | | | |
| 4. | 0 | | | | | |
| 5. | 0 | | | | | |
| 6. | 0 | | | | | |
| 7. | 0 | | | | | |
| 8. | 0 | | | | | |
| 9. | 0 | | | | | |
| 10. | 0 | | | | | |
| **CFTN Programs - Technological Needs Projects** | | | | | | |
| 11. | 0 | | | | | |
| 12. | 0 | | | | | |
| 13. | 0 | | | | | |
| 14. | 0 | | | | | |
| 15. | 0 | | | | | |
| 16. | 0 | | | | | |
| 17. | 0 | | | | | |
| 18. | 0 | | | | | |
| 19. | 0 | | | | | |
| 20. | 0 | | | | | |
| **CFTN Administration** | 0 | | | | | |
| **Total CFTN Program Estimated Expenditures** | 0 | 0 | 0 | 0 | 0 | 0 |

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

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

**County:** Nevada **30-day Public Comment Period Dates:** December 8, 2015 through January 7, 2016

**Date:** December 2, 2015 **Date of Public Hearing:** January 8, 2016

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

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

In September 2005 a MHSA Steering Committee was formed to set priorities based on community input and to prepare a MHSA CSS proposal. This committee is still being utilized today for all of the MHSA components. The original Steering Committee was structured with a majority of consumers and family as members. The other members include various interest groups, community based organizations, service providers, and Nevada County Behavioral Health Department (NCBHD) staff. This committee worked on our plan through the use of meetings, work groups, and by e-mail. Today we have stakeholders from service providers, contract providers, client/family advocates, consumers/clients, family members, County employees and interested community members attend our Steering Committee meetings. Any member of the public is welcome to attend any of our meetings and to provide input.

The Steering Committee had meetings on the following dates in FY 2014/2015: 7/17/14, 8/22/14, 9/12/2014, 10/16/2014, 11/14/2014, 12/19/14 and 5/4/2015. In FY 15/16 we have had two meetings to date, 08/10/2015 and 11/09/15.

Our Workforce and Employment Training (WET) Subcommittee had been meeting monthly since July 2007. In May 2011 the WET Subcommittee started to meet bi-monthly. As of November 2012 the WET Subcommittee joined the County's Cultural Competency Work Group and the Quality Improvement Committee. In FY 14/15 due to staff shortages the WET Subcommittee stopped meeting separately and became part of the MHSA Steering Committee.

The meeting dates for FY 14/15 for the Cultural Competency and WET Meeting were: 7/14/14 and 9/19/14.

The MHSA Coordinator attended the Truckee "Youth Café" public meeting on 11/3/15 to hear from youth what the local strengths and gaps in services are and solutions, from the perspectives of youth.

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

Nevada County has employed subcommittees to address specific components of the MHSA. In April of 2008 Capital Facility and Technology Need (CF/TN) was added to our CSS Subcommittee. In March 2010 Housing

was added to our CSS/CF/TN Subcommittee. In May 2010 a Prevention and Early Intervention (PEI)/Innovation (INN) Subcommittee was formed. These groups met on a quarterly or on as-needed bases through December 2012. As of January 2013 these subcommittees are no longer meeting on a regular basis due to the fact that the people attending were also the people attending the MHSA Steering Committee meeting. It was determined to form ad hoc committees as needed.

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

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

In FY 14/15 we conducted four Innovation Community Meetings. The dates of the meetings were: 2/20/15, 3/4/15, 3/17/15 and 3/30/15. Additionally, we had additional meetings with different targeted stakeholders on 2/9/15, 4/17/15, and 4/23/15

Our plan is shared with e-mail lists of interested individuals. These lists contain approximately 180 individuals. These individuals range from family members, consumers/clients, contractors, and community based

organizations, interested community members, to staff from varies departments with Nevada County. Included in this list are our area's major media outlets.

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

All plans were shared with the Mental Health Board, MHSA Steering Committee, and our e-mail subscribers. Our 30-day review and comment period was December 8, 2015 through January 7, 2016 which served as the opportunity for the public to provide additional input to this update of our MHSA Annual Plan and Annual Progress Report for FY 2013/2014.

The MHSA Annual Plan Update and Annual Progress Report Public Hearing was held at our local Mental Health Board on January 8, 2016.

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

The stakeholders involved in the Community Program Planning Process included:

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

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

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

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

**Local Review Process**

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

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

| |
|---|
| departments within Nevada County. Additionally, an email press release is sent to all of the major media outlets that serve Nevada County. During the 30-day comment period the Three-Year Plan and Annual Progress Report is an agenda item at all MHSA meetings. Hard copies are provided to SPIRIT Peer Empowerment Center, in our lobby and to others who request it. |
| 4. Summary and analysis of any substantive recommendations received during the 30-day public comment period. A description of substantive changes made to the proposed plan. The county should indicate if no substantive comments were received. |
| No substantive comments were received. |

# Nevada County MHSA Annual Plan Update for FY 15-16

## *General Nevada County Information:*

Nevada County is a small, rural, mountain community home to 98,764 (2010 US Census) individuals. According to the 2010 US Census a little over 91% of the Nevada County residents identified their race as White. Less than 3% of Nevada County residents identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander. Additionally, less than 3% identified their race as "Other." Lastly, 3% identified themselves by two or more races. Ninety-one point five percent of the population identified their ethnicity as non-Hispanic or Latino and 8.5 % of the population of Nevada County identified themselves as Hispanic or Latino, thus Nevada County has one threshold language, Spanish.

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

---

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

## *A) Full Service Partnerships*

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

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

(i) Be at serious risk of, or have a history of psychiatric hospitalization, residential care, or out of home placement

(ii) Children who are homeless or at risk of becoming homeless

(iii) Be at risk of aging out of the juvenile justice system or foster care with no care or support

(iv) Be at risk for dropping out of school, experiencing academic failure or school disciplinary problems

(v) Be at risk of involvement with the criminal justice system

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

c) Plan services and supports will include, but are not limited to:
(i) Psychiatric services and/or non-psychiatric Network Provider services (Network Providers include Psychiatrists, Psychologists, Clinical Social Workers, and Marriage & Family Therapists licensed for independent practice)
(ii) TAY support and peer support
(iii) Housing services
(iv) Employment and pre-employment services
(v) Outreach and Engagement activities throughout the county, but particularly for Latinos, Truckee, and North San Juan area residents
(vi) Wraparound services and supports
(vii) Case Management, rehabilitation and care coordination
(viii) Peer/Family support, advocacy, training, and education
(ix) Integrated treatment for co-occurring disorders
(x) Court liaison services
(xi) "Whatever it takes" services

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

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

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

Nevada County has Wraparound Care Organizations supporting both the western and eastern parts of the county. The Wraparound Care Organizations provide and/or arrange for all necessary services as indicated by individual needs. Substance abuse treatment is integrated within the context of overall services delivered by the

Wraparound Team.

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

**e) Latino Outreach**

The children's Wraparound providers have bi-lingual and bi-cultural staff that work with families. Promotoras, bi-lingual and bi-cultural health educators, help with outreach and engagement to Latino families and Wraparound Providers, to offer translation services and at times to join the treatment team. Comprehensive recruitment of bilingual staff is an ongoing challenge.

f) **Peer and Family Support/Advocacy Services**

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

**g) Housing Services**

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

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

h) **Employment and Pre-Employment Services**

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

**i) Out of County Placement of Program Participants**

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

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

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

a) The targeted population served in Plan II are adults age 18 and up who are seriously mentally ill (SMI) individuals whose service needs are unmet or so minimally met that they fall into the unmet category placing them at risk of:
(i) Incarceration,
(ii) Psychiatric institutionalization,
(iii)Becoming homeless or are currently homeless, or
(iv)Under involuntary care.

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

c) Adult FSP services and supports may include, but is not limited to:
(i) Peer/Family counseling
(ii) Drop in services
(iii) TAY support and peer Support
(iv) Assisted Outpatient Treatment or "Laura's Law": Engaging treatment resistive SMI individuals who may be involved with the criminal justice system. Unserved individuals must meet additional criteria for AOT as listed in W & I code 5345(a).
(v) Gay, lesbian and transgender peer services
(vi) Psychiatric Services and/or non-psychiatric Network Provider services
(vii) Rehabilitation, Case Management, and Care Coordination
(viii) Integrated treatment for co-occurring disorders
(ix) Outreach/engagement services to Latinos, Truckee, North San Juan area residents and the homeless
(x) Peer Supportive Services – Peer driven and staffed empowerment center focused on the SMI individual.
(xi) Housing services and supports
(xii) Employment and pre-employment services and support
(xiii) Veteran services and support
(xiv) Law enforcement/court/forensic services and support
(xv) "Whatever it takes" services

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

Team members share responsibility for the participants served by the team. Participants may receive services from any team member on the treatment team. The staff to participant ratio is small, approximately one staff member per 10 participants.

The range of treatment and services is comprehensive and flexible. Team members provide many different types of services to members, and these services may be outside of their respective discipline (within scope of practice, if applicable). Interventions are

carried out in vivo rather than in hospital or clinic settings. There is no arbitrary time limit on receiving services. Services are available on a 24–hour, 7 day per week basis. The team adopts an assertive attitude and is proactive in engaging those individuals needing care. Membership on the Team is maintained as long as the individual desires continued services.

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

e) **Assisted Outpatient Treatment**

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

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

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

f) **Housing Support**

Supportive housing services are also provided by the ACT Team. Funds are provided for rent, security deposits, first and last month's rent, cleaning services, housing repairs, utilities, furniture and appliance needs. Consideration will be given to creating a housing fund for loan purposes, for those individuals that possess the ability to secure and repay loans.

g) **Employment Services and Pre-Employment Services**

Employment services are included in this proposal which may include, but is not limited to, the area of peer and family support opportunities. Many individuals with lived mental health experience and family members are expected to be employed on a full or part time basis. Some places that employment may be secured are: on the ACT Team; at a peer support center; at community based organization; conducting outreach to Latinos, Veterans, and other unserved and underserved populations; at privately owned businesses in the community; and as individuals with lived mental health experience and family advocates.

h) **Out of County Placement**

Care Coordinators on the ACT Team maintain responsibility for their program participants placed out of county, hospitalized, or receiving treatment in an Institute for Mental Disease. Care Coordinators will facilitate access to treatment, provide care coordination, engage in aftercare planning with the facility, and help prepare the program participant to return to his/her home and/or to a less restrictive placement as soon as possible.

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

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

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

## *B) General System Development*

1) **Expand the Intern Program**: Expands service capacity, increases access, and broadens services in Western Nevada County and in Truckee. Interns are funded through both Plans.

2) **Expand Network Provider Program** (funded by both Plans).

3) **Expand Adult and Child Psychiatric Services**. Expands both adult and child psychiatric services for the seriously emotionally disturbed or seriously mentally ill individuals that the Behavioral Health Department serves.

   Additionally, in FY 2009/2010, NCBHD began providing psychiatric consultation and support (funded by both programs) to both of the low income primary care clinics (Federally Qualified Health Clinics), Sierra Family Medical Clinic and Western Sierra Medical Clinic. The consultation support is to help assist the clinics in providing psychiatric services and medication to the program participants that are seen by the clinics.

4) **Expand Mental Health Treatment, Care Coordination and Outreach and Engagement Services in North San Juan** (funded by both plans).
   a) The North San Juan Ridge area is an area identified as being underserved due to

geographic location. Sierra Family Medical Clinic (SFMC) provides medical and psychological services to individuals living in the North San Juan Ridge area.

b) The FSP Teams collaborate with the SFMC to implement a variety of ideas to improve access to necessary mental health services, such as contracting with individual therapists, consulting with SFMC staff, and scheduling on site office time for FSP staff to review and receive new referrals.

c) Services at SFMC may include, but is not limited to care coordination, outreach and engagement services, and treatment expansion.

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

6) **Expand Adult and Children's Behavioral Health Services** to support and implement MHSA programs (funded by both plans).

7) **Expand Crisis and Mobile Crisis Intervention Services** including **Respite Care, Crisis Stabilization Unit, and Crisis Residential facility**.

a) Expand the number and work location of crisis workers.

b) Expand Crisis Intervention Services which may include mobile crisis services (funded by both Plans). Crisis Intervention Services is being provided to the members of community in a limited capacity with the hope of expanding when funds are available. Whenever necessary and practical, this response is coordinated with law enforcement, responding as a team to mental health crisis in the community. The goal is to deliver a more effective, appropriate, and rapid response at the start of a crisis episode and thus reduce trauma to the individual and the need for hospitalization or institutionalization. Ongoing specific training for crisis intervention will be provided for participating law enforcement officers and crisis workers. Funds allotted to this service would allow the existing Crisis Service to expand its crisis worker response capacity.

c) Mental health stabilization services in the Juvenile Hall provides preventive interventions to individuals experiencing symptoms of serious mental illness. One-to-one interventions may provide enough support to stabilize or deescalate the emergent nature of a crisis situation and prevent an unnecessary hospitalization. These services are provided by, or are closely coordinated with, the Wraparound Team and move toward providing for urgent services, on site in the community, 24 hours/day, 7 days/week.

d) Creating a Respite Care Facility. Nevada County has developed and is opening a respite care facility with supportive services in 2015.

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

f) Crisis Support Unit (CSU). By utilizing SB 82 funds and MHSA CSS funds the BHD is working to develop and implement a CSU at Sierra Nevada Memorial Hospital. The CSU is anticipated to be open in late 2015 or early 2016.

8) **Truckee Outreach, Engagement, and Liaison**
   a) Concerted efforts are made to outreach and provide services to unserved and underserved Truckee residents which include the Latino population. Services include: care coordination; peer services; training; counseling by licensed therapists; case management; psychiatric care and community outreach. In addition, efforts are made to link Truckee residents to the level of care they need by adapting programs to be accessible in Truckee, or by transferring Truckee residents to more intensive services in Western Nevada County. Whenever possible, though, efforts are made to maintain residents in their primary community. When residents need to move to receive care, efforts are made to create a seamless transition. Services are delivered by collaborative efforts in both Western and Eastern Nevada County, and are culturally and linguistically competent.

9) **Emergency Department (ED) Outreach and Engagement, includes Respite Care and Crisis Stabilization Unit Facility Supports**
   a) Emergency Department Support and Follow-up Services: In an effort to increase the quality of care for patients utilizing the Emergency Department (ED) for mental health needs and to reduce ED visits, an ED support and follow-up service has been designed and is being implemented. This service provides ED support, ED follow-ups, and preventative care to individuals exhibiting the symptoms of serious mental illness who are treated and released from the hospital ED and who do not, at that time, meet 5150 criteria. Peer Advocates/Supporters build relationships with individuals and then provide warm handoffs to appropriate community service providers. The ED service support staff work in collaboration with the ACT Team, Peer Support Agency, NCBHD staff, Crisis support staff and other involved agencies. One-to-one follow-up by a Peer Supporter is offered to individuals experiencing the symptoms of serious mental illness within 72 hours of ED release. These individuals receive a phone "check in call" and an offer of support by a Peer Supporter trained in Peer support which may include, but is not limited to: symptom management; community resource referrals; and family support.
   b) Respite Center: The mission of the Respite Center is to create and support a healing environment for individuals with mental health challenges who are going through difficult times, in order to prevent crisis intervention or hospitalizations. Program participants will focus on their personal strengths and strive to gain emotional stability, balance, and resilience within their lives as they work with others toward their recovery.

      The Respite Center is used as a diversion to ED services. The Respite Center is an alternative to inpatient hospitalization for individuals experiencing a mental health crisis. Respite care is a center where individuals in crisis can receive temporary housing and supportive counseling services. The Respite Center is operated 24 hours per day, seven days per week (24/7). The center is peer-run, in coordination with clinical support. The Respite Center staff offer a safe and supportive environment for persons at risk of needing mental health crisis intervention, in a wellness-, resiliency, and recovery-oriented setting that is less restrictive than a CSU or hospital. The

Respite Center offers a relaxed, welcoming environment for individuals who need enhanced supportive services to handle an escalation decompensation in their symptoms. Program participants are linked to addition services to meet their individual needs. The Center facilitates communication and coordination across all components of the crisis continuum of care, including, but not limited to: the crisis Response Team at the ED; CSU; and other service agencies involved in the program participants support network.

c) Crisis Stabilization Unit (CSU)**:** The CSU will provide up to 23 hours of care in a comfortable, therapeutic setting for individuals presenting with mental health issues in the ED. The CSU will utilize a team that includes Physicians, Psychiatrists, Nurses, Therapists, and Peer Supporters. The role of the CSU in the crisis continuum of care is to provide stabilization and treatment services to persons who are in psychiatric crisis, thus avoiding the need for hospitalization. Nevada County residents who are in need of mental health crisis services can be treated in the CSU and return to the community without an inpatient admission to a state psychiatric hospital. The more quickly a person receives treatment, as opposed to being "held" without treatment, the less likely his or her condition will worsen. In addition, after treatment an individual will be connected to local mental health services.

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

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

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

Services are provided to this population through CSS and PEI (Prevention and Early Intervention) funds. Services may include, but is not limited to: care coordination, mental health evaluations and assessment, linkage to mental health, physical and substance use services, outreach to individuals at their camps, transitional support while transitioning to permanent housing; support while obtaining and maintaining housing, crisis intervention, forensic support, teaching/training on life skills, supporting and including family members, substance use counseling, mental health treatment/therapy, community referrals which include warm handoffs, transportation, and consultation with other service providers.

This also includes the use of CSS Housing funds to purchase permanent supportive housing to provide permanent supportive housing to SMI homeless individuals. When CSS Housing funds are all spent, CSS funds may be used to purchase permanent supportive housing.

## *C) Outreach and Engagement*

1) Providing education about CSS and mental health issues to other community service providers, community members, peers and family members. Training opportunities are available to all individuals (funded by both plans).

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

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

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

   Training is available to Peer Support Staff and individuals that seek to empower themselves to work with their peers, media, potential employers, community agencies, community members, and family members. At a minimum, participants learn how to:
   - Provide Peer Support/Mentoring
   - Increase their life skills
   - Use a computer or increase their computer skills
   - Improve overall health/well being
   - Access community resources

## *D) Program Expenditures*

Expenditures for this work plan may include: all expenditures identified in the original and subsequent Three-Year Plans; subsequent Annual Updates; and items on the MHSA Recommendations of Needed Mental Health Services FY 2014-2017 document, including but not limited to: staffing and professional services; operating expenses (office supplies, travel and transportation, program participant vouchers and stabilization funding to meet other program

participant expenses needs based on the "whatever it takes" MHSA approach, translation and interpreter services, rent, utilities and equipment, medications, and medical support); tele-psychiatry equipment; office furniture; capital purchases; training and education; food; program participant incentives; the cost of improving the functionality of information systems used to collect and report program participant information. Capital purchases may include: the cost of vehicles; costs of equipping employees with all necessary technology (cellular telephones, computer hardware and software, etc.); the cost of enhanced and/or increased space needs related to services; and other expenses associated with the services in this plan.

## *E) Future Programs*

The expansion of services in the future may include any other activities approved in the original CSS Plan or subsequent Annual Updates or the MHSA Recommendations of Needed Mental Health Services FY 2014-2017 document, including, but not limited to: homeless outreach and engagement services; other Latino outreach and engagement services; additional North San Juan Ridge and Truckee services; additional or enhanced services to court involved families; additional or enhanced jail services for inmates within six months of release from jail or juvenile wards at juvenile hall; additional services for Foster Care youth/children; additional support for at risk youth in the school system; additional wellness centers; additional services to serve unserved, underserved and inappropriate served populations: consultation to primary care clinics; additional contract services; services to Veterans and their families, use of Interns; expansion or additional contract services; expansion of crisis services including crisis residential, crisis stabilization units, mobile crisis teams and Respite Care; expansion of services for treatment for Co-occurring disorders; additional peer support; expansion of Children's System of Care (CSOC) and Adult System of Care, and psychiatric services and/or non-psychiatric Network Provider services.

## *F) CSS Program Costs and Cost per Person*

The estimated cost for CSS programs based on the number of individuals served in FY 13/14: 1) FSP programs is $2,450,000 2) General System Development programs is $900,000, 3) Outreach and Engagement Programs and activities is $200,000, and 4) Administration cost is $500,000. The estimated total cost is $4,050,000. The average estimated cost per person involved in a CSS activity will be $1,141. This is the average cost of FSP, General System Development, Outreach and Engagement activities, and Administrative costs divided by the number of individuals served in FY 13/14 with CSS funds (3,551). The BHD estimates serving during a given year: 711 children; 390 TAY; 1,786 adults; and 664 older adults.

Estimated CSS Cost per Year by Age (including all Administration costs):

| Age | Est. # Served/Year | % of the Total | Est. Cost/Age |
|---|---|---|---|
| Children | 711 | .20 | $810,000 |
| TAY | 390 | .11 | $445,500 |
| Adults | 1,786 | .50 | $2,025,000 |
| Older Adults | 664 | .19 | $769,500 |
| Total | 3,551 | 1 | $4,050,000 |
| | | | |

Estimated Cost by Age by CSS Program (not including County Administration costs):

:

| Age | # Served in FSP | % of the Total | Est. FSP cost/age | # Served in GSD | % of the Total | Est. GSD cost/age | # Served in O&E | % of the Total | Est. O&E cost/age |
|---|---|---|---|---|---|---|---|---|---|
| Children | 142 | .39 | $955,500 | 357 | .17 | $153,000 | 212 | .196 | $39,200 |
| TAY | 62 | .17 | $416,500 | 311 | .15 | $135,000 | 17 | .016 | $3,200 |
| Adults | 121 | .34 | $833,000 | 1,021 | .48 | $432,000 | 644 | .597 | $119,400 |
| Older Adults | 36 | .10 | $245,000 | 422 | .20 | $180,000 | 206 | .191 | $38,200 |
| Total | 361 | 1 | $2,450,000 | 2,111 | 1 | $900,000 | 1,079 | 1 | $200,000 |

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

## *G) Prudent Reserve*

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

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

## *H) MHSA CSS Administration*

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

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

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

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

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

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

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

# II. Prevention and Early Intervention (PEI)

## A) PEI Project Name: Early Intervention Programs

### 1) Project Name: Bi-lingual Therapy

a) **Identification of the Target Population:**
- **Demographics:** Services will be provided to Spanish speaking individuals. Services will be provided to all age groups, gender and sexual orientation. Services are provided in Eastern and Western Nevada County.
- **Mental illness or illness for which there is early onset:** Services will be provided for any mental illness that is presented that short term therapy is appropriate and that the Behavioral Health Department and contractors have the capacity to treat.

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

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

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

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

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

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

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

a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

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

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

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

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

i) Estimated Number Served Per Year: 75 individuals-estimate number of children 31; Transition Age Youth 12; Adults 27 and Seniors 5 served per year

j) The Estimated Cost Per Person: $867 ($65,000/75 individuals) - does not include County administration costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

i) Estimated Number Served Per Year: 70 individuals-estimate number of children 31; Transition Age Youth 12; and Adults 27 served per year

j) The Estimated Cost Per Person: $821 ($57,500/70 individuals) - does not include County administration costs.

## 3) Project Name: Homeless Outreach and Therapy

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

b) **Identification of the type of problems and needs for which the program intended to address:** Nevada County homeless frequently live in the woods or by one of the many rivers and lakes located in Nevada County. Per the January 2015 Homeless Point-in-Time Count, on any given day in Nevada County there are 279 individuals living in tents or different temporary shelters in the woods, in emergency shelters, transition houses, or in facilities not fit for human habitation. The homeless community represents all ages and ethnic backgrounds. Of the 279 homeless individuals, 43% identified as having a serious mental illness, 37% identified as having a substance use disorder, and 33% identified as survivors of domestic violence. Additionally, many of the homeless are people who mistrust government and government services.

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

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

Therapy will be provided to the target population. Therapy services will be provided at emergency shelters, transitional housing facilities, community-based organizations and out in the woods where the homeless are located. Besides short-term therapy the therapist will conduct outreach and engagement services, assessments and refer

homeless individuals to needed community services. Therapist will coordinate and collaborate with other service providers, non-profits, schools, and other County departments. Lastly, the Therapist will provide consultation and advice to emergency shelter staff to improve coordination of services and to have success in management of shelter guest with mental illnesses.

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

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

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

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

- **Wellness, Recovery, and Resilience Focused:** The BHD program utilizes a therapist who collaborates with Homeless Outreach Care Coordinators from homeless service organizations to help support program participants who want to get help for their mental health needs. The BHD programs reflect the cultural, ethnic, and racial diversity of the populations being serving. The treatment services provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. Each Treatment Plan is based on the individual's needs and goals.
- **Integrated Service Experience for Clients and Their Families:** This program is part of an integrated program with community based organizations, non-profits, other County departments, service providers and schools. Individuals and their families can enter the program from one of many avenues. All entities involved with the individual and their family provide for a range of services and supports from a variety of funding sources in a coordinated comprehensive manner.

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

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

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

i) Estimated Number Served Per Year: 60 individuals-estimate number of Transition Age Youth 20; Adults 30; and Seniors 10 served per year

j) The Estimated Cost Per Person: $583 ($35,000/60 individuals) - does not include County administration costs.

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

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

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

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

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

- Forensic Trainings: Nevada County currently has a community collaboration group that is called the "Forensic Task Force." This group includes individuals from: the courts; law enforcement; Probation; Behavioral Health; and individuals with lived mental health experience and family members. The Forensic Task Force examines the local systems to determine the forensic and court involved community's need and agrees on strategies for meeting those needs and helps to organize some of the First Responder Trainings which may include CIT.
- Suicide Prevention Training: The BHD's Suicide Prevention Intervention (SPI) Coordinator is working with the Suicide Prevention Task Force, Nevada County, schools, community based organizations, businesses, and service providers to bring training to the community to create a more "suicide aware community." Trainings occur out in the community at service provider sites, community meetings, schools, faith based community programs, health sites, etc. The trainings provided include, but is not limited to: Living Works, Mental Health First Aid, Know the Signs, and other evidence based curriculum as they become available.
- Crisis Training: The Crisis service provider has conducted surveys of law enforcement first responders to ask what kind of training that they need to handle crisis calls. The Crisis service provider created tailored training based on the specific needs as a result of surveys. Individuals with mental health lived

experience and Peer Supporters requested WRAP trainings so that they could help themselves and others when they or others are in crisis.

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

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

- **Community Collaboration:** The County is working with program participants, family members, schools, law enforcement, courts, faith based organizations, community based organizations and other service providers to plan and implement this program. When trainings occur, individuals with lived mental health experience and family members are usually part of the trainings to provide individuals with lived mental health experience and family member perspective and feedback.
- **Cultural Competence:** The trainings are tailored to the community that is receiving the training: law enforcement, schools, Latino population, etc.
- **Client Driven:** program participants are part of the planning, creating, implementation and evaluation of first responder trainings.
- **Family Driven:** NAMI (National Alliance for the Mentally Ill) usually have a member actively involved in the planning, creating, implementation and evaluation of the first responder training.
- **Wellness, Recovery, and Resilience Focused:** The BHD trainings reflect the cultural, ethnic, and racial diversity of the population the BHD is serving. The trainings provided support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
- **Integrated Service Experience for Clients and Their Families:** This training program is an integrated program with: community based organizations; law enforcement; faith based organizations; schools; other County departments; service providers; schools; individuals with lived mental health experience; and family members. Most of the trainings involve multiple representatives from multiple organizations, as appropriate.

c) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** This program will improve access to services because the BHD is reaching out to and targeting the general population and specific populations. The BHD is offering the trainings in Truckee, to Promotoras, to service providers that provide services to underserved populations, and to individuals with lived mental health experience and family members. Additionally, First Responders will be provided information about mental health resources available in the community, including Nevada County Behavioral Health services.

d) **For each program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations.** Trainings in general are not located at the BHD. The BHD is providing trainings in the community. Depending on who is being trained the BHD trains them at their organization or at a community meeting room. The BHD does this to increase the number of individuals trained, to lesson transportation costs for the First Responders and to have the trainings where people are most comfortable. However, trainings can occur at County offices.

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

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

g) Estimated Number Served Per Year: 150 individuals-estimate number of children 10; Transition Age Youth 20; Adults 110 and Seniors 10 served per year

h) The Estimated Cost Per Person: $117 ($17,500/150 individuals) - does not include County administration costs.

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

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

a) **Identification of the target population for the specific program, including:**
- **Participants' risk of a potentially serious mental illness:** The participants in the program have a higher than average risk of a serious mental illness due to their age, disabilities, isolation and lack of services, transportation and support. Additionally, the senior population has a lack of awareness of depression due to their generation having stigma on mental health needs.
- **How the risk of a potentially serious mental illness will be defined and determined:** Screening and referrals for this population is being done by nurses, social workers, service providers, family members and program participants (self referral). Social Outreach Nurses and/or Volunteers, and/or other health workers

are screening for depression by using the Beck's Depression scale or a similar tool. Additionally, Social Outreach Nurses are also screening for physical health issues and conducting a risk assessment to prevent falls. The Social Outreach Nurses are doing a holistic screening and assessment of program participants.

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

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

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

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

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

- ***Community Collaboration*:** This program is the results of multiple organizations working together with individuals with lived mental health experience and family members to bring services into the home of isolated elderly and/or disabled individuals. This program collaborates intimately with the Social Outreach nurses. Social Outreach nurses are conducting a mental health screening with all individuals they visit along with physical health and fall prevention screening. The nurses refer individuals that score high on the depression screening tool to physicians, mental health providers, community based organizations, family members and to the Home Visitor program.

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

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

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

g) **Indicate if the County intends to measure outcomes and how will it be measured, including timeframes for measurement.** Using a depression screening tool/survey program participants will be evaluated at intake and annually to monitor levels of depression and to determine reduction of prolonged suffers by measuring a reduction in risk factors, indicators, and/or increased protective factors that will lead to improved mental emotional, and relational functioning. Evaluations will occur at program entry and at least annual and/or at program exit.

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

**i)** Estimated Number Served Per Year: 45 individuals-estimate number of Adults 5 and Seniors 40 served per year.

**j)** The Estimated Cost Per Person: $733 ($33,000/45 individuals) - does not include County administration costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h) Estimated Number Served Per Year (includes both Wellness Centers: Adult and Youth): 1,600 individuals-estimate number of children 570; Transition Age Youth 510; Adults 500 and Seniors 20 served per year

i) The Estimated Cost Per Person: $128 ($205,000/1,600 individuals) - does not include County administration costs.

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

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

b) **Specify the type of problem(s) and need(s) for which the Prevention program will be directed and the activities:** At community meetings people spoke about the need for more screening and services for children and youth. Many Nevada County residents told us in the meetings that they thought students in the schools should be educated about mental health, social skills and violence prevention. Most thought this should start at an early age and continue through their school years. They thought education about mental health would reduce stigma, decrease bullying and make it easier for children to learn in school. They were concerned that children were

not tolerant of differences or students who were emotionally fragile and those children with mental health issues often became the target of bullying. The school administrators also voiced the above concerns. They said that they would like to include in their curriculum teaching social skills, emotional management, problem solving and cooperation. All hoped teaching pro-social skills would make the classroom a better place to learn and that the teachers would have to spend less time on discipline. It was also believed that if children were given the tools to handle conflict and emotions they would be less violent, see less violence and school disruption throughout the child's school life would decrease and the children would more likely succeed in school.

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

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

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

c) **Specify any MHSA negative outcomes as a consequence of untreated mental illness that the program is expected to affect, including reduction of prolonged suffering:** It is anticipated that prolonged suffering will be decreased in all individuals served and/or a decrease in school failure or dropout.

- **List the mental health indicators that the County will use to measure reduction of prolonged suffering:** The Second Step curriculum which works to strengthen protective factors and helps children develop self-regulation skills,

manage their emotions, treat others with compassion and solve problems without anger. The Second Step program evaluates the child's ability to identify emotions, brainstorm alternative solutions to problems, and generate pro-social responses to problems, and a reduction in disciplinary issues.

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

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

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

organizations, the Behavioral Health Department and other health providers to refer and link students to needed services.

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

g) **An explanation of how the program will use Strategies that are Non-stigmatizing and Non-Discriminatory, including a description of the specific strategies to be employed and the reasons the County believes they will be successful and meet intended outcomes:** The strategies that are being used are:
- Training as many school personnel as funds will allow and parents that interact with the youth so that the lessons and skills being taught are uniform and consistent.
- All youth are being taught the same lessons, no children are singled out, all youth are learning together. This allows the youth to practice and use the skills that they have been taught.

h) Estimated Number Served Per Year: 1,700 individuals-estimate number of children 1620; Transition Age Youth 60; and Adults 20 served per year

i) The Estimated Cost Per Person: $22 ($38,000/1,700 individuals) - does not include County administration costs.

## 4) **The Program Name:** Child and Youth Mentoring

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

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

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

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

- ***Wellness, Recovery, and Resilience Focused:*** Mentoring programs help to increase children's self-esteem, the sense of community and connectedness. School based mentoring works to reduce school absenteeism, gives young children a reason to attend school and a better chance to perform in school.
- ***Integrated Service Experiences for Clients and Their Families*:** The Mentoring program is administered by a community based program at school sites. Youth who need additional support, beyond mentoring services, receive services from school staff, community service providers and community based service providers.

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

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

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

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

**h)** Estimated Number Served Per Year: 30 individuals-estimate number of children 30 served per year

**i)** The Estimated Cost Per Person: $667 ($20,000/30 individuals) - does not include County administration costs.

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

### 1) Program Name: 2-1-1 Nevada County

a) **An explanation of how the program and strategy within each program will create Access and Linkage to Treatment for individuals with serious mental illness:** A website called www.211nevadacounty.com and a 2-1-1 Call Center has been established with all the health and human resources available to people living in Nevada County.

2-1-1 Nevada County is a call center that takes calls from people who are looking for help with a wide variety of health and human service's needs, from looking for shelter, food, or looking for a mental health provider. This is an information and referral service with a personnel follow up for callers who need follow-up services and can provide warm handoffs by phone to service providers.

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

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

d) **Explain how the program will follow up with the referral to support engagement in treatment.** Someone can call who is experiencing social anxiety and is unable to leave their home. This person would receive a follow up call at an agreed upon time and phone number. This follow up call would make sure that the individual caller connected to the resources needed and review need for additional resources. An additional feature is the 2-1-1 center "warm referral model," this feature connects the individual caller on the phone with community resources as they are talking to the Call Specialist. A conference call is created with the caller, the 2-1-1 operator and the service provider.

e) **Indicate if the County intends to measure outcome(s):** 2-1-1 Nevada County staff collects data on each phone call received. This Data is reviewed by 2-1-1 Nevada County staff and posted to their Website Monthly. 2-1-1 Nevada County also tracks the number of "warm handoff" phone calls and follow-up phone calls and the agency that these calls were connected to. Cumulative and detailed data will be provided quarterly and annual to the Behavioral Health Department.

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

- ***Community Collaboration:*** *E*stablishing and maintaining a 211 system has been a community wide endeavor. Community members are collaboratively funding the

program and all service providers have to communicate any changes to their program as they happen.

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

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

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

Additionally, 2-1-1 Nevada County offers enhanced services during and after a county wide emergency. Information is provided to 2-1-1 Nevada County by emergency personnel regarding specific resources to affected individuals. 2-1-1 Nevada County helps with the immediate needs from county wide emergencies as well as the long term effect of trauma of emergencies, referring callers to mental health treatment. Individuals experiencing trauma could use the call center for finding local mental health services or providers

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

- Centralized location- community only needs to call one number to get referrals for their service needs and service providers only need to communicate with one organization when they have a change of information.

- The service is available by phone or computer.
- The service is available 24/7, 365 days a year.
- The 211 call center has access to a language service that has approximately one hundred and fifty different languages available.

**j)** Estimated Number Served Per Year: 4,160 individuals-estimate number of children 10; Transition Age Youth 165; Adults 3,210 and Seniors 775 served per year

The Estimated Cost Per Person: $4 ($17,250/4,160 individuals) - does not include County administration costs.

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

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

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

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

- A Forensic Liaison is trained and working with jail, law enforcement personal, community members and family members. When the jail has an inmate who is going to be released from the jail and there is concerned about the mental health of the individual the Forensic Liaison will go to the jail and build a relationship with the individual and assess them for what level of service they will need upon release.
- For the homeless population the BHD has an individual that works with homeless individuals and families at homeless camps, at shelters and at other homeless service provider's organizations.

- For the senior, disabled, and isolated population the BHD has Nurses or other trained individuals going to the homes of these individuals and utilizing a depression screening tool along with other physical health and fall prevention screening tools.
- For Veterans the BHD will be the utilizing Veteran Services Office staff to connect with veterans that come into their office and may not be eligible to Veteran's benefits or need to travel so far to receive services that they cannot obtain them. This program is new in FY 15/16.
- For youth the BHD is supporting a screening program that is happening at all of the local public high schools. The screening occurs on all youth that signed a permission slip along with their parents. The target population is youth in the 9th and 10th grade.

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

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

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

f) **Provide a brief description of how each will reflect and be consistent with all applicable MHSA General Standards:**
- ***Community Collaboration:*** Each of the programs being implemented in the Access and Linkage for Underserved Populations has had to collaborate with multiple organizations for the programs to be implemented and successful.

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

g) **An explanation of how the program will be implemented to help Improve Access to Services for Underserved Populations:** See "a and f" above.

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

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

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

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

- Meet the program participant in a setting that they are familiar with or comfortable with.
- Hire staff that are connected to the population served or are trained on the subpopulations specific needs and/or culture.

- Include mental health screening tools as part of the program intake process.
- Including care coordination, "warm handoffs", and follow-up services as part of program processes and procedures.
- Listening to the program participant's goals and objectives and providing referrals that will help the program participant reach their goals.

**j)** Estimated Number Served Per Year: 950 individuals-estimate number of children 130; Transition Age Youth 190; Adults 390 and Seniors 240 served per year

**k)** The Estimated Cost Per Person: $192 ($182,750/950 individuals) - does not include County administration costs.

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

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

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

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

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

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

- ***Community Collaboration*:** This whole program is built on Community Collaboration. The Family Resource Centers, community based organizations, MHSA stakeholders, County government, representatives from the Latino community are working together to provide outreach, advocacy, support, education and training to the Spanish speaking individuals in the community so that mental health stigma to access and receiving mental health treatment is decreased.
- ***Cultural Competence*:** This program provides training, education, and support in the language of the individuals needing mental health services. Local bi-lingual and/or bi-cultural Promotoras are implementing the program. When mental health services are located at the County office Promotoras are bringing program participants to the first appointments to ensure that the program participant feels comfortable, and that a relationship is developed between the program participant and service provider. Therapists are located at Family Resource Centers where the target population are already connected and feel comfortable.
- ***Client Driven*:** The program has been developed with the input of the Latino population, they have influenced the way the BHD conducts outreach, implement and evaluate the program.
- ***Family Driven*:** Parents of children and youth who have the primary decision-making role in the care of their children continue to be involved in the planning, implementation and evaluation of the program.
- ***Wellness, Recovery, and Resilience Focused*:** The BHD programs utilize Promotoras to help support the individual(s) and families who want to learn about mental health needs so that they can break the tradition of not talking or speaking about mental health and not accessing treatment services. The BHD programs reflect the cultural, ethnic, and racial diversity of the population the BHD is serving. The trainings, education and support the BHD provides support the Recovery Vision of: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
- ***Integrated Service Experience for Clients and Their Families*:** This program is part of an integrated program with community based organizations, non-profits, schools, government agencies, families and individuals with lived mental health

experience. Individuals and their families can participate in multiple training and education opportunities offered at different locations in the community. Multiple entities are funded by a variety of funding sources are providing services and supports in a coordinated comprehensive manner to individual and their family.

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

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

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

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

The approaches to collect data may include, but is not limited to:
- Participants receive written pre and post-tests at meeting with a single theme or a series of meetings on the same theme; which indicate not only increase of knowledge, but also opportunity for a review of the topic.

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

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

- Programs are offered in Spanish: Research by Brown University in 2002 showed that offering programs in Spanish shows respect for the culture and helps to build trust.
- Programs include a family outreach approach: According to a 2003 report by the national Latino children's Institute, Hispanics and Latinos are more inclined to engage as a family rather than only as adults. This includes multigenerational family members as well. Accommodations are made to engage for care and/or to include children at outreach, community and education and training events.
- Programs utilize cultural differences: Generally, Hispanics and Latinos value family, youth, cultural art, food and music. The programs find ways to incorporate these values in program activities- outreach, community and education and training events.
- Programs provide education opportunities that focus on understanding mental illness and the mentally ill: the programs provide the opportunity to reject/combat stigma as a family and as a community; provides de-stigmatizing activities for community members to participate in; conducts anti-stigma campaigns; involves individuals with lived mental health experience in community activities; and promotes persons recovering from mental illness in educational programs.
- Using indirect methods for collection data: research and experience from Oregon State's 4-H Latino Outreach program concludes that Latinos and Hispanics feel more comfortable working as a group rather than as an individual. Group dialogue and reflection are effective data collection methods. Direct questions to an individual should be avoided. Nevada County has also experienced that a large number of program participants have limited or no ability to read or write in Spanish or English. The Promotoras complete a pre-workshop evaluation that

consists of a group conversation in which questions are allowed to be asked and discussion is encouraged. Through this initial evaluation, the Promotoras gain a sense of the knowledge base that each participant holds; areas of interest and gaps in knowledge can be identified and addressed. At the end of each workshop, the Promotoras conduct an evaluation through informal small group discussions. The purpose of the discussion format is to provide a comfortable atmosphere for participants to express the knowledge that they have gained from the workshop.

**j)** Estimated Number Served Per Year: 260 individuals-estimate number of children 90; Transition Age Youth 10; Adults 150 and Seniors 10 served per year.

**k)** The Estimated Cost Per Person: $250 ($65,000/260 individuals) - does not include County administration costs.

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

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

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

   b) **Indicate how the County will measure changes in attitude, knowledge, and/or behavior related to reducing mental illness-related suicides:** The programs will track:
      - Demographic information of individuals trained.
      - Changes in attitudes, knowledge, and/or behavior related to reducing mental illness related suicides.
      - Referrals to mental health services.

- Finished work product/documents/project as they are created/completed.

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

- Training/workshop participants receive written pre and/or post-tests at meeting with a single theme or a series of meetings on the same theme; which indicate not only increase of knowledge, but also opportunity for a review of the topic.
- The SPI Coordinator may use an informal testing model based on conversation, which provides for honest narrative through a means that is not daunting to the program participant. The SPI Coordinator completes a pre-workshop evaluation that consists of a group conversation in which questions are allowed to be asked and discussion is encouraged. Through this initial evaluation, the SPI Coordinator gains a sense of the knowledge base that each participant holds; areas of interest and gaps in knowledge can be identified and addressed. At the end of the workshop, the SPI Coordinator conducts an evaluation through informal small group discussions. The purpose of the discussion format is to provide a comfortable atmosphere for participants to express the knowledge that they have gained from the workshop. The SPI Coordinator uses a template of questions to gauge the increase in knowledge of their participants. The pre and/or post tests are directly correlated and allow the SPI Coordinator and contracted staff to determine the levels of increased knowledge and awareness of signs of suicidal behavior. Review of the discussion allow for a qualitative analysis of results.
- Written and verbal feedback from training participants and the SPI Coordinator plays an important role in understanding the impact of training for the workshop participants.
- Additionally, the number of people who opened up and asked for help and are referred to the BHD or other mental health service providers is tracked.

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

- ***Community Collaboration*:** Nevada County has formed a Suicide Prevention Task Force. The Nevada County Suicide Prevention Task Force has created a Community Action Plan based on the California Strategic Plan on Suicide Prevention 2008. Membership of the Task Force reflects a broad range of local stakeholders with expertise and experience with diverse at-risk groups. The SPI Coordinator is collaborating with Family Resource Centers, community based organizations, MHSA stakeholders, County government, and representatives from the Latino community, schools, faith based organizations and others.
- ***Cultural Competence*:** This program provides training, education, and support in in Spanish to individuals needing suicide prevention and intervention services. Local bi-lingual and/or bi-cultural Promotoras are trained in suicide prevention, early identification, referral, intervention and follow-up services.

  Training is also provided to service providers providing services to multiple other cultures and groups: primary care; first responders, licensed and non-licensed mental health and substance abuse treatment professionals; youth providers, Veteran service providers, homeless service providers and senior service providers.
- ***Client Driven*:** The program has been developed, implemented and evaluated with the input of survivors of suicide attempts.

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

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

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

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

**l)** Estimated Number Served Per Year: 1,570 individuals-estimate number of children 75; Transition Age Youth 550; Adults 720 and Seniors 225 served per year.

**m)** The Estimated Cost Per Person: $102 ($160,000/1,570 individuals) - does not include County administration costs.

## *G) Programs Being Discontinued*

1) **Activity 1: Integrated Behavioral Health (IBH) Training for Primary Medical Care Providers-**

   **a)** In the Integrated Behavioral Health (IBH) Training for Primary Medical Care Providers training for primary care physicians/medical providers and their staff to screen for mental health issues, how to provide a secured referral or "warm hand off," and how to follow up on individuals that are referred. IBH training can prevent and intervene early with many mental health problems if primary care physicians/medical providers and their staff are able to identify and practice a secured referral with follow up to appropriate resources. This project decreased the disparities in access to services in the community, by screening all who go to their primary care physician/medical provider.

## *H) PEI Technical Assistance and Capacity Building Funds*

These funds have all been expended.

## *I) PEI Funding Expenditures*

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

## *J) PEI Program Costs and Cost per Person*

The estimated cost for 1) Early Intervention programs is $157,500, 2) Outreach: First Responder Training program is $17,500, 3) Prevention Programs is $296,000, 4) Access & Linkage Programs is $200,000, 5) Stigma and Discrimination Programs is $65,000, 6) Suicide Prevention Program is $160,000, 4) PEI Assigned Funds is $5,000 and, 5) Administration $100,000. The estimated PEI program costs are $1,001,000. Using the estimated number served in PEI programs, 10,670 individuals, the BHD estimated the average cost per person involved in a PEI activity will be $93 ($996,000/10,670 individuals). This is the average cost of individuals involved in all PEI Projects. This does not include PEI Assigned Funds.

Note: These are only estimates and the actual cost by program and number served may change affecting the average cost per person. These numbers only reflect the second year of funding, funding amounts will change year to year, changing the number served and the cost to serve those individuals.

## *K) Future Funded Activities*

Activities for the PEI Plan, may include, but not limited to: the expansion of any activities approved in the original PEI Plan and subsequent Annual Updates, including, but not limited to: additional Latino outreach; additional homeless outreach; additional services to seniors; additional or enhanced services to court/law enforcement involved families; juvenile wards at juvenile hall and Foster Care children; services on the San Juan Ridge and Truckee; additional or enhanced jail services for inmates within six months of their release; additional support for at risk children and youth; additional peer support; additional Veterans support, additional contract services for program implementation, planning and evaluation; consultation to primary care clinics; additional Children's System of Care (CSOC) and Adult System of Care (ASOC) services; and psychiatric services.

## *H)MHSA PEI Administration*

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

In FY 2008/2009 the MHSA Coordinator position was expanded. Additionally, in FY 2008/2009 the number of supportive staff was increased and the amount of time supportive staff was dedicated to MHSA PEI activities. In FY 2013/14 a MHSA Evaluator was hired. In FY 15/16 a contracted evaluator services were engaged. The supportive staff included, but is not limited to: the Behavioral Health Director, Adult and Children's Program Managers, Behavioral Health Adult and Children Supervisors, Behavioral Health Workers, Behavioral Health Technicians, Analyst, Administrative Assistant, Administrative Services Officer and Accounting Technicians. All of the above staff is involved in the community planning, implementation, and/or monitoring and evaluation of the MHSA programs and activities. Yearly the benefits of assigned staff will be charged to MHSA PEI.

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

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

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

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

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

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

## *A. Workforce Staffing Support-*

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

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

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

## *B. Training and Technical Assistance-*

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

2. Budget justification:
   a. Training and technical assistance for trainers, materials, consultant fees and conference space. This may include the purchase of curriculum, rental of training facilities, and fees for trainers/content experts. Trainers/content experts are budgeted for training, facility rental, supplies, copying and curriculum.
   b. Teleseminars/webinar including the cost of the copies and general supplies for each session.
   c. Library materials, including books, audio materials, DVD and computerized software.
   d. Nevada County is requesting WET funding to support the continued operation of this Action through the end of Fiscal Year 2016/2017. The cost may include travel, food, lodging, training and technical assistance for trainers, training materials, consultant fees, conference space, incentives, stipends, the purchase of curriculum, rental of training facilities, child care fees, fees for trainers/content experts, cost for teleseminars/webinars, copies, general office supplies to support training needs, library materials which may include books, audio materials, DVD, computers, projectors, computer software, furniture and any other supplies needed to conduct a training or support the lending Library. WET Training and Technical funds may be used to support or in combination with CSS, PEI and Innovation funds. Nevada County intends to provide ongoing support for the WET Component though the MHSA Integrated Plan beginning in Fiscal Year 2014/2015 through FY 2016/2017 or until funds is exhausted.

## *C. Mental Health Career Pathway Programs*

1. Action #3: Mental Health Career Ladder Program
   a. Description: Nevada County is working with the WET Superior Region Partnership who is developing mental health career pathways across the education continuum: working with high schools and linking them to the local community colleges. The MHSA Coordinator works with the WET Superior Region Partnership to help them connect and collaborate with community based organizations, school districts, the Department of Rehabilitation; and with the community colleges to establish a career pathway program that addresses the educational needs of students to prepare them to work in the mental health system. The MHSA Coordinator will collaborate with the WET Superior Region Partnership to outreach, engage and recruit culturally diverse students, including bilingual students to meet the regional needs. The personnel to support this activity are covered under action item #1.
   b. Currently Nevada County has approximately 20 trained and certified WRAP (Wellness Recovery Action Plan) facilitators. WRAP is an evidence-based practice that has the core set of beliefs and practices that promotes a culture of Hope, Personal Responsibility, Education, Self-Advocacy and Support. WRAP facilitators are mentors to others. Facilitators work with other individuals with lived mental health experience/stakeholders one-on-one, in small groups or in larger groups with a second trainer. Nevada County is continuing to support these individuals as they become WRAP leaders in the community. The County is supporting the currently trained WRAP facilitators in the implementation of the program in Nevada County, providing refresher training, and supporting more individuals to become WRAP facilitators.

2. Budget justification:
   a. WRAP Facilitator Program, outreach, support and operating expenses: This may include hosting and paying for WRAP training. Costs may also include the cost to outreach and support WRAP facilitators. These costs may include food and incentives, meeting supplies, training materials, WRAP books, stipends, staff time, computers, computer software, and other items needed to conduct WRAP Training to residence of Nevada County.
   b. Cost associated with the WET Superior Region Partnership Mental Health Career Pathway will be supported under Action #1 and #3.
   c. Nevada County is requesting WET funding of to support the development and implementation of this Action. Funds may be used to support WET Superior Region Partnership process to outreach, engage, and support Sierra College to apply for Superior Region WET funds, which may include staff time, contractor time, stipends, travel, food, incentives and other unknown items at this time, support original WRAP facilitators and additional individuals to be trained in WRAP (WRAP Basics, Refresher WRAP, Advance WRAP, or Train-the-Trainer WRAP), participation in WRAP conferences, support implementation of WRAP in the community which may include, meeting space, food, incentives, stipends, copying, meeting supplies and materials, additional WRAP educational materials (including WRAP books) and other identified items needed during implementation. Nevada County intends to provide ongoing support for the WET Component though the MHSA Integrated Plan

beginning in Fiscal Year 2014/2015 through Fiscal Year 2016/2017or until funds is exhausted.

## *D. Residency, Internship Programs-*

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

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

## *E. Financial Incentive Programs-*

1. Action #5 –Loan Assistance and a Speaker's Bureau
   a) Description: The MHSA Coordinator is working with the Office of Statewide Health Planning and Development (OSHPD) to ensure that eligible Nevada County employees/contractors apply for the Mental Health Loan Assumption Program (MHLAP). The MHLAP increases the supply of mental health practitioners serving in hard-to-fill/retain positions within California's public mental health system by

providing a financial incentive to repay educational debt. The MHSA Coordinator and other staff work with MHLAP staff to design and review the application before it is published, get the application out to staff, ensure that forms that need to be signed by the director are processed by the deadline and answer questions from all parties. This action is funded by action #1.

b) The stakeholder outreach indicated the need to expand program participant and family member involvement in trainings, public meetings and community events, and compensate them for their efforts. A consortium of individuals with lived mental health experience and family members have received additional training, support, and mentorship opportunities to better enable them to speak at various events in the community. This consortium has developed into a group called "Our Voices Matter." "Our Voices Matter" members are now leading the planning and implementation of this program. Stipends are used to acknowledge the value of their work and experience. "Our Voices Matter" program uses a storytelling curriculum to train speakers in development of their skills and to increase their confidence in "telling ones story."

3. Budget justification:
   a) Support the "Our Voices Matter" consortium that is providing the training and the individuals who conduct a public presentation. All engagements and stipends will be coordinated through the MHSA Coordinator. Members will be funded at a rate of $25 to $100 per engagement. This includes child care which will support the speaker's ability to be involved.

   Nevada County intends to provide ongoing support for the WET Component though the MHSA Integrated Plan beginning in Fiscal Year 2014/2015 through 2016/2017 or until funds is exhausted.

## *F. Cost per Person*

The number of individuals served in FY 2013/14 (400 individuals-does not include individuals served by the Intern program) is being used to estimate the average cost per person involved in a WET activity will be $139 (55,500/400). This is the average cost of individuals involved in four of the five WET Projects: Workforce Staffing Support; Training and Technical Assistance; Mental Health Career Pathway Programs; and Financial Incentive Programs. This also includes administration costs of $7,500.

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

## *G. WET Funding Expenditures*

WET funding in Action #1-5 may be used to fund expenditures for all expenditures identified in the Original Three-Year Plan and the past Annual Updates or for activities listed in the MHSA Recommendations of Needed Mental Health Services FY 2014-2017 document, including but not limited to: staffing, professional services, stipends, operating expenses (office supplies, travel and transportation, program participant vouchers, translation and interpreter services, rent, utilities and equipment, etc.), tele/video psychiatry equipment, office furniture, capital purchases, training and education, food and incentives for meetings,

trainings, and the cost of improving the functionality of information systems used to collect and report program participant and program information. Capital purchases for staff and contractors may include the cost of vehicles, the cost of equipping new employees or contractors with all necessary technology (cellular telephones, computer hardware and software, projectors, etc.), the cost of enhanced and/or increased space needs related to services and other expenses associated with activities in this plan.

# *IV. Innovation (INN)*

Nevada County has no active approved Innovation Plans.

# *V) Technological Needs:*

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

# *VI) Capital Facilities*

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

# Nevada County Mental Health Services Act (MHSA) Annual Progress Report for Fiscal Year 2013-2014

## Overall Implementation Progress Report on Fiscal Year (FY) 2013-2014 Activities

***General Nevada County Information:***

Nevada County is a small, rural, mountain community home to 98,764 (2010 US Census) individuals. According to the 2010 US Census a little over 91% of the Nevada County residence identified their race as White. Less than 3% of Nevada County residence identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander. Additionally, less than 3% identified their race as "Other." Lastly, 3% identified themselves by two or more races. Ninety-one point five percent of the population identified their ethnicity as Non-Hispanic or Latino and 8.5 % of the population of Nevada County identified themselves as Hispanic or Latino, thus Nevada County has one threshold language, 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.

---

***MHSA Program Updates:***

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

**Full Service Partners:**

1. **Turning Point Providence Center** provides Adult Assertive Community Treatment (AACT), an evidence-based practice that supports individuals with a severe psychiatric illness at risk of or with a history of psychiatric hospitalization, incarceration, or out-of-home placement. AACT individuals are sometimes homeless, at risk of being displaced from family, jobs, etc. or at risk of losing access to basic needs. AACT is designed to help adults (18 years and older) with a severe psychiatric illness with recovery oriented services and supports. Individuals served may also have a co-occurring substance abuse or medical issue requiring treatment. Services are provided in community, hospital (medical or psychiatric), or correctional facility settings and are available 24 hours a day, seven days a week. Included in AACT services are individuals who may also meet criteria for Assisted Outpatient Treatment, designed for members who, in addition to having a severe psychiatric disability, may have committed an act of violence or made a serious threat of violence (within 48 months of the AOT referral) due to untreated mental illness. Services are grounded in a culturally responsive, respectful manner that fosters independence, self-determination and community integration.

   **Demographics:** In fiscal year (FY) 2013-14 a total of 105 individuals were enrolled into the Providence Center program. Of this total age ranges were broken out into Transition Age Youth, ages 18 to 25 (10.5%, n=11); Adults, ages 26 to 59 (70.5%, n=74); and Older Adults, ages 60

plus (19.0%, n=20). The races served were Caucasian (87.6%, n=92); Hispanic (2.9%, n=3); and African American, Asian, Native American and other (1%, n=1 each). More than half were Male (65.7%, n=69). Clients were predominantly English speaking (87.6%, n=92) with a small percentage of Spanish speakers (2.9%, n=3). Schizophrenia was the primary diagnosis of the majority of individuals served (41.9%, n=44) with Schizoaffective DO (22.9%, n=24) the second highest incident of primary diagnosis. Additionally, the highest frequency of individuals served resided in Grass Valley (72.4%, n=76), the next highest frequency lived in Nevada City (12.4%, n=13), followed by Penn Valley (3.8%, n=4), North San Juan (2.9%, n=3) and finally Rough & Ready (1%, n=1). Clients reported having a variety of cultures including: LGBTQ (n=6), Veterans (n=3), HIV/AIDS (n=2), Homeless (n=19), Disabled (n=3), and Criminal/Legal Issues (n=27).

**Outcomes:**

- Program Discharge: A total of 19 individuals were discharged in FY 13-14. The top 3 discharge settings were "Other" at 42.1%, n=8; Lower Level of Care at 21.1%, n=4; and Unknown Destination at 21.1%, n=4.
- Psychiatric Hospital Days: A total of 573 Psychiatric Hospital Days were reported for 18 individuals (17.1% of total individuals) in FY 13-14. This represents an 84.8% increase over FY 12-13. Eighty-seven individuals (82.9%) accrued zero Psychiatric Hospital Days.
- Jail Days: Jail Days were reported as 921 (a 25.3% decrease from FY 12-13) for 17 individuals (16.2% of total individuals). Eighty-eight individuals (83.8%) accrued zero Jail Days.
- Homeless Days: Twenty individuals (19%) accrued a total of 1,913 Homeless Days (8.2% decrease in days from FY 12-13). Eighty-five individuals accrued zero Homeless Days (81%).
    - Of the 23 individuals who had accrued homeless days within FY 12-13, 20 (87.0%) continued to receive services at Providence Center in the FY 13-14. Fourteen (70.0%) of those 20 individuals were reported as having a decrease in the total number of homeless days accrued. Additionally, 10 of those 14 individuals (71.4%) no longer accrued any homeless days in FY 13-14. The remaining 4 individuals showing a decrease accrued 341 homeless days, or 17.8% of the total 1,913 days accrued within FY 13-14. The remaining 1,572 (82.2%) days were accrued by individuals who had either accrued fewer homeless days in FY 12-13 or were new to Providence Center entirely.
    - Note that only 20 out of the 105 (19.0%) individuals served accrued the 1,913 homeless days in FY 13-14. This shows that a small percentage of the total population is accruing a large percentage of the total homeless days; suggesting the presence of outliers.
    - Overall, 81.0% (n=85) of the individuals served within FY 13-14 accrued zero homeless days, which is a very positive outcome.
- Emergency Interventions: Seventy-three Emergency Interventions were performed on 32 individuals (30.5%). This was a decrease of 22.3% from FY 12-13. Accrual of zero Emergency Interventions applied to 73 individuals (69.5%) in FY 13-14.
- Assisted Outpatient Treatment (AOT) Outcomes: The following outcomes are from data submitted to DHCS for the 40 individuals who were served by AOT in 2013-14.
  *AOT Hospital Days:*
    - There were a total of 495 psychiatric hospital days, of which 124 (25%) were accrued by those who volunteered to receive services and 371 (75%) were accrued by those who were court ordered. A total of 495 psychiatric hospital days were accrued by 14 individuals or 42% of the total 33 individuals observed. The majority of individuals (58%, n=19) did not accrue any psychiatric hospital days in the reporting period.

- A comparison of 12 months' of pre-referral data versus 12 months' of post-referral data, shows a decrease of 575 days or 63.6% post referral hospital days versus pre-referral. Sixteen (84.2%) of the 19 individuals who had accrued hospital days prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Ten of those 16 individuals (62.5%) no longer accrued any further hospital days post-referral.
- In comparing the pre and post-referral data, there was a reported decrease of 220 hospital days or 43.1% for individuals who were court ordered into the AOT program. One individual was an outlier who continued to accrue the majority of the hospital days post-referral (35.9%, n=104).

*AOT Incarceration Days:*

- During the reporting period a total of 151 incarceration days were accrued by four individuals or 12.1% of the total 33 individuals observed. The majority of individuals (87.9%, n=29) did not accrue any incarceration days in the reporting period.
- There was a decrease of 692 incarceration days or 67.8% post referral versus pre-referral. Eight (88.9%) of the nine individuals who had accrued incarceration days prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Five of those eight individuals (62.5%) no longer accrued any further incarceration days post-referral.
- In comparing the pre and post-referral data of only those who were court ordered into the AOT program, there was a reported decrease of 360 incarceration days or 52.4%. One individual was an outlier who continued to accrue the majority of the incarceration days post-referral (89.6%, n=293).

*AOT Homeless Days:*

- During the reporting period, a total of 418 homeless days were accrued by nine individuals or 27.3% of the total 33 individuals observed. The majority of individuals (72.7%, n=24) did not accrue any homeless days in the reporting period.
- There was a decrease of 903 days or 70.3% post referral versus pre-referral. Eight (88.9%) of the nine individuals who had accrued homeless days prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Five of those eight individuals (62.5%) no longer accrued any further homeless days post-referral.
- In comparing the pre and post-referral data of only those who were court ordered into the AOT program, there was a reported decrease of 137 homeless days or 53.9%. Three of the five individuals who reported a decrease in days (60.0%) no longer accrued any homeless days post-referral.

*AOT Emergency Interventions:*

- During the reporting period, a total of 56 emergency interventions were accrued by 14 individuals or 42.4% of the total 33 individuals observed. The majority of individuals (57.6%, n=19) did not accrue any emergency interventions in the reporting period.
- There was a decrease of 29 days or 36.3% post referral versus pre-referral. Six (46.2%) of the 13 individuals who had accrued emergency interventions prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Four of those six individuals (66.7%) no longer accrued any further emergency interventions post-referral.
- In comparing the pre and post-referral data of only those who were court ordered into the AOT program, there was a reported slight increase of 18 days or 100% in emergency interventions. Three of the 5 individuals who reported a decrease in days (60.0%) no longer accrued any emergency intervention days post-referral. Of the 11 individuals who

accrued the 36 emergency interventions, one individual accrued the vast majority of days (41.7%, n=15).

*AOT Milestones of Recovery (MORS):*

- The majority of individuals at the time of their referral were at extreme risk (38.9%, n=7) on the MORS scale. After six months, however, the majority of individuals were coping/rehabilitating (38.7%, n=12). By the end of the reporting period, the majority were continuing to be coping/rehabilitating (40.0%, n=12).

*AOT Consumer Satisfaction Survey:*

- Overall, the AOT program received a satisfaction rating of 72.4% on a scale from 0% – 100%. In a previous reporting of the Consumer Satisfaction Survey outcomes (November 2012 through April 2013), the overall satisfaction rate was 86%. The reasoning for the lowered score within the current reporting period is that only those who were court ordered were surveyed. In the prior report, those who had been referred and those who volunteered to receive services were also included which influenced the overall outcomes.

**Milestones of Recovery (MORS):** The majority of Turning Point clients on average were scored as a five (Poorly Coping/Engaged) (35.4%, n≈31.6) or as a six (Coping/Rehabilitating) (27.6%, n≈24.5) on the eight category MORS recovery scale.

2. **New Directions Program** in Nevada County Behavioral Health Department is a lite AACT program, which serves individuals with severe, persistent mental health issues and accompanying challenges to daily living. The program facilitates consumers transitioning from county services to independence and community living. Consumers in the following age categories were served in FY 13-14: five Transitional Aged Youth (18-25 years), 50 Adults (26-59) and 19 Older Adults (60 years and above). The New Directions team maintains a strong commitment to providing services which include Supported Independent Living, Supported Employment, educational and therapy groups, individual therapy and WRAP (Wellness Recovery Action Plans). During the FY 13-14 New Directions provided services to 74 consumers across the three age categories.

**Demographics**: Of these 74 participants served in FY 13-14, 48.6% were female and 51.4% were male. Of the total individuals served 98.23% were Caucasian, 0.27% were Asian, 0.30% were Hispanic/Latino and 0.39% cited multiple races. The primary language of 99.81% of participants was English while 0.19% spoke Spanish as their primary language.

**Service Intensity**: During the FYI 2013-2014 service intensity varied by individual for the 74 participants served. The focus of increased services across all age categories is to decrease hospitalization by utilizing intense case management, temporary placement at Odyssey House transitional home, medication caddy services and daily delivery support in partnership with Turning Point and nightly calls to the most high risk consumers. Comparing the year before partnership to the second year of receiving services through New Directions, the number of clients in a Psychiatric Hospital decreased from nine to one, and the number of Psychiatric Hospitalization days decreased from 162 to 11 days.

**Program Options:**

***Housing:***

- *Self-Sufficient Support ($S^3$)* - Residents who are successfully capable of living independently with minimal support are classified as "self-sufficient." These participants receive support

on an "as needed" basis from Personal Service Coordinators (PSC). The residents are able to handle and problem solve most basic daily situations of independent living. Comparing the year before partnership to the first year of receiving services through New Directions, the number of clients in Independent living situations increased from 33 to 39, and the number of Independent living days increased from 10,454 to 10,881 days. Also, comparing the year before partnership to the second year of receiving services through New Directions, the number of Homeless days decreased from 355 to 272 days.

- *Supported Independent Living (SIL)* - Residents need regularly scheduled support to remain successful in independent living. Identified shared houses are supported by Nevada County Behavioral Health in the following manner:
  - Deposits are paid by MHSA flex funds.
  - If a room is vacant, MHSA funds are used to pay the monthly rent to maintain stability of the house until residents can locate a new housemate.
  - A "basic needs" list for residents is created by staff and obtained by either clients' resources, donations and/or MHSA flex funds.
  - PSCs provide support with medication, housemate conflict resolution, money management skills, paying bills, meal planning, budget planning, shopping, leisure skill planning and other daily living skills.
  - PSCs work with landlords to ensure support for both the resident and the landlord.
- New Directions continued support for the six SIL (Supported Independent Living) houses, housing 15 people.
- Housing was provided for 23 homeless people who struggled with severe and persistent mental illness using subsidies from the HUD Supported Housing Program grants. This included Winters' Haven house and scattered sites in the Summer's Haven Project. See MHSA Housing section of this report for more details
- *The Catherine Lane House (a joint venture with Turning Point)* - The Catherine Lane House offers 24/7 support services to support residents with challenges to their independent living skills. This non-licensed house includes a focus on single room occupancy that facilitates residents in achieving their maximum level of independence. This house enables residents to live independently and keep their current community support network intact. In FY 2013-2014 the New Directions Program had one participant living at Catherine Lane.
- *The Willo House*- The Willo House is a program which provides intensive support services for participants who are on conservatorship or in need of one or more staff contacts per day. This setting provides participants an opportunity to live in the community with greater independence than an IMD (Institute for Mental Disease) or Board and Care. The Willo House is a three bedroom unit. In FY 2013-2014 the New Directions Program housed three participants in Willo House.

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

***Employment/Volunteer Employment:***

- *Snack Shack* - Vocational training is available through the Snack Shack program. The Snack Shack program is a collaborative effort between NAMI, the Behavioral Health Department and Consumers. It is a consumer driven retail program providing vocational skills and structure. Participants learn customer service, cash register skills and team building. Management of the program is provided by consumers and a consumer with bookkeeping

experience balances the receipts. In FY 2013-2014, 13 participants volunteered to work in the Snack Shack program for a total of 1,156 hours.

- *Peer Counseling Training* - Peer Counseling Training is an eight to ten month program where consumers develop skills to counsel and support peers. The goal of the counseling 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 counseling session. The training offers two outcomes: 1) a certificate of graduation or 2) a certificate of participation. Consumers are then introduced to volunteer opportunities in the community. In FY 2013-2014, 13 participants completed Peer Counseling Training and within the graduates of the program:
  - Five participants took the training for personal enrichment.
  - One participant is working at the Emergency Department.
  - Seven participants are applying for Respite Center position.

  Peer counseling challenges continue. As peer counseling continues to expand, so does the need to find paid or volunteer community placements for program graduates. Ongoing outreach to community based agencies and groups' continues to be needed to provide options for graduates to utilize their skills. Additionally, once a Peer counselor has a paid or volunteer position in the community they typically need intermittent support. Staff time is needed to develop peer counseling jobs and to support individual in the field working.

***Supportive Services:***

- *Weekly Groups:*
  - Healthy Living - Healthy Living courses provide education to consumers and healthy options for independent living. Choices include coping and time management skills; nutrition, social and budgeting skills; leisure and development of Wellness Recovery Action Plans (WRAP) and social activities based in the community.
  - Saturday Adventure Outings - Saturday Adventure Outings serve high risk consumers who have a history of being isolated on weekends. The goal of the program is to engage these individuals socially with other peers that result in decreased symptoms of mental health issues and increased quality of life. The consumers organize the adventure and determine the activities each week. A peer staff member and an MFT intern trainee provide transportation utilizing Behavioral Health vehicles. The staff also provides counseling and referral services during the program. This creative solution has enabled the consumers to access social interactions through activities they determine. In FY 2013-2014 the New Directions Program had 20 participants in the Saturday Adventure Outings program. The lead therapist/program team coordinator provided qualitative data in collaboration with the larger Behavioral Health clinical team indicating that this program had a direct role in reduction of symptoms and the need for more intensive services for program participants.
- *Therapy Support and Service Coordination:*
  - Therapy services are provided by interns through the intern program. The program offers an opportunity for interns to be trained in the mental health field while offering services to consumers who might otherwise wait or not receive individual therapy services. The long term benefit is quality services for the consumer and the training of a new generation of clinicians who have developed skills which they will bring to a variety of community based settings.

- The Interns are individuals in the process of completing or who have completed their Master's degree in psychology, sociology or a related field. Supervision is provided by a licensed therapist with the New Directions Program.
- Program treatment options range from service coordination to providing mental health rehabilitation including medication delivery.
- Individual and group therapy provides consumers the opportunity to further their goals of developing healthy life options, including choosing the abstinence or harm reduction model for recovery from substance use disorders as a component of their co-occurring disorder.

- *After Hour Services* - Nevada County is a small county and resource availability within the Behavioral Health Department is limited given budget constraints. In order to meet the criteria of 24 hour/seven day a week services, the following adjunct supports have been developed for holidays, weekends and overnight coverage. Consumers have use of the 24 hour crisis line of Nevada County Behavioral Health as a contact resource. They have the further option of requesting contact with the program team coordinator or designee alternate for support in managing critical issues through the crisis line. For consumers in New Directions utilizing daily medication deliveries, service coordinators from Behavioral Health make weekday morning deliveries. Through a partnership with Turning Point Providence Center, medication delivery services are provided at night, on weekends and holidays. During FY 2013-2014, nine daily medication caddie deliveries were made in collaboration with Turning Point for night and weekend coverage.

**Outcomes:** Notable community impact is reflected by program outcomes measuring:

- decreased hospitalizations (listed above),
- decreased legal issues (11 individuals with arrests prior to partnership, decreased to four partners with arrests during the most recent partnership year),
- maintained or increased independent living (listed above) which reduces the impact on community based homeless resources (decreased homelessness listed above),
- focus on medication compliance, nutrition and physical health to reduce utilization of emergency room services (26 individuals with emergency room visits before partnership, decreased to seven partners during the most recent partnership year).
- The employment program provides enrolled consumers with additional resources which they spend locally and thereby are financially contributing members of the local community.

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

**Service Delivery Data**

**Demographics:** For the 2013-2014 year, 126 unduplicated clients were served at VCSS Grass Valley. Forty percent of the clients were female and 60% male. The prevalent age ranges for clients were 13-18 (58%) and 6-12 (35%). The primary ethnic backgrounds of clients were

Caucasian (82%), American Native or Alaska Native (7%), Other Ethnicity (4%) and African American (3%). English (100%) was the primary language of the population served.

**Referrals:** During this fiscal year 2013-2014, 58 clients were referred for mental health services. Of the 58 clients referred, 55 (95%) clients completed the intake process and were opened to services. Referral sources were Nevada County Behavioral Health (81%), Child Protective Services (13%) and Nevada County Probation (3%).

**Intake Diagnoses:** During the intake process for the 55 clients, the primary mental health diagnoses were Posttraumatic Stress Disorder (19%), Mood Disorder NOS (15%) and Attention Deficit and Hyperactivity Disorder (11%).

**Service Intensity:** The discharged clients in the 2013-2014 year had an average length of stay of 16.96 months. Of the clients discharged, 4 had lengths of stay over 1,000 days. The Average Length of Stay analysis was conducted after removing these outliers. The ALOS for the remaining 33 clients is 13.47 months.

**Client Outcomes**

**Treatment Goals Achieved:** For the 2013-2014 fiscal year, 37 clients were discharged, with 11 clients graduating from treatment services. The remaining clients were discharged for various reasons including: parent/client declined further service (15); client moved (6); family elected other provider (2); client did not meet medical necessity (1); group home placement (1); and out-of-county placement (1). Five clients (13.5%) met the criteria for Insufficient Services Duration (ISD), which is determined when a client is not involved in treatment for more than 60-days from admission. During 2013-2014, it is important to note that 21 of the 37 (57%) discharged clients were discharged due to unexpected circumstances which included parents/clients declining further services and clients moving out of the area.

**Hospitalization and Juvenile Hall Stays:** Of the 126 clients served during the reporting period, 1 client was hospitalized and 10 clients experienced a juvenile hall stay.

**Nevada County Goals:**

*Goal #1: To prevent and reduce out- of-home placements and placement disruptions to higher levels of care.* In this fiscal year, 98% of youth served avoided a higher level of care, and remained in a community living situation.

*Goal #2: Youth will be out of legal trouble.* In this fiscal year, 93% of youth served had no new legal involvement while receiving services.

*Goal #3: Youth will improve academic performance.* In this fiscal year, 73% of youth served improved their academic performance.

*Goal #4: Youth will attend school regularly.* In this fiscal year, 71% of youth served attended school regularly.

*Goal #5: Youth will improve school behavior.* In this fiscal year, 88% of youth served improved in their school behavior.

*Goal #6: Caregivers will strengthen their parenting skills.* In this fiscal year, 93% of caregivers indicated they felt their skills, self-confidence, and/or knowledge in parenting had increased during participation in the VCSS Grass Valley program.

*Goal #7: Every child establishes, reestablishes, or reinforces a lifelong relationship with a caring adult.* In this fiscal year, 88% of youth served reported a high level of relationship permanence as reported on the CANS.

*Goal #8: Caregivers will improve connections to the community.* In this fiscal year, 73% of parents reported increased confidence in parenting and connections to natural supports.
*Goal #9: Youth and families will improve functioning.* In this fiscal year, 88% of youth/families reported no major issues with family conflict on the CANS at planned discharge.
*Goal #10: Contractor will attempt initial contact with youth and caregiver within 3 business days of receipt of referral.* In this fiscal year, newly referred families were contacted, on average, within 3.95 business days.
*Goal #11: Contractor will have face-to-face contact with 60% of children and families within 10 working days of receiving the referral.* In this fiscal year, 77% of newly referred families were seen in person within 10 business days of the referral. The average number of business days for face-to-face contact was 10.6 days.

**Satisfaction Survey Results**
VCSS Grass Valley was highly rated in the areas of efficient response time to questions and/or concerns and overall satisfaction with services. Staff were viewed as professional and helpful, and clients felt their culture was respected and valued. Furthermore, VCSS Grass Valley was highly rated as being utilized for future mental health services (100%). Areas that are being addressed for continuous quality improvement are maintaining a collaborative approach to treatment/service planning, appointments and meetings and ensuring that initial contacts are within the 3 and 10 day expectations.

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

**Demographics:** During the July 2013 to June 2014 period, 38 youth were admitted, 30 youth were discharged, and 89 total youth were served, a majority of whom were male (63%), between the ages of nine and 14 (54%) with an average age of 11 years old at admission. Caucasians made up 80% of clients with Latinos at 9% and Multi-Ethnic clients at 6%. The most common diagnoses at intake were Attention Deficit Hyperactivity Disorders (ADHD) at 23%, followed by Adjustment Disorders at 17% and Post Traumatic Stress Disorder (PTSD) at 14%. Most youth were living with an adoptive or birth parent (91%) at admission, while some (6%) were in Foster Care.

**Service Intensity:** For the 250 youth served since the inception of the Nevada County Wraparound Program, an average of 16 service hours were provided to each youth, each month. For the 89 youth served during the FY 13-14 period, an average of 10 service hours per youth per month was provided and the range of Medi-Cal service hours was 0 to 53.46 hours per child, per month.

**Community Responsiveness:** For youth admitted since July 1, 2013, 84% received an initial contact within three business days of receipt of the referral. Fifty-eight percent received face-to-face contact within ten business days of receipt of the referral.

**Outcomes/Successes:**

- **Length of Stay** - Since inception, the average length of stay, for the 175 youth who were enrolled for 60 days or more, is 13 months. For youths discharged during the July 2013 to June 2014 timeframe, all 30 youth had a length of stay of 60 days or more, and had an average length of stay of 18 months.
- **Pro-social Behavior** - Since 2011, 78 matched pair intake/discharge Child and Adolescent Needs and Strengths (CANS) tool were available to analyze. Sixty-three youth (81%) improved in at least one domain based on the Reliable Change Index (RCI). During the July 2013 to June 2014 timeframe, 100% improved in at least one domain based on the RCI.
- **In Home or Foster Care** - Since inception, 85% of youth who participated in the Nevada Wraparound Program for at least 60 days were stabilized at home or in foster care at discharge. During the July 2013 to June 2014 timeframe 86% of youth were stabilized at home or in foster care at discharge.
- **School Attendence** - Eighty-seven percent of discharged youth maintained regular school attendance or improved their school attendance during participation in the Nevada County Wraparound Program since inception. During the July 2013 to June 2014 timeframe 95% of youth maintained regular school attendance or improved.
- **School Behavior** - Eighty-four percent of discharged youth had no suspensions or expulsions in the three months prior to discharging since 2011. During the July 2013 to June 2014 timeframe, 91% of youth had no suspensions or expulsions in the three months prior to discharging.
- **Academic Performance** - Seventy-seven percent of discharged youth maintained passing grades or improved their academic performance during participation in the Nevada County Wraparound Program since 2009. In the July 2013 to June 2014 timeframe, 75% of youth maintained or improved their academic performance.
- **Legal Trouble** - Since 2011, 84% of discharged youth had no arrests, probation violations, or days spent in custody in the three months prior to discharging. During the July 2013 to June 2014 timeframe, 95% of youths had no legal trouble in the three months prior to discharging.
- **Relationship** - Since 2008, 71% of discharged youth have established, reestablished or reinforced a lifelong relationship with a caring adult while participating in the Nevada Wraparound Program. During the July 2013 to June 2014 timeframe, 76% of youth established, reestablished or reinforced lifelong relationship.
- **Caregiver Self-confidence in Parenting** - From January 2010 to June 2013, 82% of caregivers indicated they felt their skills and self-confidence in parenting had maintained or increased during participation in the Nevada County Wraparound Program. During the July 2013 to June 2014 timeframe, 60% of caregivers reported that they learned new skills while participating in the program.
- **Families Connecting to Natural Supports** - Since 2009, 73% of youth and families maintained or improved the number of natural supports at discharge, while 63% of youth and families maintained or improved natural supports during the July 2013 to June 2014 timeframe.
- **Discharge** - Since inception, 59% of youths with a length of stay of 60 days or more, were discharged from the program because they met their treatment goals. For the 28 youth who discharged during the July 2013 to June 2014 timeframe, and had a length of stay of 60 days or more, 64% were discharged because they met their treatment goals.

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

## *General System Development:*

1. Expand the **Intern Program** service capacity, increase access, and broaden services in Western Nevada County and in Truckee. Interns are funded through both Plans. See Workforce Education and Training (WET) below.

2. Nevada County Behavioral Health has licensed therapists, **Network Providers,** who work in the community at private offices, who see children, Transition Aged Youth (TAY), adults and older adults that NCBHD refer to them. Nevada County Behavioral Health refers clients with lower needs to the Network therapists. These are individuals who do not appear to need medication and a lot of case management. Network providers help to serve more individuals and offer to the individuals and families served a variety of specialties and locations that NCBHD would not be able to offer otherwise. Network Providers provided services to 351 individuals (192 individuals under age 16, 50 TAY, 103 adults and six adults over age 60). Network providers are funded under both of the CSS plans.

3. **Nevada County Behavioral Health (NCBH) Children's** staff provided services to 71 children with MHSA CSS funds in FY 2013-2014. Some of the children were being wrapped with Full Service Partner (FSP) providers. Some of these children continue to see NCBH staff individually and work with the wrap team.

   **Demographics:** Fifty-five of the children seen in FY 13-14 were ages 0-15, 16 of the children were Transition Aged Youth (TAY), ages 16-24. Fifty-six of the children were Caucasian, with four being Pacific Islanders, three Native Americans, five reporting multiple races/ethnicities and three reporting other. The primary language spoken by most of the clients was English (n=69), with two Spanish speakers. Three of the children were reported to have disabilities.

4. **Nevada County Behavioral Health Adult's** staff provided services to 105 individuals in FY 2013-2014 with MHSA CSS funds.

   **Demographics:** Eighty of the clients seen in FY 13-14 were adults ages 25-59, five were TAY ages 16-24 and 20 were older adults ages 60+. Eighty-four clients were Caucasian while two were Asian, two were Native American, six claimed multiple races/ethnicities, two were unknown and nine reported other. The primary language of 101 of these clients was English, while three clients primarily spoke Spanish and one was listed as language unknown. There was one veteran, five homeless clients, 13 clients with disabilities and 10 Latino/Hispanic clients.

5. The **Sierra Family Medical Clinic (SFMC)** provides therapy one day a week to underserved children, adolescents, adults and older adults. Therapy includes solution-focused, cognitive behavioral therapy, and other modalities that are evidenced-based/promising practices utilizing motivational enhancement/motivational interviewing counseling styles and techniques. A care

coordination is provided to high-need behavioral health patients to assure that care is patient-centered. Individuals with mental health conditions can have challenges prioritizing concerns when seeing a medical provider due to focusing and concentration difficulties. Providers may have a limited amount of time to address concerns in one appointment. The BH care coordinator meets with individuals to assist with this process and develop a multi-visit plan so that the client feels heard and valued. Connection with other community services is continually developed and supported so that clients can access services in accordance with their abilities.

**Demographics:** In fiscal year 13-14, 232 unduplicated individuals were served by SFMC. Seven children and youth (ages 0-15), ten transition aged youth (ages 16-24), 157 adults (ages 25-59) and 58 older adults (ages 60 plus) were served. Most individuals were Caucasian (n=223), however, four Latino/Hispanic, two African Americans, one Asian, one Native American and one multi-ethnic individual were also served. All individuals spoke English as their primary language. Alternative cultures such as: Lesbian, Gay, Bi-sexual, Transgender, Queer (n=2); Veterans (n=7); Homeless (n=10); Disabled (n=76); Criminal/Legal System (n=7) and Domestic Violence (n=15) were seen through SFMC as well. Additionally, the program provided Outreach and Engagement services to 189 individuals.

**Barriers/Challenges:** Challenges are primarily addressing the needs of individuals with serious mental health conditions who require more intensive support than is possible through the clinic. Some individuals have chronic mental health conditions that can be debilitating and for whom sufficient care management is not available.

Another significant challenge is transportation for individuals on Medi-Cal only, who are reluctant to change to managed care Medi-Cal in order to receive transportation to medical appointments. The ability to receive assistance for other areas of support such as food can also be impeded due to lack of public transportation in the area.

A recurring challenge is the ability to help individuals find affordable housing; some people live in substandard housing, crowded conditions and have poor transportation.

**Outcomes:** Participants report through anecdotal and satisfaction surveys over 95% satisfaction with the services provided. Surveys indicated improved overall health (90%), reduced anxiety levels/decreased stigma of mental health issues (95%), and decreased reliance on emergency services by NCBH Crisis Staff (80%).

6. **Community Recovery Resources (CoRR): Co-Occurring Disorders (COD) Program, Adolescent Services and Co-Occurring Disorders (COD) Program Adult Services** provide services to people struggling with concurrent issues of substance use and mental illness, with program components for both adults and adolescents. The adolescent component also specializes in services to youth in YES Court (Youth Empowerment System, formerly known as Juvenile Drug Court). Co-Occurring Disorders services are an integration of both mental health and substance use treatment. Services are recovery-oriented and driven by the unique needs and strengths of individuals. They are community based, family-centered and culturally relevant. Services include case management, an individualized myriad of rehabilitative life skills development and therapeutic interventions such as mood management and trauma work. The program is based on a COD best-practices model within a recovery-oriented system of care and employs evidenced-based approaches in an integrated manner within COD specific treatment stages to address and promote mental health and substance use disorders recovery. All COD

program services are provided by a multidisciplinary, integrated treatment team that functions within a framework of intensive provider collaboration both internally (within CoRR) and externally (within the greater system of care including EMQFF, Victor Services, Behavioral Health, Probation, Courts, Child Protective Services, etc.).

**Demographics:** Twenty adults were served in FY 2013-2014, with nine current active adults as of 7/30/2014. There were six family members served in association with services to these clients. Four adult clients completed the program this year by meeting their treatment goals and eight adult clients' ended services due to relapse, incarceration, withdrawal or non-participation.

Twenty-three youth were served in FY 2013-2014, with 14 current active youth as of 7/30/2014. There were 14 family members served in association with services to these clients. Six youth clients completed the program this year including two YES Court completions and eight youth ended services due to transfer of provider, MIA, relocation, placement, withdrawal and termination from YES court or transportation barriers.

**Barriers/Challenges:** In the past few months, CoRR, a non-profit organization, has lost several excellent COD team staff to local agencies that offer higher salaries and robust benefits packages. The staff members that have had to move on expressed deep chagrin with their decision, which was based on economic need.

**Outcomes/Successes:** CoRR used a variety of outcome measure tools in treatment this year including URICA 'Readiness To Change'- Stage of Change Assessment, Quality Of Life Client Outcomes, System Outcomes, SNAP (Strengths, Needs, Abilities, Preferences), Individualized Service Plans and BASIS-24. Specifically with regard to the BASIS-24, overall Scores show a clear decrease in all areas except one: Relationships. The decreases were in the areas of Depression/Functioning (scores went from 2.14 down to .90), Self-Harm (scores went from .49 down to 0), Emotional Liability (scores went from 2.40 down to .70), Psychosis (scores went from 1.36 down to .30), Substance Abuse (scores went from 1.92 down to .64) and the BASIS-24 Overall (scores went from 1.79 down to .84). The increase in relationship difficulties (scores went from 1.22 up to 1.84) is a known phenomenon in substance misuse/addiction treatment, regarding the radical change that one individual's recovery may have on his/her significant relationships, as addiction is a family disease. The first year of addiction recovery is often cited as the most difficult period of time in recovery for most and relationships can be challenging in early recovery.

The program also found a volunteer evaluation team to implement the Integrated Treatment Fidelity Scale to evaluate the success of the implementation of the SAMHSA EBP Model for Co-occurring Disorders, over the first three years of the program. The evaluation included both a General Organizational Index, and an Integrated Treatment Fidelity Scale. The results yielded valuable feedback that was then turned into improvement plans. It also highlighted the challenges faced by a program implementation that is not supported by healthcare 'system wide' integration.

7. **MHSA Crisis Worker Position and Crisis Support Team** services provide a crisis worker position onsite at the Behavioral Health office 8am to 5pm during normal weekday hours. Also provided is a crisis support position for afterhours including weekends and holidays. These services are exclusive to western Nevada County. Funding sources used to support these Crisis

Services included Medi-Cal, Senate Bill 82 Triage Grant, 1991 Realignment funds, MHSA-CSS funds.

In May, 2014 SB 82 grant funds were used to add a Crisis worker position to staff the local hospital's emergency department 24 hours a day, seven days a week. In FY 13-14 MHSA Crisis Workers had face-to-face contact with 614 individuals. Services were provided on site at the Crown Point facility. Those services included: Crisis Intervention; 5150 Assessment; Collateral Support; and collaboration with family, behavioral health staff, and other support providers. Consultation with law enforcement, the hospital, and community service providers also occurred. Phone contacts with unduplicated consumers came to 519. Those contacts provided brief crisis support, assessment and linkage and referral services. The Crisis workers also provided crisis services to individuals in county jail. In FY 13-14 982 unduplicated individuals were served by the Crisis Support Team.

8. **ED Crisis Peer Counselor Program (SPIRIT ED)**, SPIRIT's 5150 Emergency Department Program, has been funded for extended hours. Crisis Peer Counselors (CPCs) are available for 10 hours a day, 7 days a week. The Sierra Nevada Memorial Hospital Emergency Department is grateful that SPIRIT is there and feels the CPCs are making a difference. Crisis Peer Counselors and Team Leaders work closely together to support each other on any challenges that may come up during their shifts supporting community members in crisis.

**Demographics:** The SPIRIT - ED Program completed its first full fiscal year as of June 30, 2014. The program served 247 unduplicated clients in their first year, most of whom were Caucasian adults.

**Outcomes:**

- On March 5, 2014 coverage increased by four hours a day with CPCs on call from noon to 10 pm daily.
- After the SPIRIT – ED management team met with the Crisis Team in February 2014 to discuss logistical changes related to Crisis Workers being present at the hospital, the number of referrals increased by 400% over the previous quarter. This increase in referrals continued into the fourth quarter.
- In FY 13-14, at least 32 individuals seen at the ED became SPIRIT Center participants. Often, the ED Peer Counselors act as volunteer Peer Counselors at the SPIRIT Center to maintain the relationship and rapport they established with someone at the hospital.
- In FY 13-14, follow-up contact was made with 32% of people served at the ED and/or referred by the Crisis Team. Twenty percent refused contact, 23% were unavailable by phone, and 11% received calls, but did not return them. Approximately 6% of the individuals served and/or referred did not give permission for contact.
- During the 4th quarter, SPIRIT-ED staff received HIPAA training from Mali Dyck, Nevada County HIPAA Compliance Officer.
- Staff also participated in a day long training on Motivational Interviewing from a Working Well Together training consultant.
- CPCs and Team Leaders work together to build a collective knowledge base about community resources. In the upcoming fiscal year, FY 14-15, representatives from various community agencies will be meeting with CPC staff to provide more information and answer questions about services offered. SPIRIT CPCs continue to receive accolades from the Crisis Team and hospital staff, but most importantly from the individuals they serve.

9. **Welcome Home Vets (WHV)** provides a portion of Nevada County's veteran population with mental health services not provided by the Veterans' Administration (VA). Although those afflicted by combat-related Post Traumatic Stress Disorder (PTSD) are treated locally through a contracted VA provider, at the time of the original contract those veterans were required to go to Auburn or Reno for continues treatment once they received a disability rating for PTSD from the VA. Rather than go out of the county to see a new therapist and join a therapy group with which they were not familiar, most vets would discontinue treatment. WHV was initially formed for the purpose of keeping those veterans involved in the treatment they needed, and to do so locally. The CSS contract has been a major factor in funding that ongoing treatment, thus ensuring that some veterans who are at a high risk for suicide, involvement with the legal system, divorce and psychiatric hospitalization received the help they needed.
**Demographics:** In FY 13-14, WHV served 41 individuals including one Transition Aged Youth (16-24 years old), eight Adults (25-59 years old) and 32 Older Adults (60 + years old). Of those individuals the primary Race was Caucasian (36 individuals) and the primary language was English. Thirty-four of the individuals served were Veterans.
**Barriers/Challenges:** As the fiscal year ended, there was a change within the VA that allowed those veterans being treated under VA funding to remain under that funding umbrella with their local provider. However, WHV had also determined that there were a number of veterans in Nevada County whose trauma, although incurred in the military, was not related to being in combat. Those veterans were, and still are, not eligible for treatment in the county through VA funding. Yet they are often just as disabled by their PTSD and other diagnoses as the combat vet. WHV has been adding those veterans to the target population as funding has been available, both through donations, fundraising and other short-term grants. During next fiscal year (FY14-15) WHV will serve those non-combat veterans as the VA is continuing to fund treatment for combat veterans within the county.
However, there is still a pressing need to continue treatment of families of those veterans who have PTSD, a need which has been met for the past three years by the MHSA/INN contract. That contract expired on September 30, 2014, and is not renewable. Fortunately, WHV will be providing services to family members as well as veterans. Even though combat veterans are now going to be funded through the VA, WHV still has a waiting list of families and of non-combat veterans who need services. WHV continues to seek other funding sources to cover this population.

**Outcomes/Successes:** During FY 13-14, WHV has been successful in reaching more veterans than ever before. In addition, the ability to discharge veterans from psychotherapy to peer-facilitated support groups has added another dimension to the program, a further move towards a recovery-oriented program instead of a strictly "therapist provides the help" kind of program. However, there is still a reluctance on the part of many vets to move out of a group they know to an unknown situation. Unfortunately, although the therapists verbalize support for the program, they tend to empathize with the stress expressed by their clients and therefore don't highlight peer support as a growth step for vets. WHV is gradually seeing a change in this thinking by the therapists and continues to educate them on a recovery model; a model that fits the needs of this chronically disabled population quite well. As clients begin to achieve some of the goals they set, especially goals in the area of relationships with others, they become less dependent on the paid therapist and are able to engage in more social activities with peers – something many have not done since leaving the military.

With the advent of an outreach program funded through the Veteran Service Office (VSO) via MHSA funds, WHV is able to attract an even greater number of Nevada County veterans into treatment.

10. **MHSA Housing** includes:

**Winters' Haven:** Nevada County Housing Development Corporation (NCHDC) purchased a five bedroom house in Grass Valley in October 2011. NCHDC renovated the house in FY 2011-2012. The first tenants moved into the House in December 2012 and by June 2013 the house was full with five tenants. The Behavioral Health Department applied for and received Housing and Urban Development (HUD) Continuum of Care (CoC) grant to support the tenants with housing vouchers.

For FY 13-14 Winters' Haven had a total of eight tenants in the year; five males and three females. Ages of tenants varied: one was 18-24, three were 25-34, one was 35-44, two were 55-61 and one was 62+. All the tenants were non-Hispanic and six were White, one was Black or African-American and one had multiple races. Three individuals came from Emergency Shelters; four came from a place not meant for habitation and one person transferred over from another housing program. All eight tenants had physical and/or mental health conditions at program entry: all had a mental illness; one had alcohol use issues; three had drug use issues; and one had physical disabilities. All eight tenants had a source of income at the end of the fiscal year. The four individuals leaving the home had SSI and/or SSDI at program exit. The four remaining had SSI or General Assistance. Three of the four individuals exiting the program exited to other permanent supported housing or with family members, one person exited to an emergency shelter. Lastly, seven of the eight tenants (87.5%) were housed for six months or longer.

Winters' Haven had its first California Housing Finance Agency inspection and the inspection resulted in no negative findings.

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

In FY 13-14 the SHP vouchers were utilized by 16 households consisting of 19 individuals. There were nine adult males and nine adult females enrolled in the program and one male child. The ages of the individuals in the program were: one individual under the age of five and the rest ranged in age from 18 to over 62 years old. All individuals were non-Hispanic. The Race of the tenants was: 15 white, one Black or African-American, one American Indian or Alaska native, and two had multiple races. Most of the tenants had physical or mental health conditions: 17 had mental illness, one had alcohol use issues, four had drug use issues, and three had a physical disability. The residence prior to program entry varied: four from emergency shelters, 13 from a place not meant for habitation, and one from another permanent supportive housing program. One program participant served in the military. All tenants had a source of income except one. Sources of income included SSI, SSDI and General Assistance. All three households who left the program in the fiscal year left for a permanent housing situation. All 19 program participants were enrolled in the program for at least 6 months (housing stability measure).

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

**Home Anew:** The Behavioral Health Department submitted an application to HUD for three additional housing vouchers for chronically homeless individuals with a serious mental illness diagnosis. At the end of the fiscal year it was still not known if the county would be granted the award from HUD. In FY 14-15 the Behavioral Health Department learned that they would be funded for two vouchers.

**Housing Choice Vouchers (HCV) (formally known as Section 8):** The Housing Choice Vouchers waiting list opened for the first time in five years. The Nevada County Continuum of Care (NCCC) worked to educate service providers on how to complete the HCV Pre-Application. The Personal Service Coordinators from Behavioral Health and contracted service providers helped program participants complete the HCV Pre-Application form. Many Behavioral Health and contracted service provider program participants were placed on the Housing Choice Voucher wait list.

**Homeless Count January 2014:** A Homeless Shelter Count was conducted for the night of January 27, 2014 for individual in Emergency Shelters and Transitional Shelters (sheltered). The count showed that there were 94 individuals homeless that night, 89 individuals in Emergency Shelters and five individuals in Transitional Shelters. The ages of the homeless individuals were: 28 under the age of 18, five individuals between the ages of 18 and 24, and 61 individuals over the age of 24. The genders of the participants were: 38 females and 56 males. The Ethnicity of the individuals was 67 Non-Hispanic/Non-Latino and 27 Hispanic/Latino. The Race of the sheltered individuals was: 76 White, two Asian, 11 American Indian or Alaska Native and five had multiple Races. There were 22 (33.3%) individuals who were chronically homeless (homeless for a year or longer or had four instances of homelessness in three years). Other Homeless populations: adults with a serious mental illness 19 (28.7%); adults with a substance use disorder 11 (16.6%), survivors of domestic violence 23 (34.8%), and Veterans 8 (12.1%).

**11.** In order to apply for and receive Homeless Continuum of Care (CoC) funding, the United States Department of Housing and Urban Development (HUD) requires that a community establish an effective Homeless Continuum of Care. Nevada County is a member of the **Nevada-Placer Continuum of Care (NP CoC)**. **Nevada County Coordinating Council (NCCC) to End Homelessness** is one of three regional groups that provides feedback, support and information to the NP CoC. The other two regional groups are located in Tahoe Truckee and in western Placer County. The Behavioral Health Department is an active member of the NP CoC and NCCC.

In FY 13-14 NP CoC filed for and became a 501(c)(3) designated non-profit as required by HUD. NP CoC became the Homeless Resource Council of the Sierras (HRCS).

**Outcomes/Successes:** MHSA funds are used to help support the CoC Coordinator. The HRCS Coordinator in FY 13-14 completed the following:

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

- Summer's Haven: This permanent supportive housing program will be funded annually at $108,803 to provide 13 housing units for individuals with severe mental illness enrolled in an MHSA Full Service Partnership program.
- Homelessness Management Information System (HMIS): The HMIS Lead Agency, The Salvation Army Grass Valley Corps, submitted two proposals to fund a full-time HMIS Systems Operator for the HRCS and to purchase user licenses. An applicant must be using HMIS to receive HUD Homeless Assistance Funds or Emergency Solutions Grants. Since the HPRP Grant (Homelessness Prevention and Rapid Rehousing Program) expired in September 2012, it was imperative that a new funding source be developed.
- Home Anew: This permanent supportive housing program will be funded in the amount of $20,270 to provide 2 housing units for individuals with severe mental illness enrolled in an MHSA Full Service Partnership program.

- Coordinated the application, evaluation and Annual Progress Report process for the HRCS's nine HUD grants that annually total $1,093,951.
- For the January 2014 round of Emergency Solution Grant (ESG) funding, the California Department of Housing and Community Development required that the CoCs assign up to 100 Need Points to each applicant. However, the points assigned to each application needed to be at least five points apart. The Coordinator facilitated the process to develop an unbiased HRCS Committee to review the ESG applications and assign points. Six Nevada County ESG applications were reviewed. Three applications from Nevada County were funded:
  - Hospitality House was awarded two grants for a total of $317,845.
  - The Salvation Army was awarded a grant for $76,125
- Conducted the January 2014 Sheltered Homeless Count and Housing Inventory Chart.
- Facilitated the following HRCS-wide committees/task forces:
  - Nevada-Placer Governance Committee
  - Homelessness Management Information System
  - Coordinated Assessment

**12.** To **Expand Adult Psychiatric Services** in FY 13-14, NCBH provided psychiatric consultation to the Grass Valley Federally Qualified Health Clinic, Western Sierra Medical Clinic. Two NCBH doctors provided consultation, including conducting psychiatric evaluations and providing treatment recommendations to patient's primary care providers.

**Demographics:** The program served 12 clients including two Transition Aged Youth (ages 16-24), nine Adults (ages 25-59) and one Older Adult (aged 60+). Three of the clients were Caucasian and the other nine had Unknown Race & Ethnicity. All 12 clients spoke English as their primary language.

**Outcomes/Successes:**

- Improved communication with primary care providers
- Provided an additional consultation option to primary care providers
- Provided additional psychiatric services

## *Outreach and Engagement:*

1. **Full Service Partnership Agencies and Other Contract CSS Service Providers** are asked to conducted outreach and engagement services. These services are done for individuals, families, and other stakeholders and are conducted one-on-one, with families and with groups. Outreach and engagement activities were provided to 559 individuals in FY 13-14. This number does not include services provided by the individual programs listed below.

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

   **Demographics:** NAMI served 55 unduplicated adult and older adult clients in FY 13-14. Most were Caucasian and spoke English as their primary language. An Inside Mental Illness Training Series for Community Recovery Resources was held for 27 participants. Thirteen individuals also participated in the Family to Family Course Series on nine dates between January 2014 and March 2014.

   **Barriers/Challenges:** The primary challenge faced by NAMI is lack of publicity for their general public classes.

   **Solutions to Barriers:** The Union newspaper consistently publishes articles publicizing NAMI's general public classes and a strong response is seen after the articles are run. It is known that more families involved with mental health providers could benefit from NAMI services. NAMI is exploring how they can strengthen relationships with providers to enhance referrals. Information from families involved in Full Service Partnerships and Nevada County Behavioral Health services, who have participated in Family to Family and BASICS programs shows that this information and support cannot be found elsewhere.

   **Outcomes/Successes:** Evaluations showed that NAMI achieved the outcomes articulated in the contract. Sample responses: "NAMI gave me the language to talk with my daughter in ways I had no idea." "Even though I have bipolar illness, as does my son, I didn't know how to talk with him effectively; now I can." Inside Mental Illness classes for substance use services providers were well-received. After the course was over, one of the Inside Mental Illness speakers was invited to come back and talk to staff to further their understanding of co-occurring mental health and substance use disorders.

3. **SPIRIT Peer Empowerment Center (SPIRIT)** serves visitors 18 years and older. The program serves people with severe, moderate and mild mental illness including the homeless population, offering 17 different support groups. These groups cover topics such as: Dual Diagnoses, WRAP (Wellness Recovery Action Plan, currently serving 6 individuals with two recently recertified facilitators), Bi-polar Group, Men's Group, Women's Group, and LGBTQ Group.

   **Demographics:** For FY 13-14 SPIRIT had 465 unduplicated visitors.

**Outcomes:**

- Program volunteers contributed 5,760 hours of their time to help with the front desk, property maintenance, Peer Counseling, Team Leader/Rovers, the community garden and running the center on a daily basis.
- SPIRIT provided 1,072 peer counseling services and 1,012 support group services in FY 13-14.
- This year the program also supplied 1,512 showers and 599 loads of laundry to homeless participants.
- Two hundred and fifty participants came to SPIRIT for resources this year. Resources included accessing a computer, basic computer training, one-on-one help completing paperwork, socialization, and help navigating the mental health system.
- Participants were given access to food donated by the local Nevada County Food Bank 2,633 times this year. This included lunches made collaboratively by volunteers and participants.
- SPIRIT's Saturday Brunches fed over 4,800 individuals throughout the year.
- In FY 13-14 SPIRIT provided these trainings: Core Volunteer, Group Facilitation, and PC 101 training. In the fourth quarter, four individuals graduated from the Group Facilitation class and 10 more have signed up for the PC 101 class starting in FY 14-15.
- SPIRIT Center offers Peer Counseling in North San Juan (NSJ). Peers either meet the individuals at the Family Resource Center in NSJ or at the individual's home. Six unduplicated clients were served in NSJ in FY 13-14. This service is provided by two of SPIRIT's Peer Counselors. They are husband and wife and have lived in the community for years, so they know the culture in NSJ well. A SPIRIT board member does additional outreach in NSJ.
- A retreat was held at the end of this fiscal year focused on team building and Motivational Interviewing. Both the SPIRIT Emergency Department Peer Counselor staff and the SPIRIT Center staff came together for two days of learning. Staff were encouraged to step out of their comfort zone and to challenge themselves.
- SPIRIT staff had outside speaking engagements with the Domestic Violence and Sexual Assault Coalition (DVSAC), KVMR Radio, and KNCO Radio. SPIRIT representatives were also asked to speak at NAMI's (National Alliance on Mental Illness) Family to Family program and at a panel addressing stigma reduction.
- Volunteer staff attended the We Count, California training in Sacramento in July, 2013 and were subsequently asked to sit on the Continuum of Care (CoC) committee for Nevada County.
- SPIRIT has been included in several newspaper articles written this fiscal year.
- SPIRIT's first summer concert fundraiser was in June 2014 and was a great success.
- A new Volunteer Coordinator has been hired to oversee the volunteers and volunteer programs, like the one-on-one peer counseling at Wayne Brown Correction Facility.
- SPIRIT Center is an active participant on MHSA subcommittees including CSS, PEI, CoC, Cultural Competency/WET as well as, NAMI, Forensic Task Force, Suicide Prevention Task Force and Mental Health Board.

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

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

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

- Youth Mental Health First Aid (YMHFA) Train-the-Trainer Conference: Certified Instructor Course.
- Know The Signs (KTS) Media Forum: Responsible suicide reporting and do no harm media messaging.
- Workshops: Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid (MHFA), YMHFA, KTS and Question, Persuade & Refer QPR.
- Sources of Strength (SoS): Bear River High School, Park Avenue Continuation High School & Spirit Center. Spirit Center provided an SoS training to FREED Friendly Visitor Program.
- Crisis Debrief, Response, Support & Guidance: Alder Creek Middle School (ACMS), Family Resource Center (FRC) of Truckee, and Sierra Nevada Community College (SNCC).
    - ACMS: Critical Incident Stress Debriefing.
    - ACMS, FRC & SNCC: Educate and support key staff and link survivors to crisis & counseling services.
    - SNCC: Help to secure a volunteer counselor that turned into a paid staff position.
- Parent Focus Night at ACMS: Signs & invitations, open talk about suicide, help is available.
- Media Reporting: "If it bleeds it reads" industry norms featuring stories of shock and trauma. They are potentially dangerous and damaging when it comes to reporting on suicide events.

**Demographics:** In FY 13-14 the SPI Program served 1,570 individuals. Of those, 75 were Children ages 0-15, 550 were Transition Aged Youth ages 16-24, 720 were Adults ages 25-59 and 225 were Older Adults ages 60 plus. Caucasians made up the majority of individuals with 1400, while 150 Latino/Hispanics and 20 Unknown Race individuals were also served. The Primary Language of 75 of the participants was Spanish and the rest (1,495) spoke English. SPI served the following types of individuals: 75 LGBTQs, 50 Veterans, 25 HIV/AIDS, two Homeless, 10 with Disabilities, and two from the Criminal/Legal System.

**Barriers/Challenges:**

- Workshops: There was a limited number of Nevada County ASIST & safeTALK trainers (2). The administrative support for workshop implementation was limited as were facilities available, especially for the 2-day workshops.
- ACMS Staff Debrief: It was felt that the administration built 'emotional firewalls' to protect staff from outsiders.

- ACMS Parent Focus Night: Parents had cumulative fears about an on-campus suicide attempt. There were parent fears about youth suicides, helpless attitudes, and not knowing what to say or how to talk with their child about suicide.

**Solutions to Barriers:**

- Know The Signs (KTS) Media Forum: Participants learned to appreciate that the media has a powerful & influential role in educating the public. Local media was invited to join a panel of experts to share lessons learned from the field.
- Workshops: A 'Bi-County Collaborative' was developed with the Placer County Office of Education (PCOE) to increase trainer capacity and the delivery of multiple ASIST workshops. PCOE provided two ASIST trainers, administrative support, materials, Continuing Education Units (CEU) and facilities, and paid for trainer lodging (Truckee). PCOE provided workshop participants with lunches & snacks.
- ACMS Staff Debrief: Staff met with administration to build trust and co-create help strategies for staff to sort through the feelings that surrounded the traumatic event.
- ACMS Parent Focus Night: Administration worked with parents to co-create help strategies. An expert guest speaker was secured.

**Outcomes/Successes:**

- Know the Signs (KTS) Media Forum: A take away from the forum was a Media & Community Pact to "Do no harm!" The forum showed that local media cares about, and is invested in the community they serve. Local media & community groups stated that they support responsible reporting to minimize contagion and when covering the topic of suicide, they will try to highlight suicide prevention and help-seeking messages. The forum was attended by 75 individuals.
- Workshops: 6 ASIST (Bi-County Collaborative); 2 MHFA; 3 YMHFA; 6 KTS & 1 QPR were held. A total of 400 participants attended.
- ACMS Staff Debrief: A Critical Incident Stress Debriefing was held for 40 school personnel.
- ACMS Parent Focus Night: Parents opened up about youth suicide concerns. Parents gained more awareness of signs of suicide, how to talk to their kids about suicide and what types of helping resources are available on campus and in the community. The event hosted 25 parents.

**Activity 2: Integrative Behavioral Health (IBH) Training for Primary Medical Care Providers:** No Activities this FY.

**Activity 3: First Responder Training**

**First Responder Training - Mental Health First Aid (MHFA) Training** is an evidence based, community proven training provided to first responders. "First Responders" may respond to an individual in crisis in their home, on the streets, at school, on the job, at church, etc. "First Responders" are often the facilitators for mental health services for people in the community. This activity decreases the disparity of services for people who may not otherwise get services. In fiscal year 2013-2014 six Adult focused and two Youth focused Mental Health First Aid Trainings were held. A total of 143 individuals were trained.

**First Responder Training - Crisis Intervention Training (CIT)** provided training to first responders dealing with mentally ill individuals in crisis. The intent is to increase knowledge

and skill levels to assist in working with mentally ill consumers in crisis situations. During fiscal year 2013-2014 at least four separate trainings were provided to 104 attendees.

**Demographics:** All 104 individuals served were Caucasian Adults (ages 25-59), who spoke English as a Primary Language. Twenty were Peer Counselors and 84 were First Responders.

**Barriers/Challenges:** There were scheduling challenges with both hospitals and law enforcement to access training for staff. These challenges were with providers who work in 24/7 services. It was difficult to insert trainings into established law enforcement protocols. There was some resistance to concepts and possible stigma presence regarding mental health consumers. Overcoming resistance to change was difficult. Another barrier was anxiety about "people with mental illness" and misperceptions of threat levels. The program needs to improve awareness of emergency department policies and reduce resistance to working with individuals in a hospital environment.

**Solutions to Barriers**: The program continues to provide ongoing training to First Responders in order to undue preconceived stigma, and educate individuals in appropriate responses. CIT provided direct information and participation in individual contacts and trainings. The program offered in vivo exposure to the work setting, and training to identify the best practices approach with consumers and staff in the emergency room setting. CIT staff made a persistent effort to schedule future trainings with law enforcement and other first responder groups.

**Outcomes/Successes:**

- CIT established planning for several training meetings for ambulance drivers, volunteers, and nursing staff at Sierra Nevada Memorial Hospital.
- The program reduced fear and anxiousness and increased knowledge and skills for training participants.
- Further requests for expanded trainings for all staff were received.
- Training plans for peer counselor staff were established.
- Training was provided to over 100 individuals in formal training events.
- Training plans for future law enforcement and first responder events were established.

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

**211 Nevada County** is a free, confidential information and referral service that is available 24 hours a day, seven days a week. By dialing 211 Nevada County residents can access health information, community services, and disaster services throughout Nevada County. This program offers assistance in multiple languages, and services that are accessible to people with disabilities. Utilizing a comprehensive computerized database of more than 1,282 nonprofit and public agencies at 1,739 different locations in Nevada County, trained information and referral specialists give personalized attention to each caller. Specialists can refer callers to a variety of service that best meet their needs. In FY 13-14 call referrals by category included:

| Call Referrals | Count | % |
|---|---|---|
| Housing & Shelter | 773 | 19% |
| Health Care | 515 | 12% |
| Food Pantries & Programs | 487 | 12% |
| Government Agencies | 457 | 11% |
| Aging & Disability Resources | 437 | 11% |
| Behavioral Heath | 393 | 9% |
| Children & Family Services | 251 | 6% |
| Legal Services | 182 | 4% |
| Other 211 Agencies | 122 | 3% |
| Emergency Asst/Crisis Support | 101 | 2% |
| Transportation | 99 | 2% |
| Veteran Services | 90 | 2% |
| Employment | 74 | 2% |
| Emergency Services | 59 | 1% |
| Community | 56 | 1% |
| Business Services | 35 | 1% |
| Education | 24 | 1% |
| Dental Services | 5 | 0% |
| Total | 4,160 | |

**Demographics:** The total number of service calls as they relate to MHSA Prevention and Early Intervention in FY 13-14 were 4,160 calls. The majority of the calls answered, 77%, were from individuals between the ages of 25-59, while 19% were from individuals 60 years or older and 4% were from Transition Aged Youth between 16-24 years old. Of the client contacts, 73% were of unknown ethnicity, 24% were Caucasian, and 1% each were Latino/Hispanic and Native American. All participants spoke English as their primary language, except three whose primary language was Spanish. The participants included 72 Veterans, 387 Homeless, and 543 with Disabilities. In addition 7,062 individual website searches were made on the 211 website.

**Outcomes/Successes:** During the fiscal year 13-14, 211 Nevada County centralized operations in the Grass Valley call center while continuing to increase call volume. Increased call volume can be attributed to specialized programs such as enrolling consumers in Covered California health insurance, screening callers for emergency assistance services, and providing CalFresh outreach and education.

# *Prevention and Early Intervention: Outreach Projects*

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

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

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

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

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

**Demographics:** In fiscal year 2013-2014, 44 unduplicated consumers received services. All of them identified as having at least one disability. Ninety-eight percent were older, white/Caucasian adults who spoke English. Two percent were Filipino. Four percent of the consumers were Veterans.

**Barriers/Challenges:**

- Getting referrals in the Truckee area for the two volunteers was a challenge. FREED is strategically working with the Mana Project, the Senior Center, and Tahoe-Truckee Hospital social workers, as well as monthly attending the Community Collaborative of Truckee Tahoe Resource Sharing Meetings to try and get more referrals.
- Matching volunteers and consumers successfully for a long-term relationships is another challenge. FREED is revising both the volunteer and consumer applications to gather more pertinent information that will allow for more successful long-term matches.
- It has been challenging finding dates/times for Volunteer Trainings when most volunteers can participate.

**Outcomes/Successes:**

*Consumers:*

- There were 790 home visits made.
- There were 58 phone calls made.
- There were 1,174 hours of in-home visitation.
- The consumer survey reported:
  - 100% of respondents enjoyed their weekly visits.
  - 100% indicated that they felt less lonely since they have received visits.
  - 100% said that they are happier and look forward to their weekly visits.
  - 100% would recommend the Friendly Visitor Program to others.
  - 100% were satisfied with the Friendly Visitor Program.

*Volunteers and Volunteer Training:*

- Volunteers are interviewed and have reference and background checks and are given orientation training.
- This year, 44 active volunteers participated in the program.
- Currently there are two volunteers in Truckee.
- FREED provided four group trainings to volunteers in FY 13-14. Topics covered included:
  - Suicide Prevention-Know the Signs with Kim Honeywell
  - Dementia with Barbara Larsen
  - Sources of Strength with Barbara Lindsay-Burns from SPIRIT
  - End-of-Life Issues with staff from Hospice of the Foothills
- Additional training support was given by phone or in person to volunteers or potential volunteers for a total of 116 hours.
- The volunteer survey reported:
  - 100% agreed or strongly agreed that they enjoyed being a friendly visitor
  - 100% agreed or strongly agreed that they were having a positive impact in the person's life who they were visiting
  - 86% were familiar with the signs of depression, anxiety and suicidal behavior
  - 86% felt comfortable talking to the person they visit about depression, anxiety, and suicide
  - 100% felt comfortable talking to FREED staff about any issue that came up or that they had a concern about
  - 100% felt supported by the FREED staff
  - 100% would recommend the program to others
  - 100% were satisfied with the Friendly Visitor Program

**Focus for Fiscal Year 2014-2015:**

- Continuing administration of the Friendly Visitor Program and increasing services in the Truckee Area are ongoing goals.
- Another goal is to successfully provide support groups and ongoing training for the volunteers rotating on different days/times to accommodate different schedules.
- The following trainings are scheduled for FY 14-15:
  - Companioning Skills
  - Older Adults and Substance Abuse
  - CPR by the American Heart Association
  - Depression Among Older Adults

***Social Outreach Nurse Program*:** This program is in its fifth year and is continuing to grow and develop. There were 101 referrals this year as compared to 51 the previous year.

| Name of Referral Source | # of Referrals |
|---|---|
| Senior Outreach Nurses | 27 |
| Gold Country Community | 12 |
| Sierra Nevada Memorial | 10 |
| Progressive Home care | 10 |
| Adult Protective Services | 9 |
| FREED | 5 |
| Behavior Health | 4 |
| Self, Family or Care Provider | 4 |

| | |
|---|---|
| Patty Cambra | 3 |
| 2-1-1 | 3 |
| Various Community Agencies | 4 |
| Other | 4 |
| IHSS | 2 |
| Sierra Nevada Home Care | 2 |
| Helpline | 2 |
| **Total** | **101** |

The Senior Outreach Nurses do a Mental Health/PEI Screening on all new clients unless they have dementia. This fiscal year they saw 283 clients and referred 29 of them to the Social Outreach Program. Other referrals came from Gold Country Community Services, Social Workers from the hospital and home care agencies, FREED, Health Care Providers working with HIV/AIDS clients, as well as Social Outreach clients' friends and neighbors.

The Social Outreach Nurse visits seniors and disabled adults in their homes; the vast majority are living alone. Some of the many challenges they are dealing with are: isolation, loss of independence, grief, declining health issues, financial concerns and family conflicts. Many of the situations are complex. The majority of the clients are receptive to the support and work towards making changes in their lives.

**Demographics:** In fiscal year 2013-2014 the Social Outreach Nurse Program served 101 people. Of those, 16 were Adults ages 25-59 and 85 were Older Adults ages 60 plus. Seventy were female and 31 were male. Ninety-seven individuals were Caucasian, one was African American and three were Asian. Twenty people reported having Disabilities, four were Veterans and three were LGBTQ.

**Barriers/Challenges:** There have been a couple of potential referrals in the Truckee area, which did not materialize. There is a contracted Senior Outreach Nurse in Truckee who provides thorough assessments including mental health screenings. She refers to the Social Outreach program when necessary. It has been difficult to find volunteers in the eastern county. FREED now has two volunteers which may help to support these clients. The intention of the Social Outreach Nurse in this upcoming fiscal year is to further develop relationships in the Truckee Area.

Affordable housing is a huge problem for many of these client's; there are very few options open to them. Another major challenge is financial as most of the clients have very limited resources. This sometimes prohibits going for counseling and social activities.

**Outcomes/Successes:**

- The Social Outreach Nurse assesses for depression, anxiety, and fall risk while building rapport with the clients. Part of the assessment may include a Geriatric Depression Scale (Yesavage). Of the six clients who indicated mild to severe depression, when the screening was repeated, five out of the six (83%) indicated an improvement in depressive feelings. The client who's score remained the same had additional physical problems, but stated she was doing better socially primarily due to her Friendly Visitor. Of the other clients who it was too soon to re-screen, three out of the four are now receiving counseling and have verbalized that they have felt an improvement in their depression.

- It is well documented that anxiety often accompanies depression. Sometimes the issues and concerns around anxiety are easier to identify and deal with openly. When the anxiety issues are addressed the depression improves as well. Many of the clients deny being depressed but express concerns about anxiety. The nurse provides support by listening, advocating and making referrals to various public and private services. The number of visits and phone contacts vary with each client based on need. Follow up "check in" calls are frequently done and clients are always encouraged to call if any needs arise.
- Every client (100%) is under the care of a primary physician and has been seen within the past year. Many are being seen by specialists as well.
- The response from the 10 client surveys returned, indicated 100% benefited emotionally from the social visit. One hundred percent also looked forward to the visits and would recommend the program to a friend.
- Eighty percent of clients accepted referrals and stated that they felt they benefited. Of those that didn't accept referrals, one felt she had enough support, and the other did not think they would be of any benefit. The referrals that clients reported benefit from included: Counseling, Friendly Visitor, Helpline, Falls Prevention Event, Health Insurance Counseling and Advocacy Program (HICAP), Guided Imagery, Support Group, Adult Protective Services (APS), and obtaining a Primary Care Physician.
- As part of the on-going outreach and education the Social Outreach Nurse attends meetings, trainings, seminars and workshops:
  - Meetings: Falls Prevention Coalition, Adult Services Unit Meetings, Elder Care Provider's Coalition (ECPC), Community Networking Meetings, and MHSA Steering Committee.
  - Events: Falls Prevention Coalitions' Annual Community Event and Nevada County Mental Health Council: The Elephant in the Room.
  - Classes: Presented a two hour class on Anxiety and Depression through In Home Supportive Services/Public Authority.
  - In-services Attended: Options Counseling, Alzheimer's Outreach Program (Sierra Nevada Home Care), Healthy Outcomes Integration Team (HOIT), Hospice Liaison Donna Brown, Healing Journey's at Sierra Nevada Memorial Hospital (SNMH), Strokes Prevention and Treatment presented by SNMH, Aging and Disability resource Connection (ADRC) presentation by Ana Acton from FREED, and Drug Addiction and Community Resources Available.
  - Seminars/Trainings: Mental Health First Aid Stigma Reduction, Evidence Based Nutritional Strategies for the Aging Brain, Professional Education Systems, Inc. (PESI): Treatment Resistant Anxiety, Worry & Panic, and HIPPA Training.
  - Online Trainings: UC Davis Extension: Civil Rights Division 21- Nevada County 2014.

**Activity 2: Latino Outreach**

**Latino Outreach:**

In **Western Nevada County** the Latino population is growing. Behavioral Health believes that this population is underserved, in accessing Spanish speaking resources, especially mental health services. The Grass Valley Family Resource center serves the Latino population in the area. The Family Resource Center's Promotora Program conducts Mental Health Outreach and Engagement groups for the Latino Community. The goal of these groups is to educate individuals and to decrease stigma and fear about mental health issues in the Latino Population. These groups are conducted in Spanish and childcare is always available. Meetings take place at

the Family Resource Center and the Grass Valley Charter School, facilities of the Nevada County Superintendent of Schools (NCSOS).

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

**Western County Demographics:** In FY 13-14 NCBH's Latino Outreach therapists served 70 clients. Thirty-one of these clients were Children and Youth, ages 0-15; 12 clients were TAY, ages 16-24; and 27 clients were adults, ages 25-59. The Race and Ethnicity breakdown of these clients was: 41 Latino/Hispanic, 23 Unknown, five Caucasian and one multi-ethnic client. All 70 of the clients spoke Spanish as their Primary Language. Two of the clients had Disabilities and one was in the Criminal/Legal System.

In FY 13-14 NCSOS's Latino Outreach program served 203 individuals. Seventy-six of these were Children and Youth, ages 0-15; nine were TAY, ages 16-24; 122 were adults, ages 25-59; and six were Older Adults, ages 60 plus. The Race and Ethnicity breakdown of these individuals was: 199 Latino/Hispanic, two Asian, and two Caucasian. Most of the clients spoke Spanish as their Primary Language (n=199), while two spoke English and two spoke Japanese. Two of the clients reported being LGBTQ, one had HIV/AIDS, one was Homeless, two had Disabilities and two were in the Criminal/Legal System.

**Western County Outcomes/Successes:**

- A WRAP presentation was given to two High School graduates. Their evaluations revealed the youth benefited from preparing their Action Plans, expressing a proactive attitude towards their mental health.
- A Kids WRAP Day Camp was held. Ten Children: seven boys and three girls, nine to eleven years of age made WRAP Plans, learning how to manage stressful events. Nine of the ten evaluations showed they understood and expressed how they would use their WRAP plans.
- One hundred and eighteen adults and 76 children and youth participated in Educational Meetings and/or Social Events. Of these, 49 received services in the form of referrals to 34 community services, help with translation, appointments, applications, and information.
- Attendance at the following events equaled 298 occurrences: 10 psycho-educational meetings with Salsa exercise and two social events. The psycho-educational meetings were focused on stress, anxiety, depression, bipolar disorder, tobacco and alcohol use, and self-care through WRAP. Extended time was given to focus on the "Signs of and the Prevention of Suicide".
- Twenty exercise group meetings focusing on mental health and nutrition were attended by 33 participants for 306 occurrences. The meetings used SanaMente conversation starters such as myths vs. facts regarding those that suffer from a mental health challenge. The group's lively conversations on messages to reduce stigma and discrimination, cultural barriers statistics, informational sheets and additional materials on nutrition, drugs, alcohol, and the importance of making their own WRAP plan, developed new friendships and a strong sense of community.
- Nine referrals were made to NCBH; some individuals are still in therapy.
- Seven women, in three groups completed their WRAP Plans in three sessions during three weeks.

- The Promotora planned activities based on previously expressed needs, such as exercise and nutrition and used these topics to incentivize the Latino community to participate. Mental Health initiatives were an integral part of these activities. This Mental Health series attracted new Latino members and the international community to engage in healthy events. Salsa classes and the 20 one-hour Boot Camp exercise sessions attracted the young and old alike. These classes integrated mental health education and resulted in a reduction in mental health stigma. This was evidenced by the 10 people who wanted to create their own WRAP plan in the future. The number of people who opened up about their own concerns and were willing to be referred to Behavioral Health adds emphasis to the successful ground gained by Mental Health education.

In **Eastern Nevada County** the Family Resource Center of Truckee (FRCoT) Promotoras continued to see success in their outreach and education work in the Latino Community during the 2013-2014 fiscal year. The three Promotoras from last year all returned in FY13-14, two for their fourth year and one for her third year working as Promotoras. They all continue to be dedicated to, and passionate about, serving the local Latino community.

**Eastern County Demographics:** In FY 13-14 FRCoT's Latino Outreach program served 55 individuals. Fourteen of these were Children and Youth, ages 0-15; 38 were adults, ages 25-59; and three were Older Adults, ages 60 plus. All 55 individuals reported Latino/Hispanic as their Race/Ethnicity and Spanish as their Primary Language.

**Eastern County Outcomes/Successes:**

- Professional Development and Collaboration: Collaboration and partnership are defining features of the FRCoT and the same is true of the FRCoT Promotora Program. In FY 13-14 the Promotoras continued to work collaboratively with the FRCoT staff and other local partners and groups in an effort to bring further mental health education and resources to the local Latino community. The Promotoras continued to be involved in Truckee Tahoe Community Suicide Prevention efforts. They attended community meetings and worked with Question, Persuade, Refer: For Suicide Prevention (QPR) trained FRCoT staff to put on the Gatekeeper QPR Training for community members, which is described in further detail in the group description. Through the end of the FY13-14, NCBH's bilingual Children's Therapist, continued to provide therapy one day per week on site at the FRCoT; the partnership and referrals process are in their formative stage as exploration continues on how to best connect clients to the therapist through the Promotoras and FRCoT staff. Consideration is being given to the possibility of the NCBH Therapist providing direct training and support to the Promotoras as the program develops.

  This year the FRCoT has collaborated closely with North Tahoe Family Resource Center (NTFRC) in Kings Beach and Tahoe Forest Hospital District (TFHD) to evaluate how to further develop and expand the Promotora model through a regional approach. Together with NTFRC and TFHD, the FRCoT is working to coordinate an in-depth Promotora training program with renowned trainers to further enhance the Promotoras capacity in the community. The training is to take place in the fall of 2014. The goal of the training is to expand the Promotora program by providing the current Promotoras with further professional development and by recruiting new Promotoras. Hopefully this will provide even greater outreach and education in the Truckee/North Tahoe Latino community.

- Number of Groups Offered:

- "En Mi Familia Empieza el Mundo" ("The World Begins in My Family") was held January 13 - March 31, 2014 (12 workshops) at Henness Flats Apartments, a local affordable housing complex on the east end of town. The Promotoras opened the series with discussion and activities which allowed the participants to get to know each other, building familiarity, trust and confidence. Over the course of the series, the Promotoras presented information on mental illnesses including depression, anxiety, schizophrenia, post-partum depression, bipolar disorder and associated symptoms. With the discussion of each illness, participants opened up about their own personal experiences with mental illness. Participants expressed both surprise and comfort in hearing that others had gone through experiences similar to their own.

  In response to the recent occurrences of suicide in Truckee youth, the Promotoras requested the assistance of the Suicide Risk Reduction Task Force to host a session on suicide education for the group. A bilingual FRCoT staff member, who is also a member of the Task Force trained in Question, Persuade, Refer: For Suicide Prevention (QPR), met with the Promotora team to plan a culturally sensitive and relevant version of QPR. The Promotoras and the FRCoT staff member collaboratively presented a training on suicide risk reduction education to the group. The attendees received Question Persuade Refer: For Suicide Prevention (or Preguntar Persuadir Referir: Para la Prevención del Suicidio) and the Promotoras used their Know the Signs knowledge to contribute additional input.

  Through the program, the participants were able to create a space of trust and openness with each other. No longer were they isolated in their worries and concerns for their families. Together, this group of mothers and grandmothers was able to speak freely, to relate to one another, and to create a supporting, caring community of friends. One woman shared that she found a place to "un-drown" herself as a part of the program. Many women shared that they think of themselves as better mothers because of the program and how they are able to understand themselves and their children.

  Following are the demographics for the participants in "En Mi Familia Empieza el Mundo" and "Platicas de Salud":

| | Ethnicity | Gender | | Primary Language | Age | | |
|---|---|---|---|---|---|---|---|
| Total Participants | Latino | Male | Female | Spanish | Youth (0-18) | Adult (19-55) | Older Adult (56 +) |
| 8* | 8 | 0 | 8 | 8 | 0 | 8 | 0 |

**These demographics are for participants who attended at least eight of the workshops over the course of the third quarter. A total of 24 unique individuals attended at least one workshop.*

- "Platicas de Salud" ("Health Talks") was held February 7, 20, 27 and March 27, 2014 at Henness Flats Apartments. The FRCoT Promotoras partnered with local health specialists to put on a series of health talks in the Latino community. The first meeting enlisted a Tahoe Forest Health District Exercise Physiologist discussing why it is important to exercise and how to do basic exercise at home. The next two meetings saw participation with a TFHD Nutritionist discussing the importance of heart healthy eating

and demonstrating how to prepare heart healthy foods. The fourth meeting was with a local doctor who discussed general health and preventive care. All four group meetings were very interactive, with the health specialist presenting the information and the participants having the opportunity to try out their new skills. The Promotoras continue to collaborate with THFD and are working to plan future collaborative workshops.

- "Las Chicas de Truckee" ("The Truckee Girls") was held September 27 – November 15, 2013 (8 workshops) at the FRCoT. Given the great success of the adolescent youth group in FY 2012-2013, the Promotoras elected to offer another group for adolescent girls in the fall. The group was structured around the topics of greatest interest to the participants. The topics centered mainly around depression and suicide; alcohol and substance use, abuse and addiction; how to handle bullying; and how to improve healthy communication at home. The Promotoras presented information about mental health, followed by group discussion and activities. The participants had the opportunity to raise questions in the group or submit them anonymously. The Promotoras sought to answer all questions, researching the topics further when necessary. The participants expressed that the workshops were enjoyable and they learned valuable information about mental health.

  Following are the demographics for the participants in "Las Chicas de Truckee":

| | Ethnicity | Gender | | Primary Language | Age | | |
|---|---|---|---|---|---|---|---|
| Total Participants* | Latino | Male | Female | Spanish | Youth (0-18) | Adult (19-55) | Older Adult (56 +) |
| 7 | 7 | 0 | 7 | 7 | 7 | 0 | 0 |

**These demographics are for participants who attended at least four of the workshops in the series. A total of 8 unique individuals attended at least one workshop.*

- "Prevención de Alcohol en Adolescentes – Reunión de Padres" ("Prevention of Alcohol in Adolescents – Parent Meeting"), a community workshop at the FRCoT was held on November 8, 2013. In past workshops and work with the Latino community, a request the Promotoras have received often is for more information on how to prevent their children's use and abuse of drugs and alcohol. As a result, this year the Promotoras sought to put on a community workshop addressing this topic with the help of key partners. The Promotoras coordinated closely with River Coyote and Devin Bradley, directors of Tahoe Truckee Future without Drug Dependence (TT-FWDD); Ryan Moreau, Truckee Police Department School Officer, and students from Truckee High School's "Friday Night Live Natural High Club" to host a community workshop geared towards Spanish-speaking parents of adolescent youth. The Promotoras did outreach throughout the Latino community and there was a good response and showing for the workshop. River and Devin presented on trends around substance use and abuse among adolescents and the effects that it has on adolescent brain development; Officer Moreau spoke about Truckee P.D.'s role in the schools and answered many questions posed by the participants on a variety of aspects of the local youth's use and abuse of alcohol and drugs; the students from "Friday Night Live Natural High Club" spoke about their experiences with their peers' substance use and answered very poignant questions from

the parents. The parents were deeply engaged and expressed a strong interest in attending additional workshops addressing this topic as well as others relating to their children's mental health.

Following are the demographics for the participants in the "Prevención de Alcohol en Adolecentes":

| | Ethnicity | Gender | | Primary Language | Age | | |
|---|---|---|---|---|---|---|---|
| Total Participants | Latino | Male | Female | Spanish | Youth (0-18) | Adult (19-55) | Older Adult (56 +) |
| 13 | 13 | 7 | 6 | 13 | 2 | 11 | 0 |

- A "Bailando por mi Salud" ("Dancing for my Health") group met twice a week in the spring of 2014, at Henness Flats Apartments. During the fourth quarter, the Promotoras organized a group of local women who were interested in meeting regularly to increase their physical activity, through the popular dance workout, Zumba. The women greatly enjoyed not only the activity, but also the camaraderie and support they received from other participants. The Promotoras also had a local nutritionist and exercise physiologist come to give brief educational presentations on the importance of nutrition and exercise, which provided further education and encouragement to the participants.

Following are the demographics for the participants in "Bailando Por Mi Salud":

| | Ethnicity | Gender | | Primary Language | Age | | |
|---|---|---|---|---|---|---|---|
| Total Participants | Latino | Male | Female | Spanish | Youth (0-18) | Adult (19-55) | Older Adult (56 +) |
| 27 | 27 | 0 | 27 | 27 | 5 | 19 | 3 |

- Evaluation/ Increase in knowledge of mental health and substance abuse treatment resources available in Truckee and Nevada County; Increased comfort in talking about depression, anxiety, mania and suicide: Over the course of FY 13-14, the Promotoras continued to elicit feedback from the participants of their groups and workshops in order to evaluate the participants' increase in knowledge of mental health and availability of local resources. The group participants wrote down questions, issues, concerns or recommendations and submitted them anonymously at the end of each session. This method also helped the Promotoras to assess group needs and participant understanding of topics covered.

Throughout the groups, the Promotoras shared information about available resources in Truckee and Nevada County. As previously mentioned, the Promotoras coordinate closely with FRCoT staff and partner agencies in order to stay up to date on new and changing resources and to collaborate on providing appropriate referrals.

There continues to be a strong interest in discussing suicide and better understanding the signs and symptoms. Through responses, participants demonstrated an increased comfort in talking about depression, anxiety, mania and suicide over the course of the series. The participants expressed great interest in having ongoing opportunities to discuss these important issues with their peers.

The FRCoT, along with TFHD and NTFRC, is electing to incorporate data collection and evaluation modules into the aforementioned Promotora training taking place in the fall of 2014. Through this training the FRCoT aims to enhance the Promotoras' skills in collecting and evaluating participant feedback and data so as to gain more insight on the impact of their work in the Latino community.

**Activity 3: Homeless Outreach**

The **Homeless Outreach Program** provided by Hospitality House Homeless Shelter (HH) serves unsheltered individuals through many routes of engagement; social networking at food banks, bus stops, homeless camps, libraries and public parks, word of mouth referrals, law enforcement referrals, shelter guests and community referrals.

**Demographics:**
HH provided services to 624 individuals in FY 13-14. Of those, 14 were Children ages 0-15, 96 were TAY ages 16-24, 358 were Adults ages 25-59 and 156 were Older Adults ages 60+. The Race and Ethnicity of these individuals broke down as follows: 541 Caucasians, 28 Latino/Hispanic, six African American, one Asian, two Pacific Islander, 25 Native American, and 21 Multiple. The primary language spoken by 622 of those served was English, while Spanish was the primary language of two individuals. Many unique cultures were served by Homeless Outreach including: one LGBTQ, 32 Veterans, 624 Homeless, 548 Disabilities, and 134 Criminal/Legal System. HH also provided Outreach and Engagement to 2,732 individuals in FY 13-14.

**Barriers/Challenges:**
In the summer there were a number of calls/complaints regarding homeless encampments located on both public and private land. As is almost always the case with homeless encampments, the primary concerns noted by reporting parties centered on environmental health and water quality issues, trash, sewage, fires, etc., as well as generalized safety concerns ranging from crime, drug activity, theft, violence, etc.

Given the extremely rural nature of this community and the liberal crossover of members of the homeless population from one law enforcement jurisdiction to the next, obtaining the awareness and action of law enforcement can be a lengthy process from the perspective of the citizenry.

**Outcomes/Successes:**
- Once a call/situation has been investigated case managers pull in other service providers, Environmental Health workers, relevant law enforcement agencies, Social Services, Behavioral Health, etc. The culmination of these efforts is most often a re-location effort. HH Outreach partners with property owners (public and private), law enforcement agencies, and other service providers and government agencies in order to peacefully, and lawfully pickup/cleanup the encampments and re-establish residency elsewhere. Residency can be in a new camp, in the shelter, or other housing options. Most notably this process, when

successful, eliminates the need for law enforcement to get involved at a punitive and criminal level.

- Regarding the awareness and law enforcement action issue mentioned above, staff's willingness to respond to calls rapidly does a lot to minimize the fears and concerns of the community at large.
- At any one point in time there are thirty to fifty people requesting and accessing services through the Hospitality House Outreach program. This number reflects individuals who are engaged in a plan/goal oriented relationship with HH outreach. This number appears to always be steadily increasing.
- HH has been allocated the services of a NCBH Psychologist to accept referrals from both in and out of the shelter, from the local police departments and other service providers in the field. This position serves as an accessible, reliable gateway to mental health services available to clients.
- Working closely with the Rapid Re-Housing (RRH) case management team to identify, contact and support potentially 'Housing Ready' client/consumers, more than 12 outreach households have been assisted back into housing. There is a natural synergy developing between the Homeless Outreach program, the overnight shelter, and the RRH team. It is not uncommon for HH outreach workers to make initial contact with a client/consumer in a camp/street/unsheltered setting, build a relationship which empowers the client to check into the shelter, thus connecting the client with RRH case management support. The client then quickly transitions into housing of their own. As experience and familiarity is gained with the potential for overlap and interdependence between these three aspects of the organization, efficiency and productivity continue to accelerate.
- Informational meetings/presentations were attended/given at Adult Services, SPIRIT Peer Empowerment Center, the Gold County Mission group, FREED Center for Independent Living (FREED), Family Resource Centers (FRC), COC, Emergency Assistance Coalition (EAC), Sierra Nevada Memorial Hospital (SNMH) Community Collaboration on Behavioral Health and 5150's, Respite Care SB82 hosted by Behavioral Health, Healthy Outcomes Integration Team (HOIT), Business & Professional Women of Nevada County, Stigma Reduction Training, collaboration for Homeless Court attendees, and local non-profit, Sierra Roots. HH Outreach meets weekly with the leadership of Nevada County Police Department, and coordinates ongoing roundtable meetings with the Grass Valley Police Department and NCBH, where multidisciplinary strategies for homeless outreach and intervention are discussed as part of the Street Team.
- A CIT (Critical Incident Training), hosted by the Oakland Police Department was attended by HH Outreach staff. The purpose of the training was to equip a core group of individuals with the tools and skills to effectively de-escalate conflicts and better serve clients and citizens dealing with the negative consequences of addictions and mental illnesses/crisis.
- In partnership with the city of Nevada City, HH outreach has been instrumental in supporting the creation and implementation of a permitted camping system on city property, within Nevada City limits. The program focuses primarily on the increased accountability of homeless campers who have made the community of Nevada City their home. A team of community members, government officials, social workers and homeless advocates has been gathered under the leadership of Nevada City Police Chief. Regular meetings have been established for the purpose of creating a program that is in the best interest of not only homeless campers, but also the greater community, including business leaders, merchants, residents and officials. As primary points of focus, the team has been considering ways to healthily address the issues of health and sanitation in the camps, and the on-going issue of trespassing on both public and private land.

- For the second year HH is participating in an educational community service project in cooperation with the Food Love Project (FLP). FLP is a subsidiary of the Living Lands Agrarian Network, a local non-profit whose mission it is to train young farmers in organic and sustainable agriculture. Each Tuesday morning a group of homeless individuals is transported to the farm where they work and learn about what it takes to grow good, healthy food on a small and sustainable level. The project grows each week and has been a real success.
- A community service project involving the weekly cleanup of downtown Grass Valley has proven enormously successful. HH guests and outreach clients work for two hours every Friday morning picking up trash in the downtown business district, to the satisfaction of both merchants and themselves.

**Activity 4: Forensic Outreach**

**Forensic Specialist Services** aim to prevent and decrease law enforcement contact and incarceration for individuals experiencing mental health conditions. Services provided are assessment of needs and obstacles, referrals to community resources, support accessing drug and alcohol treatment, consultation, and direct counseling interventions. The Forensic Specialist engages with numerous community resources including Law Enforcement, Mental Health Court, Public Defender, Behavioral Health, Adult Protective Services, Hospitality House, CoRR, Common Goals, NAMI, SPIRIT and other social service providers.

**Demographics:** During FY 13-14 there were 17 people served under this program. Thirteen were adults (ages 25-59) and four were TAY (ages 16-24). The Race/Ethnicity of these individuals was mostly Caucasian (n=8), with many (n=8) Unknown, and one Latino/Hispanic. Almost all (n=13) were English speakers, with four Unknown. There were three homeless individuals, five with disabilities, and one individual in the Criminal/Legal System.

**Barriers/Challenges:** For the first quarter of FY 13-14 there were very few forensic referrals due to previous Forensic Specialist leaving the position. A replacement was not hired until October, 2013.

**Outcomes/Successes:**

- There were a total of 17 referrals in FY 13-14.
- All of them were assessed and provided forensic services, except one individual, who refused further help at the time of the assessment.
- Three out of 17 individuals were referred to Behavioral Health and opened to more services.
- One of these individuals was referred to Mental Health Court.
- Fourteen of 17 referrals were sent to substance abuse treatment (residential, CoRR, Common Goals, Alcoholics Anonymous, Narcotics Anonymous).
- Eight individuals were referred to long-term, residential substance abuse treatment, and six were referred to outpatient drug and alcohol treatment.
- One individual was referred back to primary care to receive psych medications.
- Five of the 17 individuals were re-arrested/re-incarcerated within the fiscal year.
- Two of these 17 individuals were still in jail at the time this report was written (8/1/2014).

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

**Wellness Center – Truckee Tahoe Unified School District (TTUSD)** provides Peer Support & Outreach

**Demographics:** In fiscal year 2013-2014 TTUSD's Wellness Program at the Wellness Center served 1,030 students. Of those, 500 were Children between 0-15 years old, 470 were Transitional Aged Youth between 16-24 years old and 60 were Adults between 25-59 years old. Most were Caucasian and spoke English as a Primary Language (n=642), while many were Latino/Hispanic and spoke Spanish as a Primary Language (n=388). Seven of the students identified as Lesbian, Gay, Bi-sexual, Transgender, Queer (LGBTQ).

**Outcomes/Successes:**

- *GOAL #1 - YOUTH*: At least 50 youth will be trained in peer mentor and leadership skills to better support themselves and their peers, as well as have authentic voices in shaping school and community initiatives.
  *ACTIVITIES SUPPORTING GOAL #1:* In school year 2013-2014, 80 youth were trained as Peer Mentors at Truckee High School, North Tahoe High School and Sierra High School. The Peer Mentors were trained in active listening, knowing the signs of suicide/depression, identifying their Sources of Strength and trusted adults they can seek out for support. Support was provided to the Peer Mentors in the following ways:
  1. Youth Empowerment/Voice provided opportunities for 14 youth to actively participate in Community Collaborative Meetings and leadership opportunities.
     - Two Peer Mentors presented at Youth Suicide Prevention Task Force.
     - Three Peer Mentors participated in the Youth Committed Summit.
     - Six Peer Mentors participated in Community Collaborative (CCTT) Director's meetings.
     - Fourteen students participated in the Community Collaborative Youth Café Meeting. This was an interactive meeting where youth had the opportunity to speak with community leaders about the following issues: youth drug & alcohol usage, depression & feeling isolated, youth activities needed in the community.
     - Two Peer Mentors spoke at the CCTT Bullying Resource Sharing Meeting.
     - One Peer Mentor spoke at the Nevada County Stigma Reduction Training. He was supported to bravely share his story of suffering from depression and the stigma he felt from mental health providers and friends at school. An unanticipated result was that he was able to be connected with more resources and receive help to figure out his insurance options so he could regularly meet with a therapist.
  2. Peer to Peer Support provided the following opportunities:
     - Eight Peer Mentors supported ninth graders at Challenge Days.
     - Twelve Peer Mentors facilitated weekly ninth Grade Peer Mentor Groups for freshmen girls and boys. The groups helped ninth graders build a stronger social and support network. The groups talked about friendships, family life, school and shared their life experiences with each other. The Peer Mentor Groups also served as a great way to outreach to new students and connect them to the Wellness Center.
     - Four participants ended up receiving additional support services from the Wellness Center for depression, anxiety, social isolation and school stress.
     - Peer Mentors met individually with 17 students about a variety of issues, such as: eating disorders, relationship issues, low self-esteem, friends gossiping, boyfriend/girlfriend problems, anxiety, school stress and family violence.

- Ten Peer Mentors trained Alder Creek Middle Students in Sources of Strength.

3. Improving School Climate:
   - Be the Change Messaging: bulletin announcements, posters and compliment letters.
   - Think Kindness Campaign: posters, bulletin announcements, radio announcements, instagram/facebook postings, kindness video, t-shirt contest.
   - Helped spread the word about the new WeTip Hotline, an anonymous hotline that the school district implemented this spring. The hotline is a way for young people and community members to report unsafe behaviors, such as: bullying, underage drug and alcohol usage and violence.

- *GOAL #2 - SUPPORT:* At least 50 youth will receive support from Wellness Center Staff and Volunteers to improve their social, emotional and mental health and will have opportunities to access community resources.

  *ACTIVITIES SUPPORTING GOAL #2:* In school year 2013-2014, 13 volunteers from partner agencies were trained in skills to help them better support and connect youth to community health resources. All the volunteers received training in mandated reporting, confidentiality, basic active listening/compassion skills, understanding the youth culture, suicide prevention (Question, Persuade, Refer - QPR) and reporting, Heart Math and setting healthy boundaries. The volunteers staff the Wellness Centers and provide group and individual support to students. This successfully creates a safe space for youth to talk, seek support and get connected to outside community resources. Some of the program accomplishments are as follows:
  - Supported and built relationships with 210 Truckee High, North Tahoe High and Sierra High students. This includes: lunch time socialization, girls support group, ninth grade peer mentor groups, Sources of Strength/Be the Change Clubs, Peer Mentor meetings, individual meetings and tutoring.
  - Worked in-depth with 51 students to listen to, support and connect them to outside resources. These students came in regularly to the Wellness Center for ongoing social/emotional support. The issues ranged from friend relationship issues to self-harm and suicidal thoughts. The program worked closely with the school counselors and psychologists to provide a coordinated system of support.
  - Improvement was noted in many of the frequent Wellness Center students' emotional stability and well-being from the fall to the spring. Many of the students who were having a very hard time in the fall/winter and seemed to be doing much better during the spring quarter. While this can't be entirely contributed to the Wellness Centers, it is felt that the Wellness Centers played a significant role in this improvement based on comments the students shared. Students really felt the Wellness Centers helped them learn to cope better, connect with others and feel good about themselves.
  - Connected 41 students with community resources, such as: Nevada/Placer County Child Protective Services (CPS) & Mental Health, Truckee Town of Police/Placer County Sheriff 51/50, Tahoe Forest Hospital, Sierra Mental Wellness, Truckee/North Tahoe Family Resource Centers, What's Up Wellness Check-Ups, Nevada County/Kings Beach Clinic, Ski Duck Program, and Community Recovery Resources.
  - Provided afterschool tutoring services to 42 Truckee High students.
  - Offered five all school retreat days for 45 students. These retreats were designed to build relationships, build a positive school culture and teach students stress reduction tools. Activities included: rock climbing, solo nature time with meditation, hiking, water/beach time, art, stress reduction and self-care techniques.
  - Conducted Core Gift Interviews with 42 Sierra High and Community School (Court Ordered School) students. The Core Gift Interviews support each student in identifying

what their unique gift is that they have to offer their families and communities. They each received typed certificates with their core gift statement, what supports their core gift, and what their assets are. They each created a piece of artwork and shared their gifts with the school community.

- *GOAL #3 - EDUCATION:* At least 200 youth will learn practical tools to improve their overall health and well-being.
  *ACTIVITIES SUPPORTING GOAL #3:* Fifty Wellness Workshops have been provided to 608 students on the following topics:
  - Fourteen Heart Math presentations were provided to 337 Health Class students. Heart Math teaches students about the impact stress has on their bodies and tools for regulating their heart rhythms and breathing. The program partnered with Wellness Partners to offer additional workshops in health classes: Alcohol Education, Healthy Relationships, Nutrition, Sexual Education and Bullying.
  - Ten Zumba Classes were provided to 160 students.
  - Sixteen Yoga/Mindfulness Classes were provided to 44 Sierra High and Community School students. These classes taught students tools to decrease their stress, connect with their bodies to calm themselves and the power that their thoughts have on their mental well-being.
  - Two Test Taking/Stress Reduction Workshops were provided to 60 students.
  - A "December Wellness Blitz" was facilitated, consisting of four weekly Wellness Workshops for seven Community School students on the following topics: Yoga, Mindfulness, Sound Healing, "Happiness" Film and Beading (students made rosaries for themselves).
- In FY 13-14 *Sources of Strength* (SOS) was implemented at four school sites: Truckee High, North Tahoe High, Sierra High and Alder Creek Middle School. Four SOS trainings were offered to over 100 students. This program served 108 students. Of those, 70 were Children between 0-15 years old and 38 were Transitional Aged Youth between 16-24 years old. Most were Caucasian and spoke English as a Primary Language (n=64), while many were Latino/Hispanic and spoke Spanish as a Primary Language (n=44). Two of the students identified as Lesbian, Gay, Bi-sexual, Transgender, Queer (LGBTQ).
  - Truckee High and North Tahoe High were combined for the SOS training with components of the Peer Helper and Natural Helpers curriculum to deepen the student's skills in peer mentoring. The work for the clubs was framed into the following areas: Youth Empowerment/Voice, Peer to Peer Supports, and Improving School Climate. The students organized into work committees and planned activities in these three areas. *See above for some examples of the activities in which they participated.
  - At Sierra High the SOS club focused on creating a positive school climate. Sierra High is unique because it is so small and there are already so many supports in place that it made sense for the students to focus on building a more supportive school community. The group met at least twice monthly throughout the year, more often if a particular event was happening. They always checked-in re: status, atmosphere of school and any concerns. There was always a lot of brainstorming about how to keep school cohesive, safe and fun. When special events occurred, i.e. holiday parties and special activities, the group branched into committees with specific tasks. The focus of the events were always about positive messaging. The following activities occurred this year:
    - The Winter Holiday party encouraged a family/home feel (pajamas, gift exchange, cooking). All students received candy canes with positive affirmation messages attached.
    - The Easter Party included a positive message egg hunt that was really fun.

- Midway through the year students put positive affirmation notes all over the school.
- The group was also very involved in the shoe drive under the guidance of the Kindness Project.

o At Alder Creek Middle School, SOS students who participated in the training were determined they wanted to spread the message of Sources of Strength school-wide. As a result, they organized the following activities:

- The Truckee High SOS Team was invited to visit each homeroom to discuss SOS during a Homeroom Day.
- They organized and ran an SOS booth at the Wellness Fair. Students visiting the booth were asked to name their strongest source and state why it was strong for them and spin the wheel. If they landed on a Source that wasn't strong for them they had to state what they would do to strengthen that source. Students were also asked to name trusted adults at home, at school, and in their community by writing their names down on stickers and placing them on a sun. The sun was placed in the foyer after the Wellness Fair for all students to see.
- SOS students supported the Think Kindness Challenge at their school.
- Students attended a celebration of all their hard work at the Grand Sierra Pool at the end of the year.

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

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

The **Nevada County Superintendent of Schools** brings the **Second Step** Curriculum into preschools of the Western Nevada County Region as a component of the County's MHSA Prevention and Early Intervention (PEI) Plan.

**Demographics:** In FY 13-14, 591 children (mostly 3-5 year olds) participated in Second Step at both new and continuing schools. Of those, 495 were Caucasian, 51 were Hispanic, 10 were African American, 10 were Asian, seven were Pacific Islanders, one was Native American, 15 were multi-ethnic and two were unknown. The Primary Language of 555 of the children was English, while 30 spoke Spanish, two each spoke Cantonese and German, and one each spoke Mandarin, Japanese and Tongan.

**Barriers/Challenges:** One of the challenges of program continuation is still the relatively high teacher turnover rate. Only once has there been a case where a new teacher took over the Second Step program the next year with mentoring from another experienced teacher. In all other cases, new staff needs to be trained. It's vital for Second Step Trainers to be able to return to schools, if needed.

**Outcomes/Successes:**

- Contacts and commitments to adopt the Second Step program were gained at 11 sites. One school did not complete the year, as the owner/teacher is about to retire and sell the business. The total number of classrooms currently using the program is 30.
- Nine State Preschools and five Head Start Centers are now using Second Step.

- Thirteen on-site training sessions were given to meet each school's staff and scheduling needs, including one for the teachers of this summer's three-week 'Step Up to Kindergarten' program.
- Twenty-two individuals were trained including: 14 teachers, four teacher/owners, one teacher/site supervisor, two teacher/directors and one director.
- Re-training was provided at three sites due to staff changes and three more sites have asked for return training next year for the same reason.
- Second Step curriculum kits were supplied to each site with the recommended thematic storybooks for each week of the first unit (263 books loaned out in FY 13-14).
- The first two weeks of daily lessons were delivered in each of 11 different classrooms, with teacher present, to model the program in their classroom with their own children.
- An additional 51 storybooks were purchased to help build the diversity of the library and to have some of the Unit One books needed for the newly acquired curriculum kits.
- Each teacher was trained based on their unique schedule to help them understand how to incorporate the multiple daily parts of Second Step into their existing program.
- Appropriate pre-tests, post-tests, Lesson Completion Records, and Teacher Feedback forms were collected from the new sites using the program.
- Pre-assessments, post-assessments and feedback was collected from previously started schools that regularly use the DRDP (Desired Results Developmental Profile) from which the assessments were created.
- To bring the supply of curriculum kits back to the full level of twelve (typical amount distributed in a year), two actions were taken. First, staff arranged an exchange with Committee for Children and SSHS. Three extra kindergarten kits were exchanged for three Early Learning kits. Secondly, a proposal was made to First Five Nevada County that they fund the purchase of four more Early Learning kits for the program's use. The proposal was accepted and kits purchased.
- Ratings on the Desired Results Developmental Profile-Preschool (DRDP) tool baseline vs. year-end, 28 weeks later were submitted to the county.
    - One county contract goal required 50% of children to have an improved score on the knowledge assessments (designed to measure the child's ability to identify emotions, brainstorm alternative solutions to problems, and generate pro-social responses to problems). Results indicated that 100% of the children in the program showed some improvement.
    - As a whole group, improvement on the twelve individual measures ranged from 78% to 90%.
- The second goal was for disciplinary issues to be reduced by 20% at the end of the school year. Based on the Final Feedback Form, teachers who could quantify the reduction as a percentage reported an average of a 50% reduction in disciplinary issues.

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

In January of 2014 two local preschools were trained in Second Step Early Learning. Seventy-five students benefited from this social-emotional curriculum. The Second Step early learning program is a universal, classroom-based program designed to increase children's school readiness and social success by building their social-emotional competence and self-regulation skills. It supports skill development in four key areas of social-emotional competence: empathy and compassion, emotion management, friendship skills and problem solving, and Skills for Learning. Equipping children with Second Step skills helps ease their transition to kindergarten and sets them up for success in school and life.

In the spring of 2014, Alder Creek Middle School piloted the Second Step Middle School Curriculum, "Student Success through Prevention," in two classrooms at the sixth, seventh and eighth grade levels, with the goal of full implementation of the middle school curriculum in 2014-2015. Leveraging the familiar Second Step concepts and vocabulary that students experienced in elementary school has provided a familiar framework and smooth transition for middle school students who, research shows, are especially challenged in the realms of social change and pressure. During these years, students witness and take part in more problem social behaviors than at any other time in their educational careers.

The Second Step Middle School Program aims to prevent or reduce aggression, violence and substance abuse through the promotion of attitudes and social and problem solving skills that are linked to interpersonal and academic success. The design draws on theory and research about adolescent development and utilizes a risk and protective factors framework. Risk factors include: inappropriate classroom behavior; favorable attitudes toward problem behavior; friendships with others who engage in problem behavior; early initiation of problem behavior; peer rewards for antisocial behavior; and peer rejection and impulsiveness. Protective factors include social skills, school connectedness, and adoption of conventional norms about substance abuse.

The elementary schools continue to teach Second Step, school-wide, at the K-fifth grade level. These schools see a marked decrease, 45%, in physical aggression referrals. There is also a 48% decrease of referrals on the playground. Students are using their self-regulation, empathy, and self-talk skills instead. There is an increase in hurt feelings due to the emphasis of the program's utilization of telling others how one feels and what solutions can be tried to reduce the behavior (problem-solving). This effect is preferred over physical violence to solve problems. Elementary staff continue to speak a common language as well as partner with parents in consistently reinforcing the Second Step skill set. Therefore, all staff are able to start a conversation with any student using this language and know they understand completely. Students continue to work on problem-solving sheets when sent to the office to problem-solve different solutions for next time and obtain a parent signature that evening and return the sheet to the office the next day. This serves the dual purpose of informing the parent of the behavior and the new solution for next time, as well as cultivating a conversation between the student and the parent about making positive choices during their school day.

**Demographics:** In FY 13-14, TTUSD Second Step served 1,173 children. Of those, 698 were Caucasian, 427 were Latino/Hispanic, nine were African American, seven were Asian, three were Pacific Islanders, five were Native American, 12 were multi-ethnic, and 12 were Unknown. The Primary Language for 836 individuals was English and 332 spoke Spanish. Thirty-one children reported being Homeless and 129 had Disabilities.

**Outcomes/Successes:**

- One hundred percent of K-fifth classroom teachers at Glenshire fully implemented curriculum.
- One hundred percent of K-fifth classroom teachers at Truckee Elementary fully implemented curriculum
- Ten percent of sixth-eighth classroom teachers at Alder Creek Middle School fully implemented curriculum.
- Early Learning curriculum was implemented at two new Preschools.
- The program benefited from participation in a National Second Step Leadership Professional Community.
- Teachers and school staff felt supported by ongoing training, support and technical assistance from a Counselor/Facilitator, and Early Childhood Educators felt supported by assistance from an Early Learning Trainer.
- TTUSD demonstrated effectiveness of curriculum via SWIS (School-wide information system) in order to track number of referrals, type of referrals, days of referrals, location of referrals, grades receiving referrals.

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

The **What's Up? Wellness Check-ups** (WUWC) program, is modeled after the Columbia University's TeenScreen program. The program screens Nevada County high school students for suicide risk, depression, anxiety and other emotional health issues. WUWC screened students at the Nevada Joint Union High School (NJUHSD) and Tahoe Truckee Unified (TTUSD) School Districts during the 2012-2013 and 2013-2014 school years, and will continue during the 2014-2015 school year. Students privately take a brief computerized diagnostic questionnaire with a follow up provided as a one-on-one interview with program staff. Staff then connects students with treatment referrals, community resources and case management as needed.

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

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

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

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

WUWC staff and promotoras provided crisis management for some clients. Because of the need for an immediate connection or referral, the WUWC staff served as one of the primary, if not only, support systems for the client's family, providing both in-person and phone-based crisis intervention and referrals to local crisis agencies.

**Demographics:** In fiscal year 13-14 WUWC served 207 individuals including 119 ages 1-15 and eight ages 16-24. Of these 148 were Caucasian, 45 were Latino/Hispanic, one was Asian, 29 were Multi-ethnic and 23 were reported as "Other". All 207 individuals spoke English.

**Barriers/Challenges:**

- WUWC developed and provided Survey Monkey questionnaires to parents of students who received referrals and case-management through WUWC in 2013-2014. Even with encouragement and offering incentives for the return of the survey, WUWC has yet to receive completed surveys. WUWC staff will continue to encourage the return of these surveys and develop new ways of outreach to parents in the upcoming school year in order to obtain program feedback.
- WUWC has experienced an ongoing challenge due to the discontinuation of Columbia University's TeenScreen program. Since the TeenScreen program ended prior to screening, WUWC has been unable to receive both program and technical support in times of need. The computerized DPS screening program used by TeenScreen has successfully identified teens in need of support, but has also had several software malfunctions throughout the screening year, resulting in already limited staff time spent troubleshooting and recovering data. The lack of technical support offered through TeenScreen has been a challenge to WUWC's resources.
- In addition, the DPS program is outdated as it was written in 2003 and teens struggle to relate to some of its essential language. The program also has vague demographics questions that need updating so that WUWC can gather more precise data for reporting. And finally, the TeenScreen version of the DPS will soon be incompatible with newer computer operating systems. WUWC has been offered an additional extension from Columbia University to use TeenScreen materials through October 1, 2014. At that point, WUWC hopes that another university will take over the TeenScreen program and update the materials and software program.
- With limited funding and a reduced budget, WUWC continues to grow. WUWC has significantly increased its outreach to youth in Nevada County with tripled numbers of students to be screened in the upcoming school year. WUWC staff has addressed the anticipated need for support through pursuing volunteer Field Placement Interns, however, it is unknown whether enough volunteer assistance is available to cover the growing need for program support.
- Another outstanding need is the lack of referral sources that meet the specific needs of Nevada County youth. WUWC has referred many students to traditional mental health service providers, however some youth do not respond well to traditional clinical settings

and have expressed a desire for alternative supports. Nevada County has limited access to alternative supports for youth leaving some youth non-responsive to WUWC's referral. WUWC staff gives attention and time to try to match individual needs of students with a treatment provider however with a limited referral base it is an ongoing concern. Some students would greatly benefit from alternative teen mentoring programs specifically designed to help increase mental health and developmental transitioning to adulthood. At both TTUSD and NJUHSD, students would also benefit from ongoing open entry groups with an arts therapy and cognitive behavioral therapy focus. These groups would benefit the high numbers of students WUWC screens who are experiencing symptoms of anxiety and their need for treatment options other than traditional individual therapy.

- In addition, an outstanding issue specific to Eastern Nevada County is the low number of affordable mental health service providers available to see students referred by WUWC staff. The strengthening of in-school student support services including on campus counseling could help remedy this issue.

**Outcomes/Successes:**

- What's Up? Wellness Checkups staff have increased community awareness about the program and teen mental health issues by engaging in outreach and collaboration with school and community groups, including TTUSD and NJUHSD, the TTUSD Wellness Center staff, Family Resource Centers, Nevada County Children's Behavioral Health staff, Whole Hearts, Minds, and Bodies Program in Truckee, the Sierra Mental Wellness Group in Placer County, NAMI, For Goodness Sake in Truckee, the Domestic Violence and Sexual Assault Coalition, Suicide Prevention Task Force in Truckee, Tahoe-Truckee Community Collaborative sponsored World Cafe, Truckee Health and Human Service Agency, and Tahoe Safe-Alliance.
- WUWC provided ongoing outreach to school communities. Program staff presented and provided materials at Truckee High School tenth grade Parent Night and Northpoint Academy's Back to School night. WUWC provided materials and information at Nevada Union (NU) High School's Career and College Night, Back to School Night, Mental Health Awareness week, as well as met with an NU teacher to brainstorm on how to outreach to School Department Heads. WUWC corresponded with and provided materials to a Nevada Union Psychology teacher to inform students/parents who might benefit from WUWC, as well as corresponded with a Nevada Union Coach to offer support and screenings to students affected by a recent crisis. WUWC collaborated with NJUHSD Assistant Superintendent and TTUSD Executive Director of Student Services for WUWC program outreach and implementation in the schools. Program staff provided WUWC consent packets and informational materials for parents in both English and Spanish at both NJUHSD and TTUSD on an ongoing basis. WUWC staff maintained webpages for parents with information and downloadable parent consent forms in both English and Spanish on both TTUSD and NJUHSD websites. The program provided incentives to students for returned consent forms. WUWC conducted wrap-up meetings with school officials at NU, Bear River, Truckee High, Park Avenue, and North Tahoe High to go over screening statistics, updates, and logistics for the upcoming school year.
- WUWC met with members of the NAMI Board to present program updates and discuss collaboration opportunities. WUWC staff participated in a Community Substance Abuse Centers (CSAC) video interview highlighting WUWC as one of the successful programs under Nevada County Children's Behavioral Health. Program staff met with Marin Teen Screen Program in Marin County, California to collaborate/brainstorm on successful program approaches including community outreach. WUWC staff attended and provided a

booth with educational resources/outreach for NAMI Community Conference on Mental Health. Staff attended Substance Abuse and the Teen Brain - a workshop and collaborative for the public as well as local teen service providers. WUWC had an educational booth at the "Turkey Trot," an annual race to support awareness of mental health and suicide prevention efforts. WUWC staff participated in a fundraiser for A New Day at The Center for the Arts by providing a booth with information and outreach materials, as well as presenting the WUWC program onstage for those attending the benefit. WUWC continued to provide outreach to existing collaboratives such as the Suicide Prevention Task Force, the Tahoe-Truckee Community Collaborative and the Mental Health Services Act Steering Committee.

- WUWC media outreach included a live interview on KNCO radio, a newspaper article featuring WUWC in the Union newspaper, as well as another feature article on WUWC in the Sierra Sun newspaper. Program staff contributed to a Union newspaper article covering the Suicide Prevention Task Force, the WUWC program, and related resources. Staff designed and developed a WUWC website: www.whatsupwellness.com, that provides program information as well as direct downloads for parent consent forms. Staff continued social media outreach on the What's Up? Wellness Facebook page for community awareness and feedback. Staff worked with IT at both districts to update and maintain the WUWC program web page on district websites and made available updated consent packet downloads on school websites for community and parents in both English and Spanish. WUWC staff created all-call program summary scripts for all school principals for their parent calls. Program staff recorded a Spanish language PSA performed by the Truckee FRC Promotoras for future outreach.
- WUWC continued to work closely with both Nevada County FRC's to provide individualized outreach to Spanish-speaking parents to help engage higher rates of Spanish-speaking families' participation in the program. WUWC presented to the Truckee FRC Promotoras specifically to increase outreach in the Tahoe-Truckee area.
- WUWC staff continued to develop and update the following for students and their families for both the Truckee/Tahoe and Grass Valley/Nevada City sides of the county:
  - One-page crisis contact list for students
  - One-page crisis/resource list for parents
  - Comprehensive resource guides on area agencies
  - Local counseling services list
  - Therapist referral list
- WUWC encouraged peer engagement through recruiting, training, and meeting with Bear River senior project interns who worked on outreach for WUWC. Staff supported interns on educating peers through their Senior Project presentations. Program staff continued to work with youth groups including Sources of Strength (SOS) at Bear River to gain youth input on outreach, and awareness building and training for classroom presentations.
- Of the 207 students who were screened in Fall 2013 and Spring 2014, 98 were Positive screens (47%), meaning that their mental health symptoms and levels of impairment required a clinical interview by a licensed clinician and potential follow-up. During the clinical interview a suicide assessment was conducted, as well as an in-depth interview regarding levels of symptoms and current impairment. Of these Positives, 57 required a referral to a resource in the community and follow-up case management. For those that did not go on to receive case management, it was determined that they were already receiving treatment by a mental health provider prior to screening and did not express interest in additional clinical support, confirmed through parent contact. A smaller number of students

upon clinical interview exhibited manageable levels of symptoms with low impairment levels, as well as adequate support systems in place.

- As of July 2014, 41 of the 57 students in case management have been completed, meaning that they have either completed three sessions for treatment-based referral, or have gotten their needs met for other types of referrals. Four of the 57 in case management have been connected to treatment and are in the process of either sending their consent for WUWC to follow up with the provider or are still attending their three sessions. The remaining 12 are currently not connected, either due to parents' lack of follow-up, student improvement, family moved out of the district, or other factors.
- For each of the 109 students who screened Negative, meaning that their mental health symptoms and levels of impairment did not appear to require clinical attention, WUWC conducted debriefing interviews. In debriefings, WUWC staff spent time with students discussing coping skills, educated them on emotional health issues, and raised their awareness on available student supports with encouragement to access them. WUWC staff made informal referrals to school mentoring programs, student assistance programs, and Sources of Strength. WUWC staff found that a large proportion of students were not aware of in-school supports, and educated students on how to obtain help within the school system. All students were offered hard copies of teen resource information and coping skill lists.
- In the larger context of community change, WUWC has succeeded in its program goal of significantly increasing the numbers of students to be screened in Nevada County. WUWC staff worked with the NJUHSD Assistant Superintendent and other school officials within the district to include parent consent forms in the ninth grade enrollment packets for the 2014-2015 school year. Thus far, this new comprehensive outreach has resulted in over three times the number of students to be screened next year. The number of students to be screened is continually increasing as the beginning of the next school year approaches.
- WUWC has succeeded in addressing this considerable increase in screening numbers by pursuing the addition of volunteers to the program through Field Placement Interns from several universities. WUWC staff has been working with university officials from Sacramento State, Chico State, University of Nevada Reno, and the University of New England in order to assist WUWC staff's ability to provide mental health assessments and follow-up support to the higher number of students that will be screened in the coming year.
- WUWC has succeeded on a macro-level in collaborating and engaging with local mental health service providers which in turn has helped to ignite more community response to the needs of teens. WUWC screening has established clear areas of need and the schools/community have begun initiating a response to that need. For example, the STARS program had an increase in referrals because of WUWC and utilized their volunteer intern for an increase in therapy hours. Another example has been WUWC staff working with DVSAC to ensure that they prioritize group locations with WUWC's student referrals in mind. The extensive community outreach efforts by WUWC staff through the media, through presentations, through presence at meetings has led to being contacted independently by school officials and individuals in other communities including Reno and Placer County with interest in implementing the program in local schools.

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

The **Big Pal Program** has a long history of serving at-risk elementary and middle school youth, called Little Pals, by providing them with a Big Pal, or high school mentor, who helps them navigate the sometimes stormy path of growing up while also providing academic support. The program began in the Nevada City School District and was expanded by Big Brothers Big

Sisters of Nevada County (BBBSNC) to the Grass Valley School District in the fall of 2009 with funding from the U.S. Office of Juvenile Justice and Delinquency Prevention. With the lack of funding from the Nevada City School District to support the program along with the retirement of their long-time Coordinator, BBBSNC consolidated the program and operated it for both school districts in the 2010-2011 school year. This is the fourth year BBBSNC has operated the program exclusively.

High School juniors and seniors are matched with elementary and middle school students, grades three through seven, for a weekly mentoring meeting on the school campus. Students are referred by administrators/teachers from one of four schools: Scotten, Lymon Gilmore – Grass Valley School District, Deer Creek, and Seven Hills – Nevada City School District. High School Big Pals are recruited from the following schools: Nevada Union High School, Forest Charter School, and Bitney Prep Charter. The Pal Program Coordinator recruits, screens, trains and matches all children and teens, conducts match support meetings on a bi-monthly bases and works closely with the schools and teachers to set goals and review progress towards those goals throughout the school year. For the school year 2013-2014 24 matches were successfully completed.

**Demographics:** In fiscal year 13-14 27 individuals were served. Twenty-two of them were Caucasian, four were Latino/Hispanic and one reported multiple races. Twenty-four of the individuals spoke English as a Primary Language, while three spoke Spanish.

**Barriers/Challenges:** The Pal Program coordinator worked on two goals with Big/Little Pals in FY 13-14: Increasing literacy skills and reducing absenteeism for the Littles referred to the program. Most of the children referred experience academic or social challenges such as lagging in academics, attention span, bullying, lack of parental support or lack of social skills. The number of matches is limited to the number of High School students that can be recruited to be Big Pals.

**Solutions to Barriers:** The Pal Program Coordinator is expanding recruitment efforts to include the alternative High School campuses: Forest Charter, Bitney Prep, and Ghidotti. Bigs are given extensive training on how to connect with a Little and how to make sure each match time is fun, and serves to reinforce a reading/literacy skills and social skills. Many of the matches have incorporated diary writing or play writing, or sports activities (basketball, soccer, jump rope) to encourage interaction between the Big Pals and Little Pals. This helps to increase the sense of well-being and inclusiveness at school for the Little.

**Outcomes:**

- The results from the "Strength of Relationship Survey" for the End of the Year are as follows: Little Pal's overall feeling toward the strength of the relationship with their Big Pal = 4.5 out of 5.
- Little Pal's overall feeling of closeness toward their Big Pal = 4.4 out of 5.
- Big Pal's overall feeling toward the strength of the relationship with their Little Pal = 4.56 out of 5.
- Big Pal's overall feeling of closeness toward their Little Pal = 4.25 out of 5.
- Overall "Match" Score in relation to Strength of Relationship of all matches = 4.15 out of 5.

In FY 13-14 the **Special Friends Program** at Truckee Elementary and Glenshire Elementary served a total of 17% of their combined student bodies. The program far exceeded its goal of

10% to 12%. This was also an increase over the previous year. Special Friends had a staff (at both schools combined) of five Special Friend Aides and two School Counselors overseeing the departments. The program is pleased to have "touched the lives" of so many children and provided them with extra support throughout their elementary school education and experience. Overall the teachers thought the Special Friends program benefited their students and classrooms. The program was an important means of support not only for the children, but for the teachers and their classrooms as well.

**Demographics:** Special Friends served 184 students, of which 59% were boys and 41% were girls. All were Children ages 0-15 and 32% are English learners. Caucasians made up 125 of the students while 58 were Latino/Hispanic, and one was African American. The Primary Language spoken by 125 of those served was English, while 59 spoke Spanish.

**Barriers/Challenges:** This program will not be funded by Nevada County in the upcoming school year.

**Solutions to Barriers:** Special Friends will continue to pursue other avenues to enable the program to continue. This is a vital program that helps support the emotional well-being of students and helps to provide them a successful, well-rounded education.

**Outcomes/Successes:**

- 50% of students displayed an improvement with mild school adjustments.
- 48% of students showed an increase in self-confidence and/or self-esteem.
- 44% of students showed an improvement in negative home/school behaviors.
- 38% of students displayed an improvement in academic performance.
- 100% of students enjoyed the program.

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

In Spring 2011 Behavioral Health Children staff were trained on MET CBT5 (Motivational Enhancement Therapy and Cognitive Behavioral Therapy, Five Sessions). This is an Evidence Based Practice and the training was done by the National Drug Court Institute. This is a short term treatment for youth who have mild to moderate substance abuse. MET CBT5 has a sequenced treatment protocol and comes with handouts for the youth and their families. Three Behavioral Health Children clinicians are using the newly learned practice. Staff assigned mild to moderate substance abusing youth to the MET CBT5 trained therapists. These therapists started a bi-weekly support group where they discuss their clients. The county is using EPSDT Medi-Cal as match with eligible youth. They planned on using PEI funds for un-insured children. During the course of the year no MHSA PEI funds were used and it was determined that the MET CBT5 therapy did not work as well with the youth. It was determined to use whatever therapy techniques that would best serve the youth given their unique needs. In FY 13-14 no children were served through this funding stream.

# *Innovation (INN):*

**Work Plan #1- Veterans' Family Wellness:**

**Welcome Home Vets (WHV):** provides individual, group, couples, child and family psychotherapy to family members of veterans who incurred psychological injury as a result of their military service. These services are provided by contracted local psychotherapists both in their office and at the WHV office. Experience in working initially with veterans with Post Traumatic Stress Disorder (PTSD) demonstrated that the members of their families had problems of their own. Not only did they have to cope with their vet's PTSD symptoms, they often developed dysfunctional ways of coping and relating to each other as a family. It is for the purpose of intervening in this issue that the INN program was developed.

**Demographics:** In FY 13-14 Welcome Home Vets served 49 individuals, including two Children (0-15 years old), two Transition Age Youth (16-24 years old), 20 Adults (25-59 years old) and 24 Older Adults (60+ years old). The Race and Ethnicity breakdown for these participants was 90% Caucasian, 4% Multiple, 2% Asian, 2% Native American and 2% Unknown. The primary language of these participants was predominantly English.

**Lessons Learned:** As the project nears its end, there have been many lessons learned. First of all, the need for family services related to living with a veteran who has PTSD is greater than initially anticipated. Not only are family members currently living with a vet being served, several adults who grew up with a father who had military-related PTSD are receiving services too. These individual's ability to live normal lives has been damaged through their early life experiences, and they benefit from therapy as much as those currently living with a PTSD vet. This speaks to the need for early intervention with family members as well as veterans.

**Barriers/Challenges:** Although the project is technically funded through September, 2014 the demand has been so great that funds will be exhausted in August.

**Solutions to Barriers:** The program will be able to continue to serve some family members through the modified CSS contract which will allow for treatment of family as well as vets in the upcoming year, but the need still exceeds available funds. As a result, therapists are having to accept any insurance payment as payment in full (vs. WHV reimbursement based on the VA rate), and in some cases clients are being served pro bono. WHV continues to search for funds to maintain and grow the program.

**Outcomes/Successes:** Once the program ends under INN support, WHV will be getting post-treatment evaluation forms (BASIS-24, Quality of Life Questionnaire and Client Satisfaction Survey) for all clients. Once that data is in, a final report will be submitted. Treating family members has added a whole new and positive dimension to the treatment of veterans with military-related psychological trauma; a dimension that must be continued for the sake of veterans and their families. WHV is committed to making sure that happens.

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

**Department of Rehabilitation (DOR) and Nevada County Behavioral Health (NCBH) Collaborative:** This program supports counseling services from Nevada County Behavioral Health (NCBH) for Department of Rehabilitation (DOR) clients, all of whom are Nevada

County residents and Transition Aged Youth (TAY) who are attending Sierra College's Truckee campus. Individuals served by this program voluntarily participate in individual counseling services provided by NCBH and are referred by the Department of Rehabilitation's Senior Vocational Rehabilitation Counselor (SVRC) who serves the Truckee/Tahoe area.

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

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

**Demographics:** In fiscal year 2013-2014 seven clients were served under this program. This included four TAY, ages 16-24 and three Adults, ages 25-59. Six of these clients were Caucasian and one was reported as "Other" for Race and Ethnicity. All seven spoke English as their primary language. One client was a veteran and one was disabled.

**Lessons Learned:** Counseling has been recommended for a number of students who would appear to be able to benefit from these services, but many young people are resistant to therapy. It was thought that the program would be utilized by a greater number of DOR clients. In some cases, TAY have disregarded the agreement contained in their Rehabilitation Plan to continue with counseling. There is a dramatic drop-off of services available to TAY once they leave high school. Effectively connecting TAY to adult services is one of the challenges of this collaborative. The challenges presented by the full schedules of both the SVRC and the Adult Therapists have presented problems in terms of communication and scheduling appointments. Because the focus has been on the TAY population in Truckee, there has been more awareness of the multiple stressors and challenges they face. The benefits of individual therapy are continually seen for those that participate in this program. Sometimes the history of emotional trauma is not given a diagnosis by the school system because of that system's focus on learning problems. However, the emotional problems that come out of childhood emotional trauma

constitute a major barrier to success for these individuals and this program has been successful in addressing these issues.

**Barriers/Challenges:**

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

**Outcomes/Successes:**

- Seven individuals have received services through this collaboration this past school year.
- The DOR/Sierra College collaboration, augmented by this program, continues to provide quality support for increasing numbers of DOR clients attending Sierra College's Truckee campus. Clients in the program received an increased level of support than would have been available without this partnership. Of significance is that throughout this collaboration, none of the clients/students has failed to stay connected to DOR following their separation from the college, a significant finding compared to the high level of DOR-sponsored TAY who

stop communicating after not doing well in other schools. The extra layer of support provided by these collaborations fills a service gap by providing more personal support than could be, in part, available through disability resources departments. This finding illustrates the need for more support services that can address the psychological needs of the TAY population.

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

**Healthy Outcomes Integration Team (HOIT)** is in its third year of the Primary Care Mental Health MHSA Innovation project. The "Healthy Outcomes Integration Team (HOIT)" project is funded through both MHSA Innovation funds and a federal Health Resources and Services Administration (HRSA) grant. The HOIT team works to develop a coordinated, collaborative system of care by integrating services between primary care, mental health, and substance use treatment. The HOIT project works collaboratively across several agencies to help participants improve their health and wellness. The collaborative services include primary care, mental health, and/or substance use services.

The mission of the HOIT project is to 1) coordinate individual's mental health and primary health care services; 2) provide person-centered health care; 3) promote wellness and recovery; and 4) prevent and/or manage chronic illness. HOIT served 69 individuals from inception to the end of FY 13-14.

**Demographics:** The individuals served by the program include 55 adults (ages 18-59) and 14 older adults (aged 60 and over). The majority (78.3%) were Caucasian, with 5.8% Native Americans, 5.8% Other/Unknown, 4.3% Hispanic, and 2.9% Asian. Almost all clients (98.6%) were English speakers, with one Spanish speaker.

**Outcomes/Successes:**

- A Memorandum of Understanding (MOU) is in place between all of the HOIT partners [Nevada County Health and Human Services Agency; Sierra Family Medical Clinic (SFMC); Western Sierra Medical Clinic (WSMC); Turning Point Community Programs; Community Recovery Resources; and Common Goals, Inc.]; Western Sierra Medical Clinic is a Federally Qualified Health Center (FQHC) and Sierra Family Medical Clinic is a Federally Qualified Health Center - Look Alike (FQHC-LA). In addition, a Release of Information was developed to allow information sharing between the key agencies involved with the HOIT project. The MOU and Release of Information allows for collaboration between agencies to coordinate services, achieve integrated services, and promote healthy outcomes.
- Several staff work together with clients to promote health and wellness. Data is being collected on a number of different health indicators and outcomes, which will allow measurement of the impact on clients of these integrated services over time.
- This project has been extremely successful at integrating services between the FQHC, Behavioral Health (Twelve clients were served by BH psychiatrists at SFMC and WSMC in FY 13-14), and substance use treatment agencies. There are weekly Medication Reconciliation calls with the FQHC Nurse, HOIT Nurse, and other HOIT staff. These calls create a consistent time to discuss shared clients, compare current medications and changes in medications, and develop a coordinated plan of care for high-need clients. These calls have also created a positive relationship between staff at the two agencies, which promotes

an environment for frequent sharing of information throughout the week.

- The Western Sierra Medical Clinic FQHC also brings a mobile van to Behavioral Health one morning each week. One of the primary care physicians from the FQHC who has been actively involved in the integration and HOIT activities delivers Primary Care services to the HOIT clients, by appointment. HOIT clients are very pleased to be able to receive all of their health services at the same location. They are also more likely to follow through with their health care appointments and manage their medications through this integrated care.
- The HOIT team offers a variety of health and wellness activities to clients. These activities include classes on nutrition, cooking healthy meals, meditation and relaxation, and walking groups. The HOIT nurse also holds an "Ask a Nurse" drop-in session at the Spirit House (a consumer-run drop-in center). This session creates an opportunity for individuals to ask different health questions, learn more about their medications, and have their blood pressure checked. This strong, collaborative partnership between the HOIT partner agencies has been successful at improving outcomes, coordinating services, and improving communication between agencies.

---

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

Nevada County's WET plan was approved on June 17, 2009. Implementation is proceeding as outlined in the plan in several areas. These include Workforce Staff Support, Training & Technical Assistance, Mental Health Career Pathways, Expansion of the Internship Program and Financial Incentives.

1. **Workforce Staffing Support:** The MHSA Coordinator worked on the implementation of the plan including providing updates as required to the Mental Health Board and the MHSA Steering Committee, participating in the state-wide WET conference calls and meetings, and providing leadership for ongoing trainings, WET activities and development. Clerical staff supported the ongoing administrative support for the MHSA Coordinator, Behavioral Health staff, contractors, consumers and families as related to WET implementation and creating the multi-media library.

2. **Training and Technical Assistance:** Numerous training events have been offered by the county for staff, service providers, and stakeholders, including consumers and family members. When appropriate, MHSA PEI and WET funds were utilized for training opportunities. For FY 13-14 events/conferences/trainings included: NAMI California Conference, Psychotic Disorders Conference, Care Integration Collaborative, Dialectical Behavior Therapy – Intensive Clinical Training, Naturopathic Treatment Options in Psychiatry, Healing the Angry Brain, Cognitive Behavioral Therapy – Mindfulness, Brainstorm: Discovering the Hidden Power & Purpose of the Adolescent Mind, SafeTALK Training, 2014 California Mental Health Directors Association (CMHDA) Small Counties Strategic Planning Meeting, Law & Ethics Training, Data Collection Reporting (DCR) Training, Mental Health First Aid Training, and Assisted Outpatient Treatment Training. A total of 325 individuals attended a training/conference/event in FY 13-14. Purchases continue to be made to expand the training library. Staff and providers are welcome to check materials out and use them as it fits their schedule. Continuing Education Units (CEU) are available for some of the materials.

3. **Mental Health Career Pathway Programs:** In FY 11-12 it was decided to utilize $15,000 in Mental Health Career Pathway funds to further support the Wellness Recovery Action Plan (WRAP) Facilitators in Nevada County. Eighteen individuals were either trained to be a WRAP Facilitator or had a booster training. These individual were representatives of a wide range of organizations/groups. Individuals from SPIRIT Peer Empowerment Center, The Alliance for Wellbeing, Grass Valley PARTNER Family Resource Center, Family Resource Center of Truckee, Community Recovery Resources, community consultant, Women of Worth, Domestic Violence and Sexual Assault Coalition, and New Directions participated in the training. These individuals included: consumers, peer counselors, young adult peer counselors, Latino Promotoras, drug and alcohol councilors, domestic violence counselors/employees, and therapists. The County continues to support the WRAP Facilitators by providing training, meeting space and materials to conduct WRAP Facilitator Support Meetings. WET funds are also used to provide WRAP Facilitation Group implementation materials. In FY 13-14 three WRAP Facilitators received Refresher Training, 50 My WRAP books, 50 Wellness Recovery Action Plan (WRAP) books and 50 Wellness Recovery Action Plan (WRAP) For Addictions books were purchased using WET Funds.

4. **Expansion of Nevada County's Internship Program:** Clinical supervision of interns has been funded by this program. In FY 2013-2014 six interns provided 2,823 hours of services for

Nevada County citizens. The interns provided services in both adults' and children's systems of care. Additionally, three different individuals provided supervision to the interns. Of the total hours of supervision provided 581 hours were funded with MHSA WET funds.

5. **Financial Incentives:** Our Voices Matter (OVM) continues to be an essential consumer/family-run speaker's bureau that provides the opportunity for consumers/family members to give voice to their experiences living with mental health conditions. First-hand information, descriptions and statistics are provided that is informative and at times more compelling than academic. Telling stories can be very effective in addressing the stigma and discrimination that individuals with mental health conditions face. Speakers often receive feedback from audience members as to how valuable the stories have been. In fact, people follow speakers out to their cars to speak privately about their own situation and personally thank the speaker for what they are doing.

   While OVM participants directly know the struggle, suffering, impact, confusion, emotional pain, and trauma that can occur, OVM helps participants take their experiences and convey them in meaningful ways. The OVM program acknowledges this can be too challenging for some, but for those who can, it gives hope to others who may be facing mental health struggles.

   The OVM program strives to make messages clear, understandable, and most of all genuine to the lay person as well as specific audiences. It conveys an overarching message that there can be hope; and with hope, hard work and luck, one can get on the road to wellness and recovery. As one speaker put it, "There was a time that knowing I have a mental health condition was important to knowing who I am. Fortunately, that is no longer the case."

   Hearing a story can awaken some audience participants to an understanding that they previously did not have. For those who tell their stories, the process of preparing a speech may help them put words to something they have never expressed before. This can be a powerful, therapeutic experience, and presenting it to an audience gives them another layer of personal empowerment. "Almost freeing in a way, it takes the cover off and says, here it is! The suffering, the disability, the experience," as one speaker describes.

   Workshops assist individuals in telling their own story. Workshop exercises elicit aspects of a person's life that then can be incorporated into their stories. Individual coaching is also provided. Some participants join without the intent of speaking; they like to come and learn. Some speak only at the workshop, and some prefer to listen only. Some speak in the community. Some do not accept the offered stipend.

   Speakers continue to present at Mental Health Board meetings, NAMI meetings, and the MHSA Steering Committee meeting. Additional venues have included Domestic Violence and Sexual Assault Coalition, the Community Support Network of Nevada County, Community Recovery Resources, and Wayne Brown Correctional Facility.

   Community speakers have presented topics including experiences with suicide attempts, suicide ideation, homelessness with schizophrenia, parenting a child with bipolar illness, taking medications, obtaining accurate diagnoses and life after a diagnosis. Anyone is welcome to participate. The program is actively supported by NAMI Nevada County and SPIRIT Peer Empowerment Center. The total number of community speakers for FY 13-14 was 6; total number of unduplicated participants was 77.

***Technological Needs (TN):***

The Nevada County Behavioral Health Department is in Phase II of IV in implementing a fully integrated electronic health system (EHR), Anasazi, to support both Mental Health and Alcohol and Drug Programs. The system provides an electronic clinical health record for both Mental Health and Drug and Alcohol programs to optimize efficiency, eliminate redundancy, and improve services to consumers for registration, eligibility, billing, clinical assessment and treatment, program monitoring, and reporting for management and State requirements, sharing clients, insurance and associated data. Funds were used to purchase the Anasazi EHR system, Anasazi staff time to train and support staff in implementation of Phase I and II and a contract for Kings View to support us and the Anasazi system.

FY 2011-2012 began with Phase I of this project going live. The new EHR system went live on July 1, 2011. Clients were scheduled into the system in July 2011. In FY 2011-2012 the EHR system was used for Medi-Cal claiming purposes, billing to private insurance companies, Medi-Care and CMSP, and to create Client statements. Training was ongoing throughout the year, so a lot of staff time was used for this task. Funds were also used to pay for mileage for individuals to conduct or attend trainings. CSI and CalOMS records to comply with state reporting requirements are also submitted through the EHR system.

Additionally, funds were used for staff time to plan, train and implement Phase II of the project, utilizing the clinicians' portion of the system: ATP (Assessment, Treatment Plans and Progress Notes). Phase II went live on February 10, 2012. This means that clinicians and doctors started to enter services and their progress notes into Anasazi.

Lastly, funds were used to purchase computers and computer screens for staff in both children's and adult programs, installation of a T1 line for the training room, purchased Dragon for Psychiatrists so they can dictate their notes, and printed materials for Anasazi trainings.

FY 12-13 began with Behavioral Health clinicians beginning to put Treatment Plans into Anasazi and doctors being trained on the Doctor's Homepage, which included e-prescribing. Signature pads had to be purchased and are used for financial forms and Treatment Plans that require consumer's signatures. Behavioral Health service providers received training on how to use the signature pads. Additionally in FY 12-13 the HOIT team members were trained on Anasazi.

All MHSA TN funds were expended prior to FY 13-14.

---

***Capital Facilities***

No MHSA Capital Facility funds were spent in FY 2013-2014.

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: MHSA Totals**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | 3,773 |
| TAY (16-24) | 1,854 |
| Adults (25-59) | 6,999 |
| Older Adults (60+) | 2,010 |
| Total | 14,636 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 7,695 |
| Latino/Hispanic | 1,597 |
| African American | 63 |
| Asian | 55 |
| Pacific Islander | 21 |
| Native American | 119 |
| Multi | 170 |
| Unknown | 4,829 |
| Other | 87 |
| Total | 14,636 |

| Culture | # of individuals |
|---|---|
| LGBTQ | 119 |
| Veterans | 397 |
| HIV/AIDS | 28 |
| Homeless | 1,446 |
| Disabilities | 1,862 |
| Criminal/Legal System | 264 |
| Latino/Hispanic | 1,517 |
| Other: | 157 |
| Other: | 75 |
| Total | 5,865 |

| Primary Language | # of individuals |
|---|---|
| English | 11,894 |
| Spanish | 1,282 |
| Arabic | - |
| Cambodian | - |
| Cantonese | 2 |
| Farsi | - |
| Hmong | - |
| Mandarin | 1 |
| Russian | - |
| Tagalog | - |
| Vietnamese | 1 |
| Other | 10 |
| Unknown | 1,446 |
| Total | 14,636 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Community Services and Supports - Adult System of Care**

| Age Group | # FSP: | # GSD: | # O&E: |
|---|---|---|---|
| Children & Youth (0-15) | - | 104 | - |
| TAY (16-24) | 11 | 243 | 17 |
| Adults (25-59) | 121 | 1,021 | 644 |
| Older Adults (60+) | 36 | 422 | 206 |
| Total | 168 | 1,790 | 867 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 1,729 |
| Latino/Hispanic | 51 |
| African American | 14 |
| Asian | 23 |
| Pacific Islander | 4 |
| Native American | 28 |
| Multi | 40 |
| Unknown | 905 |
| Other | 31 |
| Total | 2,825 |

| Culture | # of individuals |
|---|---|
| LGBTQ | 20 |
| Veterans | 236 |
| HIV/AIDS | 2 |
| Homeless | 390 |
| Disabilities | 535 |
| Criminal/Legal System | 89 |
| Latino/Hispanic | 72 |
| Other: | 47 |
| Other: | 5 |
| Total | 1,396 |

| Primary Language | # of individuals |
|---|---|
| English | 1,932 |
| Spanish | 16 |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | 1 |
| Unknown | 876 |
| Total | 2,825 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Community Services and Supports - Children's System of Care**

| Age Group | # FSP: | # GSD: | # O&E: |
|---|---|---|---|
| Children & Youth (0-15) | 142 | 253 | 212 |
| TAY (16-24) | 51 | 68 | - |
| Adults (25-59) | - | - | - |
| Older Adults (60+) | - | - | - |
| Total | 193 | 321 | 212 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 410 |
| Latino/Hispanic | 11 |
| African American | 11 |
| Asian | 4 |
| Pacific Islander | 4 |
| Native American | 19 |
| Multi | 38 |
| Unknown | 215 |
| Other | 14 |
| Total | 726 |

| Culture | # of individuals |
|---|---|
| LGBTQ | 9 |
| Veterans | - |
| HIV/AIDS | - |
| Homeless | 8 |
| Disabilities | 8 |
| Criminal/Legal System | 35 |
| Latino/Hispanic | 51 |
| Other: | 23 |
| Other: | - |
| Total | 134 |

| Primary Language | # of individuals |
|---|---|
| English | 508 |
| Spanish | 4 |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | - |
| Unknown | 214 |
| Total | 726 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Prevention & Eraly Intervention - Outreach Projects**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | 635 |
| TAY (16-24) | 591 |
| Adults (25-59) | 625 |
| Older Adults (60+) | 293 |
| Total | 2,144 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 1,337 |
| Latino/Hispanic | 712 |
| African American | 7 |
| Asian | 6 |
| Pacific Islander | 2 |
| Native American | 25 |
| Multi | 22 |
| Unknown | 31 |
| Other | 2 |
| Total | 2,144 |

| Culture | # of individuals |
|---|---|
| LGBTQ | 13 |
| Veterans | 38 |
| HIV/AIDS | 1 |
| Homeless | 628 |
| Disabilities | 621 |
| Criminal/Legal System | 138 |
| Latino/Hispanic | 656 |
| Other: | 2 |
| Other: | 2 |
| Total | 2,099 |

| Primary Language | # of individuals |
|---|---|
| English | 1,322 |
| Spanish | 714 |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | 2 |
| Unknown | 106 |
| Total | 2,144 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Prevention & Early Intervention - Access to Services**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | 204 |
| TAY (16-24) | 754 |
| Adults (25-59) | 4,127 |
| Older Adults (60+) | 1,000 |
| Total | 6,085 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 2,584 |
| Latino/Hispanic | 240 |
| African American | 11 |
| Asian | 1 |
| Pacific Islander | 1 |
| Native American | 31 |
| Multi | 10 |
| Unknown | 3,195 |
| Other | 12 |
| Total | 6,085 |

| Culture | # of individuals |
|---|---|
| LGBTQ | 77 |
| Veterans | 122 |
| HIV/AIDS | 25 |
| Homeless | 389 |
| Disabilities | 553 |
| Criminal/Legal System | 2 |
| Latino/Hispanic | 165 |
| Other: | 84 |
| Other: | 20 |
| Total | 1,437 |

| Primary Language | # of individuals |
|---|---|
| English | 5,820 |
| Spanish | 122 |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | - |
| Unknown | 143 |
| Total | 6,085 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Prevention & Early Intervention - Child, Youth & Families at Risk**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | 2,094 |
| TAY (16-24) | 88 |
| Adults (25-59) | - |
| Older Adults (60+) | - |
| Total | 2,182 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 1,458 |
| Latino/Hispanic | 574 |
| African American | 20 |
| Asian | 18 |
| Pacific Islander | 10 |
| Native American | 8 |
| Multi | 57 |
| Unknown | 14 |
| Other | 23 |
| Total | 2,182 |

| Culture | # of individuals |
|---|---|
| LGBTQ | - |
| Veterans | - |
| HIV/AIDS | - |
| Homeless | 31 |
| Disabilities | 129 |
| Criminal/Legal System | - |
| Latino/Hispanic | 573 |
| Other: | - |
| Other: | - |
| Total | 733 |

| Primary Language | # of individuals |
|---|---|
| English | 1,747 |
| Spanish | 424 |
| Arabic | - |
| Cambodian | - |
| Cantonese | 2 |
| Farsi | - |
| Hmong | - |
| Mandarin | 1 |
| Russian | - |
| Tagalog | - |
| Vietnamese | 1 |
| Other | 7 |
| Unknown | - |
| Total | 2,182 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Innovation - Veterans**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | 2 |
| TAY (16-24) | 2 |
| Adults (25-59) | 20 |
| Older Adults (60+) | 25 |
| Total | 49 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 44 |
| Latino/Hispanic | - |
| African American | - |
| Asian | 1 |
| Pacific Islander | - |
| Native American | 1 |
| Multi | 2 |
| Unknown | - |
| Other | 1 |
| Total | 49 |

| Culture | # of individuals |
|---|---|
| LGBTQ | - |
| Veterans | - |
| HIV/AIDS | - |
| Homeless | - |
| Disabilities | - |
| Criminal/Legal System | - |
| Latino/Hispanic | - |
| Other: | 1 |
| Other: | 48 |
| Total | 49 |

| Primary Language | # of individuals |
|---|---|
| English | 12 |
| Spanish | - |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | - |
| Unknown | 37 |
| Total | 49 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Innovation - Department of Rehabilitation**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | - |
| TAY (16-24) | 4 |
| Adults (25-59) | 3 |
| Older Adults (60+) | - |
| Total | 7 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 6 |
| Latino/Hispanic | - |
| African American | - |
| Asian | - |
| Pacific Islander | - |
| Native American | - |
| Multi | - |
| Unknown | - |
| Other | 1 |
| Total | 7 |

| Culture | # of individuals |
|---|---|
| LGBTQ | - |
| Veterans | 1 |
| HIV/AIDS | - |
| Homeless | - |
| Disabilities | 1 |
| Criminal/Legal System | - |
| Latino/Hispanic | - |
| Other: | - |
| Other: | - |
| Total | 2 |

| Primary Language | # of individuals |
|---|---|
| English | 7 |
| Spanish | - |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | - |
| Unknown | - |
| Total | 7 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Innovation - Healthy Outcomes Integration Team (HOIT)**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | - |
| TAY (16-24) | 6 |
| Adults (25-59) | 49 |
| Older Adults (60+) | 14 |
| Total | 69 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 54 |
| Latino/Hispanic | 3 |
| African American | - |
| Asian | 2 |
| Pacific Islander | - |
| Native American | 4 |
| Multi | - |
| Unknown | 3 |
| Other | 3 |
| Total | 69 |

| Culture | # of individuals |
|---|---|
| LGBTQ | - |
| Veterans | - |
| HIV/AIDS | - |
| Homeless | - |
| Disabilities | - |
| Criminal/Legal System | - |
| Latino/Hispanic | - |
| Other: | - |
| Other: | - |
| Total | - |

| Primary Language | # of individuals |
|---|---|
| English | 68 |
| Spanish | 1 |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | - |
| Unknown | - |
| Total | 69 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Workforce Education and Training - Training & Tech Assistance**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | 51 |
| TAY (16-24) | - |
| Adults (25-59) | 274 |
| Older Adults (60+) | - |
| Total | 325 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | - |
| Latino/Hispanic | - |
| African American | - |
| Asian | - |
| Pacific Islander | - |
| Native American | - |
| Multi | - |
| Unknown | 325 |
| Other | - |
| Total | 325 |

| Culture | # of individuals |
|---|---|
| LGBTQ | - |
| Veterans | - |
| HIV/AIDS | - |
| Homeless | - |
| Disabilities | - |
| Criminal/Legal System | - |
| Latino/Hispanic | - |
| Other: | - |
| Other: | - |
| Total | - |

| Primary Language | # of individuals |
|---|---|
| English | 325 |
| Spanish | - |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | - |
| Unknown | - |
| Total | 325 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Workforce Education and Training - Internship Programs**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | 76 |
| TAY (16-24) | 19 |
| Adults (25-59) | 40 |
| Older Adults (60+) | 14 |
| Total | 149 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | 73 |
| Latino/Hispanic | 6 |
| African American | - |
| Asian | - |
| Pacific Islander | - |
| Native American | 3 |
| Multi | 1 |
| Unknown | 65 |
| Other | 1 |
| Total | 149 |

| Culture | # of individuals |
|---|---|
| LGBTQ | - |
| Veterans | - |
| HIV/AIDS | - |
| Homeless | - |
| Disabilities | 15 |
| Criminal/Legal System | - |
| Latino/Hispanic | - |
| Other: | - |
| Other: | - |
| Total | 15 |

| Primary Language | # of individuals |
|---|---|
| English | 78 |
| Spanish | 1 |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | - |
| Unknown | 70 |
| Total | 149 |

# Individuals Served by MHSA in Fiscal Year 13-14

**PROGRAM: Workforce Education and Training - Financial Incentives**

| Age Group | # individuals |
|---|---|
| Children & Youth (0-15) | - |
| TAY (16-24) | - |
| Adults (25-59) | 75 |
| Older Adults (60+) | - |
| Total | 75 |

| Race & Ethnicity | # of individuals |
|---|---|
| Caucasian | - |
| Latino/Hispanic | - |
| African American | - |
| Asian | - |
| Pacific Islander | - |
| Native American | - |
| Multi | - |
| Unknown | 75 |
| Other | - |
| Total | 75 |

| Culture | # of individuals |
|---|---|
| LGBTQ | - |
| Veterans | - |
| HIV/AIDS | - |
| Homeless | - |
| Disabilities | - |
| Criminal/Legal System | - |
| Latino/Hispanic | - |
| Other: | - |
| Other: | - |
| Total | - |

| Primary Language | # of individuals |
|---|---|
| English | 75 |
| Spanish | - |
| Arabic | - |
| Cambodian | - |
| Cantonese | - |
| Farsi | - |
| Hmong | - |
| Mandarin | - |
| Russian | - |
| Tagalog | - |
| Vietnamese | - |
| Other | - |
| Unknown | - |
| Total | 75 |