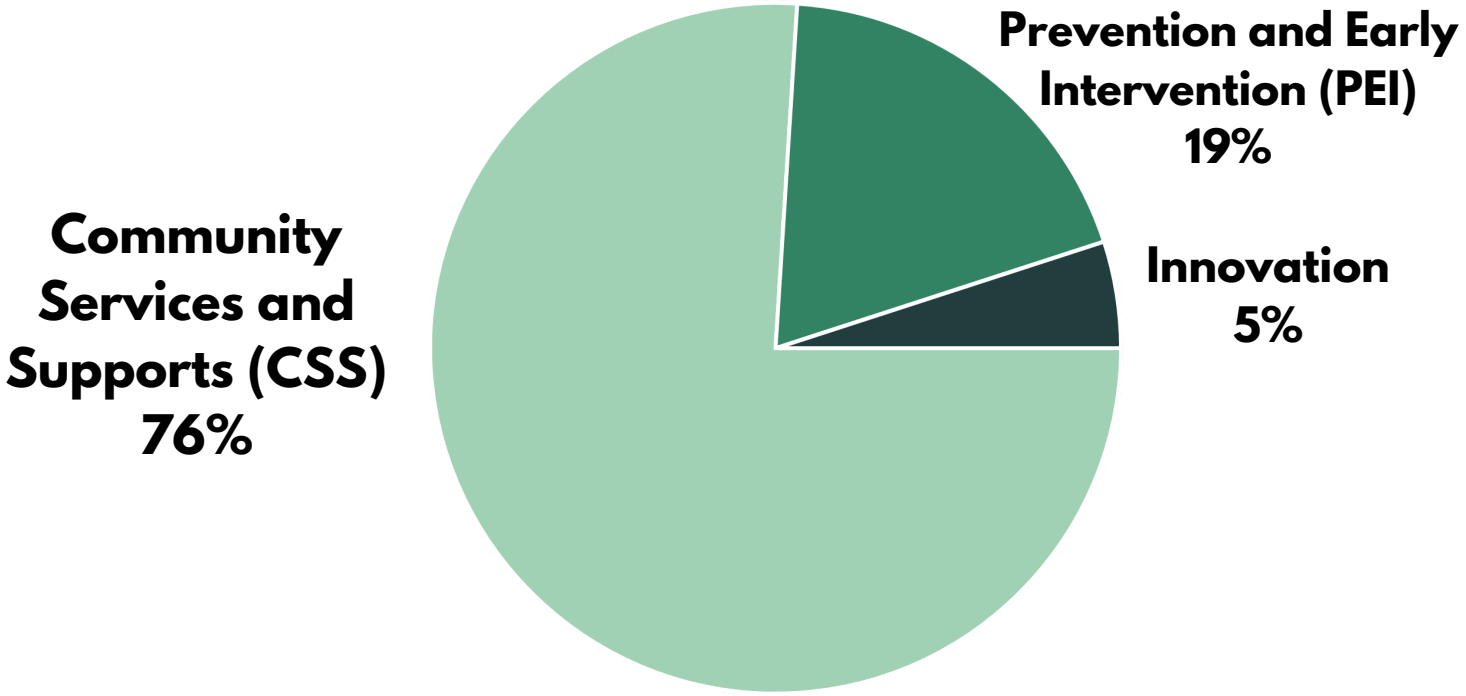
NEVADA COUNTY
MHSA ANNUAL PROGRESS REPORT
FISCAL YEAR 20/21

NEVADA COUNTY
CALIFORNIA

MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL PROGRESS REPORT FOR FY 2020/2021

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

MENTAL HEALTH SERVICES ACT (MHSA) COMPONENTS



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

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

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

ADULT FULL SERVICE PARTNERSHIP

Performance Outcomes July 2020 - June 2021

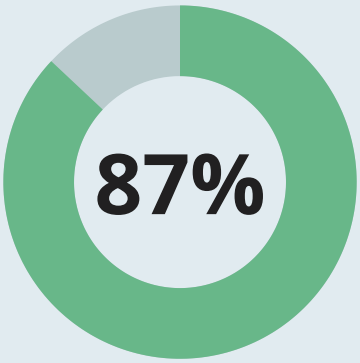
Adult Full Services Partnership (FSP) programs are designed for individuals 18+ years old who have been diagnosed with a severe mental illness and would benefit from a more intensive outpatient program. In Fiscal Year 2020/2021, Turning Point Community Programs was the primary Adult FSP provider in Nevada County.

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

87 INDIVIDUALS SERVED

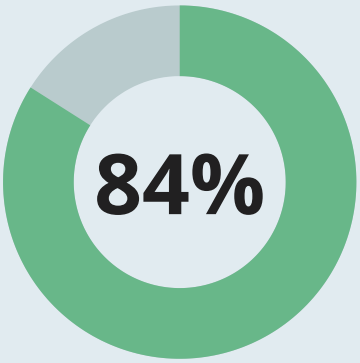
17% *15 individuals* GAINED OR MAINTAINED EMPLOYMENT

HOUSING & HOMELESSNESS



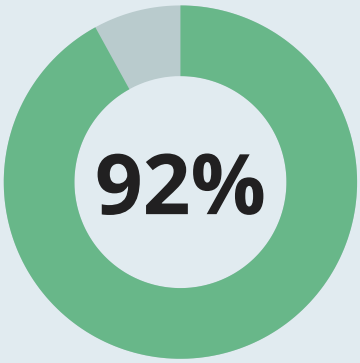
SUCCESSFULLY REMAINED HOUSED

PSYCHIATRIC HOSPITALIZATION



AVOIDED PSYCHIATRIC HOSPITALIZATION

CRIMINAL JUSTICE INVOLVEMENT



AVOIDED ARREST OR INCARCERATION

COUNTY OF NEVADA CALIFORNIA

TURNING POINT COMMUNITY PROGRAMS
A Path to Mental Health

CHILDREN'S FULL SERVICE PARTNERSHIP

Performance Outcomes July 2020 - June 2021

Children's Full Service Partnership (FSP) programs are intensive mental health treatment programs for children under age 21 diagnosed with a serious emotional disturbance or mental illness and their families. In Fiscal Year 2020/2021, Victor Community Support Services (VCSS) was the primary Children's FSP provider in Nevada County.

Staff create individualized service plans for each youth and family, and work to build upon each family's unique strengths, needs, and existing community supports. Almost all services are delivered within the homes, schools, and communities of the youth and families served.

126 YOUTH SERVED

18% increase from previous year

94%
SUCCESSFULLY REMAINED HOUSED

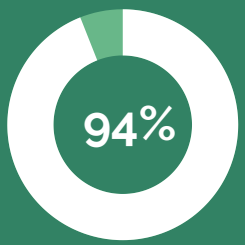
95%
AVOIDED PSYCHIATRIC HOSPITALIZATION

98%
AVOIDED NEW LEGAL INVOLVEMENT

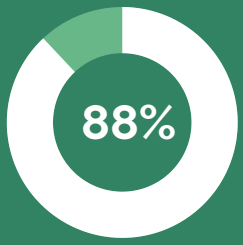
ACADEMIC PERFORMANCE

- **88%** maintained a C average or improved their academic performance
- **100%** did not experience a suspension or expulsion
- **96%** of discharged youth reported regular school attendance or improvement in school attendance

CAREGIVERS



of caregivers reported increased connections in the community



of caregivers reported their parenting skills increased or improved

COMMUNITY SERVICES AND SUPPORTS (CSS)

GENERAL SYSTEM DEVELOPMENT

Key Program Outcomes for FY 2020/21

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

1,691
INDIVIDUALS SERVED

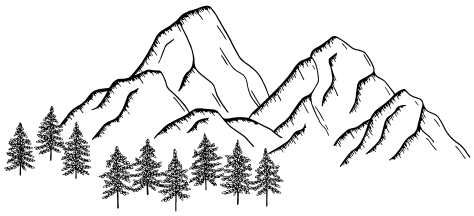
89
with serious mental illness housed through Nevada County Housing Development Corporation

35%
of individuals admitted to the Crisis Stabilization Unit on 5150 holds were stabilized without hospitalization

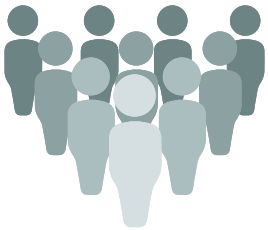
188
individuals in crisis received peer support at the Emergency Department or Crisis Stabilization Unit

63
individuals utilized the Insight Respite Center for short term peer-centered respite care

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



of 107 children served by Stanford Sierra Youth & Families were stabilized at home or in foster care



NAMI provided family education and support to 61 individuals, including holding 12 educational meetings

- 1,048 individuals received crisis intervention services
- 16 individuals were served by network providers (10 children and 6 adults)
- Nevada County Behavioral Health provided expanded psychiatric services to 537 individuals

OUTREACH AND ENGAGEMENT

1,093
INDIVIDUALS SERVED

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

Sierra Family Health Clinic connected 66% of its patients with identified needs to behavioral health services w/in 90 days in the North San Juan ridge region

956
peer support sessions provided by SPIRIT Peer Empowerment Center

132
guests were supported by the embedded therapist at the Hospitality House shelter

60% of 68 participants served by embedded case manager at Hospitality House maintained or improved their housing

Forensic Liaison engaged 139 individuals in jail with behavioral health needs to refer them to services and treatment upon discharge

55 individuals & families with mental health needs served by the Veterans Service Office

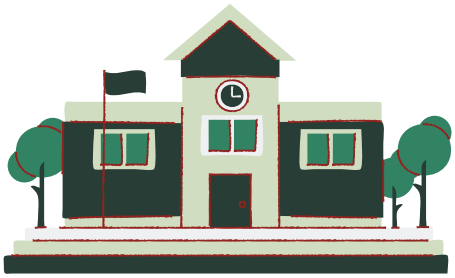
30 veterans and their families provided therapy by Welcome Home Vets

PREVENTION AND EARLY INTERVENTION (PEI)

YOUTH OUTCOMES

263

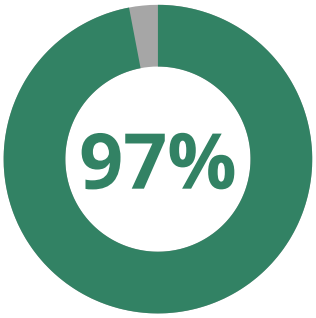
Nevada County high school youth screened for mental health needs



192

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

70% of the 10 mothers in the Moving Beyond Depression program showed improvement in depression symptoms



of 107 children served by Stanford Sierra Youth & Families were stabilized at home or in foster care

9

young adults experiencing homelessness received case management & referrals to services

91%

of 11 youth mentorships for elementary schoolers were sustained throughout the year

PREVENTION AND EARLY INTERVENTION (PEI)

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

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

89% of the 90 Tahoe/Truckee families who participated in parenting classes demonstrated improved parenting skills

LATINX OUTCOMES

74 individuals received bilingual therapy

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

24 mental health referrals made by Promotoras

153 individuals educated on mental health issues & services

PREVENTION AND EARLY INTERVENTION (PEI)

OLDER & HOMEBOUND ADULT OUTCOMES

86%

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

79%

of older adults and homebound adults surveyed by the FREED Friendly Visitor program stated that they felt less isolated

OTHER PEI OUTCOMES

- 27 young adults in the Tahoe/Truckee region participated in Youth Empowerment groups
- Provided homeless outreach to 49 individuals experiencing homelessness in Tahoe/Truckee, with 3 referrals to mental health services
- 89 individuals attended Youth Mental Health First Aid trainings
- Suicide prevention trainings provided to 1,393 individuals

INNOVATION (INN)

In FY 20/21, there were two active Innovation projects:
1) Integrated Tahoe/Truckee Services
2) Homeless Outreach and Medical Engagement (HOME) Team

INTEGRATED TAHOE/TRUCKEE SERVICES

The goal of this 5-year Innovation project (2016 - 2021) is to develop a coordinated, interagency, cross-county service delivery system to meet the needs of those in the Tahoe Truckee area, regardless of the county of residence.

Fiscal Year 2020/2021 Program Outcomes

21 **Tahoe/Truckee residents received individual support from the Family Advocate to access mental health services in Placer and Nevada counties**

8 **Individuals with mental health needs received continued case management, allowing them to remain safely housed during the COVID-19 pandemic**

Collaboration between Nevada & Placer counties was strengthened to include joint funding for regional mental health services

HOMELESS OUTREACH AND MEDICAL ENGAGEMENT (HOME) TEAM - FY 20/21

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

252 received access & linkage to services

5,374 services provided

141 received case management

53 people housed

81% retained housing

748 referrals

81% connected

MEDICAL SERVICES

47 received intensive medical engagement from Nurse

78% reduction in Emergency Room visits among case managed individuals

9 pregnant women experiencing homelessness received medical services from Nurse, and 100% obtained housing

53 COVID vaccines administered to HOME Team clients

MENTAL HEALTH SERVICES

21 assessments completed

11 connected to treatment

SUBSTANCE USE DISORDER

28 assessments completed

33 connected to treatment

Community Services and Supports (CSS)

Children's Full Service Partnership (FSP):

VICTOR COMMUNITY SUPPORT SERVICES (VCSS)

Program Description

Program Overview

Victor Community Support Services (VCSS) is an intensive treatment service program in Grass Valley that serves children diagnosed with a serious emotional disturbance or mental illness and their families through two modalities throughout FY 20/21: Family Vision Wraparound, which provides high fidelity wraparound services, including case planning, therapeutic services, medication support, and crisis intervention; and Therapeutic Behavioral Services (TBS). This report covers outcomes for children and youth being served through both modalities. Victor Community Support Services (VCSS) clinicians and staff create individualized service plans for each youth and family, and work to build upon each family's unique strengths, needs, and existing community supports. Almost all services are delivered within the homes, schools, and communities of the youth and families served. A significant portion of services were provided via telehealth for the duration of the fiscal year in response to COVID-19.

Target Population

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

Individuals are referred to Victor from the SMART (Special Multi-Agency Resource Team), Children's Behavioral Health, Child Welfare Services, Probation, or school districts, including youth qualifying for Medi-Cal, and/or Pathways to Wellbeing services.

Evaluation Activities and Outcomes

In FY 20/21, VCSS Grass Valley provided 126 youth with mental health and/or Wraparound services, an 18% increase over the total served in FY 19/20. Twelve of these clients were served at VCSS Truckee and 117 were served at VCSS Grass Valley, with three youth being served at both sites. There was outreach to an additional seven prospective participants throughout the year. The goals of these services are to reduce hospitalizations and recidivism for juvenile offenders, improve school performance, improve targeted behaviors, increase community connections, and

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

- **Housing**: During FY 20/21, 94% of the 126 youth served remained in a community living situation and avoided a higher level of residential care. No youth required group home placements, while there were six total changes in foster care.

- **Employment and education**: VCSS achieved its contractual goal of ensuring at least 80% of parents report youth maintained a C average or improved on their academic performance, as 88% of parents surveyed reported their child maintained a C average or saw improvement in their child's academic performance. Additionally, based on the Child and Adolescent Needs and Strengths Assessment (CANS) item "Academic Achievement," 82% of discharged youth had a C average or higher at discharge.

  VCSS achieved its contractual goal of ensuring at least 75% of youth maintain regular school attendance or improve their school attendance, as 96% of discharged youth reported regular school attendance or improvement in school attendance (based on the CANS item "School Attendance").

  VCSS achieved its contractual goal of ensuring that at least 70% of youth have no new suspensions or expulsions between admit and discharge; All 126 youth served did not experience a suspension or expulsion in this fiscal year.

- **Criminal Justice involvement:** VCSS achieved its contractual goal that at least 70% of youth have no new legal involvement (arrests/violations of probation/citations) between admission and discharge. In FY 20/21, 98% of youth had no new legal involvement while receiving services.

- **Acute Care Use**: Ninety-five percent (95%) of youth did not experience a psychiatric hospitalization during the fiscal year.

- **Emotional and Physical Well Being**: VCSS Grass Valley successfully supported the strengthening and development of youth, caregivers, and family members' emotional and physical well-being throughout the fiscal year.

  VCSS achieved its contractual goal of ensuring that at least 65% of children served were able to identify at least one lifelong contact. Based on the CANS item, "Relationship Permanence," 98% of youth served were able to identify at least one lifelong contact.

  VCSS achieved its contractual goal of at least 80% of parents/caregivers reporting that there was an increase in their parenting skills. In FY 20/21, 88% of surveyed caregivers reported their parenting skills increased or improved.

  VCSS achieved its contractual goal of ensuring that at least 75% of caregivers report maintaining or increasing connections to natural supports, with 94% of surveyed caregivers reporting maintaining natural supports and also reporting increased support connections in the community.

Victor achieved its contractual goal of ensuring that at least 80% of individuals improved their scores on the Comprehensive Child and Adolescent Needs and Strengths (CANS) instrument between intake and discharge. During FY 20/21, 94% of individuals with a planned discharge improved in at least one of the following CANS domains: Life Functioning, Behavioral/ Emotional Needs, Risk Behaviors, and/or Educational Needs; both engaged discharges at VCSS Truckee achieved this goal. Additionally, 88% of surveyed caregivers reported their child's targeted behaviors had decreased at time of survey.

- **Stigma and Discrimination:** Victor implemented a Racial Justice Committee during this fiscal year to analyze and combat mental health disparities as they relate to racial injustice in the community.

- **Service Access and Timeliness**: Excluding transfers between reporting units, there were 56 discharges this year, with 53 (95%) fully engaged in services. For FY 20/21, the average length of service (ALOS) for engaged discharged populations was 11.0 months for VCSS Grass Valley (n=51) and 4.1 months for VCSS Truckee (n=2).

  VCSS nearly achieved its contractual goal of attempting initial contact with referrals within three (3) business days of receipt of referral. Initial contact was *attempted* for 96% of referrals within three business days, while initial contact was *successfully made* with 84% of referrals within three business days.

  VCSS achieved its contractual goal of offering an appointment for face-to-face contact with 80% of children and families within 10 business days of receiving the referral, as 84% of eligible referrals were *offered* an appointment date in this time frame. Additionally, 99% of referrals received a face-to-face contact within 10 business days of *contact made*.

Challenges, Solutions, and Upcoming Changes

During FY 20/21, Victor has continued to refine the high-fidelity wraparound model adopted by the program in 2017. The leadership team continues to emphasize in-service coaching, targeted skill building, and ongoing development of staff as it pertains to wraparound implementation. Victor continues to employ a team of Clinicians, Facilitators, Parent Partners, and Family Support Counselors who all receive training and supervision specific to the wraparound model.

Effectively maintaining the physical safety of staff, participants, and the community against COVID-19 while continuing to provide excellent services was a primary challenge during FY 20/21. Victor quickly adapted their service model to serve beneficiaries primarily via telehealth, and staff have demonstrated consistent persistence and adaptability while continuing to meet individual participants' needs. While COVID-19 management remains an ongoing challenge, Victor has identified core strategies to provide effective telehealth care as necessary.

Victor remains committed to increasing connectedness for the youth and families served by continuing to add more group-based services, community-building activities and events, and further integrating the wraparound philosophy in both virtual and in-person settings. VCSS plans to emphasize the inclusion of family voice and choice as a primary principle of services during the

next fiscal year. The program will continue to serve all youth referred utilizing FSP and wraparound principles according to beneficiaries' individualized needs, strengths, and treatment plan goals. Length and intensity of services will be determined by assessment and current need. The anticipated length of stay will remain 8-10 months on average.

Program Participant Story

Victor worked with a teenaged boy whose older family member also received services from Victor during the year. The teenager presented with unruly behaviors when triggered. When referred for services, the teenager had been living with a foster family for nearly a year. This was one of many placements since entering foster care at a younger age.

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

Victor provided the boy and his foster family with multiple therapeutic and collateral services. Through these interventions, the foster parents learned new parenting strategies which did not trigger the boy's trauma related to previous abandonment. This allowed the family to heal their relationships and work to understand one another more successfully. The boy's behaviors improved significantly, and he became extremely committed to continuing therapeutic work. At the time that the boy successfully graduated from Victor services, the family was just a few months away from finalizing his adoption.

Adult Full Service Partnership (FSP):

TURNING POINT COMMUNITY PROGRAMS
Providence Center

Program Description

Program Overview

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

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

Target Population

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

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

Evaluation Activities and Outcomes

AACT:

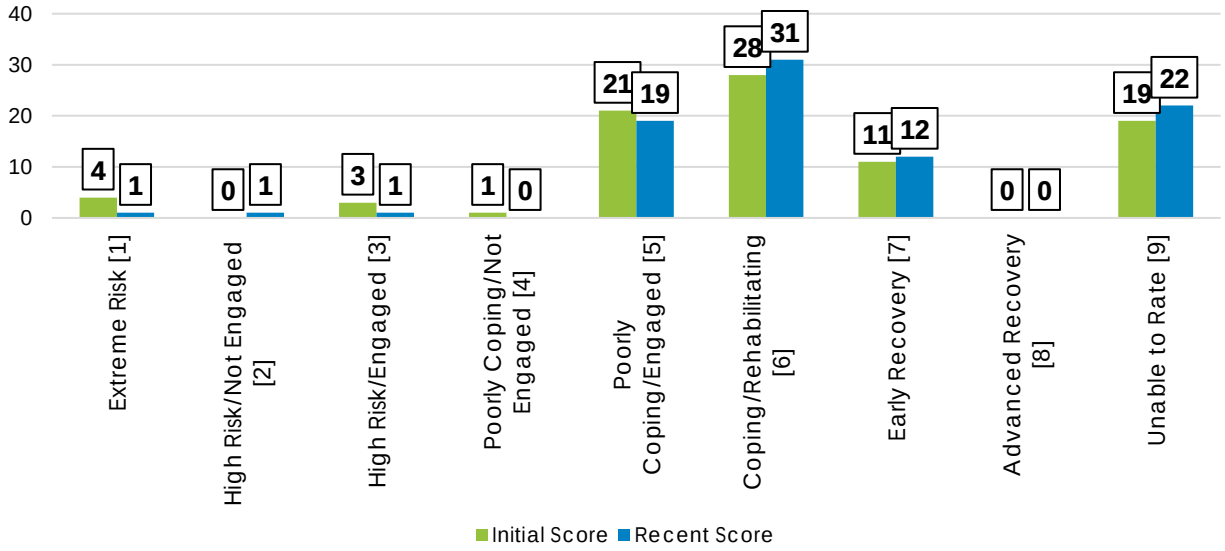
In the FY 20/21, the Providence Center FSP served 87 individuals. Two of the 87 individuals served in FY 20/21 have been excluded from FY 20/21 analysis below due to lack of engagement in services.

- **Housing**:
  - During FY 20/21, 74 individuals (87.1%) successfully remained housed in either temporary or permanent housing; avoiding homelessness. The remaining 11 individuals (12.9%) accrued a total of 1,950 homeless days.
  - A total of 69 individuals carried over from FY 19/20 and continued to accrue services in the FY 20/21. Of those 69 individuals, 60 (87.0%) either continued to avoid homelessness or decreased in the number of homeless days accrued.
- **Employment and education**:
  - **Employment**: Of the 85 individuals served within FY 20/21, a total of 15 individuals (17.6%) were reported as having some form of employment (paid or unpaid) at the end of the reporting period. When comparing to the Partnership Assessment Form (PAF), 11 individuals who were reported as being unemployed prior to their enrollment in the Providence Center were employed at the end of FY 20/21.
  - **Education:** In FY 20/21 a total of 18 individuals were reported as having spent at least one day in school since enrollment. Nine (50.0%) of those 18 had not been attending school within the 12 months prior to their enrollment.
- **Criminal Justice involvement**:
  - During the FY 20/21, 79 (92.9%) of the 85 individuals with available data avoided incarcerations or the accrual of jail days. The remaining six individuals (7.1%) accrued a total of 463 jail days.
  - Of the 69 individuals who carried over from FY 19/20 and continued to receive services through the Providence Center in FY 20/21, 65 (94.2%) either continued to avoid jail or decreased in the number of jail days accrued. Furthermore, only four individuals (5.8%) accrued jail days.
  - With regards to arrests, during FY 20/21, 82 individuals (96.5%) avoided arrests. The remaining three (3.5%) accrued a total of four arrests between them. Between

FY 19/20 and FY 20/21, no individuals were reported as having accrued arrests in both fiscal years.

- **Acute Care Use**:
  - **Psychiatric Hospitalizations:** Within FY 20/21, 72 individuals (84.7%) avoided psychiatric hospitalizations. The remaining 13 (15.3%) accrued a total of 680 psychiatric hospital days. A positive outcome is that of the 69 individuals who carried over from FY 19/20 and continued to receive services, 60 (87.0%) either continued to avoid psychiatric hospitalizations completely (n=51) or reduced in their accrual of psychiatric hospital days (n=9).
  - **Emergency Interventions:** Within FY 20/21, 72 individuals (84.7%) avoided the need for an emergency intervention. The remaining 13 (15.3%) accrued a total of 38 emergency interventions. A positive outcome is that of the 69 individuals who carried over from FY 19/20 and continued to receive services, 66 (95.7%) either continued to avoid emergency interventions completely (n=42) or reduced in their accrual of emergency interventions (n=24).
- **Emotional and Physical Well Being**:
  Turning Point continues to emphasize trauma informed care with those being served. This allows participants to feel respected and cared for in their recovery process and allows staff the opportunity to see people through a trauma informed lens. In FY 20/21 staff were faced with the pandemic and as a program and agency put emphasis on both the mental health of employees as well as those being served. Excellent service has continued to be provided even during COVID-19, ensuring that participants are informed and protected from the virus. Turning Point's Substance Use Counselor has kept in regular contact with participants in need substance use disorder services in order to reduce the occurrence of relapse. Turning Point has also been able to start therapeutic groups again at a smaller capacity in order to provide participants with that additional support.
- **Stigma and Discrimination**:
  Having employees embedded in various agencies throughout the system of care in the county has helped to increase awareness and understanding of mental illness and homelessness, reducing stigma. Turning Point currently has embedded staff in Hospitality House, the Public Defender's office, the Probation Department, the HOME Team and Nevada County Behavioral Health. In FY 20/21 several community trainings were planned to educate people on Assisted Outpatient Treatment. This is another way of supporting the reduction of stigma in the community.
- **Service Access and Timeliness**:
  - One hundred percent of non-urgent mental health service appointments were offered within 10-15 business days of initial request.
  - Five people released from acute psychiatric hospitals were readmitted within 30 days.
  - Of all the acute discharges, one hundred percent received a follow up appointment within seven days of discharge.
- **AOT Summary**:
  - **13** individuals were in the AOT Program in FY 20/21.
- **Milestone of Recovery Scale (MORS)**
  The Milestone of Recovery Scale (MORS) is both a clinical and administrative tool. It allows TPCP to measure where individuals are in their journey of recovery and produce data that describes the journey of recovery over time.

- A total of 87 individuals received a score at admission and the end of the fiscal year or at discharge.
- Fifteen individuals (17.2%) had a higher MORS score at the end of the reporting period, suggesting movement towards recovery, including a lower level of risk, an increase in the level of skills and supports beyond program services, and an increase in the participant's level of engagement with program staff.
- Thirty-two individuals (36.8%) remained at the same MORS score. As many beneficiaries have higher MORS scores, stability in their current coping levels is seen as positive indicator.
- Nine individuals (10.3%) had a lower MORS score at the end.
- Thirty-one individuals (35.6%) had at least one score unable to rate.



- **Productivity**
  - **Objective A:** Minimum productivity standard of 70% of billable time for hours worked
    - Between July 1, 2020 and June 30, 2021, despite the pandemic and some staff teleworking, the Providence Center had an average productivity of 83.8%.
  - **Objective B:** 90% of all beneficiaries are Medi-Cal eligible
    - 100% of the beneficiaries served at the Providence Center in FY 20/21 were Medi-Cal eligible.
  - **Objective C:** No higher than 5% denial rate for billed and audited services
    - Turning Point, Providence Center maintained a denial rate of only 1% for FY 20/21, meeting their contractual goal to keep denials less than 5%.
  - **Objective D:** Each Medi-Cal service provided must meet medical necessity guidelines and meet Medi-Cal requirements as described by service and activity/procedure code
    - All Medi-Cal services provided in FY 20/21 met medical necessity guidelines as well as Medi-Cal requirements as described by the service and activity/ procedure code.
  - **Objective E:** Contractor shall document and maintain all beneficiaries' records to comply with all Medi-Cal regulations

- Providence Center staff documented and maintained all beneficiaries' records in order to comply with Medi-Cal regulations.

Challenges, Solutions, and Upcoming Changes

In reflecting on last year's challenges and solutions Turning Point continues to struggle with recruiting and hiring qualified staff. COVID-19 has greatly impacted hiring capability. In restructuring some of the salary scales, adding supportive positions to the contract and being mindful in hiring practices TPCP has come out of this fiscal year with a much stronger team and program. Turning Point continues to do good work with those being served and has strengthened its documentation, data collection and timeliness of all required paperwork. The program has hired a Clinical Director who has been a tremendous part of supporting this goal. Additional clinicians on the team have increased the clinical skill and knowledge of the whole team as well as increased the number of therapy slots available for beneficiaries. TPCP looks forward to increasing their ability to support families through a family support group, and potentially with the addition of a family advocate position. Aligning with NAMI, Turning Point hears feedback and dialogue on how to best support families. Housing continues to be a challenge in the community in general. Turning Point works closely with community partners to secure additional units and to utilize hotels for homeless individuals waiting for units to become available. The program continues to oversee the existing housing units and has many tenants who have remained successfully housed for four or more years.

Program Participant Story

In FY 20/21 Turning Point voluntarily served a young man who was having difficulty both adhering to the doctor's recommendations and navigating his relationship with his mother. With Turning Points' ability to provide more intensive services, more time was spent engaging this young man while also building rapport with his mother, helping to reinforce positive boundaries between mother and son so staff could get to know him and his needs. Staff worked intensely with this young man and his mother together, and recently has been able to take the step of meeting with him independently. As a result, he is adhering to his medication protocol and speaking openly with the doctor about his needs. He now enjoys coming to Turning Point and always has a big smile and greeting for staff he sees. He still has a treatment journey ahead, but his symptoms are subsiding, he is smiling, and he has sources for support with his life.

General System Development:

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

Program Description

Program Overview
Nevada County Behavioral Health (NCBH) partners with licensed therapists, Network Providers, who work in the community at private offices. They see children, Transition Aged Youth (TAY), adults and older adults referred to them by NCBH. Nevada County Behavioral Health refers program participants with less acute needs to the Network therapists. These individuals do not appear to need medication or significant case management. Network providers help to serve additional individuals and offer partners and families a variety of specialties and locations that NCBH would not be able to offer otherwise.

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

Evaluation Activities and Outcomes

In FY 20/21, 16 unduplicated participants were served. This included 10 individuals served in the Children's System of Care and six individuals served in the Adult System of Care. Four Network Providers are contracted with Nevada County Behavioral Health to provide these services: two for Adult Behavioral Health and two for Children's Behavioral Health.

Baseline and annual Basis 24 outcome measure surveys are usually collected for individuals served by the Adult System of Care. Unfortunately, due to COVID and beneficiaries receiving few in-person sessions, none of these individuals were on-site and asked to complete a Basis 24 in FY 20/21.

The NCBH Children's System of Care is collecting the Child and Adolescent Needs and Strengths Assessment 50 (CANS 50) and the Pediatric Symptom Checklist 35 (PSC-35) outcome measures per state requirement. Due to COVID only three youth were reassessed during FY 20/21. Two youth received initial assessments, and their reassessment results will be analyzed next fiscal year. Analysis of the CANS 50 scores for the three children who were reassessed in FY 20/21 showed no significant improvement or decompensation.

Challenges, Solutions, and Upcoming Changes

Due to the COVID-19 pandemic many individuals are being served virtually. Since participants are not being seen in person, they have not been given the Basis 24 outcome measure tests for comparison to their previous scores. Therefore, even though the county has a new evaluation dashboard, accurate program evaluation is difficult due to lack of current data.

The Network Providers reported a smooth transition from in person to virtual services during the COVID-19 pandemic.

General System Development:

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

Program Description

Program Overview

The Nevada County Behavioral Health (NCBH) System of Care provided 5,294 psychiatric services to 763 individuals in FY 04/05. MHSA allows counties to expand the number of psychiatric services provided to beneficiaries starting in FY 07/08, by paying for these services out of MHSA, Community Services and Supports, General System Development funds. Due to system changes at the county between 2005 and 2007, historic data from FY 06/07 was not available to use as a baseline. Thus, FY 04/05 became the baseline measurement for the Expanded Psychiatric Services program for NCBH and the county reports annually on the amount of MHSA funds used for psychiatric services. In FY 20/21 MHSA funds paid for 3,606 Expanded Psychiatric services to 537 individuals.

Nevada County Behavioral Health (NCBH) Children's Services provided 707 Expanded Psychiatric services to 133 children with MHSA funds in FY 20/21. Some children were being wrapped with Full-Service Partnership (FSP) providers. Some children continue to see the NCBH doctor individually and work with the WRAP team.

Nevada County Behavioral Health Adult Services provided 2,899 Expanded Psychiatric services to 404 adults with MHSA funds in FY 20/21.

Target Population

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

General System Development:

SIERRA MENTAL WELLNESS GROUP

Expand Crisis and Mobile Crisis Intervention Services
Crisis Workers, Crisis Support Team

Program Description

Program Overview

MHSA funding provides a Crisis Worker Position, a Mobile Crisis Position, and a Crisis Support Team at the Crisis Stabilization Unit (CSU) at the local Sierra Nevada Memorial Hospital (SNMH). The Crisis Worker and CSU Support Team are available 24 hours a day, seven days a week, while Mobile Crisis is available four days a week, 10 hours per workday. These positions are exclusive to western Nevada County; however, Crisis serves beneficiaries from anywhere. Funding sources used to support Crisis Services included Medi-Cal, 1991 Realignment funds, and MHSA-CSS funds.

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

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

Target Population

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

Evaluation Activities and Outcomes

In FY 20/21 the targeted goal was for Crisis Specialists to serve 1,152 individuals. The result was 1,048 unduplicated people served, representing 91% of the goal. A total of 2,144 contacts occurred; many of the individuals were seen two or more times throughout the year. This is a significant (5% increase) from the total contacts during the prior FY 19/20, where the Crisis Workers had a total of 2,036 contacts. Of the 2,144 total contacts, 189 were services in Truckee, while the remaining 1,955 services were supplied in and around Grass Valley.

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

immediate access to Crisis Services and shortened response time. The presence of the Mobile Crisis Unit has already allowed for immediate response to crisis situations within the community offering evaluations and referrals and preventing folks from needing to go to the Emergency Department.

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

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

Challenges, Solutions, and Upcoming Changes

The COVID-19 pandemic was a major challenge this year. It dramatically reduced the number of beneficiaries seen in Crisis and in the CSU. Not as many consumers were coming to the facility for crisis services out of fear of being near COVID patients being treated at the hospital. Due to this virus's extremely contagious and potentially life-threatening qualities, many consumers opted to not come to the facility for fear of exposure. Many safety precautions were instituted including all staff wearing masks, sanitizing all surface areas within the Crisis office and CSU every shift, and requiring consumers that come to the CSU to immediately shower and wash their clothing upon admittance. It became obvious that if consumers were not able to come to the CSU/Crisis office, staff would need to meet people out in the community. This has been the driving force for initiating the new Mobile Crisis Unit.

Due to COVID-19, there was a significant decrease in the number of beneficiaries in the early part of the fiscal year, however in March there was a rise in numbers as restrictions were beginning to be lifted. In FY 20/21 it became necessary to move the on-call position back to an on-site shift to accommodate this surge in mental health needs. This change was approved and will begin July 1st, 2021. This change will help to provide support to crisis staff, while continuing to meet the needs of consumers and will not change the response time.

In addition, Truckee Forest Hospital expressed a need for consistent care while beneficiaries were on WIC § 5150 hold. They also recognized a need for a clinician to be connected to the community. This prompted the implementation of a full-time on-site clinician Monday through Friday to support the needs of the hospital and community. This new Truckee Crisis position was approved and began July 5, 2021. It has been very well received.

Program Participant Story

A repeat consumer was identified as being in crisis by the Truckee crisis worker, however the consumer did not meet criteria. They had many risk factors that if left unattended, could have made this consumer very vulnerable out in the community. It was deemed appropriate that they could be

transferred from the Truckee hospital to the Grass Valley CSU for crisis stabilization and services. Ultimately the consumer stayed in care at the CSU and was connected with other supportive agencies within the county. The consumer has since been stable due to the diligent work of the crisis workers recognizing this person's unique needs and facilitating necessary and specific quality of care. This individual frequently returns to inform staff of their progress and how supported they felt.

General System Development:

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

Program Description

Program Overview

The Crisis Stabilization Unit (CSU) serves individuals in Nevada County experiencing a mental health crisis or emergency. It is a four bed, unlocked unit, staffed by a licensed mental health professional and a licensed medical professional who are on-site at all times. Psychiatrists are on-call 24 hours a day, seven days a week. The CSU Manager is a Registered Nurse who has been in this position since 5/1/2019. The CSU team works in close partnership with the Crisis Response Team. Individuals may be admitted voluntarily while awaiting placement on a WIC § 5150 hold.

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

Target Population

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

Evaluation Activities and Outcomes

In FY 20/21 the CSU, served 370 individuals with 651 total admissions. This represents 80% of the annual goal of 460 individuals to be served. The CSU program allowed the rescinding of 23 of

the 116 WIC § 5150 holds (35%). Additionally, two of the WIC § 5150 holds (1%) safely expired during the individual's stay as they were able to be stabilized and connected to local medical care and resources. Collaboration between therapists, beneficiaries and their loved ones, development of personalized recovery/safety plans and follow up appointments made by the CSU staff helped to reach these successful outcomes. The availability of the CSU offers the crisis staff an additional resource as part of an individual's safety plan. For the beneficiary, it is a safe haven away from the stressors that are often catalysts to their crisis and a way to be connected with a therapist, nurse and helpful resources in the local community.

The CSU has been a success with beneficiaries. Satisfaction surveys were completed by 57% of individuals that stayed in the CSU during FY 20/21. They reported a 97% degree of satisfaction with the treatment they received and the progress they made during their stay.

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

The county jail, Nevada County Behavioral Health, Granite Wellness Center, Hospitality House, FREED, therapists and local clinics often refer individuals directly to the CSU. A working relationship has been established with these stakeholders to communicate with Crisis and CSU staff regarding patrons' care. Arrangements have also been made for Placer and Sierra Counties to admit their community members to Nevada County's CSU. In FY 19/20 this contract was reestablished after an interruption, placing five Placer County and two Sierra County residents in the Nevada County CSU.

Work with the newly establish HOME (Homeless Outreach and Medical Engagement) Team has proven successful for the individuals who are homeless and not linked to any other county resources. This partnership provides a warm hand off for these individuals when leaving the CSU.

Challenges, Solutions, and Upcoming Changes

An ongoing challenge which began in March of 2020 is the impact of COVID on both the CSU beneficiaries and staff. Staff is kept apprised of frequent changes in COVID protocols and all staff and beneficiaries wear masks in the building. The CSU and Crisis managers have done extensive outreach during the last year and a half to let community partners know that the CSU is still open and available for beneficiaries. The CSU teamed up with Briar Patch Co-op in July 2021 to make customers aware of the services offered at the CSU/Crisis. Briar Patch sent out information about the CSU/Crisis in their monthly newsletter and they have information displayed in the store.

Program Participant Story

An individual presented to the CSU for an evaluation. They had had stopped taking their psych meds and relapsed into substance use. This individual was very distraught, as they were due to

start a new job in a few weeks. The staff worked diligently at stabilizing this person, were able to rescind his WIC § 5150 for and connect him to follow up services and treatment. He was seen two more times by CSU staff, both on a voluntary basis, and he was doing better each time. The individual came to the CSU a few months later and had been clean of substance use ever since his CSU stay, he was back on medications and starting a new job.

General System Development:

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

Program Description

Program Overview

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

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

Services provided include the following:

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

Target Population

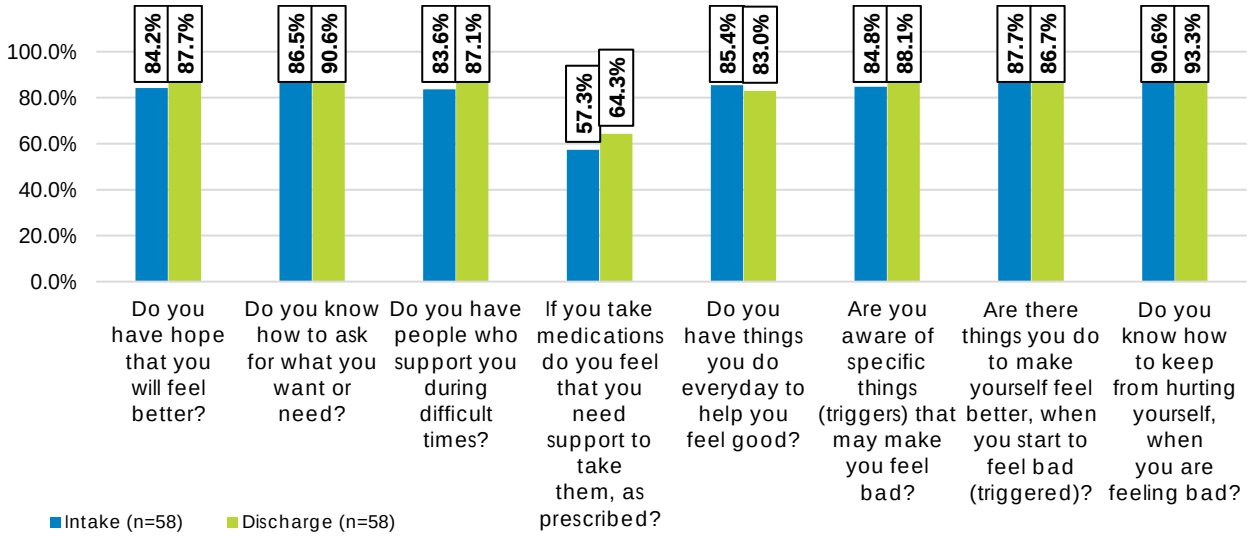
IRC serves guests 18 years of age and older, who have a mental illness, and because of the disorder, are at risk of needing a higher level of care. Guests could be at risk of needing psychiatric hospitalization, placement in an Institute of Mental Disease (IMD), Mental Health Rehabilitation Center, or Crisis Stabilization Unit. Guests may be recently discharged from one of these

placements or experiencing a first episode or re-emergence of a psychotic break. Individuals must be assessed, medically cleared and approved by Nevada County Access Team, and then screened to determine appropriate fit by the IRC Leadership Team. Guests may not be under the influence of alcohol and/or illicit drugs and must be able to maintain acceptable hygiene. Guests are responsible for preparing meals and cleaning up after themselves. Guests must be able to understand and sign necessary documentation, be willing to follow the guest agreement upon entering the house and have a place to return to when leaving IRC, even if that is a homeless shelter.

Evaluation Activities and Outcomes

In FY 20/21 the IRC provided:

- Referrals to community services: 95
- Duplicated service contacts: 97
- Unduplicated individuals served: 63
- Discharges: 97
- Linkages made to community resources: 103
- From January through June 2021, IRC staff used a Social Functioning Questionnaire to rate five guests. The survey rates guests independent living skills between one and four for 28 questions, where one is the lowest score possible and indicates limited functioning in that area and four is the highest score and indicates superior or exceptional functioning in that area (there is also a Not Applicable designation if the item is unknown or inapplicable). The average Independent Living Skills score for these guests was 3.3 which is in the Moderate range, and the average Social Functioning Score was 2.5 which is in the Intermediate range.
- As part of the guest's intake and discharge process, they are asked to fill out a Pre/Post Outcome Survey. Eight items are measured as a pre/post comparison between intake and discharge. Participants answer the following items using a 3-point Likert scale (Rarely, Some of the Time, Most of the Time). Based on the Pre/Post Outcome Survey below, guests showed improvement in all but two areas. Pre- Post Outcome Survey (see below)



- Client Satisfaction 10 question survey overall satisfaction rate: 91.5%

Challenges, Solutions, and Upcoming Changes

The FY 20/21 began with relocation of the program site, amid the escalation of the COVID-19 pandemic. In collaboration with Nevada County Behavioral Health, it was determined that IRC would maintain an open room for quarantining purposes, if needed, and protocol was put into place ensuring the health and safety of IRC colleagues and guests served. These protocols outlined Responsibilities of Leadership (Managers and Supervisors), Responsibility of Colleagues, Program Site Protective Measures, Program Site Cleaning & Disinfecting Measures, Exposure Situation Protocol and Confidentiality & Privacy. These protocols made it possible for IRC to remain free of COVID-19 infection, keeping staff & guests safe and healthy. Increased focus was placed on continuing Medi-Cal billing training in order to raise revenue, amid the pandemic, and to support the viability of the program and its provided services. Finally, the fiscal year ended with relocation of the program site, due to unforeseen circumstances, to a lovely, rural setting in the south Nevada County area.

Program Participant Story

Written by a former guest:

> *"I came here with no hope, no plans, nowhere to go and nowhere to turn. The staff talked to me, and shared stories of struggles they have been through. It gave me hope and helped me see through the dark place I was at in my life and mind. This place gave me a chance to unwind and to regroup. It has saved my life. I am so grateful that I had this chance."*

General System Development:

SPIRIT
Emergency Department Outreach and Engagement
Emergency Department (ED) Crisis Peer Support Program

Program Description

Program Overview

The goal of the SPIRIT Emergency Department Program (EDP) is to improve care, reduce the frequency, cost, and length of stay of emergency visits and to shift vital Nevada County Behavioral Health resources away from Emergency Care into effective community-based long-term solutions.

SPIRIT EDP, in collaboration with Serra Nevada Memorial Hospital and the Crisis Stabilization Unit (CSU), offers Peer Support services during and post hospitalization. EDP Crisis Supporters continue to fill the gap and provide a bridge post-hospitalization to gently guide beneficiaries through follow-up appointments, into one or more of the appropriate long-term recovery focused programs.

The SPIRIT Crisis Peer Team is on-call at the local hospital's Emergency Room and the Crisis Stabilization Unit, seven days a week from 10:00 am to 8:00 pm.

Target Population

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

Evaluation Activities and Outcomes

In FY 20/21 the EDP in collaboration with the SPIRIT Center, received funding from the most recent round of the Emergency Solutions Grants – CARES Act (ESG-CV) grant. This influx of funds allowed the program to hire two Housing Specialist staff members, increase the warm food program, and start several housing related support groups. The program is designed to get people working toward stable income and long-term housing. The goal of the dedicated housing services is to: reduce re-hospitalization rates among intensive service recipients who are served in the CSU and Emergency Room (ER), increase rates of warm handoff referrals between the CSU and SPIRIT and strengthen transitions between crisis services and community-based programs such as mental health outpatient clinics, case management services, such as the HOME Team and residential programs such as the Respite Center.

Due to the impacts of COVID-19 restrictions, the SPIRIT Emergency Department /Crisis Team completed FY 20/21 year just below the overall target numbers. The EDP's target was to serve

220 individuals. Only 188 were served, but recovery feels strong. The COVID restrictions strongly impacted the number of beneficiaries the team was able serve, but they continued to meet all supportive goals, i.e.: referrals, follow-ups and initiating WRAP plans (see below).

The SPIRT EDP Crisis Supporters completed the year with a total of 206 intakes for 188 unduplicated individuals in the ER and CSU. There were 102 Action Plans discussed, and 111 Stress Reduction Plans implemented. A total of 289 referrals were made to various partnering agencies. The team made 206 follow up calls with 23 leading to one-on-one support at the SPIRIT Center.

SPIRIT EDP Data Collected:	**FY 20-21**
Unduplicated Individuals Served	188
Requests for Post-ED Follow-up Appointments	206
WRAP Action Plans Developed	102
Stress Plans Discussed	111
Referrals Made	289
Resources Accessed	70
Referrals to SPIRIT Center	23

Challenges, Solutions, and Upcoming Changes

The EDP Crisis Team is still seeing the impacts of the COVID-19, including increased difficulty finding stable employment and sustainable housing for the beneficiaries served. Additionally, beneficiaries are having difficulty finding and maintaining cellphones and service. The Crisis Peer Counselors continue to see beneficiaries who do not have phones and who request follow-ups through other methods such as mailing updates or coordinating through the CSU or other agencies. This lack of communication adds to the struggle of making appointments and moving forward with life goals. All these challenges increase stress levels, fear, and worry and can be a major factor in triggering a mental health crisis.

The biggest success continues to be the increase in ER/CSU beneficiary becoming SPIRIT Center participants. This comes from deeper connections made at the CSU and more crossover between EDP and SPIRIT Center staff.

The recently awarded Homeless Resiliency grant has afforded SPIRIT the ability to hire two additional staff. The Homeless/COVID Specialists offer light case management, advocacy, and facilitate multiple groups with the goal of helping homeless and low-income individuals to better their own lives. Meeting basic needs with a little bit of nurturing and assistance is a necessary part of building a foundation for mental health and lowering the number and intensity of Emergency Room and Crisis stabilization Unit visits.

The EDP staff are peers with previous lived experience of mental health issues, homelessness and/or addiction issues, who can assist CSU beneficiaries through the many struggles they face.

To increase availability, the Crisis Counselors are available on-site at the ER/CSU, or a beneficiary can call the SPIRIT Center and talk with a Peer Supporter from the safety of their home. All beneficiaries received at least two follow up calls per ER/CSU visit.

Program Participant Story

An EDP staff member complete an Anger Management Program. This person came to SPIRIT as a beneficiary through the CSU. She became a participant at SPIRIT and took the Peer Support Training, and the Basic and Advance WRAP Trainings. She is now leading the first Anger Management Group with eight active participants. She's assisting participants in learning tools for healthy expressions of anger.

General System Development:

STANFORD SIERRA YOUTH AND FAMILIES
Intensive Services for Youth

Program Description

Program Overview

Stanford Sierra Youth & Families (SSYAF) provides comprehensive specialty mental health services for children and their families throughout Nevada County. There are two (2) specialized programs available to program participants: Family Preservation (FP), which seeks to provide family stability to families who have children who are at risk of removal from their home or at risk of Child Welfare or Probation involvement; and Therapeutic Support Services (TSS), which provides services to pre- and post-adoptive families. Specialty Mental Health Services provided are based on established medical necessity criteria for mental health services due to behavioral, emotional and functional impairments meeting Nevada County Behavioral Health (NCBH) Plan eligibility.

Target Population

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

Evaluation Activities and Outcomes

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

The following CANS scores are for youth served in FY 20/21. Stanford Sierra Youth & Families served 120 unduplicated youth and their families. As data collection and reporting strategies progress, data outcomes for individual domains will be shown. This data will drive new areas of focus for SSYAF as it relates to needed training and/or additional supervision.

CANS Summary: 83% of individuals' CANS scores improved this fiscal year. The individuals whose scores did not improve were either moved to a higher level of care or had significant traumas and major life changes and are working through their issues with their current treatment teams. During the past year while COVID continued to ebb and flow, children and families alike all struggled to adapt to life during a pandemic. The SSYF treatment team has managed to continue to provide support, however outcomes have not been as exceptional as in previous years.

Additional outcome results are collected quarterly and average scores for FY 20/21 are shown below. These outcomes include a focus on permanency, school performance, parenting skills increase, legal involvement and placement disruption. As seen in the table below, parents struggled to create balance between parenting at home and taking care of their own mental health and supportive needs. The treatment team at SSYAF is continuing to evaluate the needs of families and youth during the continued pandemic. See table below.

Stanford Sierra Youth & Families Outcome Measures

Goal	Objective	Fiscal Year '20-'21
To prevent and reduce out-of-home placements and placement disruptions to higher levels of care.	80% of children and youth served will be stabilized at home or in foster care.	119/120: 99%
Youth will be out of legal trouble.	At least 70% of youth will have no new legal involvement between admission and discharge.	119/120: 99%
Youth will improve academic performance.	At least 80% of parents will report youth maintained a C average or improved on their academic performance.	91/120: 76%
Youth will attend school regularly	At least 75% of youth will maintain regular school attendance or improve their school attendance.	115/120: 96%
Youth will improve school behavior	70% of youth will have no new suspensions or expulsions between admit and discharge.	108/120: 90%

Caregivers with strengthen their parenting skills	At least 80% of parents will report an increase in their parenting skills.	94/120: 78%
Every child establishes, reestablishes, or reinforces a lifelong relationship with a caring adult.	At least 65% of children served will be able to identify at least one lifelong contact.	120/120: 100%
Caregivers will improve connections to the community	At least 75% of caregivers will report maintaining or increasing connection to natural supports.	95/120: 79%

Challenges, Solutions, and Upcoming Changes

As part of a larger organization, Stanford Sierra Youth & Families is attempting to incorporate all Electronic Health Records (EHR) into one universal system. The SSYF Nevada County Family Preservation team is meeting monthly with the SSYF Quality Improvement department to determine the best practice for managing electronic health records that meet both the requirements of the county and internal record keeping measures that accommodate both systems. This challenge is primarily eradicated through conversation and consultation surrounding what each system is capable of, balanced with the needs of the county and the needs of the organization.

Stanford Sierra Youth & Families, Nevada County mental health team continues to provide more intensive care to a greater number of youth and families than the contract was designed and funded to serve. Stanford Sierra Youth & Families is pleased to be an essential part of the Nevada County Children's System of Care, however, the pace of the referrals and the time needed to meet the needs of the youth and families is demanding significant overtime commitments from the SSYAF team members. SSYAF continues to work with Nevada County leadership to address this concern in future contracts. Stanford Sierra Youth and Families continues to express interest in becoming a Full Service Partner to Nevada County Behavioral Health and are continuing to explore ways to meet the needs of children and their families on a more intensive basis.

An additional concern is experienced throughout Nevada County's rural population: retention of well-established, exceptional mental health clinicians and workers. Last year the Family Preservation team experienced a drop in staff retention and an increase in referrals due to increased mental health issues arising from COVID related issues (isolation, distance learning, etc.). The program director and NCBH director have discussed this at length in monthly meetings and continue to check in with one another surrounding hiring practices and ability to retain essential employees. This challenge continues to be an ongoing concern for most Nevada County Behavioral Health employers and contractors.

Program Participant Story

A girl was referred for services a few years ago by her school counselor. She had been living in a home that was unsafe and was voluntarily taking steps with a local organization to be placed in a foster home. When referred, she had been having trouble in school, had issues remaining housed and with substance use among other symptoms of her deteriorating mental health. This young woman had been in therapy for most of her childhood and didn't want to meet with a therapist. She reluctantly met with a therapist, naming all of the therapeutic interventions she'd learned over the years and explained that none of them worked for her, that she didn't trust people, especially adults. Over the course of the next couple years, the girl continued to consistently meet with the therapist and slowly began to build trust, sharing her thoughts and feelings during therapy. This was a case where the therapeutic relationship really was the best intervention. The girl also developed trusting relationships with other adults at local agencies where she received services.

Over the last couple of years, the girl was transferred to a new school. This was the first school she enjoyed, and that led to her graduation! Her symptoms and negative behaviors have significantly decreased over the year. More recently, COVID did increase her symptoms however it also helped her to learn the importance of relationships and connecting to others. The girl has been working for the past year and is a valued employee, showing up for every shift. She practiced nonviolent communication with her last foster mom, learning to navigate difficulties without aggression, defiance or running away. She recently moved out of her foster home and is currently living with a family member. Therapy has been reduced to monthly as the girl makes natural connections and transitions to living on her own. Therapeutic services have been continued at her request and will likely end in the next couple months after a long term transition plan was established to increase the likelihood of sustained success and progress.

General System Development:

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

Program Description

Program Overview

NCHDC, the Nevada County branch of the Advocate for the Mentally Ill (AMI) Housing, operates a total of 18 properties totaling 56 units. The programs include Permanent Supportive Housing (PSH), Prop 47, and Purdon/28 Day House. In the permanent supportive housing program NCHDC provides case management and other supportive services to formerly homeless individuals who now reside at one of the master leased or owned properties. The Prop 47 program receives referrals from the Public Defender's office for individuals experiencing a high level of recidivism and who are currently homeless. While at the Prop 47 house, tenants receive case management including

transportation, housing search assistance, substance use referrals, and obtaining income or other necessary services. The Purdon/28 Day House provides temporary respite while homeless individuals may be seeking out or waiting for other housing options such as a bed at a substance use treatment facility, an apartment, or an opening at the shelter or other transitional housing. NCHDC provides numerous repairs to the master lease units, operates a work training program for beneficiaries to receive income while learning basic handyman skills, and has obtained over 30 Housing Choice Vouchers (formerly known as Section 8) for individuals in the community.

Target Population

NCHDC serves individuals who are currently experiencing or have previously experienced homelessness in Nevada County. The clientele are typically involved with Nevada County Behavioral Health, FREED, or Turning Point and are receiving services for a physical or mental disability. In the housing units 62% of individuals have been chronically homeless in Nevada County.

Evaluation Activities and Outcomes

Through the support of the NCHDC team, tenants are able to obtain and maintain housing in an independent living situation while still receiving the support services necessary from the agency and other community partners, significantly reducing the likelihood of a return to homelessness, relapse, or incarceration. In FY 20/21, NCHDC served 89 individuals, seven of whom were children, four of whom were veterans.

The average length of stay in permanent supportive housing (PSH) is over 2 ½ years. Additionally, 13 individuals have been successfully housed in NCHDC permanent housing for over five years. Thirty-one individuals in PSH have three or more disabling conditions, and 14 individuals in transitional housing have three or more disabling conditions. Forty-five individuals had been homeless for more than three years prior to entering these programs. Prior to being housed at NCHDC, 34 individuals came from the shelter, four from transitional housing, 16 were either camping or sleeping in their vehicle, three were in a recovery residence, two were in a hotel, seven were renting their own unit, and two were in a psychiatric facility or nursing home. The goal is to assist these individuals in adjusting from institutional or unstable living environments to their own home through supportive services that teach everything from how to maintain their living environment to finance and budget skills to various interpersonal and social skills.

Challenges, Solutions, and Upcoming Changes

The current housing market in Nevada County continues to be a challenge for which NCHDC is working on creative solutions. With a lack of affordable housing units, income, vouchers or credit history are no longer the primary barrier to obtaining housing for these beneficiaries. The primary barrier is often simply a lack of inventory. NCHDC has increased landlord engagement through the implementation of a housing team, increased outreach efforts, and increasing community awareness of the program. In doing so NCHDC has been able to nurture old relationships and

create new ones. In previous fiscal years NCHDC worked primarily with independent owners, and in FY 20/21 they have expanded to include local property management companies and larger corporations.

Program Participant Story

Mary* and John* are good friends who have spent the majority of their lives on the streets in Grass Valley. John looked out for her, denying a bed at the shelter to sleep outside with her instead. They have a combined 40 years of homelessness between them and have been familiar faces to service providers for many years. They came to NCHDC transitional housing and were able to obtain Housing Choice Vouchers and case management. Through NCHDC case management, they are now sober and compliant with medication and other services necessary to their success. They are now permanently housed locally and are stable and enjoying living indoors for the first time in many years. A local church group supplied them with all the furnishings for their new place. NCHDC visits them periodically to make sure they have everything they need and are enjoying their new home.
**No real names not used to protect privacy*

General System Development

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

Program Description

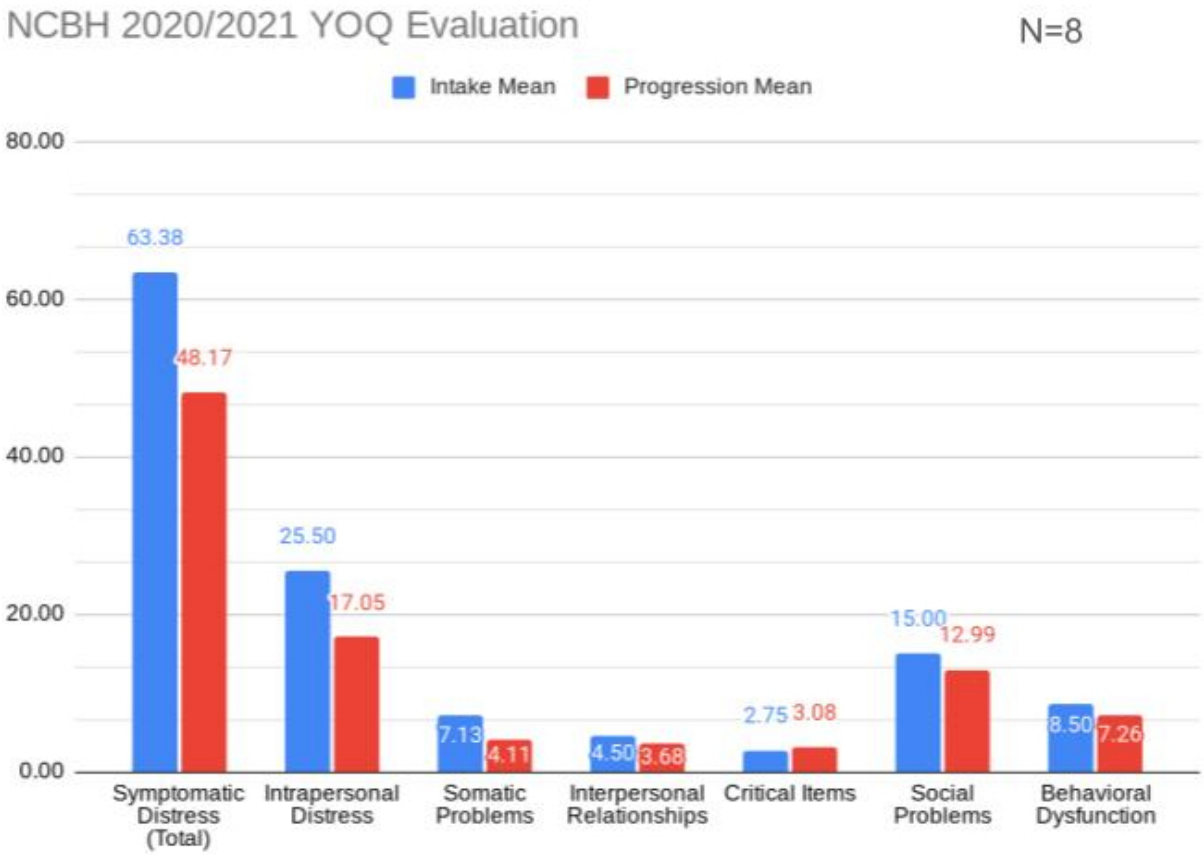
Program Overview
Whole Hearts, Minds and Bodies (WHMB) pairs clinically supervised Mental Health Workers (MHW) & Mental Health Rehabilitation Specialists (therapeutic mentors) with high need youth and transitional age youth in the Tahoe-Truckee community in a one-on-one relationship. Mentors meet with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

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

Evaluation Activities and Outcomes

Whole Hearts seeks to reduce negative outcomes of untreated mental illness in at least 80% of youth served. This is measured through the completion of a Youth Outcome Questionnaire Self Report (YOQ-SR 2.0) at intake and every six months thereafter. Additionally, youth take a Participant Perception of Care survey.

Gateway successfully served 13 youth and families in the Truckee region in FY 20/21. Of the 13 youth served, eight successfully completed at least two YOQ surveys allowing meaningful conclusions to be drawn. The data revealed that overall symptomatic distress was reduced by 22% (see figure below). The remaining five youth have not been in the program long enough to have at least two data sets completed.



Additionally, data collected from Perception of Care surveys indicated improvement in the following areas:

- 71.4% of youth experienced improvement in Living Situation
- 57.1% of youth experienced improvement in School
- 83.3% of youth did not require Emergency Services
- 66.7% of youth learned coping mechanisms other than using substances

No referrals were made to other mental health agencies beyond Gateway internal programs.

Challenges, Solutions, and Upcoming Changes

The ever changing environment of a pandemic year continued to stress resources, however WHMB is proud of their pandemic response and were successful at continuing in person outdoor sessions throughout the year.

Administration capacity was also challenged to meet the data management and tracking needs. Gateway has invested in Case Management Software that should alleviate much of the burden in the future. Integration of the software is expected by October 2021.

Program Participant Story

When completing a service verification, a participant's father broke down in tears praising the positive role model the mentor has been to his daughter over the years; saying that the mentor has made such a difference in her life.

General System Development

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

Program Description

Program Overview

The National Alliance of Mental Illness (NAMI), Family Education and Support program provides peer-led education and support meetings three times per month. One of these meetings is in collaboration with Turning Point, and one is school-based for parents of school-aged youth. Educational meetings are provided 12 times per year.

The program develops relationships with families of youth and young adults affected by mental health conditions and facilitates linkage with NAMI Basics, a six-session education program for parents, caregivers and other family who provide care for youth (ages 22 and younger) who are experiencing mental health symptoms. Follow-up education and support is also provided.

The Family Education and Support program hires or contracts with navigators to help families navigate community systems while providing specific support, education, and coaching to individual families who are struggling with understanding and navigating the forensic, education, social services, and treatment arenas.

Target Population

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

Evaluation Activities and Outcomes

The Family Education and Support (FES) program served 61 unduplicated individuals in FY 20/21. Three support meetings were held each month for a total of 36 meetings. The attendance ranged from three to 14 people per meeting. The average attendance was eight participants; 12 educational meetings were held with the following speakers and topics:

- Dr. Romer; Bipolar Disorder
- Dr. Mazer, PhD; Understanding Therapy
- Colleen Phalen, Psychiatric NP; "Ask the Doctor"
- Susan Leff, Assistant Public Defender; Understanding the Public Defender Office, How the Criminal System Can Affect Us, and What We Can Do
- Lt Joe Matteoni of GVPD; How GVPD Addresses Mental Illnesses
- Cathy and Rich Stone: NAMI's Family to Family Education Program
- Brendan Phillips, Nevada County Housing; Housing Options for the Homeless and Mentally Ill
- Kelly Carpenter, Public Guardian; Conservatorships
- Nick and Amanda Wilcox: Laura’s Law
- Judge Tom Anderson; Criminalization of Mental Illness
- Julie Lang, MFT; Self-care for Those Dealing with Mental Illnesses
- Sandy Farley, RN; Crisis Stabilization Unit - How it Works and What to Expect

Twelve participants registered for the NAMI Basics program. Two people have begun the program, and none have finished the program yet. Forty-eight participants were provided navigation services.

The Caregiver Strain Questionnaire is given to all caregivers every six months to measure improvement. Out of 33 caregivers in the program, 18 submitted baseline surveys (55%) in April. Follow-up surveys will be disseminated in the fall. Improvement scores will be shared in next year’s Annual Progress Report.

Challenges, Solutions, and Upcoming Changes

The greatest challenges addressed this year were the constraints of COVID-19 and having to provide all services remotely via Zoom and telephone. Fortunately, staff with technological capability were able to set up the Zoom meetings and educate those who had difficulty. Facilitation style had to adapt to Zoom meetings too. A benefit has been that families can participate irrespective of their location. Family members from Iowa, Arkansas and Santa Barbara were able to attend calls to meet with ill family members located in Nevada County. However, there also have been barriers with Zoom meetings. Families who don’t have a computer/phone access or a

private place (away from other family members) were limited as to the number of meetings/calls they could participate in. A number of these participants were helped individually via telephone. Because of COVID the Family Education and Support program was not able to join with Turning Point (TP) for mutual support meetings. However, parents of TP beneficiaries participated in the FES support and educational programs. Additionally, FES staff are meeting with TP staff to move forward on a mutual support process. FES has also partnered with Nevada County Behavioral Health (NCBH) and TP to develop a Family Orientation program to strengthen family members' expectations as to the services provided and how to connect with the staff who help their ill family members.

Also, as a result of COVID, plans to reach out to parents of young people was not as successful as planned. A presentation was given to all of the school counselors in the western county schools in the fall. Unfortunately, only two families were referred to the FES program. One of those families has continued to participate in the support program. The other could not participate virtually because their Ill child in the home (privacy). In talking with others, including those who had registered for NAMI Basics, but did not continue, it appears that the impact of online schooling along with other issues brought on by the pandemic affected their availability to commit to additional virtual meetings.

A true strength of the program is that some participants/families receive services from the private sector, some from the public sector, and some who don't receive services at all. These diverse points of view provide for a wide range of experiences to share.

Program Participant Story

The overarching purpose of the Family Support and Education program is to help families to address the profound trauma that results when a family member develops a severe mental illness and help them build resilience to manage their own lives. All of this while still being there for the family member with mental illness. This can take years. One member has been coming for a number of years to regular support meetings. She has been very impacted by the mental illness of her family member. The family member was marginally functioning, but with the isolation of the pandemic, has become more agitated. Through this woman's participation in the FSE program, she has learned the landscape of what is available, is seeing a therapist herself, is able to define stronger boundaries with her ill family member and is helping others in group meetings.

Outreach and Engagement:

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

Program Description

Program Overview

Sierra Family Health Center (SFHC) provides outreach, engagement and care coordination services to patients in underserved areas and keeps abreast of community services that are available to help patients and their families. Services include connecting patients to therapy services either at the clinic or with a provider of preference in the community which accepts the patient's insurance. SFHC staff meet with each individual to determine their needs. This includes potentially new patients, as well as existing patients who need assistance. Other services include connecting patients to food and community resources; housing, insurance, disability assistance, encouraging patients to identify and connect with family and/or community support systems; patient education regarding resources; and supporting patients in connecting to FREED, Hospitality House, Community Beyond Violence, and other community agencies.

Target Population

Sierra Family Health Center serves low income and underserved individuals in Nevada County**.** Approximately 60% of patients seen have some type of Medi-Cal coverage, with another 10% having Medi-Cal as secondary insurance to Medicare. SFHC provides discounted assistance to patients above the Medi-Cal income eligibility and below the Federal Poverty Level. SFHC serves patients who have Medi-Cal as their primary insurance and those who have Medi-Cal as secondary insurance to Medicare.

Evaluation Activities and Outcomes

During FY 20-21, 65 unique patients needed assistance. Forty-three of them engaged in accessing community supports within 90 days, representing only 66% per cent of patients. COVID-19 had a clear impact on the behavioral health program as therapy and care coordination services were all provided remotely, as were a number of community services. Patients required more assistance in accessing services and mental health symptom acuity increased. However, because there were less no-shows/transportation barriers, some patients were also able to be seen by therapists more frequently which resulted in stronger resilience. SFMC has now started to transition back to in-person visits for those who request them and are vaccinated.

Initial outreach efforts were to ensure that patients had food as 23 patients had comorbidities which impacted their ability to access services outside their home. FREED's food delivery program has been essential as well as the Nevada County Left Coalition food assistance program. Overall patients were referred to Hospitality House (4); Logisticare transportation (9), Medi-Cal or assist

with changes (10), CalFresh (8), Alta Regional Center (1), Community Beyond Violence (3), SPIRIT Center (3), Granite Wellness Centers (4), Common Goals (2), Nevada County Behavioral Health (NCBH) for either Mental Health or Substance Use (11), FREED (21), Nevada County Left Coalition Workforce Development (2), Connecting Point (9), Interfaith Food Ministry (3), Salvation Army (2), and community therapists (8).

Challenges, Solutions, and Upcoming Changes

As reported in previous years, housing continues to be the highest overall challenge. Rental units, including rooms, are very difficult to find. Homelessness is increasing with a number of patients' couch surfing, living in their cars, and in shelters on properties. Few patients wish to go into town for assistance at Hospitality House, although they are encouraged to try. Fortunately, several patients were able to receive assistance from FREED to get into affordable housing.

Secondly, transportation continues to be a challenge as services open up for in-person visits. A silver lining due to the pandemic has been the ability to have remote visits with providers. Initially patient response was mixed, with some really liking the convenience of remote visits while others preferring to come to the clinic - which was not possible until patients were vaccinated. The isolation from the pandemic has increased the acuity of mental health symptoms for a significant number of patients who now are being seen more frequently. Therefore, SFHC has hired an additional clinician due to demand.

Moreover, SFHC was successful in obtaining a community grant from Dignity Health for the Patient Access to Care Gas Card Program. This program provides eligible patients with a $25 fuel card who meet income requirements and have appointments with SFHC and/or need to get to Sierra Nevada Memorial Hospital. SFHC has partnered with the North San Juan Community Center and the HOME Team who refer individuals to SFHC who need care.

Due to COVID, there have been timeliness delays beyond 45 days for patients being approved for Medi-Cal. The program hopes this abates as COVID restrictions are lifted.

Program Participant Story

A local family was linked to FREED Center for Independent Living by the Sierra Family Health Clinic so they could receive assistance. FREED was able to connect them with a program to have their rent paid by Nevada County to avoid eviction.

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

Program Description

Program Overview

The Housing Assistance Program (HAP) is a collaborative with Hospitality House and Turning Point Community Programs. The goal of the Housing Assistance Program is to deliver mental health services to participants of the Hospitality House shelter and outreach program. One (1) Shelter Case Manager is responsible for assisting Hospitality House participants in meeting their expressed mental health-related goals, including specific assistance with medication management, housing, counseling, medical services, support, brokerage for other needed services, and advocacy. The Shelter Case Manager works directly under the supervision and direction of the Hospitality House Social Services Manager and a Turning Point Manager. The Housing Assistance Program began serving the community in April 2018.

Target Population

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

Evaluation Activities and Outcomes

Hospitality House and Turning Point Housing Assistance Program collected evaluation activities for MHSA, including demographic information on every individual receiving service. Besides, information on individual services, referrals to outside agencies, and the connection rate of those referrals were also collected.

Referrals:

During FY 20/21 Housing Assistance Program staff were able to perform 116 Nevada County Behavioral Health Screenings. Of the 116 screenings completed, 21 individuals were referred for further services with Nevada County Behavioral Health. Of those 15 individuals (71%) connected with Behavioral Health services at the Crown Point facility or with the on-site therapist at Hospitality House emergency shelter.

Services:

During FY 20/21, the HAP was able to provide 478 services, of which 357 (74%) were Case Management sessions. Additionally, the HAP program was able to provide 23 housing counseling sessions/housing search assistance services and 43 mental health support sessions.

Program Goals and Outcomes:

1. Serve approximately 60 unduplicated individuals/families

Outcome: During this time period the HAP program served 68 unique individuals.

2. One third (roughly 33%) of shelter guests, Rapid Re-housing tenants, and Outreach Program participants maintain their housing or improve their housing situation.

Outcome: 2% went to treatment, 37% left to a place not meant for habitation, 45% maintained their housing status, and 15% moved into permanent housing.

3. Ninety percent of program participants (with permanent housing in #2 above) maintain their permanent housing or improve their housing situation.
Outcome: As of 6/30/2021, 100% of participants in permanent housing have not returned to homelessness

4. Program participants receive the services and benefits that they need to obtain or maintain permanent housing or to be able to be a successful shelter guest. Ninety percent of program participants have identified at least one service or benefit that they need and has received that service or benefit.
Outcome: All 68 individuals enrolled in the program (100%) have received at least one service following the initial intake and needs assessment.

5. Ninety percent of program participants show a decrease in prolonged suffering from mental illness as measured by reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning on the Behavioral Health Client Perception Survey.
Outcome: 91% of program participants showed a decrease in prolonged suffering from mental illness. This outcome was primarily tracked by individuals responding positively that they now had people they could go to for support and that they were better able to do the things they wanted to do.

6. Ninety percent of program participants show a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning.
Outcome: 73% of program participants showed a reduction in risk factors. This outcome was primarily tracked by the number of individuals who reported having individuals they could go to for support on the Behavioral Health Client Perception Survey.

7. Seventy percent of referrals provided to program participants are followed up on by the program participant.
Outcome: During the reporting period the HAP program made 38 referrals to outside agencies, unfortunately due to the pandemic and other challenges only 10 participants (26%) were only able to follow up on their referrals.

8. Ninety percent of mental health referrals provided to program participants are followed up on by the program participant.
Outcome: During the reporting period the HAP program made 21 referrals to Nevada County Behavioral Health. Of those, 15 (71%) accepted services at NCBH or from the on-site NCBH therapist at Hospitality House and six (29%) declined referrals.

Challenges, Solutions, and Upcoming Changes

The biggest challenge faced by the HAP program has been an ongoing struggle with COVID-19 as throughout this reporting period the shelter has fluctuated from shelter-in-place to a return to the sending folks to stay overnight in a model. The evolving shelter policies continue to negatively impact HAP participants' mental health and housing opportunities. The risk of becoming ill is much higher among homeless populations, and at the beginning of the outbreak, there was much concern over contracting and spreading COVID-19. As the pandemic has progressed the fears of contracting COVID-19 have continued despite encouragement from program staff. Further, with a frozen housing market and much of the program year spent under shelter-in-place protocols many of the individuals have been sheltering at Utah's Place/ Hospitality House emergency shelter. The setting of a 69-bed emergency shelter for extended periods of time has been reported as having a great impact on the mental well-being of the clients served by the HAP program.

Program Participant Story

One program participant during this reporting period was dealing with some very serious anger issues. He struggled to vent his frustrations in healthy ways often leading to self-destructive sequences that ended in homelessness. After several years in and out of Hospitality House's emergency shelter, he began to lower his guard and engage with the Housing Assistance Program Case Manager. After successfully working with the case manager and developing healthy coping skills the individual was able to secure a local job. Hospitality House currently receives monthly calls raving about this individual's performance and how much of an asset he has been to the workplace. Further this individual has secured permanent housing that will be available later this year and will be moving out of Utah's Place and into a home of his own.

Outreach and Engagement:
NEVADA COUNTY BEHAVIORAL HEALTH
Case Management and Therapy for Homeless Individuals with Mental Illness
Homeless Therapist

Program Description

Program Overview

Nevada County Behavioral Health's (NCBH) Homeless Early Intervention Program provides therapy, referral and linkage to behavioral health services, outreach and engagement services to guests at Hospitality House Homeless Shelter as well as the "low barrier" dormitory. Staff also assists in immediate intervention with guests exhibiting troublesome behaviors due to ongoing mental health issues, stress, difficulty adjusting to shelter life and frustration with current life stressors.

Target Population

NCBH Homeless Early Intervention Program serves homeless guests at the Hospitality House Homeless Shelter and homeless individuals and families that seek outreach services.

Evaluation Activities and Outcomes

In FY 20/21, 58 unduplicated individuals were served plus an additional 74 individuals received outreach for a total of 132 individuals reached throughout the year. A breakdown of outreach activities showed 132 shelter outreach activities performed at Hospitality House including 132 attendees for 176 hours.

A total of 132 contacts with shelter guests were recorded for FY 20/21. Guests were seen within three business days of initial referral.

- Approximately nine guests were referred to NCBH for services. Four met criteria for services at NCBH and five were referred to services in the community. Three individuals, who would have met criteria for NCBH, declined services.
- Eight individuals were referred to other Mental Health services though Chapa de, Sierra Nevada Memorial Hospital, Communities Beyond Violence, Crisis Stabilization Unit, and private providers who accept Medi-Cal. At least four of these individuals followed through.
- Fourteen individuals were opened through NCBH assessments and received Case Management services by Turning Point staff stationed at Hospitality House.

The Behavioral Health Screening Form was documented for 58 intakes. Fourteen people reported an average of 1.7 Emergency Room visits for care and 14 people reported an average of one night spent in the hospital for care. The posttest data was not collected due to accessibility during COVID-19.

Challenges, Solutions, and Upcoming Changes

The FY 20/21 brought many challenges to Hospitality House and the Program. The most significant challenge was the COVID-19 pandemic. Due to the pandemic, the therapist's contact with program beneficiaries was severely limited. Therapist hours and access were limited and at times not offered due to COVID outbreaks and shelter quarantine. Some services were conducted by telehealth, however due to the lack of space and privacy, these services were limited too. Nonetheless, efforts were made to collect data and complete assessments.

Upcoming changes include the resignation of the Shelter therapist, the search to fill this position, the opening up of the community after COVID vaccinations are in place, and more contact with shelter guests.

A solution to an existing problem would be for the Shelter Therapist to be given the demographic and Behavioral Health screening forms when they are completed at shelter intake. It has been difficult to get guests to complete the demographic and screening forms again when they see the

therapist, since they have already completed the forms at intake, and they are generally not in a mental state to fill out the forms again when they meet with the therapist, so they often decline.

Program Participant Story

A guest came to Hospitality House after losing his home due to employment loss and the breakup with his partner. He was struggling with some depression, shame, and loss. He also has some health issues which render him unable to work full-time. He has had tragedies and losses in his life. He agreed to complete an intake assessment and was accepted for case management services through Turning Point and therapy services at the shelter.

He made good use of his time in quarantine by becoming a volunteer "caretaker" at the shelter, participating in therapy and case management services. In therapy, he worked on issues of loss, mood and self-worth. He had many moments of being frustrated and feeling as though his situation was hopeless, but he proved himself to be a hard worker and was motivated to get his life back on track. He gained confidence as he was able to get connected to the Veteran's Administration, a psychiatrist, and to apply for disability income. At the time of this report, he has been accepted into a temporary housing situation and is working to find permanent housing.

Outreach and Engagement

NEVADA COUNTY SYSTEM OF CARE
Forensic Liaison

Program Description

Program Overview

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

Target Population

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

Evaluation Activities and Outcomes

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

During FY 20/21, Forensic Outreach provided services to 139 unduplicated participants. The program provided 436 referrals to participants over the year, averaging about three referrals per participant. See the table below for more detailed referral information.

Agency Referred To:	**# of Referrals**
NCBH	97
Hospitality House/Homeless Shelter	81
Granite Wellness Centers	81
Common Goals	80
Human Services (Benefits)	19
Employment (one-stop)/ CalWORKs	17
Therapist/ Psychiatrist (Private)	14
SPIRIT	13
Freed	7
Community Beyond Violence	5
Other	22
TOTAL:	**436**

Services: The Forensic Liaison received 146 requests for service. All Requests for Service received a Forensic Assessment on the same day as the request. In addition to initial requests for service, the liaison also contacted participants for an additional 164 follow-ups. Of the 97 referrals to NCBH, 69 were referrals for Substance Use Disorder (SUD) Assessments. Of the 69 SUD referrals 65 were authorized for services. The average time between the Forensic Assessment and the SUD Assessment or Treatment Start Date was 20 days.

Challenges, Solutions, and Upcoming Changes

Challenges/Solutions relating to COVID-19: For much of FY 20/21 the Forensic Liaison was unable to visit inmates face-to-face at Wayne Brown Correctional Facility (WBCF). During this

time services were coordinated via phone, and the Forensic Liaison focused on aiding the HOME Team with case managing some of their more challenging participants. Eventually forensic worker was allowed to resume visitation at WBCF. The major challenge that COVID-19 continues to pose is the impact on services available to inmates. Treatment facilities often close their doors during local flare-ups of COVID cases, adding an element of uncertainty to exit plans, and Hospitality House is not accepting clients daily, moving instead to a cohort quarantine system.

Challenges/Solutions General: The most difficult obstacle to overcome while working with inmates is locating a safe shelter to where the individual can exit. A shelter is a key element of participant success, in addition to being a basic need. Having shelter can reduce criminality related to meeting basic needs, it gives the individual's support system a place to locate them, a place to receive mail, a place to safely store belongings, and a myriad of other benefits which contribute to rehabilitation and encourage prosocial behavior. Very few inmates being released from jail have the means to enter traditional housing and Hospitality House is the only shelter option available to them. Hospitality House, however, does not have enough beds to support the entirety of the shelter needs for Nevada County's population facing homelessness. Additionally, Hospitality House does not accept individuals with a history of violent felonies, arson charges, or sex offences. In response to this challenge the Forensic Liaison has been working with Parole connected resources and out-of-area providers without these barriers, such as the Oroville Rescue Mission, to place these challenging forensic individuals, as well as working with community nonprofits to develop future shelter options.

Upcoming changes: Historically the Forensic Outreach worker has spent a great deal of time in case management with those individuals recently released from jail and experiencing homelessness. With the creation of the HOME Team however, there is a great deal more support for unsheltered individuals, making warm hand-offs from the jail to case management specializing in homelessness-related issues possible. The Forensic Outreach worker still provides some case management for both sheltered and unsheltered individuals, depending on the needs of the participant and availability of the HOME Team. This has allowed for more contact with currently incarcerated individuals and a greater involvement with coordinating SUD services for inmates. The SUD service coordination for incarcerated clients has grown to the point that the Forensic Outreach worker has been trained in ASAM (American Society of Addiction Medicine) assessments in order to streamline the flow of individuals going from the jail to local treatment facilities.

Finally, the Forensic Liaison for most of FY 20/21 resigned his post in March 2021. Recruitment has begun to find a new liaison, but as yet no one has been hired.

Program Participant Story

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

Outreach and Engagement

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

Program Description

Program Overview

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

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

Target Population

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

Evaluation Activities and Outcomes

In January of 2021, the NCVSO released its first annual "All Veterans County Survey", where targeted information and data was collected from the veterans of Nevada County. The information from this survey communicated the need for the NCVSO to diversify how it provides services to the underserved populations. The NCVSO used this data to focus on implementing new technology, increasing its presence on social media, participating in monthly radio interviews, and

developing written articles for local newspapers and circulars. The Veterans Services Officer (VSO) met monthly with different outside service providers, agencies, and local Veterans Services Organizations to educate the public on the mental health services that were available to them through its "Virtual VSO" platform. Additionally, the NCVSO developed an "Underserved Veterans Population" Outreach Coordinator position. This person meets weekly with veterans at the county jail, receives weekly reports from the probation department, and performs bi-weekly outreach at local rehabilitation clinics and homeless shelters.

The first six-months of the fiscal year proved to be an extremely difficult period for the veterans of Nevada County. During this time 14 unduplicated veterans were enrolled for services through Welcome Home Vets. It is believed that increased awareness of social justice issues, the national election, and local unrest from restrictions due to COVID-19 were some of the reasons that the NCVSO saw an increase in referrals for mental health services over this period. Over the final six months of the fiscal year an additional 16 unduplicated veterans were enrolled for free and confidential mental health services for a total of 30 unduplicated veterans who enrolled in the program during FY 20/21.

The NCVSO was responsible for the enrollment of 30 unduplicated veterans during the fiscal year through Welcome Home Vets. This is because Welcome Home Vets' ability to conduct its own outreach was severely impacted by the pandemic and its fully volunteer staff's own health concerns and their inability to access their main office during the pandemic. Welcome Home Vets maintains its office at the Grass Valley Veterans Memorial Building and it was closed by state order during the entirety of the stay-at-home order.

The Nevada County Veterans Services Office (NCVSO) was successful in providing 55 referrals for mental health services to the proper agency depending based on the eligibility criteria of the different services available. Of these 55 referrals, 23 were made to the Citrus Heights Vet Center and 32 were made to Welcome Home Vets.

Other outcomes that were tracked include those listed below:

- NCVSO Outcomes:
  - Served 55 unduplicated individuals/families with mental health needs
    - Scheduled monthly meetings with service providers to ensure enrollment in services
  - No physical Outreach Events were attended
    - 8 Virtual Outreach events were participated in reaching 234 attendees
    - Monthly newsletters were disseminated
- WHV Outcomes:
  - Served 30 (target of 60) unduplicated individuals/families receiving therapy
  - 29 group therapy sessions were led by a Licensed Clinical Psychologist, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker or Peer Specialist (Goal = 50)
  - 305 individual therapy sessions were led by a Licensed Clinical Psychologist (Goal = 100)
  - 70 individual sessions lead by a Licensed Marriage and Family Therapist or a Licensed Clinical Social Worker (Goal 225)

- The 24-item Behavior and Symptom Identification Scale Basis-24 results:
  - 0% Percent of veterans were incarcerated in jail or prison during the time of treatment (Goal = less than 5%)
  - 92% Percent of veterans in treatment reported thinking about ending their life none of the time or only a little of the time (Goal = 95% or more)
  - 0% of veterans in treatment hospitalized in a psychiatric hospital during the treatment period (Goal = No more than 10%)
  - 0% of veterans in treatment reporting being in a shelter or homeless on the street more than one time during treatment (Goal = 15% or less)
  - 88% of veterans in treatment reported feeling short tempered less often during a week (Goal = 70% or more)
  - 100% of veterans reported getting along well in social situations half the time or more during a week (Goal = 70% or more)

Challenges, Solutions, and Upcoming Changes

The COVID-19 pandemic and the restrictions that were implemented out of safety concerns for the citizens of Nevada County was the major challenge to conducting outreach and engaging with veterans. However, the pandemic also provided an opportunity for the NCVSO to focus on how it provides services and collaborates with outside agencies. The following is a list of solutions and changes that the VSO has implemented or is developing to engage more veterans as the community has more restrictions removed or relaxed.:

- Development of Virtual VSO
- Released first Annual “All Veterans County Survey”
- Development of “Underserved Population” Outreach Coordinator Program
- Online booking to ease access to services
- Development of Quarterly CVSO Newsletter
- Increased focus on various social media platforms
- Ability to apply for select benefits through CVSO website
- Increased focus on digital services
- Increased efforts on positive communication with local veterans’ service organizations
- Collaborative Participation with Grass Valley Cal-VIP team (social worker/officer team)

It is believed that with the relaxed COVID-19 restrictions and the changes listed above, the NCVSO and Welcome Home Vets should meet each of their outcome metrics next year.

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

Program Participant Story

During the early phases of the pandemic the NCVSO was contacted by a veteran whose family member had received services the NCVSO. She was living out of state and her family member suggested that she contact the Nevada County VSO because she was having suicidal thoughts due to her isolation and recurrent thoughts of traumatic events she experienced while in service.

The NCVSO spent the entirety of the night on the phone with her discussing the events that happened to her in service, how she felt unsupported while she served, and how she was managing her current obstacles. She had just completed a medical training course and had decided that she could not pursue this career because of her past experiences.

During the morning hours the following day, the VSO successfully made an emergency referral to the VA Medical Center closest to where the woman lived. Additionally, the VSO assisted the veteran with submitting her claim to the VA for compensation due to the personal traumatic events that experienced while serving in the US Army. Her claim for compensation was granted and she recently purchased her first home. This decision allowed her to become eligible for the VA's Veteran Ready & Employment (VR&E) program that assists with re-educating veterans on different career paths. This spring, she learned that she had been accepted into the program where the VA will pay for her to earn her degree in the medical field.

Outreach and Engagement:

SPIRIT
Adult Wellness Center
SPIRIT Peer Empowerment Center

Program Description

Program Overview

The SPIRIT Peer Empowerment Center is open five days a week for people seeking support with issues related to mental health and/or recovery. Approximately 71% of those seeking services are unhoused. The entirely peer-run Center offers one-on-one peer support to individuals and hosts a variety of support groups and classes. These include Diagnosis with Dignity, Depression and Anxiety, Anger Management, Women's and Men's Groups. Additionally, SPIRIT has recently added two groups to assist the unhoused: Steps to Home (formerly Housing Circle) and Resiliency & Relationships. The goal is to create pathways towards connection and creativity, in a way that meets each individual's interests and stage of growth. There are a variety of planned activities throughout the week. Some of these include Peer Music, Beading for Wellness, Creative Expressions, and Gentle Yoga. Participants may also get their hands dirty tending the organic garden.

Target Population

The target population at the SPIRIT Center is any adult with mental health issues who indicates they would like to make positive changes in their life; this may include those with substance abuse issues, co-occurring conditions, or homelessness.

Evaluation Activities and Outcomes

In FY 20/21 SPIRIT Peer Empowerment Center served 957 unduplicated individuals.

SPIRIT Center	FY 20/21
Unduplicated # of participants	957
Empower peers to engage in the highest level of work or productive activity appropriate as measured by:	
# of peers who obtained gainful employment	30
Volunteer hours spent maintaining the facility	475
Peer Support sessions	956
Peer Support phone sessions	42
Peer Support training hours	95
Opportunities offered to peers to optimize productive activity (list hours for each service):	
Front Desk/Data Entry	433
One-on-one Peer Support	959
Group Facilitation	529
Peer Support Interning	180
Reduce isolation of persons with mental illness as measured by:	
Support Groups in FY	229
-Support Group's Attendance	768
Social Activities in FY	217
-Social Activity Attendance	1012
Physical Movement Sessions in FY	52
-Physical Movement Attendance	183
Improve quality of life of homeless individuals as measured by:	
# of Homeless receiving basic services (enrolled)*	197
# of homeless participants who obtained housing	12
Survey Results - # of participants who improved in each of these areas: Note: Performed in fourth quarter, 42 Surveys Returned	
Suicide	6
Housing	16
Education/Life Skills/Coping Skills	23
Hospitalizations	8
Court/Legal	6
Employment	4

Prolonged Suffering	26
# of people in SPIRIT sponsored structured educational class:	
Peer Support 101	16
WRAP I	5
WRAP II	0
Interactive Journaling/Recovery. Goals and Life Skills	37
Other Data to be collected:	
Fundraising (Holiday Letter, donations, outreach)	$46,211
Number of bi-lingual Peer Support Sessions	157

This year SPIRIT made some major improvements to their internet connectivity to be able to offer a hybrid in-person and Zoom Certified Peer training. The training was a success with 20 participants in attendance (five live and 15 on Zoom) of whom 16 graduated. A WRAP 1 seminar was held with eight attendees, five of whom graduated with WRAP 1 Certification, ready to continue next year into the Advanced WRAP 2 course**.**

Staff training has continued as well. One staff member at SPIRIT was certified in Anger Management, with another set to train in the next quarter. The first class started in June with four participants enrolled. Working with anger has long been a challenge for many program participants, so staff are excited to be able to offer this class at no cost.

Multiple trainings and resources are being brought to the Tuesday All Staff Meetings, so staff have the knowledge of resources in the community to help refer beneficiaries when things come up during peer support sessions. Some of these trainings/resources have been, Ethics & Boundaries training, Insight Respite Center referral process, and Santa Cruz County's Rapid Re-Housing program. In addition, a Nevada County Housing Funding Resources list was created, which includes FREED, Rapid Re-Housing, Home Safe Monies, Adult Reentry Program Grant, Advocates for Mentally Ill Housing (AMIH), Common Goals, and Granite Wellness referral and eligibility requirements. Other referral resources that staff were trained on included tkMomentum for beneficiaries looking for work, Crisis Stabilization Unit and Insight Respite for those needing some recuperation time, Homeless Outreach and Medical Engagement (HOME) Team for beneficiaries needing medical attention or support with housing, and Hospitality House for those looking for shelter.

SPIRIT also continued social media outreach, posting de-stigmatizing messages and a variety of ways people can engage to support their mental health, from doing a puzzle to connecting with a peer.

Challenges, Solutions, and Upcoming Changes

Meeting basic needs is a necessary part of building a foundation for mental health. The one-on-one peer support sessions are key for participants to connect with someone they trust, in a stigma-free, compassionate, and empathetic environment. It is often during these sessions where participants come together with who they are, decide what direction they want to go, and determine

the steps they need to take to get there. SPIRIT regularly refers out to other agencies, and frequently has members of the HOME Team on site to assist with transportation needs and getting people into treatment.

A major challenge for SPIRIT is keeping Gates Place clean of trash, drug, drama, and camping free. In an effort to minimize the impact, SPIRIT is working with Grass Valley Police Department to facilitate conversation and connection between the homeless population, and law enforcement. The goal is to support homeless individuals to feel heard and acknowledged regarding the effects law enforcement behavior has on them and how they would like to be treated. SPIRIT will be coaching them on how to express themselves in advance of these conversations, to increase the likelihood that their requests will be honored. SPIRIT will also model appropriate, respectful treatment of law enforcement and other authority figures.

Program Participant Story

One of the most non-verbal and aggressive participants at SPIRIT got a full-time job and has been filling out housing applications with projected housing before winter. Staff have witnessed a total transformation in this participant due to his hard work with dedicated SPIRIT staff and the additional onsite housing program.

Prevention and Early Intervention (PEI)

PEI Category: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH (NCBH)
Bilingual Therapy
Bilingual Early Intervention

Program Description

Program Overview
Staff provide psychotherapy to children, adolescents, and adults using a wide range of modalities, including individual, family, and play therapies. Individual therapy primarily involves Motivational Interviewing and Cognitive-Behavioral Therapies (CBT), with an emphasis on Trauma-Focused CBT for children and exposure-based trauma treatments for adults. Family therapies include Attachment-Based Family Therapy and systemic family therapies.

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

NCBH maintains good communication with these community agencies by:

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

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

Evaluation Activities and Outcomes

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

During FY 18/19, the program served 24 individuals. In FY 19/20, that number increased to 57 individuals. In FY 20/21, the number increased to 74 individuals. Over the years, the average

number of hours each participant received services varied. In FY 18/19, staff delivered an average of 19.7 hours of service, in FY 19/20, the average decreased to 4.3 hours, then in FY 20/21, the average increased to 14.5 hours of service. See the tables below for more information on services.

	FY 18/19			FY 19/20			FY 20/21		
Service Category	**Number of Hours**	**Number Served**	**Average Hours per Participant**	**Number of Hours**	**Number Served**	**Average Hours per Participant**	**Number of Hours**	**Number Served**	**Average Hours per Participant**
Assessment/ Screening	57.3	14	**4.1**	155.4	41	**3.8**	261.1	62	**4.2**
Individual/ Family Therapy	320.0	19	**16.8**	285	28	**10.2**	600.95	43	**14.0**
Rehab./ Mental Health Services	46.4	4	**11.6**	6.7	2	**3.6**	.96	2	**.48**
Case Management/ Linkage	19.0	12	**1.6**	67.7	31	**2.2**	60.6	43	**1.4**
Collateral	6.1	5	**1.2**	83.62	19	**4.4**	87.3	30	**2.9**
Crisis Services	2.3	1	**2.3**	1.2	1	**1.2**	-	-	**-**
Other	22.3	15	**1.5**	-	-	**-**	-	-	**-**
Total (All Services)	**473.4**	**24**	**19.7**	**644.6**	**57**	**4.3**	**1069.9**	**74**	**14.5**

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

Qualitative FY 18/19 Data:

Treatment Goals:	**Individuals with Improvement**	**Individuals without Improvement**	**Total Individuals w/ symptom**
Increase Interest in Activities	100%	0%	10
Reduce Psychological Reactivity	100%	0%	9
Managing day-to-day life	100%	0%	9
Coping with life problems	100%	0%	7
Reduce Conflicts	100%	0%	6
Increase Compliance	100%	0%	6
Increase Energy	100%	0%	6
Reduce Anger	100%	0%	4
Increase Sleep	100%	0%	4
Reduced Panic Attacks	100%	0%	2
Reduce Hearing Voices	100%	0%	1

Reduce sadness/ depressed mood	92%	8%	13
Reduced Anxiety/ Worry	90%	10%	10
Reduce Guarding for Danger	83%	17%	6
Reduce Intrusive Memories	83%	17%	6
Reduce Guilt	83%	17%	6
Think about ending your life	75%	25%	8

In FY 19/20 Child Adolescent Needs and Strengths (CANS) outcomes demonstrated that 83% of participants showed a decrease in symptoms related to actionable items (scored as 2 or 3) identified in the CANS. Decrease in symptoms is evidenced by a rating that decreased from a 3 to a 2 or 1, or from a 2 to a 1. Indicators where participants showed the most improvement were: adjustment to trauma, anxiety, depression, family functioning, social functioning, community life and resiliency. Eleven adults were given an Intake Basis 24 assessment, and two of those were given a Basis 24 Mid-Treatment assessment. Both individuals who were reassessed showed improvement in their overall Basis 24 reassessment scores. The indicators where participants showed the most improvement were in the Depression/Functioning Domain.

In FY 20/21 Child Adolescent Needs and Strengths (CANS) outcomes showed that 67% of participants had a decrease in symptoms related to actionable items (scored as 2 or 3) identified in the CANS. Decrease in symptoms is evidenced by a rating that decreased from a 3 to a 2 or 1, or from a 2 to a 1. It is anticipated that this percentage decrease will improve as with additional treatment. The Basis 24 adult outcome measure showed 50% of participants improved outcomes on reassessment.

	FY 18/19		**FY 19/20**		**FY 20/21**	
Assessment/Reassessments with Outcomes	**Number of Participants**	**Percent of Participants**	**Number of Participants**	**Percent of Participants**	**Number of Participants**	**Percent of Participants**
CANS Assessments	N/A	N/A	35	61%	22	30%
CANS Reassessments	N/A	N/A	15	26%	9	12%
CANS % Improved (Decrease 2s, 3s)		N/A		83%		67%
Basis 24 Assessments	N/A		11		12	
Basis 24 Reassessments	N/A		2		2	
Basis 24 % Improved		N/A		100%		50%
Unduplicated Total	**24**		**57**		**74**	

Challenges, Solutions, and Upcoming Changes

The lack of affordable housing is an ongoing problem facing the target population. There is subsidized housing in the area, but there is a two (2) to three (3) year wait list. Another related problem is the difficulty in qualifying for Medi-Cal. In this area, both parents must work in order to afford housing, but that puts their income above the cut-off for getting insurance through Medi-Cal. With more needy families failing to qualify for Medi-Cal, the funding provided by the MHSA PEI Program is even more essential.

A second challenge for the program is treating such a diverse group of clients. The Nevada County PEI Program serves all age groups and a wide range of mental health diagnoses. In the current treatment sample, the treated problems include: Post-Traumatic Stress Disorder and other trauma related disorders; alcohol and drug abuse, including problems related to living with a caregiver who has a drug or alcohol problem; domestic violence; video-game addiction; school failure; sluggish cognitive tempo; eating disorders; depression; complicated grief; panic attacks; and Generalized Anxiety Disorder. It is challenging for therapists to have effectively mastered treatments in so many areas.

A third challenge that this population faced in recent years is living in a pandemic. The pandemic has brought difficulties in accessing services; some participants are afraid of meeting in person for fear of coronavirus exposure, and others have no access to technology to access services virtually. Possible solutions would include having more Spanish-speaking staff facilitating services with additional technology resources. This involves identifying each participant's individual needs, including technology gaps, to provide additional support to this population.

Since the pandemic began, the overall number of applicants for clinical vacancies has declined significantly. The department has stepped-up recruitment strategies to specifically attract Spanish-speaking clinicians who are culturally competent. Efforts have successfully attracted three more Spanish-speaking clinical applicants this year than previous years. However, two of them were not able to complete registration of associate status. The third applicant accepted the offer of employment, then declined when offered a significantly higher benefits package by a private employer.

Program Participant Story

A middle aged Hispanic woman was referred by a family member. When she started therapy last year, symptoms included: sadness, anger, and anxiety. She was not able to sleep well, cried frequently, had problems communicating effectively, and had negative thoughts about herself. The stressors at that time included relational issues with family. Some brought on by the pandemic.

The therapist has been using CBT to address the depressive symptoms. The woman has been learning relaxation skills, assertive communication, problem solving skills, and identifying thoughts that are unhelpful, and changing them to more rational/helpful thoughts. The woman is

benefiting from treatment; she is improving family relationships and is sleeping better. She is implementing relaxation skills, feeling that she has more control of her anger, improving communication skills, and is thinking about going back to school and/or starting her own business.

PEI Category: Early Intervention Program

NEVADA COUNTY PUBLIC HEALTH
Perinatal Depression Program
Moving Beyond Depression

Program Description

Program Overview

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

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

Target Population

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

Evaluation Activities and Outcomes

MBD collected evaluation activities for MHSA including demographic information for each individual receiving services, along with any children in the household. In addition, information on the date of the service was collected. Individuals receiving services also completed an Edinburgh Postnatal Depression Scale (EPDS) at intake, during ongoing services, and at discharge

from the program. Individuals receiving services also completed the Interpersonal Support Evaluation List-Short Form (ISEL-SF) to assess perceived social support at intake to and discharge from the program. Perception of Care surveys were collected at the end of services. Information on referrals to community services was also collected. Demographic, service, EPDS, and ISEL-SF data were collected and managed using REDCap (Research Electronic Data Capture) hosted at NCBH[1].

During FY 18/19, MBD offered services to 30 unduplicated participants. Of the 30 offered services, 21 enrolled in the program, with 16 completing at least six sessions. In FY 19/20 that number decreased to 16 referrals, 11 of which accepted services. Also, during this period and those following, the program went from two therapists to one. During FY 20/21, the number of unduplicated referrals was 14, with 10 mothers (and 26 children) accepting services. Across the years, most participants (between 75% and 100%) received seven (7) or more IH-CBT sessions with the therapist. See the table below for more detailed information.

	FY 2018-2019		**FY 2019-2020**		**FY 2020-2021**	
	# Served	**% improved by 6th session**	**# Served**	**% improved by 6th session**	**# Served**	**% improved by 6th session**
Clients Completing Six Sessions or more	16	93%	11	70%	10	70%

Participants who completed the MBD program showed overall improvement in both their EPDS and ISEL-SF scores. A decrease in a client's EPDS score demonstrates a decrease in symptoms of depression. An increase in ISEL-SF scores indicates that participants perceive better social support. Below are average improvement scores for each year for both EPDS and ISEL screens.

	FY 2018-2019		**FY 2019-2020**		**FY 2020-2021**	
	Average Pre Score	**Average Post Score**	**Average Pre Score**	**Average Post Score**	**Average Pre Score**	**Average Post Score**
Edinburgh Postnatal Depression Scale (EPDS)	19	12	17	11	18	12
Interpersonal Support Evaluation List - Short Form (ISEL-SF) Pre to Post	22	25	20	24	22	27

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

In addition, the Participant Perception of Care survey was administered in FY 18/19, FY 19/20, and FY 20/21. Responses indicated better social functioning at completion of the program. See the table below for more perception of care information.

	FY 2018-19		FY 2019-20		FY 2020-21	
Participant Perception of Care Survey	**% Agree**	**N**	**% Agree**	**N**	**% Agree**	**N**
I am getting along better with my family.	100%	2	83%	6	80%	5
I do better in school and/or work.	100%	2	67%	6	50%*	2
My housing situation has improved.	100%	2	50%	6	100%	5
I am better able to do things that I want to do.	100%	2	67%	6	60%	5
I am better able to deal with crisis.	100%	2	83%	6	60%	5
I do better in social situations.	100%	2	83%	6	60%	5
I have people with whom I can do positive things.	100%	2	100%	6	100%	5
I do things that are more meaningful to me.	100%	2	67%	6	80%	5
I have learned to use coping mechanisms other than alcohol and/or other drugs.	100%	2	83%	6	100%	5
In a crisis, I would have the support I need from family or friends.	100%	2	83%	6	80%	5
Staff welcome me and treat me with respect.	100%	2	100%	6	100%	5
Staff are sensitive to my cultural background.	100%	2	100%	6	100%*	3
Average/ Total Surveys Submitted	**100%**		**81%**		**88%**	

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

During FY 18/19, MBD made three (3) referrals to NCBH. While two accepted services, one declined, but was supported by staff at Tahoe Forest Hospital. One additional participant was referred to a local behavioral specialist. Of the participants referred for mental health services, three had not been previously treated for their current symptoms. These individuals did not know the duration of their untreated mental illness.

During FY 19/20, MBD initiated 10 referrals. Seven referrals were made to non-county Adult Mental Health Services. One referral was made to Nevada County Adult Behavioral Health Department. This individual had previously been treated for the symptoms for which they were referred.

During FY 20/21, two participants of the MBD program were referred to Behavioral Health services, and one to a non-county mental health provider. Only one participant had untreated mental illness for a duration of more than 10 years. One participant was referred to a physical health provider, one was referred for housing and public health in another county.

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

Challenges, Solutions, and Upcoming Changes

During this three-year reporting period, service capacity was affected on the western side of the county due to one of the two therapists not renewing her contract. As this therapist was also a bilingual Spanish speaker, her leaving created a gap in the Spanish-speaking community. Additionally, the eastern side of the county continues to be supported by the western program as there were two failed recruitments for a therapist to serve the eastern community. The need for bilingual services is also very high in the Truckee region.

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

Lastly, the biggest challenge in the last year and a half has been the SARS CO V 2 or COVID-19 pandemic. Stay at home orders, physical distancing, and the deferral of staff from programmatic activities to COVID-19 response have all had a negative impact on the performance of the program. Though some participants appear to do well with virtual visits, others have stated that the virtual visits are not optimal. Additionally, beneficiaries appear to have had greater needs during this pandemic. Social isolation, economic issues, and health concerns have all exacerbated depression in the families being served. This increased anxiety and depression manifested in longer time in the program for some, requiring additional sessions.

A silver lining in the COVID storm was that, by doing virtual appointments the therapist did not have any drive time, so she was able to serve more individuals.

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

Program Participant Story

"I'm writing you today to tell you a little bit about my experience and hopes this program can continue on for so many more, it truly saved me from so much despair and has flipped my life 180 degrees for the better.

Last year I filled out a questionnaire on depression, with my home visitor from Foothill Truckee Babies. I knew I didn't feel myself at the time in my life, but I didn't know it was due to postpartum depression until I took the questionnaire. I always thought depression was lying in bed all day, not showering, those kinds of things. For me it looked very different and I'm so thankful for Foothill Truckee Babies taking the time to do the questionnaire with me because what followed was life changing. It's taken me some time to sit down and write this because it is so emotional for me. When I started with Moving Beyond Depression and I received my first phone message from Tony McCormick I froze, like I always use to do when something new comes along especially with a new person. After a few weeks of letting the idea of talking to someone new settle, I decided to make the leap. And that's when I was introduced to Tony, there's truly no words that can describe how wonderful she is, I've never felt a stranger care so deeply about what I was going through. I tear up writing this but truly she was like this angel with a security blanket that wrapped around me and swaddled me with unconditional acceptance and care.

I honestly had no idea what to expect with the program, I just knew that I didn't want to be where I was, and Tony was the next step. Week by week we would talk about the previous week and how it went and she'd give me guidance and teach me tools and would give a little bit of homework to help identify my thinking patterns and what to do with them. Even on my worst days I still did my best to do the work and practice what she was teaching. I never felt scared or ashamed or embarrassed to speak with her since the start. With the homework she gave I realized how much negative talk i had going on in my head. I also had a very difficult time feeling joy, even for my most favorite people, places, and things. My relationships were all struggling. My friends, my family, my children, I had such a hard time connecting with them. I dreaded talking to my neighbors and was scared every time my phone rang, my self-talk had thought me that whatever was on the other line that is was negative, bad and that id need to defend myself. My hour to hour life was miserable. It was not a life, I was not living, I was merely existing.

As the weeks went on through the program, I started to feel a shift. With her guidance I was able to start catching the negative things I said about myself. A snowball effect started happening in my life, I started to feel joy again and with that I was spending more quality time with family and friends, saying YES! to activities with them and with that they all saw me shift and change into the person I am now. It's truly day and night. I am able to trust myself and my decisions, I am able to build relationships with people, I am able to give myself understanding and forgiveness, I am able to have my phone ring and actually answer it and most importantly I am able to catch myself when I have a negative thought and shift it to something that will suit me better. This thinking pattern has become a habit now, its automatic and I'm so thankful.

Moving Beyond Depression is truly amazing and I wish everyone could go thru it. It's the kind of help we all could use. Thank you all for the support and time you've put into this program."

PEI Category: Early Intervention Program

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

Program Description

Program Overview

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

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

FY 20/21 is the first year this program was funded by MHSA in Nevada County. Therefore, there is no three-year comparison reported.

Target Population

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

Evaluation Activities and Outcomes

In FY 20/21 the following Performance Outcome Measures were tracked:

- Target Outcome 1: Serve 15 youth/families per year across Nevada and Placer Counties.
    - Unduplicated youth served for FY 20/21: 19
- Target Outcome 2: 100% of youth will be discharged with adequate supports in place and/or to appropriate levels of long-term care as applicable.
    - In FY 20/21, 10 youth were discharged from the program. Two of them were referred to county Full Service Partnerships, six were referred internally to ongoing support programs, and two were assessed and did not require more intensive or ongoing services.
- Target Outcome 3: 60% of youth will show an increase in at least one of the following outcomes: stability in living situation; improvement in school attendance; reduction in

substance use/abuse; increase in positive social connections; reduction in involvement with legal entity agencies.
    - Of the 19 served, only one had involvement with a legal entity.
    - Of the 3 surveyed, all displayed signs of improvement in at least one of the above listed areas. Poor survey census due to COVID-19 restrictions.
- Target Outcome 4: 75% of youth will not utilize crisis services during treatment.
    - Of the 19 served, 0 required crisis services during treatment.
- Target Outcome 5: Reduce the number of 5150s for youth and TAY in Tahoe/Truckee region.
    - Of the 19 served, 0 required a 5150.

Challenges, Solutions, and Upcoming Changes

Administration capacity was an ongoing challenge. It was difficult to keep up with the requirements of tracking services. This was especially true regarding data input into the PEI Portal and collection/administration of outcome measurements for short term services. Plans to add a reporting element into the PEI Portal should resolve some of the report building burden.

Gateway has invested in implementing a case management software that will streamline and automate much of the manual labor of data and service tracking. This should resolve the issue of ensuring that outcome assessments are done and timely.

Program Participant Story

Going into the Tahoe Truckee Unified School District spring break, a participant's private therapist was worried that no one would have eyes on the participant who was experiencing suicidal ideation. The Gateway mentor worked collaboratively with the therapist and the school district to formulate a plan that involved the mentor having three sessions in the week vs. the normal weekly (which included the weekend) as well as daily phone check-ins as a safety net. The participant was able to safely stabilize in an unstructured environment and able to connect to necessary ongoing support.

"If you can, come tomorrow & every day" - Child participant to his mentor who we were able to connect to a county mental health service for long term support (we continue seeing this child regularly as well).

"This is the best day ever!" - Child participant after receiving support and coaching from a mentor to overcome a fear of water and build trust in others. By the end of the services the participant was standing on a paddle board on the lake by himself. This participant grew up very close to the lakeshore and never had the opportunity to experience this resource.

PEI Category: Early Intervention

NEVADA COUNTY BEHAVIORAL HEALTH
Homeless Outreach and Therapy

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) Homeless Outreach and Therapy Program provides therapy, referral and linkage to behavioral health services, outreach and engagement services to guests at Hospitality House as well as the "low barrier" dorm through an embedded NCBH clinician. Staff also assists in immediate intervention with guests exhibiting troublesome behaviors due to ongoing mental health issues, stress, difficulty adjusting to shelter life and frustration with current life stressors.

In FY 20/21 this program's MHSA funding came from Community Services and Supports, Outreach & Engagement.

Target Population

NCBH Homeless Outreach and Therapy Program serves homeless guests at Hospitality House Homeless Shelter and homeless individuals and families that seek outreach and therapy services.

Evaluation Activities and Outcomes

A total of 605 contacts with shelter guests were recorded during the 2018-2020 reporting period. Guests were seen within three business days of initial referral to Early Intervention Services.

- 40 of 62 referrals (65%) connected to services
  - 31 referrals to County Adult Mental Health programs
    - 27 (87%) referrals connected to services
    - Five days was the average time to connection
    - No untreated mental illness was reported
    - Three individuals reported previous mental health treatment
  - 27 referrals to non-county Mental Health provider, nine (33%) connected
  - Three referrals to Physical Health Care providers
    - Three connected to services
    - Seven days was the average time to connection
  - One referral to a Licensed Clinical Social Worker connected in six days

During the 2018-19 reporting period eighty-six unduplicated individuals were served by the Early Intervention Therapist. The number of service contacts for each individual served by the therapist is recorded in the table below.

	FY 2018-19

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

Challenges, Solutions, and Upcoming Changes

Finding space in which to meet with clients confidentially and privately is a struggle as there simply is not adequate space. With the outreach dorm continuing to be part of the program, more monitor staff and a housing staff were added, leading to less room for privacy and therapeutic services and lowered numbers. Solutions have included utilizing dorm space during non-op hours for confidential meeting space as well as communicating and collaborating with HH and NCBH staff regarding needs.

Ongoing challenges included unknown outcomes, lack of follow-through by participants and drug/alcohol issues due to transient population and lifestyle. With more county supports for SUD, more clients are being offered and are receiving services. Hospitality House is now including the Behavioral Health Screening form in the intake process so that individuals experiencing symptoms of distress and or mental illness can be identified and referred to this writer early on.

Other factors causing reduced numbers in this program were PG&E electric shutdown and the COVID-19 pandemic. The pandemic led to quarantine of both shelter guests and this worker. Nonetheless, some services that this writer was able to conduct by telehealth were intake assessments for Nevada County Behavioral Health and brief therapy.

Program Participant Story

A guest came to Hospitality House after several years of homelessness, substance use and legal problems. The HOME Team (Homeless Outreach and Medical Engagement) first made contact with him and provided him with temporary shelter where he received support, food, clothes and a place to sleep and bathe. The guest then transitioned to the Shelter Program, stayed substance free, and began working with a caseworker. He was struggling with communal living due to his mental illness and feeling a lot of distress. After several weeks being substance free and continuing to experience mental health symptoms, the guest was identified by his caseworker as needing a mental health assessment. The guest completed an intake assessment for services at Nevada County Behavioral Health (NCBH). He was accepted for services and began to meet with a NCBH psychiatrist and be treated with medication. He continued to meet with the Early Intervention Homeless Therapist for therapy and with his caseworker for housing, linkage to community

services such as substance use treatment and support services. The guest was able to begin receiving his Supplemental Security Income for his mental disability through assistance from his caseworker. Through NCBH the guest secured housing and moved out of Hospitality House. He has since been assigned an NCBH case manager and continues to receive medication management and therapy through NCBH. He has been fairly stable in his housing situation and is able to have visits with a family member who lives locally.

PEI Category: Early Intervention

STANFORD SIERRA YOUTH AND FAMILIES

Program Description

Program Overview

Stanford Sierra Youth & Families (SSYF) provides comprehensive specialty mental health services for children and their families throughout Nevada County. There are two (2) specialized programs available to program participants: Family Preservation (FP), which seeks to provide family stability to families who have children who are at risk of removal from their home or at risk of Child Welfare or Probation involvement; and Therapeutic Support Services (TSS), which provides services to pre and post-adoptive families. SSYF provides support and mental health treatment to Pathways to Well-Being Program participants as well and provides increased supportive services as necessary. Specialty Mental Health Services provided are based on established medical necessity criteria for mental health services due to behavioral, emotional and functional impairments meeting Nevada County Behavioral Health (NCBH) Plan eligibility.

Target Population

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

Evaluation Activities and Outcomes

Stanford Sierra Youth & Families collects demographic and service-level data for participants of programming. During FY 18/19, 104 youth received services, with an average of 44.3 services per participant. During FY 19/20, 107 youth received services, with an average of 49.6 services per participant. In FY 20/21 SSYF was moved to Community Services and Supports MHSA funding. Their report for that year can be found in the CSS section.

See the table below for averages of service data over the full reporting period for FY 18/19 and 19/20.

	FY 18/19 & 19/20 Average (N=218)	
Number of Service Contacts	**# Participants**	**% Participants**
1 Contact	4	1.8%
2 – 4 Contacts	12	5.5%
5 – 7 Contacts	18	8.3%
8+ Contacts	184	84.4%

The Child and Adolescent Needs and Strengths (CANS) is collected at intake, periodically, and at discharge from the program. Eighty-eight percent of individuals' CANS scores improved during the reporting period. The individuals whose scores did not improve were either moved to a higher level of care or had significant trauma and major life changes and are working through their issues with their current treatment teams.

Additional outcome results are collected quarterly and average scores for FY 18/19 and 19/20 are shown below. These outcomes include a focus on permanency, school performance, parenting skills increase, legal involvement and placement disruption. See table below.

		FY 18/19 and 19/20 Averages
		N = 206
Goal	**Objective**	**Outcome**
To prevent and reduce out-of-home placements and placement disruptions to higher levels of care.	***80%** of children and youth served will be stabilized at home or in foster care*	**97%** of youth stabilized at home or in foster care
Youth will be out of legal trouble.	*At least **70%** of youth will have no new legal involvement between admission and discharge*	**99.5%** of youth had no new legal involved
Youth will improve academic performance.	*At least **80%** of parents will report youth maintained a C average or improved on their academic performance.*	**92%** maintained or improved academic performance
Youth will attend school regularly	*At least **75%** of youth will maintain regular school attendance or improve their school attendance.*	**96%** of youth maintained regular school attendance
Youth will improve school behavior	***70%** of youth will have no new suspensions or expulsions between admit and discharge.*	**90%** of youth had no new suspensions or expulsions
Caregivers with strengthen their parenting skills	*At least **80%** of parents will report an increase in their parenting skills.*	**90%** of parents increased parenting skills
Every child establishes, reestablishes, or reinforces a lifelong relationship with a caring adult.	*At least **65%** of children served will be able to identify at least one lifelong contact.*	**99.5%** of youth are able to identify one lifelong contact
Caregivers will improve connections to the community	*At least **75%** of caregivers will report maintaining or increasing connection to natural supports.*	**95%** maintained or increased connections to natural supports

Nine referrals were made by Stanford Sierra Youth & Families to other county agencies throughout FY 18/19. These referrals were made to agencies like Big Brothers, Big Sisters, Adoption Support Group, A New Day, and Behavioral Health Services outside of Nevada County to meet the individuals' needs. No referral information was submitted for FY 19/20

In Fiscal Year 20/21, the program was funded through Community Services and Supports (CSS) funding to better align with the target population and services of the program.

Challenges, Solutions, and Upcoming Changes

Early program challenges included the need for integration of data platforms and data entry systems to provide for accuracy of data collection. Identifying a universal system that could accommodate all data reporting needs was needed and beneficial to the accuracy of data collection.

Additional challenges in the 18/19 service year were an increase in the pace of the referrals and the time needed to meet the needs of the youth and families which demanded significant overtime commitments from staff.

In July of 2019, Sierra Forever Families merged with a new counterpart, Stanford Youth Solutions into the new organization, Stanford Sierra Youth & Families. With this merge of organizations came several bouts of restructuring, policy changes and programmatic updates agency-wide. It has and continues to take time for staff to adjust to this change.

In addition to the merge SSYF also experienced for the first time, the Public Safety Power Shutoffs (PSPS) that affected the office, staff and beneficiaries. SSYF discovered and implemented new ways of supporting beneficiaries and staff while maintaining proper budgetary boundaries.

And of course, COVID-19 which was an unprecedented event that challenged staff both personally and professionally. SSYF asked staff to continue to provide mental health services through a worldwide pandemic while managing personal anxiety regarding the physical and mental health of themselves and their families.

Solutions to these challenges included creating spaces in the office that are social distance friendly. Staff created virtual offices in their homes to provide a sense of safety and stability for beneficiaries who were used to the familiarity of the SSYF treatment rooms. Staff also met beneficiaries who needed to be seen in person, with masks and safe social distancing. SSYF continues to evaluate not only the beneficiaries needs on a weekly basis but also staffing needs to encourage continued well-being and supportive mental health and to avoid burnout.

Program Participant Story

One year ago, Stanford Sierra Youth & Families received a referral for two sisters, whose family survived a natural disaster. Both girls and their parents suffered mental health symptoms. Through the Family Preservation program with Stanford Sierra Youth & Families, each family member was able to receive individualized treatment including educating them on how to engage in healthy conflict resolution, using healthy communication skills, how to implement limits and boundaries and how to trust themselves and one another.

Stanford Sierra Youth & Families treatment team advocated for the girls with school staff which resulted in the children receiving support and modifications to their workload. The team also helped the students maintain attendance and manage anxiety while at school to help them succeed in the classroom. Additionally, the treatment team assisted the children and their family in discovering natural supports such as increased connection with the community, friends and increased contact with extended family members. The SSYF treatment team also assisted the family in engaging in healthy outlets such as time spent outdoors including hiking, paddle boarding

and mountain biking. The family also explored spirituality and engaged in mindfulness practices with the help of the treatment team.

Through these interventions the family's behaviors and symptoms have significantly improved. The family members are able to express their feelings, process trauma, increase tolerance to frustrations, become regulated and resolve feelings of grief and loss. The family is more connected and more able to work through conflict. The children are able to engage more in school, raising their grades and participation rates. The parents are able to provide a more stable environment for the girls to grow and develop. With the creation of a more stable family environment, each individual is able to focus on their own health and healing while also learning how to live without on-going family dysfunction.

PEI Category: Early Intervention

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

Program Description

Program Overview

Whole Hearts (formerly Gateway Mountain Center in FY 18/19) pairs clinically supervised Mental Health Workers (MHW) & Mental Health Rehabilitation Specialists (therapeutic mentors) with high need youth and transitional age youth in the Tahoe-Truckee community in a one-on-one relationship. Mentors meet with their mentees once a week for two to four sessions. Using the therapeutic model, "4 Roots for Growing a Human", sessions are centered around Authentic Relationships, Connection to Nature, Embodied Peak Experiences and Helping Others in order to support participants' health and growth. Sessions are typically provided in the field. Locations of outings vary and include trails, rock climbing areas, ski areas, lakes (for kayaking activities), or the local climbing gym. During sessions, mindfulness practices, and techniques from therapeutic modalities, such as Dialectical Behavior Therapy or Acceptance and Commitment Therapy may be utilized.

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

Target Population

Whole Hearts serves high-need and under-resourced youth ages five to 23, impacted by trauma and suffering from serious emotional disturbance, suicidality, serious substance use Disorders, self-harm, and debilitating anxiety

Evaluation Activities and Outcomes

Whole Hearts, Minds, and Bodies collects evaluation activities for MHSA including demographic information for each individual receiving services. In addition, the Youth Outcomes Questionnaire (YOQ- SR 2.0) is administered at the beginning and end of services. Information on referrals to community services is also collected.

Whole Hearts seeks to reduce negative outcomes of untreated mental illness in 80% of youth served. This is measured through the completion of a Youth Outcome Questionnaire Self Report (YOQ-SR 2.0) at intake with the goal of every six months thereafter, as well as the Participant Perception of Care survey.

During FY 2018-19, the program (Gateway at the time) delivered 117 services to 14 participants.

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

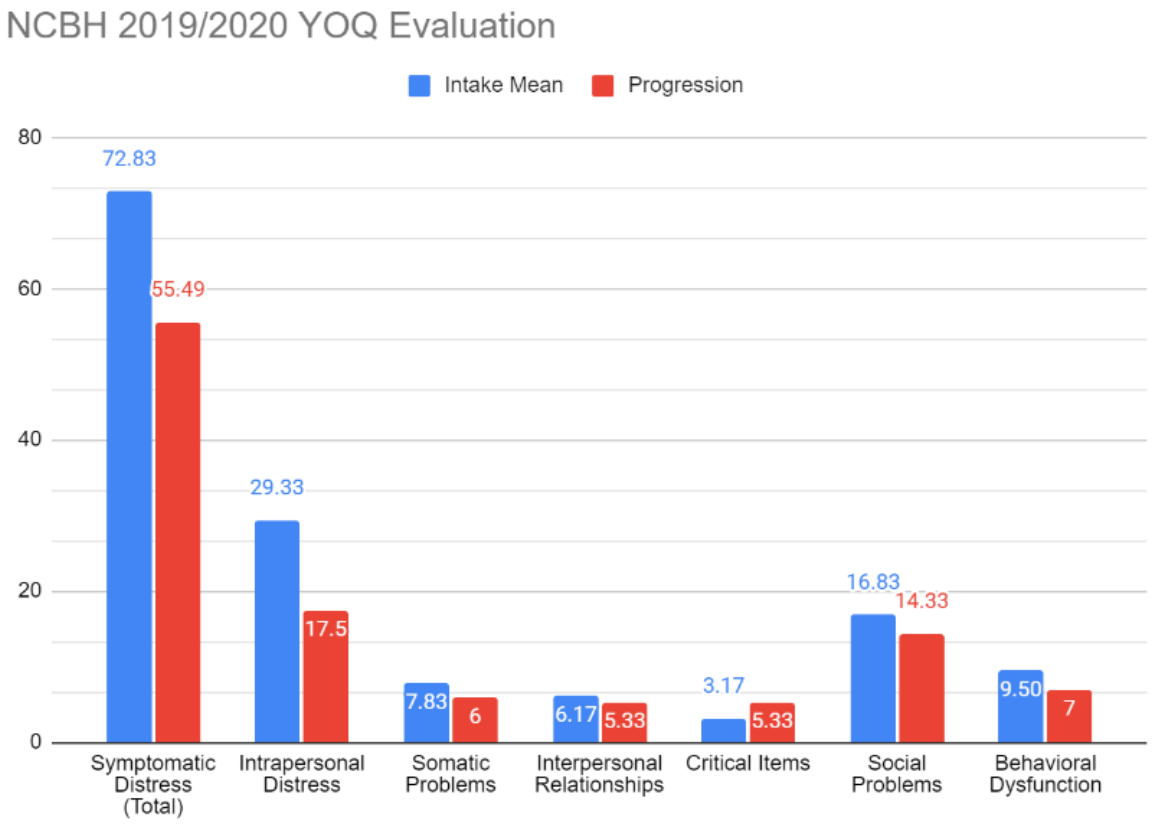
Of the 13 participants in the Nevada County program in FY 19/20 only six had a follow up YOQ to draw comparisons. Of those, participants displayed a mean reduction in overall symptomatic distress of 23.82%. Areas of improvement included reducing feelings of depression, hopelessness, anxiety as well as increasing cooperativeness and reducing argumentative behavior as measured by intra & interpersonal distress. Furthermore, acts of truancy, running away, vandalism and use of substances were all shown to decrease as evidenced by social problem reduction of 14.87%. See chart below.

In Fiscal Year 20/21, the program was funded through Community Services and Supports (CSS) funding to better align with the target population and services of the program.

Perception of Care

From the Participant Perception of Care survey, all participants (100%) displayed improvement in one or more of the following areas:

1. Stability in living situation: 2 participants agreed
2. Improvement in school attendance: 5 participants agreed
3. Reduction in substance use/abuse: 4 participants agreed
4. Increase in positive social connections: 7 participants agreed
5. Reduction in involvement with Law Enforcement agencies: Only 1 participant experienced a 5150 involving law enforcement. None of the other 12 participants had involvement with Law Enforcement.



Challenges, Solutions, and Upcoming Changes

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

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

Capacity Building:

To further bolster clinical oversight, Whole Hearts hired a clinical manager and director. Additionally, Whole Hearts will begin providing clinical therapy and support for youth and families in the new fiscal year.

Case Management Team:
Case management shifted from the program director to a Case Management Team, with a lead Case Manager. Each team member manages and reviews their own caseload. The team will connect with each other and the clinical supervisors as needed for support.

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

Data Management:
Whole Hearts has seen a significant growth in data management needs to ensure necessary tracking of program services and outcomes. To assist with this management, an administrative assistant position was added to help compile data from measurement tools. Additionally, the Whole Hearts admin team has set a goal to collect YOQ-SR every three months versus every six months. This will help to generate a more complete picture.

Crisis:
Whole Hearts had two major challenges to overcome in FY 19/20.
First, a sexual misconduct accusation was made to another program within Gateway Mountain Center that was later dropped. This halted services for two and a half months. **Solution:** All Whole Hearts Staff received 10 hours of mandated reporting & sexual harassment training. Gateway Mountain Center Policies & Procedures received a major overhaul resulting in an even more rigorous hiring process.

Second was the COVID-19 pandemic. **Solution:** Gateway swiftly created safety plans for staff and beneficiaries as well as created a new avenue of service delivery via telehealth.

Program Participant Story

- "Self-awareness, confidence, and achievement through cooperation are natural [program] outcomes... It is a truly holistic outreach and I am forever grateful to have Peter Mayfield and the folks at Gateway Mountain Center in our lives." - Parent of program participant
- "[Our MHW] has been incredible. We don't know what we would do without her. She has played such a huge role in our family." - Parent of program participant
- "I can be real when I am with [my MHW] and she is the main person I turn to when I am in a crisis." - Program participant

PEI Category: Access and Linkage to Treatment Program

SIERRA COMMUNITY HOUSE
Homeless Outreach
Truckee Homeless Outreach

Program Description

Program Overview

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

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

The Tahoe/Truckee Homeless Outreach Coordinator works in conjunction with multiple agencies to assist individuals experiencing homelessness in the region. In addition to building trust and relationships with the homeless population, the Coordinator works to connect individuals with services to promote health, safety, and housing. Each beneficiary has a unique set of challenges and the Coordinator must prioritize and strategize best methods to effectively create a positive change for each individual. The Coordinator assists in connecting beneficiaries to different social services, including CalFresh, MediCal, SSI, and works with Veterans Affairs to connect individuals with VA benefits. They also work to identify housing options, housing vouchers, and rapid rehousing funds that beneficiaries are able to apply for. The Coordinator assists with any application and is in constant communication with other agencies to make sure beneficiaries don't slip through the cracks.

Target Population

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

Evaluation Activities and Outcomes

Outcomes for FY 18/19:
The Homeless Outreach Coordinator worked with 38 beneficiaries providing 72 referrals to 29 different services and agencies. This included nine 211 referrals, nine SSI referrals, five referrals to Social Services, six shelter referrals, and four referrals to the Emergency Warming Center.

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

Outcomes for FY 19/20:
The Homeless Outreach Coordinator had a total of 696 contacts with community members, resulting in 20 unduplicated individuals completing demographic forms. There were 38 total referrals to 24 different services and agencies. This included seven referrals to 211, eight referrals to SSI, five referrals to Social Services, six referrals to shelters, and four referrals to the Emergency Warming Center. Two individuals were referred to mental health services and both connected to services. Neither of the individuals referred to county mental health had a previously untreated mental illness. Of the 38 total referrals, 36 (95%) were documented as having connected with the referral agency with an average time to connection of three and a half days.

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

Outcomes for FY 20/21:
Performance Measure: Contractor shall serve a minimum of 36 individuals or families per year in Eastern Nevada County and North Tahoe (Eastern Placer County).
Outcome: 49 individuals were served from March (when the position was filled) through June.

Performance Measure: 90% of homeless individuals will be referred to the Coordinated Entry HMIS (Homeless Management Information System).
Outcome: 24 beneficiaries (49%) were entered into HMIS. The remaining individuals have either left the area, are currently housed and risk homelessness, or have not been willing to complete the process.

Performance Measure: 90% of homeless and severely mentally ill individuals with no Social Security income (or other source of income) will be offered assistance with a referral to the Social Security office and/or an application for benefits so that the individual can receive Social Security income.

Outcome: Many beneficiaries are already receiving SSI. During FY 20/21 two new individuals have started the SSI process. The Outreach Coordinator has assisted in working with FREED to initiate the SSI process. There are currently no other beneficiaries on the Coordinator's case load that require assistance with SSI.

Performance Measure: 90% of homeless and severely mentally ill individuals will be referred to mental health services.
Outcome: Three individuals have been referred to the Crisis Stabilization Unit. Although the Coordinator discusses frequently with beneficiaries the different mental and behavioral health services, it is rarely an avenue that beneficiaries are comfortable discussing and pursuing.

Data Metrics

Outreach	**FY 2018-2019**	**FY 2019-2020**	**FY 2020-2021**
# Hours	283.6	214	n/a
# Contacts	169	165	n/a
Avg. Hours/Contact	**0.8**	**1.2**	**n/a**

The scope of work has changed significantly for FY 20/21 to focus on case management rather than street outreach. Moving forward, the program will compare the number of referrals made by the Homeless Outreach Coordinator as shown in the table below. This data metric emphasizes collaboration and relationship building between Sierra Community House and partnering agencies.

Referrals Made to Other Providers FY 20/21	**# of Referrals Made**	**# of Referrals Connected**	**Average Interval - Referral Date to Connected Date**
Hospitality House/Homeless Shelter	10	3	
Physical Health Care Provider	5	5	0
Family Resource Center/Sierra Community House	4	4	0
FREED	2	2	
Crisis Stabilization Unit	2	1	1
Veterans Affairs	1	1	18
Social Security Administration	1	1	7
Substance Use Treatment Facility	1		
Total:	**26**	**17**	**Average 5.2 days**

Challenges, Solutions, and Upcoming Changes

The scope of work for this position has changed in the last year. This position focuses highly on case management and connecting individuals to services rather than conducting outreach and distributing supplies. The Coordinator is the only individual within Sierra Community House who works specifically with homelessness. Due to the ongoing housing crisis in the Truckee/Tahoe area, the Coordinator has received an overwhelming number of referrals for individuals being

evicted, losing housing, or unable to obtain housing. This area has very limited low-income housing and extensive waitlists, which makes housing individuals exceedingly difficult.

Additionally, staff turnover during the past three years led to a lack of data collection for July-September 2020. It is challenging to hire skilled staff in the North Tahoe-Truckee region, and so the Coordinator position was vacant from September 2020 to March 2021. Currently, the Homeless Outreach Coordinator is fully trained and has been very successful in her work thus far.

Program Participant Story

Since beginning this position, the Coordinator has been able to connect four individuals with long term housing. Two of these beneficiaries have been homeless in the region for five to ten years. Housing these individuals is a major victory, but to ensure their continued success, it is critical that the Coordinator continues case management. The Coordinator will continue to identify supports for the health and wellbeing of these individuals to ensure stable, long-term housing remains available. The Coordinator has worked to secure benefits from SSI and the VA for both individuals and to provide them the necessary physical, mental, and administrative support throughout this process. With the Coordinator's ongoing support, both individuals continue to gain the skills necessary for independent living.

PEI Category: Access and Linkage to Treatment

UNITY CARE
Homeless Outreach
Transition Aged Youth Homeless Outreach

Program Description

Program Overview

Unity Care Group was founded in 1993 with the mission to provide quality youth and family programs for the purpose of creating healthier communities through life-long partnerships. Unity Care will leverage its experience, networks, and organizational infrastructure to deliver effective services to the targeted Transition Age Youth (TAY) experiencing homelessness. As a strengths-based, family-focused, culturally proficient agency founded on a commitment to social justice, Unity Care's goals include empowering youth to achieve self-sufficiency and overall wellness through educational, employment, social, mental health, housing, and other crucial supports.

Target Population

The target population for this Unity Care program is Transition Aged Youth, ages 16-24 residing in Nevada County who are experiencing homelessness. It is expected that a significant percentage of the

youth will have a history of being in foster care as well as having mental health and/or substance use disorders or being at risk for such.

Evaluation Activities and Outcomes

Unity Care saw the opportunity to impact change for youth and young adults who were becoming homeless, especially in rural counties with no housing resources by applying for the Nevada County Request for Proposal for FY 20/21 programming. The original proposal from Unity Care was countered by Nevada County with a lower start-up budget than what was requested. Unity Care realized in hindsight that they should have adjusted the target number to be served by the program down from the original requirement of 37 youth. The revised caseload should have been smaller based on only affording staffing for a one-third time case manager. The program served nine unduplicated individuals in FY 20/21.

COVID-19 hit at the beginning of this contract period. Meetings that should have been in person so that relationships could be developed did not happen. When schools shut down, Unity Care discovered they were a major referral source for the program. As soon as school went back to in-person instruction Unity Care referral numbers doubled. However, the decision had already been made not to continue the program beyond FY 20/21, so those nine individuals were referred to community partners for further assessments.

One legacy that the Unity Care Case Manager, Maria Espinoza is very proud of is that she worked hard finding true homeless youth in Nevada County. Using all kinds of electronic media including Facebook, Instagram, texting, etc., she was able to connect with youth. She was also able to set up a group of professionals who started meeting weekly and they all continue to this day with a group text of support.

Unity Care reduced risk of serious mental illness for five program participants by linking them to Nevada County Behavioral Health. The program assisted with connecting participants to additional social and mental health services such as Cal Fresh, Homeless Services, Room and Board, Case Management, Vouchers and therapy. Unity Care reached out to the Housing Research Team and received some ideas about how to work with mental health providers to provide weekly treatment to youth in this program. Unity was able to find outside resources to provided mental health screenings as well. Additional referral details below:

# of Individuals	Agency Referred to:
5	Nevada County Behavioral Health
4	Spirit Peer Empowerment Center
3	Home Start Team
2	211 – Connecting Point
2	AMIH
2	Sierra Community House
1	Adult Re-Entry Grant Program
1	Nevada Youth Empowerment

1	The Salvation Army
1	Hosanna Home
1	Casa De Vida
1	Lighthouse of the Sierra
1	Truckee Housing Authority
1	Eddy House
1	Blossom House
1	Compassion Planet
1	Nevada County Adult Education
29	**Total Referrals**

Of the nine participants served 78% became enrolled in school (such as adult school or the local junior college), a job readiness program or employed (at local retail or food service establishments).

Many participants received assistance in finding housing. Some were housed at the local shelter and others were linked with AMIH (Alliance for Mental Illness, Housing) which assisted the participates with motel vouchers for 30-60 days. Unity Care also linked the participates to Sierra Community House, and ARGP (Adult Re-entry Grant Program). Unity Care assisted with transferring a Housing Voucher to Sacramento Housing Authority, Sacramento Self- Housing Help, Wind Youth Services and Sacramento LGBTQ Community Services.

Challenges, Solutions, and Upcoming Changes

The main challenge in Nevada County is housing. Most youth who are at risk of homelessness are couch surfing or sleeping in cars. There is not affordable housing. There is a voucher program, however every time the case manager would find an apartment that was vacant, she would be told there was a two to three year waiting list to use vouchers. This is a problem being experienced across California in every town. Unity Care attempts to be part of the solution by doing this important work in Placer County where they have been very successful in housing youth and young adults. Unity is working with developers who are putting aside units in their developments that can be used for affordable housing. This tactic should be used in Nevada County as well.

Program Participant Story

This is a quote from a Unity Care program participant, “Maria (the Unity Care Case Manager) has been the best-case worker I've worked with through my life's tough journey. We clicked great because she is so easy going and she is such a sweet lady. She's helped me search for housing, getting me to doctor's appointments, grocery shopping etc. Because I've been homeless without transportation, she has linked me to resources I need, and her communication is great. I have gotten further in life thanks to her help. Now I've got housing and other things moving forward and things are now looking up thanks to her support and other community resources…”

PEI Category: Access and Linkage to Treatment

FREED
Senior, Disabled and Isolated Outreach Program
Friendly Visitor Program

Program Description

Program Overview

The FREED Friendly Visitor Program is designed to provide prevention and early intervention mental health services and access and linkage to treatment to reduce isolation in seniors and people with disabilities.

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

The program is supported by a Phone Reassurance Program that was used extensively over the last 18 months to meet the needs of isolated individuals when in person visits were restricted during the COVID Pandemic. Individuals could receive up to five calls a week from volunteers.

The Program to Encourage Active and Rewarding LiveS (PEARLS) was implemented in 2020 as a strategy to meet the needs of older adults who were experiencing an increase in symptoms of depression. PEARLS is a community-based treatment program designed to reduce depression in physically impaired and socially isolated people. PEARLS was developed and researched by the Health Promotion Research Center (HPRC) at the University of Washington, in close collaboration with local community partners. A FREED person-centered counselor collaborated with the Senior Outreach Nurse, and the Social Outreach Coordinator to provide services. Participants are continually monitored through the administration of the PHQ-9 and engage in eight sessions of a problem-solving process and plan for increasing social events, physical activities and enjoying pleasant activities.

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

Target Population

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

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

Evaluation Activities and Outcomes

The FREED Friendly Visitor Program provided services to 42 individuals during FY 18/19, 40 individuals during FY 19/20, with an additional 178 who received meal deliveries and 131 individuals during FY 20/21.

In March of 2020, when the Covid-19 pandemic started, there was a large number of Older Adults and people with disabilities being isolated at home, feeling lonely and depressed. At the same time, we had a large increase of community members, who were also home and had extra time, wanting to volunteer. Together with an increase of referrals from family, friends, and neighbors, we expanded the program and it tripled in size.

FREED continually recruits new volunteers each year to maintain a pool of about 30 volunteers. FREED volunteers visited with participants for a total of 1,438 hours in FY 18/19, 1,820 hours in FY 19/20, and 4,706 hours in FY 20/21. See the table below for more detailed services information.

	FY 18/19	**FY 19/20**	**FY 20/21**
Number of Volunteer hours	1,438	1,820	4,706
Unduplicated participants	42	40	131
Unduplicated Meal Delivery Recipients (due to COVID)		178	

During FY 18/19, volunteers referred participants to outside agencies a total of 84 times. During FY 19/20, there were 60 referrals, and during FY 20/21, there were 607 referrals to other FREED services and outside agencies. This increase of referrals was due to a greatly increased number of participants, a greater need among participants, and a new, more accurate system used by the volunteers to record their referrals. The connections, familiarity, and rapport with community service organizations, which were strengthened during the pandemic, also played a role.

An annual survey was conducted each year with participants of the program. Across the fiscal years, most respondents indicated that visits from the volunteers made them feel less anxious and depressed, and improved their quality of life.

During FY 18/19, there were six training/ support groups for volunteers. During FY 19/20, there were eight training/ support groups for volunteers. During FY 20/21, there were 45 training/ support groups for volunteers. Topics included: Identifying Signs of Depression and Anxiety; Drug and Alcohol Abuse Among the Elderly; Suicide Prevention; Communication with People with Dementia, mandating reporting, and community services.

A year-end Volunteer Survey was conducted by phone each year to gather information about volunteers' knowledge, ability and comfort level in identifying and directly addressing the symptoms of depression, anxiety, and suicide ideation. Here are the results:

Volunteers	**FY 18/19**	**FY 19/20**	**FY 20/21**
% Responded	50%	50%	64%
Depression	100%	100%	90%
Anxiety	100%	100%	90%
Suicide ideation	83%	92%	77%

A year-end consumer phone survey was also done to gain information about the impact of isolation on consumers and the ease and comfort level they have in sharing any feelings of depression, anxiety, or suicide ideation with their visitor. Here are the results:

Consumers	**FY 18/19**	**FY 19/20**	**FY 20/21**
% Responded	60%	76%	43%
Reduced Isolation			79%
Depression	100%	100%	93%
Anxiety	100%	100%	93%
Suicide ideation	92%	85%	70%

The FREED Friendly Visitor Program conducted 25 outreach events during FY 18/19. During FY 19/20, FREED conducted 46 outreach events. In FY 20/21, FREED conducted 23 outreach events. During the COVID-19 pandemic, in-person outreach events have been severely curtailed in keeping with the CDC Guidelines, but virtual outreach events were focused on and expanded. In addition, brochures with information about the program were distributed to various locations.

Referrals Trainings and Outreach	**FY 18/19**	**FY 19/20**	**FY 20/21**
Number of Referrals	84	60	607
Number of trainings/support groups	5	8	45
Number of Outreach Events	25	46	23

Performance Goals and Outcomes for FY 20/21:

1. **Goal**: 70 unduplicated individuals will receive weekly Friendly Visitor home visitations or Phone Reassurance phone calls by trained and screened volunteers annually.
    a. **Outcome**: 131 unduplicated individuals received phone calls by trained and screened volunteers this year during Covid-19 restrictions.
2. **Goal**: 10 unduplicated individuals will participate in the Program to Encourage Active, Rewarding LiveS (PEARLS), a national evidence-based program for late-life depression.
    a. **Outcome**: 35 unduplicated individuals qualified for The PEARLS Program. Thirteen completed some or all of the program. Ten are currently actively engaged in the process. There are 12 participants on a waitlist.
3. **Goal**: 75% of consumers will demonstrate improvement in depression symptoms as measured by the pre/post Geriatric Depression Scale screening

   a. **Outcome:** We have not implemented the pre/post Geriatric Scale Screening due to the transition from in-person to our remote intake process and the logistics and practicality of administration. An annual survey question was added to measure the decrease in isolation among all participants instead.
4. **Goal**: 75% of PEARLS consumers will demonstrate improvement in depression symptoms as measured by the PHQ-9.
   a. **Outcome:** 83% of PEARLS consumers demonstrated improvement in depression symptoms as measured by the PHQ-9.
5. **Goal**: The consumer satisfaction survey will be given annually. At least 75% of consumers will report improvement in quality of life and enhanced mental health
   a. **Outcome:** 79% of consumers reported an improvement in the quality of life measured by the reduction in isolation question.
6. **Goal**: At least 75% of volunteers will express comfort in talking about depression, suicide and anxiety with the people they visit, as measured via a volunteer comfort assessment given annually.
   a. **Outcome:** 90% of volunteers expressed comfort in talking about depression and anxiety and 77% felt comfortable talking about suicide.

Other FY 20/21 data collected:

- There were 120 referrals to the Friendly Visitor and the PEARLS Program
- 456 Referrals were made from FREED to outside Organizations and FREED.
- There are 23 Friendly Visitor Matches
- There were 43 Volunteers. Thirty currently remain active.
- 36 Volunteers participated one or more trainings.

Volunteers gave participants additional information about: Planning for Public Safety Power Shutoffs, getting a backup battery if needed, and getting a Go Bag for fire evacuation. Vaccine info (Flu & COVID-19), Personal Protective Equipment distribution event, PEARLS, Voting Plan, Grief Group (and holiday specific group), the Nevada County Needs Assessment.

Challenges, Solutions, and Upcoming Changes

The challenges during the last three years have been to engage volunteers to provide the visiting and calling services. FREED is constantly looking for new opportunities to advertise and recruit new people who are a good match for this program. 211 Connecting Point Volunteer Hub has been helpful. FREED has increased their online presence in social media particularly during FY 20/21 when most outreach events were curtailed.

Another challenge was seeing the degree of depression and the number of people who were really struggling with their mental health during the pandemic. The PEARLS Program, started in the fall of 2020, was the perfect program to provide extensive weekly support for those participants who met the criteria. There were 27 people who started, are currently active, or who completed the program. Their symptoms of depression decreased substantially, and they have new tools that they can use for life. The collaborations with the Senior Outreach Nurse and the Social Outreach Coordinator were very supportive and successful.

Looking at the future, the program is transitioning to provide more in-person services, so volunteers continue to be needed to match up and meet the participants in their homes. Hopefully more individuals will be provided the opportunity to participate in the PEARLS Process to further decrease the level of depression older adults in the community are feeling.

Program Participant Story

This year, one of the participants was a gentleman who had been diagnosed with cancer. He went to the hospital daily for treatment. He was very isolated and alone with no family support. He started to receive calls from the volunteers, and they provided a great outlet for him to talk about his experience through the treatments. He participated in the PEARLS Program to address issues that caused him to have symptoms of depression. His depression symptoms decreased as he made plans to live the rest of his days. He was so grateful for the support he received.

PEI Category: Access and Linkage to Treatment

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

Program Description

Program Overview

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

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

An integral part of this program is coordinating outreach activities by networking with other individuals and organizations. The Social Outreach Program Coordinator partners closely with the Falls Prevention Coalition, FREED Friendly Visitor Program and Telephone Reassurance

Program, Senior Outreach Nurses, Adult Protective Services, and multiple other county programs and resources.

Target Population

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

Evaluation Activities and Outcomes

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

The Social Outreach Program delivered services to 66 unduplicated participants during FY 18/19, 87 during FY 19/20, and 70 during FY 20/21.

During FY 18/19, the Program Coordinator made 312 referrals to other agencies/services. Of these, 55.7% or 174 successfully connected with the agency or service. During FY 19/20, the Program Coordinator made 365 referrals to other agencies/services. Of these, 50% or 182 successfully connected with the agency or service with an average connection time of 30 days. During FY 20/21, the Program Coordinator made 254 referrals to other agencies/services. Of these, 59% or 150 successfully connected with the agency or service with an average connection time of 14 days. Unfortunately, due to many agencies and/or services being closed during COVID-19 the number of referrals went down slightly in FY 20/21. (See the table below for more detailed referral information).

REFERRED TO	FY 18/19			FY 19/20			FY 20/21			
	# Referrals	# Connected	% Connected	# Referrals	# Connected	% Connected	# Referrals	# Connected	% Connected	Average Timeliness*
211/Connecting Point	38	32	84%	63	50	79%	31	27	87%	16
Crisis Stabilization Unit	2	0	0%	5	0	0%	5	0	0%	-
FREED	50	39	78%	43	33	77%	28	24	86%	13
Therapist/ Psychiatrist (Private)	8	5	63%	41	17	41%	33	14	42%	10
Physician/ MD	3	1	33%	2	2	100%	0	0	0%	-

SPIRIT	4	1	25%	3	1	33%	2	0	0%	-
County MH	37	11	30%	3	0	0%	0	0	0%	-
Other	170	85	50%	205	79	39%	155	85	55%	14
Total Referrals Connected/ Average	**312**	**173**	**55%**	**365**	**182**	**50%**	**254**	**150**	**59%**	**22**

**Timeliness refers to the number of days between referral to an agency and appointment at the agency. Timeliness was not available for FY 18/19 so the averages include FY 19/20 and FY 20/21. The average is not calculated for referrals that did not connect.*

FY 18/19, 19/20, 20/21 Performance Goals and Outcome Measures:

Goal: 50% of the participants served who scored moderate-severe on the pre-screening tool will score lower on the post-screening tool.

Outcome:

- FY 18/19 60% of the participants served who completed a post-screening tool scored lower (26/43). Six screened with no changes, and 11 screened as showing an increase in depression symptoms (average +1.8 points).
- FY 19/20 67% of the participants served who completed a post-screening tool scored lower (8/12). Four of the participants had not yet received post-test scores at the end of the fiscal year.
- FY 20/21 83% of the participants served who completed a post-screening tool scored lower (10/12).

Goal: 50% of the participants served who haven't seen their primary provider in the past year will have made and kept and appointment.

Outcome:

- FY 18/19: Four participants served had not seen their primary care physician within the prior 12 months. These four participants were referred to primary care and 50% connected with the referral (2/4).
- FY 19/20: All participants served had seen their primary care physician within the prior 12 months. Additionally, two participants requested and received referrals to physical health providers and 100% connected with the referral.
- FY 20/21: All participants served had seen their primary care physician within the prior 12 months.

Goal: 50% of the new participants served with report an increase in social activity or increased positive mood at the time of follow-up.

Outcome:

- FY 18/19: 74% of participants reported an increased positive mood or increased social activities (32/43).
- FY 19/20: 89% of the new participants served who completed at post-screening tool reported an increase in social activity or increased positive mood at follow-up (33/37).
- FY 20/21: 86% of the new participants who completed a post-screening tool reported an increase in social activity or increased positive mood at follow-up (32/37).

Other Outcome Measurements:

- Of the new individuals seen how many scored at a moderate-severe risk using the pre-screening tool?
    - FY 18/19: 24% of participants scored moderate-severe risk (10/42).
    - FY 19/20: 20% of participants scored moderate-severe risk (12/60).
    - FY 20/21: 37% of participants scored moderate-severe risk (19/51).
- Of the new individuals seen how many hadn't seen their primary physician in the past year?
    - FY 18/19: 1% had not seen their primary physician in the past year (4/42).
    - FY 19/20: 0% had not seen their primary physician in the past year.
    - FY 20/21: 0% had not seen their primary physician in the past year.
- Of the follow-up visits completed how many scored lower using the post screening tool?
    - FY 18/19: 61% of participants scored lower (26/43).
    - FY 19/20: 72% of participants scored lower (34/47).
    - FY 20/21: 81% of participants scored lower (30/37).

Challenges, Solutions, and Upcoming Changes

A primary and ongoing challenge for the Social Outreach Program this fiscal year was the COVID-19 pandemic. Telehealth services were continued exclusively until some restrictions were lifted and at that time safety protocols were implemented (in accordance with national, state, and county guidelines) to provide in-home services to participants who desired face-to-face visits. Furthermore, participants became more isolated which further impaired their mental health, quality of life, and access to services. Many community supports and services became more limited, unavailable, or inaccessible to participants, particularly those without technology skills or equipment. This often required additional case management to obtain available and accessible resources for participants that could meet their needs. Phone related socialization services such as FREED Phone Reassurance, COVID Social Call and Well-Connected classes/groups were frequently utilized to assist with this need for technologically impaired participants. For those that were able to utilize technology there were additional on-line classes, meetings, groups and other associated supports that existed or became available this year. Services such as home food delivery and Meals on Wheels became increasingly vital. Additionally, as in FY 19/20, therapists were able to provide telehealth services for mental health support. It was more challenging this fiscal year to connect participants and therapists due to the ongoing impact of the pandemic and mental health challenges for the general population resulting in many therapists having full practices requiring more case management time spent locating available therapists for mental health services/support for participants. The pandemic has resulted in the overall need for the Social Outreach Coordinator to be more creative and diligent in connecting participants to currently available and accessible long-term supports and services as well as engaging and encouraging development of additional natural supports where available.

The COVID-19 pandemic appears to have resulted in fewer referrals despite increased needs, as many potential participants were not being seen by referring parties or viewing outreach materials/presentations in the community due to increased isolation and changes in services of

referring parties. Next year's budget includes additional funding for materials and plans are being developed for increased outreach to address this barrier.

Program Participant Story

A referral from a Nevada County Senior Outreach Nurse resulted in the Social Outreach Coordinator collaborating with a new homebound participant with severe depression, suicidal ideation, an anxiety disorder, and social isolation. This participant experienced impairment in psycho-social functioning limiting their quality of life. They lived alone but had some family in the area, however the support available was limited and communication challenging. Despite a diagnosis of depression and anxiety earlier in her life and prior treatment, the participant did not have mental health support in place. One barrier to connecting the participant to supports and services was her fears of engaging with new people or having them to her home. Over a period of approximately two months the Social Outreach Coordinator provided assessments, built rapport, provided psycho-education and skill training, developed a safety plan, and connected them to long-term supports and services based on their needs and interests. This included a therapist who was able to provide telehealth services weekly and a crisis plan to support the participant's mental health. Communication with her family improved with skills training and encouragement and the participant also utilized the Friendship Line increasing her social interaction. Additionally, solutions to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) needs were addressed with assisting participant to risk reaching out for and solidifying outside assistance through a person known to her in the past. The participant's second screen showed a reduction in their depression symptoms as well as increased socialization resulting in a positive outcome and increased life satisfaction. Moreover, the participant expressed gratitude for the support of the Social Outreach Program believing the interventions, support, and connection to services to be fundamental to their progress and life enhancement.

PEI Category: Access and Linkage to Treatment

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

Program Description

Program Overview

The What's Up? Wellness Checkups (WUWC) program screens high school students in the Nevada Joint Union High School District (NJUHSD) and Tahoe Truckee Unified School District (TTUSD) for suicide risk, depression, anxiety, and other emotional health issues. Either virtually or in-person, students take a brief, computerized diagnostic questionnaire, followed by a private one-on-one interview with program staff, who then connect students with community resources, in-school supports, and/or case management and crisis support as needed. In the case of a

necessary, immediate connection or referral, WUWC staff serve as one of the primary support systems for the student's family, providing both in-person and phone-based crisis intervention and referrals to local crisis agencies. WUWC also facilitates evidence-based stress reduction groups for students on campus or virtually, as extra prevention support for those identified with mild to moderate symptoms. WUWC identifies and helps youth at-risk, promotes wellness, increases peer support systems, and strengthens family connections.

WUWC recruits, trains, and supervises contracted screening counselors, case managers and group facilitators. When possible, the program collaborates with schools and agencies to provide in-school and virtual psychoeducational groups including Mindfulness Skills Groups at Nevada Union, Silver Springs, and Ghidotti Early College High Schools. WUWC also creates accessible, up-to-date referral and resource guides for case management.

WUWC coordinates with district officials, school administration, and staff to find on-campus screening sites and provide student follow-ups. The program supports community awareness via newspaper, radio, social media, website, school, community, and fundraising events. WUWC attends local collaboratives and agency meetings, including the Suicide Prevention Task Force, MHSA, and Nevada County Behavioral Health. The program shares resources, coordinates services, and participates in events with local youth-serving agencies and organizations such as Sierra Family Therapy, Granite Wellness Centers, and Bright Futures for Youth.

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

Target Population

WUWC targets high school students at the NJUHSD and TTUSD schools, including Bear River, Ghidotti Early College, Nevada Union, Nevada Union Tech, Silver Springs, Northpoint Academy, North Tahoe and Truckee High Schools. WUWC also provides screenings for high school students at Forest Charter School. WUWC focuses outreach on incoming 9th graders for suicide prevention, as grade 10 has the highest national suicide completion rate.

Evaluation Activities and Outcomes

WUWC collects evaluation activities for MHSA including demographic information for each individual receiving referrals. In addition, information on the type, date, location, and duration of the service is collected for group services. Information on referrals to community services is also collected.

During FY 18/19, 459 high school students were screened for mental health issues. Of those students, 145 students (32%) who screened positive received clinical interviews to assess the need for further evaluation or treatment. Eighty-one percent of students who received clinical interviews were provided WUWC case management services including referrals, screening summaries, consultations, in-person family meetings, and/or group services.

During FY 19/20, 331 high school students were screened for mental health issues. Of those students, 78 students (24%) who screened positive received clinical interviews to assess the need for further evaluation or treatment. Sixty students received WUWC case management services, 77% of total positive screens and 18% of total screened.

During FY 20/21, 263 high school students were screened virtually for mental health issues. Of those students, 124 students (47%) screened positive and received in-depth clinical interviews to assess the need for further evaluation or treatment. Seventy-three total students received WUWC case management services, 59% of the total positive screens and 28% of the total screened.

Fiscal Year	# of Students Screened	# Screened Positive	% Screened Positive	% of Positive Screens Receiving Services	% of Total Students Screened Receiving Services
FY 18/19	459	145	32%	81%	25%
FY 19/20	331	78	24%	77%	18%
FY 20/21	263	124	47%	59%	28%

During FY 18/19, 83 WUWC prevention groups were provided with an average attendance of 2.3 students per group. During FY 19/20 there were 25 meetings of prevention groups with an average attendance of 13 students per group. During FY 20/21, there were no group meetings due to COVID-19. See the table below for more information.

	FY 18/19	FY 19/20	FY 20/21
Number of Groups	83	25	0
Attendance	204	331	0
Avg. Attendance/Group	**2.3**	**13**	**0**

During FY 18/19, WUWC provided 97 referrals to school-based or outside agencies with 78 (80%) of those referrals successfully connecting. During FY 19/20, WUWC provided 65 referrals to mental health providers or in-school services with 50 (77%) of those referrals connecting. During FY 20/21, WUWC provided 94 referrals to school-based or outside agencies with 68 (72%) of those referrals connecting. See the tables below for more information noting that due to COVID 19 and school/agency closures data is limited for FY 19/20.

Referrals to Nevada County Agencies and Services	FY 18/19 Referrals Connected	FY 19/20 Referrals Connected	FY 20/21 Referrals Connected
211/ Connecting Point	100%	100%	100%
Academic Support	100%		100%
Anti-Bullying Support		100%	
Behavioral Specialist	100%		100%
Children's Protective Services			100%

Community Beyond Violence	0%		
Community Mental Health Provider		47%	29%
Counseling Center	0%		
County Behavioral Health Provider		57%	67%
Crisis Stabilization Unit			100%
Family Resource Center			25%
Family Therapist		0%	33%
Follow-up Student Meeting			85%
In School Mental Health Support	90%	92%	50%
LGBTQ Virtual Support Group			NA
Mental Health	59%		
NEO/BFFY Teen Center			33%
NJUHSD Virtual Calming Room			NA
Other	100%		
Parent Consultation/Meeting			100%
Physician/ MD			100%
Resources Provided to Parents (#s of emails and exchanges regarding resources)			100%
School Administration Consultation			100%
School Counselor Consultation			100%
Screening Summary			100%
Student Crisis Line Information			NA
Suicide Prevention Video			NA
Support Group	83%		
Therapist/ Psychiatrist (Private)	58%		20%
Treatment Provider Consultation			100%
Wellness Center	100%		
Wellness Centers NTHS and THS			67%
WUWC Support Group – In-school		100%	
WUWC Support Group - Virtual		100%	
WUWC Virtual Resource Page			NA
WUWC YouTube Channel – Mind Your Mind			NA
Total Referrals Connected	**80%**	**77%**	**86%**
Count of Total Referrals Made per FY	**97**	**65**	**365**

During FY 18/19 and FY 19/20, Group Evaluation Surveys were administered to participants in groups that offered content on both stress response recognition and identifying coping mechanisms. Data showed that groups were effective in delivering those with positive results. Data showed moderate increases in each of the four markers in the chart below from pre-test to post-

test. Results show an increase in protective factors for all four markers listed below. No groups were offered in FY 20/21 due to COVID-19.

	FY 18-19			FY 19-20		
Group Evaluation Survey Items	Pre-Survey Agree or Strongly Agree	Post-Survey Agree or Strongly Agree	% Improvement	Pre-Survey Agree or Strongly Agree	Post-Survey Agree or Strongly Agree	% Improvement
I view stress as a manageable part of my life.	52%	68%	**17%**	65%	78%	**13%**
I am aware of how stressed I am.	75%	81%	**5%**	77%	84%	**7%**
I am aware of how I respond to stress.	63%	72%	**9%**	74%	84%	**10%**
I am able to use positive coping skills to deal with my stress.	35%	56%	**21%**	52%	58%	**6%**
Total Surveys Submitted	**N = 157**	**N = 129**		**N = 62**	**N = 45**	

In FY 18/19, WUWC put on 18 community engagement and awareness activities and presentations, reaching a total of 852 individuals, as well as media outreach through radio and newspapers, reaching up to 68,000 listeners and readers. In FY 19/20, WUWC conducted 21 outreach activities including media outreach and school presentations reaching an estimated 18,772 people. In FY 20/21, WUWC conducted WUWC social media outreach (ongoing posts and creating a new Instagram account), initiated a WUWC mailing list, created its first WUWC newsletters, created a WUWC logo, collaborated with Nevada Union High School staff to create two videos to engage parent checkups support, presented at an MHSA meeting on COVID-19 impacts, and conducted 35 live virtual WUWC classroom presentations to students. Total outreach for FY 20/21 reached 7,573 individuals.

Challenges, Solutions, and Upcoming Changes

As expected, the main screening challenges since March 2020 have been related to COVID-19 when participating school sites closed and in-person screenings/ support groups were no longer an option. With not being able to screen students in person, WUWC continued to develop its virtual approach to mental health screenings and providing prevention supports. In FY 20/21 WUWC revised screening protocols for virtual Wellness Checkups to be integrated into curriculum in online health classes and other virtual classroom settings through the school year. New virtual crisis protocols were a challenge, requiring close collaboration with administration and school staff for immediate crisis assessments in a distance learning setting. Efforts in resource gathering on virtual supports also intensified in order to increase access and linkage virtually during the pandemic.

Another challenge of virtual mental health screening was the increased time and effort in tracking down students online in FY 20/21. Many students were overwhelmed already with virtual school requirements. WUWC worked with school staff to find ways to engage students, urging them to show up as assigned. However, decreased virtual engagement including no-shows and repeated rescheduling was time-consuming and ultimately led to decreased numbers of student screenings. Engaging parents in the pandemic was also a challenge. Decreased responses to case-management services and contacts was labor intensive. In response, follow-up efforts increased with the

repeated use of multiple platforms (texts, phone calls, emails) in order to promote more engagement with services and resources.

In the coming school year, WUWC plans to return to in-person, in-school Checkups in accordance with County and CDC guidelines. WUWC will continue to use some virtual tools that were developed in FY 20/21 to help assist the effectiveness of screening systems in FY 21/22. The program plans to also develop new tools and screener training for transitioning back to in-person schooling. Increasing case management services is planned for FY 21/22 to help build and strengthen resource referral connections. WUWC will also be offering screenings at two new campuses, Forest Charter in Nevada City and in Truckee.

Program Participant Story

Provided by WUWC Screening Counselor FY 20/21:
"I worked with What's Up Wellness as my primary position for the past year during a global pandemic. In my experience, this program proved to be crucial. My work as a therapist, in many ways, felt more important than ever. To have the opportunity to talk to so many students about what is happening for them in their lives during this challenging time, and to be in the role of a caring adult that is not making them do something but there to listen and help, was a gift.

Teens have a lot of pressures and tasks being put on them by adults. What we do with What's Up Wellness is different. We are screening them, yes. And we may encourage them to receive services, yes, but they always have a choice. Because of giving them room to choose and be heard *every one of the students I listened to was a success story.* Even if they didn't get connected to services, they were given an opportunity to be right where they are and know that when they are ready, a path is open to them.

One of the students I screened was connected to services. They identified as LGBTQ+ and a person of color. They had high levels of family stress and disruptive mental health symptoms that were affecting their academic life. Being online for high school at home in their family system was making it more and more difficult for them to manage their symptoms. They were not at risk of suicide but were on a path of increased symptoms and were failing out of school. I listened to them. I asked questions. I told them there was hope and in turn, they no longer felt so alone. They developed more awareness and conviction in their process of screening and getting connected to services. They went from being isolated in emotional pain to knowing what it felt like to get support.

I talked to school staff which ultimately led to the creation of a school accommodation plan for this student. Discussions between the What's Up Wellness program, their school and their parent clarified the mental health issues that have been at work in this youth's academic challenges. This youth now has an educational support plan in place and is in the process of receiving the therapeutic support they need. Mental health symptoms can be debilitating and left untreated could have resulted in a very different outcome. Because of What's Up Wellness, I was able to reach out my hand and when they said yes, I was able to help get them connected to the support that they need."

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY
Veterans Service Office

Program Description

Program Overview
The Veterans Service Office (VSO) promotes the interest and welfare of veterans, their dependents, and their survivors by enhancing their quality of life through counseling, education, benefit assistance, and advocacy. Veterans Service Representatives meet with veterans and/or their dependents to assist them with access to benefits and resources. The representatives conduct regular follow-up meetings or phone calls with the veterans and their dependents to ensure timely and reliable access to resources.

The Veterans Outreach and Linkage program began contracting with Nevada County PEI in July 2016. In FY 18/19 no MHSA funds were used for this program. FY 19/20 evaluation is below. In FY 20/21 the Veterans Service Office program was shifted to Community Services and Supports in our Three Year Program Plan for FY 20/21, 21/22, and 22/23 (see CSS/Outreach & Engagement section for additional reporting).

Target Population
Nevada County's veterans and their dependents. There are approximately 8,700 veterans in Nevada county.

Evaluation Activities and Outcomes

The Nevada County VSO made 33 referrals during FY 19/20. Using all the available resources at its disposal the VSO worked to ensure that veterans were directed into the proper treatment programs for their specific needs. For veterans who suffer from combat related stress, 12 veterans were referred to the Sacramento Veterans Center, which specializes in treating combat related Post Traumatic Stress Disorder (PTSD) symptoms. The Sacramento Veterans Center has a contract with a local therapist, which allows for veterans to be seen locally and receive assistance from a person who specializes in the veteran's specific trauma. Twenty-one referrals were made to Welcome Home Vets, which is a local nonprofit that specializes in treating various mental health conditions. These treatments, as with referrals made to the Sacramento Veterans Center, are free and confidential.

The VSO was active in outreach activities speaking at senior facilities, veterans' organizations, and county clubs. In all 4,607 veterans were reached during 25 different events, including four

events in the Tahoe/Truckee region, 18 events in Western Nevada County, two events in Sacramento and one radio spot on local KNCO radio. Additionally, the VSO performs outreach on various social media platforms with over 530 followers and over 200 connections on LinkedIn. These efforts have proven to be successful in reaching veterans in different locations. Finally, the VSO produces a newsletter that is made available to local Veterans Services Officers, and the newsletter is added to the Nevada County CEO's newsletter to provide information to as many veterans as possible.

Challenges, Solutions, and Upcoming Changes

The current pandemic has had a negative effect on the VSO's ability to perform outreach. The VSO continually uses social media to educate the public on the office's ability to make mental health referrals and that the office is still working to assist local veterans and dependents. Additionally, the VSO has been operating below normal staffing levels since December of 2019, following a staff retirement. The solution to these issues is for the VSO to continue to use every tool and resource that is available. A new member will be joining the VSO staff in late September 2020 and this will allow for more shared workload following a training period. The VSO is in the early stages of planning for a Virtual Nevada County VSO Symposium. The pandemic has caused the cancelation of the yearly Veteran's Stand Down event which is used to reach low-income and homeless veterans. The Virtual VSO Symposium will provide an opportunity for local service providers, internal and external agencies, and the public at large to be educated on the services that are available to veterans.

Program Participant Story

The VSO works with the county eligibility department for Medi-Care to ensure that all veterans who apply for this benefit are referred to the VSO. The VSO processes the referral and then sends a letter to the veteran informing him or her that they may be entitled to Veteran's Administration (VA) benefits. This year a young woman visited the VSO with a letter informing her she would be seen that day. Upon review of her DD-214 (Discharge Document) the County VSO (CVSO) recognized that she had only served six weeks in the Armed Forces. When questioned on this, she informed the CVSO that she had been sexually assaulted shortly before she left for bootcamp. When she had a mental breakdown during bootcamp the agency processed her for discharge and labeled her condition as "pre-existing". The CVSO assisted her in filing a claim with the VA and she was subsequently granted her claim at the 100% and is now attending college via a VA funding program.

PEI Project Name: Access and Linkage to Treatment Program

CONNECTING POINT
Dial 211

Program Description

Program Overview
211 Nevada County is a resource and information hub that connects people with community, health and disaster services through a free, 24/7 confidential phone service and searchable online database.

FY 19/20 was the last year this program was MHSA funded. The contracted provider was not selected in the Request for Proposal process for the new plan year.

Target Population
211 serves the entire population of Nevada County.

Evaluation Activities and Outcomes

During the two years that 211 participated in the PEI Program:

- 27,808 calls were received and handled
    - 2,594 of these calls ended with a "warm referral" direct connection to a community resource
    - 385 of these calls were referred to Nevada County Behavioral Health
- 14,698 unduplicated callers were served
- 29,804 referrals were made
- No caller identified with suicide ideation was let off the line without a warm-transfer to a crisis line and/or referrals to suicide first aid resource(s).

In addition, 211 staff attended trainings in: Diversity & Inclusion, Trauma Informed Care, Best Practices in Ageing & Disability Client Engagement, LGBTQ+ Transgender Diversity & Awareness, Housing First & Built for Zero, and Suicide Prevention & Awareness. Staff also conducted multiple educational presentations for local resource providers in order to increase awareness of services.

Challenges, Solutions, and Upcoming Changes

FY 18/19:
The need for more intensive case management for Seniors in the community was identified. 211 will be working closely with our Senior Navigator to refer seniors who need personalized case management and resources. The Senior Navigator position is new and will be filled by Leslie Kerns.

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

An ongoing challenge for 211 has been in serving the homeless population in Nevada County. 211 currently provides these clients service through Coordinated Entry. They help people with emergency shelter and additional resources, however, continue to see a need for additional long term and permanent housing options for homeless individuals.

FY 19/20:
There were some staffing challenges, with the huge increase in calls resulting from the COVID-19 pandemic. Two additional full-time bilingual Call Agents were hired to meet this demand. 211 Nevada County recently extended their hours of response to text chat and web-based chat, now assisting individuals through that channel from 8:30 am - 6:30 pm.

Program Participant Story

A caller reached out to 211 Nevada County for information on Inpatient Addiction Treatment options. The caller indicated that he had Medi-Cal. He was referred to Nevada County Behavioral Health. Upon follow-up, the caller indicated that he had met with Behavioral Health, done an assessment and was waiting to go into treatment. He also stated that he was set up with a counselor and would be doing regular counseling appointments through Behavioral Health. He expressed satisfaction with the service and referrals and said he would call us again for future needs.

PEI Project Name: Access and Linkage to Treatment Program

HOSPITALITY HOUSE
Homeless Street Outreach

Program Description

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

This Program was moved under the Innovation program umbrella as part of the HOME Team starting in FY 20/21.

Target Population

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

Evaluation Activities and Outcomes

During the reporting period, the Street Outreach Team served a total of 297 individuals experiencing homelessness in Nevada County.

Aggregate Outcomes from FY 18/19 and FY 19/20:

Goal 1: 90% of homeless and severely mentally ill individuals with no Social Security income (or other sources of income will be offered assistance with a referral to the Social Security office and/or an application to benefits so that the individual can receive Social Security Income.
Outcome: 52 individuals were identified as needing severely mentally ill and needed assistance with benefit applications. Of those 52 individuals, all were assisted in completing and submitting an application for services.

Goal 2: 90% of homeless and severely mentally ill individuals will be referred to mental health services.
Outcome: 149 individuals who reported experiencing severe mental illness were referred to mental health services. Of the 149 referred, 130 (87%) were connected to mental health services. During FY 19/20, 16% of those referred to mental health services were not previously treated for the mental health symptoms they are currently exhibiting and the average duration of untreated mental illness for these clients was 3.3 years.

Goal 3: 70% of individuals with a drug problem will be referred to drug treatment services.
Outcome: 202 individuals reported experiencing a substance abuse issue (either alcohol or drugs) of this, 119 (59%) individuals were referred to either Granite Wellness or Common Goals.

Goal 4: Refer a minimum of 10 individuals per year to mental health services.
Outcome: A total of 115 individuals experiencing mental illness were referred to mental health services during the reporting period.

Goal 5: 70% of individuals who are referred engage in the referred service, defined as participating at least once in the service.
Outcome: Of the 990 referrals made during the reporting period, 810 referrals were connected, defined as participating in the service at least once; a connection rate of 82%. The average interval between referral and engagement was 9.4 days. Of those referred, 45 were sent to Nevada County Behavioral Health (NCBH). All 45 NCBH referrals were connected to services. The average interval between referral and connection to NCBH services was 19 days. The top agencies that referrals were sent to were:

- Community Recovery Resources - 183
- Nevada County Behavioral Health - 114
- Utah's Place (Foothill House of Hospitality) – 112
- Interfaith Food- 81
- HOME Team - 51
- Western Sierra Medical Clinic -39

The following are the service types most often provided by the Homeless Outreach Team:

Service/ Need Type	Number of Services
Case/Care Management	218
Substance Use Disorder Counseling	90
Emergency Shelter	77
Meals	67
Substance Use Disorder Services	45
Mental Health Evaluation	43
Local Automobile Transportation	39
Health Care Referrals	29
Outreach Programs	27
Residential Substance Use Disorder Treatment Facilities	27

Challenges, Solutions, and Upcoming Changes

FY 18/19:
From July 1, 2018 to June 30, 2019 Hospitality House served 107 clients through its PEI program. Meeting outreach clients "where they are at" poses certain challenges that are not found in sheltered guests. With no fixed address, and most not having cell phones, ongoing case management can be challenging. The expansion of services through the HOME Team and Hospitality House Outreach team is a step in the right in the right direction if more meaningful case management is to occur. While most of Hospitality House's outreach clients have severe substance use or mental health issues, many of them are unwilling to engage in treatment or have engaged in the past and are unwilling to do so again. A lack of options in our community for super utilizers can create a "been there, done that" mentality from both providers and outreach clients. Some clients have voiced negative experiences with our local treatment options and encouraging engagement for those who have been disappointed with the outcome creates a barrier for case management. Ongoing relationship and rapport building as well as a willingness from agencies to reengage clients is necessary for long term success in outreach.

Connecting individuals from the outreach cohort to housing poses a difficult challenge. Individuals who have lack of income, shortage of life skills, no rental history, and issues with authority are not seen as good candidates for potential landlords. Lack of funding to incentivize housing providers to take on higher risk renters has also been a barrier to getting outreach clients housed. Finally,

community backlash has prevented housing opportunities for master leasing as a “not in my backyard” mentality can be prevalent in this community. Compounding these issues are the unrealistic expectations from those experiencing homelessness in Nevada County. Most clients don’t want to share a room and would rather live alone. Individual units which are priced between $300-$600, in order accommodate a person living alone, do not exist.

While many challenges face the efforts of homeless outreach, moving forward the additional HOME team staffing and associated “flex” funding for housing, is a step in the right direction. The ability to master lease homes and give landlord incentives while also being able to meet clients where they are at provides hope that we can begin to resolve some of these issues. However, ongoing flexibility from service providers and embracing a “Housing First” model is necessary to keep these individuals in permanent housing.

FY 19/20:
The biggest challenge faced during FY 19/20 was a combination of the COVID-19 pandemic and the departure of the PEI Outreach Case Manager, in April 2020. The Case Manager served as the agency's Certified Drug and Alcohol Counselor (CDAC), an essential resource for homeless community members struggling with substance use. His departure amid the COVID-19 pandemic led to Hospitality House evaluating its policies and procedures for Homeless Street Outreach during the pandemic. To remedy this loss, Hospitality House hired a new Case Manager in June 2020, and has been working with him to prepare for the next contract year.

There has also been a shift in data collection with the change from a third party evaluator to in-house evaluation. Hospitality House will now assume responsibility for collecting and analyzing data collected by the Outreach Team. The changes of staff and data management duties are the only significant changes to this year's PEI contract.

Program Participant Story

One individual experiencing homelessness was also experiencing both ongoing mental health and substance use challenges. After working with the Outreach Case Manager, it was determined that a disease outbreak had been circulating within the homeless population. After engaging in medical appointments scheduled by the Outreach Case Manager, it turned out that this individual had contracted the disease, which was negatively impacting her mental health. After building rapport and assisting the individual in connecting with medical services, the Outreach Case Manager placed the individual in substance use treatment and enrolled her in mental health services. She has been clean for months and is currently living in a recovery residence. She has reconnected with and estranged family member, has gained income, and is working towards leasing her own apartment.

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

WHAT'S UP? WELLNESS CHECKUPS
Community Mental Health and Crisis Training
Mental Health First Aid

Program Description

Program Overview
What's Up Wellness (WUW) provides Adult Mental Health First Aid (MHFA), Youth Mental Health First Aid (YMHFA) and Teen Mental Health First Aid (tMHFA) trainings in Nevada County.

All Mental Health First Aid trainings provide outreach to help build the community's capacity to identify mental health and substance use issues early and teach skills in intervening and referring a distressed person to existing resources. Trainings increase basic knowledge about mental health and substance use issues while decreasing negative perceptions often associated with these issues within the general population, as well as within school systems.

Target Population
What's Up Wellness offers MHFA, YMHFA and tMHFA trainings to adults and youth in Nevada County.

Evaluation Activities and Outcomes

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

For the last three years, WUW has provided at least four trainings per year, with an average attendance of 14 to 19 participants per training. See the table below for more information.

	FY 18/19	**FY 19/20**	**FY 20/21**
# Trainings	4	4	6
Attendance	78	69	89
Avg. Attendance/Training	**19.5**	**17.25**	**14.8**

Participants who completed the post-training evaluation indicated that they felt more confident that they would be able to attend to individuals exhibiting mental health problems effectively.

Standard evaluation outcomes for FY 18/19 and FY 19/20 were as follows:

MHFA Post-Training Evaluation	**FY 18/19**	**FY 19/20**
As a result of the MHFA Training:	**Agree/Strongly Agree**	**Agree/Strongly Agree**
I feel more confident that I can recognize the signs that someone may be dealing with a mental health problem/challenge or crisis.	100%	100%
I feel more confident that I can reach out to someone/a youth who may be dealing with a mental health problem/challenge or crisis.	98%	100%
I feel more confident that I can ask a person/young person whether s/he is considering killing her/himself.	95%	96%
I feel more confident that I can actively and compassionately listen to someone/a young person in distress.	100%	100%
I feel more confident that I can offer a distressed person/young person basic "first aid" level information and reassurance about mental health problems.	98%	99%
I feel more confident that I can assist a person who may be dealing with a mental health problem or crisis to seek professional help.	97%	99%
I feel more confident that I can assist a person/young person who may be dealing with a mental health problem or crisis to connect with community, peer, and personal supports.	95%	100%
I feel more confident that I can be aware of my own views and feelings about mental health problems and disorders.	95%	100%
I feel more confident that I can recognize and correct misconceptions about mental health and mental illness as I encounter them.	98%	100%
Total Surveys Submitted	N= 67	N= 68

In FY 20/21 Evaluation forms distributed by National Council of Mental Wellbeing were lost due to technological challenges of the Council's portal. The Council was able to contact participants again and provided the following data for WUW's Youth Mental Health First Aid Trainings provided in Quarter One and Quarter Three:

Quarter One - Youth Mental Health First Aid - 10 participants responded.

1. 80% of participants responded that the course was helpful and informative.
2. 80% of participants responded that the course better prepared them for work they do professionally.
3. 0% of all participants responded that they did not benefit from this course.

Quarter Three - Youth Mental Health First Aid - 12 participants responded

1. 92% responded that the course was helpful and informative.
2. 83% responded that this course better prepared them for the work that they do.
3. 0% responded that the course did not have enough activities and information to prepare them to be a First Aider.

WUW provided program evaluations for Teen Mental Health First Aid. Out of the 26 responses the following data was provided:

1. 85% responded that after taking the classes that they are more confident in supporting a friend with a mental health challenge.
2. 88% responded that after taking the classes they are more confident in supporting a friend in a mental health crisis.
3. 92% responded that after taking the classes that they are more familiar with resources and support available to help a friend with a mental health challenge or mental health crisis.

Challenges, Solutions, and Upcoming Changes

In FY 20/21 a main challenge was creating enough time in trainings to address the community's need to process impacts of COVID-19 and regional fires. In the 20/21 trainings, these issues and their impacts came up repeatedly but due to the nature and pace of our trainings there wasn't adequate time for these discussions. Trainers tried to provide space for this but saw a greater need at a community level for a discussion on the repercussions and anticipatory trauma of these times – possibly through low to mid-level support so folks could feel heard. Solutions might include offering increased numbers of town halls or other community discussion forums.

COVID-19 also necessitated continued use of a virtual platform that led to obstacles and frustrations for participants and instructors alike. Participants couldn't navigate the complicated platform technology and access materials in a timely way. The trainers were up against deadlines and trying to help participants troubleshoot and get what they needed to be prepared for the live trainings. Many emails and phone calls to MHFA support staff were not answered which put the trainers in a bind. And, after completing the trainings, evaluations for the first four trainings were embedded into the platform and inaccessible to both the trainers and MHFA support staff. In response to this, MHFA support staff tried to assist with resending evaluations months later the trainings, but overall, the data and feedback were greatly reduced from previous years. Solutions to these challenges have included accessing MHFA Facebook pages for troubleshooting, reaching out to other trainers country-wide to find answers to the platform obstacles, and providing home grown evaluations in virtual trainings to ensure the necessary data collection.

Upcoming WUW FY 21/22 program changes include implementing more Teen Mental Health First Aid (tMHFA) trainings to local youth. WUW will be offering four series of six classes in both Ghidotti Early College and Silver Springs High Schools.

Program Participant Story

After the first Teen Mental Health First Aid training series completed, one of the staff at the participating school contacted What's Up Wellness. One of the students who received the training came to talk to this school staff (a trusted adult) about concerns they have with their friend's mental health. This student shared that they were "really glad" they had the Teen MHFA training. They said they weren't sure at first if they would ever need the skills/info that they learned but turned out the training was really useful and helped them - and their friend.

PEI Category: Prevention

BIG BROTHERS, BIG SISTERS
Youth Mentoring

Program Description

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

One-to-one meetings take place at a variety of locations. Prior to COVID the majority of this PEI funding went to the PAL Program, and matches met at school locations in Nevada County. However, since COVID the program has had to shift how matches are made and maintained, and how children are served. Now, the majority of matches are meeting in the more traditional program called the Community Based Program, where they meet with their Big Brother or Big Sister in the community and do activities with them in no one particular setting. Hopefully, schools will begin to allow the PAL program once again this fall.

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

Target Population
Big Brothers, Big Sisters mentoring programs serve children ages 6-14.

Evaluation Activities and Outcomes

FY 18/19 Goals and Outcomes:

These goals and outcomes were prior to the merger of the agencies. In November of 2019, Big Brothers Big Sisters of Nevada County and North Lake Tahoe merged with Big Brothers Big Sisters of El Dorado County. This merger enabled the organization to better serve local children by combining resources to provide higher quality services more efficiently. The combination of the two affiliates necessitated a new name to better describe the area collectively served. The new name is Big Brothers Big Sisters of Northern Sierra (BBBSNS).

In FY 18/19, there were 52 matches. There were a total of 1,625 confirmed contacts and over 968 hours spent between mentors and their matches.

	FY 2018-19	
Number of Service Contacts*	**Number of Matches**	**Percent of Matches**
1 Contact	1	2%
2 – 4 Contacts	3	6%
5 – 7 Contacts	3	6%
8+ Contacts	47	86%
Unduplicated Total	**52**	**100%**

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

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

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

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

Improved Healthy Behaviors

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

Improved School Performance

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

Improved Interpersonal Relationships

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

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

FY 19/20 Goals and Outcomes*:*

FY 19/20 was during the merger of the two agencies. While there is some data, it does not fully represent the program due to the merge. All 41 matches had to be suspended during the merge. Staff worked hard during FY 19/20 to re-engage as many as possible. However, the Performance Goals originally required for this program were not able to be met due to the disruption in Pal Program matches caused by the merge and COVID-19.

Instead, MHSA funds were used to train two new Case Managers for Nevada County. These staff members work exclusively for the children in Nevada County and have been actively working to re-engage existing matches using appropriate vetting guidelines, as well as recruiting new Littles and Bigs to the program.

Big Brothers, Big Sisters of Northern Sierra (BBBSNS) maintained constant contact with the matches, via phone calls and weekly newsletters (21 total between March and July). Ideas for connecting virtually were suggested and included various activities (105 total) and virtual "trips" (63 total), as well as tips and guidance to recognize and overcome the feelings of depression and isolation. While all previous participants were encouraged to continue their visits, it became impossible due to school closures and the threat of COVID-19.

FY 20/21 Goals and Outcomes:

- Goal: A minimum of 33 matches will be made.
  Outcome: 11 matches were made. As the program rebounds from COVID and the merger, it is hoped that the PALs program will be able to return in the fall.

- Goal: 90% of matches will be sustained throughout the school year.
  Outcome: Only one match closed prematurely, so 91% (10/11) of the matches were sustained through the year.

- Goal: 95% of matches that were successful for one year or more will show positive change on the Strength of Relationship survey.
  Outcome: The two matches that reached their one-year SOR survey, individually reported a successful and positive match with their Big or Little. Of the two matches that were past one year, the Littles rated their match a 5 - I feel close to my Big (the highest rating). Three-month SORs continue to be captured, and both the Bigs and Littles are progressing at developing positive relationships. Of the matches with surveys being captured every three months of their relationship development, the average rating is score is a 4. This shows the matches are tracking to the goal of 95% showing positive change in their relationship development.

- Goal: 95% of matches that were successful for one year or more will show a positive change on academic performance, behavior and other key indicators of success using the Youth Outcomes Survey.
  Outcome: Of the two matches that have reached their one-year Youth Outcomes Survey both are tracking individual positive changes:
  - ✓ Both identified a plan for attending community college or tech school
  - ✓ One identified they work hard in school the majority of the time
  - ✓ One felt they want their parents to be proud of them

- ✓ One said they work well with other kids
- ✓ Both have not been a part of bullying behavior
- ✓ Both have not been a part of risky behavior

- Goal: 80% of Case Management will be completed on or before due date.
  Outcome: On-time case management is currently at 91% for completion.

Of the 11 matches, five were in the Grass Valley service area and six were in Eastern Nevada County/ Placer County.

	FY 18/19	**FY 19/20**	**FY 20/21**
Number of Matches	52	41	11

Due to the merger of the two agencies, there is no referral data for FY 18/19 or 19/20. As of right now, with the 11 matches BBBS has made, there have been no referrals to outside agencies for services. During the monthly match support contacts with the parents/guardians and volunteers, referrals might be discussed as options, but no formal referrals have been made.

Challenges, Solutions, and Upcoming Changes

The merger and the pandemic have made the goals difficult to ascertain. While the merge was positive for both of the independent agencies, BBBSNS encountered some negativity and hesitancy within the community whose perception was that the organization was perhaps being "taken over", changing focus, or closing altogether. BBBSNS has had to work to create a positive community presence. In the midst of that struggle, the world encountered COVID which not only shut down the site based programs (PALs), but literally stopped all growth. These two factors made it difficult to keep matches open and grow new matches.

Now, that COVID is starting to allow the program to move forward and with new staff, the program has seen a resurgence in new potential volunteers and families wanting mentors. Processing and screening everyone is being done as quickly as possible. When school starts, BBBSNS will be working towards implementing the PAL program once again and meeting with school partners to see what is allowable. New staff have been working with community partners and meeting with new contacts to get the BBBSNS name out more in the community.

Program Participant Story

One of the longer matches in Nevada County is between a Big Brother John (name changed for privacy) and Little Brother Sam (name changed for privacy). Sam lives at home with his parents but does not get out much. He loves playing video games, making his social life and match with his Big Brother a struggle. Recently, his mother reached out and asked if BBBSNS could find a martial arts program for Sam at a low cost. BBBSNS went to work and found a studio that would sponsor him at no cost to take classes. The Little Brother is loving his new social life, filled with

learning, and having peers with the same interest. To make it better, his Big Brother loves to take him to his practices! Little Brother's mom has told BBBSNS that the two come back and do not stop talking about that day's lesson. This has been a huge step forward, as the Little Brother was pushed out of his comfort zone and has thrived. He is excited for the future of Karate and his match, while his Big Brother is excited that his Little Brother has come out of his shell and has renewed interest in the match. BBBSNS is excited to see where this match goes in the future.

PEI Category: Prevention

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

Program Description

Program Overview

The Boys & Girls Club of North Lake Tahoe (BGCNLT) provides year-round, out-of-school time prevention activities and programs to local youth in need. One such program is The Boys & Girls Club of America accredited "Positive Action" curriculum which is shown to produce significant benefits in children and adolescents by reducing the rates of social, behavioral, and academic problems. "Positive Action" is designed to promote a healthy self-concept in youth, and to provide them with tools and techniques to improve social-emotional competencies, academics, behavior, and mental and physical well-being.

One staff member at the Kings Beach Clubhouse and Truckee Elementary School Site was tasked with implementing Positive Action to cohorts in specified age groups. The intention was to meet weekly, and to supplement the robust programming offered to all Club Members ages 3-18.

The COVID-19 pandemic and lockdown has led to mental health implications for children and adolescents. The Boys & Girls Club buffered the effects, prevalence, and severity of these circumstances through a multitude of mechanisms: serving free meals, providing a physically safe environment for school and program participation, and offering access to supportive adults through programs like Positive Action.

Target Population

Early, effective intervention, targeting young people aged 3-18 years (mostly first through fourth graders) in Placer and Nevada County, was the priority. Participants represent the demographics of the broader community and are current BGCNLT Members.

Evaluation Activities and Outcomes

In FY 20/21 The Boys & Girls Club of North Lake Tahoe had 100 members, including 37 from Truckee, 63 from Kings Beach. In total, 35 Club Members, consisting of 12 children from Kings Beach and 23 children from Truckee spanning 1st-4th Grade, completed the "Positive Action" curriculum over nine sessions. Over the duration of the program, staff members observed a significant improvement across multiple variables: academic performance, behavior, social and emotional character, and physical and mental health in all participants. Structured evaluation tools were not in place until the end of the year to capture qualitative data.

Aside from the specific "Positive Action" break-out sessions, the Boys & Girls Club Staff incorporated all of the lessons from Positive Action into daily programming for 100 children across both Sites, but unfortunately, only 35 children were served with small, break-out group Positive Action sessions.

BGCNLT has kept the doors open and continued to serve the youth in the communities throughout the challenging and rapidly-changing school year. Youth actively engaged in distance learning as well as grew socially and emotionally through the wellness programs. Regardless of the challenges everyone inevitably faced, when these kids walk through the Club doors, they know the consistent and dedicated attention and support they are going to receive.

Challenges, Solutions, and Upcoming Changes

Working with split cohort days created a gap in the ability to provide regular programming to all enrolled Positive Action participants, as half the members were absent on any given day. Increased absences were seen as well due to travel quarantines, cautionary sick days, and COVID exposures, in addition to regular absences caused by sports or other outside commitments. An unexpected challenge was the lack of buy-in from Club members. This may be due to the lack of social time or consistent recreational play in comparison to in-person schooling.

Moreover, staff retention and recruitment has been a significant challenge in the execution of this program. As BGCNLT rapidly approached capacity during the pandemic months, they experienced a shortage of workers and were strained to handle the demand of youth in need of services. Onboarding additional qualified workers to implement Positive Action was not an option, and it was difficult to optimize staff schedules and to allow for optimal allocation of staff resources.

In order to combat the challenges seen during the 20/21 school year, creating a targeted program pool of participants and focusing on consistent program delivery may help to increase the success of Positive Action. Enrolling a targeted group of children will increase the impact of the program and support the community that most needs intervention, thus increasing buy-in as well as regular attendance. Assuming the 21/22 school year takes place in-person, the Boys & Girls Club will step back from virtual learning and resume operations as an after-school youth development program.

Program Participant Story

Late in the spring 2021, Club members were particularly on-edge, and there was an uptick in the fighting and conflicts seen at Club. While creating the "Friendship Tree", participants discussed all of the things that go into creating a friendship: kindness, understanding, help, and support, and spent the hour coming up with and discussing the many aspects of friendship and kind things their friends had done for them.

This lesson not only re-centered the group and brought down the rate of conflict, but also helped inspire the kids to be the best Positive Pal they could be to their secret partner. Positive Pals (used by K-2nd grade) is a supplement to a lesson in Positive Action. Participants were paired up (similar to a secret Santa) and used what they had learned to do something kind and supportive for their "Pal". When kids were asked to guess who their pal was, they were able to recall the discussion and use their understanding of other kids to guess who might have been their Positive Pal.

Because of the pandemic, this program was a huge portion of the kids' social-emotional learning this year. Programs that normally take place at school were cancelled, but Positive Action allowed Club members to be actively working towards personal development in a time where gaps in social-emotional learning were quickly widening. At the Boys & Girls Club, school was virtual, but the connections and growth created by this program were very real.

PEI Category: Prevention

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
Youth Wellness Center (Eastern County Only)
Wellness Program

Program Description

Program Overview

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

The TTUSD Wellness Program has Wellness Centers at North Tahoe High School and Truckee High School, as well as supportive Wellness Programming at the Sierra High Continuation High and Middle schools. The Wellness Centers provide a comfortable setting for students to drop-in during their breaks to ask questions, get support, or just relax. The Centers are furnished with cozy

chairs and couches, artwork, music, games, art supplies, and healthy snacks to make it a fun place for students to hang out.

Key Focus Areas include:
Youth Voice- The TTUSD Wellness Program facilitates a Peer Mentor Program that trains students to become Peer Mentors and teaches them skills to better support themselves and their peers. The Peer Mentors are trained as Link Leaders and offer support to 9th graders during their first year of high school. The Wellness Centers also provide leadership opportunities for students to have an authentic voice in shaping school and community initiatives, such as: Sources of Strength and Hope Squad, Pride Club, youth leadership workshops, Breaking Down the Walls Workshops and participation in Community Collaborative and County meetings.

Support- TTUSD Wellness Centers provide trained staff to listen to, support, and connect students to community health and wellness resources. The Wellness Centers offer a variety of empowerment and peer support groups (e.g., coping skills, social skills, girls' and boys' groups) to build stronger connections with students and provide ongoing social emotional supports. The Wellness Program also collaborates with school and county partners to provide additional mental health resources for students on campus, such as: Coordinated Care Teams, school-based therapists, a Tahoe Forest Hospital Youth Health Navigator, and What's Up Wellness Mental Health Screenings.

Education- The TTUSD Wellness Program offers a variety of wellness workshops to provide students with practical tools to improve their overall health. Topics cover the range of social, emotional, mental, and physically healthy choices and lifestyle tools, such as: Healthy ways to deal with stress, Heart Math, Mindfulness, Know the Signs/Sources of Strength and Breaking Down the Walls Workshops.

The TTUSD Wellness Centers offer three types of programming.

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

Wellness Center Locations and Hours:

- North Tahoe High School – The Wellness Center is located in Room 217 and is open Monday- Friday: 7:30-2:30pm
- Truckee High School – The Wellness Center is located in Room 118 Monday-Friday: 7:30-2:30pm

Target Population

The TTUSD Wellness Centers program primarily serves high school students, ages 14-18 years, but it also provides peer mentor supports, wellness workshops, and Sources of Strength (SOS)

trainings to middle school students, ages 11-13 years. Most of the high school students served seek out Wellness Center programming on their own, but the program also receives referrals from the counselors, psychologists, school administrators, and teachers.

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

Evaluation Activities and Outcomes

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

Over the years, TTUSD Wellness Centers have offered Groups, Peer Mentoring and Clubs, such as: Girls Empowerment, Boys Mindful Warriors, Grief Groups, and Mindfulness Substance Abuse Groups. These activities require more commitment on the part of the student, to attend and to complete sign-ins and demographic forms. The unduplicated number of students who attended groups, participated in Link Crew and Clubs has increased across the years despite not having students on campus during the pandemic for nine months: in FY 18/19, 92 students attended, in FY 19/20, 126 students attended, and in FY 20/21, 192 students attended. See the table below for more info.

Groups or Clubs (Link Crew, Pride Club, Boys and Girls Groups, Hope Squad* started 20/21)	**FY 18/19**	**FY 19/20**	**FY 20/21**
# Meetings	59	119	106
Attendance	493	1,650	1,400
Avg. Attendance/Meeting	**8.4**	**13.9**	**13.2**
Unduplicated	**92**	**126**	**192**

The program was significantly impacted by not being on campus with students for nine months. Staff put in extra effort to pivot and offer virtual wellness programming, but it was difficult. The decrease in drop-in numbers in 19/20 and 20/21 were a result of the pandemic. See the table below for more info.

		FY 18/19	**FY 19/20**	**FY 20/21**
North Tahoe High	# Attendees	4,412	2,015	663
	# Days Available	153	119	180
	Avg. Attendees/Day	29	17	3.6
Truckee High	# Attendees	2,500	2,329	548
	# Days Available	180	119	180
	Avg. Attendees/Day	14	20	3

Both Schools	**# Attendees**	**6,912**	**4,344**	**1,211**
	Avg. # Days Available	**167**	**119**	**180**
	Avg. Attendees/Day	**41**	**37**	**7**

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

During FY 18/19, TTUSD Wellness Centers made 32 referrals to outside agencies, with 31 successfully connecting. In FY 19/20, the Wellness Centers made 27 referrals, with 24 successfully connecting. In FY 20/21, the Wellness Center made 21 referrals, with 21 connecting. The number of referrals also decreased as a result of Wellness Staff connecting with a fewer number of students due to distance learning and not meeting with students in person. See the table below for more information.

	FY 18/19			FY 19/20			FY 20/21		
Agencies	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**
Adventure Risk Challenge	7	7	**100%**	-	-	-	**3**	**3**	**100%**
Child Welfare Services (CWS/ CPS)	4	3	**75%**	6	6	**100%**	**1**	**1**	**100%**
Sierra Community House (FRC/Tahoe Safe Alliance/Project MANA)	10	10	**100%**	-	-	-	**4**	**4**	**100%**
Gateway Mountain Center	-	-	-	-	-	-			
County Mental Health	-	-	-	13	11	**85%**	**1**	**1**	**100%**
Partner Agency	-	-	-	-	-	-			
Physician/ MD	-	-	-	2	2	**100%**			
Social Services Agency	-	-	-	-	-	-			
Therapist/ Psychiatrist (Private)	1	1	**100%**	3	2	**67%**	**8**	**8**	**100%**
Tahoe Forest Youth Health Navigator	8	8	**100%**	3	3	**100%**			
Community Partner/Substance Abuse	-	-	-	-	-	-	**4**	**4**	**100%**
Other	-	-	-	-	-	-			
Total Referrals Connected	**32**	**31**	**97%**	**27**	**24**	**89%**	**21**	**21**	**100%**

The Wellness Centers had between 67 and 99 outreach events over the fiscal years 18/21, reaching estimated audiences of up to 5,651 individuals. During FY 20/21, weekly Social Emotional Learning (SEL) lessons were offered which was counted in the number of outreach events but did not include each lesson in the estimated attendance because it would have skewed the numbers too high (Placer HHS Server reported 35,260 in total attendance). See the table below for more information.

	FY 18/19	FY 19/20	FY 20/21
Number of Outreach Events	91	67	99
Estimated Attendance	5,651	3,859	2,016
Average Attendance per Event	**62**	**58**	**20**

The Link Crew Peer Mentor Program collected end of the year surveys assessing attitudes toward mental health during FY 18/19 and 20/21. Surveys were unable to be collected in 19/20 due to school abruptly transitioning to distance learning as a result of the pandemic. Overall, the results were positive but there was a drop in the number of students reporting that their interactions with friends and families had improved. This is an interesting data point and it is suspected that this was due to students being online for most of the school year and not able to connect with their Link Crew Team, Wellness Center staff and other students in the same way as they had in previous years. See the tables below for more information.

Link Crew Survey Results	18/19 % Often or Always	20/21 % Often or Always
I am comfortable talking with and welcoming others who visit the Wellness Center.	96.3%	91%
I am able to recognize when others are upset.	96.3%	88%
I am comfortable with my ability to actively listen to others.	94.4%	97%
I feel I have the skills to support other people when they need help.	98.1%	86%
I feel comfortable taking a leadership role.	92.6%	97%
I feel empowered to advocate for others.	92.6%	86%
I am able to help others be their authentic/true self.	90.7%	83%
I am respectful and accepting of others when they have different points of view.	96.3%	90%
I feel that my voice is heard and valued at the Wellness Center.	92.6%	91%
I feel that I can make a difference at my school.	79.6%	83%
My interactions with friends and family have improved.	83.3%	68%
Link Crew provided me with the support I needed to be a Peer Mentor.	92.6%	91%
I felt that the Link Crew facilitator(s) respected me.	98.1%	100%
Total Surveys Submitted	**N=54**	**N= 42**

Participant Perception of Care surveys were administered in FY 18/19 and FY 20/21. Responses indicated that students are feeling less connected and supported by the Wellness Centers than in previous years which makes sense since connecting with students wasn't as effective during distance and hybrid learning. Even after students came back to school, there was a tighter minimum day schedule which didn't allow for students to come into the Wellness Center during breaks. Additionally, everyone was wearing masks which made it harder to connect and build relationships. See the table below for more information.

Participant Perception of Care Survey Items	FY 18/19		FY 20/21	
	% Agree	N (Neutral)	% Agree	N (Neutral)
I am getting along better with my family.	45%	38%	21%	50%
I do better in school and/or work.	58%	34%	41%	35%
My housing situation has improved.	37%	39%	17%	41%
I am better able to do things that I want to do.	70%	22%	53%	29%
I am better able to deal with crisis.	72%	25%	50%	26%
I do better in social situations.	70%	25%	47%	26%
I have people with whom I can do positive things.	80%	16%	74%	12%
I do things that are more meaningful to me.	70%	50%	76%	18%
I have learned to use coping mechanisms other than alcohol and/or other drugs.	62%	22%	53%	18%
In a crisis, I would have the support I need from family or friends.	66%	25%	56%	15%
Staff welcome me and treat me with respect.	84%	13%	79%	12%
Staff are sensitive to my cultural background.	55%	23%	44%	24%

Average (All Responses) / Total Surveys Submitted	**62.7% (83 surveys)**	**28%**	**51%**	**26% (34 surveys)**

Challenges, Solutions, and Upcoming Changes

The last three years (18/21) have been challenging and have made staff very grateful that there was already a robust Wellness Program in place. There have been multiple staff changes, increasing student mental health needs and navigating online-learning during a pandemic.

In the spring of 2019, the school experienced the devastating loss of a student who died by suicide. This loss shook the entire school community. It was a student the Wellness staff, Counseling Team and Coordinated Care Team had all been closely supporting. The student had been offered many mental health resources, so it was quite the blow when everyone learned about the suicide. The hardest part was that the program could only offer postvention services to students and staff for a few days following the death because the school district then went into shelter in place mode due to COVID-19. The Wellness Program continued to check in with students, staff and family members via distance learning, but the virtual platform made it difficult to connect with some of the students who needed the most support. In response, it was decided to enhance the Wellness Center's suicide prevention efforts by implementing a new peer mentor suicide prevention program called Hope Squad in all the middle and high schools. The virtual Hope Squad was launched in the fall of 2020 and 80 students were able to be trained in QPR – Question Persuade Refer and in peer to peer support skills. The program was very well received by students and will be fully implemented in this school year.

As with most organizations, the COVID Pandemic made it extremely difficult to continue programming. In the spring of 2019, there was very limited contact with students. Most students and teachers were overwhelmed, had spotty Wi-Fi and were inundated with emails. The Wellness Center did their best to reach out to students through virtual wellness programming, such as: Girls Group, Mindfulness Based Substance Abuse Treatment Groups, Link Crew and Wellness Check-Ins but it was difficult. District leadership directed the center not to administer any surveys, including the Healthy Kids survey and the end of the year Wellness Surveys because school sites were stretched too thin. So, there was no survey data collected for the 19/20 school year.

Students were also hesitant to talk about their mental health challenges while at home, often surrounded by family members. The Wellness Program decided to contract with local therapists to provide emergency counseling to the highest needs students. The therapists were able to offer virtual and in person therapy in a safe, socially distanced way. They were able to check-in with, refer and/or provide individual therapeutic supports to 76 high need students from May 2020 through June 2021.

A silver lining of the pandemic is that there is an increased focus and attention on the importance of supporting the mental health needs of students. In collaboration with Tahoe Forest Hospital ACEs (Adverse Childhood Experiences) Aware Grant, TTUSD offered a district-wide Trauma Informed School Training with Heather Forbes on trauma informed intervention tools to support

students who have experienced trauma. Through the training, all staff will have ongoing access to a Trauma-Informed Online Academy with a video library of 50+ hours of video content packed with self-regulation strategies. The following programming is also being implemented this school year:

- Expanding the Wellness Centers into the middle schools
- Contracting with three school social workers to support the middle school and high school counselors, students, and families in crisis
- Expanding Social Emotional Learning (SEL) curriculums in all the schools
- Implementing the DESSA (Devereux Student Strengths Assessment), a strength-based behavior rating scale in all the elementary schools
- Expanding the Caring Connections Surveys (survey where students identify safe, caring adults at school) in all local schools
- Continuing to contract with therapists

Student mental health is becoming more of a priority at the state level. Recently staff attended the Wellness Together Student Mental Health Conference and were inspired and felt validated for the work they are already doing in the school district and community. The Wellness Center plans to continue to expand and deepen the Wellness programming to meet the ever-growing mental health needs of students and families.

Program Participant Story

The COVID Pandemic and distance learning has been difficult for everyone but was especially hard for our new 9th grade students. They never had a chance to be at school to connect with teachers and peers before being thrown into online learning. We did our best to offer a virtual Freshman Orientation but it was not the same as being all together, in-person in the gym. We anticipated that 9th graders would be a particularly vulnerable group, but we were shocked by just how many Freshmen struggled with academic, family and mental health challenges. Our Coordinated Care Teams (CCT) comprised of School Site Administrators, Counselors, School Psychologists and Wellness Staff met weekly to identify students who were struggling and strategized supportive interventions. We emailed, google chatted, texted and even did home visits for students who were struggling or not logging into classes.

During one of our CCT meetings, we identified a 9th grade student who was having a very difficult time. This student was failing classes, not engaging with teachers and the student's mother had called the school counselor worried that the student was depressed and wouldn't leave the bedroom. After a few unsuccessful email attempts from the school counselor, the Wellness Specialist tried Google chatting the student. After a couple of unresponsive check-in messages, she tried a funny message. She finally got a response and engaged in a funny banter about cats. This was the start of their relationship. She was soon able to talk to the student via Google meet. At first, they just talked about random things but soon transitioned to deeper conversations about how hard it was being home all the time, not having any friends at school and the stress of the student's mom being out of work because of the pandemic. The Wellness Specialist continued to meet with the student and convinced the student to join a virtual Wellness Student Support Group.

The student was hesitant at first but after a couple of meetings, started to open up about how difficult it had been.

In February, we were able to return to hybrid in-person learning and the student started coming into the Wellness Center to talk to the Wellness Specialist and began meeting new students. The student was also able to meet their Link Leader in person. The Link Leader offered additional support and helped the student feel more connected to school. That spring, school sports resumed, and the Wellness Specialist encouraged the student to join a team. Even though the student wasn't skilled in that sport, the team welcomed all levels and it turned out to be a very positive experience for the student. The student's second semester grades also started to improve, and the student became much more engaged in school. The Wellness Specialist was able to build a special relationship with the student when other efforts from parents, teachers and counselors had failed. This helped the student access support, make new friends, improve grades and feel more connected to school at a critical time. We were able to provide a safety net and support system for this student and prevented the student from slipping through the cracks.

PEI Category: Prevention

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

Program Description

Program Overview

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

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

Staff is ready to share with participants information about resources and refer them to available services when they express needs in relation to safety, mental and behavioral health. Many participants who attend the parenting classes respond to media promoting classes throughout the community. These parents self-identify as wanting additional knowledge and support around parenting their children. Means of promotion include Facebook, Twitter, the organization's

website, and traditional print media, including fliers distributed in the community and through the school district. Some participants are referred from County agencies, including Child Welfare services, Placer/Nevada County Court, and Placer and Nevada County WRAP programs. Tahoe Truckee Unified School District (TTUSD) school counselors and local mental health therapists in the community also refer parents to this program.

Target Population

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

Evaluation Activities and Outcomes

The Family Support/Parenting Classes at Sierra Community House was a new program for Nevada County that began in FY 20/21. The Program served 90 community members through family support and parenting classes. Twenty-nine received individual services. Of the 90 served, 47 individuals were Nevada County residents and 43 were Placer County residents. Nine referrals were made, two of which were to County Behavioral Health.

Four six-week Parent's Café sessions in Spanish and two in English were offered during the fiscal year. Mom's Café weekly meetings were offered between October 2020 and June 2021.

Though the number of community members served was less than the annual target, all other contract benchmarks were exceeded:

- 92% of individuals demonstrated improvement in overall mental health, as evidenced by improved score on the Participant Perception of Care posttest.
- 89% of individuals/families in the support program demonstrated improved parenting skills, as evidenced by a decrease in the number of problematic behaviors reported in the *Problem score* on the Eyberg Child Behavior Inventory posttest.
- 87% of individuals/families in the support program demonstrated improved parenting skills, as evidenced by a decreased intensity of child behavioral issues reported in the *Intensity score* on the Eyberg Child Behavior Inventory posttest.

Challenges, Solutions, and Upcoming Changes

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

Sierra Community House continued to provide different instances of connection and interaction for the community such as classes, workshops and activities on parenting, mental health prevention, nutrition, health and wellness, open to everyone in the community. All these ultimately contributed to building stronger and healthier families and represented an effective way of combating the COVID-19 isolation.

However, services continued to be provided mainly virtually during this period – with various exceptions. This represented a challenge as the program's core approach to working with families in person. The in-person interaction is really key to building trust and developing relationships that allow families in need to effectively access resources. Even as community members accepted the changes fairly quickly and were ready to work together with staff, several challenges remained, mostly around engagement in activities and the ability to have sustained attendance.

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

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

Sierra Community House (SCH) starts FY 21/22 with staff in the offices five days a week and the ability to start offering more and more of the community activities in person. As this phase evolves and the situation varies, the organization continues working on adjustments to processes and service delivery, with the goal of developing every opportunity of supporting the community more and better in these difficult times.

Program Participant Story

This is the case of two young parents struggling to keep their family together. These parents of a two-year old boy have had several ups and downs in their relationship. Reports received by a local agency painted a difficult picture of substance abuse and of domestic violence incidents that stem from harsh quarrels between the parents. They have the great support of the young father's parents, who have been taking good care of the two-year old and of the young parents themselves. But there are many issues for the couple to deal with. In particular, the young mother has a history of abuse and alcoholism in her family which interferes with her attempts to bring things back on track with her husband.

A local agency referred the family to SCH and Family Support Advocates have been meeting with the couple since then, providing solid case management services and referrals to stabilize their situation and help build a system of support. Legal counseling was also provided to the couple to work on a custody agreement in case they decided to separate. The Crisis Intervention team was engaged to help the couple end the circle of violence and enjoy a healthy relationship. Parenting classes were provided to improve and increase their skills as parents.

The last time SCH met with the young couple, they were together again, they were both working and living in an apartment right near close relatives. The baby was looking healthy and happy, and a new baby was on his way. In the context of the young family's situation, a new baby is an

additional stress factor and a new challenge they will have to deal with, and they will continue to have the support of SCH.

PEI Category: Prevention

NEVADA COUNTY SUPERINTENDANT OF SCHOOLS
Second Step for Early Learning

Program Description

Program Overview

The SECOND STEP Curriculum is part of Nevada County's MHSA Prevention and Early Intervention (PEI) Plan. In the FY 18/19 school year, the SECOND STEP Curriculum was brought into preschools, a transitional kindergarten (TK), typical kindergarten, and a Special Day Class (SDC) kindergarten in the Western Nevada County Region.

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

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

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

FY 18/19 was the last year this program was MHSA funded. The contracted provider ended the program, indicating that the project was a success and had completed its run.

Target Population

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

Evaluation Activities and Outcomes

In the classrooms that received the full training, classroom modeling, and year-long support, a total of 98 children and 26 educators participated in the SECOND STEP program for the 2018-2019 school year. To begin, 31 schools, of which 29 have been previously trained in SECOND STEP, were contacted. Two of the schools had closed and one school began using the Center on the Social and Emotional Foundations for Early Learning curriculum, CSEFL (a more recent social-emotional learning program). Four schools did not respond. Sixteen schools reported they were still using some level of the SECOND STEP curriculum, reaching over 255 children. Eight classrooms agreed to accept more training for FY 18/19. One teacher received training in the fall of 2018 and lost her position, so the new replacement teacher received the training in the spring.

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

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

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

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

Percentage of children in Mainstream classrooms Showing Growth:

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

- Reciprocal Communication and Conversation: 78%
- 100% showed some growth

Percentage of Children in Special Education Kindergarten Showing Growth:

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

Teacher Reporting:

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

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

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

Reduction in behavior challenges since the beginning of the year:

- Mainstream: 45%
- Special Education: 20%

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

Other teacher comments included:

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

Challenges, Solutions, and Upcoming Changes

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

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

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

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

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

Program Participant Story

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

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

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

"'John' entered the program with a lot of anger. We used the emotions poster daily and had each child put a sticky note with their 'special letter' (first letter of their name) on the emotion they were feeling at the time. Everyday John put his on angry and he really did feel angry. During free choice time he would have a scrunched angry look on his face and would get easily angered about

issues with other children or something not going the way he wanted. After several weeks of us using the emotions poster and talking about taking breaths when we feel angry and ways to calm our bodies, he gradually started to change to a calmer and happier person at school. I remember the day he chose ‘happy’ for his emotion with his sticky note. He has not gone back to angry since then and he plays with others so much better than in the beginning. His self-regulation skills have dramatically improved.”

PEI Category: Prevention

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
Second Step

Program Description

Program Overview

Second Step is a research-based curriculum that teaches social and emotional learning for children. The Collaborative for Academic, Social and Emotional Learning (CASEL), recently published findings of the largest, most scientifically rigorous review of research ever done of school-based intervention programs (Durlak, Weissberg, Taylor, & Dymnicki). The findings indicate "…students receiving school-based Social Emotional Learning (SEL) scored 11 percentile points higher on academic achievement tests than their peers who did not receive SEL."

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

This program was not funded by MHSA after FY 19/20. It was not selected through the PEI Request for Proposal process.

Target Population

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

Evaluation Activities and Outcomes

The program focused on training schoolteachers and school support staff in the Second Step curriculum in order for these staff to train and support their students in the evidence-based practice. Trainings occurred over both years of program implementation. Trainings took place at Truckee Elementary School, Tahoe Lake Elementary School, Glenshire Elementary, Alder Creek Middle School, North Tahoe Middles School, Kings Beach Elementary, and the Boys and Girls club after school program. Materials were purchased and provided for teachers and staff. Second Step Kits were purchased for all who needed a replacement or for new teachers. Replacement materials were purchased as needed for damaged or missing curriculum pieces. The new mindfulness part of the Second Step program the Mind Yeti licenses were purchased for each school and each teacher, counselors and principals were given access to the Mind Yeti app.

By the end of the reporting period:

- Trainings took place at North Tahoe Middle school, 100% of the teachers had access to the new middle school curriculum. Alder Creek, 100% of the teachers were implementing the program during advisory period.
- At Glenshire Elementary 90% percent of the teachers were implementing the Second Step Curriculum. They were also identifying students who needed reteaching of SEL through a data program they purchased that looks specifically for SEL competencies through Second Step.
- Truckee Elementary had 90% of teachers implementing the Second Step curriculum.
- Preschools were offered training and the Second Step curriculum as needed.
- Early learning curriculum also had lessons to implement during the distance learning as well as programs for parents to use with children at home.

Challenges, Solutions, and Upcoming Changes

The COVID-19 pandemic greatly impacted the education system and modalities of learning. Fortunately, the second step program is continually updating with technology and ease of use for the teachers. The Second Step Middle school program was restructured to be used digitally and to be more user friendly for their advisory periods. New all-digital kits were used to replace the kits that use DVD's.

The California Healthy Kids Survey that usually would be given in the spring March/April was not implemented for 2019/2020 as students were distance learning.

Committee for Children implemented a Covid19 Response curriculum for teachers and parents during the Spring of 2020. These were selected lessons that teachers implemented targeting the SEL lessons appropriate for the distance learning. The lessons were recorded for Tk-5th grade. There was also a component for the middle school response to Covid19 and a section for parents.

Program Participant Story

During the closure of the schools and the beginning of distance learning the school counselors were still implementing the Second Step lessons to students at a TTUSD school. The students looked forward to these lessons on emotion management, problem solving, mindfulness, empathy building, accepting differences and more. During these difficult times the lessons were crucial to the wellbeing of the students and within their families. One of the families reported that the problem-solving techniques and the empathy building were very helpful for all family members. They would watch the videos and discuss in a family meeting setting. The counselor was so appreciative to hear this and recommended it to other families as well.

PEI Category: Prevention

TURNING POINT
Housing Assistance Program

Program Description

Program Overview

The Housing Assistance Program (HAP) is a collaborative with Hospitality House and Turning Point Community Programs. The goal of the Housing Assistance Program is to deliver mental health services to participants of the Hospitality House shelter, rapid re-housing, and outreach program. Two (2) Shelter Case Managers are responsible for assisting Hospitality House participants in meeting their expressed mental health-related goals, including specific assistance with medication management, housing, counseling, medical services, support, brokerage for other needed services, and advocacy. The Shelter Case Managers work directly under the supervision and direction of a Hospitality House Supervisor or Program Manager and Turning Point management. The Housing Assistance Program began serving individuals in April 2018.

Target Population

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

Evaluation Activities and Outcomes

Hospitality House and Turning Point Housing Assistance Program collected evaluation activities for MHSA, including demographic information on every individual receiving service. Besides, information on individual services, referrals to outside agencies, outreach activities, and participant perception of care was collected. This program served 172 unduplicated individuals in FY 19/20. Thirty-nine (39) or 22.6% of the participants in the HAP program were housed in a positive housing situation in FY 19/20. Positive housing situations include, recovery treatment facilities, permanent housing with friends or family, and rentals of their own with no ongoing subsidies.

According to the participant perception of care data collected from 32 unique individuals, 84% of individuals reported that their housing situation had improved because of engaging in services provided by the program. Additionally, 84% reported being "better able to do things that I want to do, 81% reported having people they could go to for support, 97% said that HAP staff were welcoming and treated the individuals with respect, and 88% reported that staff was sensitive to their unique cultural background.

Referrals:
During FY 19/20 Housing Assistance Program, staff were able to perform 130 Nevada County Behavioral Health Screening intakes and provided follow up with four individuals. Of the 130 Behavioral Health intake screenings completed, 21 individuals were referred to further services at Nevada County Behavioral Health, all of whom were connected to Behavioral Health services, within an average interval of 22 days between referral and connection. Of the 21 individuals referred to further services, 14% had never been treated for mental illness before. The average duration of untreated mental illness for these participants was 12 months.

Services:
During FY 19/20, the HAP was able to provide 769 services, of which 289 (37%) were Case Management sessions. Additionally, the HAP program was able to provide 84 housing counseling sessions and 75 mental health support sessions. The HAP program team also preformed mental health assessments & treatment 32 times during the reporting period.

Starting in FY 20/21 this program was moved under MHSA's Community Services and Supports, Outreach and Engagement funding where it has remained since then.

Challenges, Solutions, and Upcoming Changes

The biggest challenge faced by the HAP program during the reporting period came at the tail end of the program year as Utah's Place shelter shifted to new shelter-in-place policies recommended by Nevada County Public Health due to COVID-19. The shift in shelter policies had a negative impact on HAP participants' mental health and housing opportunities. The risk of becoming ill is much higher among homeless populations, and at the beginning of the outbreak, there was much concern over contracting and spreading COVID-19. Housing Assistance Program staff did their best to assuage participant's fears highlighting the changes in Utah's Place were designed to keep them safe and healthy.

Another challenge faced by the HAP program was the departure of the part-time Turning Point HAP Case Manager in December 2019, and the departure of the full-time Turning Point HAP case manager in May 2020. The loss of these two individuals was enormous. Many of the program participants had built a rapport with both Case Managers and as embedded case managers; many of the staff had similar relationships. To overcome this challenge, Turning Point has been working diligently to find prospective candidates who are able to provide the same level of personalized Case Management to all HAP participants. Additionally, Hospitality House case managers have

stepped up to help provide similar services to those at Utah's Place. The only upcoming changes to the program this coming year will be two new Turning Point embedded Case Managers.

Program Participant Story

One program participant who has had a history of chronic homelessness and state incarceration worked closely with the HAP Case Manager and was determined to be eligible for another Hospitality House program. This individual was referred to the program and has since moved into housing. Her housing has been maintained since October 2019. This individual's story would not have been possible without consistent work on the part of the HAP Case Manager.

PEI Category: Stigma Reduction and Discrimination Reduction

SIERRA COMMUNITY HOUSE
LatinX Outreach
Promotora Program - Latino Outreach Services

Program Description

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

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

Target Population
The Program primarily serves Latinx families and individuals who could benefit from supportive services and assistance to link them to needed services in the community.

Evaluation Activities and Outcomes

The program collects evaluation activities for MHSA including demographic information on each individual receiving services. In addition, information on the Family Room group services, outreach, and referrals to outside agencies is collected. Direct service information includes date, location, and duration of the service.

During FY 18/19, the Program delivered services to 135 unduplicated individuals. During FY 19/20, that number decreased to 91 unduplicated individuals. In FY 20/21, the number increased again to 123 unduplicated individuals.

Across the period in review, the number of group services offered and accessed by community members variated. In FY 18/19, 151 meetings were offered, 88 in FY 19/20 and 154 during FY 20/21. As shown by the table below, the average attendance per group decreased over the years.

	FY 18/19	FY 19/20	FY 20/21
Number of Groups	151	88	154
Attendance	2769	1460	1619
Average Attendance per Group	**18.3**	**16.5**	**10.5**

Referrals followed a more consistent upward path. Through the Program, 18 referrals during FY 18/19, 14 in FY 19/20 and 50 during FY 20/21. As shown in table below, successful connections improved over the years.

Referrals	**FY 18/19**		**FY 19/20**		**FY 20/21**	
Agencies	**# Referrals**	**# Connected**	**# Referrals**	**# Connected**	**# Referrals**	**# Connected**
Family Support Advocate	3	3	1	1	19	19
Legal Services	1	1	1	1	6	6
Mental Health Service Provider	9	5 = **56%**	11	10 = **91%**	16	12 = **75%**
Physician/ MD	2	2	0	0	2	0
Crisis Intervention	1	1	0	0	2	0
Other	2	0	1	0	5	0
Total Referrals & Connected	**18**	**12**	**14**	**12**	**50**	**37**

A survey assessing attitudes towards mental health was administered to the attendees of the groups during the period. Results were positive in all the three years after attending the groups as compared to before attending. Results shown below:

Performance Measures	**FY 18/19**	**FY 19/20**	**FY 20/21**
% of individuals showing an improvement in attitudes, knowledge, and/or behavioral **change** related to mental illness.	91%	82%	87%
% of individuals showing an improvement in attitudes, knowledge, and/or behavior related to **seeking** mental health services.	82%	84%	81%

Challenges, Solutions, and Upcoming Changes

Several changes occurring at the organizational level, like the merger of four individual organizations into Sierra Community House in 2019, and the related staff turnover, made the data collection and entry an ongoing challenge around the ability to consistently measure and

understand the impact of the Program. To address this challenge, a sustained effort has been put in place to train staff and establish processes that allow for a more effective collection of data at the source and more organized recording and entry into the system.

But arguably, the impact of the COVID-19 pandemic on the service delivery model was the biggest challenge during the period. The process of shifting all the activities to a virtual format created the need for staff to adjust to these new circumstances, including familiarizing themselves with technology that they otherwise wouldn't need to use.

This also represented a challenge to the core of the Program's approach with community members, in which the in-person interaction is really a key to building trust and developing relationships that allow families in need to effectively access resources. And even as community members accepted the changes fairly quickly and were ready to work together with staff, several challenges remained, mostly around engagement in activities and the ability to have sustained attendance.

Nonetheless, the Program continued to provide varied instances for connection and interaction, open to the everyone in the community. All these contributed to building a stronger and healthier community and represented an effective way of combating the negative impact of COVID-19 isolation on the community's wellbeing.

In this sense, the crisis created by COVID was an opportunity for growth in the number of participants served by peer support, as it is a type of individual service that can be delivered safely, virtually and allows for one-on-one connections amidst the dire context created by the pandemic. This peer support service, that started by building capacity with staff training and education, provided 341 individual one and two hour sessions during FY 20/21 and has already become a main point of access for the community to access broader mental health care.

Towards the end of FY 20/21 Sierra Community House staff started to come back in person to the offices five days a week, with the expectation of having the ability to start offering more and more group activities in person. As this phase evolves and the situation changes, the organization has to continue working on adjusting processes and service delivery, with the goal of developing every opportunity for community support in these difficult times.

Program Participant Story

"Carlos" (not his real name) was having medical issues related to a chronic disease. His job had also been impacted the COVID-19 pandemic, with reduced hours and the risk of it ending altogether. His personal life was also deeply affected. He economically supported his wife and daughter, who lived in Mexico, and with the travel restrictions in place, the chances of seeing each other were lower than ever. When one of the Promotoras connected with him at an outreach activity for a different Sierra Community House program, he expressed an interest in talking with someone about how to access care. The Promotora, who saw "Carlos" was overwhelmed and troubled due to the different things he was dealing with, offered to introduce him to an Advocate that could help him navigate the options available in terms of medical care. She also mentioned the possibility of peer support one-on-one meetings. He then met every week, for almost two months, with one of

the certified Peer Supporters who became probably "Carlos's" main support in the community, to help him deal with the different issues he faced. Isolation, unmet medical needs, work uncertainty and a background of mental health issues in the family, were all factors combining with the extraordinary circumstances of the pandemic, affecting "Carlos" overall wellbeing. The cultural element of being a man asking for help, was also a barrier that "Carlos" managed to overcome to take care of himself. After the peer support meetings, he was eventually referred by the Peer Supporter to a bilingual Therapist available in the area, with whom "Carlos" continued to meet periodically.

PEI Category: Stigma Reduction and Discrimination Reduction

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

Program Description

Program Overview

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

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

Target Population

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

Evaluation Activities and Outcomes

The Promotora/ Latinx Outreach Program collects evaluation activities for MHSA including information on individual demographics, outreach and referrals to community resources on each

person receiving services and/or being trained. The Promotora provided varied services, such as: assistance with medical and dental appointments, school issues, individualized education programs (IEPs), and referrals for immigration and other family legal issues, translation assistance with medical applications and other documents. Also provided was an English as a Second Language (ESL) tutor and a Yoga Wellness Class with a certified instructor. A Mental Health Awareness presentation was facilitated for the ESL Nevada Union High School students, along with a summertime Kids WRAP (Wellness and Recovery Action Plan) class for children. A WRAP Walk was started to help participants develop a personal wellness plan by blending mental wellness with physical movement. A more individualized WRAP planning program was also offered and WRAP Mental health awareness pamphlets were distributed.

FY 18/19 Outcome Measures:
In FY 18/19 the outcome measures tracked for this program were different from those collected in FY 19/20 and 20/21. Therefore, they are not able to be compared. The FY 18/19 Outcomes are as follows:

During FY 18/19, the program provided 226 occurrences of service delivery at the Partners Family Resource Center to 99 unduplicated individuals. These activities included:

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

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

The program's survey results are shown below:

NCSOS Promotora MOQA Survey Results	# Agree	%
As a direct result of this training, I am MORE willing to:		
...live next door to someone with a serious mental illness.	7	50%
...socialize with someone who had a serious mental illness.	6	43%
...start working closely on a job with someone who had a serious mental illness.	5	36%
...take action to prevent discrimination against people with mental illness.	8	57%
...actively and compassionately listen to someone in distress.	11	79%
...seek support from a mental health professional if I thought I needed it.	12	86%
...talk to a friend or a family member if I was experiencing emotional distress.	12	86%
As a direct result of this training, I am MORE likely to believe:		

...people with mental illness are different compared to everyone else in the general population.	3	21%
...people with mental illness are to blame for their problems.	1	7%
...people with mental illness can eventually recover.	8	57%
...people with mental illness are never going to be able to contribute much to society.	0	0%
...people with mental illness should be felt sorry for or pitied.	5	36%
...people with mental illness are dangerous to others.	3	21%
Please tell us how much you agree with the following statements:		
The presenters demonstrated knowledge of the subject matter.	10	71%
The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.).	10	71%
This training was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).	6	43%
TOTAL SURVEYED:	**14**	

FY 19/20 and 20/21 Outcome Measures:
During FY 19/20, the program provided 657 contacts/ services to 69 unduplicated individuals from the Partners Family Resource Center. These activities included both group and individual services with six face-to-face groups and 11 virtual Skype groups. Thirty-five unduplicated individuals attended groups with an average of six participants attending each group. The program provided direct mailing of over 200 postcards to maintain contact and help increase awareness of activities and provide mental health information for the Latinx Community during the COVID quarantine.

During FY 20/21, the program provided 702 contacts with community members providing both individual services and group meetings including 36 sessions of Skype Yoga y Beinestar, 32 sessions of WRAP Walk, five sessions of WRAP Mental Health Awareness Class, and two sessions of Kid's WRAP. Gift bags for King's Day were provided to approximately 70 children. All of this was provided to 119 unduplicated individuals.

Eight individuals with mental health symptoms were referred to Nevada County Behavioral Health for services. Five individuals were referred to Adult Services and three were referred to Children's Services. All were connected to services within a day of their referral.

The survey results below are from 28 individual program participants.

Outcome Measures Comparison	**FY 19/20**	**FY 20/21**
Unduplicated Individuals Served	69	119
Number of services/meetings/groups (Goal: 16 psycho-educational meetings yearly)	18	71
% of individuals showing increase in knowledge of mental health and substance use services and treatment resources available in Nevada County.	36%	95%

% of individuals showing increased comfort in talking about mental health illnesses and symptoms.	73%	80%
% of individuals showing increase comfort in seeking mental health services for themselves or others.	82%	100%
Number of adults who receive education on mental health issues per year (Goal 50)	69	34
Number of children/youth who receive education on mental health issues per year (Goal 15)	11	25
Number of individuals who have prepared their Wellness Recovery Action Plan (Goal 3 to 5)	0	8
% of individuals who report satisfaction with the services provided (Goal 80%)	N/A*	N/A*

**A specific question to measure satisfaction will be added to the present survey. Only verbal comments from participants have been shared to express the appreciation for the programs to date.*

The Promotora has, over the past two years, attended many trainings including:

- Youth Mental Health
- Adverse Childhood Experiences (ACE) Training
- WRAP 1
- WRAP 2
- Applied Suicide Intervention Skills Training (ASIST)
- Implicit Bias Training
- UndocuAlly - an educational training dedicated to increasing the community's awareness of the unique needs of undocumented students
- Opioid Summit

Additionally, the Promotora has been increasingly engaged in forming connections with:

- Suicide Prevention Task Force
- Equity and Inclusion Leadership Alliance (EILA)
- Black Indigenous People of Color (BIPOC) Council
- Sierra Harvest Food Education Project
- Earth Justice Ministries
- English Learner Advisory Committee (ELAC)
- District English Learner Advisory Committee (DELAC)
- Dual Immersion for Grass Valley School District
- Nevada Union Highschool English as a Second Language Staff

Over the years, this program has worked in collaboration with many other organizations, schools and professionals including: Alcoholics Anonymous, Alta Regional Center, Anew Day, Nevada County Schools, Chapa-De Indian Health Clinic, Child Protective Services (CPS), Children's Health Insurance Program (CHIP) Committee, Community Beyond Violence, Foothill Healthy Babies, local attorneys, Medical Professionals, Nevada County Behavioral Health, Spirit Peer Empowerment Center, Sierra Nevada Memorial Hospital (SNMH), SNMH Foundation, SNMH

Emergency Department, SNMH Crisis Stabilization Unit, Western Sierra Medical Clinic, Suicide Prevention Task Force, Equity & Inclusion Alliance, and the BIPOC Council.

Trainings are provided to the Promotoras in order to provide informative and quality workshops for the community including: ACE (Adverse Childhood Experiences), Building Resilience, Census, Mental Health First Aid, Know the Signs (Suicide Prevention), ASIST (Applied Suicide Intervention Skills and Training), UndocuAlly (Undocumented Student Assistance Program), and Wellness and Recovery Action Plan (WRAP). Promotoras also participate in the Suicide Prevention Task Force, and the Equity and Inclusion Leadership Alliance.

Challenges, Solutions, and Upcoming Changes

Challenges:

- COVID-19 and the Delta Variant have and continue to cause fear in the community, despite the availability of vaccines.
- It continues to be difficult to provide services when resources for families and the need for housing assistance has not been adequately addressed.
- It continues to be a goal to reduce the time that it takes new families to integrate into the community and to bridge the gaps in service that come with these transitions.

Solutions:

- Continue to gain connections with individuals in the community to further develop the phone tree for rapid communication.
- Actively work through schools to reach parents for Parenting Classes and WRAP.
- Look for more opportunities to advertise and invite people to Wellness and Recovery Action Plan (WRAP) meetings, one-on-one or in groups of children, youth, and adults.
- Promote WRAP to help people learn how to care for their own wellness during crises.
- Increase modes of communication with the community.
- Continue to seek assistance offerings to provide housing to members of the Latinx community.
- Utilize the developed relationships with school staff to keep up-to-date on students/families that are new to the community.

Upcoming Changes:

- New volunteers with Spanish language skills are interested in participating in Latinx Outreach to help with outreach and support during program presentations.
- Focus on conducting programs that address mental health stigma and discrimination in meetings that are designed to survey a positive change of attitude in the audience.

Program Participant Story

A lovely young lady, “Maria” (not her real name) recently immigrated here with her husband, and young child. Unfortunately, Maria became very ill during the pandemic, so she had to be in

confinement for months. Now, thankfully, she is well enough to be up and around. Sadly, during her illness, the relationship with her husband became strained and it has not recovered as well as her health. He grew increasingly aggressive with her and held expectations that she could not fulfill because she is not a legal resident. She has started the process of earning her residency and citizenship, but the COVID limitations have slowed every aspect that process, including her ability to get a job to help the family's financial situation. She is unable to work a traditional job until she establishes legal residency. Considering all the stress she was under, she needed emotional support and information on what she could do for herself and her little child in the situation. She called the FRC and joined the yoga class to help with her mental wellness. She also asked for help with applying for preschool for her very active child. The Promotora connected her to Social Services to check their eligibility for assistance and informed her of the food bank availability. Her relationship with the Family Resource Center Promotora continues.

PEI Category: Stigma Reduction and Discrimination Reduction

GATEWAY MOUNTAIN CENTER
LatinX Outreach

Program Description

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

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

Evaluation Activities and Outcomes

Fiscal Year 20/21 was the first year that this program was funded by Nevada County Behavioral Health, MHSA funds. The program served 68 unduplicated individuals during the reporting period.

Two youth were trained and certified in MBSAT and lead an eight-week program held on site at two Tahoe Truckee Unified School District (TTUSD) campuses. Two additional youth have been

recruited to be trained and supported in the fall, and two others were close to being recruited. Twenty-five youth were served by these programs. A weekly peer led Mindful Warriors Circle was established and eight youth were served.

Programs in Outreach in Self-control, Reduction of Reactivity, and Managing Stress were held at two additional TTUSD campuses; one campus for eight weeks and the other campus for a full field day. Thirty-four students were served.

Additional activities included a Peer led Promotional Outreach for six site visits on three campuses; a Youth Voice Art Installation at the Youth Wellness Center; and a Youth Voice video clip promoting peer listening recovery circles that aired on two entire campuses. Additionally, one youth was awarded a scholarship for peer leadership through Rotary Youth Leadership Awakening.

Going forward the program is developing a youth co-authored Peer Model Training Program for TTUSD students and an outreach from Peer to Peer High School Pipeline into TTUSD Middle Schools.

Due to challenges brought on by COVID the Emotional Regulation Questionnaires were not able to be widely collected throughout the program year and overall outcomes were not able to be reported. While there was some data collection, it was intermittent and inconclusive. It did not reflect the feedback heard in listening circles held at every program. However, one participant indicated decreased days with feelings of depression in a two week span from "several" to "none at all" and increase in "successfully cutting down or stopping substance use" from "not successful" to "nearly every day".

Challenges, Solutions, and Upcoming Changes

There were several challenges with trying to meet the contracted outcome measures. The requirement to assist in leading planned Community Wellness Walks in Kings Beach was unable to be pursued due to COVID restrictions and mandates. Regarding increasing Emotional Regulation Questionnaire (ERQ) score for MBSAT students by 10% from baseline; attendance, due to COVID was sporadic and not conducive to pre and post assessments. Much of the programming was taught outdoors, at night, in Tahoe winters, huddled around fire pits. Youth engagement in these conditions was inconsistent at best. The same was true of trying to reduce reported substance use in the past 30 days by 10% from baseline for youth in MBSAT classes. It seemed that assessments created barriers to engagement with programming due to length and number of deeply personal and potentially triggering information. The program has re-designed how and when to administer these questionnaires based on a model following a neuro-sequential approach (Dr. Bruce Perry). Staff are still learning how to do assessments from a trauma-informed perspective.

Program Participant Story

Youth Voice Testimonials:

- *"When I first came to Mindful Warriors, I wasn't really open to change but everybody including the other kids were just all so inviting and really made me feel at home".*
- *"What shifted for me is a new ability to navigate the challenges in my life mindfully."*
- *If you are really going through it, there is a real sense of community with everyone who attends. This provides so much support."*
- *"Now I understand where addiction stems from for me. MBSAT helped me cope with my triggers. I have better tools for dealing with them. Because of this, I have an easier time, and I don't get triggered as much"*
- "*My favorite part is talking with people my own age about mutual struggles."*
- *"M.A.S.K. / MBSAT saved my life."*
- *"I would highly recommend these services. I am now able to be with my emotions and feelings, rather than running from them."*

PEI Category: Stigma Reduction and Discrimination Reduction

SIERRA COMMUNITY HOUSE
Youth Empowerment

Program Description

Program Overview

Empowerment Groups are offered to students to enhance a variety of skills and opportunities. Topics for these groups include creating positive environments and communities, promoting healthy friendships, relationships and choices, increasing positive self-worth, engaging and empowering youth to speak out and model healthy lifestyles, and increasing the understanding of mental health stigmas and how to support others and seek help. Empowerment groups help individuals identify personal strengths and supportive resources and develop new ways of thinking and addressing challenges, both internal and external. Facilitators build rapport with youth and provide the space and opportunity for students to open up through discussion, activities, writing, media and art. Multiple curricula are used, depending on the topic needs and focus of the specific group but Young Men's Work and Young Women's Lives are referenced the most. FY 20/21 was the first year this program was funded using Nevada County MHSA resources.

Target Population

Youth in grades 4-12 (ages 10 through 18) in the North Lake Tahoe-Truckee community are the target population for this program. Students are often referred by school counselors and teachers as those who would benefit from extra support, and students are also referred for being identified as those who could take new skills and teach/influence their peers.

Evaluation Activities and Outcomes

During the 20/21 school year, five 10-week, and one year-long, Youth Empowerment Groups were provided with 27 unique participants. Due to the pandemic, the program census did not meet the contract goal of 56 participants. Demographic Forms were completed by students to capture data at the start of each Youth Empowerment Group, and Group Services Sign-in sheets helped track the attendance at each group session. From the 27 Demographic Forms captured, all participants resided in Nevada County. None of the program participants lived in Placer County.

Four of the 27 participants took the Participation of Care Survey, and 100% of those students reported improvement on at least one of the 12 areas surveyed. The Stigma and Discrimination Reduction Survey was not made available to staff until later in the reporting year, and only participants 12 years old and older are asked to take this survey at the end of the Youth Empowerment Group. Due to participants' age, there were no Stigma and Discrimination Reduction Survey results available for this fiscal year.

Discharge/Closing Forms are also completed by staff at the end of a Youth Empowerment Group for each participant. Of the 26 Discharge/Closing Forms collected, 18 were reported as "Goals Met" (18/26 = 69%), seven were marked "Other" (7/26 = 27%) as the group ended short of completion due to the pandemic, and "Client left" was reported for one participant (4%).

Challenges, Solutions, and Upcoming Changes

The biggest challenge this year was working to provide successful virtual Youth Empowerment Groups during the COVID-19 pandemic. Agency staff facilitating groups had to alter all documents and activities to work in a remote setting, as well as navigate learning how to use different online platforms to lead engaging groups, depending on what platform the specific school/counselor wanted to use. Other obstacles included students being burned out on screen time, building rapport with students while not meeting in-person, students not having privacy to fully engage in group, and school staff feeling burdened and overwhelmed with the additional task to set-up the virtual groups. This overwhelm felt by school staff carried over while setting-up a year-long Youth Empowerment Group at a local middle school. The planning began, but as the schoolyear went on the start of group was pushed back multiple times as school staff weren't prepared to help get it going on their end. Additionally, with students going from remote learning to hybrid learning, back to remote learning, and then to in-person, the school staff were having to adapt to a lot already. Some of the 10-week groups met less than 10 weeks, as there ended up being scheduling conflicts and lack of participation. Group sessions were also shorter in the virtual format, most being 30-45 minutes, to help with the amount of screen time the students were incurring. Although agency staff were not allowed in the schools even when students were back in-person, to increase engagement and participation staff could drop off "goody bags" for students or have drawings at group and drop gift cards for the winners at the schools. Although the year presented many challenges for staff, it was a learning and growing experience. Staff look forward

to hopefully being able to offer programming in-person next schoolyear and feel more prepared if virtual Youth Empowerment Groups are required again in the future.

Program Participant Story

During the 20/21 school year, the Community Education & Prevention Program facilitated a year-long Youth Empowerment Group focused on raising mental health awareness and ending stigma in the school and community. Due to the COVID-19 pandemic, this Youth Empowerment Group was held virtually once a week for any students attending North Tahoe High School. Although it was challenging getting students to attend the virtual meetings and participate, there was one student, in particular, who attended meetings throughout the entire school year and was actively engaged in the group activities. This student was extremely passionate about stopping the spread of misinformation regarding mental health and continuously advocated for others to learn the facts about mental illnesses. Even though the facilitator did not meet this student in person, they built a strong connection throughout the year, and the student reported that they hope they can participate in the group again in the 21/22 school year.

PEI Category: Suicide Prevention

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

Program Description

Program Overview

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

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

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

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

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

The coordinator also convenes the Suicide Prevention Task Force (SPTF) in Western Nevada County, supports the work of the Tahoe Truckee Suicide Prevention Coalition in Eastern Nevada County, and collaborates with many other organizations and agencies. Both the SPTF and the Tahoe Truckee Suicide Prevention Coalition are in the process of developing strategic plans to guide their work.

Target Population

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

Evaluation Activities and Outcomes

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

As a direct result of this training:	**% Agree* FY 18/19**	**%Agree FY 19/20**	**% Agree FY 20/21**
I am better able to recognize the signs, symptoms and risks of suicide.	100%**	93%	100%
I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide.	100%	92%	100%
I am more willing to reach out and help someone if I think they may be at risk of suicide.	93%	92%	99%
I know more about how to intervene (I've learned specific things I can do to help someone who is at risk of suicide).	100%	92%	98%
I've learned how to better care for myself and seek help if I need it.	87%	82%	89%
Please tell us how much you agree with the following statements:			
The presenters demonstrated knowledge of the subject matter.	100%	94%	100%
The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.).	100%	93%	88%
This training was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).	100%	91%	90%

**includes respondents answering "strongly agree" or "agree"*
***FY18/19 = 15 participants, FY19/20 = 149 participants, FY20/21 = 393 participants (100 responses)*

SPP provided trainings to 15 unduplicated participants in FY 18/19, 149 unduplicated participants during FY 19/20 and 393 unduplicated participants during FY 20/21 in various suicide prevention modalities. Across the three years, these trainings included Know the Signs, safeTALK and ASIST (Applied Suicide Intervention Skills and Training). In FY 19/20, additional trainings were planned, but were canceled because of the COVID-19 pandemic. In FY 20/21, all trainings were virtual Know the Signs trainings.

Between April 7, 2019 and June 30, 2021, the Clinical Supervisor followed up with next of kin for 30 suicides, including 4 in FY 18/19, 12 in FY 19/20 and 14 in FY 20/21, to offer resources and support. Of these postvention efforts, the Clinical Supervisor was able to connect with 14 contacts

to offer mental health referrals (two in FY 18/19, three in FY 19/20 and six in FY 20/21). In addition, the Clinical Supervisor attended the National LOSS (Local Outreach to Suicide Survivors) Conference in Tulare County in October 2019 to learn more about the LOSS model of postvention services. In FY 20/21, SPP partnered with Friends for Survival to bring a Survivors of Loss group to Nevada County, with a first meeting of the peer support group on July 15, 2021.

Challenges, Solutions, and Upcoming Changes

The two primary challenges were a new staff member in FY 18/19 and adapting to the COVID-19 pandemic at the end of FY 19/20 and throughout FY 20/21.

Training numbers were low in FY 18/19, as the new Coordinator started in February 2019 after nine months where the position was vacant, and the Coordinator had to learn the training modalities prior to offering trainings. In March 2020, the pandemic stay-at-home order began. Since that time, the county has relied exclusively on virtual Know the Signs trainings, since safeTALK and ASIST are in-person only. The program managed to train the largest number of participants during FY 20/21 (393). The virtual offerings may have made the trainings more accessible, and more trainings than usual were offered because they were less time-intensive to organize. Moreover, the Coordinator also saw more requests for trainings than previous years due to additional stressors brought on by the pandemic.

The SPTF has changed significantly since FY 17/18. Attendance has increased with broader representation from across the community. The SPTF launched its strategic planning process at the end of FY 18/19 and the process continued through FY 20/21 because of the pandemic. During the COVID-19 pandemic, the group met virtually.

During FY 19/20 and 20/21, the coordinator had significant responsibilities related to COVID-19, which has taken some time away from suicide prevention activities.

The number of postvention follow-up calls to suicide loss survivors has increased each year, but reliable contact information for next of kin and timely notification remain challenges. SPP staff has met with the Coroner and Vital Records Office over the past year to improve data and notification systems for suicide in the county.

Program Participant Story

Below are some quotes from training evaluation forms on participants' experience in virtual Know the Signs trainings hosted by the county during FY 20/21:

"I was struggling with what to say, or more importantly what not to say. After the training I am confident that I know how to better handle this situation if it comes up."

"This is very applicable to someone in my life. I feel like I have some more tools to provide resources now. Thank you."

"[The coordinator] did a wonderful job presenting and had so much information to share! Definitely very informed about this topic."

"I got feedback from the staff that they really liked your style and approach to sharing this sensitive material. Thanks so much for sharing with us!"

PEI Category: Suicide Prevention

SIERRA COMMUNITY HOUSE
Truckee Tahoe Suicide Prevention Coalition

Program Description

Program Overview
Sierra Community House's (SCH) Tahoe Truckee Suicide Prevention Coalition (TTSPC) formed in 2013 out of concern for the mental health and safety of youth in the community. Since that time, the goal of the TTSPC has grown to provide education, outreach and strategies that will mobilize and support all members of the community, while preventing future suicides. This is a collaborative effort involving a number of community agencies, including the local school district (Tahoe Truckee Unified School District - TTUSD), Tahoe Forest Hospital District (TFHD), Nevada and Placer County Health & Human Services and the Tahoe Truckee Community Foundation (TTCF). This program began receiving Nevada County MHSA funding in FY 19/20.

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

Evaluation Activities and Outcomes

In FY 19/20, the TTSPC served 3,627 individuals via trainings (1,034 individuals) and outreach (2,593 individuals). The program tracked roughly 60 events or activities throughout the year. A breakdown of some of these event types are shown below. TTSPC created a media calendar to target prevention work towards special populations going forward. The focus in April was starting up the social media platforms - Instagram, Facebook, and YouTube, as well as getting TTSPC's website (www.tahoelifeline.org) updated. In May, the team focused on Mental Health Awareness. In June, the focus was on Men's Mental Health, LGBTQ+ populations, and Minority Mental Health to support the social unrest of the Black Lives Matters movement. The program focused media attention & communications on COVID-19 and connectedness, which contribute to the reduction of stigma surrounding mental illness.

April 2020 - June 2020	Events/Activities
Community Outreach Events	14
Education/Training	17
Infrastructure Building	5
Media Outreach/Stigma Busting Work	13

In FY 20/21, the TTSPC served 3,173 individuals via trainings and outreach. The breakdown of some of these event types are shown below. During the fiscal year, challenges continued around working during a pandemic. However, the opportunity to utilize media outlets such as social media and radio spots to work toward reducing mental health stigma and encourage the community to seek help when in need, presented themselves.

July 2020 - June 2021	Events/Activities
Community Outreach Events	23
Education/Training	49
Infrastructure Building	24
Media Outreach/Stigma Busting Work	48

Following virtual Mental Health First Aid (MHFA) trainings, participants were provided a link to complete a training assessment survey. Only 16 people completed surveys in FY 20/21, and feedback showed participants chose “3=Agree” or “4=Strongly Agree” for all survey questions. Some examples of survey questions include, “Course goals and objectives were achieved,” “Course content was practical and easy to understand,” “From the training, I can assist a person who may be dealing with a mental health crisis to seek professional help,” and “From the training, I can reach out to someone who may be dealing with a mental health problem or crisis”.

Challenges, Solutions, and Upcoming Changes

In April 2020 a Suicide Prevention Coordinator (SPC) for Truckee/North Lake Tahoe was hired amidst the COVID-19 pandemic. TTSPC had to get creative to provided suicide prevention education during times of physical distancing. Know the Signs Trainings were offered on Zoom and staff began promoting the community trainings to local residents.

In January 2021, the Suicide Prevention Coordinator left Sierra Community House. In order to refine the search for a new Coordinator, and to continue to work toward the grant objectives, SCH contracted hours with the former SPC during the job posting and interviewing process. On June 1, 2021, a new SPC came on board.

As the Coordinator position was not housed under Sierra Community House in past years, it has been very helpful to have the Suicide Prevention Coalition Steering Committee to help support the Coordinator and their supervisor. The Steering Committee also works as a team to plan the direction of the work, as well as guidance around budgetary spending for outreach and awareness

(speakers, events, media, etc.). Plans are to continue the Mental Health in the Mountains speaker series, as attendance and response were positive for past events, and to continue with Know the Signs and Question, Persuade, Refer (QPR) trainings in the service area.

Program Participant Story

On January 19, 2021, the Tahoe-Truckee Suicide Prevention Coalition hosted an educational session titled “The Basics of Teen Substance Use” as part of the Mental Health in the Mountains speaker series. The free online evening community conversation was intended for parents and caregivers of teens that wanted to learn more about substance use and was interpreted in real-time for Spanish speaking participants. The conversation covered signs of substance use, up to date research on current substance use trends, treatment options, a Question & Answer session, and a Call to Action. Speakers included a parent of a teen who died by overdose, a teen in recovery, a local young adult speaking of substance use trends in the service area, and a presentation from a local Psychiatric-Mental Health Advanced Practice Nurse sharing personal and professional information. Sixty-eight community members attended, and although it was scheduled for 90 minutes, most participants stayed on as the conversation continued for over two hours.

PEI Assigned Funds - CalMHSA

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CalMHSA)
Statewide PEI Project

Program Description

Program Overview

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

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

In FY 19/20, funding to the Statewide PEI Project supported programs such as maintaining and expanding public awareness and education campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to county agencies, schools and community based organizations, providing mental health/stigma reduction trainings to diverse audiences, engaging youth through the Directing Change program, building the capacities of schools to address mental health, stigma reduction and suicide prevention.

Funding also supported the North Valley Suicide Prevention Hotline, a regional call center providing crisis line telephone support for regional callers who have reached out to the National Suicide Prevention Hotline.

In FY 20/21, funding to the Statewide PEI Project supported programs such as beginning the planning and formative research to launch California's next statewide mental health campaign, providing technical assistance and outreach to PEI contributing counties, providing mental health and suicide prevention trainings to diverse audiences and engaging youth through the Directing Change program, and the North Valley Suicide Prevention Hotline.

Target Population

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

Evaluation Activities and Outcomes

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

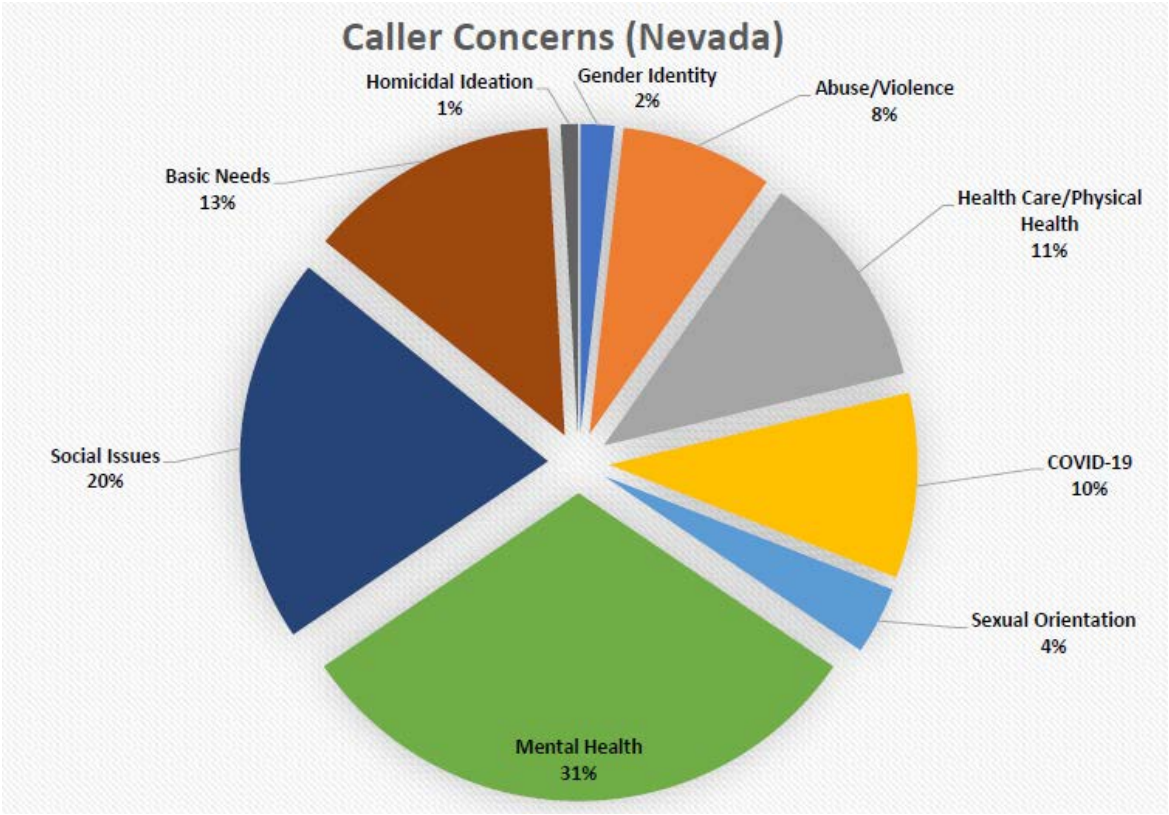
Key statewide achievements of the Statewide PEI Project in FY 18/19 included:

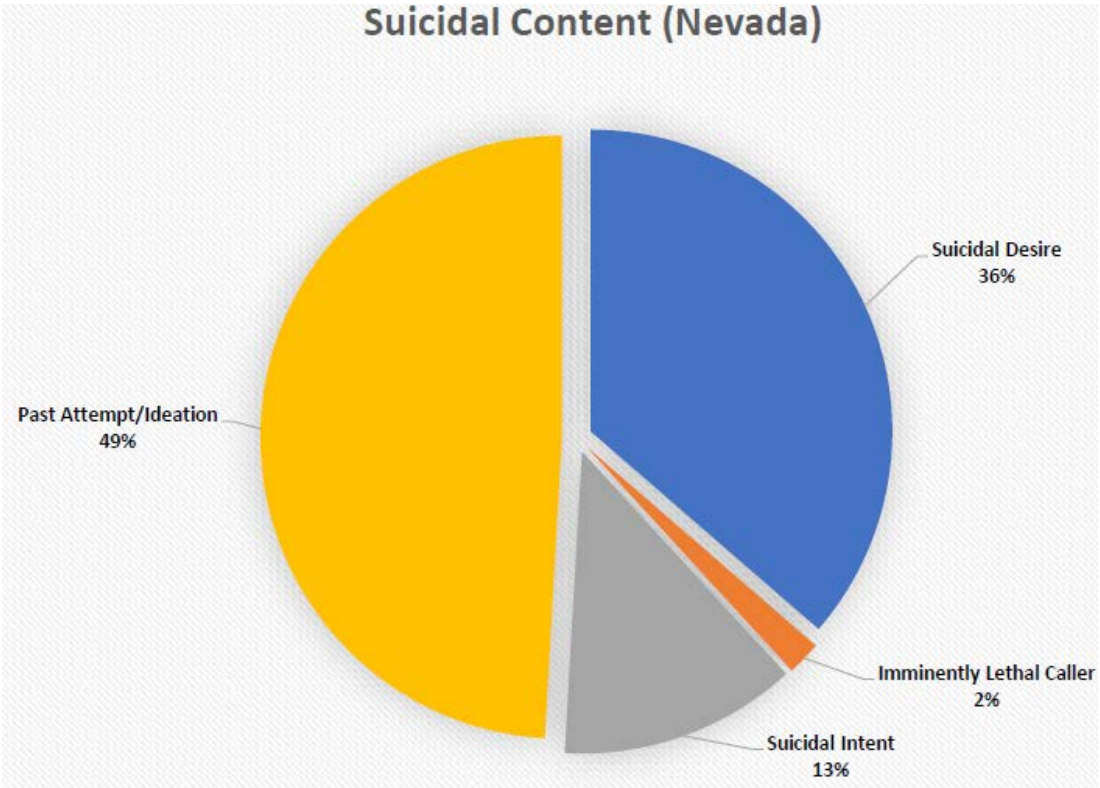
- Over 1 million hardcopy materials were disseminated in counties, schools, and CBOs
- Over $94,000 in mini-grant funds were provided to various agencies to host community outreach events utilizing Each Mind Matters resources and messaging
- The Directing Change Program received over 1,000 videos submissions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

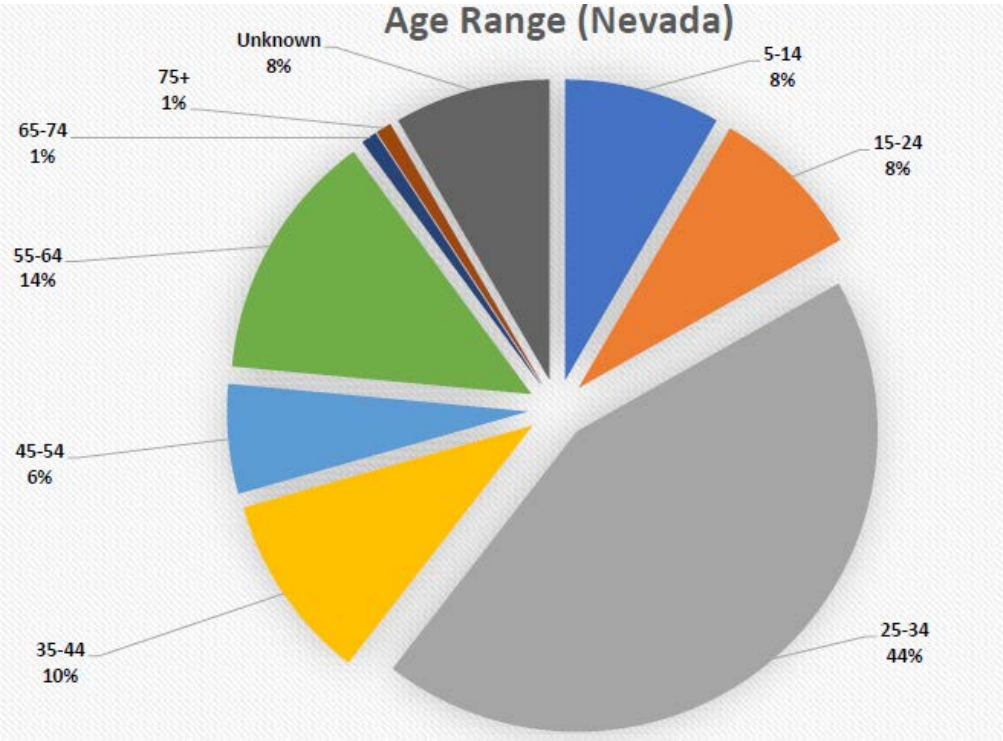
Key statewide achievements of the Statewide PEI Project in FY 19/20 included:

- Over 250,000 Lime Green Ribbons disseminated throughout the state
- Almost 1 million hardcopy materials were disseminated in counties, schools, and CBOs
- Over $80,000 in mini-grant funds were provided to CBOs, NAMI affiliates, Active Minds Chapters and Community Colleges to host community outreach events utilizing Each Mind Matters resources and messaging
- The Directing Change Program received over 1,000 videos submissions from almost 200 schools across California, engaging over 3,400 students
- 5 new Each Mind Matters culturally adapted resources were developed
- 29 news broadcasts, news articles and radio reports discussed programs implemented by the Statewide PEI Project
- Over 500 county agencies, schools, local and statewide organizations across California were touched by programs implemented by the Statewide PEI Project

In FY 19/20, the North Valley Suicide Prevention Hotline addressed 205 crisis calls from Nevada County residents, including 18 moderate or higher lethality calls, 7 active rescue callers, and 1 imminently lethal caller who was deescalated. Active Rescues are initiated to secure the immediate safety of a caller at risk if, in spite of the crisis line counselor's best efforts to engage the at-risk caller's cooperation, they remain unwilling and/or unable to take actions likely to prevent their suicide, or they remain at imminent risk/danger to themselves or others. Of Nevada County callers, 52% identified as male, 40% as female, and 8% were unknown. Most callers were between the ages of 25 and 34 (44%).


Caller Concerns (Nevada)
Homicidal Ideation
1%
Gender Identity
2%
Abuse/Violence
8%
Basic Needs
13%
Health Care/Physical
Health
11%
Social Issues
20%
COVID-19
10%
Sexual Orientation
4%
Mental Health
31%

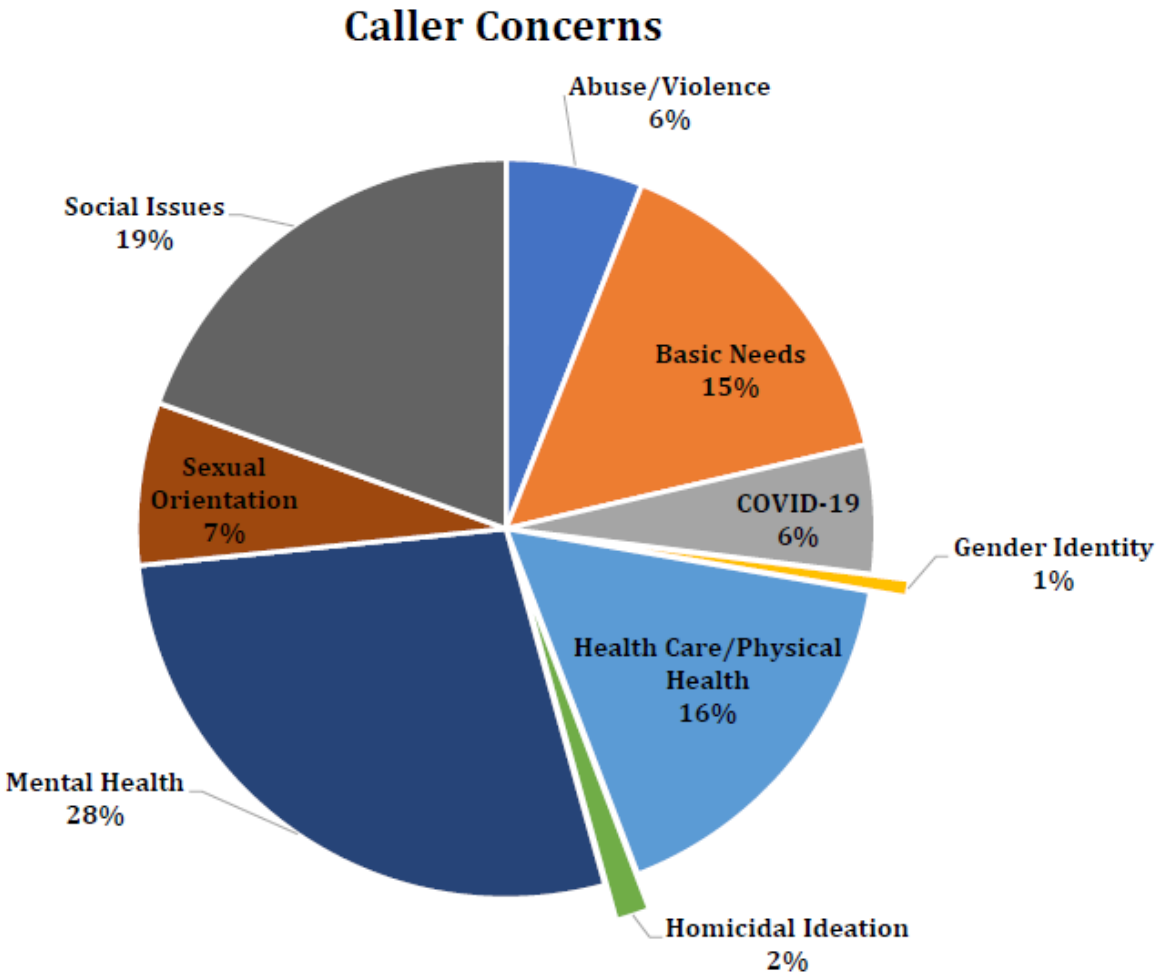

Suicidal Content (Nevada)
Suicidal Desire
36%
Past Attempt/Ideation
49%
Imminently Lethal Caller
2%
Suicidal Intent
13%

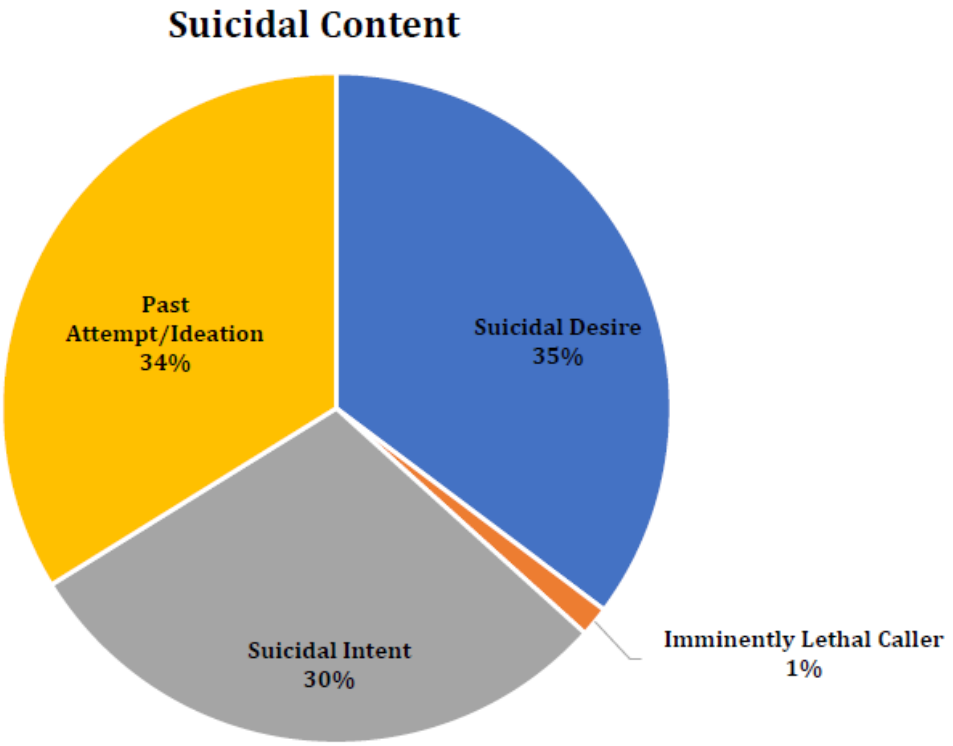


Key statewide achievements of the Statewide PEI Project in FY 20/21 included:

- Selection of Your Social Marketer (YSM) for Training and Technical Assistance Services, through an RFP process.
- Selection of Civilian for social marketing and campaign development, through an RFP process.
- The YSM team conducted regular meetings with PEI contributing counties throughout the year to provide technical assistance and resource navigation.
- The Directing Change Program received 982 videos submissions from 176 schools across California, engaging over 1,800 students.
- 34,154 parents were reached through Directing Change webinars and Facebook Live events.
- More than 13,250 youth, parents, and community members reached through Directing Change awareness activities created by youth and educators through mini grant funding to 31 schools.
- 8 monthly contests through the Directing Change Hope and Justice Category
    - "What This Election Means to Me" (September 2020)
    - "Creative Ways to Measure 6 Feet Social Distancing" (October 2020)
    - "My Reasons for Wearing a Face Mask" (November 2020)
    - "My Beautiful Brain" (January 2021)
    - "The Art of Self Love" (February 2021)
    - "Hope for Change" (March-April 2021)
    - "More Than One" (May 2021)

In FY 20/21, the North Valley Suicide Prevention Hotline addressed 153 crisis calls from Nevada County residents, including 19 moderate or higher lethality calls, and 2 active rescue callers. Active Rescues are initiated to secure the immediate safety of a caller at risk if, in spite of the crisis line counselor's best efforts to engage the at-risk caller's cooperation, they remain unwilling and/or unable to take actions likely to prevent their suicide, or they remain at imminent risk/danger to themselves or others. There were 17 callers requiring follow-ups and 63 total follow-ups placed. Two referrals were made to Nevada County Behavioral Health. Of Nevada County callers, 38% identified as male, 50% as female, 2% declined to state, and 9% were unknown. Most callers were between the ages of 25 and 34 (32%), and most calls came from Grass Valley (67%).




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

Innovation (INN)

Innovation Project Name: Integration of Rural Mental Health Services to Improve Outcomes (Integrated Tahoe/Truckee Program)

SIERRA COMMUNITY HOUSE & VICTOR COMMUNITY SUPPORT SERVICES

Program Description

Program Overview

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

This collaboration was facilitated by the Innovation Personal Services Coordinator (PSC), an individual who was employed half-time by Placer County and half-time by Nevada County for the majority of the project. In 2020 the PSC position was moved from Sierra Mental Wellness Group to Victor Community Support Services for Nevada County and to Uplift Family Services for Placer County. This shift siloed the intention of the position back to each county. In efforts to address these silos, hours of services from the Sierra Community House (SCH) Family Advocate were expanded to provide bilingual, bicultural services to the community. Given that SCH is a regional agency, the Family Advocate is able to serve the community regardless of county residency and is able to provide referrals to the county of residence for additional services as needed.

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

Through one-on-one appointments at Sierra Community House, home visits and outreach through Promotora workshops, the SCH Family Advocate performed the activities under this Innovations project. This work was done with guidance from the bilingual Nevada County Behavioral Health therapist and Victor Community Support Services (Victor), PSC. Activities included outreach to

local Latinx community members, linkage and access to services regardless of which county the community members lived in, one-on-one support, referrals to a bilingual therapist, and attending meetings with Nevada/Placer County and groups facilitated by Promotoras.

Victor served adults who were Medi-Cal eligible and had a mental illness who resided in Eastern Nevada County, including identified Nevada County Behavioral Health beneficiaries and other eastern Nevada County residences with mental health needs. Victor staff provided case management, support, and rehabilitation services. Staff worked collaboratively with other service providers in the area including: The Homeless Outreach Workers and other key staff located within Sierra Community House and Nevada County. Referrals were received from a variety of sources including, community partners, Nevada County Behavioral Health, other county departments, and Tahoe Forest Hospital. Victor clinicians and staff created individualized service goals for each beneficiary in partnership with Nevada County Behavioral Health, and worked to build upon each individual's unique strengths, needs, and existing community supports. Almost all services were delivered within the homes and communities of each individual served regardless of whether they lived in Placer or Nevada County. Services were also expanded to include tele-health service delivery options as a result of COVID-19 safety protocols.

Target Population

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

Evaluation Activities and Outcomes

Over the course of the five year Innovation Project there were multiple changes in staff and staff vacancies. The program was not fully staffed until April 2017. Because of this the data for FY 16/17 and FY 17/18 were combined to be more meaningful in the overall analysis. Program information collected during the reporting period included Demographics, Individual Service Tracking, Referrals, Outreach Activities and Collaboration Surveys.

Family Advocate:

During FY 20/21, 21 individuals received one-on-one support and consultations from Sierra Community House's Family Advocate to get connected with mental health services. The Family Support Advocate delivered a total of 53 hours of individual direct services (an average of 2.5 hours of services to each individual).

Eight of those served received continued case management to stay connected, not only to mental health services but also to housing/utility support. This allowed the individuals to continue to stay in the community during the COVID-19 pandemic and continue to access services from Nevada County and Sierra Community House. The Advocate worked directly through virtual and in-person meetings following COVID-19 guidelines so these community members could receive housing assistance, utility credits, legal support, food and mental health services, information and referrals.

Across the entire Innovation period, the Family Advocate served 60 individuals in the Tahoe/Truckee region.

Family Support Advocate	**16/17-17/18**	**18/19**	**19/20**	**20/21**
Provider	Family Resource Center of Truckee	Family Resource Center of Truckee	Sierra Community House	Sierra Community House
Family Advocate - Number Served	9	14	16	21
Family Advocate - Hours	23	81	41	53
Family Advocate - Avg Hours per Individual	2.5	5.8	2.5	2.5

Personal Services Coordinator:
In FY 20/21, Victor Community Support Services provided 11 adults with mental health services in Truckee. The goals of these services are to improve the quality of life of individuals served by decreasing homelessness, incarceration, and/or hospitalization days; and by increasing connections to community, employment, participation in education, and to mental health, and/or substance use disorder treatment services. None of the 11 beneficiaries experienced homelessness during FY 20/21. In addition, 89% of clients reported living in the same place for the past three months, while all clients reported feeling safe in the place they slept the night before, indicating safety and stability of housing. Three participants reported finding employment while in service, and participants reported feeling more connected to their place of employment on average between Q2 (when the program started) and Q4 (the end of the fiscal year). None of the 11 individuals experienced incarceration or hospitalization during service. Six individuals reported having had routine medical appointments in the past three months, indicating they were making healthy, appropriate self-care decisions.

Over the entire period of the Innovation project, the Personal Services Coordinator served 68 individuals in the Tahoe/Truckee region.

Personal Services Coordinator	**16/17 - 17/18**	**18/19**	**19/20**	**20/21**
Provider	Sierra Mental Wellness Group	Sierra Mental Wellness Group	Sierra Mental Wellness Group	Victor (additional outcomes above)
PSC - Individuals Served (Nevada)	9	15	Vacant	11
PSC - Individuals Served (Placer)	18	15		
Hours of Case Management	219	119		
Avg Hours/ Individual	8.1	4.0		
Outreach Activities/Events	16	33		
Referrals Made	53	32		
Referrals Connected	39	28		

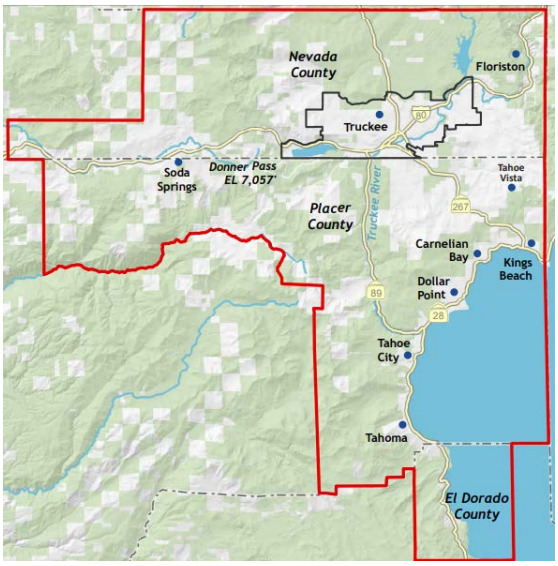
Collaboration Survey:
The survey was conducted twice a year to assess the levels of collaboration between agencies in the Tahoe Truckee area. The highest levels of collaboration were reported with agencies such as Sierra Community House (formally Tahoe SAFE Alliance, North Tahoe Family Resource Center, Family Resource Center of Truckee) and Tahoe Truckee Unified School District. This survey was to be distributed every six months to assess and monitor changes in levels of collaboration across agencies in the Tahoe Truckee area. Improvements in collaboration across all agencies assessed in the Tahoe Truckee region were expected. Unfortunately, due to the reduction in agencies participating in the survey over time, the results were not as meaningful.

The innovation project encouraged and tracked collaboration between agencies. Below is a comparative chart with the number of respondents on the Collaboration Survey per survey period. Placer County's participation in this program ended after FY 18/19 so the Placer agencies were less likely to respond to the Collaboration Survey after that. Due to the small number of agencies participating in the survey in FY 19/20, it was decided that the Collaboration Survey would not be collected for the last year of the program, FY 20/21.

	August 2017	February 2018	August 2018	February 2019	August 2019	May 2020
Number of Respondents	43	35	36	40	25	17

The Innovation Project results will be disseminated to project stakeholders through the Three Year Progress Report submitted to DHCS and MHSOAC as well as posting the report on the Nevada County website.

Project Sustainability and Summary of Learnings



One of the key challenges this project aimed to address is the complicated geography of the Tahoe/Truckee region. As illustrated in this map of the region, county lines cut through the region and can provide significant challenges to accessing services based on county of residence. The goal of this project was to remove the geographical barriers to care and serve individuals with one central provider regardless of county of residence.

This pilot project had wide reaching impacts to the behavioral health service delivery model in the Tahoe/Truckee region in both Nevada and Placer counties. Building off the success of this pilot,

Nevada and Placer Counties launched an innovative joint Request for Proposal in 2019 to identify a contractor to provide specialty mental health services in the region, including the case management function that was initiated through this Innovation project. Unfortunately, both counties were not able to partner with the same organization for a variety of administrative and fiscal reasons. Placer County partnered with Uplift Services for specialty mental health services and Nevada County is providing those services through a combination of the Behavioral Health department and contracts with Victor Community Support Services.

While Nevada and Placer Counties were not able to apply the project model to long-term specialty mental health services, this project inspired several other significant areas of collaboration. In late 2019, Nevada and Placer Counties released a joint Request for Proposal for all MHSA Prevention and Early Intervention (PEI) programming in the region. Previously, both counties had independent processes, at times funding the same providers but without coordination. By joining processes, the counties were able to maximize funding available to regional providers who serve residents of both counties, as well as create efficiencies around contract development and performance measures.

Additionally, Nevada and Placer Counties have expanded their joint partnership around crisis services in the region, including recently jointly expanding funding to the contracted crisis provider, Sierra Mental Wellness Group to launch a mobile crisis pilot in the region.

Both the Personal Services Coordinator position and the Family Advocate position funded by this Innovation project will be sustained and continued through Nevada County Community Services and Supports (CSS) funding. Nevada County and its contracted providers remain committed to increasing connectedness for beneficiaries and families served by continuing to add more group-based services, community-building activities and events, and further integrating teaming into their process in both virtual and in-person settings. Victor plans to emphasize the inclusion of beneficiary voice and choice as a primary principle of services during the next fiscal year. Victor continues to serve all individuals referred to their program via sound practices according to individualized needs, strengths, and treatment plan goals. Length and intensity of services will be determined by assessment and current need.

Program Participant Story

Family Advocate:
John* and his family were referred to SCH and began receiving one on one support with the SCH Family Support Advocate through home visits. The Advocate started working closely with the behavioral health therapist and then with the Victor Clinician to better support and assist the family. The family had many issues ranging from health to housing. The Advocate supported them with housing assistance, utility assistance, and connected them with Tahoe Forest Hospital for treatment of additional health issues. The Advocate was able to meet with the family weekly, in collaboration with the Victor Clinician, to provide support with the language barrier. The Advocate also referred John to the Peer Support Program, where he continues to receive one-on-one support from a Trained Peer Supporter. Although COVID-19 interrupted home visiting during parts of 2021 the family's goals to become more social and continue accessing services were achieved

through a cautious return to meetings in person. The Family Advocate continues to support John with check-ins over the phone, or in person, when needed, to support with the language barrier. **Not real name*

Personal Services Coordinator:
In FY 20/21 Victor served an adult with both case management and rehabilitation services. This individual was identified by Nevada County Behavioral Health as requiring intensive support in order to access effective mental health care. This person experienced significant delusions as well as impaired social functioning. He has been in and out of treatment for his entire adult life and has historically been a heavy drug user of multiple substances.

This individual readily agreed to participate in services and engaged well. After months of receiving case management and rehabilitation services from Victor, this person has reduced his drug use to infrequent use of marijuana at this time. He is using his own agency to schedule appointments and is remaining compliant with his medications. With the support of Victor's team, he recently moved out of his family home and is living independently for the first time. He remains open to services and will continue to work with staff on increasing activities of daily living and coping skills to manage his mental health symptoms. He hopes to find and maintain employment in the near future. This would not have felt like an option to him just a short time ago.

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

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

Program Description

Program Overview

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

- Providing physical health care services first, which is a less stigmatized form of care than substance use or mental health services.
- Embedding a Peer with lived experience in the team who is able to address issues of mistrust in this population.
- Offering low-barrier, housing-first options that do not require sobriety or service engagement for entrance.

- Creating a close connection with the County jail and law enforcement staff so that people who are arrested or incarcerated are quickly offered services and housing.

Target Population

Chronically Homeless residents of Nevada County.

Evaluation Activities and Outcomes

Demographics were collected for 240 individuals served by this program in FY 20/21.

HOME Team Client Engagement:

- 252 unduplicated individuals were engaged by the HOME Team. Engagement includes linkages and service connections and limited case management. This exceeds the target goal of 150 individuals engaged per year.
- 62 SPARS Intakes Completed. This refers to individuals who have completed an intake through the Substance Abuse and Mental Health Services Administration's Performance Accountability and Reporting System (SPARS).
- 141 unduplicated individuals received Intensive Case Management (ICM) services. This is the cumulative number of individuals who have completed a SPARS intake and are considered "intensively case managed" by the HOME Team during the fiscal year.
- 47 individuals received Intensive Medical Case Management services from the Team Nurse.
- 28 unduplicated individuals completed assessments for Substance Use Disorders (SUD) with the goal of placement in appropriate SUD services.
- 33 unduplicated individuals were placed in inpatient and/or outpatient SUD treatment programs. This number exceeds the number assessed for SUD during the reporting period due to wait times for services between assessment and placement in the early part of the fiscal year.
- 21 Mental Health Assessments were completed through Nevada County Behavioral Health (NCBH).
- 11 connected to Behavioral Health Services. Of the 21 individuals assessed through NCBH, 11 connected to services through Nevada County Behavioral Health. The number placed in Behavioral Health treatment refers to all people on the HOME Team list that are connected to mental health services through NCBH, including Turning Point.

Housing Data:

53 individuals obtained housing during the reporting period. Of those 53 individuals, 40 obtained permanent housing and 13 were placed in transitional housing. Of the 40 individuals who obtained permanent housing, 34 retained their housing through the end of the reporting period. Of the 13 individuals placed in transitional housing, nine retained their placement through the end of the reporting period.

HOME Team Services: A total of 5,374 services were provided to 252 unduplicated individuals in FY 20/21. A breakdown of the services provided is listed below:

Service Provided	Count

Case/Care Management	3122
Local Automobile Transportation	1290
Food Banks/Food Distribution Warehouses	195
Meals	183
Local Bus Fare	177
Gas Money	74
Clothing	56
Homeless Motel Vouchers	55
Housing Counseling	47
Housing Search Assistance	30
Automotive Repair and Maintenance	14
Personal/Grooming Supplies	14
Landlord/Tenant Dispute Resolution	10
Outreach Programs	8
Crisis Intervention	7
Pet Food	7
Street Outreach Programs	6
Drinking Water Donation Programs	5
Benefits Assistance	5
Homeless Transportation Programs	4
At Risk/Homeless Housing Related Assistance Programs	4
Other Services	61
Grand Total	**5374**

Referrals: The HOME Team program made 748 referrals to 163 unduplicated individuals. Of those referrals 607 (81%) were accepted. The number of referrals excludes referrals made by the HOME Team Nurse. Nursing referrals are denoted under the "HOME Team Medical Engagement" section of the report. See referral breakdown by provider/agency name and need type below:

The top needs/reasons for referrals are listed below:

Need Type of Referral	**Count**
Substance Use Disorder Services	81
Emergency Shelter	80
Food Banks/Food Distribution Warehouses	66
Housing Counseling	61
Assessment for Substance Use Disorders	51
Housing Search Assistance	44
Crisis Intervention	28
Case/Care Management	28
Benefits Assistance	24
Mental Health Evaluation	23
Mental Health and Substance Use Disorder Services	21

Medical Information Services	20
Meals	20
Employment Preparation	16
Clothing	15
Supportive Housing Placement/Referral	14
Emergency Medical Care	14
General Medical Care	12
Personal Enrichment	11
Street Outreach Programs	10
Health Care Referrals	9

The list of agencies individuals were referred to is below:

Referred To- Provider Name	**Count**
Nevada County Behavioral Health	92
Interfaith Food	69
Granite Wellness (Formerly CoRR)	64
Utah's Place (FHH)	64
AMI Housing, Inc.	45
Referral Provider	45
Foothill House of Hospitality	39
Crisis Stabilization Unit	33
Common Goals, Inc.	24
Freed	24
ARGP (FHH)	24
HOME(ICM)	22
Chapa De	18
Sierra Nevada Memorial Hospital	18
Stability Project (SPIRIT)	18
Sierra Roots	16
Western Sierra Medical Clinic	14
CalWorks - Employment Services NevCo	12
Nevada County Dept. of Social Services	10
Veteran Services Referral	10
Rapid Rehousing/Post Housing(FHH)	9
Adult Protective Services Nevada County (NC DSS)	8
Food Bank Referral	8
Business & Career Network (formerly One Stop)	6
Regional Housing Authority of Sutter and Nevada Counties	6
Pets of the Homeless Nevada County	4
Emergency Shelter (CBV)	4
Insight Respite	4
Law Enforcement	4

Community Beyond Violence	4
Other Agencies	30
Grand Total	**748**

Exit Data:
A total of 78 individuals were exited from the HOME Team Intensive Case Management program in the Homeless Management Information System (HMIS) during the reporting period. Of those exited:

- 31 exited to permanent housing destinations
- 32 exited to temporary housing destinations
- Eight exited to institutional settings (six to SUD/Detox centers, four to jail or detention facility)
- Seven exited to "other" destinations

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

- 47 unduplicated individuals received Intensive Medical Engagement from the HOME Team Nurse. For those receiving Intensive Medical Engagement services:
    - 413 individual face-to-face contacts were made.
    - Each participant contact was an average of 70 minutes.
    - Total of 484 hours spent performing direct face-to-face medical services to individuals.
    - 66 referrals for services were made and provided warm hand off by the HOME Nurse.
- Nine women began receiving services from the Nurse in their second trimester of pregnancy, none of whom had received pre-natal care prior to engagement with the HOME Nurse.
    - All nine of these women were experiencing homelessness prior to referral and all were able to be housed.
    - Seven of the nine had delivered healthy babies by the end of the reporting period. The other two are due to deliver in the upcoming months.
- 160+ COVID test were administered.
- 53 COVID vaccines were administered to HOME Team clientele.

The Primary Medical needs of the 47 intensively case managed individuals were tracked and reported. Up to two primary medical needs were reported per contact. See chart below.

Medical Need	**# of Contacts**
Medication Outreach	286
Wound Care	113
Pregnancy	49

SUD Assessment	47
Chronic Pain	40
Diabetes	15
Cancer	12

Referrals made by the HOME Team Nurse: 66 Referrals

Referral Type	# of Referrals
Primary Medical Care	15
SUD services	10
MAT- SUD Program	8
NCBH MH Assessment	6
NCBH SUD Assessment	6
Social Services	4
Hospitality House	4
Housing	4
Emergency Department	2
Mental Health Support Services	2
HOME Team	1
CBV	1
Freed	1
CSU	1
Odyssey House	1
Sierra Roots	1
Grand Total	**66**

Emergency Room Recidivism Data:

Of the 47 individuals who received ongoing intensive services from the HOME Team Nurse, Emergency Room (ER) recidivism data was collected on 16 individuals. These individuals had participated in services with the HOME Team Nurse for long enough of a duration to analyze data collected for six months prior to working with the HOME Team Nurse and six months following working with the Nurse. These 16 individuals demonstrated a 78% reduction in ER visits following working with the HOME Team Nurse, from a cumulative count of 54 days before HOME Team engagement to a cumulative count of 12 days after engagement. Eleven of the 16 individuals had an overall reduction in ER visits, four individuals showed no change, and only one individual had an increase of ER visits by one day. The average number of contacts with each of these 16 individuals was 27 contacts and they worked with the Nurse for an average duration of 175 days from intake to discharge.

Emergency Room Recidivism Data					
# of Clients	Average # of Contacts	Average Duration of Services	# of ER Visits Pre-Intervention	# of ER Visits Post Intervention	% Reduction
16	27 days	175 days	54	12	78%

Challenges, Solutions, and Upcoming Changes

- **Staffing**- The HOME Team saw an influx of staffing through the fiscal year. Having vacant positions and the need to onboard new staff impacted direct services. Additionally, due to shifting needs during COVID-19, staff dedicated more time to COVID screening and response. The HOME Nurse took on the additional duties of COVID Testing and Vaccination for the target population, as well as for the staff of community partners servicing individuals within the community who are experiencing homelessness.

- **COVID-19 and State Stay and Home Orders** continuing throughout the fiscal year: The COVID-19 global pandemic impacted institutions and individuals across the globe in 2020 and 2021. Below are a few specific examples of COVID-19 impacts on the HOME Team's consumer population and services.
    - Stay at home orders called for an increase in online based services, further limiting access to services for the target population as many individuals are lacking in access to technology and live in remote areas without cell phone reception or internet services.
    - Shelter in place orders limited residential program movement and shelter capacity, impacting access to services.
    - SUD program assessments and intakes were put on hold and slowed due to social distancing and program quarantines, creating backlogs of clients waiting for assessment and placement.
    - Advocates for Mentally Ill (AMI) Housing program intakes were delayed and limited due to program quarantines.
    - Private landlords were hesitant to rent and there was limited movement in the housing market, further limiting an already limited housing market.

- **Housing:** A key challenge in successfully housing program participants has been low housing inventory within the county. The County, the local Continuum of Care organization, and cities in Nevada County are actively working to address the affordable housing crisis that is facing, not just Nevada County, but the entire state of California. Despite these barriers, the HOME Team was able to house 50 individuals during the fiscal year, 40 of whom were housed in permanent housing situations.

  Nevada County was awarded Project HomeKey Funding and purchased a local hotel for renovation to provide an additional 22 units of permanent housing for the county's homeless population. During renovations, nine of the building's 18 units are being utilized for emergency housing.

  In addition to Project HomeKey, Nevada County has four new affordable housing projects moving forward:
    1. The Brunswick Commons project in Grass Valley will provide 28-units of low-income housing (rent set at 30% of Nevada County's average median income) and 12-units of Permanent Supportive Housing (PSH) for chronically homeless individuals with severe

mental illness who are receiving supportive services from the County's Department of Behavioral Health.

2. The Cashin's Field project in Nevada City aims to create a community setting by providing the local workforce with 56 affordable long-term apartments.
3. With No Place Like Home funding, Nevada County is working to remodel an existing county facility to double the units count at that facility from three to six units. These units will continue to serve as housing for Permanent Supportive Housing (PSH) for chronically homeless individuals with severe mental illness who are receiving supportive services from the County's Department of Behavioral Health.
4. The Lone Oak Senior Apartments in Penn Valley are underway to bring 31 new units of affordable senior housing, including 24 one-bedroom, and seven two-bedroom units. The project will house low-income seniors earning between 30-60% of the median income for Nevada County.

Program Participant Story

During the fiscal year, nine women were referred to the Home Team Nurse through the HOME Team Street Outreach Program, Law enforcement, and the Emergency Department. Each of these women were in their second or third trimesters of pregnancy and had not received any previous prenatal care. They were each experiencing homelessness and living in their vehicles or within one of the local homeless camps. Most of these mothers were also suffering from ongoing addiction.

All of these women received intensive medical case management services from the HOME Team Nurse. Throughout the year, the nurse invested over 160 hours of direct face-to-face time providing direct medical services and support, as well as countless more hours advocating on their behalf to connect to other needed support services.

Through the dedication and hard work of the HOME Nurse and support service staff, each of these women were connected to prenatal care, social service support, and housing. With these connected supports and the perseverance of these strong women, seven of the nine women delivered healthy and substance free babies during the fiscal year. The other two women continued with their programs and pregnancies and are due in the upcoming months. All of the mothers have been placed in stable housing situations where they are able to care for themselves and their babies and thrive together.

Workforce Education and Training (WET)

NEVADA COUNTY BEHAVIORAL HEALTH
Intern Supervision

Program Description

Program Overview

In FY 20/21 WET resources added service capacity in Nevada County by funding clinical supervision of behavioral health interns. In FY 20/21, 1,821.5 hours of intern supervision were funded by this source, including 1,254 hours to Children's Behavioral Intern Supervision and 567.5 hours to Adult Behavioral Health Intern Supervision.