Nevada County Mental Health Services Act (MHSA)
Annual Progress Report for Fiscal Year 2017/2018

Overall Implementation Progress Report on Fiscal Year (FY) 2017/2018 Activities

General Nevada County Information:

Nevada County is a small, rural, mountain community, home to an estimated 99,814 (2017 US Census Bureau estimate https://www.census.gov/quickfacts/) individuals. According to the 2017 US Census estimate over 93% of the Nevada County residents identified their race as White, while over 3% of residents combined identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander. Additionally, 3% identified themselves by two or more races. In regards to ethnicity, an estimated 85.2% of the population identified as Non-Hispanic or Latino and 9.5% of the population of Nevada County identified themselves as Hispanic or Latino. Therefore, Nevada County's one threshold language is Spanish.

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

Notes:

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

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

MHSA Program Updates:

Community Services and Supports (CSS)

Full Service Partners:

VICTOR COMMUNITY SUPPORT SERVICES (VCSS)

Program Description

Program Overview

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

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 MHSA Team, Child Protective Services, Probation, or school districts, including youth qualifying for Medi-Cal, Educationally Related Mental Health Services, and/or Katie A services.

Evaluation Activities and Outcomes

- In FY 17/18, VCSS Grass Valley provided 125 youth with mental health and/or Wraparound services. There was outreach to an additional 16 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 fiscal year 17/18, 93% of the 125 individuals served remained in a community living situation and avoided a higher level of residential care. There were five incidents of temporary homelessness.
- **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 84% 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," 85% of youth served were maintaining at least a C average and were not failing any classes at discharge.

  VCSS achieved its contractual goal of ensuring at least 75% of youth maintain regular school attendance or improve their school attendance, as 85% 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; 90% of youth did not experience a suspension or expulsion in this fiscal year.
- **Criminal Justice involvement:** VCSS achieved its contractual goal that at least 70% of youth have no new legal involvement (arrests/violations of probation/citations) between admission and discharge. In FY 17/18, 94% of individuals had no new legal involvement while receiving services.
- **Acute Care Use**: Ninety-five percent (95%) of youth served did not experience a psychiatric hospitalization during the fiscal year.
- **Emotional and Physical Well Being**: VCSS Grass Valley successfully supported the strengthening and development of youth, caregivers, and family members' emotional and physical well-being throughout the fiscal year. A new line of less-intensive support was established to further assist individuals as they transition out of the Wraparound program.

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

  VCSS achieved its contractual goal of at least 80% of parents/caregivers reporting that there was an increase in their parenting skills. In FY 17/18, 83% of surveyed caregivers reported they learned additional strategies to address behaviors at home.

  VCSS achieved its contractual goal of ensuring that at least 75% of caregivers report maintaining or increasing connections to natural supports, with 90% of surveyed caregivers reporting maintaining natural supports and 83% reporting increased connections in the community.

Victor achieved its contractual goal of ensuring that at least 80% of individuals improved their scores on the Comprehensive Child and Adolescent Needs and Strengths (CANS) instrument between intake and discharge. During FY 17/18, 82% of individuals with a planned discharge improved in at least one of the following CANS domains: Life Functioning, Mental Health/Behavioral/Emotional Needs, Risk Behaviors, and/or Educational Needs.

- **Stigma and Discrimination:** Victor provided Mental Health First Aid trainings to law enforcement and other community members to increase awareness and decrease stigma related to mental illness.
- **Service Access and Timeliness**: Excluding transfers between reporting units, there were 57 discharges this year. For the 2017/2018 fiscal year, the average length of service (ALOS) for the discharged population was 9.9 months, 25% shorter than the ALOS of the previous fiscal year.

  VCSS has a contractual goal of attempting initial contact with referrals within three (3) business days of receipt of referral. While initial contact was attempted for all individuals within three days, initial contact was successfully made with 89% of referrals in this period.

  VCSS achieved its contractual goal of offering an appointment for face-to-face contact with 80% of children and families within 10 business days of receiving the referral, as 81% of referrals were offered an appointment date in this time frame. Additionally, 73% of referrals received a face-to-face contact within 10 business days of referral.

Challenges, Solutions, and Upcoming Changes

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

Victor also implemented the Child and Adolescent Level of Care Utilization System (CALOCUS) in January. The CALOCUS, in addition to the CANS assessment already in place, along with the existing intake/assessment process, improved staff's ability to identify necessary services and appropriate level of interventions for incoming participants. In the upcoming year, Victor will further refine this model, adding more groups and community building activities and events, and identifying clear criteria for both Wraparound and Less Intensive Treatment services.

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

Program Participant Story

Victor began Wraparound services with a young child, and subsequently expanded services to a younger sibling a few months later. Child Protective Services (CPS) referred the children to Victor as their parent was in treatment. Both children presented with externalized behaviors (physical aggression, tantrums, eloping, and general defiance towards authority) that endangered their parent's treatment and the elder child's school placement. The family was provided with a Wraparound facilitator, individual therapists for the children, and a Family Parent Partner for the parent. The team actively engaged to provide behavioral stabilization, to assist the parent in organizing/prioritizing needs related to the family's multiple service providers, and to help the parent meet the family's basic needs.

Shortly after beginning services with Victor, the family lost their housing and entered a prolonged period of homeless. The Victor team was active in maintaining shelter for the family while searching for long-term options. The family successfully transitioned to a shelter. Victor's team collaborated with CPS to help the family stay together. The parent has been forthcoming about instances of relapse during recovery and Victor has helped link the parent to mental health and substance use services. The parent receives almost daily parenting/collateral support and the family reports being more stabilized, which is having a positive impact on the children's mental health. Additionally, the wrap team is actively supporting the children in re-engaging supervised visits with their non-primary parent, and is supporting the primary parent in accessing a natural support network of family members. The family has stayed together during some difficult months, and has now expanded their natural support network, stabilized overall, and made significant progress in terms of housing, recovery, and mental health.

Full Service Partners:

TURNING POINT COMMUNITY PROGRAMS
Providence Center

Program Description

Program Overview

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

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

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

Target Population

The AACT target population consists of individuals 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 17/18, 105 unduplicated individuals were served by TPCP.

- **Housing:** A total of 748 (63.6%) homeless days out of the 1,176 homeless days accrued within the 17/18 fiscal year reporting period were accrued by 13 individuals who were either new to the program (23.1%, n=3) or had not accrued any days in the prior year (76.9%, n=10).

  Although there was an increase in the total number of homeless days from one fiscal year to the next, it is important to note the following. Of the 17 individuals who accrued homeless days in the 16/17 fiscal year, four (23.5%) continued to receive services through the Providence Center in the 17/18 fiscal year. Of those four, two (50%) had a decrease in days accrued, and two (50%) had an increase in days accrued when compared to the 16/17 fiscal year. Of the 17 individuals who accrued homeless days in the previous fiscal year, seven individuals (41.2%) no longer accrued days in the 17/18 fiscal year.

  A positive outcome is that the majority of individuals served in the 17/18 fiscal year did not accrue any homeless days (n=88, 83.8%).

Homeless Days	FY 16/17	FY 17/18
# of Homeless Days Accrued	**855**	**1,176**
# of Individuals who Accrued Homeless Days	17	17
# of Individuals who Accrued 0 Homeless Days	102	88

FY 17/18 Homeless Outcomes	#
# of Individuals who Continue to Receive Services from FY 16/17 into FY 17/18:	**95**
# of Individuals who Continued to Accrue Homeless Days in both Fiscal Years	4
# of Individuals who Decreased Homeless Days Accrued from FY 16/17 to FY 17/18	15
# of Individuals who No Longer Accrued Homeless Days in FY 17/18	7

- **Employment and Education:** Out of 105 individuals, the majority remained unemployed; however, 19 (18%) individuals had some form of employment at the end of the 17/18 fiscal year, and one engaged in volunteer work. The 16/17 fiscal year does not represent all of the clients served.

Employment Type	FY 16/17 End-of-Period	FY 17/18 End-of-Period
Competitive Employment	2	10
Supported Employment	3	1
Paid In-House Work (Sheltered Workshop/Work Experience/ Agency-Owned Business)	2	8
Non-paid (Volunteer) Work Experience	3	1
Unemployed	51	85
Total	61	105

- **Criminal Justice Involvement:** A total of 284 (79.1%) out of the 359 jail days accrued within the FY 17/18 reporting period were accrued by five individuals who had not accrued any jail days in the prior year

Jail Days	FY 16/17	FY 17/18
# of Jail Days Accrued	**467**	**359**
# of Individuals who Accrued Jail Days	13	6
# of Individuals who Accrued 0 Jail Days	106	99

FY 17/18 Jail Outcomes	#
# of Individuals who Continued to Receive Services from FY 16/17 into FY 17/18	**95**
# of Individuals who Continued to Accrue Jail Days in both Fiscal Years	1
# of Individuals who Decreased Jail Days from FY 16/17 to FY 17/18	13
# of Individuals who No Longer Accrued Any Jail Days in FY 17/18	9

- **Acute Care Use:** A total of 252 (49.2%) psychiatric hospital days out of the 512 hospital days accrued in the FY 17/18 reporting period were accrued by 15 individuals who were either new

to the program (13.3%, n=2) or had not accrued any hospital days in the prior year (86.7%, n=13).

FY 17/18 Hospitalization Outcomes	#
# of Individuals who Continued to Receive Services from FY 16/17 to FY 17/18	**95**
# of Individuals who Continued to Accrue Hospital Days both Fiscal Years	5
# of Individuals who Decreased Hospital Days from FY 16/17 to FY 17/18	19
# of Individuals who No Longer Accrued Any Hospital Days in FY 17/18	14

Psychiatric Hospital Days	FY 16/17	FY 17/18
# of Hospital Days Accrued	**639**	**512**
# of Individuals who Accrued Hospital Days	21	20
# of Individuals who Accrued 0 Hospital Days	98	85

- **Emotional and Physical Well Being**: The consumer satisfaction survey for the past fiscal year indicated an 85.4% satisfaction rate overall with services provided by Providence Center. Consumers also indicated an 82% satisfaction rate with their personal outcome as a result of services.

  Turning Point's intensive case management services include connecting individuals to primary care physicians as well as specialty doctors for their medical care. Service coordinators also participate in many physical activities with program participants such as walking, hiking, playing basketball and other recreational activities.
- **Stigma and Discrimination:** Turning Point's continual collaboration with community partners in Nevada County supports the reduction in stigma of mental illness within the community. The Providence Center's welcoming environment and respectful approach to working with individuals supports the reduction in participants' stigma of mental illness. Another support in the reduction of stigma is the continued practice of hiring people with lived mental health experience to work at Providence Center and other Turning Point programs.
- **Service Access and Timeliness:**
  - One hundred percent of non-urgent mental health service appointments were offered within 10-15 business days of initial request.
  - Only two people released from acute psychiatric hospitals were readmitted within 30 days. This was 8% of all people who were admitted to acute psychiatric hospitals during the fiscal year.
  - Of all the acute discharges, 70% received a follow up appointment within seven days of discharge. Of the remaining 30% who were not seen timely, 20% were No Shows.
- Outreach and Engagement was provided to 35 potential partners throughout FY 17/18.

AOT:

- DOMAIN OUTCOMES
  Psychiatric Hospital Days
  Between May 2017 and April 2018, a total of 169 psychiatric hospital days were accrued by four individuals or 36% of the total 11 individuals observed. This was an increase of 104 days over the pre-referral hospital days accrued by all 11 individuals. This increase was mostly due to one outlier who accrued 114 hospital day in the current Fiscal Year. Three of the 11

individuals reduced their hospital days from a combined total of 65 days pre-referral to seven days in the current Fiscal Year.

# of Days Accrued by Those Who Volunteered to Receive Services	0 (0%)
# of Days Accrued by Those Who Were Court Ordered	169 (100%)

Jail Days

Between May 2017 and April 2018, a total of 42 jail days were accrued by one individual or 9% of the 11 individuals observed. The remaining ten individuals did not accrue any jail days in the reporting period. This was a decrease of 187 jail days from the pre-referral total of 229 days.

# of Days Accrued by Those Who Volunteered to Receive Services	0 (0%)
# of Days Accrued by Those Who Were Court Ordered	42 (100%)

Homeless Days

Between May, 2017 and April, 2018, a total of 195 homeless days were accrued by five individuals or 45% of the total 11 individuals observed. The rest of the individuals (55%) did not accrue any homeless days in the reporting period. This was a decrease of 652 homeless days from the pre-referral total of 847 days.

# of Days Accrued by Those Who Volunteered to Receive Services	66 (34%)
# of Days Accrued by Those Who Were Court Ordered	129 (66%)

Emergency Interventions

Between May, 2017 and April, 2018, a total of 30 emergency interventions (EIs) were accrued by six individuals or 55% of the total 11 individuals observed. This was a decrease of four EIs from the pre-referral total of 34.

# of Days Accrued by Those Who Volunteered to Receive Services	17 (57%)
# of Days Accrued by Those Who Were Court Ordered	13 (43%)

- MILESTONE OF RECOVERY SCALE (MORS)

  Out of 11 individuals served between May 1, 2017 and April 30, 2018, four were included in the following analysis (seven participants were excluded due to insufficient data). Individuals' first MORS score following their referral date was compared to their most recent MORS score. Some participants were discharged within the period; however, the majority had their most recent test given within the month of March 2018 (April scores were not entered until mid-May).

  On average, at the time the first MORS score was assigned, the majority of clients were at Poorly Coping/Engaged (a score of five) (75.0%, n=3). At the time of their most current MORS score assignment the Poorly Coping/Engaged with staff (a score of five) dropped to 50.0%, n=2. Overall, one (54.5%) of the 11 individuals included in the analysis had an increase between their initial and their most current MORS score. This is a very positive outcome showing that progress was made towards recovery once the Providence Center began providing services.

- CONSUMER SATISFACTION SURVEY

Between May 1, 2017 and April 30, 2018, of the 11 individuals served, eight surveys were administered. Of those administered, one (12.5%) survey was completed. The remaining seven (87.5%) individuals declined to participate. Due to the low response rate, the outcomes of the survey cannot be generalized to the entire population. As such, the outcomes of the consumer satisfaction surveys within the reporting period have been excluded from this report.

Challenges, Solutions, and Upcoming Changes

In FY 17/18 Turning Point was challenged with a large staff turnover. Throughout the year Turning Point became creative with hiring Career Exploration Staff (program participants hired to work for the agency) and focusing on building them up to improve their work skills and to become part-time or full-time employees. This was cost effective and supported many participants in their recovery. Several new staff were also hired to replace outgoing staff. Some new staff were previously interns at Turning Point, which decreased the amount of training time necessary. Insight Respite staff began cross training with Catherine Lane House staff so more people will be available to fill shifts in both programs and reduce the need to overwork the Personal Service Coordinators, thus decreasing burnout.

A new contract in FY 17/18 allowed Turning Point to hire two additional Service Coordinators for the homeless shelter program, Hospitality House. They are being trained to enter services into the Electronic Health Record so their time can be billed to Medi-Cal and reimbursed. There continue to be more funding opportunities for services that support work with homeless individuals and Turning Point hopes to be available for more contracting opportunities.

Program Participant Story

Mr. X came to Turning Point at the end of 2016 after being incarcerated. He stayed in transitional housing until he was ready to move into his own apartment in 2017. Mr. X had a bad reputation with county officials due to some threats he had made. He remained on formal probation and participated in our Assertive Community Treatment services at Turning Point, including attending group and individual therapy. Midway through 2017, Mr. X was approved for Social Security Disability Income with the support of his Personal Service Coordinator. He continued to remain drug and alcohol free and to stay out of jail. Mr. X was originally from another state where he has children that he has not seen in years. His goal was to be able to return to that state and reestablish his relationship with his children and family. Mr. X has now completed his formal probation and is completely set up to return to his home state. All of his children are scheduled to visit with him as soon as he arrives.

Full Service Partners:

NEW DIRECTIONS

Program Description

Program Overview

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

Target population

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

Service Intensity

During the FY 17/18 service intensity varied by individual for the 18 participants served. The focus of increased services across all age categories is to decrease hospitalization by utilizing intense case management, temporary placement at Odyssey House transitional home, medication caddy services, and nightly calls to the most high-risk consumers.

Program Options

Housing:

- *Self-Sufficient Support (S^3)* - Residents who are successfully capable of living independently with minimal support are classified as "self-sufficient." These participants receive support on an "as needed" basis from Personal Service Coordinators (PSC). The residents are able to handle and problem solve most basic daily situations of independent living. Three Full Service Partners were supported in this program in FY 17/18.
- *Supported Independent Living (SIL)* - Residents need regularly scheduled support to remain successful in independent living. Identified shared houses are supported by Nevada County Behavioral Health in the following manner:
    - Deposits are paid by MHSA flex funds.
    - If a room is vacant, MHSA funds are used to pay the monthly rent to maintain stability of the house until residents can locate a new housemate.
    - A "basic needs" list for residents is created by staff and supplies are obtained by either residents' resources, donations and/or MHSA flex funds.
    - PSCs provide support with medication, housemate conflict resolution, money management skills, bill paying, meal planning, budget planning, shopping, leisure skills planning and other daily living skills.
    - PSCs work with property owners to ensure support for both the resident and the property owner.

  New Directions continued supporting two Full Service Partners within the SIL (Supported Independent Living) houses in FY 17/18.

- Housing was provided for four homeless adults or previously homeless adults who struggled with severe and persistent mental illness, using subsidies from the Housing and Urban Development (HUD) Supported Housing Program grants. This included *Winters' Haven* house and scattered sites in the *Summer's Haven* and *Home Anew* Projects. See MHSA Housing section of this report for more details.
- *The Catherine Lane House (a joint venture with Turning Point)* - The Catherine Lane House offers 24/7 support services to residents with independent living skills challenges. This permanent supportive house includes a focus on single room occupancy that facilitates residents achieving their maximum level of independence. This house enables residents to live independently and keep their current community support network intact. In FY 17/18 the New Directions Program had two participants living at the Catherine Lane House.
- *The Willo House* - The Willo House is a program which provides intensive support services for participants who are on conservatorship or in need of one or more staff contacts per day. This setting provides participants an opportunity to live in the community with greater independence than an IMD (Institute for Mental Disease) or Board and Care facility. The Willo House is a three bedroom unit. In FY 17/18 the New Directions Program housed two participants in Willo House.

Employment/Volunteer Employment:

- *Snack Shack* – Vocational training is available through the Snack Shack program. The Snack Shack program had previously been a collaborative effort between the National Alliance for the Mentally Ill (NAMI), the Nevada County Behavioral Health (NCBH) Department (both adult services and children's) and Consumers. In December 2017 NAMI left this partnership and was replaced by SPIRIT Peer Empowerment Center in collaboration with NCBH. The Snack Shack is a consumer driven retail program providing vocational skills and structure. Participants learn customer service, cash register skills and team building. Management of the program is provided by consumers and a consumer with bookkeeping experience balances the receipts. In FY 17/18 there are three managers and 10 participants that volunteered to work in the Snack Shack program. None of these workers were FSP participants, but this program remains a valuable volunteer option for Full Service Partners.
- *Peer Support Training* - Peer Support Training is an eight-month program where consumers develop skills to counsel and support peers. The goal of the support services is to promote self-empowerment, independence and interdependence, facilitating consumers functioning and thriving in their community. Training requirements are no more than four missed sessions and completion of a mock peer support session. The training offers one of two outcomes: 1) a certificate of graduation or 2) a certificate of participation. Of the 13 training participants in FY 17/18 who completed Peer Support Training, one was a Full Service Partner. Within the graduates of the program:
  - Two participants took the training for personal enrichment.
  - Eight participants graduated with diplomas.
  - Four participants were still in training at the end of the fiscal year.

  After graduation, consumers are introduced to volunteer opportunities in the community. At the end of FY 17/18:
  - Two graduates worked at Behavioral Health,
  - One graduate continues to facilitate a depression group at Tuning Point,

- One graduate was employed at Insight Respite Center (IRC) and Turning Point and has recently been promoted to within IRC.

Supportive Services:

- *Weekly Groups:*
  - Healthy Living - Healthy Living courses provide education to consumers and healthy options for independent living. Choices include coping and time management skills; nutrition, social and budgeting skills; leisure and development of Wellness Recovery Action Plans (WRAP) and social activities based in the community. This program served 23 individuals in FY 17/18, one of whom was a Full Service Partner.
  - Saturday Adventure Outings - Saturday Adventure Outings serve high-risk consumers who have a history of being isolated on weekends. The goal of the program is to engage these individuals socially with other peers resulting in decreased symptoms of mental health issues and increased quality of life. The consumers organize the adventure and determine the activities each week. Two peer staff members provide transportation utilizing Behavioral Health vehicles. The staff also provides support and referral services during the program. This creative solution has enabled individuals to access social interactions through activities they determine. The lead therapist/program team coordinator provided qualitative data in collaboration with the larger Behavioral Health clinical team indicating that this program had a direct role in reduction of symptoms and reduced the need for more intensive services for program participants. In FY 17/18, two of the seven participants in the Saturday Adventure Outings program were New Directions, Full Service Partners.
  - Art Therapy is the application of the visual arts and the creative process within a therapeutic relationship, to support, maintain, and improve the psychosocial, physical, cognitive and spiritual health of individuals. It is based on current and emerging research that art making is a health-enhancing practice that positively affects quality of life by improving concentration and attention. New Directions art-based groups support, maintain, and improve overall health, physical, emotional and cognitive functioning, interpersonal skills, and personal development. In FY 17/18, the Art Therapy group served 21 participants, including nine Full Service Partners.
- *Therapy Support and Service Coordination:* Therapy services are provided by interns through the intern program. The program offers an opportunity for interns to be trained in the mental health field while offering services to individuals who might otherwise wait or not receive individual therapy. The long-term benefits are quality services for the consumer and training for a new generation of clinicians who have developed skills, which they bring to a variety of community, based settings. The Interns are individuals are completing or have completed their Master's degree in psychology, sociology or a related field. A licensed therapist with the New Directions Program provides supervision. Program treatment options range from service coordination to providing mental health rehabilitation, including medication delivery. Individual and group therapy provides participants the opportunity to further their goals of developing healthy life options, including choosing the abstinence or harm reduction model for recovery from substance use disorders as a component of their co-occurring disorder.
- *After Hour Services* - Nevada County is a small county and resource availability within the Behavioral Health Department is limited, given budget constraints. In order to meet the criteria of 24 hour/seven day a week services, the following adjunct supports have been developed for holidays, weekends and overnight coverage. Individuals have use of the 24 hour crisis line of

Nevada County Behavioral Health as a contact resource. They have the further option of requesting contact with the program team coordinator or designated alternate for support in managing critical issues through the crisis line. For participants in New Directions utilizing daily medication deliveries, service coordinators from Behavioral Health make weekday morning deliveries.

Evaluation Activities and Outcomes

Notable community impact is reflected by these program outcomes.

- Independent Living was maintained or increased which reduces the impact on community based homeless resources. The number of Independent Living days for individuals living alone increased from 1,584 to 1,781 days.
- Out of the 18 program participants prior to actively engaging in FSP treatment, two had a previous history of eviction and 10 had a history of evictions *and* were chronically homeless. Ten out of 18 were successfully living in independent living locations in 17/18. Four of the participants were supported in finding housing but did not remain housed during this time.
- Comparing the year before partnership to the second year of receiving services through New Directions, the number of Homeless days decreased from 320 down to 111.
- Three of the six partners being served for two or more years, were hospitalized the year before partnership. Only two partners were hospitalized in year two of their partnership in FY 17/18.
- There was a decrease in legal issues. Three individuals with arrests prior to partnership, decreased to two partners with arrests during the first year of partnership.
- There was a decrease in homelessness. The number of homeless days in the year prior to FSP treatment was 660, which decreased in the first year of FSP treatment to 190 days in FY 17/18. Comparing the year before partnership to the first year of receiving services through New Directions, the number of individuals in Residential Placement remained the same at seven. The number of supervised participants decreased from five to four in FY 17/18.
- Comparing the year before partnership to the first year of receiving services through New Directions, the number of participants in an Emergency Shelter increased from two to three.
- The employment program provided enrolled consumers with additional monetary resources, which they spent locally and thereby became financially contributing members of the local community.

Challenges, Solutions, and Upcoming Changes

- It is difficult to find landlords for the chronically homeless who are willing to lease, rent, or master lease to New Directions participants.
- There is a chronic shortage of hospital beds in California, which puts the beds in the local Crisis Stabilization Unit and Odyssey House in shortage when New Directions partners need them.

- The Supported Housing component of the New Directions program continues to have challenges related to staffing restrictions. These restrictions limit the number of units that can be adequately developed and managed to meet the participant's needs.
- Peer support challenges continue. As peer support continues to expand, so does the need to find paid or volunteer community placements for program graduates. Ongoing outreach to community based agencies and groups is continually needed to provide options for graduates to utilize their skills. Additionally, once a Peer Counselor has a paid or volunteer position in the community they typically need intermittent support. Staff schedule an alumni meeting once a month to provide support for the individuals working in the community. Staff also facilitate visits to other agencies to foster knowledge of future referral resources, as well as meet prospective employers.

Program Participant Story

A woman who was homeless and pregnant with an additional child was delusional and staying at a local shelter. A family member tried to connect her with Behavioral Health on several occasions, but the woman did not feel that she had a mental illness. She was paranoid and often fearful. She did not seek any prenatal care and eventually Child Protective Services became involved. After a hospitalization, the woman came into New Directions for treatment and over time developed a working relationship with one of the doctors. The woman finally agreed to go on medications.

She worked closely with a service coordinator who was able to secure housing for her and she was consistent with taking her medications. After a year of struggling with mental illness, homelessness and abuse, the woman developed trust with her doctor and service coordinator and began to have some successes in her life.

Currently the woman has safe affordable housing, she is engaged in mental health services, she was able to keep the new baby, and there is a marked improvement in her relationship with her family members. They are able to provide her with emotional support.

General System Development:

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

Program Description

Program Overview

In FY 17/18 Intern Program Expansion added service capacity, increased access, and broadened services in Nevada County. Interns and their clinical supervision were funded through Community Services and Supports (CSS), General System Development (GSD). In FY 17/18, 14 interns provided 13,993.45 hours, treating 294 individuals. The Adult System of Care provided 4,068 hours, treating 64 individuals; The Children's System of Care provided 9,925.45 hours, treating 230 individuals. Additionally, 1,058.75 hours of intern supervision were funded by this source.

Target Population

Nevada County Behavioral Health (NCBH) program participants who work with clinical staff interns. This program serves all age groups.

Evaluation Activities and Outcomes

Baseline and annual Basis 24 outcome measure surveys continue to be collected for individuals served by the Adult System of Care. Individual reporting on outcomes is available through the county's new outcome measure system, Electronic Behavioral Health Solutions (eBHS). However, aggregate reporting for this subset of program participants is not yet available through eBHS. The county hopes this functionality will be in place by next year's report.

The NCBH Children's System of Care is collecting the Achenbach Child Behavior Checklist (CBCL) for children/youth. State regulations require staff to collect the Child and Adolescent Needs and Strengths Assessment (CANS) and the Pediatric Symptom Checklist 35 (PSC-35) outcome measures in the next year, so staff are working with the eBHS vendor to add these assessments to the electronic tool. Since energies and dollars are going toward entering the CANS and PSC-35 into eBHS, the automation of the CBCL has been put on hold. The Children's team collects the CBCL data, but there is no way to aggregate it for overall reporting. Next year's MHSA reporting should include aggregate CANS and PSC-35 data.

Challenges, Solutions, and Upcoming Changes

Finding a system that will collect, collate and summarize outcome data for NCBH has been a challenge. With the implementation of the eBHS software, staff, supervisors and management will be able to pull reports using a wide range of filters to better understand the data that is being collected. This will enable programs to report out on participants' progress and improvements due to treatment they have received. Implementation of the eBHS system through contract with eCenter continues. Effective aggregate reports are not yet available.

General System Development:

NEVADA COUNTY BEHAVIORAL HEALTH
Network Providers

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) has licensed therapists, Network Providers, who work in the community at private offices. They see children, Transition Aged Youth (TAY), adults and older adults referred to them by NCBH. Nevada County Behavioral Health refers program participants with less acute needs to the Network therapists. These individuals do not appear to need medication or significant case management. Network providers help to serve additional individuals and offer partners and families a variety of specialties and locations that NCBH would not be able to offer otherwise. Network providers are funded under both the Adult and Children's programs within CSS. In FY 17/18, 44 unduplicated participants were served. This includes 36 individuals served in the Children's System of Care and 8 individuals served in the Adult System of Care.

Target Population

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

Evaluation Activities and Outcomes

Baseline and annual Basis 24 outcome measure surveys continue to be collected for individuals served by the Adult System of Care. Individual reporting on outcomes is available through the county's new outcome measure system, Electronic Behavioral Health Solutions (eBHS). However, aggregate reporting for this subset of program participants is not yet available through eBHS. The county hopes this functionality will be in place by next year's report.

The NCBH Children's System of Care is collecting the Achenbach Child Behavior Checklist (CBCL) for children/youth. State regulations require staff to collect the Child and Adolescent Needs and Strengths Assessment (CANS) and the Pediatric Symptom Checklist 35 (PSC-35)

outcome measures in the next year, so staff are working with the eBHS vendor to add these assessments to the electronic tool. Since energies and dollars are going toward entering the CANS and PSC-35 into eBHS, the automation of the CBCL has been put on hold. The Children's team collects the CBCL data, but there is no way to aggregate it for overall reporting. Next year's MHSA reporting should include aggregate CANS and PSC-35 data.

Challenges, Solutions, and Upcoming Changes

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

General System Development:

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

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) Children's Services provided Expanded Psychiatric services to 28 children with MHSA CSS funds in FY 2017/2018. Some of the children were being wrapped with Full Service Partner (FSP) providers. Some of these children continue to see the NCBH doctor individually and work with the WRAP team.

Nevada County Behavioral Health Adult Services provided Expanded Psychiatry to Case Management/Auxiliary program participants using General System Development funds. These funds payed for 30 individuals in FY 17/18. Expansion of psychiatry services and expansion of behavioral health services within the Adult System of Care included the same individuals. All Integrated Service Team program participants received both psychiatric and case management services.

Target Population

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

Evaluation Activities and Outcomes

The NCBH Children's System of Care is collecting the Achenbach Child Behavior Checklist (CBCL) for children/youth. State regulations require staff to collect the Child and Adolescent Needs and Strengths Assessment (CANS) and the Pediatric Symptom Checklist 35 (PSC-35)

outcome measures in the next year, so staff are working with the eBHS vendor to add these assessments to the electronic tool. Since energies and dollars are going toward entering the CANS and PSC-35 into eBHS, the automation of the CBCL has been put on hold. The Children's team collects the CBCL data, but there is no way to aggregate it for overall reporting. Next year's MHSA reporting should include aggregate CANS and PSC-35 data.

Baseline and annual Basis 24 outcome measure surveys continue to be collected for individuals served by the Adult System of Care. Individual reporting on outcomes is available through the county's new outcome measure system, Electronic Behavioral Health Solutions (eBHS). However, aggregate reporting for this subset of program participants is not yet available through eBHS. The county hopes this functionality will be in place by next year's report.

Challenges, Solutions, and Upcoming Changes

Finding a system that will collect, collate and summarize outcome data for NCBH has been a challenge. With the implementation of the eBHS software, staff, supervisors and management will be able to pull reports using a wide range of filters to better understand the data that is being collected. This will enable programs to report out on participants' progress and improvements due to treatment they have received. Implementation of the eBHS system through contract with eCenter continues. Effective aggregate reports are not yet available.

General System Development:

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

Program Description

Program Overview

Community Recovery Resources (CoRR) provides services to adult Medi-Cal beneficiaries experiencing concurrent issues of substance use and mental illness. Services are recovery-oriented and driven by the unique needs, strengths and natural supports of individuals. They are community based, family-centered and culturally relevant. Services include case management, an individualized myriad of rehabilitative life skills development and therapeutic interventions such as mood management and trauma work. The program is based on Co-Occurring Disorders (COD) best-practices model within a recovery-oriented system of care.

Target Population

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

Evaluation Activities and Outcomes

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

Program Outcomes:
The COD Adult program served 37 unduplicated adults. Of the 37 Adults, 20 remain enrolled, eight successfully completed the program, four were transferred to other services, one lost her Medi-Cal eligibility, one returned to prison, and three withdrew from services.

Of the people that were enrolled in the program, 30% of the population were inconsistent with treatment service and did not continue with services.

- Treatment goals: Approximately 78% of the population met their treatment goals measured by self and staff report.
- Symptom reduction (Basis-24 items 10-20): Approximately 93% of enrolled adults reported a history of trauma. Of those, 79% reported a decrease in individualized symptom reduction according to the Basis-24 (treatment team tracking, progress notes, assessments, individual BASIS-24 responses).
- Involvement with the law: Approximately 47% of the population began the program on probation, and 20% successfully terminated probation. Three percent of individuals had return incarcerations while in the program, the result of sanctions from Adult Drug Court or other probation violations. However, there were no new offenses.
- Substance Use: Approximately 72% of the population saw a decrease in substance use, and the URICA-24 subcategory, Action Phase, saw the highest increase in rates at approximately an 82% increase.
- Satisfied with services/Dissatisfied with services: Due to delays with the state submitting data to eCenter for Consumer Perception Data analysis, this data is not available.
- Homelessness: There was no increase or decrease in homeless rate as measured by self and staff report.
- Emergency Department Visits: Less than 10% of the population experienced medical or psychiatric hospitalization.
- Employment: Approximately 55% of the population achieved volunteer and gainful employment as measured by self and staff report.
- Education: Approximately 5% of the population returned to school to further their education.
- Self-Help: 55% utilized community self-help groups.

Scores for the BASIS-24, the Quality of Life (QLS) and URICA-24 (Readiness for Change) were taken at the beginning, middle and end of treatment. A comparison was made between the scores

taken at intake and the scores taken during the middle of treatment. The closing sample was not used in comparison due to low sample size.

BASIS-24: A significant difference was noted between the BASIS-24 overall mean scores of clients at admission (mean=1.81) and mean scores taken in the middle of treatment (mean=1.61). This finding denotes that participant average scores increased by 0.2 and that the higher scores at intake indicate greater symptom distress was found in the admission sample.

QLS: The total mean score at admission (mean=66.86) was compared to the total mean score at the middle of treatment at (mean=78). The overall findings of the Quality of Life Scale (QLS) indicate that the participant average scores increased by 11.14. Higher scores on the QOL indicate a higher quality of life and an average score for a healthy population is 90. These findings indicate that client perception of and emotions related to different areas of their life were more difficult or problematic at admission than at mid-treatment.

URICA: The readiness scores derived from the URICA-24 were used to indicate client progress during treatment. The subscale scores represent attitudes and activities related to the stages of change and not precisely state status. The subcategories include pre-contemplation, contemplation, action and maintenance. Shifts in subscale scores are associated with the shifting people go through during the process of change, which is not a linear, single variable. Average scores at admission: pre-contemplation: 1.6, contemplation: 4.125, action: 4.125, maintenance: 3.575. Average mid scores: pre-contemplation: 1.2875, contemplation: 4.4, action: 4.6, maintenance: 3.175. Overall, these findings indicate an increase in the average scores of pre-contemplation and contemplation subcategories and a decrease in action and maintenance. These results signify a greater awareness of the alcohol or substance related problem/with more difficulty engaging in behavior change regarding drinking or substance use.

Challenges, Solutions, and Upcoming Changes

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

Program Participant Story

Mike (not real name) was self-referred and admitted to CoRR's Co-occurring Disorders Program. At intake, the counselor determined Mike had potential co-occurring disorders based on his behaviors. The COD program coordinator was called in, and after discussing the program,

scheduled an intake for the following day. Mike kept the appointment and revealed that he had a long history of substance use that originated in adolescence. He no longer used any substance except alcohol, which was on a near-daily basis. In childhood, Mike was exposed to trauma and was diagnosed with Posttraumatic Stress Disorder based on his symptoms. Mike immediately began attending bi-weekly therapy sessions, one individual rehab session per week, and two-to-three groups per week. He was also referred to the clinic for a medication evaluation to address his mental health needs.

Mike was compliant with appointments. He was open and forthright regarding his drinking habits and expressed a strong desire to stop drinking. However, Mike's anxiety increased as the result of familial dysfunction and his symptoms of PTSD resulted in continued alcohol use. Approximately one month after treatment started, Mike began to experience relief from his symptoms, which he attributed to "finally starting to talk about some things," and the start of medical intervention. Soon after he made the decision to stop alcohol use, began attending community-based self-help groups, and achieved nearly six months of sobriety.

Mike maintained sobriety, but experienced a triggering life stressor that resulted in a significant binge-drinking episode. Throughout the relapse, Mike continued to make contact with the COD program via his therapist and rehab counselor. With encouragement from COD and outpatient staff, Mike agreed to enter CoRR's residential treatment program. After six weeks of in-patient treatment (and continued care in COD) it became evident that Mike was thriving in the program and he was discharged to transitional housing. While in transitional, he found a job, attended community-based self-help meetings multiple times per week, and sustained his sobriety and overall health. Mike eventually returned to his family's home and was told by his family members, "Your positive changes have made all of us look at ourselves, and see how we contributed to your drinking."

Mike shared with COD providers that the frequency of individual therapy and rehab sessions as well as the unlimited period in which to participate in the COD program, enabled him to begin the process of exploring his childhood trauma in a safe environment. He noted that this process is what enabled him to fully utilize residential treatment, which greatly improved his communication skills in self-help groups. Mike continues to maintain abstinence from all substances. He recently returned to college to complete his degree and works part time. He no longer experiences debilitating periods of anxiety, and often uses the tools he learned in treatment. Mike successfully completed his work with his COD rehab counselor. He continues to attend bi-monthly individual therapy sessions for "fine-tuning," with a plan to begin the COD rehab group as soon as feasible. Mike stated recently, "My dreams don't trouble me anymore." He also said, "The past and future don't run my life today."

General System Development:

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

Program Description

Program Overview

Nevada County Behavioral Health (NCBH) Children's Services provided Expanded Mental Health services to 30 children with MHSA CSS funds in FY 2017/2018. Some of the children were being wrapped with Full Service Partner (FSP) providers. Some of these children continue to see NCBH staff individually and work with the WRAP team. This data excludes services provided by interns. Intern services are funded separately.

Nevada County Behavioral Health Adult Services provided Expanded Mental Health services to Case Management/Auxiliary program participants using General System Development funds. These funds payed for 30 individuals in FY 17/18. Expansion of psychiatry services and expansion of mental health services within the Adult System of Care included the same individuals. All Integrated Service Team program participants received both psychiatric and case management services. This data excludes services provided by interns. Intern services are funded separately.

Target Population

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

Evaluation Activities and Outcomes

The NCBH Children's System of Care is collecting the Achenbach Child Behavior Checklist (CBCL) for children/youth. State regulations require staff to collect the Child and Adolescent Needs and Strengths Assessment (CANS) and the Pediatric Symptom Checklist 35 (PSC-35) outcome measures in the next year, so staff are working with the eBHS vendor to add these assessments to the electronic tool. Since energies and dollars are going toward entering the CANS and PSC-35 into eBHS, the automation of the CBCL has been put on hold. The Children's team collects the CBCL data, but there is no way to aggregate it for overall reporting. Next year's MHSA reporting should include aggregate CANS and PSC-35 data.

Baseline and annual Basis 24 outcome measure surveys continue to be collected for individuals served by the Adult System of Care. Individual reporting on outcomes is available through the county's new outcome measure system, Electronic Behavioral Health Solutions (eBHS). However, aggregate reporting for this subset of program participants is not yet available through eBHS. The county hopes this functionality will be in place by next year's report.

Challenges, Solutions, and Upcoming Changes

Finding a system that will collect, collate and summarize outcome data for NCBH has been a challenge. With the implementation of the eBHS software, staff, supervisors and management

will be able to pull reports using a wide range of filters to better understand the data that is being collected. This will enable programs to report out on participants' progress and improvements due to treatment they have received. Implementation of the eBHS system through contract with eCenter continues. Effective aggregate reports are not yet available.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Crisis Workers, Crisis Support Team

Program Description

Program Overview

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

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

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

Target Population

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

Evaluation Activities and Outcomes

In FY 17/18 the targeted goal was for Crisis Workers to serve 1,000 individuals. The result was 1,030 unduplicated people served, representing 103% of the goal. A total of 2,219 contacts occurred; many of the individuals were seen two or more times throughout the year. This is a

substantial increase from the total contacts during the prior FY 16/17, where the Crisis Workers had a total of 1,740 contacts.

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

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

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

Challenges, Solutions, and Upcoming Changes

Licensure requirements for Crisis Workers changed in 2018 and several seasoned Crisis Workers who did not meet the requirements left SMWG. Staffing challenges persisted until recently, when five new Crisis Workers were hired in one month. This created training challenges initially, but now that training is completed, this issue has resolved.

Two consumer categories are particularly challenging; the highly acute, potentially violent individual, and the efficient use of Tele-psyche services in the Emergency Room (ER). The Crisis office has improved security measures by adding a security monitor, and training staff on using emergency call buttons and codes. Recent meetings have prompted improved efficiency of hospital security responses to the Crisis office and CSU. Additional staff training on de-escalation would be helpful.

Tele-psyche is a program where remote psychiatrists are able to see beneficiaries in the ER when medications are necessary for stabilization. It has been difficult to establish the best method of communication between the psychiatrist working remotely, the ER, and the Crisis Worker in the nearby office when Tele-psyche is necessary. Meetings are currently underway to establish a protocol to ensure better communication so that departments can collaborate effectively for the individuals' best care, and potentially reduce the need for 5150 holds and placements through the effective use of Tele-psyche and medications.

Program Participant Story

Recently an individual who had been homeless and living locally for the past few months came to the CSU. The beneficiary revealed that others in the community were after him to harm him. Although this was not confirmed, he was able to stay in the CSU overnight. The following day he showed nervousness about leaving the CSU and went to the ER for further evaluation by the Crisis

team. The Crisis Worker spent time working with him to determine what he needed. The individual stated that he would be safe from the people who were going to harm him if he went back up north to be with his family. Once the Crisis Worker determined what the beneficiary needed and hoped for, she was able to collaborate with county resources to get him a bus ticket back home, where he felt he would be safe with family. He was even able to get a ride to the bus station, where he was seen off safely!

General System Development:

SIERRA MENTAL WELLNESS GROUP
Crisis Stabilization Unit (CSU)

Program Description

Program Overview

Sierra Mental Wellness Group's Crisis Stabilization Unit (CSU) opened on December 14, 2015 to better serve Nevada County residents experiencing a mental health emergency. The facility is a four bed, unlocked unit, staffed by a mental health professional and a medical professional on-site at all times. Psychiatrists are on-call 24/7. Individuals may be admitted while awaiting placement on a 5150 hold or voluntarily. For the Fiscal Year of 17/18, the CSU served 436 individual clients with 767 total admissions.

Per Medi-Cal requirements, individuals are allowed to stay up to 24 hours in the CSU. During that time the individuals are assessed by the medical professional for medical issues that may be contributing to their crisis. Current medication interactions are investigated. A "wellness and recovery" plan is developed by the mental health professional in conjunction with the participant. The plan explores the participant's strengths and support systems to help resolve their crisis and improve their coping mechanisms. Specific referrals to meet the individual's needs are offered and, where possible, warm-handoffs are provided. The local respite center received 21 documented warm handoffs from the CSU in FY 17/18. Many more CSU participants could have used the service, were beds available. Many avenues are explored for individuals with drug and alcohol issues e.g. Behavioral Health Drug and Alcohol Treatment, Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and local outpatient programs. Spirit Peer support staff provide services to individuals residing in the CSU daily. An estimated 98% of the time, family contact helps to stabilize clients to rescind their 5150 holds through collaboration in recovery plans.

Target Population

A CSU is established with the intention of reducing the need for psychiatric hospitalization when someone is in crisis due to exacerbation of symptoms resulting from a mental illness, or as a reaction to life stressors, or both. Medi-Cal clients on a 5150 hold whose crisis can be relieved by a 24 hour stay in the CSU with therapeutic and medical intervention is the primary goal of the program. The program serves uninsured and privately insured individuals 18 years old and older.

Evaluation Activities and Outcomes

During FY 17/18, this program helped rescind 92 of the 275 5150 holds for individuals in the CSU. The availability of the CSU offers the crisis staff an additional resource as part of the participant's safety plan. For the participant, it is a safe haven away from the stressors that are often catalysts to their crisis.

The CSU has been a huge success with the community. Satisfaction surveys were completed by 20% of individuals that stayed in the CSU during the 17/18 fiscal year. Survey participants reported 98% satisfaction with the treatment they received and the progress they made while in residence. Those that were unfortunate enough to have mental health emergencies prior to the CSU being built are particularly appreciative of the services provided and the compassionate, therapeutic nature of the care.

Sierra Nevada Memorial Hospital (SNMH) is also appreciative of the CSU. The emergency room (ER) boarding time has decreased 61% since the CSU doors opened. This data is collected and shared by SNMH Community Health Outreach Specialist. Participants evaluated in the emergency room (individuals must be 18 years or older, medically stable, and not violent) are presented to the CSU staff and transferred to the CSU as quickly as possible. With only 18 beds in the emergency room, freeing up beds for medical patients is vital.

The impact of the CSU cannot be overstated. It is lauded at community meetings on a frequent basis. Spring of 2018 showed record highs in the number of CSU admissions. For instance, in March of 2018 there were 77 admissions.

Challenges, Solutions, and Upcoming Changes

One notable challenge has to do with the CSU Admission Policy. The policy limits admission of individuals with challenging medical issues. Those on 5150 holds with medical issues are difficult to place at psychiatric facilities for longer-term care.

Another challenge is the budgetary restrictions, allowing only one clinician and one nurse to be working at a time in the CSU, despite an increased caseload. For instance, during one eight-hour shift there could be four individuals in beds, followed by four discharges, and four intakes. When the maximum stay for beneficiaries is only 24 hours, there is a time scarcity. For improved efficiency, the CSU staff have learned to start a recovery plan immediately when a beneficiary is admitted.

Tele-psych services have been increased at the ER, for manic and psychotic individuals. The tele-psych psychiatrist is then able to make a medication recommendation and help the beneficiary stabilize faster. This enables more individuals to meet admissions criteria for the CSU and to stabilize. Approximately 50% of individuals on a 5150 hold who have a tele-psych consult are able to stabilize with a solid safety plan, and have their hold rescinded.

Program Participant Story

An individual with a history of mental illness and substance abuse has stayed at the CSU for stabilization in between various residential placements. Her first stay at the CSU actually resulted in her needing to leave with the help of law enforcement. After treatment and time, she was able to stay at the CSU for stabilization, as her symptoms and behaviors had improved drastically when she stayed clean/sober. She was a testament to the opportunities offered by CSU to help clients who might initially appear to others to be hopeless. " The staff are encouraged to look at individuals based on how they are doing currently, rather than based on experiences of failure. The CSU worked directly with other agencies in communicating updated information and linking her to services. She has more recently been able to sustain housing, sobriety, employment and treatment and she is working on rebuilding family relationships.

General System Development:

TURNING POINT
Insight Peer Respite Center

Program Description

Program Overview

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

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

Services provided include the following:

- Therapeutic interventions
- Crisis intervention
- Rehabilitation
- Client advocacy
- Life skills

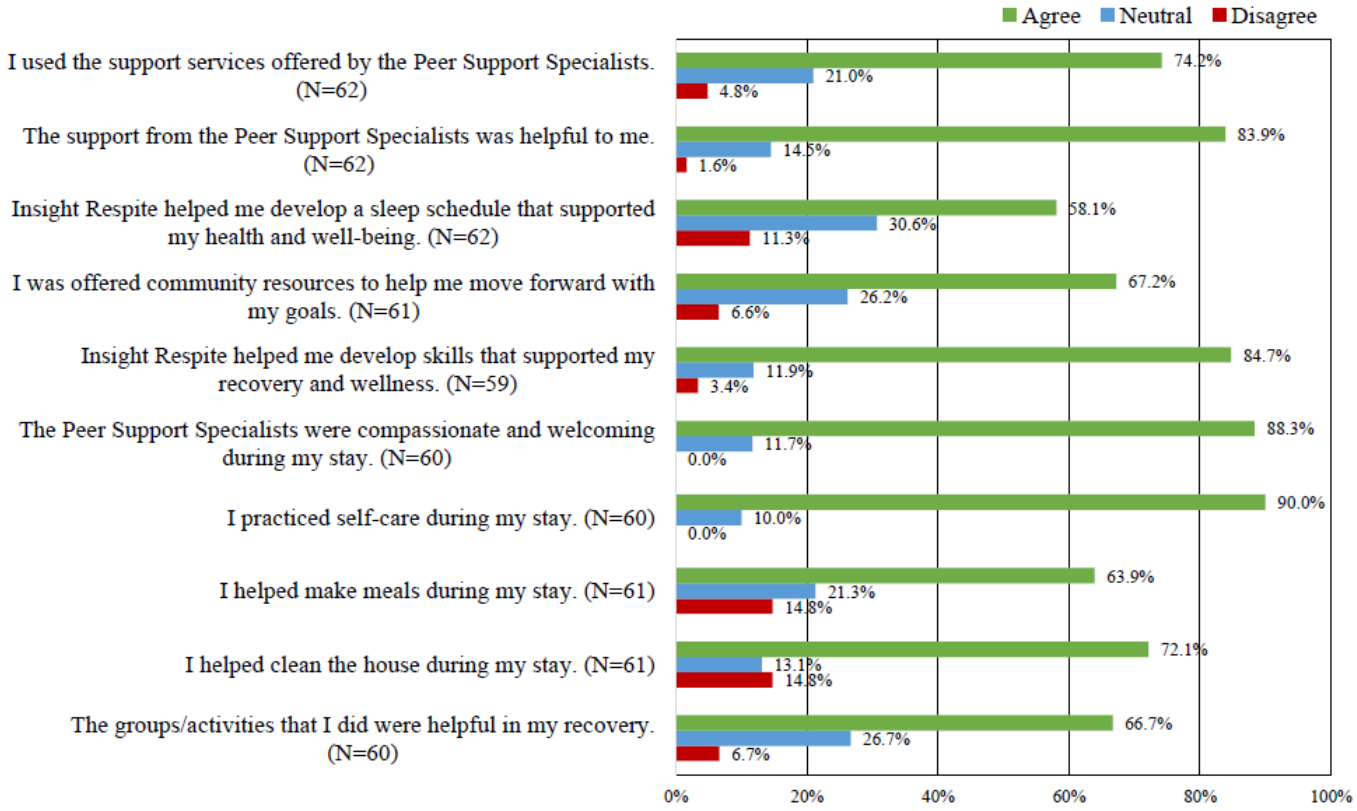
Target Population

The program serves guests 18 years of age and older, who have a mental illness, and because of the disorder, the individual is 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, Crisis Stabilization Unit, or guests may be recently discharged from one of these placements, or experiencing a first episode or re-emergence of a psychotic break. Guests must be assessed and approved by the Nevada County Access Team and its Program Manager, or his/her designee and be medically stable. Participants may not be under the influence of alcohol and/or drugs and must be able to maintain acceptable personal hygiene. Guests are responsible for preparing meals and cleaning up after themselves. Participants must understand and sign or initial necessary documentation, be willing to follow the participant agreement upon entering the house, and have a place to return to when leaving the IRC, even if that is a homeless shelter.

Evaluation Activities and Outcomes

- A total of 79 unduplicated guests were served at IRC in FY 17/18; the total number of duplicated guests served in FY 17/18 was 120 (41 guests were served more than once).
- The total number of duplicated service contacts for FY 17/18 was 1,314.
- Demographic data is gathered on all guests served.
- Insight Respite Center is 87% peer staffed.
- Insight Respite Center guests received 50 referrals to community services during their stay.
- At discharge, 64.5% of guests met their goals.
- Prior to admission, 13.9% of guests had an inpatient psychiatric hospitalization in the previous six (6) months; in the months following discharge, only 5.1% of guests had an inpatient psychiatric hospitalization, for a decrease of 8.8%.
- Based on data from the Satisfaction Survey below, guests are satisfied with the services they receive.

Nevada County
Insight Respite Center
Satisfaction Survey Results
FY 2017-18



Challenges, Solutions, and Upcoming Changes

With the anticipated conclusion of SB82 funding at the end of FY 2017-2018, IRC is making preparations to become Medi-Cal certified.

Program Participant Story

Written by a former guest:

> *"I am so grateful to Insight Respite! I was so vulnerable when I first arrived. Immediately, the staff made me feel welcome and comfortable. I felt safe for the first time in a long time. Everyone is great – thank you! I don't know what I would have done without Insight Respite Center."*

General System Development:

SPIRIT
Emergency Department (ED)
Crisis Peer Support Program

Program Description

Program Overview

The SPIRIT Peer Empowerment Center (SPIRIT Center) has Crisis Peer Supporters to provide additional on-call support to individuals in crisis in the Emergency Department (ED). The trained and experienced SPIRIT Center Crisis Peer Supporters (CPS) are available to respond to a call from a Crisis Worker, and immediately come to the ED. CPSs are available from 12:00 p.m. (noon) until 10:00 p.m., seven days per week.

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

Target Population

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

Evaluation Activities and Outcomes

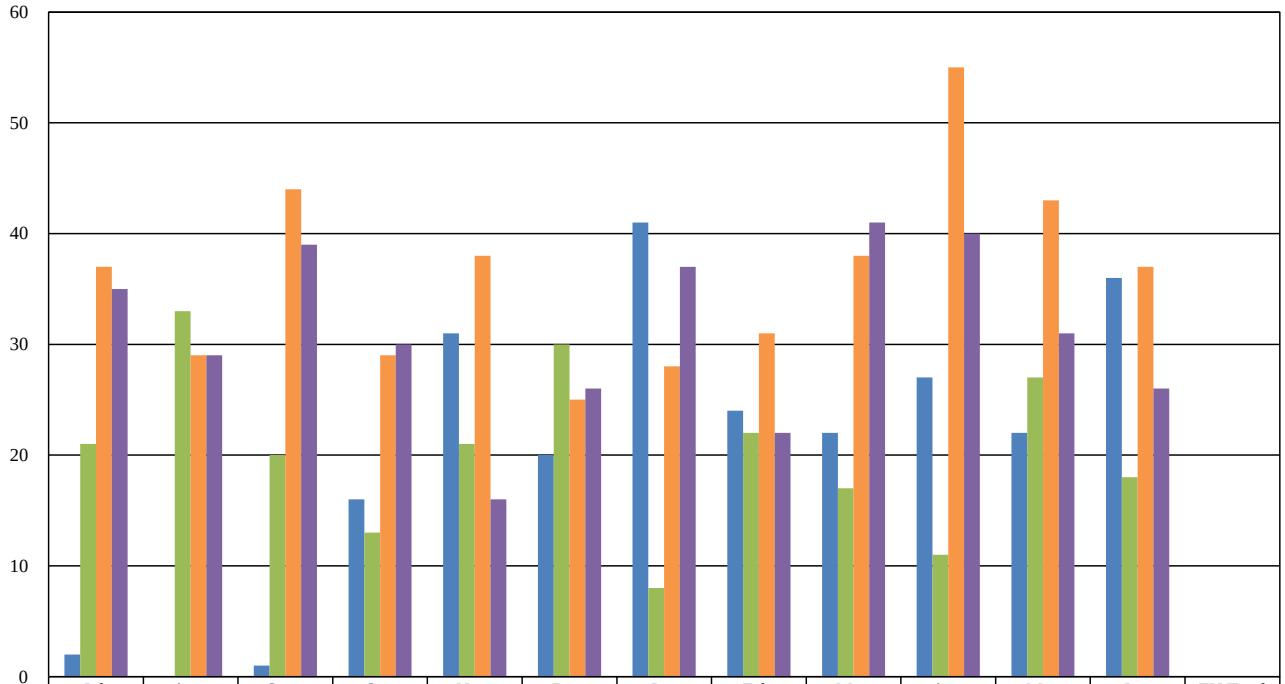
The total number of unduplicated people served in FY 17/18 was 232. Of those, 61 people became SPIRIT Center participants. There were 256 Action Plans developed. Stress Reduction Techniques were discussed with 271 participants and 110 participants put the techniques to use. There were 697 referrals made. The purpose of referrals is to:

- Enable individuals in mental health crisis to utilize other community resources and move towards recovery.
- Provide information about early intervention resources for individuals and families to help reduce recidivism rates relating to mental health crisis.
- Educate individuals about personal tools and resources for self-care to aid them in avoiding psychiatric hospitalization.
- Provide lower cost intervention opportunities before symptoms escalate to high cost crisis status.
- Reduce trauma; provide comfort and support to the individual who is in psychiatric crisis.

The tables below show information regarding the crisis calls from the Crisis Workers in the Emergency Department requesting services from the Crisis Peer Counselors at the SPIRIT Center.

Table 1 shows the number of calls to SPIRIT by month, across the four years. In FY 2014-15, there were 242 calls and in FY 2015-16, there were 241 calls. There was a large increase in calls in FY 2016-17, with 434 calls, and a slight reduction in call in FY 2017-18 to 372. This illustrates the high volume of calls to the Crisis Peer Counselors, to help support persons in crisis and their families, while in the ED.

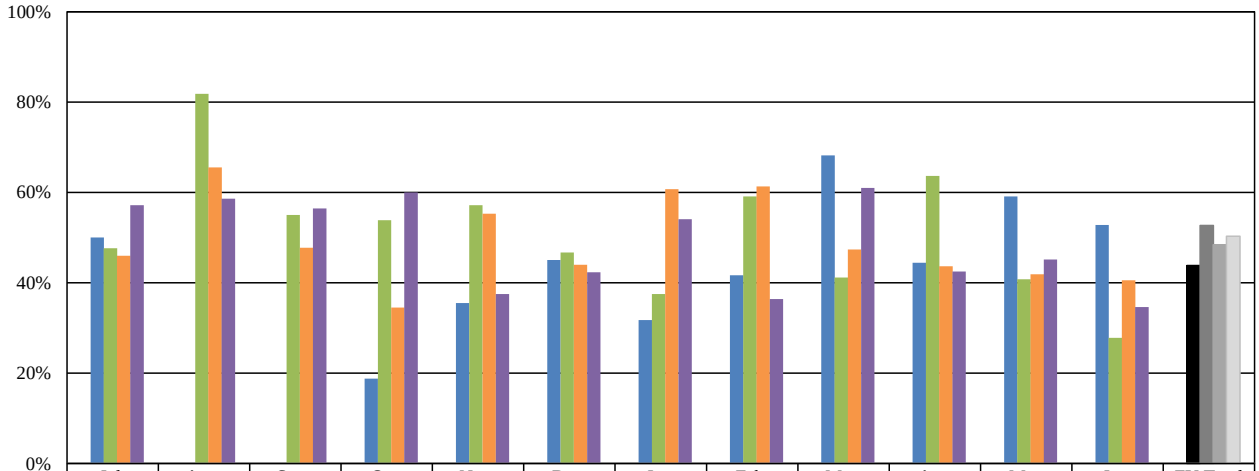
Table 1
Number of Calls to SPIRIT Crisis Peer Counselors, by <u>Month</u>
FY 2014-15 to FY 2017-18



	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.	FY Total
FY 2014-15	2	0	1	16	31	20	41	24	22	27	22	36	242
FY 2015-16	21	33	20	13	21	30	8	22	17	11	27	18	241
FY 2016-17	37	29	44	29	38	25	28	31	38	55	43	37	434
FY 2017-18	35	29	39	30	16	26	37	22	41	40	31	26	372

Table 2 shows the number of calls to the SPIRIT Crisis Peer Counselors in the same four-year period and the percentage with a 5150 hold. Approximately 50% of the calls each year included a 5150 hold. This number ranged from 43.8% in FY 2014-15 to a high of 52.7% in FY 2016-17.

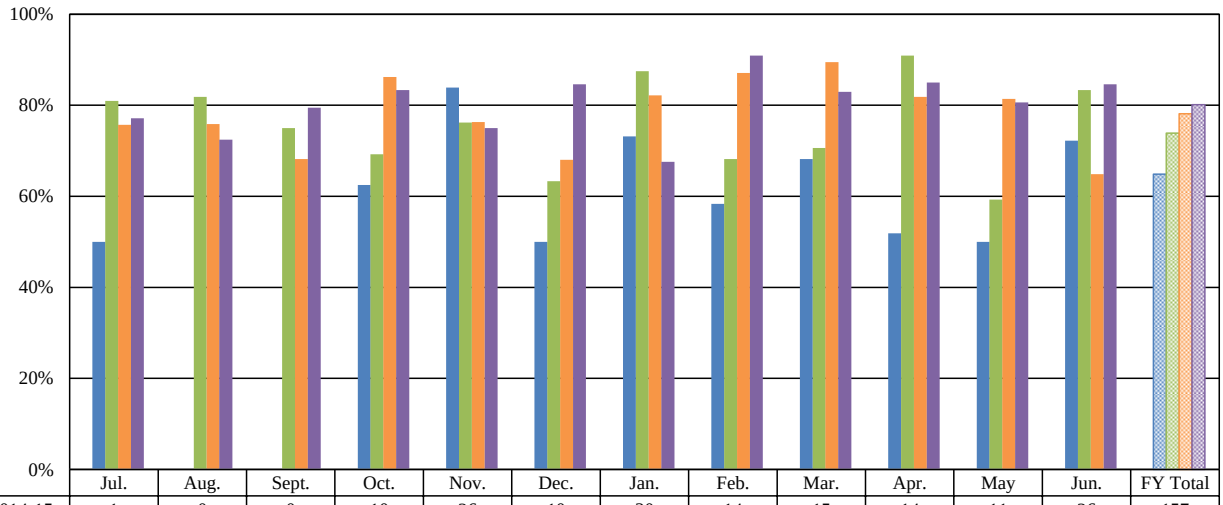
Table 2
Number and Percent of Calls, with a 5150 Hold
FY 2014-15 to FY 2017-18



	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.	FY Total
# 5150 FY 2014-15	1	0	0	3	11	9	13	10	15	12	13	19	106
# Calls FY 2014-15	2	0	1	16	31	20	41	24	22	27	22	36	242
% 5150 FY 2014-15	50.0%	0.0%	0.0%	18.8%	35.5%	45.0%	31.7%	41.7%	68.2%	44.4%	59.1%	52.8%	43.8%
# 5150 FY 2015-16	10	27	11	7	12	14	3	13	7	7	11	5	127
# Calls FY 2015-16	21	33	20	13	21	30	8	22	17	11	27	18	241
% 5150 FY 2015-16	47.6%	81.8%	55.0%	53.8%	57.1%	46.7%	37.5%	59.1%	41.2%	63.6%	40.7%	27.8%	52.7%
# 5150 FY 2016-17	17	19	21	10	21	11	17	19	18	24	18	15	210
# Calls FY 2016-17	37	29	44	29	38	25	28	31	38	55	43	37	434
% 5150 FY 2016-17	45.9%	65.5%	47.7%	34.5%	55.3%	44.0%	60.7%	61.3%	47.4%	43.6%	41.9%	40.5%	48.4%
# 5150 FY 2017-18	20	17	22	18	6	11	20	8	25	17	14	9	187
# Calls FY 2017-18	35	29	39	30	16	26	37	22	41	40	31	26	372
% 5150 FY 2017-18	57.1%	58.6%	56.4%	60.0%	37.5%	42.3%	54.1%	36.4%	61.0%	42.5%	45.2%	34.6%	50.3%

Table 3 shows the number and percent of people who agree to a follow-up from SPIRIT after they are in the ED. Approximately 70-80% of the callers agreed to a follow-up call from the Crisis Peer Counselors, after they were back home. As shown, each year shows an improvement in the percent of people who agree to a follow-up, with 64.9% agreeing in FY 2014-15 to a high of 80.1% in FY 2017-18. This clearly illustrates the importance of this program and the value of offering follow-up support after a crisis service.

Table 3
Number and Percent of Callers, Who Agree to a Follow-up
FY 2014-15 to FY 2017-18



	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.	FY Total
# Follow-up FY 2014-15	1	0	0	10	26	10	30	14	15	14	11	26	157
# Calls FY 2014-15	2	0	1	16	31	20	41	24	22	27	22	36	242
% Follow-up FY 2014-15	50.0%	0.0%	0.0%	62.5%	83.9%	50.0%	73.2%	58.3%	68.2%	51.9%	50.0%	72.2%	64.9%
# Follow-up FY 2015-16	17	27	15	9	16	19	7	15	12	10	16	15	178
# Calls FY 2015-16	21	33	20	13	21	30	8	22	17	11	27	18	241
% Follow-up FY 2015-16	81.0%	81.8%	75.0%	69.2%	76.2%	63.3%	87.5%	68.2%	70.6%	90.9%	59.3%	83.3%	73.9%
# Follow-up FY 2016-17	28	22	30	25	29	17	23	27	34	45	35	24	339
# Calls FY 2016-17	37	29	44	29	38	25	28	31	38	55	43	37	434
% Follow-up FY 2016-17	75.7%	75.9%	68.2%	86.2%	76.3%	68.0%	82.1%	87.1%	89.5%	81.8%	81.4%	64.9%	78.1%
# Follow-up FY 2017-18	27	21	31	25	12	22	25	20	34	34	25	22	298
# Calls FY 2017-18	35	29	39	30	16	26	37	22	41	40	31	26	372
% Follow-up FY 2017-18	77.1%	72.4%	79.5%	83.3%	75.0%	84.6%	67.6%	90.9%	82.9%	85.0%	80.6%	84.6%	80.1%

Challenges, Solutions, and Upcoming Changes

Collaboration with the Crisis Team and the CSU Team has always been a challenge, in that they are very busy with their own duties and organization's structure. The supervisor of the EDP program is working with the supervisors of Crisis and the CSU to continue to come up with a plan for better collaboration. SPIRIT ED continues to invite Crisis and CSU staff to monthly staff meetings. Crisis and CSU staff work hard to attend these meetings. SPIRIT ED is also working on a yearly gathering to include all available Crisis and CSU staff available, to continue to familiarize staff from all teams with each other.

Program Participant Story

A woman was in the ED and in a crisis. When the Crisis Peer Supporter came, the woman was so pleased to see someone who was not in hospital clothes, the woman said later that she felt relaxed. This made it easier for the CPS to talk with her. The Crisis Peer Supporter explained the services offered at SPIRIT Peer Empowerment Center, and the woman agreed to meet with the CPS again in the future. The woman is now signed up for the next Peer Support Training Class.

General System Development:

WELCOME HOME VETS

Program Description

Program Overview

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

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

Target Population

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

Evaluation Activities and Outcomes

During the 17/18 fiscal year, 26 individuals were served by this program. WHV delivered 36 group sessions. Licensed Marriage & Family Therapists (LMFT) provided 198 individual sessions and Licensed Clinical Psychologists (LCP) provided 84.5 individual sessions. The 282.5 individual sessions by LCP/LMFT exceeded the combined contract requirement of 192 sessions. Note these numbers do not include any charges for Nov/Dec 2017. At that time, WHV was focused on the Sierra Health Foundation Grant, which had a deadline of 12/31/17. WHV has made every effort to make up this under-spending in 2018.

During FY17-18, outreach and engagement contacts were made at monthly collaborative meetings and at the annual Bike Run, which involved a large number of Veterans. WHV participated in the Nevada County, All Veterans Stand Down. WHV also continued its Life Pack distribution to homeless Veterans. In December WHV & the Nevada City Elks Lodge, obtained additional funding to continue and improve the Life Pack distribution.

FY 17/18 BASIS-24 OUTCOMES:

- Contract Goal: Less than 5% of veterans will be incarcerated in jail or prison during the time of treatment. Basis-24 FY 17/18 outcomes showed 3.7% of veterans were incarcerated in jail or prison during the time of treatment. WHV met the contract requirement for this goal.
- Contract Goal: 95% of veterans in treatment will report thinking about ending their life only a little or none of the time. Basis-24 FY 17/18 outcomes showed 100% of veterans in treatment reported thinking about ending their life only a little or none of the time. WHV met the contract requirement for this goal.
- Contract Goal: 90% or more of veterans in treatment will not be hospitalized in a psychiatric hospital during the treatment period. Basis-24 FY 17/18 outcomes showed 100% of veterans in treatment were not hospitalized in a psychiatric hospital during the treatment period. WHV met the contract requirement for this goal.
- Contract Goal: 15% or less of veterans in treatment will report being in a shelter or homeless on the street more than one time during treatment. Basis-24 FY 17/18 outcomes showed 3.7% of veterans in treatment reported being in a shelter or homeless on the street more than one time during treatment. WHV met the contract requirement for this goal.
- Contract Goal: 70% or more of veterans in treatment will report feeling short-tempered less during a week. Basis-24 FY 17/18 outcomes showed 70.4% of veterans in treatment reported feeling short-tempered less during a week. WHV met the contract requirement for this goal.
- Contract Goal: 70% of veterans will report that they got along well in social situations half the time or more during a week. Basis-24 FY 17/18 outcomes showed 59.3% of veterans reported that they got along well in social situations half the time or more during a week. WHV did not meet the contract requirement for this goal.

Challenges, Solutions, and Upcoming Changes

WHV has seen an increase in donations (e.g. $5,000 from Patriots Honor/LWW Injured Veteran Golf Tournament) and has conducted/participated in a number of fundraisers. Several Grants from the Elks Foundation have been completed and received to supply life-packs to homeless Veterans. On March 20, 2018, the Nevada County Veteran's Services Office and WHV were notified that CalVet was awarding a Proposition 63 Grant worth $40,000. This Grant will be utilized to support Outreach activities.

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

General System Development:

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

Program Description

Program Overview

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

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

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

Summer's Haven Program
Behavioral Health received a renewal grant from Housing and Urban Development (HUD) Continuum of Care (COC) for $110,841 to house a minimum of thirteen individuals. There are 15 sites that housed 26 tenants in FY 17/18.

Home Anew
Behavioral Health was awarded a renewal grant for $38,840 from HUD in FY 17/18. These funds subsidize the rent for three units that housed six tenants.

Winters' Haven
Behavioral Health received a renewal grant from HUD for $23,102 for the Winters' Haven Program. The Winters' Haven Program provides project-based vouchers for five bedrooms in the first home purchased with MHSA Housing funds. In addition, Winters' Haven funds an additional unit in the community. Six tenants have been housed by Winters' Haven in FY 17/18.

Catherine Lane - Second MHSA funded House
Catherine Lane is a six-bedroom house. There are six tenants housed there. A House Manager is present during the day and House Monitors spend the night. The tenants need this level of care to remain housed. The home was upgraded in FY 17/18, including a new roof, deck replacements, bathroom fixtures, ceiling fans and new flooring.

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

Evaluation Activities and Outcomes

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

A total of 44 individuals were housed through NCHDC in FY 17/18. This included two tenants that have remained housed for over five years, and twelve tenants who have been housed for more than three years. Four tenants left the program and of those, two secured independent housing.

The success of NCHDC is keeping tenants housed long term and having tenants who have been able to move onto independent living. Those who left the program in FY 17/18 had an average length of stay of 30 months. The remaining tenants in FY 17/18 have an average length of stay of 18 months. Four tenants had no income at program entry, and now two have Social Security Income, one is employed and one has general assistance.

Challenges, Solutions, and Upcoming Changes

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

Program Participant Story

NCHDC reports two tenants who are now employed in the social service field. These are true success stories.

Outreach and Engagement:

FULL SERVICE PARTNERSHIP AGENCIES AND OTHER CONTRACT CSS SERVICE PROVIDERS

Program Description

Program Overview

Full Service Partnership Agencies and Other Contract CSS Service Providers conducted outreach and engagement services throughout the fiscal year. These services were done for individuals, families, and other stakeholders through Turning Point, New Directions, Victor, Insight Respite Center, and the Crisis Stabilization Unit. Outreach and engagement activities were provided to 961 individuals under these programs in FY 17/18. This number does not include services provided by the individual programs listed separately in this section of the report.

Outreach and Engagement:

SIERRA FAMILY MEDICAL CLINIC

Program Description

Program Overview

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

Target Population

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

Evaluation Activities and Outcomes

A total of 64 unduplicated individuals were served by SFMC in FY 17/18. Consistent with clinic practice, warm-handoffs from medical providers resulted in approximately 90% of participants connecting and continuing with behavioral health services. Eighty percent of individuals engaged in referred services within 90 days. Participants were referred to Hospitality House, LogistiCare transportation, Medi-Cal, CalFresh, Family Resource Centers (FRC), Alta Regional Center, Community Beyond Violence, SPIRIT Center, Common Goals, Nevada County Behavioral Health, FREED, Community Legal, Workforce Development, Connecting Point, Interfaith Food Ministry, Salvation Army, North San Juan Senior Center, and community therapists.

Challenges, Solutions, and Upcoming Changes

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

Participants have cancelled appointments due to the inability to pay for gas for their cars, or a participant's car breaks down, and cannot be fixed due to lack of funds.

Food scarcity is an increasing problem; transportation to obtain food can be crucial and not readily available to some participants. Referrals to the FRC, food banks, and Interfaith Food Ministry are very helpful, but for beneficiaries with transportations barriers, this continues to be a problem. SFMC encourages carpooling and individuals connecting, but overall SFMC does not have the resources to address the transportation problem.

Lack of housing also continues to be a major challenge. Rentals still are hard to find, let alone affordable housing and temporary housing for participants who are not eligible for current community programs; some participants continue to live in substandard housing and crowded conditions. SFMC helps beneficiaries sign up for Personal Choice Housing vouchers when available, but the problem continues to grow.

The combination of homelessness and lack of transportation is potentially harmful. One participant walked from where she was camping by the river to the clinic for her appointment and developed heat stroke.

Program Participant Story

After four years of engagement, an adult participant who struggles with severe depression and anxiety has moved through the stages of change and is now in the Action stage to address his substance misuse.

Another common success story is the participant who comes in without insurance and is able to be signed up for Medi-Cal. Typically, these participants have multiple health needs, including psychiatric and behavioral health concerns.

Outreach and Engagement:

SPIRIT
SPIRIT Peer Empowerment Center

Program Description

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

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

Evaluation Activities and Outcomes

- During FY 17/18 SPIRIT had 9,232 visits by 661 unduplicated visitors. SPIRIT's volunteers contributed 5,042 hours. These volunteers engage in helping SPIRIT to grow and thrive. Some of their jobs entail front desk, property maintenance, one-on-one peer support, group facilitation, Peer Support Interning and other things to help the center run on a daily basis.
- SPIRIT provided 512 one-on-one peer support sessions during the year. SPIRIT's support group attendance was 859. SPIRIT provided 971 showers; 433 loads of laundry were also done. SPIRIT also assisted its participants with access and linkage to other community resources, provided assistance with completing applications to receive services from other agencies, and assisted with locating housing and jobs for participants. The program continues to provide food that is donated from The Food Bank of Nevada County. In FY 17/18 SPIRIT supplied 2,083 bags of food to participants.

- SPIRIT offered six Social activities per week, in addition to the regularly offered support groups and educational classes. The attendance in FY 17/18, to all of the Social Activities (Music and Movement, Restorative Yoga, Garden Project, Brunch, Beading for Wellness and Creative Expressions) was 1,742.
- Of the 200 surveys collected in the fourth quarter; 12% of participants showed an improvement in housing, 11% improved in Education/Life Skills/Coping Skills, 3% improved in number of hospitalizations, 1% improved in number of incarcerations, 61% improved in employment and 79% improved their prolonged suffering.
- Additional statistics from FY 17/18 are below:

SPIRIT Center Stats	**Year End Total FY 17/18**
Empower peers to engage in the highest level of work or productive activity appropriate:	
# of peers who obtained gainful employment	**71**
Peer Support training hours	**752**
# of people in SPIRIT sponsored structured educational class:	
- Advanced Peer Support	**90**
- Yoga WRAP	**145**
- WRAP	**79**
- Recovery, Goals and Life Skills	**174**
Other Data to be collected:	
New Participants	**227**
-New Participants that came to SPIRIT from the ED program	**83**
Fundraising efforts (Holiday Letter, donation jar, Flea Market)	**$ 3,976.72**
# of participants in the weekly Co-Occurring Diagnosis Group	**74**
Hours the Center was open	**1,280**

Challenges, Solutions, and Upcoming Changes

Finances continue to be the largest challenge SPIRIT faces, specifically, the inability to hire more Peer Supporters. A large percentage of participants (currently 65%) are homeless. The homeless participants take quite a bit more staffing resources than those participants who are housed. SPIRIT struggles with a lack of staff to handle the needs of both housed and un-housed participants in an effective way. SPIRIT continues to try to maximize their volunteer efforts to fill the gaps in staffing, and are actively researching grant opportunities for additional funding sources.

Program Participant Story

A recent participant told staff, if SPIRIT was not available as a place to go, and a place to be accepted, the participant would not have had the support needed to stay in recovery, and make the

positive changes needed to become employed. This participant is now employed, and attends SPIRIT educational classes to ensure they keep up the skills to stay employed and in recovery.

Prevention and Early Intervention (PEI)

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Gateway Mountain Center

Program Description

Program Overview

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

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

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

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

Target Population

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

Evaluation Activities and Outcomes

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

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

Gateway Mountain Center began its contract with Nevada County in March, 2017. During FY 2016-17, Gateway delivered services to four (4) participants. In FY 2017-18, that number increased to seven (7) participants. An increase in services delivered and number of contacts each youth received was seen with the increase in youth served. In FY 2016-17, three (3) youth had 11 or more contacts and in FY 2017-18, all seven (7) youth had 11 or more contacts with Gateway staff. See the tables below for more information.

	FY 2016-17			FY 2017-18		
Service Category	**# Hours**	**# Served**	**Average Hours per Participant**	**# Hours**	**# Served**	**Average Hours per Participant**
Collateral	1.3	2	**0.7**	-	-	**-**
Crisis Intervention	-	-	**-**	2.0	1	**2.0**
Family Team Meeting	1.7	2	**0.8**	2.0	1	**2.0**
Individual/ Family Therapy	-	-	**-**	63.4	1	**63.4**
Rehab./ Mental Health Services	145.0	4	**36.2**	754.1	7	**107.7**
Total (All Services)	**148.0**	**4**	**37.0**	**821.5**	**7**	**117.4**

	FY 2016-17		FY 2017-18	
Number of Service Contacts	**# Served**	**% Served**	**# Served**	**% Served**
1 Contact	-	-	-	-
2 – 10 Contacts	1	25.0%	-	-
11 - 20 Contacts	3	75.0%	2	28.6%
21 - 30 Contacts	-	-	2	28.6%
31 - 40 Contact	-	-	1	14.3%
41+ Contacts	-	-	2	28.6%
Unduplicated Participants	**4**	**100.0%**	**7**	**100.0%**

The YOQ was administered to all participants at the start of the program. However, there were no post-test data available for outcome analysis. Also, no referrals to outside agencies were made across the years.

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

Challenges, Solutions, and Upcoming Changes

The biggest challenges have come through Gateway's growth. Gateway has had to shift and build the processes in the organization and in the methods to accommodate its growth, while maintaining and building on services to youth. Gateway has increased the modes of contact used to work together in the organization and is changing some of the methods of working with families. An additional challenge is the growth of the team while staying mindful of Gateway's values and methods.

Gateway is increasing the number of trainings offered to staff, including expanding cultural and gender issues training, to help staff be aware of these issues and how they affect Gateway youth. Gateway is developing ways to ensure the integration of these trainings into the work being done with youth. In addition to increasing numbers and types of trainings, Gateway is increasing the frequency of mentor team meetings. These meetings facilitate mentor support of each other and help integrate the trainings into practice. As mentor staff become equipped with more skills, tools, and knowledge through support from each other, this will further add to the capacity of the team to support youth and meet their needs.

This fall Gateway is excited to be hosting a UC Davis Psychiatry resident on his final rotation. He is excited to experience Gateway's method, working both as an active rehabilitation specialist and as a clinical consult on the cases.

In order to maintain integrity and provide services to youth effectively, Gateway is researching new and more in-depth ways to evaluate interventions.

Program Participant Story

A program participant that Gateway has been working with for over a year clearly shows the impact the program can have on an individual. This youth had been diagnosed with a chronic mental disorder and lived with a single parent who has serious mental health issues.

This youth was experiencing isolation both in and out of school. The first priority for this youth's rehabilitation specialist was to establish a strong, authentic, and trusting relationship. This required learning how this youth communicates and interacts with the world. As the mentor began to understand this youth's unique way of showing up, his experience with the youth became very different from what he had read about the youth in clinical reports. The youth's greatest desire has been to be seen and accepted for who he is. After developing a strong bond and mutual understanding together, the mentor was able to get the youth to go on adventures, such as white water rafting and snowshoeing, allowing the youth to experience a different side of himself and see all of which he was capable. Through the mentor's ability to see and accept the youth, this youth is beginning to see and accept himself. Together, the mentor and the youth are working on ways for the youth to make friends and communicate whom he is to his peers while also connecting with them.

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH (NCBH)
Bilingual Early Intervention

Program Description

Program Overview

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

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

NCBH maintains good communication with these community agencies by:

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

Target Population

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

Evaluation Activities and Outcomes

The Bilingual Early Intervention Program collects demographic and service-level data through NCBH's Electronic Health Record (Cerner). NCBH is in the process of implementing Electronic Behavioral Health Solutions, a software and support product that will facilitate efficient quantitative data-gathering and aggregation of outcome measures.

During FY 2015-16, the program served 69 individuals. In FY 2016-17, that number decreased to 27 individuals. In FY 2017-18, the number decreased to 20 individuals. Over the years, the average number of hours each participant received services varied. In FY 2015-16, staff delivered

an average of 10.1 hours of service, in FY 2016-17, the average decreased to 6.7 hours, then in FY 2017-18, the average increased to 13.2 hours of service. Over the years, the majority of participants received five (5) or more services during the year. See the tables below for more information on services.

	FY 2015-16			FY 2016-17			FY 2017-18		
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	120.0	47	**2.6**	49.0	16	**3.1**	52.0	16	**3.3**
Individual/ Family Therapy	303.0	47	**6.4**	68.0	15	**4.5**	170.0	18	**9.4**
Rehab./ Mental Health Services	-	-	-	-	-	-	13.0	5	**2.6**
Case Management/ Linkage	129.0	34	**3.8**	42.0	17	**2.5**	19.0	7	**2.7**
Collateral	143.0	23	**6.2**	8.0	3	**2.7**	8.0	2	**4.0**
Crisis Services	-	-	-	-	-	-	1.0	1	**1.0**
Other	-	-	-	15.0	14	**1.1**	-	-	-
Total (All Services)	**695.0**	**69**	**10.1**	**182.0**	**27**	**6.7**	**263.0**	**20**	**13.2**

	FY 2015-16		FY 2016-17		FY 2017-18	
Number of Service Contacts	**Number of Participants**	**Percent of Participants**	**Number of Participants**	**Percent of Participants**	**Number of Participants**	**Percent of Participants**
1 Contacts	9	13.0%	2	7.4%	-	-
2 – 4 Contacts	17	24.6%	11	40.7%	3	15.0%
5 – 7 Contacts	13	18.8%	4	14.8%	3	15.0%
8+ Contacts	30	43.5%	10	37.0%	14	70.0%
Unduplicated Total	**69**	**100.0%**	**27**	**100.0%**	**20**	**100.0%**

In FY 2016-17, 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 goals.

Treatment Goals:	Percent Improvement	Percent No Improvement	Unknown
Reduce Anger	100%	0%	0%
Reduce Conflicts	100%	0%	0%
Increase Compliance	100%	0%	0%
Reduce Intrusive Memories	100%	0%	0%
Reduce Psychological Reactivity	100%	0%	0%
Reduce Guilt	100%	0%	0%
Increase Interest in Activities	100%	0%	0%
Increase Energy	100%	0%	0%
Reduce Hearing Voices	100%	0%	0%
Increase Sleep	100%	0%	0%
Reduce sadness/ depressed mood	83%	6%	11%
Reduced Anxiety/ Worry	82%	0%	18%
Reduced Panic Attacks	80%	0%	20%
Reduce Guarding for Danger	75%	0%	25%
Unknown	0%	0%	100%

In FY 2017-18, anecdotal outcomes from descriptions of treatment goals and progress by the therapists show that most participants who stay in the program are working towards their treatment goals: reducing negative thoughts and emotion, approaching situations that they typically avoid, and sleeping regularly, among other specific goals.

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 to live here, 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 third 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.

Program Participant Story

A participant in the program had a history of physical abuse. At intake, she said she had been under a lot of stress, to the point where she had lost her appetite, often could not sleep, and had gone to the emergency room due to her stress. She was at a difficult crossroads in her life.

Treatment was based on Person-Centered Therapy, which emphasizes active listening so that the person has sufficient psychological space to clarify thinking and better recognize her own values and preferences. Through this process, the participant was able to set strong boundaries with family who had been taking advantage of her. Two (2) months after treatment started, the participant's symptoms were much improved.

The participant completed the Basis-24 at the beginning and at the end of services. According to the Basis-24, the participant's feelings of sadness and anger reduced. In addition, the participant's difficulty in managing day-to-day life, and difficulty coping with problems also reduced. These improvements were sustained at a follow-up check-in after services. At that time, the participant was still doing well.

PEI Project Name: Early Intervention Program

NEVADA COUNTY PUBLIC HEALTH
Moving Beyond Depression - Every Child Succeeds

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 NCBH.

MBD is in partnership with home visitation programs in Nevada County: Foothills-Truckee Healthy Babies (FTHB), Early Head Start, the Young Parents Program of the Nevada Joint Union High School District, the STEPP Program of TTUSD, and the Nevada County Maternal-Child Public Health Nurses.

Target Population

This program is designed to meet the needs of low-income, underserved women who are enrolled in a home visitation program in Nevada County and who are experiencing 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 person 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 electronic data capture tools hosted at NCBH[1]. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources.

During FY 2015-16, MBD delivered services to 16 unduplicated participants. In FY 2016-17, that number slightly increased to 17 participants. During FY 2017-18, the number increased again to 25 unduplicated participants. 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 2015-16		**FY 2016-17**		**FY 2017-18**	
Number of Sessions	**# Served**	**% Served**	**# Served**	**% Served**	**# Served**	**% Served**
1 Session	2	12.5%	-	-	1	4.0%
2 – 7 Sessions	2	12.5%	-	-	5	20.0%
7 – 15 Sessions	6	37.5%	13	76.5%	6	24.0%
16+ Sessions	6	37.5%	4	23.5%	13	52.0%
Unduplicated Total	**16**	**100.0%**	**17**	**100.0%**	**25**	**100.0%**

During FY 2017-18, MBD made three (3) referrals to NCBH. All three (3) successfully connected with NCBH. No referrals were made in the previous years.

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

Participants who complete two (2) or more EPDS assessments showed improvement, overall, in their symptoms. Across the years, responses indicated that between 91.7% and 100% of participants had fewer symptoms of depression after receiving services. Across the years, 50% to 100% of participants who completed the ISEL-SF at intake to and completion of the program perceived better social support after services. See the tables below for more information.

	FY 2015-16		**FY 2016-17**		**FY 2017-18**	
	% Improved	**N**	**% Improved**	**N**	**% Improved**	**N**
Edinburgh Postnatal Depression Scale (EPDS) Pre to Post	92.3%	13	100.0%	17	91.7%	24
Interpersonal Support Evaluation List - Short Form (ISEL-SF) Pre to Post	100.0%	5	50.0%	4	100.0%	5

In addition, the Participant Perception of Care survey was administered in FY 2016-17 and FY 2017-18. Responses indicated better social functioning at completion of the program. See the table below for more perception of care information.

	FY 2016-17		FY 2017-18	
Participant Perception of Care Survey	**% Agree**	**N**	**% Agree**	**N**
I am getting along better with my family.	100.0%	3	66.7%	3
I do better in school and/or work.	-	2	66.7%	3
My housing situation has improved.	33.3%	3	100.0%	1
I am better able to do things that I want to do.	100.0%	3	100.0%	3
I am better able to deal with crisis.	100.0%	3	100.0%	3
I do better in social situations.	66.7%	3	100.0%	3
I have people with whom I can do positive things.	100.0%	3	100.0%	3
I do things that are more meaningful to me.	100.0%	3	100.0%	3
I have learned to use coping mechanisms other than alcohol and/or other drugs.	100.0%	3	100.0%	3
In a crisis, I would have the support I need from family or friends.	66.7%	3	100.0%	3
Staff welcome me and treat me with respect.	100.0%	3	100.0%	3
Staff are sensitive to my cultural background.	33.3%	3	100.0%	3
Average/ Total Surveys Submitted	**77.1%**	**3**	**94.1%**	**3**

It is important to note that through providing mothers with IH-CBT, the positive effects of the therapy are felt by the whole family. All of the mothers who receive services in this program have at least one child, and many have several children. These mothers have reached out for help with their mental health and this work helps them function better within the family and acts as early intervention and prevention of negative downstream consequences for their children.

Challenges, Solutions, and Upcoming Changes

The Eastern side of the county (e.g., Truckee) is still without a bilingual MBD therapist. Western county therapists have only a limited capacity to serve the families in the eastern part of the county. During the winter months, the Donner Summit/I-80 area is often unpassable. During this time, MBD refers Truckee families to alternate services for their mental health needs.

Referrals to MBD tend to ebb and flow. The first two (2) months of the year, there was a decline in referrals. By October, the therapists were at capacity and had to triage participants through another program, Project Launch, and place them on a waiting list. Wait times were approximately three (3) weeks.

The MBD program coordinator retired at the beginning of the fiscal year and was not officially replaced until October. This created a lack of continuity in the program. With the new coordinator, however, some of the tracking mechanisms have been automated enabling more efficiencies in the program.

Local obstetrics (OB) providers are becoming more familiar with the MBD program, incorporating universal screening of their pregnant moms in their practices, and making referrals to the program.

Program Participant Story

After successfully completing the MBD program, a mom referred another mom to the program. The Maternal Child Adolescent Health (MCAH) Public Health Nurse (PHN) provided all home visits. The mom accepted enrollment in the MBD program. During one of the home visits, the mom experienced an acute psychiatric crisis and the PHN worked with the mom to get urgent help. The mom stated that she would not have reached out or opened up if not for the fact that she has been working with the MBD therapist on self-care and learning that it is ok to ask for help. The mom was able to be linked with a primary care provider who is treating her clinically for depression. The mom stated that she felt she really needed the medical treatment, but would not have had the nerve to ask for it if it were not for the encouragement of her home visitation PHN and her MBD therapist. Mom completed therapy and feels that she is a better communicator with her husband and has learned more meaningful self-care, which allows her to be a better mother. She stated that she is becoming the mother that she has always wanted to be. This mother's story highlights how the services provided by the MBD program have lasting effects on the whole family through providing moms with the resources they need.

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Homeless Early Intervention Services

Program Description

Program Overview

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

Target Population

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

Evaluation Activities and Outcomes

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

The Early Intervention position was staffed in late 2015, so data collection did not begin until early 2016. Thus, FY 2015-16 services only reflect about six (6) months of services.

During FY 2015-16, staff delivered services to 44 unduplicated participants. In FY 2016-17, that number increased to 98 unduplicated participants, then in FY 2017-18, the number slightly decreased to 93 participants. See the tables below for more detailed service information.

	FY 2015-16			FY 2016-17			FY 2017-18		
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	-	-	-	-	-	-	2.0	1	**2.0**
Individual/ Family Therapy	116.3	44	**2.6**	423.7	98	**4.3**	331.7	93	**3.6**
Total (All Services)	**116.3**	**44**	**2.6**	**423.7**	**98**	**4.3**	**333.7**	**93**	**3.6**

	FY 2015-16		FY 2016-17		FY 2017-18	
Number of Service Contacts	**Number Served**	**Percent of Served**	**Number Served**	**Percent of Served**	**Number Served**	**Percent of Served**
1 Contact	15	34.1%	42	42.9%	37	39.8%
2 – 4 Contacts	20	45.5%	31	31.6%	35	37.6%
5 – 7 Contacts	8	18.2%	9	9.2%	8	8.6%
8+ Contacts	1	2.3%	16	16.3%	13	14.0%
Unduplicated Total	**44**	**100.0%**	**98**	**100.0%**	**93**	**100.0%**

During FY 2015-16, staff made a total of 60 referrals to outside agencies. In FY 2016-17, that number decreased to 22 referrals. In FY 2017-18, staff made 48 referrals to outside agencies. Across the years, between 27.3% and 43.8% of these referrals successfully connected with the agency. In FY 2017-18, information on timeliness of the referrals was collected. Of those that connected, the average time from referral to date of appointment with the agency was 0.9 days. In other words, most connections were made the same day as the referral, or one day later (i.e., zero (0) or one (1) day). See the table below for more detailed referral information.

	FY 2015-16			FY 2016-17			FY 2017-18			
Agency	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**	**Average Timeliness***
A New Day	3	0	**0.0%**	-	-	-	-	-	-	-
Chapa De	5	0	**0.0%**	2	0	**0.0%**	6	1	**16.7%**	**2.0**
Common Goals	-	-	-	1	0	**0.0%**	2	0	**0.0%**	**N/A**
CoRR	3	1	**33.3%**	1	0	**0.0%**	2	0	**0.0%**	**N/A**
Crisis Stabilization Unit	7	4	**57.1%**	2	1	**50.0%**	5	4	**80.0%**	**0.0**
Cultural-Specific Services	1	0	**0.0%**	-	-	-	-	-	-	-
Community Beyond Violence	-	-	-	1	0	**0.0%**	2	1	**50.0%**	**Unknown**
FREED	-	-	-	-	-	-	2	0	**0.0%**	**N/A**
Human Services (Benefits)	1	1	**100.0%**	-	-	-	1	1	**100.0%**	**Unknown**
In-home Support Services	1	1	**100.0%**	-	-	-	1	0	**0.0%**	**N/A**
Insight Respite House	-	-	-	1	0	**0.0%**	1	0	**0.0%**	**N/A**
Mental Health	10	5	**50.0%**	3	2	**66.7%**	7	7	**100.0%**	**0.8**
Partner Agency	1	1	**100.0%**	-	-	-	-	-	-	-
Physician/ MD	2	1	**50.0%**	1	0	**0.0%**	1	0	**0.0%**	**N/A**
Sierra Nevada Memorial Hospital	-	-	-	1	0	**0.0%**	-	-	-	-
Social Services Agency	1	1	**100.0%**	-	-	-	-	-	-	-
School/ Training Program	1	0	**0.0%**	-	-	-	-	-	-	-
SPIRIT	12	4	**33.3%**	3	1	**33.3%**	2	0	**0.0%**	**N/A**
Therapist/ Psychiatrist (Private)	5	4	**80.0%**	5	2	**40.0%**	9	3	**33.3%**	**7.0**
Western Sierra Medical Clinic	6	0	**0.0%**	1	0	**0.0%**	3	1	**33.3%**	**0.0**
Other	1	1	**100.0%**	-	-	-	4	3	**75.0%**	**0.3**
Total Referrals	**60**	**24**	**40.0%**	**22**	**6**	**27.3%**	**48**	**21**	**43.8%**	**0.9**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. Timeliness was not collected before FY 2017-18. Unknown averages are due to dates of referral and/or dates of appointment being unavailable. The average is not calculated for referrals that did not connect.

Staff makes outreach visits to the Hospitality House shelter regularly. Many times it takes multiple contacts with the same individual before the individual agrees to participate in the program or staff determines the individual is appropriate for the program. During FY 2015-16, staff made 56 visits to the shelter in order to outreach to Shelter Guests. During these visits, staff made 127 contacts with guests. In FY 2016-17, staff made 157 visits, for a total of 442 contacts with guests. In FY 2017-18 staff made 138 outreach visits at the shelter, for a total of 362 contacts with Shelter Guests. See the table below for more detailed outreach information.

Shelter Outreach	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**
# Visits	56	157	138
# Contacts	127	442	362
Average Contacts per Visit	**2.3**	**2.8**	**2.6**

Challenges, Solutions, and Upcoming Changes

Challenges include unknown outcomes for participants, lack of continuity of services for participants, and lack of follow-through by participants. These difficulties are due to, or exacerbated by, the fact that participants are a transient population. Other challenges include drug and alcohol issues for many of the participants, resulting in more varied outcomes, difficulty with participant follow-through, instability, and difficulties in ability to make use of services offered.

Some solutions include finding additional supports for the program with outreach and case management and networking with community supports. Use of brief assessment tools to screen for mental health, physical health, and substance use issues helps staff understand the needs of the participants and connect them quickly to appropriate services. The current staff has been in the position for close to three (3) years, which has allowed for knowledge of and the ability to build relationships with the homeless population. The longevity of this program has been of benefit to the homeless population of Nevada County.

Upcoming changes include streamlining processes and collaboration with the Turning Point personnel. This will allow staff to conduct more intake assessments, facilitating assistance to more homeless individuals to obtain needed mental health treatment.

Program Participant Story

A person with untreated mental health issues who had been homeless and abusing alcohol and drugs for many years attempted to shelter at Hospitality House many times. Due to being under the influence of drugs or alcohol, the individual was unable to shelter at Hospitality House much of the time. This person was given food, clothing, and sleeping items. The individual had many arrests and run-ins with law enforcement due to public intoxication. This person had fractured relationships with family and no real support system.

After being released from a several month stay in jail, this person came back to Hospitality House. The individual was able to shelter due to being drug and alcohol free. Within days, the individual was assessed and accepted for services at NCBH. Outreach and Case Management provided support and transportation for the individual to make appointments at NCBH. The individual started medication with positive response for the untreated mental health issues and started going to outpatient treatment for substance abuse. The individual has had one brief relapse, but quickly got back on track and back into Hospitality House. The Behavioral Health therapist, the Case Manager, and Shelter staff provided daily support and encouragement. With assistance, this person applied for and obtained SSDI. With income, sobriety, medication adherence, stability, and ongoing access to counseling and support from shelter staff, the individual was able to work with the Housing Coordinator at Hospitality House and is currently days away from moving into a shared housing situation. The house is overseen by the Housing Coordinator who provides support in the form of house meetings, rules compliance, and contact, so this person will get continued housing support.

PEI Project Name: Early Intervention Program

SIERRA FOREVER FAMILIES

Program Description

Program Overview

Sierra Forever Families (SFF) provides comprehensive specialty mental health services for children and their families throughout Nevada County. There are three (3) specialized programs available to program participants: Destination Family (DF), which seeks to identify permanent connections to children in congregate care; Family Preservation (FP), which seeks to provide family stability to families who have children who are at risk of removal from their home or at risk of Child Protective Services (CPS) 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.

SFF began contracting with Nevada County for PEI services in July 2017.

Target Population

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

Evaluation Activities and Outcomes

SFF collects demographic and service-level data for participants of programming. In addition, the Child and Adolescent Needs and Strengths (CANS) is collected at intake, periodically, and at discharge from the program. SFF began Nevada County PEI services in July 2017.

During FY 2017-18, the first year of services for SFF, 104 youth received services, with an average of 49.4 services per participant. Most participants (81.7%) received eight (8) or more contacts during the fiscal year. See the tables below for more information.

	FY 2017-18		
Service Category	**# Services**	**# Participants**	**Average Services per Participant**
Assessment	181	54	**3.4**
Case Management Brokerage	1,052	81	**13.0**
Collateral	1,287	85	**15.1**
Individual Rehab	324	41	**7.9**
Individual Therapy	1,723	87	**19.8**
Intensive Care Coord – KTA	214	23	**9.3**
Intensive Home-Based Serv - KTA	217	18	**12.1**
Plan Development	139	68	**2.0**
Total (All Services)	**5,137**	**104**	**49.4**

	FY 2017-18	
Number of Service Contacts	**# Participants**	**% Participants**
1 Contact	4	3.8%
2 – 4 Contacts	11	10.6%
5 – 7 Contacts	4	3.8%
8+ Contacts	85	81.7%
Unduplicated Total	**104**	**100.0%**

The table below describes goals and outcomes of the 104 unduplicated youth assessed using the CANS. Overall, youth showed positive outcomes across many domains.

		FY 2017-18
		N = 104
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*	**98%** of youth stabilized at home or in foster care
Youth will be out of legal trouble.	*At least **70%** of youth will have no new legal involvement between admission and discharge*	**100%** of youth had no new legal involved
Youth will improve academic performance.	*At least **80%** of parents will report youth maintained a C average or improved on their academic performance.*	**91%** 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.*	**95%** 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.*	**95%** of youth had no new suspensions or expulsions
Caregivers with strengthen their parenting skills	*At least **80%** of parents will report an increase in their parenting skills.*	**89%** of parents increased parenting skills
Every child establishes, reestablishes, or reinforces a lifelong relationship with a caring adult.	*At least **65%** of children served will be able to identify at least one lifelong contact.*	**100%** of youth are able to identify one lifelong contact
Caregivers will improve connections to the community	*At least **75%** of caregivers will report maintaining or increasing connection to natural supports.*	**94%** maintained or increased connections to natural supports

A total of 25 youth completed a discharge questionnaire, listing the reason for leaving the program. Most of the youth (68%) were discharged due to meeting the goals outlined for participation in the program. See the table below for more information.

	FY 2017-18	
Discharge Reason	**# Participants**	**% Participants**
Goals Met	17	68.0%
Goals Partially Met	2	8.0%
Person Left Program/ Did Not Complete Program	2	8.0%
Person Moved	3	12.0%
Unknown	1	4.0%
Unduplicated Total	**25**	**100.0%**

Challenges, Solutions, and Upcoming Changes

Ongoing challenges are the lack of an electronic health record for these programs. The online database system currently used by SFF continues to have limitations regarding efficient data collection. With the move to Anasazi in July 2018, SFF is hoping to streamline the data collection process to extract data and submit it more readily and easily. However, SFF continues to utilize its own internal online database for additional data that cannot be entered into Anasazi. Having two systems creates the potential for making more errors.

Program Participant Story

SFF received a referral for a youth whose parents expressed concern over the youth's coping after losing their home. During the course of treatment, the youth experienced more trauma. The youth's teachers, school staff, and parents were very concerned about the youth's deteriorating mood and elevated anxiety. Through therapeutic intervention, the youth was able to identify that one goal they had was to secure housing in an area where they could complete the academic year at the same school. The therapist and the youth worked to improve the youth's sense of hopelessness and loss as well as to look forward and secure housing to satisfy the need for continuity. With the help of the therapist, the youth learned to be resourceful and resilient and was able to secure housing. The youth is living with a "host" family for the next school year. The youth has been able to negotiate between the two families: their expectations, rules and needs. A family support specialist also helped the youth's biological parent to embrace this situation and supported the parent to be actively involved in supporting the youth. The youth's symptoms and behaviors have improved dramatically, and the youth looks forward to the next academic year with the typical expectations and concerns of a teenager.

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

WHAT'S UP WELLNESS CHECKUPS
Mental Health First Aid

Program Description

Program Overview

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

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

Target Population

The target population is first responder service providers and other interested community members.

Evaluation Activities and Outcomes

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

Across the years, MHFA has one (1) to three (3) trainings per year, with an average attendance of 13 to 27 participants per training. See the table below for more information.

	FY 2015-16	**FY 2016-17**	**FY 2017-18**
# Trainings	3	2	1
Attendance	39	54	13
Avg. Attendance/Training	**13.0**	**27.0**	**13.0**

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

MHFA Post-Training Evaluation Items	**FY 2015-16**	**FY 2016-17**	**FY 2017-18***	
I feel more confident that I can recognize the signs that someone may be dealing with a mental health problem/challenge or crisis.	100.0%	100.0%	60.0%	100.0%
I feel more confident that I can reach out to someone/a youth who may be dealing with a mental health problem/challenge or crisis.	100.0%	95.7%	40.0%	100.0%
I feel more confident that I can ask a person/young person whether s/he is considering killing her/himself.	100.0%	100.0%	50.0%	100.0%
I feel more confident that I can actively and compassionately listen to someone/a young person in distress.	100.0%	100.0%	80.0%	100.0%
I feel more confident that I can offer a distressed person/young person basic "first aid" level information and reassurance about mental health problems.	100.0%	95.7%	40.0%	100.0%
I feel more confident that I can assist a person who may be dealing with a mental health problem or crisis to seek professional help.	100.0%	100.0%	70.0%	100.0%
I feel more confident that I can assist a person/young person who may be dealing with a mental health problem or crisis to connect with community, peer, and personal supports.	100.0%	100.0%	70.0%	100.0%
I feel more confident that I can be aware of my own views and feelings about mental health problems and disorders.	100.0%	95.7%	80.0%	100.0%
Total Surveys Submitted	**N = 28**	**N = 23**	**N = 12**	

*Beginning in FY 2017-18, responses from pre- and post-training were collected.

Challenges, Solutions, and Upcoming Changes

Challenges for this program include the expectations of MHFA – USA for their instructors and the county. The requirement is for each instructor to conduct a minimum of three (3) workshops per year. Each workshop is led by a maximum of two (2) instructors. When the county has only two (2) instructors, then three (3) workshops are offered per year. However, when the county has, for example, four (4) instructors, MHFA was expected to offer six (6) workshops. In addition, the most cost-effective way to run workshops is to have attendance near or at capacity (20

participants), which also allows for effective group interaction. However, meeting this base standard, while running workshops at capacity is especially challenging for rural communities who have a smaller participant market to draw from. In addition, MHFA – USA instructor support is extremely limited.

One change to help with this challenge was contracting the MHFA training out to a non-county provider, What's Up? Wellness Checkups (WUWC). FY 2017-18 was the first year that the WUWC provided the MHFA training.

Program Participant Story

Participant comments about the training:

- "Great information, important"
- "Really enjoyed it"
- "Glad I went"
- "Good for community members"

PEI Project Name: Prevention Program

TURNING POINT
Hospitality House and Turning Point Housing Assistance

Program Description

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

The Housing Assistance Program began services in April 2018.

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

Evaluation Activities and Outcomes

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

The Housing Assistance Program served 75 unduplicated participants from April to June 2018. Of those participants, 69 received an individual service, such as Case Management/ Linkage or Housing Services. Participants received services for a total of 173 hours, for an average of 2.5 hours per participant. Most participants received between one (1) and four (4) services (75%). See the tables below for more information on individual services delivered.

Service Category	# Hours	# Served	Average Hours per Participant
Case Management/ Linkage	151.7	65	**2.3**
Housing Services	7.0	3	**2.3**
Crisis Intervention	5.8	5	**1.2**
Other	8.5	8	**1.1**
Total (All Services)	**173.0**	**69**	**2.5**

Number of Service Contacts*	# Served	% Served
1 Contact	21	30.4%
2 – 4 Contacts	31	44.9%
5 – 7 Contacts	9	13.0%
8+ Contacts	8	11.6%
Unduplicated Participants	**69**	**100.0%**

Staff made a total of 87 referrals to outside agencies. Of these referrals, 51 (59%) connected to the outside agency. Of those that connected, the average time from referral to date of appointment with the agency was 4.5 days. A significant number of referrals (12) were marked "Other." Examples of these are referrals to AA Meetings, CAL Fresh, and Transportation. See the table below for more referral information.

Agency	# Referrals	# Connected	% Connected	Average Timeliness*
211	2	2	**100.0%**	**0.0**
Chapa De	9	6	**66.7%**	**9.3**
Child Welfare Services (CWS)	1	0	**0.0%**	**N/A**
CoRR	1	0	**0.0%**	**N/A**
Crisis Stabilization Unit	1	1	**100.0%**	**0.0**
Community Beyond Violence	2	1	**50.0%**	**0.0**
Employment/ CalWORKs	2	2	**100.0%**	**2.0**
Faith-Based Organization	1	1	**100.0%**	**Unknown**
Family Resource Center	1	0	**0.0%**	**N/A**
Financial Assistance	3	3	**100.0%**	**0.0**
Human Services (Benefits)	11	8	**72.7%**	**3.3**
In-Home Support Services (IHSS)	1	1	**100.0%**	**1.0**
Insight Respite House	1	0	**0.0%**	**N/A**
Legal Services	4	4	**100.0%**	**7.0**
Mental Health	8	3	**37.5%**	**18.0**
Physician/ MD	6	2	**33.3%**	**4.0**
Social Services Agency	7	4	**57.1%**	**5.5**
SPIRIT	5	4	**80.0%**	**0.3**
Therapist/ Psychiatrist (Private)	3	0	**0.0%**	**N/A**
Veteran Services	1	0	**0.0%**	**N/A**
Western Sierra Medical Clinic	5	2	**40.0%**	**8.0**
Other	12	7	**58.3%**	**0.4**
Total Referrals Connected	**87**	**51**	**58.6%**	**4.5**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. Timeliness was not collected before FY 2017-18. Unknown averages due to dates of referral and/or dates of appointment being unavailable. Average not applicable for referrals that did not connect.

Housing Assistance case managers had one (1) outreach event from April to June 2018 to an estimated total of 220 contacts. Staff set up a booth at the Food Bank to educate community members about CalFresh and Medi-Cal.

In all, 13 participants were discharged from the Housing Assistance program from April to June 2018. Of those discharged, 62% indicated that their goals for the program had been completely or partially met. See the table below for more detailed discharge information.

Discharge Reason*	# Served	% Served
Goals Met	6	46.2%
Goals Partially Met	2	15.4%
Person Left Program/ Did Not Complete Program	3	23.1%
Referred to Another Program	2	15.4%
Person Moved	8	61.5%
Unduplicated Total	**13**	**100.0%**

Note: Participants may have more than one Discharge Reason

Participants who are discharged from the program are asked to complete a Participant Perception of Care survey. Eleven (11) discharged participants completed the survey, with a mostly positive response. Overall 87% of respondents agreed that the Housing Assistance Program had a positive impact on their lives and that the program staff was sensitive to their needs. See the table below for more detailed perception of care information.

Participant Perception of Care Survey	Agree	Neutral	Disagree	N
My housing situation has improved	80.0%	20.0%	-	10
I am better able to do things that I want to do.	90.9%	9.1%	-	11
I have people who I can go to for support.	100.0%	-	-	11
Staff welcome me and treat me with respect.	90.9%	9.1%	-	11
Staff are sensitive to my cultural background.	90.0%	10.0%	-	10
Average (All Responses) / Total Surveys Submitted	**87.3%**	**9.1%**	-	**11**

Challenges, Solutions, and Upcoming Changes

Hiring qualified staff for this program took time; when the candidate was identified and finally hired, only three (3) months remained in the fiscal year. While training for HMIS and Anasazi began as soon as possible, challenges surfaced around establishing training schedules. Ongoing HMIS training and monthly Anasazi training have helped to keep staff trained and accountable for data entry. Monthly audits of data entry has also been a useful tool in improving the process.

Program Participant Story

Two (2) long-term, married Hospitality House participants had participated in the Ready to Rent classes. They worked to identify their barriers to and needs for housing. Working with this couple, the Housing Assistance staff was able to identify the Advocates for Mentally Ill Housing (AMIH) as a fit for them. AMIH is supportive, yet the couple would be able to maintain their independence

working with AMIH. They applied for and secured a 1-bedroom apartment with AMIH. They both have income and one person from the couple has been doing work in the community. Their apartment is beautiful, well put together, and they are happy. The couple has expressed how grateful they are for this opportunity.

PEI Project Name: Prevention Program

FREED
Friendly Visitor Program

Program Description

Program Overview

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

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

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

Target Population

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

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

Evaluation Activities and Outcomes

The FREED Friendly Visitor Program provided services to 48 individuals during FY 2015-16, 30 individuals during FY 2016-17, and 42 individuals during FY 2017-18. FREED continually recruits new volunteers each year to maintain a pool of about 30 volunteers. Harsh winters make it difficult to match individuals in Truckee, but efforts made to match resulted in between one (1)

and two (2) matches made in Truckee over the fiscal years. FREED volunteers visited with participants for a total of 1,509 hours in FY 2015-16, 1,222 hours in FY 2016-17, and 1,453 hours in FY 2017-18. See the table below for more detailed services information.

	FY 2015-16	**FY 2016-17**	**FY 2017-18**
Number of Hours	1,509	1,222	1,453
Unduplicated Participants	48	30	42
Average Hours per Participant	**31.4**	**40.7**	**34.6**

During FY 2015-16, volunteers referred participants to outside agencies a total of 23 times. During FY 2016-17, there were 14 referrals, and during FY 2017-18, there were 16 referrals to outside agencies.

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 2016-17, there were six (6) training/ support groups for volunteers. During FY 2017-18, there were seven (7) training/ support groups for volunteers. Topics included: Identifying Signs of Depression and Anxiety; Drug and Alcohol Abuse Among the Elderly; Suicide Prevention; and Communication with People with Dementia.

A year-end survey was conducted with all volunteers each year. All (100%) of those who responded know what the signs of depression and anxiety are and feel comfortable discussing them with the person they visit. If they saw signs of suicidal thoughts, 100% felt comfortable talking directly with the person or contacting the Program coordinator to discuss their concerns. Some volunteers during FY 2015-16 felt a need for further training to help identify signs of these issues, as well as learning how to deal with dementia, grief, and documenting family history, which was addressed in the following years.

The FREED Friendly Visitor Program conducted 28 outreach events with an estimated attendance of 1,315 individuals during FY 2016-17. During FY 2017-18, FREED conducted 31 outreach events with an estimated attendance of 1,823 individuals. In addition, brochures with information about the program were distributed to various locations.

Challenges, Solutions, and Upcoming Changes

It is a challenge to keep up with all of the documentation required for the program when it has become such a robust program. There are a number of referrals, in any given week, which requires additional follow-up time. Most are time sensitive, if not urgent, and often require additional home

visits. To address this challenge, the Program Coordinator is reorganizing to allow for more documentation time on a weekly basis to be able to keep current with data input.

The Partnership with the new Social Outreach Coordinator is flourishing and making a big difference in the number of referrals that are received. The Coordinator is a delight to collaborate with and together the two (2) programs are working hand-in-hand to support isolated individuals and improve mental health.

With the help of a front-page article in the Union and extensive outreach, particularly in the south county area, the program was able to recruit a record number of volunteers, which has been wonderful!

It has been a perfect complementary service to coordinate the Phone Reassurance Program alongside the Friendly Visitor Program. There are many crossovers as well as people getting calls while they are waiting for a match.

Outreach to recruit volunteers will continue, as well as work collaborating with 211 Connecting Point.

In sum, this last fiscal year was extremely successful in getting referrals, training volunteers, and making matches. It was encouraging to see the results of the year-end surveys and to hear what a difference is being made in the lives of participants and volunteers.

Program Participant Story

The Friendly Visitor Program received a referral from the Social Outreach Coordinator for a person who was living alone and isolated. Although the person was fairly healthy, the person was no longer driving and was unable to have the social contact that this person once loved.

This person was matched up with a volunteer who made regular visits. After a short time, this person's depressive symptoms decreased and the person indicated feeling much more interested in life, in general. The volunteer was also visiting someone else in that same neighborhood and invited the two to meet each other. After meeting, their relationship has organically evolved and the two (2) are now good friends. Now, on top of each of these participants receiving their own weekly visit, they also have a time for all three of them to get together. The volunteer picks up one (1) participant and they meet at the other person's home.

What a difference it has made in their lives to have a caring community member spend time weekly with them.

PEI Project Name: Prevention Program

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
Wellness Program

Program Description

Program Overview

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

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

Key Focus Areas include:

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

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

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

The TTUSD Wellness Centers offer three types of programming.

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

Wellness Center Locations and Hours:

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

Target Population

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

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

Evaluation Activities and Outcomes

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

Over the years, TTUSD Wellness Centers has offered formal groups and informal clubs. The formal groups require more commitment on the part of the student, to attend and to complete sign-ins and demographic forms. The unduplicated number of students who attended groups across the years has increased: in FY 2015-16, 95 students attended, in FY 2016-17, 121 students attended, and in FY 2017-18, 124 students attended formal groups. Clubs are less formal and only require a sign-in from students.

Some examples of groups are: Girls Empowerment, Boys Empowerment, and Link Crew (new group in FY 2017-18). Some examples of clubs are: Body Image, Girls Relationship, One Another Project, Peer Mentors, PRIDE, Sexual and Gender Acceptance, and Teens Offer Peer Support (TOPS).

The groups and clubs have increased their offerings and attendance over the years, from 53 meetings to 244 meetings. See the table below for more information.

Groups or Clubs	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**
# Meetings	53	189	244
Attendance	652	2,188	4,311
Avg. Attendance/Meeting	**12.3**	**11.6**	**17.7**

Note: Attendees are a duplicated count of students. Students sign in each time they attend a group or club meeting.

In addition, the Drop-In center increased its open days and attendance over the years, from 66 open days to 193 open days. See the table below for more information.

		FY 2015-16	**FY 2016-17**	**FY 2017-18**
North Tahoe High	# Attendees	1,130	3,340	3,848
	# Days Available	43	149	141
	Avg. Attendees/Day	26	22	27
Truckee High	# Attendees	881	3,939	8,907
	# Days Available	23	125	186
	Avg. Attendees/Day	38	32	48
Both Schools	**# Attendees**	**2,011**	**7,279**	**12,755**
	# Days Available	**66**	**168**	**193**
	Avg. Attendees/Day	**30**	**43**	**66**

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

During FY 2016-17, TTUSD Wellness Centers made 91 referrals to outside agencies, with 71 successfully connecting. In FY 2017-18, the Wellness Centers made 45 referrals, with 31 successfully connecting. No referrals were recorded in FY 2015-16. See the table below for more information.

	FY 2016-17			FY 2017-18		
Agencies	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**
Adventure Risk Challenge	14	12	**85.7%**	1	1	**100.0%**
Child Welfare Services (CWS/ CPS)	16	15	**93.8%**	4	3	**75.0%**
Family Resource Center	2	0	**0.0%**	1	0	**0.0%**
Gateway Mountain Center	-	-	-	1	1	**100.0%**
Mental Health	-	-	-	8	8	**100.0%**
Partner Agency	-	-	-	2	1	**50.0%**
Physician/ MD	-	-	-	1	1	**100.0%**
Social Services Agency	-	-	-	2	1	**50.0%**
Tahoe SAFE Alliance	8	6	**75.0%**	4	3	**75.0%**
Therapist/ Psychiatrist (Private)	51	38	**74.5%**	10	5	**50.0%**
Other	-	-	-	11	7	**63.6%**
Total Referrals Connected	**91**	**71**	**78.0%**	**45**	**31**	**68.9%**

The Wellness Centers had between 31 and 59 outreach events over the fiscal years, reaching estimated audiences of 2,180 to 3,786 individuals. See the table below for more information.

	FY 2015-16	FY 2016-17	FY 2017-18
Number of Outreach Events	59	31	54
Estimated Attendance	3,786	2,228	2,180
Average Attendance per Event	**64.2**	**71.9**	**40.4**

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

TTUSD began administering the Social Emotional Assets and Resiliency Scale (SEARS) to participants in FY 2016-17. There were 18 participants who had a pre- and a post-measure for the SEARS in FY 2016-17 and in FY 2017-18, 15 participants had both measurements. All (100%) of participants scored in the "Average to high functioning" category of the SEARS across both years.

The Peer Mentor Training collected surveys assessing attitudes toward mental health during FY 2016-17. During FY 2017-18, the Link Crew Training collected surveys assessing the training goals. Overall, the outcomes of both years were positive. See the tables below for more information.

Attitude Survey FY 2016-17	Before attending		After attending		Attitude Change
	% Agree	N	% Agree	N	%
I believe that a person who has a mental illness can eventually recover	75.0%	28	75.0%	28	**0.0%**
I know how to support a person who has a mental illness	24.1%	29	78.6%	28	**54.4%**
I plan to take action to prevent discrimination against people who have a mental illness	69.0%	29	92.9%	28	**23.9%**
People who have a mental illness experience high levels of prejudice and discrimination	82.8%	29	78.6%	28	**-4.2%**
	% Disagree	N	% Disagree	N	%
I believe that a person who has a mental illness is a danger to others	69.0%	29	71.4%	28	**2.5%**
People who have had a mental illness are never going to be able to contribute to society	89.7%	29	96.4%	28	**6.8%**
	% Never	N	% Never	N	%
Imagine that you had a problem that needed to be treated by a mental health professional. Would you deliberately conceal your mental illness from your friends or family?	10.3%	29	57.1%	28	**46.8%**
Imagine that you had a problem that needed to be treated by a mental health professional. Would you deliberately conceal your mental illness from others?	10.3%	29	42.9%	28	**32.5%**
Imagine that you had a problem that needed to be treated by a mental health professional. Would you deliberately conceal your mental illness from your friends or family?	17.2%	29	60.7%	28	**43.5%**
If someone in your family had a mental illness, would you feel ashamed if people knew about it?	55.2%	29	75.0%	28	**19.8%**
	% Always	N	% Always	N	%
If you had a mental illness, would you seek professional help?	55.2%	29	85.7%	28	**30.5%**
Average (All Responses) / Total Surveys Submitted	**50.6%**	**29**	**74.0%**	**29**	**23.4%**

Link Crew Survey FY 2017-18	**% Often or Always**
I am comfortable talking with and welcoming others who visit the Wellness Center.	100.0%
I am able to recognize when others are upset.	100.0%
I am comfortable with my ability to actively listen to others.	88.9%
I feel I have the skills to support other people when they need help.	100.0%
I feel comfortable taking a leadership role.	100.0%
I feel empowered to advocate for others.	94.4%
I am able to help others be their authentic/true self.	88.2%
I am respectful and accepting of others when they have different points of view.	100.0%
I feel that my voice is heard and valued at the Wellness Center.	88.9%
I feel that I can make a difference at my school.	77.8%
My interactions with friends and family have improved.	76.5%
Link Crew provided me with the support I needed to be a Peer Mentor.	94.4%
I felt that the Link Crew facilitator(s) respected me.	100.0%
Total Surveys Submitted N = 18	

Participant Perception of Care surveys were administered in FY 2016-17 and FY 2017-18. Responses indicated that, overall, participants reported better functioning as a result of attending groups or clubs at the TTUSD Wellness Centers. See the table below for more information.

Participant Perception of Care Survey Items	**FY 2016-17**		**FY 2017-18**	
	% Agree	**N**	**% Agree**	**N**
I am getting along better with my family.	43.5%	46	47.4%	38
I do better in school and/or work.	54.0%	50	58.3%	36
My housing situation has improved.	37.2%	43	25.0%	36
I am better able to do things that I want to do.	82.4%	51	71.1%	38
I am better able to deal with crisis.	82.7%	52	69.2%	39
I do better in social situations.	75.0%	52	57.5%	40
I have people with whom I can do positive things.	88.7%	53	72.5%	40
I do things that are more meaningful to me.	78.0%	50	61.5%	39
I have learned to use coping mechanisms other than alcohol and/or other drugs.	65.1%	43	57.6%	33
In a crisis, I would have the support I need from family or friends.	70.6%	51	56.4%	39
Staff welcome me and treat me with respect.	86.8%	53	67.5%	40
Staff are sensitive to my cultural background.	89.6%	48	42.9%	35
Average (All Responses) / Total Surveys Submitted	**72.0%**	**53**	**57.6%**	**40**

Challenges, Solutions, and Upcoming Changes

During FY 2017-18, TTUSD Wellness Centers launched a new Peer Mentor Program: Link Crew. There were 73 Truckee High and North Tahoe High juniors and seniors trained to be Link Leaders for the freshmen class. As positive role models, the Link Leaders supported the 9th graders during their first year of high school. Overall, Link Crew had a successful first year. The Link Leaders ran Freshmen Orientation Days, monthly 9th grade workshops, fun social get-togethers, and supported students individually.

The Wellness Centers learned a lot during the first year of Link Crew and have many ideas for how to improve the program for next year. The biggest take away is that the earlier the program can connect with 9th graders, the better. The majority of freshmen issues seem to stem from a desire to fit in and belong. By offering a Freshmen Orientation before school started, the Wellness Centers were able to connect with students right away and plug them into school activities. This worked well for some students, but not every student attended the summer Orientation Day, so did not get a chance to connect with their Link Leaders early. In the future, the Wellness Centers will do more to outreach to incoming 9th graders about the Orientation Day and follow-up with students who missed it. The Wellness Centers will plan follow-up social events at the beginning of the school year, so the new freshmen can bond with their Link Leaders and fellow classmates right away.

There are plans to expand the Link Crew message to all 10th and 11th graders, by implementing Breaking Down the Walls workshops every other year. Breaking Down the Walls is a day-long workshop designed to unify, empower, and engage students to create positive and supportive campus climates. Students work side-by-side, learn from one another, and share their stories under the framework that it is hard to hate someone whose story you know. The Wellness Centers plan to align this message with the Link Crew program and social emotional lessons offered in Student Success and Pathways classes throughout the school year.

The last change is that the Wellness Centers have had staffing turnover and room changes at Truckee High. The wonderful Truckee High Wellness Liaison left the position after four (4) years and a new staff person is being trained. The new staff person has attended the Link Crew Leader Training and will be jumping in this August to facilitate the Link Crew Leader Trainings and Freshmen Orientation Day. The staff turnover may have affected students' responses to the Participant Perception of Care Surveys (see table above). There was a decrease in student satisfaction between FY 2016-17 and FY 2017-18 that may be attributable to the turnover in the Wellness Liaison position. Truckee High is also going through a three-year school facility improvement plan, so the Wellness Centers will be moving classrooms while the new location is being worked on during the year.

Program Participant Story

One of our students had been regularly attending Wellness Center programming for a while. The student developed a strong relationship with our Wellness Liaison and talked about all aspects of life, including that this student suffered from anxiety, feeling tremendous pressure from parents to succeed. Our Wellness Liaison connected the student to one of our groups, which provided the space for this student to open up about these pressures and to get support from peers. This student made new friends, feeling safe and assured. The student also learned mindfulness strategies that helped with anxiety. This student used the Wellness Center as a safe place to reset when feeling overwhelmed at school.

Over the next few years, this student became more involved in the Pride Club, as the student began to feel changes in identity. The student also met regularly with our Wellness Liaison to talk about the range of emotions the student was feeling. Our Wellness Liaison helped the student navigate health insurance, find a therapist, and encouraged the student to open up to one of the student's parents about the changes the student was going through. Initially, the parent was confused, but supported the student in seeing a therapist. The therapist supported the student in exploring identity, managing anxiety, and facilitating healthier communication between the student and the student's parents.

In this student's involvement in Pride Club, one of the goals the student had was to educate students, staff, and community members about the LGBTQ youth culture and ways to support LGBTQ youth. The student designed educational workshops and presented them in our Health Classes, Wellness Partner Meetings, and staff meetings. Through the process of educating others, the student became more self-confident and as a result, the student's anxiety decreased. The student stepped into this new identity and flourished. We were happy to know that we played an important role in helping this student feel supported and celebrated.

PEI Project Name: Prevention Program

NEVADA COUNTY SUPER INTENDENT OF SCHOOLS
Second Step for Early Learning

Program Description

Program Overview

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

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

findings of the largest, most scientifically rigorous review of research ever done of school-based intervention programs (Durlak, Weissberg, Taylor, & Dymnicki). The findings indicate "…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 classroom teacher implements the curriculum 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. There are also daily, short movement/listening activities called "brain builders" designed to exercise executive brain functions. Parents are sent weekly Home Link letters to inform them of what their children have learned and to give them ideas for supporting these concepts at home.

Target Population

The target population for NCSOS Second Step is preschool teachers in Western Nevada County and their students.

Evaluation Activities and Outcomes

NCSOS collects evaluation activities for MHSA including demographic information on each preschool teacher that implements the program. The Desired Results Developmental Profile (DRDP) is collected at the beginning and end of the year to measure the impact of the program on the student's behavior. Information on referrals to community services is also collected.

At the beginning of each academic year, the Second Step Trainer connected with each potentially active classroom to assess their status, offer new training and/or support. During FY 2015-16, 35 classrooms were contacted: eight (8) had new lead teachers who needed training, 23 were continuing, and four (4) were on hiatus for this year for various reasons. During FY 2016-17, 32 classrooms were contacted: five (5) had new lead teachers who needed training, 24 were continuing, and three (3) were on hiatus for this year for various reasons. During FY 2017-18, 29 classrooms were contacted: two (2) classrooms had new lead teachers who needed training and 25 classrooms reported that they were continuing to use Second Step at some level.

During FY 2015-16, across classrooms continuing Second Step and classrooms new to Second step, a total of 557 children experienced the program. During FY 2016-17, 473 children experienced the program, across continuing and new classrooms. During FY 2017-18, 425 children experienced Second Step, across continuing and new classrooms.

During FY 2015-16, Second Step Staff provided nine (9) on-site trainings for 27 adults. During FY 2016-17, the trainer provided seven (7) on-site trainings for 26 adults. During FY 2017-18, the trainer provided six (6) on-site trainings for 12 adults. See the table below for more detailed information on training and attendance.

	FY 2015-16	FY 2016-17	FY 2017-18
# Trainings	9	7	6
Attendance	27	26	12
Avg. Attendance/Training	**3.0**	**3.7**	**2.0**

Across the years, the Trainer modeled the first two (2) weeks of daily lessons in the classrooms with the students and provided guidance on working the program activities into the teachers' existing schedules. Each year the classrooms incorporating Second Step included one (1) to two (2) special education classrooms: one (1) preschool and/or one (1) kindergarten through 3rd grade. At the end of each unit, the Trainer met with all new teachers to check in, gather feedback, provide support and deliver curriculum story books from the Second Step library. In the case of the special education classrooms, where the children move through the lessons at a slower rate, meetings were held every four (4) to six (6) weeks.

The Desired Results Developmental Profile (DRDP) assesses growth in nine (9) measures of self-regulation and social-emotional competence: Self-Control of Feelings and Behavior; Shared Use of Space and Materials; Identity of Self in Relation to Others; Social and Emotional Understanding; Relationships and Social Interactions with Familiar Adults; Relationships and Social Interactions with Peers; Conflict Negotiation; Responsible Conduct as a Group Member; and Reciprocal Communication and Conversation. Pre-assessments and post-assessments were collected on all of the children in FY 2015-16. During the last two (2) years, the DRDP was collected on all of the children in the classrooms with new teachers. All students showed growth in at least one (1) of the nine (9) measures. See the tables below for more information.

	FY 2015-16		FY 2016-17		FY 2017-18	
	% Growth	**N**	**% Growth**	**N**	**% Growth**	**N**
Growth in at Least One Measure of the DRDP	100.0%	557	98.3%	69	100.0%	67

Teachers surveyed regarding the implementation of Second Step in their classrooms were enthusiastic. Teachers concurred with the DRDP results, reporting that they observed social and emotional growth in their students. All of the teachers across the years responded, "Yes" to the question: "Do you feel Second Step is beneficial to the mental health of your students and teachers?"

No referrals to outside agencies were made for students or teachers during FY 2015-16 or FY 2016-17. During FY 2017-18, Second Step referred one (1) student to their doctor and the student was able to see their doctor two (2) days after being referred.

Across the years, new classrooms reported a 63% to 68% reduction in behavior problems after implementing Second Step, according to teacher reports.

Challenges, Solutions, and Upcoming Changes

As has been the case for the past several years, a wonderful challenge was working in the county SDC K-1 (special education) classroom with severely affected children with low verbal abilities and very challenging behavioral issues.

For this classroom, we dedicated more than the normal amount of time. Additional hours were spent in classroom observation time, spanning multiple days before coming in to teach and work with the children. This was a crucial step in being prepared to work effectively with the particular children in this classroom. There was also additional time spent working in the classroom to model the program, observing the students and teachers, and discussing ways to modify the curriculum, as it is not written for special education students.

Another challenge was working with the three (3) classrooms that did not have the typical five-day school week. In one (1) classroom, the students attended three (3) days a week and in the other two (2) classrooms, the students, as a group, attended two (2) days a week. Therefore, the program could not be delivered at the usual rate of one (1) curriculum theme week per one (1) calendar week. Each theme week contains many activities that integrate a variety of learning strategies and builds on what came before. The challenge presented was to strike the right balance between giving the children enough time to experience and practice each theme concept and still move through enough of the program to maximize its benefits.

Our solution involved a combination of curriculum adjustments and scheduling that evolved throughout the year. One (1) change was to double up the main lesson one (1) day of the week by adding in the 'theme storybook lesson'. This alone meant we were fitting a week's worth of lessons into four (4) days. Another was, if the teacher could not fit both of the 'skill-practice activities' into their weekly schedule, to choose the one (1) they felt would be most meaningful to their students. We were successful in finding the right balance in all three (3) classrooms to promote student growth.

This year, for several reasons, we did not meet our goal of training twenty teachers. First, transportation funds for the trainer were less than they were in past years. Second, the three (3) classrooms with the two/three-day-a-week programs required the trainer to spend about a month with each of them in order to model the first two (2) theme weeks. Since we need to start schools in roughly the first half of the year, this meant starting fewer schools. And finally, none of this year's schools had large numbers of staff to send to training.

Significant time was spent this year on administrative tasks to make sure our reporting and back-up documentation would meet the state requirements. This included organizing and preparing all the student assessments we collected from years 2011-12 through 2015-16. It was important work and a good time to get all the historical data in order because the trainer, who's been the sole executor of the contract since the first grant year, will be leaving at the end of this contract on June 30, 2018.

Program Participant Story

In one (1) classroom, a group of students, independent of their teacher, decided to work together to solve a problem. There was a heavy bucket of toys that they needed to move, but they would need to work together to move it, since it was too heavy for any one of them to lift it. The students planned, organized, and executed their teamwork to move the bucket without an adult's help. They were able to identify the problem (needing to get the big, heavy bucket of trains back on the train table), come up with a solution (everyone helps lift), a leader emerged from the group, and the problem was solved. The teacher was blown away by this demonstration of teamwork!

Teacher comments include:

- "Sharing was a real issue for a specific child. The Second Step components gave a good 'gateway' to help the child be a successful sharer."
- "Thank you so very much! I have greatly appreciated having the program in my classroom."
- "The program gave a great, simple but effective guideline to help us teach about how to handle emotional situations."
- "Second Step is beneficial to the mental health of my students because it gives them language to describe how they are feeling. It's empowering and helpful in communicating. It allows us as teachers to then share our calm, and help reduce chaotic feelings in children"
- "The students relate really well to the stories and puppets. They love to reenact what we learn each week with my classroom puppets and stuffed animals. I love to see them work through an experience that happened. It helps them heal and move forward."
- "Empathy is a critical social skill and they are becoming aware of it through this program."
- "I love having this program and I'm so glad it was introduced to our preschool program."

PEI Project Name: Prevention Program

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

Program Description

Program Overview

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

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

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

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

Target Population

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

Evaluation Activities and Outcomes

TTUSD Second Step collects evaluation activities for MHSA including demographic information on each teacher that implements the program. The Desired Results Developmental Profile (DRDP) is collected at the beginning and end of the year to measure the impact of the program on the student's behavior. Information on referrals to community services is also collected.

Over the past three (3) fiscal years, Second Step has increased the number of schoolteachers and staff trained in the program, from 12 in FY 2015-16, six (6) in FY 2016-17, and 53 in FY 2017-18. See the table below for training and attendance information.

	FY 2015-16	**FY 2016-17**	**FY 2017-18**
# Trainings	2	2	5
Attendance	12	6	59
Avg. Attendance/Training	**6.0**	**3.0**	**11.8**

Over the past three (3) fiscal years, the Second Step program has reached roughly the same number of students. During FY 15/16, 1,450 students were in schools where TTUSD Second Step had been implemented. During FY 16/17, the number increased to 1,598 students. In FY 17/18, there were 1,573 students in schools with TTUSD Second Step.

Every year, visits to sites that have implemented Second Step are made. Across the years, Glenshire Elementary, Truckee Elementary, and Alder Creek Middle school have been implementing Second Step successfully, as well as two (2) preschools. During FY 2016-17, Mind Yeti licenses were purchased to facilitate the new mindfulness part of the Second Step program. At each school, teachers, counselors, and principals were given access to the Mind Yeti application. Mind Yeti will also be offered to parents on an as-needed basis to use in the home.

In FY 2017-18, an Evaluation Survey was administered to trainees showing that the Second Step training was largely successful. Most of the 47 participants who responded to the survey (71.1%) agreed that Second Step was beneficial to their students. See the table below for more information.

Second Step Evaluation Survey Items	**% Agree**
I understand the goals and objectives of the Second Step program.	97.8%
I have or know how to get the materials I need to teach and /or reinforce Second Step program skills and concepts (for example, program kits, posters etc.)	97.8%
I have a specific time scheduled for delivering the lessons.	76.1%
I feel adequately trained to deliver Second Step lessons.	84.8%
I have adequate implementation support (for example, from my administrator, coordinator, and/or district.	84.8%
I send Home Links to my students' families.	28.2%
I believe my students are benefiting from the Second Step program.	71.1%
Total Surveys Submitted N = 47	

The program has checks for understanding built into each lesson and students consistently demonstrate new skills. The language is also visible on the playground, in the cafeteria and in each classroom. Anecdotally, teachers report that they see evidence that the lessons have a positive impact on student behavior and support sound decision-making skills. Every school site within the Tahoe Truckee Unified School District develops an annual School Accountability plan and one of the goals specifically addresses school climate. Schools implementing the program list Second Step as one of the activities that supports their positive school climate goal. Re-teaches from the Second Step program are often used as an alternative to school suspension when inappropriate behavior does occur. As a district, TTUSD is committed to keeping students in class and actively engaged. TTUSD diligently looks for alternatives to suspension that teach appropriate behavior.

There were a total of 56 referrals during FY 2017-18, the first year these types of referrals were tracked. Examples of reasons for referrals are difficulties in being successful learners, getting along with peers, or if students are experiencing anxiety or depression symptoms. A staff member, teacher, or parent will request a meeting when they see an issue arise with a student.

Challenges, Solutions, and Upcoming Changes

A new addition to the Second Step program is the mindfulness component. With this component, students and teachers have yet another tool to help with emotion and anxiety management, ease of transitions, self-regulation, empathy, compassion, gratitude, and more.
This mindfulness training is another way to foster emotional well-being in the students.

An upcoming change will be to put into place a new survey at the beginning of the year and to continue with the post-survey at the end of the year. The surveys will be administered to each staff member teaching the program, helping to identify any challenges staff are having in teaching the program.

The Second Step program is continually being updated with technology making it easier for teachers to use Second Step in their classrooms. All of the kits are now digital, allowing continual access to updated materials. Second Step no longer needs to replace outdated DVDs or other outdated materials.

Program Participant Story

A story from a counselor at a Second Step school (edited for clarity):

I am only at my sites one (1) to three (3) days a week and almost every day that I work as a school counselor, I have children come up to me to ask if I am going to teach Second Step and or Mind Yeti that day. I always get a hug or a big smile when I tell them "yes." The students want to learn about making connections, how to get along with others, how to calm themselves down when they have strong emotions, etc. I know that this program and similar programs for learning social emotional skills are so important for our students. These are tools for life and each student is getting a special tool belt of skills they can use in all areas of their lives. That is powerful.

PEI Project Name: Prevention Program

BIG BROTHERS, BIG SISTERS
Pal Program

Program Description

Program Overview

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

High School juniors and seniors are matched with elementary and middle school students, Grades 3 - 8, for a weekly mentoring meeting. All meetings are held on the school campus. Students are referred by administrators/teachers from Grass Valley School District: Scotten Elementary, Lymon Gilmore Middle, and Grass Valley Charter; from Nevada City School District: Deer Creek Elementary and Seven Hills Middle; and from Pleasant Ridge School District: Cottage Hill Elementary. High School Big Pals are recruited from the following schools: Nevada Union High School, Bear River, NorthPoint Academy, and Forest Charter School. The Pal Program Coordinator recruits, screens, trains, and matches all children and teens, conducts match support meetings on a bi-monthly basis, and works closely with the schools and teachers to set goals and review progress towards those goals throughout the school year.

Target Population

The Pal Program serves at-risk elementary and middle school youth, Grades 3 - 8.

Evaluation Activities and Outcomes

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

Across the fiscal years, between 21 and 22 matches were made each year. The total number of hours that the matches met decreased across the years from 357 hours in FY 2015-16, to 315 hours in FY 2016-17, to 222 hours in FY 2017-18. The average hours per year also decreased across the three (3) years, for an average of 16.2 hours in FY 2015-16 to 10.6 hours in FY 2017-18. Most matches met eight (8) or more times throughout each fiscal year.

	FY 2015-16	**FY 2016-17**	**FY 2017-18**
Number of Hours	357	315	222
Number of Matches	22	21	21
Avg. Hours per Match	**16.2**	**15.0**	**10.6**

	FY 2015-16		**FY 2016-17**		**FY 2017-18**	
Number of Service Contacts*	**Number of Matches**	**Percent of Matches**	**Number of Matches**	**Percent of Matches**	**Number of Matches**	**Percent of Matches**
1 Contact	-	-	-	-	-	-
2 – 4 Contacts	-	-	2	9.5%	3	14.3%
5 – 7 Contacts	1	4.5%	-	-	2	9.5%
8+ Contacts	21	95.5%	19	90.5%	16	76.2%
Unduplicated Total	**22**	**100.0%**	**21**	**100.0%**	**21**	**100.0%**

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

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

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

The end-of-year SoR surveys showed that, across the fiscal years, the Littles felt close to their Bigs. On average, 75% to 100% of Littles reported that their Big was helpful on a number of dimensions of the SoR (e.g., the Big Pal guided the Little Pal in problem-solving).

The end-of-year YOS showed that, across the fiscal years, the Pal Program had a positive impact on the Littles, with 47% to 75% showing stable or improved school absences, 81% to 90% reporting having a positive adult in their lives, and no Littles reporting having been arrested.

Big Brothers, Big Sisters also measures program impact by the length of the mentoring relationship. Big Brothers, Big Sisters expects a one-year minimum commitment from mentoring matches because research has shown that matches that remain together for one year or longer demonstrate higher relationship quality and more positive outcomes for the children being mentored.

No referrals to outside agencies were made during any of the fiscal years.

Challenges, Solutions, and Upcoming Changes

One major challenge this year was the recruitment of high school students to be Big Pals. Because of the rigorous academics in their junior year, it is difficult to recruit new Big Pals. A focused effort is being made to begin recruitment in the spring of the students' sophomore year, so that Bigs may be retained through their junior and senior year. Connections are being developed with clubs on campus whose mission is to do community service, such as Interact, Leo, and Key clubs.

Another challenge this year has been Bigs, at times, do not give ample advance notice if they will not be at their match meeting. Meeting attendance and notice for missing meetings has been discussed with the continuing Bigs and this issue will be reinforced at the beginning of the year training.

Among the successes is the number of referrals the program received from the feeder schools, as well as requests from new schools to join the program. Bell Hill Academy (Grass Valley School District) and Ready Springs School (Penn Valley School District) have requested to send Little Pals to the program. All current feeder school counselors are very appreciative of this program and are very eager to refer students.

Program Participant Story

A request from a student at Bear River resulted in the expansion of the Pal Program into Bear River High School and Cottage Hill elementary school, in the southern area of Nevada County. The high school student used the expansion of this program as their senior project. Four (4) students from Bear River met with their fourth graders once a week, all together as a sort of club, during lunch period. Each Big met individually with their little for lunch, then, as a group, they decided on a sports activity in which to engage: soccer, Frisbee, baseball, etc. They also planted a garden towards the end of the year. A grandparent of one (1) of the Littles was thrilled that their grandchild was able to be a part of this program. The grandparent noticed an improvement in the grandchild's social skills, cooperation and sharing skills, and an increased interest in school.

PEI Project Name: Access and Linkage to Treatment Program

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

Program Description

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

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

Evaluation Activities and Outcomes

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

Over the three (3) fiscal years, 2-1-1 staff have handled between 9,973 and 10,324 calls per year. There were between 4,907 and 5,616 unduplicated callers per year. Across the years, there were between 82,186 and 123,969 searches of the 2-1-1 website (211connectingpoint.org**)** from between 4,907 and 5,616 unique Internet Protocol (IP) addresses. See the tables below for information on calls to 2-1-1 and web searches of the 2-1-1 website:

Calls to 2-1-1	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**
Total Calls Handled	**9,973**	**10,324**	**10,065**
Follow-up Calls	1,503	1,807	1,740
"Warm" Referrals	873	1,849	1,530
Callers Transferred to NCBH	42	73	163
Callers Requesting MH Services	479	271	759
Total Referrals Provided to Callers	10,506	10,211	9,858
Unduplicated Callers	**4,907**	**5,616**	**4,921**

2-1-1 Nevada County Website: 211connectingpoint.org	FY 2015-16	FY 2016-17	FY 2017-18
Total Number of Searches	123,969	111,193	82,186
Searches from Unique IP Addresses	14,732	16,480	14,206

Over the years, staff participated in a variety of training opportunities. These included:

- AIRS (Alliance of Information and Referral Systems) CIRS (Certified Information and Referral Specialist)
- Mental Health First Aid
- Motivational Interviewing
- safeTALK Suicide Prevention
- Alertness, Identity Theft/Fraud Prevention
- Language Line
- Transportation Trip Planning with Gold Country Stage
- California Alliance of Information and Referral Services Conference
- Compassion Fatigue
- CA Department of Aging
- Security Awareness Training
- Quality Assurance for Information and Assistance Specialists
- In-house educational presentations from local resource providers

Across the three (3) fiscal years, every person who reported suicidal ideation received a referral to a suicide prevention specialist. Examples of suicide-related calls included:

- Caller whose child was threatening suicide was warm transferred to the Crisis Line.
- Caller reported thoughts of suicide for many years. After discussion, caller stated he was not suicidal at the moment and did not want to be transferred to a suicide prevention specialist. The 2-1-1 Agent requested a welfare check from the Sheriff's Dept.
- Caller who was grieving and depressed with thoughts of suicide daily was referred to SPIRIT Center and Anew Day for additional counseling, as the caller was already getting counseling through a managed Medi-Cal plan.
- Caller whose friend was talking about suicide was given two (2) crisis line numbers and the Friendship Line. The 2-1-1 Agent set up a follow-up call.
- Caller knew of a homeless person in the area who had thoughts of suicide and the caller wanted the number of a crisis line to give to the person. The 2-1-1 Agent provided the caller with the Behavioral Health crisis line. Caller was invited to call back if other resources were needed.
- Caller was a staff member at an area school. A student had expressed suicidal ideation to the caller. Caller wanted to confirm numbers for BH crisis line and national suicide prevention line. Caller also discussed calling the Children's BH line to check whether it's appropriate for someone to go out to speak with the student. The 2-1-1 Agent confirmed the numbers.

Challenges, Solutions, and Upcoming Changes

Requests for resources for affordable housing, both emergency and long-term, continue to present challenges to 2-1-1 call agents. The inventory of housing options in Nevada County is inadequate to meet the needs of the community.

By implementing the Coordinated Entry System, in conjunction with the Continuum of Care in Nevada County, we are able to systematically collect valuable data on service needs for homeless individuals and report gaps to decision makers in the county.

Program Participant Story

Caller wanted referrals to drug and alcohol treatment facilities. The 2-1-1 Agent referred the caller to Nevada County Behavioral Health. The caller declined additional referrals and wanted to work on the NCBH referral first. A follow-up was scheduled to make sure the caller received the service.

The caller called back to update the 2-1-1 Agent, after the Agent had called and left messages. Caller had gone to NCBH the day after speaking to the Agent and checked into an inpatient program. The caller had just got out a few days prior and would be going into sober living very soon. The caller thanked the 2-1-1 Agent for the referral and needs no other help at this time.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY ADULT SERVICES
Social Outreach Program

Program Description

Program Overview

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

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

opportunities to link participants to long-term supportive services.

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

Target Population

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

Evaluation Activities and Outcomes

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

The Social Outreach Program delivered services to 24 unduplicated participants during FY 2015-16, 51 during FY 2016-17, and 33 during FY 2017-18.

The average number of hours spent with each participant decreased across the years, from 7.7 hours in FY 2015-16, to 5.3 hours in FY 2016-17 to 3.4 hours in FY 2017-18. Reflecting the decrease in average hours spent with each participant, the percentage of participants receiving fewer than four (4) visits from the Program Coordinator increased across the years. During FY 2015-16, 54.2% received one (1) to four (4) visits, during FY 2016-17, 70.6% did, and in FY 2017-18, 90.9% of participants received one (1) to four (4) visits. See the tables below for more detailed service information.

	FY 2015-16			**FY 2016-17**			**FY 2017-18**		
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	176.7	24	**7.4**	266.0	51	**5.2**	62.9	31	**2.0**
Case Management/ Linkage	-	-	-	1.0	1	**1.0**	48.2	7	**6.9**
Collateral	3.2	4	**0.8**	-	-	-	-	-	-
Family Team Meeting	1.5	1	**1.5**	-	-	-	-	-	-

Other	3.7	3	**1.2**	5.5	6	**0.9**	-	-	-
Total (All Services)	**185.0**	**24**	**5.6**	**272.5**	**51**	**8.3**	**111.1**	**33**	**3.4**

	FY 2015-16		**FY 2016-17**		**FY 2017-18**	
Number of Service Contacts	**Number Served**	**Percent of Served**	**Number Served**	**Percent of Served**	**Number Served**	**Percent of Served**
1 Contacts	3	12.5%	14	27.5%	18	54.5%
2 – 4 Contacts	10	41.7%	22	43.1%	12	36.4%
5 – 7 Contacts	5	20.8%	8	15.7%	2	6.1%
8+ Contacts	6	25.0%	7	13.7%	1	3.0%
Unduplicated Total	**24**	**100.0%**	**51**	**100.0%**	**33**	**100.0%**

Of the 24 participants in FY 2015-16, 21 completed the Geriatric Depression Screening. Of these participants, most (66.7%) screened as having no or mild symptoms of depression. In FY 2016-17, there were 35 new participants, of which, one (1) was unable to complete the screening. For the 34 participants who completed the screening, most (70.6%) screened as having no or mild symptoms of depression. There were 23 new participants in FY 2017-18. Of those new participants, one (1) was unable to complete the screening due to cognitive difficulties. A staff change resulted in six (6) participants with the previous coordinator not having a complete screening. For the 16 participants who completed the screening, most (62.5%) screened as having no or mild symptoms of depression. Of those who screened as having severe symptoms of depression, two (2) completed a post-services depression scale and both showed improvement in their symptoms of depression. See the table below for more detailed depression screening information.

	FY 2015-16		**FY 2016-17**		**FY 2017-18**	
Geriatric Depression Screening	**Number Served**	**Percent of Served**	**Number Served**	**Percent of Served**	**Number Served**	**Percent of Served**
No Symptoms	4	19.0%	8	23.5%	6	37.5%
Mild Symptoms	10	47.6%	16	47.1%	4	25.0%
Moderate to Severe Symptoms	7	33.3%	10	29.4%	6	37.5%
Unduplicated Total	**21**	**100.0%**	**34**	**100.0%**	**16**	**100.0%**

During FY 2015-16, the Program Coordinator made 77 referrals to other agencies. Of these, 41 successfully connected with the agency. Consistent with the previous year, during FY 2016-17, the Program Coordinator made 78 referrals, of which 34 successfully connected with the agency. During FY 2017-18, the Program Coordinator made 58 referrals to other agencies. A staff change during this fiscal year left the Program Coordinator position vacant for a couple of months, leading

to a lower number of participants as well as a lower rate of referrals than the previous year. Of the 58 referrals, 26 successfully connected with the agency. The timeliness of referrals to connections was recorded for these successful connections. Most connections (69.2%) were made within 2 weeks of the referral. The average across all connected referrals was 16.5 days (a referral to a private therapist took over 3 months to connect, so the average was skewed). See the table below for more detailed referral information.

Agencies	FY 2015-16			FY 2016-17			FY 2017-18			
	# Referrals	# Connected	% Connected	# Referrals	# Connected	% Connected	# Referrals	# Connected	% Connected	Average Timeliness*
211	6	0	**0.0%**	14	5	**35.7%**	5	1	**20.0%**	**13.0**
A New Day	1	1	**100.0%**	-	-	**-**	-	-	**-**	**-**
Chapa De	-	-	**-**	-	-	**-**	1	1	**100.0%**	**0.0**
Concern Aid	-	-	**-**	-	-	**-**	1	1	**100.0%**	**12.0**
Faith-Based Organization	2	1	**50.0%**	-	-	**-**	-	-	**-**	**-**
Financial Assistance	-	-	**-**	-	-	**-**	1	1	**100.0%**	**13.0**
Crisis Stabilization Unit	-	-	**-**	1	0	**0.0%**	-	-	**-**	**-**
Food Bank	-	-	**-**	1	1	**100.0%**	3	3	**100.0%**	**11.3**
FREED	10	4	**40.0%**	16	5	**31.3%**	8	5	**62.5%**	**8.4**
Helping Hands	-	-	**-**	-	-	**-**	1	0	**0.0%**	**N/A**
In-Home Support Services (IHSS)	5	2	**40.0%**	3	2	**66.7%**	2	1	**50.0%**	**0.0**
Insight Respite House	-	-	**-**	1	0	**0.0%**	-	-	**-**	**-**
Legal Services	-	-	**-**	2	0	**0.0%**	1	1	**100.0%**	**7.0**
Mental Health	-	-	**-**	-	-	**-**	1	0	**0.0%**	**N/A**
Partner Agency	6	4	**66.7%**	5	3	**60.0%**	-	-	**-**	**-**
Physician/ MD	6	3	**50.0%**	1	1	**100.0%**	1	1	**100.0%**	**0.0**
Sierra Nevada Memorial Hospital	1	1	**100.0%**	-	-	**-**	-	-	**-**	**-**
Social Services Agency	2	2	**100.0%**	-	-	**-**	-	-	**-**	**-**
SPIRIT	1	1	**100.0%**	1	1	**100.0%**	-	-	**-**	**-**
Therapist/ Psychiatrist (Private)	8	4	**50.0%**	4	2	**50.0%**	6	1	**16.7%**	**109.0**
Veteran Services	2	0	**0.0%**	-	-	**-**	1	0	**0.0%**	**N/A**
Western Sierra Medical Clinic	-	-	**-**	3	2	**66.7%**	1	1	**100.0%**	**3.0**
Other	27	18	**66.7%**	26	12	**46.2%**	25	9	**36.0%**	**21.8**
Total Referrals Connected/ Average	**77**	**41**	**53.2%**	**78**	**34**	**43.6%**	**58**	**26**	**44.8%**	**16.5**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. Timeliness was not collected before FY 2017-18. The average is not calculated for referrals that did not connect.

During FY 2015-16, the Program Coordinator performed a total of five (5) outreach presentations with an estimated attendance across presentations of 47 attendees. During FY 2016-17, there were fewer presentations, but a larger audience was reached, with two (2) outreach presentations and 95 estimated attendees. The Program Coordinator performed a total of nine (9) outreach presentations during FY 2017-18 with an estimated attendance across presentations of 88 attendees.

Challenges, Solutions, and Upcoming Changes

One (1) of the biggest challenges during FY 2017-18 was that the Social Outreach Program Coordinator position was vacant for approximately two (2) months. The position was originally available only to registered nurses (RNs). A decision was made to enlarge the pool of applicants by opening the position to either an RN or a social worker (MSW). A social worker (MSW) was hired at the end of February 2018 and the name of the program and form titles were changed to reflect this change. The program was changed from Social Outreach Nurse Program to the Social Outreach Program and the title of Nurse was replaced by Social Outreach Coordinator. The new Program Coordinator needed an orientation, training, and support to take over the duties of the role. The vacancy in the position and the training of new staff resulted in fewer referrals during this FY as compared to previous FYs. The Program Coordinator addressed this by doing outreach to community partners to introduce herself, advise that the position was filled and services were available for new referrals, and inform any community partners/agencies that may have been unaware of the program.

Outreach to the Truckee community (Eastern Nevada County) was identified as a challenge by the prior Social Outreach Nurse and continues to present challenges to the current Program Coordinator. The Program Coordinator is working with community partners in the Truckee area to increase referrals to the Social Outreach Program and support for participants.

During FY 2017-18, changes in practice and policy by local licensed mental health therapists resulted in a lack of in-home therapy availability for participants. The Program Coordinator has been in contact with local therapists who provided in-home therapy in the past, but none of them are currently providing this service. This creates a gap in service to participants due to the characteristics of the population served by the Social Outreach Program. Many participants of the program have mobility issues, serious health conditions, chronic pain, anxiety, and memory impairment, which, in many cases, make it difficult to attend appointments outside of the home. A therapist in Western Nevada County may be willing to provide this service after being approved for Medicare billing, but only for one (1) to two (2) participants at a time. In the meantime, the Program Coordinator is working with participants to access transportation through ride shares and other alternative transportation services to facilitate the ability to attend therapy appointments.

Program Participant Story

The Social Outreach Coordinator worked with a participant who lived alone and had recently lost her spouse after a prolonged illness. The participant was experiencing chronic depression, as well

as grief, and stated she felt isolated and lonely. The individual had grown children who were only minimally involved in her life and had no other close friends or family. The individual was reluctant to engage or trust new people at first. The Program Coordinator spent several visits building rapport and encouraging the participant's acceptance of referrals.

The participant was seeing a psychiatrist for medication management and did not follow through on a referral to an outside therapist for additional mental health support. However, the individual did agree to visits by a Friendly Visitor through the FREED program, as well as a volunteer grief support specialist from a local hospice program. The individual was connected to Meals on Wheels and the Senior Outreach Nurse Program, as well. Additionally, the participant had not seen her primary care physician in over a year and, while reluctant and presenting with symptoms of anxiety regarding physician visits, was willing to allow the Program Coordinator to assist her in scheduling an appointment and providing transportation. With further encouragement from the Program Coordinator, the participant also reached out in an attempt to meet her neighbors, as she was new to the neighborhood and had not connected with anyone, yet.

With the increased support in the participant's home, the second depression screen showed a reduction in symptoms of depression. The participant reported an increase in socialization and appreciation for the support of the Social Outreach Program. The participant also reported appreciation for the new connections to vital community programs, which have increased the individual's quality of life.

PEI Project Name: Access and Linkage to Treatment Program

HOSPITALITY HOUSE

Program Description

Program Overview

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

Target Population

Hospitality House serves individuals who are homeless in Nevada County.

Evaluation Activities and Outcomes

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

During FY 2015-16, Hospitality House Homeless Outreach case managers made contact with 103 unduplicated individuals. In FY 2016-17, that number increased to 175 unduplicated individuals and in FY 2017-18, the number decreased to 134 unduplicated individuals.

Information on referrals to outside agencies was collected in FY 2016-17 and FY 2017-18. Staff made a total of 46 referrals in FY 2016-17. In FY 2017-18, that number increased to 260 referrals to outside agencies. Across the years, 67% and 74% of the referrals connected to the outside agency. In FY 2017-18, information on timeliness of the referrals was collected. Of those that connected, the average time from referral to date of appointment with the agency was 0.8 days. In other words, most connections were made the same day as the referral, or one day later (i.e., zero (0) or one (1) day). A significant number of referrals were marked "Other" across the years. Examples of these are referrals to Sierra Roots, One Stop, and Clothing Vouchers. See the table below for more detailed referral information.

	FY 2016-17			FY 2017-18			
Agencies	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**	**Average Timeliness***
211	-	-	-	8	6	**75.0%**	**0.0**
Chapa De	-	-	-	2	0	**0.0%**	**N/A**
Common Goals	-	-	-	12	5	**41.7%**	**7.8**
CoRR	-	-	-	10	7	**70.0%**	**0.7**
Crisis Stabilization Unit	-	-	-	8	6	**75.0%**	**0.2**
Community Beyond Violence	-	-	-	2	1	**50.0%**	**Unknown**
Employment/ CalWORKs	-	-	-	2	2	**100.0%**	**0.0**
Food Bank	-	-	-	34	33	**97.1%**	**0.1**
Hospitality House/ Homeless Shelter	12	9	**75.0%**	26	18	**69.2%**	**0.5**
Human Services (Benefits)	-	-	-	5	3	**60.0%**	**0.0**
Legal Services	-	-	-	1	1	**100.0%**	**0.0**
Mental Health	10	9	**90.0%**	19	14	**73.7%**	**1.5**
Physician/ MD	-	-	-	13	9	**69.2%**	**8.8**
Sierra Nevada Memorial Hospital	-	-	-	9	8	**88.9%**	**0.0**
Social Services Agency	5	3	**60.0%**	20	14	**70.0%**	**0.1**
SPIRIT	2	2	**100.0%**	31	23	**74.2%**	**0.0**
Veteran Services	-	-	-	9	6	**66.7%**	**0.8**
Western Sierra Medical Clinic	-	-	-	6	1	**16.7%**	**0.0**
Other	17	8	**47.1%**	43	36	**83.7%**	**0.1**
Total Referrals Connected	**46**	**31**	**67.4%**	**260**	**193**	**74.2%**	**0.8**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. Timeliness was not collected before FY 2017-18. Unknown averages due to dates of referral and/or dates of appointment being unavailable. Average not applicable for referrals that did not connect.

During FY 2015-16, Hospitality House Homeless Outreach case managers made a total of 17 outreach attempts to an estimated total of 378 individuals. In FY 2016-17, the case managers made nine (9) outreach attempts to 15 individuals. In FY 2017-18, the case managers made 38 outreach attempts to an estimated total of 375 individuals. See the table below for more detailed outreach information.

	FY 2015-16	FY 2016-17	FY 2017-18
# Outreach Attempts	17	9	38
# Estimated Contacts	378	15	375
Average Contacts per Attempts	**22.2**	**1.7**	**9.9**

In FY 2017-18, Hospitality House case managers collected data on housing destinations of participants discharged from the Homeless Outreach program. There were 65 participants who had this information on file, though one (1) had died during the year. So of the 64 remaining participants, 30 (47%) exited the program to positive housing situations (e.g., living with family, admitted to a substance use facility, etc.).

Challenges, Solutions, and Upcoming Changes

The necessity of fully integrating HMIS into all of Hospitality House's program areas required a steep investment in training and staff time to learn and understand how to enter and collect data. The learning curve took time and investment to ensure accuracy and comprehensive understanding. Additionally, Hospitality House made staffing changes to the outreach program that left a staffing vacancy for several months in a concerted effort to hire skilled and knowledgeable staff.

New construction in areas where homeless individuals historically have congregated has created movement among Hospitality House's homeless outreach participants and made it more difficult for staff to find and access their camps/living situations. The implementation of the Homeless Outreach Team (HOT) has been helpful as law enforcement and other service providers now meet bi-weekly to help communicate information and locate clients.

Complaints from concerned citizens and business owners in the Brunswick Basin has been addressed by the hiring of a new Community Outreach Liaison (COL) who is on foot engaging homeless people where "they are at" as well as serving as a contact for residents and businesses. The goal of the COL is to help reduce tensions and bring about better understanding among those who live, work and do business in the Brunswick Basin. The COL spends a good amount of time trying to provide access and linkage to services otherwise unknown to some homeless individuals. The addition of a Homeless Access Transport Driver has also helped in getting people where they need to go and coordinating their referrals.

Program Participant Story

During the winter, a person arrived at the shelter displaced, wet, cold, and hungry. This individual's home had burned down. The person presented with substance use issues, as well as feelings of grief and loss. Hospitality House staff was able to get the Red Cross involved and provided the individual with emergency funds to get a motel room and food for a few days. The individual was kept out of the cold and was sheltered while Hospitality House staff could arrange

other services. In that time, the individual's parents were contacted and insight was gained into this person's history. Namely, the individual's substance use issues involved an opiate addiction that had been an ongoing issue. Hospitality House staff was able to provide a referral to a long-term residential treatment facility near where the person's parents live. Further, staff was able to arrange grief and loss counseling through the Red Cross. The individual agreed to get help and showed an enormous amount of gratitude to Hospitality House.

PEI Project Name: Access and Linkage to Treatment Program

PROJECT MANA
Truckee Homeless Outreach, Access, and Linkage to Treatment Program

Program Description

Program Overview

The Truckee Homeless Outreach Program provides outreach, access, and linkage services for homeless individuals in the Truckee area. One goal of the program is to engage with homeless individuals in order to reduce the risk of harm and enhance safety. Homeless Outreach Coordinators work with homeless individuals to connect them to benefits, jobs, housing, services, and treatment. Homeless Outreach Coordinators also support and assist individuals to utilize warming shelters, when available.

In addition, the program provides essential items to homeless individuals including socks, sleeping bags, jackets, blankets, clothes, personal hygiene items, etc.

Target Population

The Truckee Homeless Outreach Program serves individuals who are homeless or at risk of homelessness in the Truckee area.

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on the people served, the location of services, and number of persons referred to community resources, including housing.

During FY 2015-16, Project MANA served 25 unduplicated individuals. During FY 2016-17, that number decreased to seven (7) unduplicated individuals. And in FY 2017-18, the number increased to 31 unduplicated individuals.

During FY 2015-16, staff made six (6) referrals to other agencies, of which five (5) successfully connected. In FY 2016-17, staff made 72 referrals, of which five (5) connected. In FY 2017-18. Staff made 70 referrals to other agencies, of which 52 successfully connected. The timeliness of

referrals to connections was recorded for these successful connections in FY 2017-18. Most connections (86%) were made within 2 weeks of the referral. The average across all connected referrals was 9.9 days. See the table below for more detailed referral information.

	FY 2015-16			FY 2016-17			FY 2017-18			
Agencies	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**	**Average Timeliness***
211	-	-	-	-	-	-	5	4	**80.0%**	**0.0**
Mental Health	1	0	**0.0%**	4	0	**0.0%**	-	-	-	-
CoRR	-	-	-	2	0	**0.0%**	3	1	**33.3%**	**0.0**
Common Goals	-	-	-	1	0	**0.0%**	-	-	-	-
County Substance Use Access	-	-	-	-	-	-	-	-	-	-
Court Legal Services	-	-	-	-	-	-	-	-	-	-
Emergency Warming Center	-	-	-	-	-	-	1	1	**100.0%**	**3.0**
Employment Services/ CalWORKS/ One Stop	-	-	-	-	-	-	3	1	**33.3%**	**0.0**
Faith-Based Org.	-	-	-	-	-	-	1	0	**0.0%**	**N/A**
FRC	1	1	**100.0%**	7	0	**0.0%**	4	2	**50.0%**	**10.5**
Financial Assistance	-	-	-	11	1	**9.1%**	-	-	-	-
Food Bank	-	-	-	2	2	**100.0%**	2	1	**50.0%**	**21.0**
Homeless Shelter	1	1	**100.0%**	2	0	**0.0%**	2	2	**100.0%**	**1.0**
Human Services (Benefits)	-	-	-	10	0	**0.0%**	10	-	**100.0%**	**9.3**
Legal Services	-	-	-	2	0	**0.0%**	-	-	-	-
Physician/ MD	1	1	**100.0%**	2	2	**100.0%**	-	-	-	-
Project MANA	-	-	-	-	-	-	5	2	**40.0%**	**1.0**
Public Health	-	-	-	-	-	-	-	-	-	-
SSI/ SSDI	-	-	-	-	-	-	6	3	**50.0%**	**1.0**
Tahoe Forest Hospital	-	-	-	-	-	-	2	2	**100.0%**	**143.0**
Tahoe SAFE Alliance	-	-	-	-	-	-	2	2	**100.0%**	**8.5**
Truckee Senior Housing	-	-	-	-	-	-	-	-	-	-
Veteran Services	-	-	-	-	-	-	1	1	**100.0%**	**0.0**
Other	2	2	**100.0%**	29	0	**0.0%**	23	20	**87.0%**	**2.6**
Total Referrals Connected/ Average	**6**	**5**	**83.3%**	**72**	**5**	**6.9%**	**70**	**52**	**74.3%**	**9.9**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. Timeliness was not collected before FY 2017-18. The average is not calculated for referrals that did not connect.

During FY 2016-17, staff engaged in targeted outreach to potential participants 72 times, averaging 1.5 hours per targeted outreach contact. At these target outreach meetings, 173 individuals were present for a total of 2.4 individuals per targeted outreach contact. During FY 2017-18, staff engaged in targeted outreach to potential participants 169 times, averaging 0.8 hours per targeted outreach contact. At these target outreach meetings, 192 individuals were present for a total of 1.1 individuals per targeted outreach contact. See the tables below for more detailed information.

Outreach	**FY 2016-17**	**FY 2017-18**
# Hours	105.7	126.8
# Contacts	72	169
Avg. Hours/Contact	**1.5**	**0.8**

Outreach	**FY 2016-17**	**FY 2017-18**
# Individuals Present	173	192
# Contacts	72	169
Avg. # Individuals/Contact	**2.4**	**1.1**

Across the years, staff has provided participants with many needed items, such as

- Camping supplies (e.g., sleeping bags, tents, backpacks)
- Blankets and warm clothes
- Hygiene bags
- Food vouchers
- Gas vouchers and local bus passes

Over the years, staff has spent time with participants to educate them or assist them towards meaningful goals, such as:

- Obtaining Snap card, Social Security card, California I.D., SSI/SSDI Benefits
- Obtaining permanent housing or transitional housing, Section 8 vouchers
- Advocating for and assisting admittance into extended care unit at the hospital
- Giving safety talks on snow/cold weather, bear safety
- Transporting participants to various locations (e.g., Warming Room)
- Moving out of county
- Discussing benefits of taking prescribed medications on a regular basis
- Promoting participants to go to rehab for drug and alcohol abuse.
- Obtaining restraining order against abuser
- Forming strong relationships with many participants in town
- Organizing the Homeless Count in Truckee and North Lake Tahoe

Challenges, Solutions, and Upcoming Changes

An ongoing challenge is the lack of resources for homeless individuals in the Truckee area, including a lack of permanent shelters and a lack of transitional housing. In addition, it can be difficult to locate potential program participants.

To address some of these challenges, we continue to train staff and learn about new skills such as **t**rauma-informed care, action planning, and small county wellness. In addition, we provide Life Skills and Personal Life-Enhancing Activities/Plans, Housing Readiness Workshops, and Job Readiness Workshops.

Program Participant Story

Staff worked extensively with an elderly Community Member who had lost their housing. The person was staying at a local hotel with money that they received through a deal with the landlord. This Community Member also was receiving SSI on a monthly basis and had a Section 8 voucher. Staff became aware of this situation through the public health nurse in Placer County, who had been working with the person for several years. The nurse let staff know that this person was not in good health, having abused alcohol and smoked cigarettes for many years. The person also had a pet, which further complicated the search for housing.

Working with the public health nurse, staff was able to get the pet to the Humane Society. Staff then assisted this Community Member in the decision to go to detox and rehab. In addition, staff transported this person to a detox facility. Staff looked for housing options for the person when they were ready to leave the facility. Unfortunately, there was no affordable housing in the area. In addition, the ability to stay sober and healthy in this area was a concern to this Community Member. The person decided that it would be best to move to Placer County.

Staff worked with the public health nurse to find and turn in several housing applications in Placer County, but none of these residences had immediate openings. Staff worked with this Community Member to help explain this process. The person decided that it would be best to live in a shelter temporarily as long as they had their pet. A shelter was found in Placer County that the person was willing and able to go to. An employee of the county transported this Community Member to the shelter.

Eventually, the Community Member was enrolled into the Placer County Whole Person Care program. The program assisted the person to obtain housing. As of the last contact staff had, this Community Member was successfully maintaining their housing as well as their sobriety.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY BEHAVIORAL HEALTH

Forensic Outreach

Program Description

Program Overview

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

Target Population

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

Evaluation Activities and Outcomes

Forensic Outreach collects evaluation activities for MHSA including demographic information on 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 2015-16, Forensic Outreach provided services to 67 unduplicated participants. In FY 2016-17, that number decreased to 18 unduplicated participants. In FY 2017-18, the number increased to 71 unduplicated participants. The program provided between 32 and 216 referrals to participants over the years, all of which connected successfully (100%). See the table below for more detailed referral information.

	FY 2017-18			FY 2017-18			FY 2017-18		
	# Referrals	# Connected	% Connected	# Referrals	# Connected	% Connected	# Referrals	# Connected	% Connected
Partner Agency	6	6	100.0%	2	2	100.0%	10	10	100.0%
NCBH	30	30	100.0%	6	6	100.0%	10	10	100.0%
Insight Respite House	3	3	100.0%	1	1	100.0%	3	3	100.0%
Crisis Stabilization Unit	7	7	100.0%	2	2	100.0%	2	2	100.0%
SPIRIT	10	10	100.0%	4	4	100.0%	5	5	100.0%
Hospitality House/Homeless Shelter	31	31	100.0%	6	6	100.0%	15	15	100.0%
A New Day	1	1	100.0%	-	-	-	-	-	-
Freed	6	6	100.0%	2	2	100.0%	1	1	100.0%
CoRR	14	14	100.0%	-	-	-	3	3	100.0%
Common Goals	19	19	100.0%	-	-	-	7	7	100.0%
First Five	1	1	100.0%	-	-	-	-	-	-
Chapa De	2	2	100.0%	-	-	-	1	1	100.0%
Physician/ MD	5	5	100.0%	1	1	100.0%	3	3	100.0%
Therapist/ Psychiatrist (Private)	5	5	100.0%	-	-	-	-	-	-
Sierra Nevada Memorial Hospital	4	4	100.0%	1	1	100.0%	2	2	100.0%
Western Sierra Medical Clinic	19	19	100.0%	-	-	-	4	4	100.0%
Social Services Agency	9	9	100.0%	1	1	100.0%	8	8	100.0%
Food Bank	1	1	100.0%	-	-	-	3	3	100.0%
APS	2	2	100.0%	1	1	100.0%	2	2	100.0%
IHSS	1	1	100.0%	1	1	100.0%	1	1	100.0%
Human Services (Benefits)	23	23	100.0%	2	2	100.0%	3	3	100.0%
Employment(one-stop)/ CalWORKs	5	5	100.0%	1	1	100.0%	1	1	100.0%
Legal Services	1	1	100.0%	1	1	100.0%	1	1	100.0%
Veteran Services	2	2	100.0%	-	-	-	-	-	-
Faith-Based Organization	4	4	100.0%	-	-	-	3	3	100.0%
Community Beyond Violence	3	3	100.0%	-	-	-	-	-	-
211	-	-	-	-	-	-	10	10	100.0%
Sierra Family	1	1	100.0%	-	-	-	-	-	-
Other	1	1	100.0%	-	-	-	-	-	-
Total Referrals	**216**	**216**	**100.0%**	**32**	**32**	**100.0%**	**98**	**98**	**100.0%**

Challenges, Solutions, and Upcoming Changes

One challenge of the program is having a single point of contact for both local police departments, and still no consistent point of contact in the Nevada County Sheriff's Office (NCSO). Based upon a successful and evolving partnership with the Grass Valley Police Department there is a viable and functioning model for community partnership in place. Under the leadership of officials from Nevada County Health and Human Services Agency (HHSA), a Homeless Outreach Team (HOT) has been formed and has been meeting bi-monthly for two (2) months. This forum provides community partners with a platform to collaborate and build relationships with law enforcement officers. With the Sheriff's race set to be decided in November, a designated liaison officer and a more consistent level of participation from the NCSO is expected and will be appreciated.

The lack of low barrier, affordable housing in our community continues to be an obstacle to stabilization and 'housing readiness' with individuals who are chronically homeless and have substance use disorders. Supportive program housing options that do exist often come with behavioral expectations. These expectations create barriers to providing bridge housing for individuals who require adjustment periods to acclimate successfully to the structure and change of living indoors. HHSA staff are working on the creation and implementation of new housing programs that would make accessible more low-barrier housing options in the community. These programs are currently in the development stage.

Program Participant Story

Staff worked intensively with an individual who had been arrested for a violent crime. Due to the presence of untreated mental illness and pervasive, chronic substance use, staff was able to work with this individual's attorney, the Superior Court of Nevada County, and a variety of local service providers, including Hospitality House, Insight Respite Center, Nevada County Probation, and Advocates for Mentally Ill AMI Housing (AMIH) to pursue a reduction of the individual's charges, and a community driven treatment model.

From the individual's release from custody at the Nevada County jail to the first night in Hospitality House, this program was able to connect the individual with community partners and informed, supportive services. The individual was able to transition to Insight Respite Center, connect with mental health treatment providers and substance abuse counselors at NCBH and Common Goals, and eventually transition into permanent supported housing with assistance from AMIH and NCBH.

This individual is currently housed and actively receiving both mental health treatment and addiction and recovery support and services. This individual is pursuing employment.

PEI Project Name: Access and Linkage to Treatment Program

WHAT'S UP? WELLNESS CHECK UPS

Program Description

Program Overview

The What's Up? Wellness Checkups (WUWC) program screens high school students in the Nevada Joint Union High School District (NJUHSD) and Tahoe Truckee Unified School District (TTUSD) for suicide risk, depression, anxiety, and other emotional health issues. Students privately take a brief, computerized diagnostic questionnaire, followed by a one-on-one interview with program staff, who then connect students with community resources, in-school supports, and/or case management and crisis support as needed. In the case of a necessary, immediate connection or referral, WUWC staff serve as one of the primary support systems for the student's family, providing both in-person and phone-based crisis intervention and referrals to local crisis agencies. WUWC also facilitates evidence-based stress reduction groups for students on campus, as extra prevention support for those identified with mild to moderate symptoms. WUWC identifies and helps youth at-risk, promotes wellness, increases peer support systems, and strengthens family connections.

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

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

Ongoing translation and interpretation services are provided by the WUWC Translator/ Interpreter/ Promotora, and local Family Resource Centers as needed. In FY 2016-17, WUWC's Translator/ Interpreter/ Promotora as well as the Grass Valley FRC Promotora provided support and outreach to students and families. Staff have continued to develop systems to ensure that Spanish-speaking families are receiving outreach, case management, and follow-up services.

Target Population

WUWC targets high school students at the NJUHSD and TTUSD schools, including Bear River, Ghidotti, Nevada Union, Nevada Union Tech, Silver Springs, Northpoint Academy, North Tahoe, Truckee, Sierra, Western Sierra Youth Build, Sierra Academy for Expeditionary Learning, and

Earl Jamieson high schools. WUWC focuses outreach on incoming freshmen for prevention, as Grade 10 has the highest national suicide completion rate.

Evaluation Activities and Outcomes

WUWC collects evaluation activities for MHSA including demographic information for each individual person 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 2015-16, 292 high school students were screened for mental health issues. Of those students, 75 received case management services including referrals, screening summaries, in-person family meetings, and/or prevention group services (e.g., Mindfulness groups, Boys groups). During FY 2016-17, 366 students were screened. Of those students, 163 received case management services and/or prevention group services. During FY 2017-18, 393 students were screened. Of those students, 141 received case management services and/or prevention group services.

During FY 2015-16, 38 WUWC prevention groups (e.g., Mindfulness groups, Boys groups) were provided. During FY 2016-17 and FY 2017-18, more detailed information on attendance in groups was collected. During FY 2016-17, there were 53 meetings of prevention groups with an average attendance of 5.8 students per group. During FY 2017-18, there were 35 group meetings with an average attendance of 7.1 students per group. See the table below for more information.

	FY 2016-17	**FY 2017-18**
Number of Groups	53	35
Attendance	310	247
Avg. Attendance/Group	**5.8**	**7.1**

During FY 2015-16, WUWC provided 159 referrals to school-based or outside agencies with 110 (69%) of those referrals successfully connecting. During FY 2016-17, WUWC provided 132 referrals to school-based or outside agencies with 99 (75%) of those referrals connecting. During FY 2017-18, WUWC provided 94 referrals to school-based or outside agencies with 68 (72%) of those referrals connecting. See the tables below for more information.

	FY 2015-16			FY 2016-17		
Agencies	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**
211	3	3	**100.0%**	1	1	**100.0%**
Anew Day	-	-	**-**	1	1	**100.0%**
Academic Support	9	6	**66.7%**	-	-	**-**
Chapa De	1	1	**100.0%**	2	2	**100.0%**
Community Teen Center	1	0	**0.0%**	-	-	**-**
CoRR	-	-	**-**	1	1	**100.0%**
Cultural-Specific Services	2	2	**100.0%**	4	4	**100.0%**
Community Beyond Violence	2	2	**100.0%**	1	0	**0.0%**
Employment/ CalWORKS	2	2	**100.0%**	-	-	**-**
Family Resource Center	2	2	**100.0%**	3	1	**33.3%**
Food Bank	1	1	**100.0%**	-	-	**-**
Hospitality House/ Homeless Shelter	1	1	**100.0%**	-	-	**-**
Human Services (Benefits)	-	-	**-**	1	1	**100.0%**
Legal Services	1	1	**100.0%**	-	-	**-**
Mental Health	26	13	**50.0%**	36	25	**69.4%**
Mental Health Support	18	14	**77.8%**	-	-	**-**
NAMI	2	1	**50.0%**	-	-	**-**
Partner Agency	10	6	**60.0%**	1	1	**100.0%**
Physician/ MD	1	1	**100.0%**	3	2	**66.7%**
School-Based Services	24	12	**50.0%**	40	34	**85.0%**
Sierra Nevada Memorial Hospital	-	-	**-**	1	1	**100.0%**
Support Group	24	19	**79.2%**	-	-	**-**
Tahoe SAFE Alliance	-	-	**-**	2	2	**100.0%**
Therapist/ Psychiatrist (Private)	13	11	**84.6%**	7	6	**85.7%**
Western Sierra Medical Clinic	-	-	**-**	1	0	**0.0%**
Other	16	12	**75.0%**	27	17	**63.0%**
Total Referrals Connected	**159**	**110**	**69.2%**	**132**	**99**	**75.0%**

	FY 2017-18			
Agencies	**# Referrals**	**# Connected**	**% Connected**	**Average Timeliness***
211	1	0	**0.0%**	**N/A**
Academic Support	5	5	**100.0%**	**Unknown**
Behavioral Specialist	2	2	**100.0%**	**Unknown**
Counseling Center	1	0	**0.0%**	**N/A**
Community Beyond Violence	1	1	**100.0%**	**0.0**
Family Resource Center	1	1	**100.0%**	**0.0**
Financial Assistance	1	1	**100.0%**	**0.0**
Mental Health	17	12	**70.6%**	**Unknown**
Mental Health Support	19	16	**84.2%**	**Unknown**
Physician/ MD	1	0	**0.0%**	**N/A**
Support Group	18	8	**44.4%**	**Unknown**
Therapist/ Psychiatrist (Private)	7	6	**85.7%**	**Unknown**
Wellness Center	2	1	**50.0%**	**Unknown**
Other	18	15	**83.3%**	**0.0**
Total Referrals Connected	**94**	**68**	**72.3%**	**0.0**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. Timeliness was not collected before FY 2017-18. Unknown averages are due to dates of referral and/or dates of appointment being unavailable. Average is not calculated for referrals that did not connect.

During FY 2016-17 and FY 2017-18, a Group Evaluation Survey was administered to group participants. The surveys indicated that most students felt the group improved their stress-coping skills. See the table below for more information.

	FY 2016-17		FY 2017-18	
Group Evaluation Survey Items	**% Pre Agree**	**% Post Agree**	**% Pre Agree**	**% Post Agree**
I view stress as a manageable part of my life.	30.8%	48.0%	36.0%	56.7%
I am aware of how stressed I am.	69.2%	80.0%	76.0%	90.0%
I am aware of how I respond to stress.	28.0%	70.8%	54.0%	63.3%
I am able to use positive coping skills to deal with my stress.	30.8%	68.0%	38.0%	43.3%
I have replaced negative coping skills with positive coping skills.	26.9%	64.0%	40.0%	47.8%
Total Surveys Submitted	**N = 26**		**N = 32**	

Over the years, WUWC provided media outreach through radio and newspapers, reaching up to 64,000 listeners and readers.

Challenges, Solutions, and Upcoming Changes

One challenge has been low screening participation rates at North Point Academy due to the independent study schedules of the students. To address this challenge, WUWC attempted both Fall and Spring outreach to engage consenting parents, including offering online appointments, email links, and paper mailings. These attempts did not increase participation, so screenings at North Point Academy in FY 2018-19 will continue on an as-needed basis, opening up the possibility of offering services at a new school site in FY 2018-19.

Another challenge has been the lack of parent engagement in case-management services. Case management protocol has been developed to include in-person meetings with parents to increase parent participation in WUWC services.

One challenge was the sudden medical leave of a WUWC Volunteer Screening Counselor in mid-year. WUWC staff increased hours to manage gaps in the screening schedule

Program Participant Story

One of the main strengths of the WUWC program is screening and helping students who are experiencing mental health symptoms that have not yet been identified. In one case, WUWC helped a student who had been identified in school as having "discipline" issues and had been given a few detentions. Because of the checkup, WUWC was able to see that the student had actually been having acute anxiety and possible panic attacks in school and often left class to become calm. The student was afraid to approach teachers with this issue. WUWC engaged with the teen and the teen's parent to get permission to talk with the school counselor and connect the student with STARS. The student also became involved with one of WUWC's prevention groups. The teen began working with the counselor on tools to not only manage stress in school but also to make a plan with teachers for when extra support is needed. These tools allowed the teen to no longer have the label as having "discipline" issues, which helped strengthen both the teen's emotional and academic worlds.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY ADULT SERVICES
Veterans Service Office Outreach and Linkage

Program Description

Program Overview

The Veterans Service Office 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.

Target Population

Nevada County's veterans and their dependents. There are approximately 9,500 veterans in the county.

Evaluation Activities and Outcomes

The Veterans Outreach and Linkage program collects evaluation activities for MHSA including demographic information for each individual person receiving referrals. Information on referrals to community services is also collected. The Veterans Outreach and Linkage program began Nevada County PEI services in July 2016.

During FY 2016-17, the first year of services for the Veterans Outreach and Linkage program, a total of 20 veterans and/or their dependents were served. In FY 2017-18, that number increased to 27 veterans and/or their dependents.

The number of referrals to other agencies increased across the two (2) years, from 24 to 85 referrals to other agencies. Due to the program coordinator position, being vacant for several months at the end of FY 2017-18, follow-up on connections to referrals did not happen for several referrals. See the table below for more information.

	FY 2016-17			FY 2017-18			
Agencies	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**	**Average Timeliness**
211	-	-	**-**	4	0	**0.0%**	**N/A**
Adult Protective Services (APS)	2	2	**100.0%**	-	-	-	**-**
Crisis Stabilization Unit	1	1	**100.0%**	-	-	-	**-**
Faith-Based Organization	-	-	**-**	4	0	**0.0%**	**N/A**
Food Bank	-	-	**-**	12	0	**0.0%**	**N/A**
Freed	-	-	**-**	10	0	**0.0%**	**N/A**
Hospitality House/ Homeless Shelter	-	-	**-**	2	0	**0.0%**	**N/A**
In-Home Support Services (IHSS)	-	-	**-**	3	0	**0.0%**	**N/A**
Partner Agency	12	11	**91.7%**	-	-	-	**-**
Sierra Nevada Memorial Hospital	-	-	**-**	2	0	**0.0%**	**N/A**
Social Services Agency	-	-	**-**	8	0	**0.0%**	**N/A**
SPIRIT	-	-	**-**	1	0	**0.0%**	**N/A**
Veteran Services	8	7	**87.5%**	10	0	**0.0%**	**N/A**
Western Sierra Medical Clinic	-	-	**-**	3	0	**0.0%**	**N/A**
Other	1	1	**100.0%**	26	10	**38.5%**	**12.0**
Total Referrals Connected	**24**	**22**	**91.7%**	**85**	**10**	**11.8%**	**12.0**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. Timeliness was not collected before FY 2017-18. Average is not calculated for referrals that did not connect.

The program engaged in outreach to the community over the years, as well. During FY 2016-17, there was a total of seven (7) outreach events with an estimated 335 in attendance across all events. In FY 2017-18, there were four (4) events with an estimated 505 in attendance across events. Some examples of outreach events are the All Veterans Stand Down events and outreach at community colleges.

Challenges, Solutions, and Upcoming Changes

The Veterans Service Office has been challenged with a limited amount of time to accurately complete the data collection forms. The Veterans Service Representative's (VSR's) calendar typically consists of back-to-back appointments. Usually, each Veteran spends upward of 45 minutes with a VSR when applying for Federal or State benefits. The forms that the VSR produces are also lengthy and each application for benefits consists of many different forms. Each of these forms is necessary to ensure that each Veteran is submitting a fact-based claim that has a high

probability to be successfully funded.

An additional challenge the Veterans Service Office encounters is that Veterans, in general, dislike applying for benefits or services that are not Veteran focused. This obstacle is overcome through the coaching by the VSR, explaining that these County programs will assist them in overcoming the challenges they are facing as they wait for a decision on their claim. It is because of this challenge that documentation from the Veterans Service Office does not reflect all of the referrals made. Many times, the VSR will do a soft hand-off to other agencies within the building to ensure the Veteran is comfortable with the new process that he or she is engaging in.

Compounding these issues, the program coordinator left the position during FY 2017-18, leaving the position vacant for several months through the end of FY 2017-18. The position was filled in September 2018 and the new program director has spent the remainder of the year getting acclimated to the new position and engaging the Veteran community. The new program director has been trained on the data collection protocol and is committed to ensuring that the Veteran Service Office makes prompt referrals to Social Services.

Program Participant Story

Due to the program director position being vacant at the end of FY 2017-18, there is no new participant story for this program.

PEI Project Name: Stigma and Discrimination Reduction Programs

FAMILY RESOURCE CENTER OF TRUCKEE
Promotora Program - Latino Outreach Services

Program Description

Program Overview

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

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

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

The Promotoras link individuals and families that they serve to needed services in the community, which include mental health services, and when necessary, they accompany individuals to their first appointment for a warm handoff to the mental health professional. Promotoras can refer individuals and families to NCBH Spanish-speaking therapists in Truckee. The therapists provide services to individuals, or if the consumer is a child, services are provided to the child and their family.

Target Population

The Family Resource Center of Truckee Promotora Program primarily serves Latino families who could benefit from supportive services and assistance to link them to needed services in the community.

Evaluation Activities and Outcomes

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

The FRCoT Promotoras Program has grown over the fiscal years. During FY 2015-16, FRCoT delivered services to 61 unduplicated individuals. During FY 2016-17, that number increased to 120 unduplicated individuals. In FY 2017-18, the number increased again to 156 unduplicated individuals.

The number of individuals accessing individual services increased across the fiscal years, as well. Of the 61 participants in FY 2015-16, 20 accessed individual services. In FY 2016-17, of the 120 participants, 20 accessed individual services. During FY 2017-18, of the 156 individuals, 36 accessed individual services. Most participants across the years (from 65% to 90%) had one (1) contact with the Promotora. See the table below for more detailed individual service information.

	FY 2015-6		**FY 2016-17**		**FY 2017-18**	
Number of Service Contacts*	**# Served**	**% Served**	**# Served**	**% Served**	**# Served**	**% Served**
1 Contact	18	90.0%	13	65.0%	28	77.8%
2 – 4 Contacts	2	10.0%	7	35.0%	7	19.4%
5 – 7 Contacts	-	-	-	-	1	2.8%
8+ Contacts	-	-	-	-	-	-
Unduplicated Total	**20**	**100.0%**	**20**	**100.0%**	**36**	**100.0%**

Across the fiscal years, the number of participants accessing group services also increased. All of the 61 participants in FY 2015-16 accessed group services. In FY 2016-17, of the 120 participants, 105 accessed group services. During FY 2017-18, of the 156 individuals, 129 accessed group services. All groups aimed to help destigmatize mental health by focusing on how mental and physical well-being are linked. See the table below for more detailed group service information.

	FY 2015-16	**FY 2016-17**	**FY 2017-18**
	Unduplicated N=61	*Unduplicated N=105*	*Unduplicated N=129*
Number of Groups	34	82	89
Attendance	244	568	740
Average Attendance per Group	**7.2**	**6.9**	**8.3**

Referrals to outside agencies were recorded during FY 2016-17 and FY 2017-18. Promotoras made 32 referrals during FY 2016-17 and 64 referrals during 2017-18. Successful connections improved from 37.5% to 85.9% across the fiscal years. The timeliness of referrals to connection

was recorded for 10 of the successful connections during FY 2017-18. The average time to connection was 4.7 days. See the table below for more detailed referral information.

	FY 2016-17			FY 2017-18			
Agencies	**# Referrals**	**# Connected**	**% Connected**	**# Referrals**	**# Connected**	**% Connected**	**Average Timeliness***
Adult Mental Health	1	1	**100.0%**	1	1	**100.0%**	**Unknown**
Faith Based Organization	-	-	-	1	1	**100.0%**	**Unknown**
Financial Benefits	-	-	-	1	0	**0.0%**	**N/A**
Family Resource Center	7	4	**57.1%**	9	7	**77.8%**	**14.5**
Immigration	2	0	**0.0%**	4	2	**50.0%**	**Unknown**
Legal Services	1	1	**100.0%**	6	6	**100.0%**	**Unknown**
Mental Health Service Provider	11	1	**9.1%**	10	9	**90.0%**	**Unknown**
Partner Agency	-	-	-	3	2	**66.7%**	**4.0**
Physician/ MD	4	2	**50.0%**	-	-	-	**N/A**
Private Therapist	-	-	-	2	2	**100.0%**	**Unknown**
Public Health	-	-	-	1	1	**100.0%**	**Unknown**
School/ Training Program	-	-	-	8	8	**100.0%**	**Unknown**
Social Services Agency	3	3	**100.0%**	1	1	**100.0%**	**Unknown**
Tahoe Forest Hospital District	-	-	-	2	2	**100.0%**	**Unknown**
Tahoe Forest Hospital Multi-Specialty Clinic	-	-	-	1	1	**100.0%**	**Unknown**
Tahoe SAFE Alliance	-	-	-	1	1	**100.0%**	**1.0**
Transportation Services	-	-	-	6	4	**66.7%**	**1.0**
TTUSD	-	-	-	1	1	**100.0%**	**Unknown**
Other	3	0	**0.0%**	4	4	**100.0%**	**5.0**
Unknown	-	-	-	2	2	**100.0%**	**1.0**
Total Referrals Connected	**32**	**12**	**37.5%**	**64**	**55**	**85.9%**	**4.7**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. Timeliness was not collected before FY 2017-18. Unknown averages due to dates of referral and/or dates of appointment being unavailable. The average is not calculated for referrals that did not connect.

Promotoras also outreached to the community over the fiscal years. During FY 2015-16, Promotoras offered 97 outreach activities to different individuals and/or groups, attempting to destigmatize mental health in the community and attract community members to other FRC programming. At these outreach activities, Promotoras provided peer and parenting support to community members, organized arts and crafts activities, and provided mental health education. For the past two (2) fiscal years, Promotoras focused more on providing outreach activities to

organized groups, and as a result fewer outreach activities were documented. Promotoras outreached at two (2) events each year. See the table below for more detailed outreach information.

	FY 2015-16	**FY 2016-17**	**FY 2017-18**
# Outreach Events	97	2	2
# Estimated Attendance	1,985	44	155
Average Estimated Attendance per Event	**20.5**	**22.0**	**77.5**

Promotoras administered a survey assessing attitudes toward mental health to attendees of the psycho-educational groups during FY 2017-18. Results were positive with most respondents reporting a more positive and understanding attitude toward mental health issues after attending the groups as compared to before attending. For example, 45.5% of respondents agreed with the statement, "I believe that a person who has a mental illness can eventually recover" before attending the group, whereas 64.6% agreed after attending. See the table below for more detailed attitude survey information.

Attitude Survey FY 2017-18	Before Attending		After Attending		Attitude Change
	% Agree	N	% Agree	N	%
I believe that a person who has a mental illness can eventually recover	45.5%	55	64.6%	48	**19.1%**
I know how to support a person who has a mental illness	25.5%	55	49.0%	51	**23.6%**
I plan to take action to prevent discrimination against people who have a mental illness	32.7%	55	55.1%	49	**22.4%**
People who have a mental illness experience high levels of prejudice and discrimination	40.0%	55	42.9%	49	**2.9%**
	% Disagree	N	% Disagree	N	%
People who have had a mental illness are never going to be able to contribute to society	32.1%	53	42.9%	49	**10.8%**
I believe that a person who has a mental illness is a danger to others.	35.2%	54	49.0%	51	**13.8%**
Imagine that you had a problem that you needed to be treated by a mental health professional. Which of the following would you do? Would you…	% Never	N	% Never	N	%
… deliberately conceal your mental illness from your friends or family?	31.5%	54	59.6%	52	**28.1%**
… deliberately conceal your mental illness from others?	35.2%	54	58.8%	51	**23.6%**
… delay seeking treatment for fear of letting others know about your mental illness?	27.8%	54	58.8%	51	**31.0%**
	% Never	N	% Never	N	%
If someone in your family had a mental illness, would you feel ashamed if people knew about it?	29.1%	55	51.9%	54	**22.8%**
	% Always	N	% Always	N	%
If you had a mental illness, would you seek professional help?	14.5%	55	33.3%	54	**18.8%**

Challenges, Solutions, and Upcoming Changes

The Promotora team has a new Program Coordinator who brings different strengths and ideas to FRCoT. She is essential to this role as demonstrated by her ability to work with culturally and economically diverse individuals and families.

In the coming year, FRCoT will begin offering education and community building workshops at Truckee Pines and Sierra Village Apartments.

This fiscal year, FRCoT struggled with data collection and entry. Staff have put in a new protocol of reviewing all submitted data collection forms after they are entered into the database in order to ensure fidelity. Staff will continue to work hard to improve this area of work.

Program Participant Story

An adolescent girl began participating in a physical fitness class at FRCoT. Her mother had encouraged her to attend after noticing that the girl had begun feeling sad and insecure. The girl seemed to be getting messages from many different parts of her life that her body was not ideal. From social media to her peers, the girl was receiving comments about her weight, which had a negative impact on her. She felt that clothes did not fit her well, when comparing herself to the thin mannequins at the store or to her peers. This made her feel more pressure to live up to these 'beauty' standards. These pressures led to her lowered self-esteem, insecurity, and sadness that bordered on depression.

The girl and her mom began to attend the fitness classes regularly. The girl began to feel motivated to lift herself out of her sadness. With help from her mother, she started to see changes and her mood improved. The Promotoras also connected the family with a nutritionist and a counselor. Eventually, the girl felt so motivated, she started arriving at workshops by herself, without her mother telling her to go. The girl now knows that she has support not only from her mother, but also from the network of Promotoras and other staff of FRCoT. She is feeling healthy and, most of all, she is feeling happy.

PEI Project Name: Stigma and Discrimination Reduction Program

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

Program Description

Program Overview

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

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

Target Population

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

Evaluation Activities and Outcomes

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

During FY 2015-16, the NCSOS Promotora program delivered services to 228 unduplicated individuals. That number increased to 275 in FY 2016-17, then decreased to 235 in FY 2017-18.

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

During FY 2015-16, the program provided:

- Eight (8) Wellness and Recovery Action Plan (WRAP) sessions
- One (1) Know the Signs workshop
- Three (3) safeTALK workshops
- One (1) Diabetes and Mood group
- Four (4) Nutrition and Yoga for Stress groups

- 10 English as a Second Language (ESL) Mental Health Conversations

During FY 2016-17, the program provided:

- Emergency Preparedness by Fire Chief M. Buttron and Emergency Services J. Gulserian
- Six Keys to Physical and Mental Health by Dr. Vassar
- Uncertainties by Attorney Sara Coppin with Q&A session
- Kings Day Traditional Event
- Less Stress for Better Health
- Know Yourself
- Yoga Breathing to Destress by Spec. Sari Pinto
- Personalities … Weakness Overcome by Strengths by Meg Luce, LMFP
- WRAP Presentation to FRC Staff by N. Mead.
    - 11 individuals made WRAP plans in one (1) to three (3) hour sessions.

During FY 2017-18, staff provided varied services, such as information regarding domestic violence, alcohol and drugs; assistance with medical and dental appointments, school issues, individualized education programs (IEPs), traffic violations, and immigration information; translation assistance with medical applications, housing applications, rental issues (e.g., eviction notices), and other documents. Staff also provided translation clinics, ESL tutors and parenting classes. Staff distributed mental health awareness pamphlets. See the table below for more information on services provided by the Promotora.

Activity/ Service	# Attendance/ Contacts	% Attendance/ Contacts
Medi-Cal Enrollment and Information	30	4.9%
WRAP Plan Sessions	7	1.1%
WRAP Invitation	12	2.0%
Immigration / DACA Information	31	5.1%
Referral to NCBH	10	1.6%
Mental Health Pamphlet Distribution	19	3.1%
NCBH Follow-Up	9	1.5%
Community Beyond Violence Referral	5	0.8%
Individualized Education Plan (IEP) Translation Parent contact and assistance	17	2.8%
Dental / Medical Information	7	1.1%
Clothes / Food	60	9.8%
DMV Drivers license test/ Car Insurance Information	7	1.1%
Homeless Assistance	1	0.2%
Psychoeducational Meetings Unduplicated Attendance	219	35.8%
Legal Documents Assistance	12	2.0%
Miscellaneous Assistance	47	7.7%
Housing Assistance	16	2.6%
Know the Signs Information	11	1.8%
School Enrollment Information and Assistance	34	5.6%
AOD Information	2	0.3%
ESL / GED Information Assistance	25	4.1%
Volunteers	31	5.1%
Total Attendance/ Contacts	**612**	**100.0%**

Postcards	# Mailings
Total Postcards Mailed	860

During FY 2016-17, after the "Know the Signs" workshop, 12 individuals reported a deeper understanding of suicide awareness. In addition, after a series of three (3) stress-reduction meetings, participants were surveyed. Approximately 40% reported a reduction in their stress levels, felt they learned how to manage stress better, and felt they would sleep better. Over 90% of those attending the meetings increased their knowledge of mental health illnesses and are aware of available resources.

During FY 2017-18, participants of the psycho-educational groups were asked to complete a survey assessing their views of mental health issues after attending the groups. Overall, participants responded positively. See the table below for a sample question from the survey.

Mental Health Survey	**% Yes**	**N**
¿Te sientes cómodo para solicitar servicios de salud mental para ti u otros? *Translation: Do you feel comfortable requesting mental health services for yourself or others?*	100.0%	11

During FY 2015-16, 149 referrals were made to outside agencies. During FY 2016-17, in collaboration with Staff made 11 referrals to outside agencies, of which 7 (63.6%) successfully connected.

Challenges, Solutions, and Upcoming Changes

A major working challenge in the Western Nevada County Latino community is the lack of Spanish-speaking mental health therapists available to deliver services to community members. Currently, there is one (1) female bilingual therapist endeavoring to provide services to all the Spanish speaking referrals. There is no male bilingual therapist to serve the two (2) male participants who solicited treatment by a male therapist. The two (2) participants are still waiting for their preferred treatment.

An ongoing challenge is attracting and maintaining the interest of the community members on mental health issues. Currently community members' needs for resources outweighs their desire to be educated and acquire new information regarding mental health. Providing translation services and assistance with legal and other documents, helps attract visitors to the FRC, and once they are engaged, staff is able to advertise the psycho-educational groups, educate community members about mental health disorders though pamphlets, and invite open discourse. Staff will continue to update approaches to outreach in order to engage new families.

Program Participant Story

A story from a visitor to the FRC (edited for clarity):
I went to see the doctor several times because I could not sleep and felt very depressed and anxious. Everything bothered me, even the light and any sounds. I considered taking all of the sleeping pills I had because I did not want to live feeling that way. At one point, I even thought I might cut my veins. I called Mrs. Mead (the FRC Promotora) for help. She took me to the Crisis Stabilization Unit where everybody was very understanding and courteous. After three (3) resting days, I was able to see things in a different way. I am still in treatment, but now I feel supported. Thank you for offering me help without monetary cost. I value my life and love my family. Thank you, thank you.

PEI Project Name: Suicide Prevention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Suicide Prevention and Intervention

Program Description

Program Overview

The Suicide Prevention and Intervention (SPI) Program is working to build a "suicide-safer community." An SPI Coordinator organizes and leads the implementation of this program. The SPI Coordinator works with consumers, individuals, families, support groups, task forces, community-based organizations, local and state governments, schools, crisis lines, and health clinics. The goals of the program are to raise awareness that suicide is preventable, reduce stigma around suicide and mental illness, promote help-seeking behaviors, and implement suicide prevention and intervention training programs.

The SPI Coordinator uses an evidence-based curriculum, such as safeTALK, and other evidence-based practices to conduct outreach in the community, build community capacity, and provide linkage to services. The Coordinator provides these services in schools, faith-based organizations, business communities, county offices, public health sites, city offices, and to individuals and organizations that request assistance. The SPI Coordinator reaches people in the community who ordinarily would not be aware of mental health resources or how to access them.

The SPI coordinator collaborates with a number of community organizations, including, the Suicide Prevention Task Force (SPTF), the Tahoe Truckee Suicide Prevention Coalition, the Fall Prevention Coalition (FPC), the Elder Care Providers Coalition (ECPC), PFLAG, the Hope and Heal Fund (to stop gun violence), TTUSD, Tahoe SAFE Alliance, among others.

Target Population

The SPI program serves the entire population of Nevada County.

Evaluation Activities and Outcomes

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

During FY 2015-16, the SPI Program offered 10 Training Workshops to 165 attendees. In FY 2016-17, the program offered nine (9) workshops to 111 attendees. In FY 2017-18, the program offered 13 Training Workshops to 230 attendees. During FY 2015-16 and FY 2016-17, workshops included Know the Signs and safeTalk. In FY 2017-18, Applied Suicide Intervention Skills

Training (ASIST) and Suicide to Hope workshops were added. See the table below for more detailed training information.

		FY 2015-16	FY 2016-17	FY 2017-18
ASIST	# Trainings	-	-	1
	Attendance	-	-	26
	Avg. Attendance/Training	-	-	26.0
Know the Signs	# Trainings	6	5	10
	Attendance	72	57	168
	Avg. Attendance/Training	12.0	11.4	16.8
safeTALK	# Trainings	4	4	1
	Attendance	93	54	25
	Avg. Attendance/Training	23.3	13.5	25.0
Suicide to Hope	# Trainings	-	-	1
	Attendance	-	-	11
	Avg. Attendance/Training	-	-	11.0
Total Attendance (All Programs)	# Trainings	**10**	**9**	**13**
	Attendance	**165**	**111**	**230**
	Avg. Attendance/Training	**16.5**	**12.3**	**17.7**

At the safeTALK, ASIST, and Suicide to Hope training workshops, surveys were administered to assess the effectiveness of each training. Overall, attendees responded positively to the training workshops. See the table below for selected survey responses.

	FY 2015-16		FY 2016-17		FY 2017-8	
SafeTALK Feedback Questionnaire	**% Prepared**	**N**	**% Prepared**	**N**	**% Prepared**	**N**
How prepared do you now feel to talk directly and openly to a person about their thoughts of suicide?	97.3%	74	100.0%	43	95.2%	21
ASIST Survey	-	-	-	-	**% Agree**	**N**
I feel prepared to help a person at risk of suicide.	-	-	-	-	100.0%	25
Suicide to Hope Survey	-	-	-	-	**% Agree**	**N**
I have improved knowledge and skills that will help me work with those with lived experience of suicide	-	-	-	-	100.0%	10

Challenges, Solutions, and Upcoming Changes

One major change for the new fiscal year is that the SPI Coordinator retired from County service at the end of FY 2017-18. Public Health and Behavioral Health are working together to identify essential job functions. Program transitional challenges are to be expected.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is tasked with developing a Statewide Suicide Prevention Plan with the goal to reduce suicide deaths, attempts, and self-harm. This will become the framework California counties will reference in developing local strategies. The MHSOAC will work with survivors of suicide attempts, mental health consumers and family members, state agencies, counties, providers, community leaders and others to develop the plan. Once complete, it will outline an action agenda for the State of California, counties, the mental health community, and other partners to reduce suicide deaths, attempts, suicidal thoughts and related harm to individuals, families, loved ones and communities.

Program Participant Story

A letter from a training workshop attendee (edited for clarity):

I met Kim (the SPI Coordinator) at a suicide prevention workshop; she was the SPI trainer at this workshop. I originally questioned why I needed to go and whether it would be helpful. I had gone through similar episodes that were reviewed in the workshop myself. However, Kim inspired me to take responsibility for my mental health, to not ignore or bypass the disease that lies beneath the surface but to accept that it is there and take action. She gave me space to feel, to be sad, angry, and upset that there is in fact something to address and take action on. She motivated me to reach out for help in a time when I felt stuck with my mental health and felt like I was spinning my wheels not getting anywhere. She connected me with different programs and people that would help me to see beneath the surface and get to the core of proper self-care. Kim checked in with me at least once a month to see how I was doing and how things were coming along. Her support helped me feel uplifted, as if I was being held and someone really truly believed in my abilities, my healing, and me. Kim, thank you for being you, for helping people like me to believe that we can get better.

A letter from a school administrator (edited for clarity):
The death of students has rocked our community. Students struggled with emotions and unfamiliar feelings of grief. I want to personally thank you and your amazing team of counselors for stepping up to the call to provide words of wisdom and personal attention to students across our county. Your willingness to share the load with school counselors is remarkable and I am so grateful to have the collaboration that we have here in Nevada County. I know the strain of "sharing" therapists can be burdensome, but you and your team were quick to respond to the call and I wanted you to know that it did not go unnoticed. Thank you so very much.

CALMHSA STATEWIDE PEI PROJECT

Program Description

Program Overview

In FY 2017-18, 46 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 2017-18, funding to the Statewide PEI Project supported programs such as maintaining and expanding public awareness and education campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to county agencies, schools and community based organizations, providing mental health/stigma reduction trainings to diverse audiences, engaging youth through the Directing Change program, and building the capacities of schools to address mental health, stigma reduction and suicide prevention.

Target Population

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

Evaluation Activities and Outcomes

The agencies, schools, and organizations that were reached with Statewide PEI Programs included Nevada County Children's Behavioral Health, Sierra College, Nevada County Public Health, Bear River High School, NAMI Nevada County, and the Giants Tickets Giveaway Winner.

Through the Statewide PEI Project during FY 2016-17, Nevada County agencies received:

- Online trainings that provided an overview of best practices in suicide prevention and mental health messaging, as a platform for judging submitted Directing Change videos.
- Directing Change: young people have the opportunity to create 60-second films about suicide prevention and mental health. Bear River High School submitted 7 total films in FY 17-18.
- E-Newsletters created specifically for service providers that provide information about relevant resources, upcoming events and opportunities for providers to get involved in California's Mental Health Movement.
- A total of 5,513 physical, hardcopy materials for Each Mind Matters programs and initiatives. In addition, county contacts received numerous emails to access and share resources electronically via the Each Mind Matters Resource Center (www.emmresourcecenter.org).

- Each Mind Matters Promotional Items: 3,019
- Each Mind Matters Educational Materials: 1,062
- SanaMente Materials (Spanish language Each Mind Matters Materials): 473
- Know the Signs/El Suicidio Es Prevenible Educational Materials: 800
- Directing Change Materials: 632

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 2017-18 include:

- Over 350,000 Lime Green Ribbons disseminated throughout the state
- Nearly 1 million hardcopy materials were disseminated in counties, schools, and CBOs
- Over $170,000 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 740 videos submissions from over 150 schools across California, engaging over 2,400 students
- Nearly 10 new Each Mind Matters culturally adapted resources were developed
- Over 30 news broadcasts, news articles and radio reports discussed programs implemented by the Statewide PEI Project
- Over 400 county agencies, schools, local and statewide organizations across California were touched by programs implemented by the Statewide PEI Project

Workforce Education and Training (WET)

Nevada County's WET plan was approved on June 17, 2009. By FY 16/17 all WET funds were expended. Thus, there are no outcomes to report for WET in FY 17/18

Innovation (INN)

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

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

Program Description

Program Overview

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

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

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

Target Population

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

Evaluation Activities and Outcomes

Unfortunately, the Innovation Personal Services Coordinator position experienced a lot of turnover during its start. As a result, it has been difficult to consistently collect data for this project. The first Personal Services Coordinator to deliver services began in April 2017, the Personal Services Coordinator position was vacant starting August 2017, and the current Personal Services Coordinator has been consistently delivering services since March 2018. Due to the inconsistent delivery of services, the data below is displayed for the time span April 2017 to June 2018.

During this time, the Personal Services Coordinator served 27 unduplicated participants, 18 Placer and nine (9) Nevada County residents. The Personal Services Coordinator delivered individual direct services for an average of 8.1 hours per participant. Most participants (74.1%) received two (2) or more contacts during this time period.

Service Category	**# Hours**	**# Served**	**Average Hours per Participant**
Assessment/ Screening	1.0	2	**0.5**
Case Management/ Linkage	152.4	24	**6.3**
Collateral	8.5	6	**1.4**
Rehab./ Mental Health Services	0.3	1	**0.3**
Support Services	27.5	10	**2.8**
Other	29.5	6	**4.9**
Total (All Services)	**219.2**	**27**	**8.1**

Number of Service Contacts	**# Served**	**% Served**
1 Contact	**7**	**25.9%**
2 – 4 Contacts	**10**	**37.0%**
5 – 7 Contacts	**2**	**7.4%**
8+ Contacts	**8**	**29.6%**
Unduplicated Participants	**27**	**100.0%**

The Personal Services Coordinator made 53 referrals, of which 39 were successfully connected. Of those that connected, the average time from referral to appointment was 8.2 days. See the table below for more information.

Agencies	# Referrals	# Connected	% Connected	Average Timeliness
Adult Mental Health	1	0	**0.0%**	**N/A**
EDD	2	1	**50.0%**	**3.0**
Employment Services/ One Stop	4	3	**75.0%**	**0.0**
Employment/ CalWORKS	2	0	**0.0%**	**N/A**
Family Resource Center	6	6	**100.0%**	**0.2**
In-home Support Services (IHSS)	2	2	**100.0%**	**4.5**
Legal Services	6	6	**100.0%**	**31.5**
Physician/ MD	2	2	**100.0%**	**0.0**
Project MANA	8	5	**62.5%**	**1.8**
Public Health	1	0	**0.0%**	**N/A**
Sierra Mental Wellness Group	3	2	**66.7%**	**3.5**
Social Services/ Human Services	1	1	**100.0%**	**1.0**
SSI/ SSDI	4	4	**100.0%**	**13.0**
Tahoe SAFE Alliance	2	2	**100.0%**	**3.5**
Wellness Centers	2	1	**50.0%**	**7.0**
Western Sierra Medical Clinic	2	2	**100.0%**	**0.0**
Western Sierra Medical Clinic - Kings Beach	1	1	**100.0%**	**21.0**
Other	4	1	**25.0%**	**15.0**
Total Referrals Connected	**53**	**39**	**73.6%**	**8.2**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. The average is not calculated for referrals that did not connect.

Three (3) participants were referred to the Personal Services Coordinator by NCBH Adult Mental Health and three (3) by Placer County Adult Mental Health. The remaining 21 participants did not indicate where they were referred from.

The Personal Services Coordinator also conducted outreach 16 times to an estimated 171 individuals, disseminating information regarding SMWG and mental health programs.

A part-time, bicultural Innovation Promotora is employed at the FRCoT, to support the Innovation Personal Services Coordinator. This position also had staffing challenges. During the April 2017 to June 2018 time period, the Promotora delivered individual direct services to nine (9) unduplicated participants for an average of 2.5 hours per participant.

Service Category	# Hours	# Served	Average Hours per Participant
Rehab./ Mental Health Services	0.8	1	**0.8**
Support Services	20.2	8	**2.5**
Crisis Intervention	1.3	1	**1.3**
Total (All Services)	**22.2**	**9**	**2.5**

Number of Service Contacts	# Served	% Served
1 Contact	8	88.9%
2 – 4 Contacts	-	-
5 – 7 Contacts	-	-
8+ Contacts	1	11.1%
Unduplicated Participants	**9**	**100.0%**

The Promotora made five (5) referrals during this time period, of which four (4) successfully connected. Of those that connected, the average time from referral to date of appointment with the agency was 16 days. See the table below for more information.

Agencies	# Referrals	# Connected	% Connected	Average Timeliness
Benefits (food bank, financial, etc.)	1	1	100.0%	**13.0**
Legal Services	1	1	100.0%	**27.0**
Nevada County Mental Health	2	1	50.0%	**8.0**
Private Mental Health Provider	1	1	100.0%	**Unknown**
Total Referrals Connected	**5**	**4**	**80.0%**	**16.0**

*Timeliness refers to the number of days between referral to an agency and appointment at the agency. Unknown averages are due to dates of referral and/or dates of appointment being unavailable.

One (1) participant was referred to the Promotora by NCBH Children's Mental Health. One (1) participant was referred by NCBH Adult Mental Health, In-Home Support Services, and the Family Resource Center. The remaining seven (7) participants did not indicate where they were referred from.

The Promotora also conducted targeted outreach visits four (4) times to 19 individuals, disseminating information regarding FRCoT and mental health programs.

A survey was conducted in August 2017 and again in February 2018 to assess the levels of collaboration between agencies in the Tahoe Truckee area. The highest levels of collaboration were reported with agencies such as Tahoe SAFE Alliance, North Tahoe FRC, FRCoT, and TTUSD. The lowest levels of collaboration were reported with agencies such as Right Hand Auburn, Insight Respite Center, and Turning Point. Across the two (2) time points, levels of collaboration increased for most agencies. This survey will be distributed every six (6) months to assess and monitor changes in levels of collaboration across agencies in the Tahoe Truckee area. Improvements in collaboration across all agencies assessed in the Tahoe Truckee region are expected.

Challenges, Solutions, and Upcoming Changes

Pertaining to the Innovation Personal Services Coordinator, the biggest challenge has been ensuring participant attendance. With this population, it can be very difficult to get participants to arrive at the time and place the Personal Services Coordinator has planned. Another challenge is the use of the Personal Services Coordinator's personal vehicle to drive from North Lake Tahoe to Truckee for outreach and participant appointments. The final challenge is the lack of a private workspace in the Joseph building for the Personal Services Coordinator. In Truckee, the Personal Services Coordinator shares an office, which makes it difficult for participants to meet. The Personal Services Coordinator tends to meet Nevada County participants at their homes or in the community because of this lack of a private workspace.

Pertaining to the Innovation Promotora, the FRCoT experienced challenges around defining the duties and responsibilities of the role in coordination with the County staff. These challenges required the FRCoT and partner service providers to develop clear expectations and working agreements to best meet the needs of community members. Each week, the Promotora will continue to dedicate time to meeting with County staff, the Promotora team, and participants identified through County staff, while also providing mental health services and referrals at the FRCoT. Additionally, it was difficult to facilitate joint meetings between the Personal Services Coordinator, NCBH Therapist, and the Homeless Outreach Coordinator, given the staffing changes that occurred throughout the year. In the coming fiscal year, these meetings will become more regular, so that the partners can effectively discuss coordination among service providers, identify barriers to services, and better serve the needs of Latino community.

Program Participant Story

Innovation Personal Services Coordinator Story:

A program participant was in an abusive relationship and needed assistance. The Personal Services Coordinator connected the participant to the Tahoe Safe Alliance in Kings Beach for domestic violence aid. The Personal Services Coordinator worked with Tahoe Safe Alliance to get the participant into a safe house for three (3) months. While the participant was in the safe house, the

Personal Services Coordinator worked with Tahoe Safe Alliance and found the participant affordable housing. Tahoe Safe Alliance was able to pay for the first few months of rent while the Personal Services Coordinator assisted the participant in enrolling in SSI benefits. Now the participant is living independently, paying rent with their social security benefits, and safely away from their abuser.

Innovation Promotora Story:

An elderly community member with many health issues was having difficulty managing her health. She was in a constant cycle of forgetting to take her medicine, missing doctors' appointments, and missing mental health appointments. Also, as a monolingual Spanish speaker, it was difficult for her to get the proper care she needed and to access resources and services.

This person began to work with both the Nevada County therapist and the Innovation Promotora. In weekly case conferences, the two (2) agencies were able to discuss the needs of this person and her action plan. Through this collaboration, the therapist and the Promotora were able to better support this person in making sure she was properly taking care of her physical and mental health. The Promotora was able to support the progress this person was making with her mental health. The Promotora made several home visits to check on this person, accompanied her to doctor appointments to ensure she understood what the doctor said, and connected her to doctors out of the area. The Promotora helped with transportation and interpretation, as well. By connecting and linking services between Nevada County and the FRCoT, this person was able to get the support she needed. This person is on track for following through with all of her appointments. The linkage of services has helped her overall well-being and she is on a path to better managing her health.