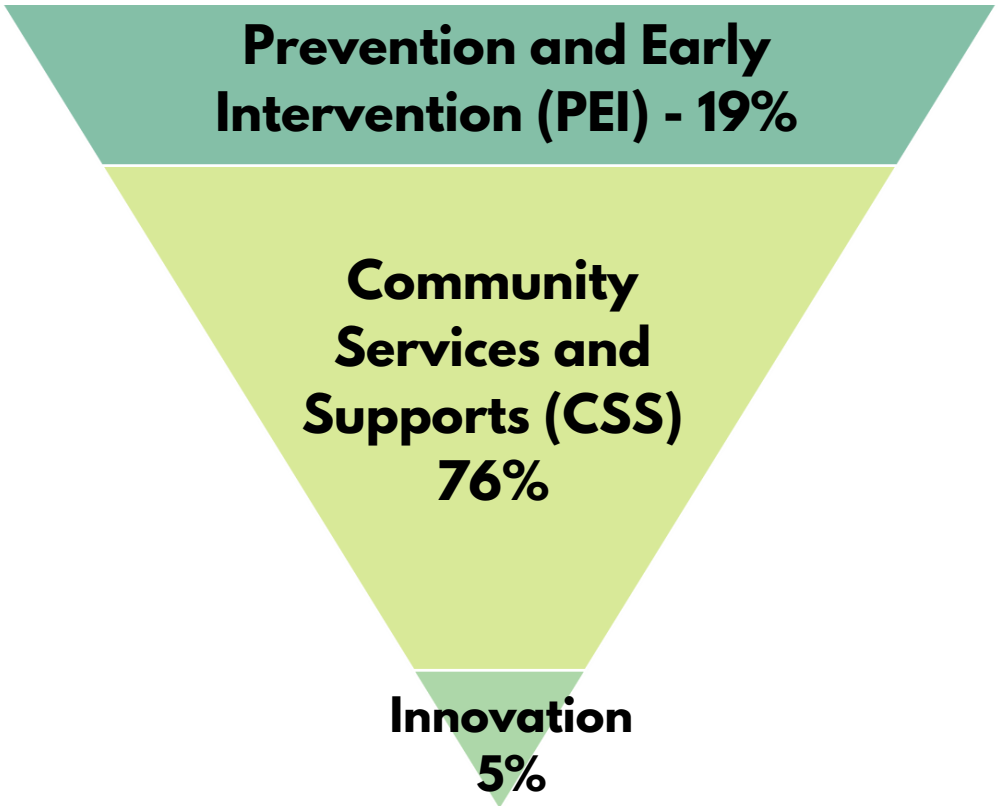
Nevada County Mental Health Services Act (MHSA)

Annual Progress Report (APR) for Fiscal Year 2019/2020

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

MENTAL HEALTH SERVICES ACT (MHSA) COMPONENTS



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

CSS programs (76% of total funding) provide treatment and recovery services to individuals living with serious mental illness or emotional disturbance. 51% of CSS funding is set aside for Full Service Partnerships (FSP) – "whatever it takes" services.

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

ADULT FULL SERVICE PARTNERSHIP

JULY 2019 - JUNE 2020

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

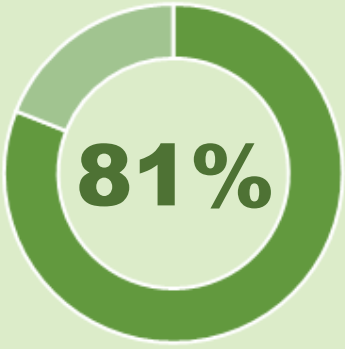
Adult Full Services Partnership (FSP) programs are designed for individuals 18+ years old who have been diagnosed with a severe mental illness and would benefit from a more intensive outpatient program. In Fiscal Year 2019/2020, **Turning Point Community Programs** was the primary Adult FSP provider in Nevada County.

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

81 INDIVIDUALS SERVED

12% *10 individuals* GAINED AND MAINTAINED EMPLOYMENT

HOUSING & HOMELESSNESS

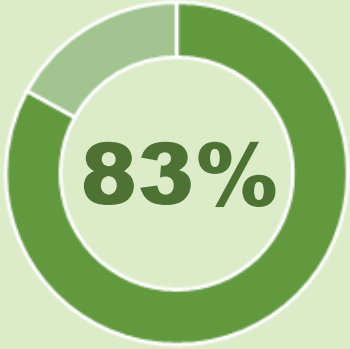


SUCCESSFULLY REMAINED HOUSED

66 individuals

↓21% REDUCTION IN HOMELESSNESS

PSYCHIATRIC HOSPITALIZATION



AVOIDED PSYCHIATRIC HOSPITALIZATION

67 individuals

↓14% REDUCTION IN DAYS OF PSYCHIATRIC HOSPITALIZATION

CRIMINAL JUSTICE INVOLVEMENT

AVOIDED ARREST OR INCARCERATION

74 individuals

↓42% REDUCTION IN CRIMINAL JUSTICE INVOLVEMENT

CHILDREN'S FULL SERVICE PARTNERSHIP

JULY 2019 – JUNE 2020

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

Children's Full Service Partnership (FSP) programs are intensive mental health treatment programs for children under age 21 diagnosed with a serious emotional disturbance or mental illness and their families. In Fiscal Year 2019/2020, **Victor Community Support Services (VCSS)** was the primary Children's FSP provider in Nevada County.

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

107 YOUTH SERVED

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

92%

SUCCESSFULLY REMAINED HOUSED

94%

AVOIDED PSYCHIATRIC HOSPITALIZATION

97%

AVOIDED NEW LEGAL INVOLVEMENT

ACADEMIC PERFORMANCE

- **88%** of youth maintained a C average or improved their academic performance
- **91%** of youth did not experience a suspension or expulsion
- **100%** of discharged youth reported regular school attendance or improvement in school attendance

CAREGIVERS

of caregivers reported increased connections in the community

of caregivers reported their parenting skills increased or improved

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

COMMUNITY SERVICES AND SUPPORTS (CSS)

GENERAL SYSTEM DEVELOPMENT

Key Program Outcomes for FY 2019/20

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

2,377
INDIVIDUALS SERVED

37
with serious mental illness permanently housed through Nevada County Housing Development Corporation

40%
of individuals admitted to the Crisis Stabilization Unit on 5150 holds were stabilized without hospitalization

216
individuals in crisis received peer support at the Emergency Department or Crisis Stabilization Unit

64
individuals utilized the Insight Respite Center for short term peer-centered respite care

- 1,053 individuals received crisis intervention services
- Enhanced behavioral health workforce development by providing 1,799 hours of intern supervision
- 100% of 35 veterans surveyed who received therapy avoided psychiatric hospitalization, remained housed and reported reduced suicidal thoughts

COMMUNITY SERVICES AND SUPPORTS (CSS)

OUTREACH AND ENGAGEMENT

976
INDIVIDUALS SERVED

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

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

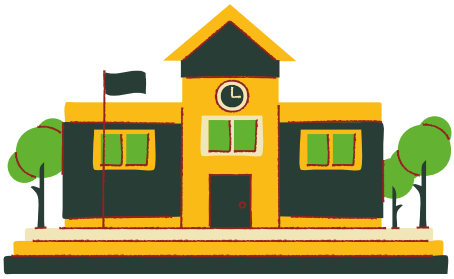
598
peer support sessions provided by SPIRIT Peer Empowerment Center

PREVENTION AND EARLY INTERVENTION (PEI)

YOUTH OUTCOMES

331

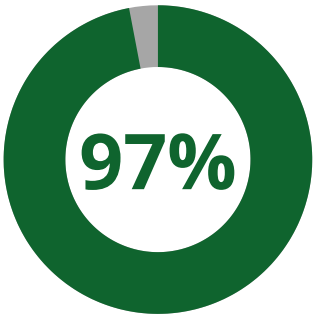
Nevada County high school youth screened for mental health needs



122

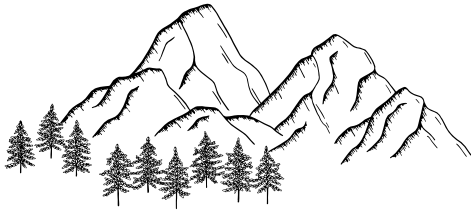
Eastern County high school youth supported at school-based Wellness Centers

70% of the 11 mothers in the Moving Beyond Depression program showed improvement in depression symptoms



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

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



PREVENTION AND EARLY INTERVENTION (PEI)

LATINX OUTCOMES

57

individuals received bilingual therapy

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

16

mental health referrals made by Promotoras

106

individuals educated on mental health issues & services

HOMELESSNESS OUTCOMES

164 Hospitality House residents were supported by the embedded Behavioral Health therapist at the shelter

50

individuals experiencing homelessness were referred to mental health services

84%

of 32 participants served by embedded case manager at Hospitality House reported improved housing situation

PREVENTION AND EARLY INTERVENTION (PEI)

OLDER & HOMEBOUND ADULT OUTCOMES

87%

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

100%

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

OTHER PEI OUTCOMES

- 69 individuals attended Youth Mental Health First Aid trainings
- 209 of the 9,429 individuals served by 2-1-1 were referred to Nevada County Behavioral Health
- The Forensic Outreach Liaison worked with 202 program participants in the jail to refer to services and treatment upon discharge
- The Veterans Service Office referred 33 veterans to mental health treatment
- Suicide prevention trainings provided to 1,183 individuals

INNOVATION (INN)

In FY 19/20, there were two active Innovation projects:
1) Integrated Tahoe/Truckee Services
2) Homeless Outreach and Medical Engagement (HOME) Team

INTEGRATED TAHOE/TRUCKEE SERVICES

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

Fiscal Year 2019/2020 Program Outcomes

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

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

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

HOMELESS OUTREACH AND MEDICAL ENGAGEMENT (HOME) TEAM - FY 19/20

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

322 received access & linkage to services

4,327 services provided

113 received case management

43 people housed

70% retained housing

938 referrals

40% connected

MEDICAL SERVICES

133 received medical engagement

12 received nursing case management

62% reduction in Emergency Room visits among case managed individuals

TOP MEDICAL NEEDS

- Wound Care
- Nutrition
- Chronic health conditions

MENTAL HEALTH SERVICES

42 assessments completed

41 connected to treatment

SUBSTANCE USE DISORDER

31 assessments completed

26 connected to treatment

21 completed treatment programs

Community Services and Supports (CSS)

Children's Full Service Partnership:

VICTOR COMMUNITY SUPPORT SERVICES (VCSS)

Program Description

Program Overview

Victor Community Support Services (VCSS) is an intensive treatment program in Grass Valley that served children diagnosed with a serious emotional disturbance or mental illness and their families through two modalities during FY 19/20: Family Vision Wraparound, which provides high fidelity wraparound services, including case planning, therapeutic services, medication support, and crisis intervention; and Therapeutic Behavioral Services (TBS). This report covers outcomes for children and youth being served through both modalities. Victor Community Support Services 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. Services were also expanded to include tele-health service delivery options during the last quarter of FY 19/20, as a result of COVID-19 safety protocols.

Target Population

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

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

Evaluation Activities and Outcomes

In FY 19/20, VCSS Grass Valley provided 107 youth with mental health and/or Wraparound services. There was outreach to an additional six prospective participants throughout the year. The goals of these services are to reduce hospitalizations and recidivism for juvenile offenders, improve school performance, improve targeted behaviors, increase community connections, and

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

- **Housing**: During FY 19/20, 92% of the 107 clients served remained in a community living situation and avoided a higher level of residential care. No clients required group home placements, while there were eleven total changes in foster care placement and two incidents of temporary homelessness.

- **Employment and education**: VCSS achieved its contractual goal of ensuring at least 80% of parents report that youth maintained a C average or improved on their academic performance, as 80% 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," 88% of discharged clients had a C average or higher at discharge.

  VCSS achieved its contractual goal of ensuring at least 75% of youth maintain regular school attendance or improve their school attendance, as 100% 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; 91% 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 19/20, 97% of clients had no new legal involvement while receiving services.

- **Acute Care Use**: Ninety-four percent (94%) of clients did not experience a psychiatric hospitalization during the fiscal year.

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

  VCSS achieved its contractual goal of ensuring that at least 65% of children served were able to identify at least one lifelong contact. Based on the CANS item, "Relationship Permanence," 94% of clients 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 19/20, 90% of surveyed caregivers reported their parenting skills increased or improved.

  VCSS achieved its contractual goal of ensuring that at least 75% of caregivers report maintaining or increasing connections to natural supports, with 75% of surveyed caregivers reporting maintaining natural supports and 65% reporting increased support connections in the community.

  Victor achieved its contractual goal of ensuring that at least 80% of individuals improved their scores on the Comprehensive Child and Adolescent Needs and Strengths (CANS) instrument between intake and discharge. During FY 19/20, 94% of individuals with a planned discharge

improved in at least one of the following CANS domains: Life Functioning, Behavioral/Emotional Needs, Risk Behaviors, and/or Educational Needs.

- **Stigma and Discrimination:** Victor provided Mental Health First Aid trainings to community members to increase awareness and decrease stigma related to mental illness.
- **Service Access and Timeliness**: Excluding transfers between reporting units, there were 50 discharges this year. For FY 19/20, the average length of service (ALOS) for the engaged discharged population was 11.9 months.

  VCSS nearly achieved its contractual goal of attempting initial contact with referrals within three (3) business days of receipt of referral. Initial contact was *attempted* for 81% of referrals within three business days, and initial contact was *successfully made* with 60% of referrals within three business days.

  VCSS nearly 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 76% of eligible referrals were *offered* an appointment date in this time frame. Additionally, 92% of referrals received a face-to-face contact within 10 business days of contact made.

Challenges, Solutions, and Upcoming Changes

During FY 19/20, Victor continued to refine the high-fidelity wraparound model adopted by the program in 2017. The leadership team continued and continues to emphasize in-service coaching, targeted skill building, and ongoing development of staff as it pertains to wraparound implementation. Victor continues to employ a team of clinicians, Facilitators, Parent Partners, and Family Support Counselors who all receive training and supervision specific to the wraparound model. Victor's leadership team is currently undergoing restructuring following the recent departure of the Executive Director; bringing in a new Executive Director and expanding management capacity will be goals of the upcoming fiscal year.

Victor remains committed to increasing connectedness for the clients and families served by continuing to add more group-based services, community-building activities and events, and further integrating the wraparound philosophy and teaming into the process. Victor is paying particular attention to the inclusion of natural supports on Child and Family Teams; the plan is to emphasize the building and maintaining of teams as a means to help individual participants increase stability and sustain progress during the upcoming fiscal year. The program will continue to serve all youth referred utilizing Full Service Partnership (FSP) and wraparound principles according to individual needs, strengths, and treatment plan goals. Length and intensity of services will be determined by assessment and current need. The anticipated length of stay will remain 8-10 months on average.

Like other community providers, Victor is currently facing the challenge of ensuring that program participants continue to receive intensive, responsive, and appropriate care in light of barriers presented by COVID-19. Victor is providing staff with regular training and supervision related to tele-health services, and is approaching program participant care on an individualized basis to

determine what level of in-person support is required to help youth achieve their goals, while sustaining safety for staff and the community. Victor expects that this will be an ongoing challenge during the upcoming fiscal year which will require a great deal of adaptability.

Program Participant Story

VCSS worked with a young girl whose parents were in early stages of substance use recovery. The parents, the girl and her siblings were engaged with Victor services from the beginning and were ready to accept help and make positive changes for their family.

After about a year of Victor's services, one of the parents relapsed. The girl and one of her siblings were placed in foster care. Through this difficult transition, the Victor team continued to believe in the inherent strengths of this family and held hope for their eventual reunification. The parents were determined to recover and get their children back.

During the girl's time in foster care, she continued to receive a multitude of services from Victor to ensure that she was receiving trauma informed care from all providers and caregivers. The parents worked with a parent partner weekly, attended a support group weekly and received additional interventions, both therapeutic and practical, in Child and Family Team meetings.

Over the next 12 months, the girl's parents focused on sobriety, completed parenting courses, and consistently attended all the services provided by the Wraparound team at VCSS. The girl engaged in services consistently and worked hard to process adverse experiences and make connections between experiences, feelings and behavior. In services with Victor she built coping skills for regulating difficult emotions. Her symptoms and behaviors decreased in severity and frequency in all areas.

The parents were successfully reunified with their children the following year. The difficult symptoms and behaviors that the children presented with had decreased so significantly that most of them graduated from Victor's program quickly thereafter with great success. Later the family's case was closed, due to the maintained progress of the parents and the obvious successes within the family system. Even after closing their case, the family has opted to continue receiving therapy at VCSS Grass Valley to continue their journey of supported healing.

Adult Full Service Partnership:

TURNING POINT COMMUNITY PROGRAMS
Providence Center

Program Description

Program Overview

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

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

Target Population

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

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

Evaluation Activities and Outcomes

AACT:

In FY 19/20, the Providence Center FSP served 81 individuals. One of the individuals served in FY 18/19 has been excluded from the FY 18/19 figures below due to being incarcerated at time of referral.

- **Housing:** *Goals – show a decrease in homelessness, decrease in number of days homeless, emergency shelter use, increase in independent living, decrease in out of home placement for children, and/or residential status for children.*
    - During the FY 19/20, 66 (81%) individuals successfully remained housed in either temporary or permanent housing; avoiding homelessness. The remaining 15 (19%) individuals accrued a total of 1,944 homeless days. Three (3) of those 15 individuals accrued over 300 days each, totaling 1,023 days or 52.6% of the 1,944 homeless days.
    - A total of 75 individuals carried over from the FY 18/19 and continued to accrue services in the FY 19/20. Of those 75 individuals, 65 (87%) either continued to avoid homelessness or decreased in the number of homeless days accrued.

- **Employment and Education:** *Goal – show an increase in employment, paid or unpaid, school attendance, and/or grades in school improve.*
    - **Employment**: Of the 81 individuals served within the FY 19/20, a total of 10 (12.3%) individuals were reported as having some form of employment (paid or unpaid) at the end of the reporting period. When comparing to the Partnership Assessment Form (PAF), five individuals who were reported as being unemployed prior to their enrollment in at Providence Center are now employed.

- **Education:** In the FY 19/20 a total of 16 individuals were reported as having spent at least one day in school since enrollment. Nine (56%) of those 16 had not attended school prior to enrollment.

- **Criminal Justice Involvement:** *Goal – show arrest decrease, and/or days and times incarcerated decrease.*
  - During the FY 19/20, 74 (91%) of the 81 individuals with available data avoided incarcerations or the accrual of jail days. The remaining 7 (9%) individuals accrued a total of 837 jail days. Three (3) of those seven (7) individuals accrued over 150 days each, totaling 660 days, or 78.9% of the 837 jail days.
  - Of the 75 individuals who carried over from the FY 18/19 and continued to receive services through the Providence Center in the FY 19/20, 69 (92%) either continued to avoid jail or decreased in the number of jail days accrued. Furthermore, only six (8%) individuals accrued jail days.
  - With regards to arrests, during the FY 19/20, 77 (95.1%) individuals avoided arrests. The remaining four (4.9%) accrued a total of 13 arrests amongst them. Two (2) of the four (4) individuals accrued the majority of the arrests; 11 total or 84.6% of the 13 arrests. Between FY 18/19 and FY 19/20, one individual was reported as having accrued arrests in both fiscal years. The individual was reported as having a decrease in the number of arrests.

- **Acute Care Use:** *Goal – show a decrease in time and number of days in Psychiatric Hospital, and/or decrease in mental health emergency events.*
  - **Psychiatric Hospitalizations:** Within the FY 19/20, 67 (83%) individuals avoided psychiatric hospitalizations. The remaining 14 (17%) accrued a total of 478 psychiatric hospital days. A positive outcome is that of the 75 individuals who carried over from the FY 18/19 and continued to receive services, 64 (85%) either continued to avoid psychiatric hospitalizations completely (n=56) or reduced in their accrual of psychiatric hospital days (n=8).
  - **Emergency Interventions:** Within the FY 19/20, 53 (65%) individuals avoided the need for an emergency intervention. The remaining 28 (35%) accrued a total of 64 emergency interventions. A positive outcome is that of the 75 individuals who carried over from the FY 18/19 and continued to receive services, 58 (77%) either continued to avoid emergency interventions completely (n=28) or reduced in their accrual of emergency interventions (n=30).

- **Emotional and Physical Well Being**: *Goal – to show reduction in mental health symptoms, decrease in depression, decrease in trauma, Recovery/Quality of Life improvement, reduction in substance and/other drug use, and/or improvement in physical health.*
  Turning Point continues to emphasize trauma informed care when serving program participants. This allows participants to feel respected and cared for in their recovery process and allows staff the opportunity to see people through a trauma informed lens. In FY 19/20 providers have been faced with the worldwide pandemic and as a program and agency have put emphasis on both the mental health of employees as well as those who are served. Turning Point has continued to provide excellent service even during this pandemic ensuring that

participants are informed and protected from the COVID virus. The substance use counselor has kept in regular contact with many participants in need of that service in order to reduce the potential for relapse. See Milestone of Recovery Scale scores below for quantitative data.

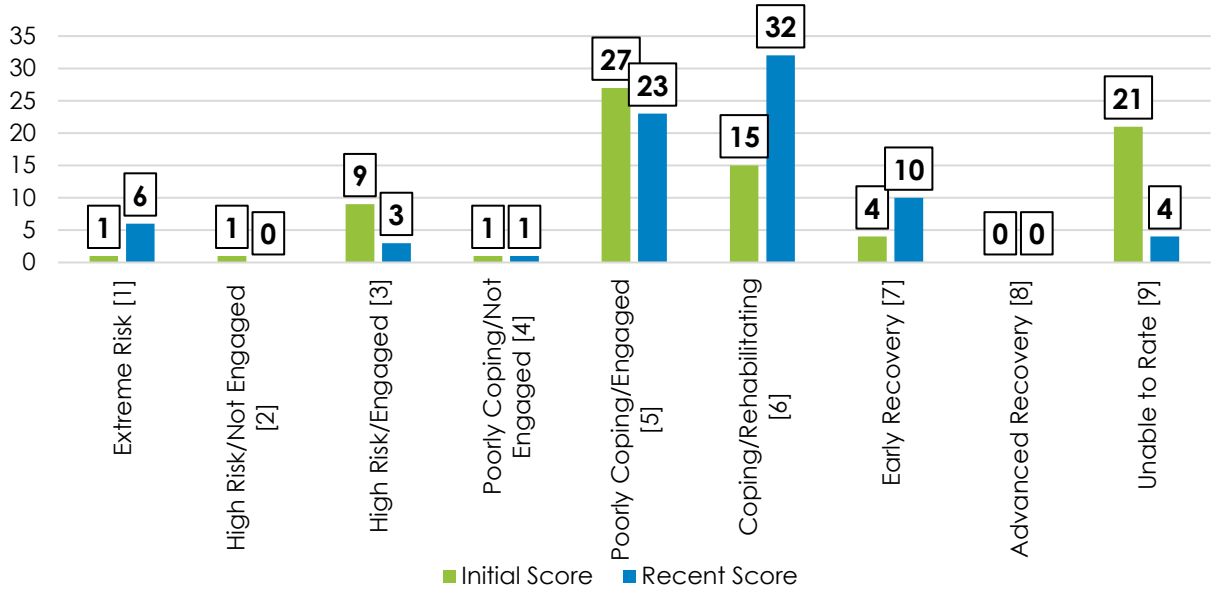
- **Stigma and Discrimination:** *Goal – to show the level or degree of stigma of mental illness, either at the individual or community level is decreased.*
  Over the last year Turning Point's homeless outreach and medical engagement team has made an impact on stigma in Nevada County in the services that they are providing to the local homeless community. This team is a collaboration between Hospitality House, Nevada County Behavioral Health and Turning Point. They are a public ally, and their services have reduced stigma among community partners, as well as the community in general, not only for combatting mental health stigma, but also the stigma of homelessness.

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

- **AOT Summary:** *Goal – to show the number of Laura's Law clients served by Turning Point Providence Center in the fiscal year and describe the Evaluation Activities/Outcomes for this subset of Turning Point clients.*
  - Ten individuals were in the AOT Program for FY 19/20.
  - Given the state's decision to alter the reporting and tracking timeline for AOT, data for FY 19/20 has yet to be verified. As such, information is unavailable currently.
  - Please note participant story outlined below is reflective of a FY 19/20 AOT member.

- **Milestone of Recovery Scale (MORS)**
  The Milestone of Recovery Scale (MORS) is both a clinical and administrative tool. It measured where individuals are in their journey of recovery and produces data that describes the journey of recovery over time.
  - A total of 79 individuals received a score at admission and the end of the fiscal year or at discharge.
  - Twenty-eight (35.4%) individuals had a higher MORS score suggesting movement towards recovery including a lower level of risk, an increase in the level of skills and supports beyond program services, and an increase in the individual's level of engagement with program staff.
  - Seventeen individuals (21.5%) remained at the same score.

- Ten individuals (12.7%) had a lower MORS score at the end, showing a decline in recovery.
- Twenty-four individuals (30.4%) had at least one score of unable to rate.



- **Productivity**
  - **Objective A:** Minimum productivity standard of 70% of billable time for hours worked.
    - Between January 1, 2020 and July 31, 2020, despite the pandemic beginning in March and some staff teleworking, the Providence Center had an average productivity of 88%.
  - **Objective B:** 90% of all clients are Medi-Cal eligible.
    - 100% of the clients served at the Providence Center in FY 19/20 were Medi-Cal eligible.
  - **Objective C:** 5% denial rate for billed and audited services.
    - Turning Point, Providence Center maintained a denial rate of only 1% for FY 19/20, meeting their contractual goal to keep denials less than 5%.
  - **Objective D:** Each Medi-Cal service provided must meet medical necessity guidelines and meet Medi-Cal requirements as described by service and activity/procedure code.
    - All Medi-Cal services provided in FY 19/20 met medical necessity guidelines as well as Medi-Cal requirements as described by the service and activity/procedure code.
  - **Objective E:** Contractor shall document and maintain all clients' records to comply with all Medi-Cal regulations.
    - Providence Center staff documented and maintained all client records in order to comply with Medi-Cal regulations.

Challenges, Solutions, and Upcoming Changes

In reflecting on last year's challenges and solutions, Turning Point continues to struggle with recruiting and hiring qualified staff. In past years, Providence Center has made compromises by hiring people who showed promise but were not qualified in terms of education and/or experience. In FY 19/20 Turning Point recognized that this isn't always the best solution and that the programs really benefit when truly qualified people are hired. Because of this, the open positions have stayed open longer than usual. COVID-19 has also greatly impacted hiring ability. In restructuring some of the salary scales, adding supportive positions to the new contract and being mindful in hiring practices it is the belief that Turning Point will come out of FY 20/21 with a much stronger team and program. Turning Point will continue to do the good work with the individuals served, and there is a plan in place to strengthen documentation, data collection and timeliness of all required paperwork. Turning Point has changed its expectation of progress note due dates to 72 hours after service and is hiring a Clinical Director and Assessment Coordinator to support this goal. Additional clinicians on the team will also increase clinical skill and knowledge for the whole team as well as increase the number of therapy slots available for individuals served.

Program Participant Story

One of the program's Assisted Outpatient Treatment (AOT) participants came in with an urgent referral because of the severity of the participant's symptoms and the significant threat to those around him. This gentleman was on probation when he entered the program, but probation was soon ending. He had no insight into his symptoms and was volatile, angry and paranoid. He did not want medications and screamed and yelled every time he came to court or into the Turning Point office. A couple of months into his AOT order, the court team and AOT clinician discussed dropping his AOT order due to the aggravation it caused the individual and because it did not appear to be helping him at all. When this was discussed in court with the client, he still responded in an angry manner but called his Personal Service Coordinator (PSC) a few days later and asked to make an appointment with the psychiatrist. The individual told the PSC he was ready to take medications. The participant reported to the treatment team that he was exhausted from "fighting" the court that day and realized there was nothing to fight. He started taking medication and has not had any moments of uncontrollable angry outbursts since. He continued going to court because he was proud of the work he had been doing. When his order was complete, he wanted to continue coming to court to talk with the judge. He then offered to mentor a young man with similar issues and even spoke out about his experience at community meetings.

Adult Full Service Partnership:

NEVADA COUNTY BEHAVIORAL HEALTH
Full Service Partners

Program Description

Program Overview

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

Target population

NCBH FSP participants are identified as the most severely impaired by mental illness in the community. These individuals need at least weekly case management, and sometimes daily support to function in society. Consumers aged 18 and above are served by this program. During FY 19/20 service intensity varied by individual for the six participants served. The focus of increased services across all age groups is to decrease hospitalizations, homelessness and incarcerations by utilizing intense case management, temporary placement at a local transitional home, medication caddy services, and nightly calls to the most high-risk consumers.

Evaluation Activities and Outcomes

Housing - Of the six Full Service Partner participants identified in FY 19/20, all have a history of homelessness. All six have lived in transitional housing in the past. The local transitional housing has 24-hour staff and is intended as a step down for individuals released from IMD's (Institute for Mental Disease). Residents may stay at transitional housing for up to 18 months while learning independent living skills, medication management and community resources. Residents also focus on housing readiness to enable them to move to a lower level of care and live semi-independently.

Of the six Full Service Partner participants identified, two have been able to transition from some level of supported housing to living independently or semi-independently. One currently lives in Supervised Independent Living (SIL) housing. Service coordinators facilitate house meetings in the SILs to ameliorate conflict and provide support to all residents. One partner has graduated and has moved home to live with a family member. Two Full Service Partner participants continued to reside at Odyssey House in FY 19/20.

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

Criminal Justice involvement – Of these six participants, none had an arrest in FY 19/20

Acute Care Use - Of the six participants, none had psychiatric hospitalizations in FY 19/20.

Emotional and Physical Well Being – The Basis 24 Outcome Measure was administered to five of the six participants. Three of the five participants showed improvement in their overall Basis 24 score from FY 18/19 to FY 19/20. Four participants showed improvement in the Relationships category, three showed improvement in the Substance Abuse category, three showed improvement in the Psychosis category, one showed improvement in the Emotional Liability category, and one showed improvement in the Depression/Functioning category.

Stigma and Discrimination - The NCBH FSP program is increasing awareness of mental health needs especially among the homeless population in this community. The program has been able to work with a property owner on stigma and discrimination against mental illness and homelessness. The grant funded HOME Team is working to identify potential NCBH participants who are homeless and living in homeless encampments within Nevada County.

Service Access and Timeliness - All partners in FY 19/20 were existing from the previous year, so timeliness from initial request to first service was not applicable in FY 19/20. All partners (100%) received an appointment for follow up within seven days of discharge.

Challenges, Solutions, and Upcoming Changes

Transportation in a small rural county continues to be a challenge as does the stigma associated with mental illness. Many Full Service Partner participants continue to struggle with co-occurring disorders and tend to find connections with people who use drugs and who sell drugs. NCBH is working with a provider and Federally Qualified Health Center's Medication Assisted Treatment programs to help some of these participants remain "clean" from drugs while living in Supervised Independent Living situations. Due to the rural location of Nevada County, ongoing fire danger, COVID-19, and PSPS (Public Safety Power Shut-off) power outage events present challenges for participants. NCBH has been able to modify programs and processes to continue to meet the needs of individuals on-site and in the field.

Moving into FY 20/21, the NCBH program will transition out of an FSP model. All participants will continue to be supported through case management by NCBH but will no longer be classified as FSP to better align with program participants' treatment needs as well as FSP program fidelity.

Program Participant Story

This is the story of an individual who has been receiving services at NCBH for many years. This person has had numerous traumatic life events and has a history of multiple psychiatric hospitalizations for as long as they have been seen at NCBH. The mental illness is exacerbated by a substance use disorder. This person also has a history of homelessness and was victimized repeatedly while homeless.

While in an Institution for Mental Disease (IMD), it took more than six months for this person to begin to show signs of stabilization. Once stabilized, they were able to move from an IMD where they had been for several months, into a social rehabilitation facility. This is where the individual still lives.

During this time, the person was able to follow house rules, take medications as agreed upon with the psychiatrist and remained clean and sober. The person engaged in weekly therapy, where they worked on their issues. The person has spoken at meetings, has acted as a peer supporter and has volunteered at a local agency. With the support of the rehabilitation facility staff, NCBH staff, and other agencies, this person has been able to move into a less restrictive independent living situation. This person hopes to find work as a peer supporter. When COVID restrictions can be lifted, they would like to do more volunteer work.

General System Development:

NEVADA COUNTY BEHAVIORAL HEALTH
Expand Intern Program

Program Description

Program Overview
In FY 19/20 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 19/20, six interns provided 5,161 hours of Mental Health services, treating 300 individuals. Additionally, 1,799 hours of intern supervision were funded by this source.

General System Development:

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

Program Description

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

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

Evaluation Activities and Outcomes

In FY 19/20, 19 unduplicated participants were served. This included 13 individuals served in the Children's System of Care and six individuals served in the Adult System of Care. Four Network Providers are contracted with Nevada County Behavioral Health to provide these services.

Baseline and annual Basis 24 outcome measure surveys continue to be collected for individuals served by the Adult System of Care. Only two of the program participants completed a follow up Basis 24 during the reporting period. Of these two, one showed improvement in score while the other showed a decline in outcomes. Two other individuals started the test but did not complete it so accurate scoring was not possible.

The NCBH Children's System of Care is collecting the Child and Adolescent Needs and Strengths Assessment 50 (CANS 50) and the Pediatric Symptom Checklist 35 (PSC-35) outcome measures per state requirement. Analysis of the CANS 50 scores for the 10 children who took the test in FY 19/20 showed a decrease/improvement in score between the most recent test and the test taken before that. Out of these 10 individuals, six had only taken the test once so no comparison of scores could be made. Of the other four children whose scores were compared, three of them showed improvement in the Child Behavioral/Emotional Needs section of the test.

Challenges, Solutions, and Upcoming Changes

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

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

General System Development:

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

Program Description

Program Overview

The Nevada County Behavioral Health (NCBH) System of Care provided 5,294 psychiatric services to 763 individuals in FY 04/05. MHSA allows counties to expand the amount of psychiatric services provided to beneficiaries starting in FY 07/08, by paying for these services out of MHSA, Community Services and Supports, General System Development funds. Due to

system changes at the county between 2005 and 2007, historic data from FY 06/07 was not available to use as a baseline. Thus, FY 04/05 became the baseline measurement for the Expanded Psychiatric Services program for NCBH and the county reports annually on the amount of MHSA funds used for psychiatric services. In FY 19/20 MHSA funds paid for 3,284 Expanded Psychiatric services to 517 individuals.

Nevada County Behavioral Health (NCBH) Children's Services provided 709 Expanded Psychiatric services to 123 children with MHSA funds in FY 19/20. Some children were being wrapped with Full-Service Partnership (FSP) providers. Some children continue to see the NCBH doctor individually and work with the WRAP team.

Nevada County Behavioral Health Adult Services provided 2,574 Expanded Psychiatric services to 394 adults with MHSA funds in FY 19/20.

Nevada County Behavioral Health (NCBH) also provided Expanded Mental Health services to program participants using General System Development funds. These funds paid for 198 individuals in FY 19/20.

Target Population

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

Evaluation Activities and Outcomes

Employment and Education:

- Snack Shack – Vocational training is available through the Snack Shack program. The Snack Shack program had previously been a collaborative effort between the National Alliance for the Mentally Ill (NAMI), the Nevada County Behavioral Health (NCBH) Department (both adult services and children's) and Consumers. In December 2017 NAMI left this partnership and was replaced by SPIRIT Peer Empowerment Center in collaboration with NCBH. The Snack Shack is a consumer driven retail program providing vocational skills and structure. Participants learn customer service, cash register skills and team building. Management of the program is provided by consumers and a consumer with bookkeeping experience balances the receipts. In FY 19/20 there were three managers and 13 participants that volunteered to work in the Snack Shack program. The program has three managers; one who keeps track of accounts, one who oversees schedules at Adult Behavioral Health and one who oversees schedules at Children's Behavioral Health.
- 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. There were fifteen training

participants in FY 19/20 who completed Peer Support Training. Within the graduates of the program:

- Two participants took the training for personal enrichment.
- Eight participants graduated with diplomas.
- Five were unable to complete the program due to COVID -19.

After graduation, consumers are introduced to volunteer opportunities in the community. At the end of FY 19/20:

- One graduate volunteers as an assistant in the Peer Support program at Behavioral Health.
- One participant is now employed full-time as a peer supporter in Roseville, CA.
- One graduate is employed in Sacramento and said that it was this training that "landed" her the job.
- One participant was able to move from homelessness to independent housing in Placer County.
- One graduate is speaking at schools and other Behavioral Health facilities sharing his story with others.

Supportive Services:

- Saturday Adventure Outings - Saturday Adventure Outings serve high risk consumers who have a history of being isolated on weekends. The goal of the program is to engage these individuals socially with other peers resulting in decreased symptoms of mental health issues and increased quality of life. The consumers organize the adventure and determine the activities each week. Two peer staff members provide transportation utilizing Behavioral Health vehicles. The staff also provides support and referral services during the program. This creative solution has enabled individuals to access social interactions through activities they determine. In FY 19/20 the New Directions Program had six participants in the Saturday Adventure Outings program. The lead therapist/program team coordinator provided qualitative data in collaboration with the larger Behavioral Health clinical team indicating that this program had a direct role in reduction of symptoms and the need for more intensive services for program participants.
- Art Therapy: Art is the application of the visual arts and the creative process within a therapeutic relationship. It is designed to support, maintain, and improve the psychosocial, physical, cognitive, and spiritual health of individuals. It is based on current, and emerging research that art-making is a health-enhancing practice, that positively impacts quality of life. In FY 19/20 18 participants attended this group.
- Co-occurring disorders group is designed to address the needs of individuals with mental illness who are seeking support to maintain sobriety. The group provides useful techniques, and social support in a clean, sober and nonjudgmental environment. Research demonstrates that treating these disorders concurrently tends to lead to higher levels of success than treating each individually. In FY 19/20 13 participants attended this group.
- Sierra Outreach Services (SOS): SOS provides opportunities for socialization skill-building in the community. The group facilitator transports clients to various community events and activities to facilitate "real world" interactions between clients and the community where they live. The program provides opportunities to observe and practice appropriate social behaviors, foster connections in the community and reduce the stigma around mental illness. In FY 19/20 this program had 22 participants.

Challenges, Solutions, and Upcoming Changes

Transportation in a small rural county continues to be a challenge as does the stigma associated with mental illness. Many Behavioral Health participants continue to struggle with co-occurring disorders and tend to find connections with people who use drugs and who sell drugs. NCBH is working with a provider and Federally Qualified Health Center's Medication Assisted Treatment programs to help some of these participants remain "clean" from drugs while living in Supervised Independent Living situations. Due to the rural location of Nevada County, ongoing fire danger, COVID-19, and PSPS (Public Safety Power Shut-off) power outage events present challenges for participants. NCBH has been able to modify programs and processes to continue to meet the needs of individuals on-site and in the field.

Program Participant Story

This individual has been known to NCBH and has been homeless for many years. They have a long history of declining to engage with NCBH. The consumer had a number of legal issues and misdemeanors over the past several years.

A few years ago, this person agreed to have an assessment at NCBH. He was not interested in medication, therapy or case management, and chose to live in his car in an undisclosed location. The individual exhibited grandiose plans, hallucinations, aggression, and delusional thoughts when not taking medication.

Recently he presented for an intake again, following a psychiatric hospitalization. He reported to NCBH staff that he was now more willing to try medication and therapy. He has a family history of mental health disorders. Unfortunately, he refused to follow through with taking medications as prescribed and was hospitalized two more times in the next two years. He continued to live in his car, and sometimes, during inclement weather, he would stay at the local shelter.

In the last two years, he has actively engaged with NCBH, creating positive relationships. He also has taken advantage of the supportive housing options, which included a few stays in temporary, supported housing before being moved into a permanent, supportive housing. His symptoms have remained stabilized and he has remained in independent housing for the first time in many, many years.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Expand Crisis and Mobile Crisis Intervention Services including Respite Care, Crisis Stabilization Unit, and Crisis Residential Facility
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). Crisis services are available 24 hours a day, seven days a week. These positions are exclusive to western Nevada County; however, Crisis serves individuals from anywhere. Funding sources used to support Crisis Services include Medi-Cal, 1991 Realignment funds, and MHSA-CSS funds.

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

The location of the Crisis Worker in the CSU at SNMH offers an integrated service where people being held on a 5150 (an involuntary 72-hour hold, for evaluation) can, if appropriate, be moved from the hectic atmosphere of the local emergency room to a more appropriate level of care at the CSU. It also offers a place where individuals experiencing a crisis can stay for 23 hours on a voluntary basis with therapeutic services, 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 19/20 the targeted goal was for Crisis Specialists to serve 1,152 individuals. The result was 1,053 unduplicated people served, representing 91% of the goal. A total of 2,036 contacts occurred; many of the individuals were seen two or more times throughout the year. This is a significant decrease (10% decrease) from the total contacts during the prior FY 18/19, where the Crisis Workers had a total of 2,275 contacts.

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

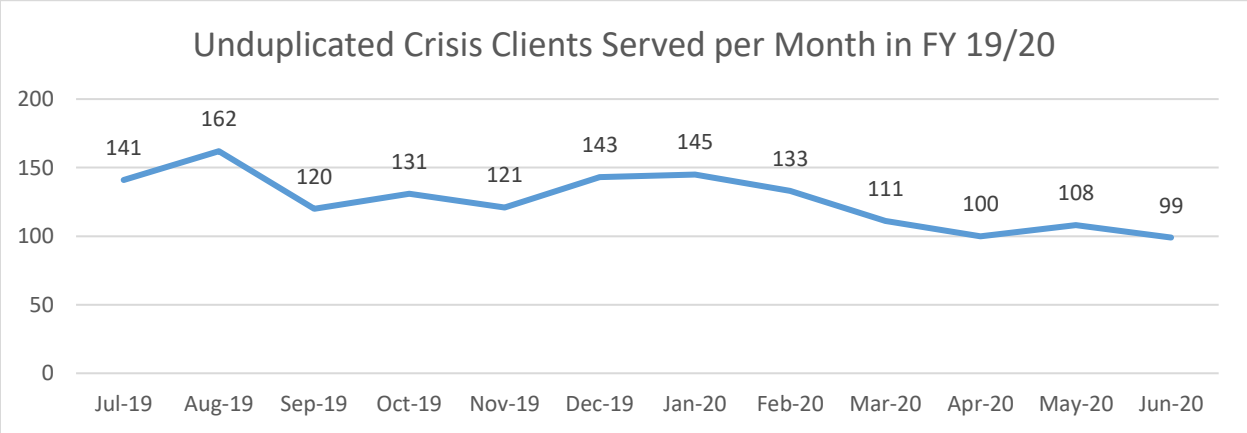
Consumers have also expressed satisfaction with the immediate service and additional resources. Crisis Specialists provide quicker crisis stabilization with the CSU in the same building as the Crisis office. With the walk-in policy from 10 am – 10 pm, consumers get immediate crisis response without having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

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

Challenges, Solutions, and Upcoming Changes

A major challenge that has occurred this year was with the COVID-19 pandemic. This dramatically dropped the number of people served in Crisis and in the CSU. Not as many consumers were coming to the facility for crisis services due to COVID patients also potentially being present at the hospital for treatment. Due to this virus's extremely contagious and potentially life-threatening qualities, many consumers opted to not come to the facility for fear of exposure. Many safety precautions were implemented including all staff wearing masks, sanitizing all surface areas within the Crisis office as well as the CSU every shift, and requiring consumers that come to the CSU to immediately shower and wash their clothing upon admittance. Additionally, a Brief Solutions Focused Crisis training manual is being created and will be scheduled to train staff within the next year.

Lastly, due to COVID-19, there has been a significant decrease in the number of individuals seen within the last few months (see chart below). In FY 19/20 it became necessary to move one on-site shift every day to an On-Call position. This change was approved July 1st and will begin July 20th, 2020. This change will help to provide support to crisis staff, while also still meeting the needs of consumers and will have an unchanged response time to individuals.



Program Participant Story

A repeat consumer utilized the Crisis facility and services several times within the span of three months, all while crisis staff were keeping a close eye on him and collaborating with community resources. Ultimately the consumer stayed within Crisis' care at the CSU and was connected with an Adult Residential Facility within the county. The consumer has since been stable due to the

diligent work of the crisis workers recognizing this person's unique needs and facilitating necessary and specific quality of care.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Expand Crisis and Mobile Crisis Intervention Services including Respite Care, Crisis Stabilization Unit, and Crisis Residential Facility
Crisis Stabilization Unit (CSU)

Program Description

Program Overview

The Crisis Stabilization Unit (CSU) opened on December 14, 2015 to better serve individuals in the county experiencing a mental health crisis or emergency. The CSU is a four bed, unlocked unit, staffed by a licensed mental health professional and a licensed medical professional on-site at all times. Psychiatrists are on-call 24 hours a day, seven days a week. The current CSU supervisor is Sandy Farley, a Registered Nurse. She's been in this position since 5/1/2019 and also serves as the Medical Coordinator. The CSU team works in close partnership with the Crisis Response Team. Individuals may be admitted voluntarily for a maximum stay of 23 hours or while awaiting placement on a WIC § 5150 hold. For the FY 19/20 the CSU served 338 individuals with 607 total admissions.

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

Target Population

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

Evaluation Activities and Outcomes

The target goal for FY 19/20 was to serve 460 individuals; 338 unduplicated individuals were served. In FY 19/20 the CSU program has resulted in the rescinding of 40 of the 133 WIC § 5150 holds and the expiration of 13 others by stabilizing and connecting these individuals to local doctors and resources. This breaks down to 30% of the WIC § 5150 holds being rescinded and 9% being able to safely expire. Collaboration by therapists with CSU patrons and their loved ones, development of personalized recovery/safety plans and follow up appointments made by the CSU staff have helped to stabilize individuals. The availability of the CSU offers the Crisis staff an additional resource as part of the participant's safety plan. For the consumer, it is a safe haven away from the stressors that are often catalysts to their crisis and it's a way to be connected with a therapist, a nurse and resources in the local community that can help them.

Satisfaction surveys were completed by 43% of the individuals that stayed in the CSU during the 19/20 fiscal year. Surveys showed 98% satisfaction with treatment and progress towards goals. Those that were unfortunate enough to have mental health emergencies prior to the CSU being completed in December of 2015 are particularly appreciative of the services provided and the compassionate, therapeutic nature of the care.

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

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

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

Challenges, Solutions, and Upcoming Changes

One unexpected challenge that arose in March of 2020 was the impact of COVID on both the CSU participants and staff. Policies and procedures were developed based on Centers for Disease Control (CDC) and Nevada County Public Health guidelines to keep the CSU safe. Wearing of facial masks at all times was instituted and two cloth masks were provided to each staff member from a local agency donating them to essential workers. Teaching of these guidelines is repeated as needed to keep staff up to date, and a list of all people entering the building along with their temperature was implemented. The "Visiting Policy" was suspended. Only therapists working on personal recovery plans for CSU participants on WIC § 5150 could visit. Since COVID began to impact the CSU in March, there has been a dramatic drop in CSU patrons. Many consumers are

receiving wrap-around services at home or in local hotels instead of coming to the CSU, therefore, CSU outreach efforts have increased.

Program Participant Story

An individual with a long history of mental illness was frequently in the CSU, at times under the influence of substances and off medications prescribed by their psychiatrist. They had been involved in a challenging relationship where their significant other was abusive & also using substances. CSU staff were supportive and encouraged this individual to make changes in their life, however the individual was not ready. Eventually the beneficiary was ready to make a change and has now been clean and sober for several months, has a job, is taking their medications and utilizes the support offered by a community agency. This person has expressed appreciation of the CSU and its role in helping to make a difference in their life. In summary: The CSU serves those with mental health emergencies in the most compassionate, therapeutic way possible while also serving the community stakeholders and residents.

General System Development:

TURNING POINT
Expand Crisis and Mobile Crisis Intervention Services including Respite Care, Crisis Stabilization Unit, and Crisis Residential Facility
Insight Peer Respite Center

Program Description

Program Overview

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

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

available 24 hours a day, offering hope, compassion and understanding in a stigma-free environment.

Services provided include the following:

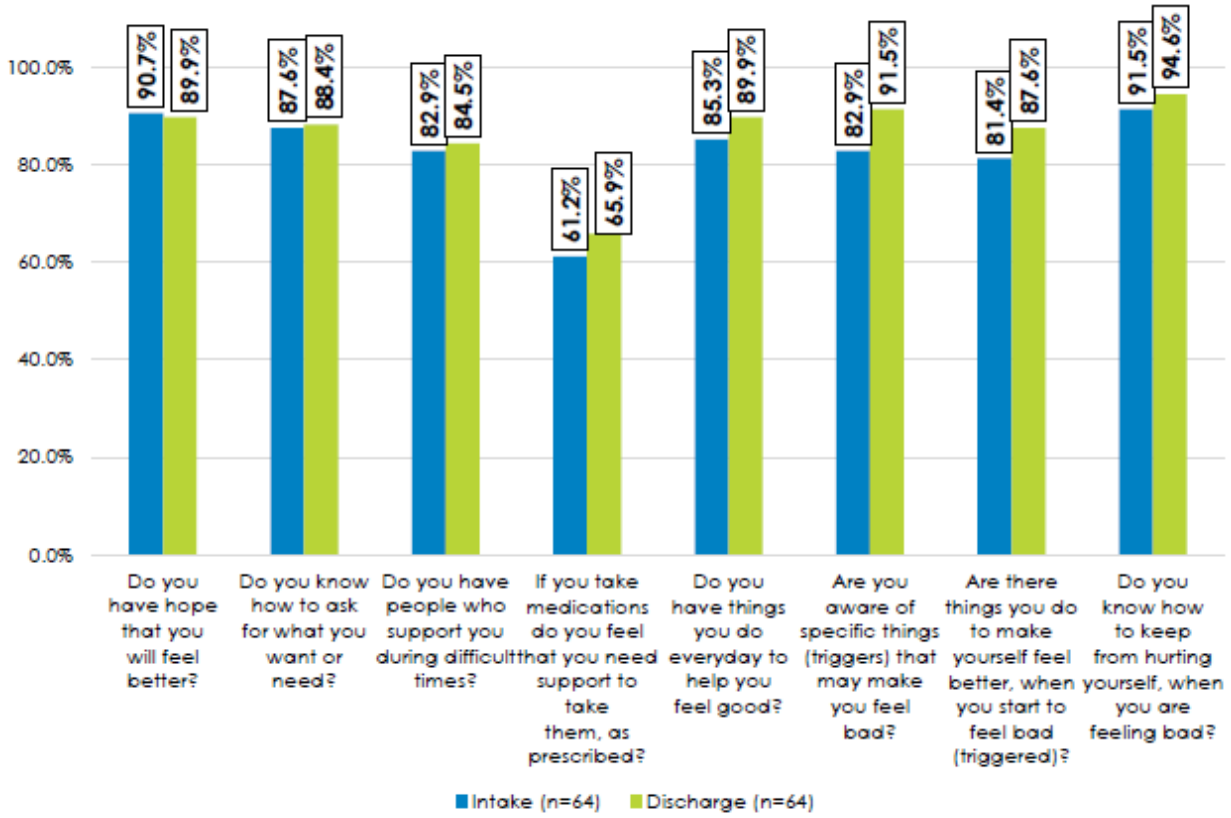
- Crisis intervention
- Rehabilitation
- Guest advocacy
- Life skills

Target Population

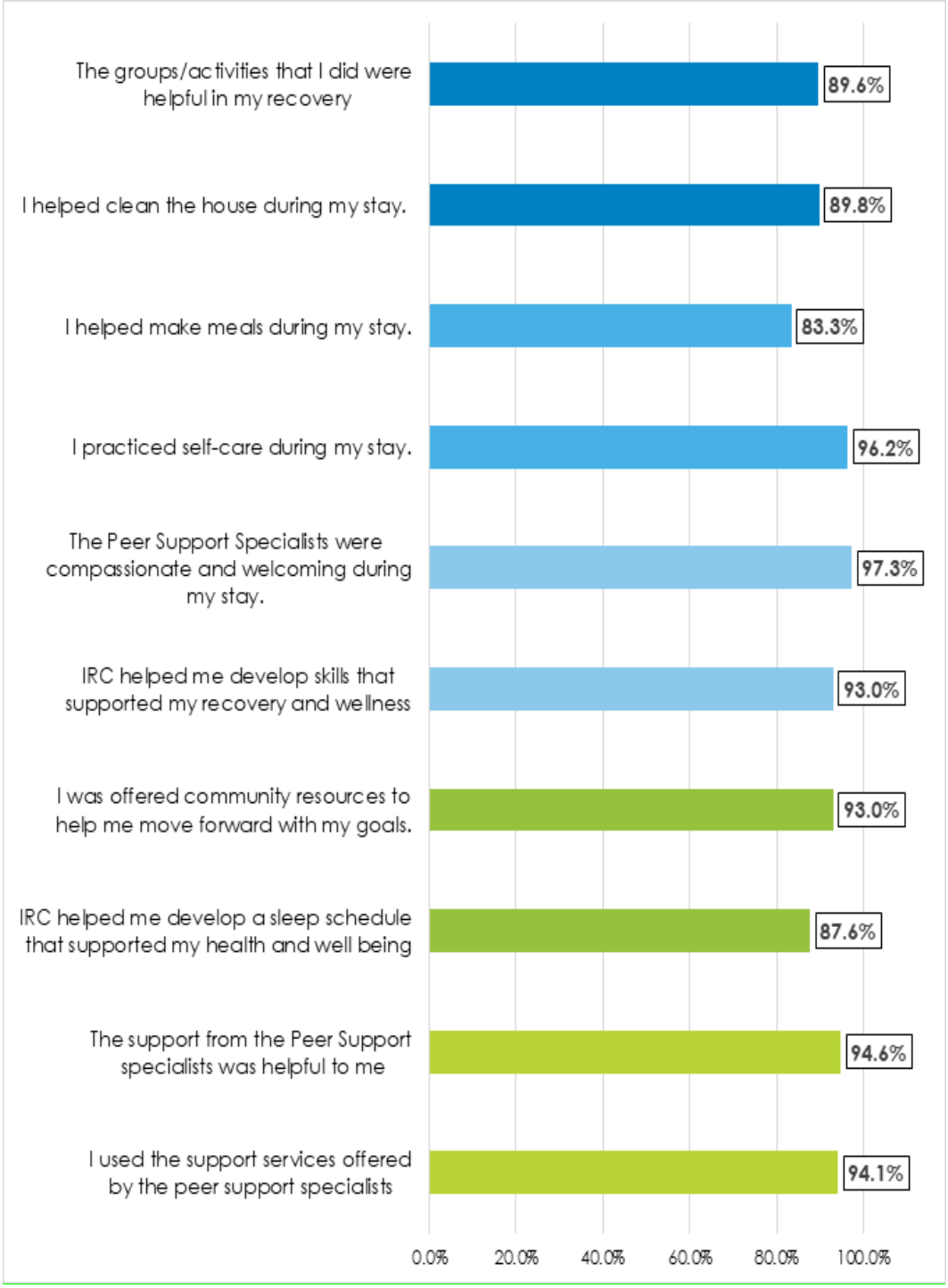
The program serves guests 18 years of age and older, who have a mental illness, and because of the disorder, are at risk of needing a higher level of care. Guests could be at risk of needing psychiatric hospitalization, placement in an Institute of Mental Disease (IMD), Mental Health Rehabilitation Center, or Crisis Stabilization Unit. Participants may be recently discharged from one of these placements or experiencing a first episode or re-emergence of a psychotic break. Individuals must be assessed, medically cleared, and approved by the Nevada County Access Team and then screened and determined to be an appropriate fit by the IRC Leadership Team. 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/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 64 deduplicated guests were served at IRC in FY 19/20.
- The total number of duplicated service contacts for FY 19/20 was 104. Guests may have multiple service contacts in a year.
- Demographic data is gathered on all guests served.
- Insight Respite Center is 100% peer staffed.
- Insight Respite Center guests received 92 referrals to community services during their stay (84 to SPIRIT, five to FREED, and three others).
- At discharge, 59.6% of guests met their goals.
- In FY 19/20 six guests were referred to Insight Respite Center from the Crisis Stabilization Unit (CSU). Of the 104 discharges during FY 19/20, three (4.8%) guests were discharged to an inpatient psychiatric hospital, Psychiatric Health Facility, or Veterans Hospital.
- As part of the guest's intake and discharge process, they are asked to fill out a Pre/Post Outcome Survey. Eight items are measured as a pre/post comparison between intake and discharge. Participants answer the following items using a 3-point Likert scale (Rarely, Some of the Time, Most of the Time). Based on the Pre/Post Outcome Survey below, guests showed improvement in all but one area.



- Of the 104 discharges that occurred within the reporting period (many individuals had multiple episodes of care which led to multiple discharges), 62 (59.6%) completed a satisfaction survey. This led to a Client Satisfaction Survey overall satisfaction rate of 91.9%. The remaining 42 (40.4%) of discharges did not complete a survey, due either to declining to participate, or having an unplanned discharge. Based on data from the Satisfaction Survey below, guests are satisfied with the services they receive. Overall, guests gave IRC services a satisfaction rate of 91.9%. Results for the 62 surveys completed are shown below.



Challenges, Solutions, and Upcoming Changes

The FY 19/20 posed challenges including the needed upkeep and maintenance of the IRC facility and decision to relocate, as well as the onset of the COVID-19 pandemic. After an exhaustive five-month search Turning Point Community Programs (TPCP) was able to locate a facility just four

and a half miles from the previous site. Although smaller in size, the new property elicits a warm inviting home-like feel. Additionally, with the onset of the COVID-19 pandemic, efforts were focused on ensuring the safety of guests and colleagues at IRC. TPCP quickly acquired needed Personal Protective Equipment (PPE), evaluated the needs of the program, and immediately developed a COVID-19 Exposure Prevention, Preparedness, and Response Plan specific to each program. In collaboration with the county, it was determined that IRC would maintain an open room for quarantining purposes if needed and protocol was put into place to ensure the health and safety of IRC colleagues and the guests served. Protocols outlined Responsibilities of Leadership (Managers and Supervisors), Responsibilities of Colleagues, Program Site Protective Measures, Program Site Cleaning and Disinfecting Measures, Exposure Situation Protocol, and Confidentiality and Privacy. Lastly, additional focus was placed on increased training specific to Medi-Cal billing to help raise revenue amid the pandemic, to support the viability of the program and its provided services.

Program Participant Story

Written by a former guest:

> *"Staff never made fun of me when I was unsure of myself. They were kind and smart, and Theresa said I could always come back. No one has said that to me in a long, long time. I enjoyed everyone here and will bring what I have learned home with me. Thank you."*

General System Development:

SPIRIT
Emergency Department (ED)
Emergency Department Outreach and Engagement, including Emergency Department and Crisis Stabilization Unit (CSU) facility supports
Crisis Peer Support Program

Program Description

Program Overview

The 2020 vision of the SPIRIT ED Program is to: Shift vital Nevada County Behavioral Health resources and focus the funding further upstream from repeat emergency care into community-based long-term solutions. The EDP Crisis Supporters fill the gap and provide the bridge post-hospitalization to gently guide individuals through follow-ups, into one or more of the appropriate long-term recovery focused programs.

SPIRIT Crisis Peer Supporters are on call at the local hospital's Emergency Room and the Crisis Stabilization Unit, seven days a week in two shifts from 10am to 3pm and 3pm to 8pm. Working with the Nevada County Crisis Team and the Hospital, SPIRIT Peer Supporters provide

individuals in crisis with support, referral information and follow-up, and many times they become connected to the SPIRIT Center, as well.

Target Population

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

Evaluation Activities and Outcomes

Due to the COVID-19 restrictions, the EDP's January through June 2020 numbers were low, but the SPIRIT Emergency Department Team completed the year reaching the overall annual FY 19/20 target numbers. Because of the low on-site calls, the EDP team has directed their energy toward following up with patrons from earlier in the year.

After COVID restrictions are lifted, community partners will once again be invited to speak at the monthly meetings and present various training topics to staff. In the meantime, the EDP Staff is giving well-researched presentations to the team. The SPIRIT Administrator and SPIRIT EDP staff met monthly in the first half of the fiscal year for on-going training and collaboration and did virtual monthly meetings during the COVID-19 restrictions. Meetings were kept consistent to ensure the EDP Team worked together. The EDP Supervisor continues to attend Nevada County calls to stay informed with the most up to date COVID-19 information.

In FY 19/20 the SPIRIT EDP served 216 unduplicated individuals at the ED/CSU. There were 166 Action Plans and 169 Stress Reduction techniques discussed, 71 Stress Reduction techniques were used and 399 referrals to partner agencies were made. Fifteen individuals who were seen by the SPIRIT EDP became regular SPIRIT participants at SPIRIT Peer Empowerment Center. All 216 people seen received two follow up calls per CSU/ED visit. The EDP staff get in touch with individuals served in the ED who do not have phones, through other methods, such as mailing appointment updates or coordinating through the CSU and/or other agencies.

Additional Outcomes:

	Q1	Q2	Q3	Q 4	FY 19-20 Total
Action Plans Developed	60	51	37	21	169
Stress Plans Discussed	61	46	36	28	169
Stress Plans Used	23	25	8	15	71
Referrals Made	111	159	75	54	399
Resources Accessed	50	49	29	12	140

Challenges, Solutions, and Upcoming Changes

Challenges and Changes: The EDP experienced low CSU and ED numbers due to COVID-19 restrictions. This resulted in missing the quarterly target numbers for the third and fourth quarters of FY 19/20. Even with that decrease, the EDP ended the year only four short of their targeted annual number served (Target = 220, Actual = 216).

In an effort to increase availability, the EDP Staff were available both on-site at ED/CSU and by HIPAA verified Google Phones.

There were three staff changes during the fiscal year. The new Crisis Counselors are training, integrating into their positions and working well with ER and CSU staff members.

Solutions and Successes: To assist the Crisis/CSU Staff, the SPIRT EDP staff continue to call in at the beginning of their shift or check in at CSU/ED on site when necessary. The supervisor of the EDP program is working closely with the supervisors of both Crisis and the CSU, to better collaborate and serve the ED and CSU patrons.

The EDP Director and Staff receive regular training in various peer topics including: Motivational Interviewing, Advanced Peer Support, Suicide Prevention and other monthly peer training topics through The Copeland Center.

Program Participant Story

A woman with multiple CSU visits in recent years was feeling better and recovering. She felt a little stronger each time she visited the CSU. Staff at the CSU gave her information and schedules for SPIRIT's support groups. After several months of regaining stability and strength and attending groups and certification programs, she is now a Peer Supporter at two local agencies. She is enjoying encouraging others in their journey to recovery. She's amazed every day at the paradigm of giving and receiving support.

General System Development:

WELCOME HOME VETS
Veterans' Services

Program Description

Program Overview

Welcome Home Vets (WHV) received its 501 (c)(3) certification in 2010. WHV provides a continuum of psychotherapy to veterans and their families who are afflicted with Post Traumatic Stress Disorder (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 and family's programs.

Target Population

Veterans and their families who are afflicted with PTSD and other diagnoses related to psychological trauma incurred in the military.

Evaluation Activities and Outcomes

During FY 19/20, WHV served 54 unduplicated individuals vs. the contractual goal of 60. They delivered 203 group sessions vs. the contractual goal of 50 group sessions. WHV delivered 200 individual sessions by Licensed Marriage Family Therapist (LMFT) versus a goal of 100 sessions. The 225 individual sessions by a Licensed Clinical Psychologist/LMFT met the contract requirement of 225 sessions.

There were 35 respondents to the 24-item Behavior and Symptom Identification Scale - Basis-24 used to measure the change in participants' self-reported symptoms and problem difficulties over the course of treatment. The remainder of the individuals served did not take the Basis-24 due to dropping out, moving, very new clients, and one participant reluctant to answer questions.

- Goal: Less than 5% of veterans will be incarcerated in jail or prison during the time of treatment.
  Outcome: 0% were incarcerated.
- Goal: At least 95% of veterans in treatment will report thinking about ending their life only a little or none of the time.
  Outcome: 100% reported thinking about ending their life only a little or none of the time.
- Goal: 90% or less of veterans in treatment will not be hospitalized in a psychiatric hospital during the treatment period.
  Outcome: 100% were not hospitalized.
- 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.
  Outcome: 0% reported being in a shelter or homeless.
- Goal: 70% or more of veterans in treatment will report feeling short-tempered less during a week.
  Outcome: 69% reported feeling short-tempered less.
- Goal: 70% or more of veterans will report that they got along well in family situations half the time or more during a week.
  Outcome: 59% reported getting along well in family situations.

Challenges, Solutions, and Upcoming Changes

WHV did not achieve the unduplicated goal of 60 individuals served; 54 were recorded. WHV is making every effort to recruit new participants; especially Vietnam Veterans. Beside this contract,

WHV has a CalVet contract with an unduplicated requirement of 30 participants. To balance both contracts, WHV used a two for one factor for new clients; two for WHV and one for CalVet. If the CalVet participants were included in the total, WHV could have easily met the unduplicated requirement.

WHV has been gradually transitioning many of their longer-term beneficiaries to a recovery model which features peer-facilitated support groups in place of therapist-led support. This model fits the needs of the chronically disabled population quite well. As participants 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.

Program Participant Story

A veteran in this program has been in therapy for over a year. He has been unable to work due to a service-connected injury. He was in a lot of pain, had PTSD and had been depressed and impatient. He developed a habit of drinking to excess to manage his symptoms and he got mean when he drank. The only activity he enjoyed was working in his garden while isolating from his family and others.

When the pandemic prevented his children from going to school, the therapist was worried about them being around him. But the man felt bad that they couldn't attend class and see their friends. He decided to use the opportunity to spend quality time and get to know each of his children as individuals. He imbibed less and helped them with their homework. He gave each of them a plot of their own in the garden to grow whatever they liked as long as they tended to the plots. His four year old son only wanted to grow potatoes, so that is what he is growing.

The veteran is now a happier man and at ease with his family. He has been utilizing the tools he learned from his therapist in therapy to control his anger and develop empathy. Amazing that it took a pandemic to open his eyes to the love of his family.

General System Development:

NEVADA COUNTY HOUSING DEVELOPMENT CORPORATION (NCHDC)
Provide Housing and Supportive Services to the Severely Mentally Ill Homeless
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, case management, maintenance and repairs for the two homes they own as well as the ones they master lease.

NCHDC assists tenants with their rental applications, rental assistance applications, lease agreements and general living skills to maintain their housing. NCHDC also assists with grant applications, grant reviews and grant evaluation reports as needed. NCHDC meets weekly with County and contract housing personnel: Case Managers/ Personal Service Coordinators, Program Manager, Supervisors and others. Multiple lines of communications are kept open with tenants' family members and all owners to address any concerns and to provide necessary services to prevent a return to homelessness. 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.

Consolidated Home Anew Program

Behavioral Health consolidated the Home Anew and Summer's Haven programs this year and received a renewal grant from Housing and Urban Development (HUD) Continuum of Care (COC) for $140,484.00 to provide, a minimum, of fifteen vouchers to individuals and/or families.

Winters' Haven

Behavioral Health received a renewal grant from HUD for $27,474.00 for the Winters' Haven Program. Winters' Haven provides project-based vouchers for five bedrooms in the first home purchased with MHSA Housing funds. In addition, Winters' Haven funds two voucher units in the community.

Catherine Lane - Second MHSA funded House

Catherine Lane is a six-bedroom residence, which houses six tenants. A House Manager is present during the day and House Monitors are present during the hours that the Manager is away. This provides the tenants with Twenty-Four-hour mental health support and companionship. 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. In FY 18/19, the house was upgraded with new bathroom facilities.

Target Population

The target population for these programs are individuals with mental illness who are potentially homeless, are homeless or are chronically homeless. In addition to serving the mentally ill population of Nevada County, NCHDC has recently become involved with serving formerly incarcerated populations with the goal of reducing recidivism and providing rehabilitation services to these individuals.

Evaluation Activities and Outcomes

NCHDC meets with tenants and their support 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 37 individuals were housed through these NCHDC programs in FY 19/20. This included 24 tenants that have remained housed for over three years, nine of whom have been housed for more than five years. Of the 37 individuals housed through these programs, 13 individuals were unsheltered homeless, one individual came from transitional living, and 12 came directly from the shelter.

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 19/20 had an average length of stay of over 48 months. The remaining tenants in FY 19/20 have an average length of stay of over 39 months. Eleven adults have either gained, or increased their income amounts since they entered the programs.

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. NCHDC has many upcoming positive changes including an additional new permanent supportive three-bedroom house.

Program Participant Story

NCHDC reports three tenants who are now employed in the social service field. These individuals represent the true success of programs such as NCHDC as well as the field of Mental Health Services.

Outreach and Engagement:

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

Program Description

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

Target Population

Sierra Family Health Center serves low income and underserved individuals in Nevada County**.** Approximately 83% of patient visits are with patients with Medi-Cal and/or Medicare insurance, with more than half having some type of Medi-Cal insurance. SFHC staff work to identify and assist patients on Medicare without a secondary insurance plan who are eligible for Med-Cal.

Evaluation Activities and Outcomes

During FY 19/20, 62 unique patients were identified as needing engagement and assistance to obtain behavioral health treatment and/or community supports.

As leaders in the warm-hand off process for patients being seen by more than one clinician, 56 individuals or 90% connected and continue with behavioral health services. SFHC is an integrated services health center where medical and behavioral health treatment overlap. Most of the medical providers have participated in the UC fellowship which trains primary care clinicians to diagnose and treat many psychiatric conditions. All are trained in motivational interviewing. Behavioral health services encompass medical, therapy, and care coordination services. Depending on the individual patient's needs, he or she may begin treatment with either a therapist or a medical provider or even dental. Dental will provide a warm handoff to the behavioral health care manager or a therapist when warranted. Sometimes the patient has been seen only for general medical reasons but exhibits a behavioral health condition requiring more support. That support may include bringing in a licensed clinical social worker (LCSW) and perhaps no medical intervention is needed. Sometimes a patient may need to receive medical treatment for the behavioral health condition and also see an LCSW. Sometimes patients are resistant to seeing a therapist, and it

takes time for the medical provider to help the patient see the benefit. The medical provider sometimes brings the behavioral health care manager onto the health team. Some patients prefer to see a community therapist and facilitation is provided to identify a good fit while addressing insurance compatibility. Some patients see a psychiatrist in the community and an LCSW at SFHC. Since the onset of COVID-19, the overall number of patients seeing Behavioral Health clinicians has increased, and due to telehealth and telephonic visits, patients are being seen more frequently. Clinicians report stronger progress toward treatment goals.

Eighty percent of patients engaged in referred services do so within 90 days. Patients were referred to Hospitality House (4); Logisticare transportation (24), Medi-Cal or assist with changes (33), CalFresh (18), Family Resource Centers (FRC), especially the San Juan Ridge FRC until it closed due to COVID-19 (6), Alta Regional Center (1), Community Beyond Violence (3), SPIRIT Center (9), Granite Wellness (4), Common Goals (2), NCBH (3), FREED (21), Workforce Development (2), Connecting Point (4), Interfaith Food Ministry (9), Salvation Army (2), North San Juan Community Center (3), and community therapists (6).

Challenges, Solutions, and Upcoming Changes

Challenges

The two greatest challenges continue to be housing and transportation. Since last year's report, the bus service through specialized Route 7 was modified so that a bus now stops in front of the center at mid-day. However, the other two times it goes by the center are well before and after the center is open. Since the modified bus route only provides support for transportation one way, utilization is not common. Although individuals are grateful that Managed Care Medi-Cal patients can access transportation through Logisticare services for appointments, there can be significant challenges. Sometimes a ride is not available resulting in missed appointments. A number of times patients have experienced extended waits while the services find a driver who can come to pick the patient up after an appointment; they don't always wait. Patients on regular Medi-Cal or Medicare continue to have challenges getting to town for medical specialty appointments due to transportation barriers. Patients not on Regular/Straight Medi-Cal do not have access to Logisticare and have cancelled appointments due to the inability to pay for gas for their cars. The Center is looking to address that through other channels. Patients' cars break down but cannot be fixed due to lack of funds.

In light of COVID-19, housing scarcity has increased. Rentals are hard to find. SFHC has several patients receiving housing assistance through FREED, although there are those who live in their cars and in make-shift shelters on others' property. Fortunately, FREED has assisted patients with food scarcity, although due to the remote, and challenging dirt roads, some patients have not been able to benefit, but have other ways of being resourceful.

Program Participant Story

A positive patient story is about a woman who has multiple chronic health conditions, including behavioral health conditions that were exacerbated by her situation. She came to SFHC this year as a new patient, and through repeated outreach and engagement strategies, meeting her where she is at, the patient has now strongly engaged in treatment and is making progress.

Outreach and Engagement:

SPIRIT
Adult Wellness Center
SPIRIT Peer Empowerment Center

Program Description

Program Overview

SPIRIT is a comfortable, home-like mental health recovery day center on five acres. Entirely peer-run, peers on staff offer one-on-one counseling to individuals and host a variety of support groups. Groups include Diagnosis with Dignity, Co-Occurring, Women's Group, Men's Group, and Identity Diversity (LGBTQ+). The aim is to create pathways towards connection and creativity in a way that meets each individual's interests and stage of growth. The center has a variety of board games, puzzles, as well as planned activities throughout the week, including Peer Music, Beading for Wellness, Creative Expressions, and Gentle Yoga. Participants may also get their hands dirty tending the organic garden.

Meeting basic needs is a large part of building a foundation for mental health. To this end, the center offers access to their food pantry, showers, and laundry. Peers on staff support participants in connecting with what they want out of life. Frequent referrals are made to other agencies, and the center offers access to public computers and support searching for housing, jobs, or simply to building computer skills.

Periodically throughout the year there are various educational/training classes such as WRAP (Wellness Recovery Action Plan) classes and facilitator trainings, Peer Support 101, and Recovery, Goals, and Life Skills classes.

Target Population

SPIRIT Center's target population is anyone with a mental health issue who indicates that they would like to make positive changes in their life; this may include those with substance abuse issues, co-occurring conditions, or homelessness. The SPIRIT Center targets individuals 18 years and older with severe, moderate or mild mental illness.

Evaluation Activities and Outcomes

SPIRIT staff learned a model of Peer Support called Recovery Coaching. In this model, both participant and Peer Supporter are called to step up into a braver version of themselves and hold one another accountable with support and feedback in the process. The team was so inspired that they created a Participation Committee, and further refined their intake process to feel more like a peer support session, even as they gather the necessary data. This work, along with a moving, celebratory, and relaxing Volunteer Appreciation Day brought fresh life to the team and the corresponding work they do.

In FY 19/20 SPIRIT almost tripled their independent income from $3,570 raised in FY 18/19 to $9,220 raised in FY 19/20. The mailing list for the annual letter was expanded, bringing in $3,295. This represented an improvement from the $600 the letter brought in in FY 18/19. Creating a dedicated Grants Administrator position was helpful in acquiring $4,641 awarded from the Briar Patch's CAUSE for Change donation program. The Center signed up as a non-profit to receive donations from Amazon Smile and eScrip at SPD Market. Two additional funding sources are pending, one for a $500 donation from a local church, and the other from the COVID Relief Fund. Other efforts included applying for PEI funding to create an Integrative RESToration program at SPIRIT, applying for the Census 2020 grant, researching private foundation grant opportunities as well as community funds and large donors. SPIRIT Center continues to research regional health foundations for more funding opportunities.

This year the Center deepened their community connections and collaboration with the local Grass Valley Police Department, the HOME Team (Homeless Outreach and Medical Engagement), the Continuum of Care (CoC), and other organizations like FREED, Anew Day, and Sierra Roots by attending meetings, giving presentations, and inviting speakers to the SPIRIT Tuesday staff meeting.

SPIRIT Center Statistics for FY 19/20	**Year End Total 19/20**
Unduplicated # of clients	545
# of New Each Quarter	389
Empower peers to engage in the highest level of work or productive activity appropriate as measured by:	
# of peers who obtained gainful employment	10
Volunteer Hours spent maintaining the facility	319
Peer Support sessions	598
Peer Support training hours	128
Services offered to peers to optimize opportunities for productive activity (list hours for each service):	
- Front Desk	1,603
- Property Maintenance	548
- One-on-one Peer Support	598
- Group Facilitation	671
- Peer Support Interning	905

Reduce isolation of persons with mental illness as measured by:	
Duplicated Visits (Walk-ins)	5,834
Support Groups per Quarter	397
-Support Group's Attendance	1,137
Social Activities per Quarter	171
-Social Activity attendance	1,147
Improve quality of life of homeless individuals as measured by:	
# of Showers to homeless	759
# of Loads of Laundry to homeless	282
# of Bags of Food given to homeless	390
# of Homeless receiving basic services	206
# of homeless participants who obtained housing	13
Survey Results - # of clients who improved in each of these areas: Note: Performed in 4th Quarter	
Suicide	6
Housing	1
Education/Life Skills/Coping Skills	19
Hospitalizations	12
Court/Legal	10
Employment	6
Prolonged Suffering	19
# of people in SPIRIT sponsored structured educational class:	
- Peer Support 101	6
- Yoga	73
- WRAP I	5
- WRAP II	14
- Recovery, Goals and Life Skills	62
Other Data to be collected:	
New Participants	364
- New Participants to SPIRIT from ED Program	12
Un-interviewed Individuals (e.g. one-time visit or class)	157
Fundraising (Holiday Letter, donations, outreach)	$9,220
Number of bi-lingual PSS (phone)	202
Bus passes issued	115
Number of public computer use sessions	492
Hours the Center was open	1,319

Challenges, Solutions, and Upcoming Changes

SPIRIT Center received a notice from the Fire Department to take down all the blackberry bushes and other brush at the edge of the property. The Center has diligently been looking for a solution to get the job done by the due date.

SPIRIT has been deepening connections and collaboration with the Grass Valley Police Department. Together, a plan was made to keep Gates Place clean and clear of trash and excessive parking once the city puts some two-hour parking signs up. SPIRIT Center now offers validation tickets for those who'd like to park for more than the allotted two hours while they spend the day at the Center. Trash is regularly being picked up on Gates Place to keep the drive well-cared for and professional-looking.

Staffing has been an ongoing issue, as it has been for many during COVID-19. There are just enough staff to run the center. SPIRIT is recruiting for a male and/or a Spanish-speaking Peer Supporter to bolster the team. Once there are enough supporters on the floor, the Center plans to authorize certain peers to drive participants needing emotional support to doctor appointments, job interviews, and other locations and agencies that will support participants on their road to wellness.

The SPIRIT team is making final adjustments before launching a new website. It will offer a closer (as well as more professional) look at who and what SPIRIT is, as well as offering on-the-spot action steps for interested participants, donors, and volunteers. These efforts will likely further increase SPIRIT's community participation and increase income from donations next fiscal year.

Program Participant Story

A longtime participant recently opened up about how instrumental the SPIRIT Center has been in his recovery. In his words, "Before I came to SPIRIT, I was lost in darkness, I had no concept or idea of what being clean and sober was about or know about feelings and emotions. I've learned all this stuff through SPIRIT Center." He had been to other support groups, but never felt totally safe sharing about the mental health component to his addiction, until he connected in with one of SPIRIT's support group. He now has years of sobriety, and no longer has to be hospitalized, which had been a pattern for him prior to engaging with SPIRIT Center and other county agencies. These days, he spends his time going to support groups, reading, taking walks, spending time with his family, and is looking for volunteer work to enrich his life and give back to the community. Stories like this show how the healing process can take some time, but with community support, guidance, and dedication to the work, feeling better really is possible.

Prevention and Early Intervention (PEI)

PEI Project Name: Early Intervention Program

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

Program Description

Program Overview

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

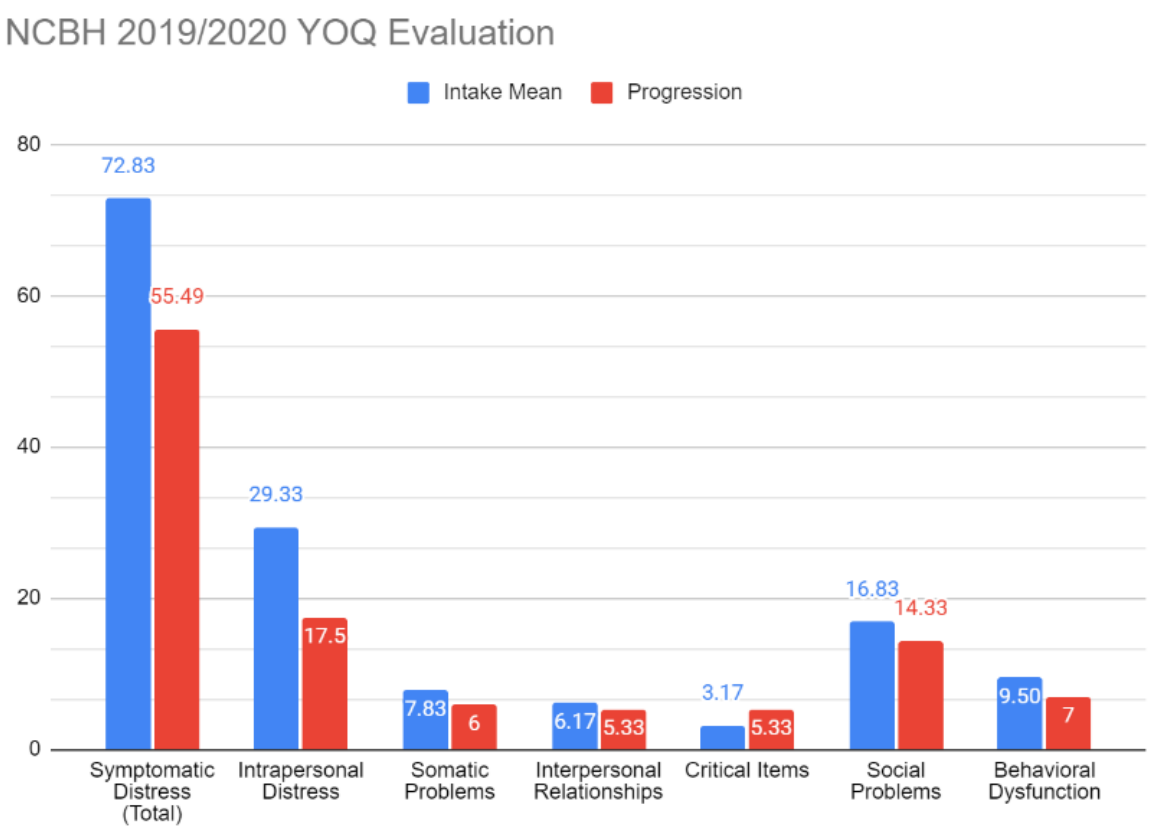
Target Population

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

Evaluation Activities and Outcomes

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

YOQ-SR 2.0



Of the 13 participants in the Nevada County program in FY 19/20 only six had a follow up YOQ to draw comparisons. Of those, participants displayed a mean reduction in overall symptomatic distress of 23.82%.

Areas of improvement included reducing feelings of depression, hopelessness, anxiety as well as increasing cooperativeness and reducing argumentative behavior as measured by intra & interpersonal distress. Furthermore, acts of truancy, running away, vandalism and use of substances were all shown to decrease as evidenced by social problem reduction of 14.87%.

Perception of Care

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

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

Challenges, Solutions, and Upcoming Changes

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

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

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

Data Management:
Whole Hearts has seen a significant growth in data management needs to ensure necessary tracking of program services and outcomes. To assist with this management, an administrative assistant position was added to help compile data from measurement tools.

Furthermore, to better track progress, the Whole Hearts admin team has set a goal to collect YOQ-SR every three months versus every six months. This will help to generate a more complete picture.

Program Participant Story

"Self-awareness, confidence, and achievement through cooperation are natural [program] outcomes... It is a truly holistic outreach and I am forever grateful to have Peter Mayfield and the folks at Gateway Mountain Center in our lives." **- Parent of program participant**

"[Our MHW] has been incredible. We don't know what we would do without her. She has played such a huge role in our family." **- Parent of program participant**

"I can be real when I am with [my MHW] and she is the main person I turn to when I am in a crisis." **- Program participant**

PEI Project Name: Early Intervention Program

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

Program Description

Program Overview

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

Staff work closely with community agencies that have already built trust with Latino families by providing needed basic services. Examples of such community agencies are Child Advocates of Nevada County, and Sierra Community House. NCBH maintains good communication with these community agencies by:

- Coordinating care of mutual participants
- Funding programs at Sierra Community House
- Providing bilingual Case Management
- Delivering quality treatment for participants referred from Sierra Community House

Target Population

Bilingual Early Intervention primarily aims to serve the Spanish-speaking population but will provide services to any individual. Bilingual Early Intervention Program services are crucial in Eastern Nevada County where a large percentage of the population speaks only Spanish, and there are virtually no mental health services available in Spanish, except those provided by NCBH.

Evaluation Activities and Outcomes

The Bilingual Early Intervention Program collects demographic and service-level data through NCBH's Electronic Health Record System (Cerner). During FY 19/20, the program served 57 unduplicated individuals; including 26 adults and 31 children and provided 522 services in Spanish. At the Grass Valley office 27 unique individuals were served, and at the Truckee office 30 individuals were served.

The CANS 50 was used for child outcomes, and the Basis 24 was used for adult outcomes. Thirty-five children were assessed with CANS 50, and 15 of those were reassessed following at least six

months of services. The 15 children who were reassessed showed an average of 26% improvement in their overall CANS score. Indicators where participants showed the most improvement were: adjustment to trauma, anxiety, depression, family functioning, social functioning, community life and resiliency. Eleven adults were given an Intake Basis 24 assessment, and two of those were given a Basis 24 Mid-Treatment assessment. Both individuals who were reassessed showed improvement in their overall Basis 24 reassessment scores. The indicators where participants showed the most improvement were in the Depression/Functioning Domain.

Challenges, Solutions, and Upcoming Changes

Early in the pandemic lockdown NCBH provided psychotherapy by phone and video. Most adult Spanish-speakers were able to engage well through these means. But younger individuals, less verbal beneficiaries, and those needing play therapy, did not engage well through electronic media. NCBH was sensitive to the needs of these individuals and NCBH management gave approval in mid-May 2020, to treat them in-person, outside or in a large room with physical distancing. Therapists responded to this adjustment and began seeing many younger beneficiaries in person.

A large percentage of Spanish-speaking participants lost their jobs in spring 2020 as the service and tourist sectors shut down. These families were vulnerable, living paycheck-to-paycheck, needing food and money to pay rent. In eastern Nevada County, Sierra Community House provided most of that needed help, but they were also inundated with phone calls. Community members had a difficult time reaching Sierra Community House and there were long wait times to get a call back or to receive needed aid. PEI beneficiaries benefited from the close relationship that NCBH has established with Sierra Community House. PEI beneficiaries received a call from the Sierra Community House case manager, were assisted with their applications, and all received financial help.

Getting pre and post-treatment results on the Basis 24 Outcome Measure has been an historical challenge. The Basis 24 has been added to the packet of initial paperwork to be completed during Intake as a way to improve data gathering. Moving forward, chart audit protocols and chart-tracking databases can include the Basis 24 Mid-Treatment Assessment in order to improve mid-treatment data gathering.

Recent focus on racial injustice has left many Spanish speakers or undocumented people feeling even more afraid of being different. Some people felt so afraid they decided not to ask for help. NCBH works to provide education about their rights in their language, to increase cultural competency among staff, and asks beneficiaries about their needs to facilitate solutions.

Many MHSA-funded individuals experience complex case management needs. These needs include help navigating the legal system, accessing medical care without health insurance, and finding housing. For example, during this funding period, one individual needed help navigating the local court system, locating intimate partner violence services regarding a restraining order, finding safe housing, and accessing prenatal medical care. Assisting these participants with their case management needs can sometimes lead indirectly to mental health improvements but can also take time away from direct service work on treatment goals.

One solution for addressing participants' case management needs is effective utilization of local community partners, particularly Sierra Community House and newly-established Victor Community Support Services near the Truckee office. For the MHSA-funded individual referenced above, Sierra Community House provided intimate partner violence services as well as medical referrals, while Victor Community Support Services provided much of the case management.

Program Participant Story

An Hispanic young adult self-referred to NCBH for services after participating in the NCBH Children's Behavioral Health program as a minor. The individual had been diagnosed with mental health issues and was struggling to manage day-to-day tasks. The individual also experienced economic and interpersonal difficulties. Treatment included psychiatry, medication management and therapy to address the symptoms of his disorder. The individual reported reduced symptoms once an appropriate medication was determined. As a result, the individual learned techniques for identifying unhelpful patterns in thinking style and developed a more stable sense of self, leading to acquiring employment. As other case management-related challenges surfaced during treatment, the individual was referred to another local provider, which has helped him in attaining even more of his interpersonal and economic goals.

PEI Project Name: Early Intervention Program

NEVADA COUNTY PUBLIC HEALTH
Early Intervention for Referred Children, Youth, Pregnant Women, Postpartum Women and Their Families
Moving Beyond Depression

Program Description

Program Overview

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

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

Target Population

- Nevada County women experiencing depression in the prenatal and postpartum period.
- Designed to meet the needs of low-income, underserved women, enrolled in a home visitation program in Nevada County.

Evaluation Activities and Outcomes

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

During FY 19/20, Moving Beyond Depression served 16 individuals and 23 additional family members. Of those 16, 11 accepted services, four declined and one was referred to other services. Currently, there are seven mothers who are progressing through the program, three that have completed the program, and one who dropped out of the program after the ninth session. Participants were screened up to 21 times during their involvement in the program.

While scores fluctuated during participation, all 11 individuals showed improvement in their scores at some point in the program. Of the 11 mothers who completed at least six sessions, 70% saw an improvement in their EPDS scores. For those who completed 15 sessions plus the booster session, 100% of the mothers had improved scores, averaging almost 40% improvement.

All 11 individuals were screened with the Interpersonal Support Evaluation List (ISEL) at admission. Because only three participants had so far completed the program during this period, there were only three ISEL scores at discharge to compare with the admission scores. All three mothers who completed the program had increased their ISEL scores by an average of 9%, indicating that they felt somewhat of an increase in interpersonal support.

Six individuals completed the Perception of Care Survey with an average agreement to the questions of 81%:

Perception of Care Question:	**% Agree**
1. I am getting along better with my family.	83%
2. I do better in school and/or work.	67%
3. My housing situation has improved.	50%
4. I am better able to do things that I want to do.	67%
5. I am better able to deal with crisis.	83%
6. I do better in social situations.	83%
7. I have people with whom I can do positive things.	100%
8. I do things that are more meaningful to me.	67%
9. I have learned to use coping mechanisms other than alcohol and/or other drugs.	83%
10. In a crisis, I would have the support I need from family or friends.	83%
11. Staff welcome me and treat me with respect.	100%
12. Staff are sensitive to my cultural background.	100%
Average:	**81%**

Five Outreach Activities were held with an estimated 36 attendees. Four of these activities were held in western Nevada County and one was held in the Tahoe/Truckee Area.

The Moving Beyond Depression program initiated 10 referrals. Seven referrals were made to non-county Adult Mental Health Services. One referral was made to the Nevada County Adult Behavioral Health Department. This individual had no duration of untreated mental illness.

Challenges, Solutions, and Upcoming Changes

- Service capacity has been affected on the western side of the county as one therapist did not renew her contract in this fiscal year. In addition, the end of the program Project Launch has impacted the number of clients able to be seen.
- The Moving Beyond Depression program is still unable to serve the Spanish-speaking community adequately as recruitment for a bilingual therapist has proved unfruitful.
- The eastern side of the county still is unable to be supported by Moving Beyond Depression. A part-time position had been offered to two different therapists, but one chose another position, and the other was unable to obtain her California licensure. Currently Truckee moms are referred to other services on the eastern side of the county for mental health services.
- SARS COV 2 or COVID-19 has had a big impact on services. Because of stay-at-home orders and physical distancing, in-home therapy visits were discontinued. Therapy sessions have been conducted via telephone or virtual visits via video modalities. Statements made by program participants suggest that this is not optimal, especially during this time of isolation, but is still definitely helpful.

- One benefit related to COVID-19 is that the therapist has been able to serve more individuals due to them not having to drive to various locations in order to see them in their homes.
- Clients seem to have had greater needs during this pandemic period. Many have needed additional sessions, lengthening their time in the program in order to help with the added depression and anxiety related to COVID-19.
- During the pandemic, the program was still able to serve moms in the community, helping to create healthier family relationships. The Moving Beyond Depression program was offered to 16 moms who otherwise may not have connected with services. Eleven moms participated in the program; however, when looking at the total number of individuals who were affected by the positive outcomes of this program, it includes 13 children, partners and extended family members; This demonstrates that the impact is far reaching.
- Treating perinatal depression increases bonding with infants, allowing for better breastfeeding outcomes, and an improved family dynamic. The strength of the program lies in the dedicated home visitors, the therapist, and the family's willingness to have outsiders in their homes and/or virtually in their lives. It is apparent that this program creates positive change, no matter how small. There is a great appreciation for those who fund and also believe in the program.
- Moving Beyond Depression has been a model program, and though not implemented anywhere else in the state, it is recognized by many counties as being a solution for widespread perinatal depression.
- Additionally, the program was able to increase the therapist's hourly wage closer to the market rate, which has increased her personal satisfaction and value, and thereby ensure that she will continue to be motivated to provide these valuable services.

Program Participant Story

I have been working as a home visiting Public Health Nurse in the MBD program for two years. I am both delighted and surprised by how effective MBD therapy is for our clients. I remember having a client who was depressed and had been diagnosed with a mental illness. Her therapist encouraged her to see a psychiatrist. The psychiatrist told her she did not have a mental disorder. The mom found great relief in knowing this. Over the 15 weeks in MBD, I was witness to dramatic changes in this mom. She learned how to communicate clearly about her needs to her husband which changed their relationship for the better. She learned how to set limits at her job and became a happy thriving individual, thus making her a better mother. Another mom's depression was linked to challenges in being able to care for herself. MBD therapy helped her find ways to work within the confines of her life and still find peace, joy and pleasure. She left the program delighted with the changes she had made. I currently am working with a mother who in the beginning was expressing extreme negative thoughts. Last week when I spoke with her, she was happy and looking forward to the future. I have seen this scenario play out many, many times. It is a privilege to be part of this program.

PEI Project Name: Early Intervention Program

STANFORD SIERRA YOUTH & FAMILIES
Early Intervention for Referred Children, Youth, Pregnant Women, Postpartum Women and Their Families
Family Preservation and Therapeutic Support Services

Program Description

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

Target Population

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

Evaluation Activities and Outcomes

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

During FY 19/20, 107 youth received services, with an average of 49.6 services per participant. Most participants (85%) received eight (8) or more contacts during the fiscal year. See the tables below for more information.

	FY 19/20	
Number of Service Contacts	**# Participants**	**% Participants**
1 Contact	2	1.87%
2 – 4 Contacts	5	4.67%
5 – 7 Contacts	9	8.41%
8+ Contacts	91	85.05%

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

Goal	**Objective**	**FY 19/20 Thru April 30th**
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	104/107: 97%
Youth will be out of legal trouble.	At least 70% of youth will have no new legal involvement between admission and discharge	106/107: 99%
Youth will improve academic performance.	At least 80% of parents will report youth maintained a C average or improved on their academic performance.	98/107: 92%
Youth will attend school regularly	At least 75% of youth will maintain regular school attendance or improve their school attendance.	104/107: 97%
Youth will improve school behavior	70% of youth will have no new suspensions or expulsions between admit and discharge.	98/107: 92%
Caregivers with strengthen their parenting skills	At least 80% of parents will report an increase in their parenting skills.	98/107: 92%
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.	106/107: 99%
Caregivers will improve connections to the community	At least 75% of caregivers will report maintaining or increasing connection to natural supports.	104/107: 97%

Challenges, Solutions, and Upcoming Changes

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

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

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

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

Program Participant Story

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

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

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

PEI Project Name: Early Intervention Program

NEVADA COUNTY BEHAVIORAL HEALTH
Homeless Outreach and Therapy
Homeless Early Intervention Services

Program Description

Program Overview

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

Target Population

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

Evaluation Activities and Outcomes

In FY 19/20, 164 unduplicated individuals were served plus an additional 260 individuals received outreach for a total of 424 individuals reached throughout the year. A breakdown of outreach activities showed 104 shelter outreach activities performed at Hospitality House including 260 attendees for 375.5 hours.

A total of 265 contacts with shelter guests were recorded for FY 19/20. Guests were seen within 3 business days of initial referral.

- Approximately 25 guests were referred to NCBH for services in which 22 of those individuals followed through. Of those individuals who followed through, 12 met criteria for services at

NCBH and 13 were referred to services in the community. Three individuals, who would have met criteria for NCBH, declined services.

- At least 26 individuals were referred to other Mental Health services though Chapa de, Sierra Nevada Medical Center, Communities Beyond Violence, Crisis Stabilization Unit, and private providers who accept Medi-Cal. At least eight of these individuals followed through.
- Twenty-one individuals were opened through NCBH assessments and received Case Management services by Turning Point staff stationed at Hospitality House.

The Behavioral Health Screening Form was documented for nine intakes. Three people reported an average of three Emergency Room visits for care and three people reported an average of four nights spent in the hospital for care. There was no posttest data available for comparison.

Challenges, Solutions, and Upcoming Changes

This fiscal year brought many challenges to Hospitality House and the Homeless Early Intervention Program. With the outreach dormitory continuing to be part of the program, more monitor staff and a housing staff were added, leading to less room for privacy and therapeutic services and lowered numbers served.

Other factors causing reduced numbers in this program were Public Safety Power Shutoffs by PG&E and the COVID-19 pandemic. The pandemic led to quarantine of both shelter guests and staff. Nonetheless, some services were able to be conducted by telehealth. These services included intake assessments for Nevada County Behavioral Health and brief therapy. The Early Intervention Homeless Therapist has physically returned to the shelter with safety measures in place and the availability of more space, including a designated private office space.

Program Participant Story

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

and therapy through NCBH. He has been fairly stable in his housing situation and is able to have visits with a family member who lives locally.

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

WHAT'S UP? WELLNESS CHECKUPS
First Responder Training
Mental Health First Aid

Program Description

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

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

Target Population
What's Up Wellness offers MHFA and YMHFA trainings to adult participants as well as mature youth participants with parent consent.

Evaluation Activities and Outcomes

What's Up Wellness collected evaluation activities for MHSA including training sign-in sheets, demographic data on each training participant, and post training evaluation surveys.

During FY 19/20, WUW facilitated a total of four YMHFA trainings. One training was offered in Eastern Nevada County, the other three trainings were offered in Western Nevada County. Two trainings were offered in a school setting, one training was offered in a local youth serving agency, and one training was offered in a public training facility. Participants included parents of youth, staff from youth serving organizations, school staff, student peer helpers, hospital staff, homeless outreach workers, counselors and other youth serving employees/volunteers. A total of 69 unduplicated individuals participated in the trainings and 68 evaluation forms were completed.

Evaluation survey data showed that as a result of the trainings 94-99% of participants agreed or strongly agreed that they experienced changes in attitude and behaviors around mental illness. Participants agreed or strongly agreed that after the training they had an increased knowledge of mental illness and symptoms, were more willing to ask a person about suicide, and were more willing to approach, assist and listen to distressed persons actively and compassionately. Overall,

97-100% of participants agreed that their trainers, training materials and content were beneficial to their increased knowledge.

Direct referrals were inapplicable as no individual participants disclosed a need for mental health services. However, local resource sharing as well as national resource sharing takes a significant role both in the curriculum and materials provided onsite at all MHFA and YMHFA trainings. Crisis support information and mental health resources in both English and Spanish, as well LGBTQ resource information were provided to all training participants.

Challenges, Solutions, and Upcoming Changes

As expected, training challenges in FY 19/20 were related to COVID-19, which created a series of cancellations and the inability to complete contracted services. In March 2020, WUW discontinued in-person trainings for the remaining contract year due to gathering restrictions. At that time facilitators began working on a virtual YMHFA format. After the preparation/coordination of the virtual training, it was announced by The National Council for Behavioral Health that facilitators would need to wait until an approved virtual option became available for use. This began a series of forced training cancellations for WUW. What's Up Wellness facilitators were trained in the approved virtual YMHFA format in mid-April, however ongoing technological obstacles in the virtual platform were too significant for participants to access the virtual learning system in a timely way and trainings needed to be cancelled again. This happened again in June, and later in July. In total, WUW was forced to cancel five virtual MHFA trainings due to circumstances beyond WUW's control. This was resolved by consulting with and getting approval from MHSA managers for contract flexibility and budget shifts for the two remaining FY 19/20 contracted trainings to take place in FY 20/21.

After the closure of schools due to COVID-19, WUW received numerous community requests for Youth Mental Health First Aid due to rising emotional distress among youth sheltered in place. What's Up Wellness was contracted to offer two additional adult MHFA trainings in FY 19/20, however Nevada County MHSA managers again agreed to contract flexibility so that WUW could address the community need for additional Youth trainings.

Upcoming WUW FY 20/21 program changes include implementing Teen Mental Health First Aid (tMHFA) in a local high school. Teen Mental Health First Aid trainings teach youth how to identify mental health challenges in one another, as well as how to access critical mental health supports in the earlier stages of need before symptoms begin to impair academic and personal areas of life.

Program Participant Story

Participant Quotes:

- "Overall fantastic course, glad I signed up. Super helpful and happy that it is FREE - these trainings should be available to everyone/anyone."

- "The instructors were great at facilitating open discourse and participation with all attendees. The group's diversity in experiences and training made for an intelligent, thoughtful and insightful discourse."
- "Very well presented and engaging."

PEI Project Name: Prevention Program

HOSPITALITY HOUSE & TURNING POINT COMMUNITY PROGRAMS
Housing Assistance Program (HAP)

Program Description

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

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

Evaluation Activities and Outcomes

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

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

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

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

Challenges, Solutions, and Upcoming Changes

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

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

Program Participant Story

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

PEI Project Name: Prevention Program

FREED
Senior, Disabled and Isolated Home Visitor Program
Friendly Visitor Program

Program Description

Program Overview
The Friendly Visitor Coordinator meets with the consumer in their home, builds rapport, gets to know them, and identifies their needs and desires through motivational interviewing. Appropriate referrals are made for a range of community services as needed at that time. After identifying their interests, they are matched with a volunteer visitor if one is available. In addition to providing community contact, the FREED Friendly Visitor Program complements other mental health programs and connects individuals to other necessary mental health and community services. Many choose to participate in the FREED Phone Reassurance Program while they are waiting for a match.

All volunteers have completed applications, interviews, background, and reference checks. Volunteers also attend an orientation on consumer-centered services as well as regular monthly trainings. There are two mandatory trainings on being a Mandated Reporter and Community Services. Volunteers are expected to spend a minimum of one hour per week visiting with their matched consumer, but many volunteers spend several hours more than the minimum.

The program is administered by FREED Center for Independent Living, an organization that provides a consumer-driven, peer support model of services to people with any type of disability 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. Individuals are referred by family members and friends, or by a variety of local agencies.

Evaluation Activities and Outcomes

In FY 19/20 the Friendly Visitor Program:
- Provided services for 40 unduplicated individuals. Twenty-five percent more than the target goal of 30.
- Trained 20 new volunteers. One hundred percent more than the target goal of 10.
- Maintained a volunteer pool of 33. Three above our target goal of 30.
- Provided service for three consumers in Truckee. One more than the target of two.

- Had a pool of five volunteers in Truckee. Three more than the target of two.
- Received 60 new referrals for services.
- Currently has 45 people on the waitlist, down from 68 at the end of the FY 18/19. Most are participating in the Phone Reassurance Program until in-person meetings can be resumed.
- Held five Training/Support Groups in person and three Zoom format Trainings. There were a total of 31 volunteers in attendance.
- Through conferences, fairs, collaboratives, committees, clubs, etc. FREED reached out to more than 900 community members with information about the Friendly Visitor Program.

A year-end Volunteer Survey was conducted by email to gather information about their ability and comfort level to identify and directly address the symptoms of depression, anxiety, and suicide ideation. There was a 50% response rate from the current volunteers. Therefore, the target goal of 75% was not met. One hundred percent of the volunteers who responded felt confident that they can identify symptoms of depression, anxiety and signs of suicide ideation. One hundred percent of the volunteers felt comfortable in directly addressing the signs of depression and anxiety. Ninety-two percent felt comfortable addressing suicide ideation directly and 100% felt comfortable talking to a FREED staff member about a concern regarding suicide ideation.

A year-end consumer phone survey was done to gain information about the impact of isolation on consumers and the ease and comfort level they have in sharing any feelings of depression, anxiety, or suicide ideation with their visitor. Seventy-six percent of the consumers responded. The highest ever response rate, meeting the goal of 75%. One hundred percent of consumers said that they felt less isolated. One hundred percent of those said that they felt less lonely, depressed, and anxious. Eighty-five percent said that they would feel comfortable talking to their visitor about thoughts of suicide. Fifteen percent reported that they would either talk to a pastor or their doctor.

Challenges, Solutions, and Upcoming Changes

This year in March, when the stay at home order was in place and volunteers could not visit in person, they transitioned to calling the consumer twice a week. In addition, the volunteers were active in delivering food bags to consumers, picking up pre-ordered groceries and medications for those who were isolated. Volunteers received a $35 Gift Certificate for California Organics or Briar Patch as recognition of all the great work!

Unduplicated recipients	178
Volunteer Delivery Total	288
FREED Staff Delivery Total	252
Partner Organizations (Paratransit/ NCA)	190
Total	730

Going forward, the program will continue to have volunteers call the consumer and follow the Health and Safety Guidelines until there is a return to in person visits. The program will expand including a new Volunteer Coordinator to do outreach, and process, and orient new volunteers. She will focus on outreach in Truckee and for bilingual volunteers. The Program Coordinator will

work more closely with consumers providing better follow up and more extensive services. After being trained in the Pearls Program in October, she will be able to provide an eight-week counseling service to those who are identified as moderately to severely depressed. Many participants will be receiving Chromebooks and orientation so they can increase their connection and communication with those they love more easily. There will be more outreach targeting diverse populations.

Program Participant Story

One day, the Program Coordinator received a phone call from a consumer in the Friendly Visitor Program who wanted to say thank you. She shared that her visitor has changed her life. She had helped her discover a reason to be grateful for the life she had lived and hopeful for the future. She did not feel as alone and isn't as depressed as she once was. She wanted FREED to know that. It was a wonderful conversation and so uplifting to know what a difference the program makes.

PEI Project Name: Prevention Program

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT
Wellness Center: Peer Support and Outreach Services
Wellness Program

Program Description

Program Overview

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

The TTUSD Wellness Program has Wellness Centers at North Tahoe High School and Truckee High School. 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 works closely with Sierra High School and Placer County

Community School to provide individualized supports and tools for students to develop sustainable wellness practices.

Key focus areas include:

1. **Youth Voice**- The TTUSD Wellness Program facilitates a Peer Mentor Program that trains students to become Peer Mentors and teaches them skills to better support themselves and their peers. The Peer Mentors are trained as Link Leaders and offer support to 9th graders during their first year of high school. The Wellness Program also provides leadership opportunities for students to have an authentic voice in shaping school and community initiatives, such as: The Sources of Strength Club, Pride Clubs and participation in the Community Collaborative of Tahoe Truckee and Wellness Partner meetings.
2. **Support**- TTUSD Wellness Centers provide trained staff to listen to, support, and connect students to community health and wellness resources. The Wellness Centers offer a variety of empowerment and peer support groups (e.g. social skills, girls and boys empowerment groups) to build stronger connections with students and provide ongoing social emotional supports. The Wellness Program also collaborates with school and county partners to provide additional mental health resources for students on campus, such as: Coordinated Care Teams, school-based therapists and the What's Up Wellness Program.
3. **Education**- The TTUSD Wellness Program offers a variety of wellness workshops to provide students with practical tools to improve their overall health. Topics cover a 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 (every other year).

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, presentations in the health classes, and Wellness Workshops at Sierra High School and the Community School.

Wellness Center Locations and Hours:

- North Tahoe High School – The Wellness Center is located in Room 217 and is open Monday-Thursday: 7:30-3:00pm, Friday: 10:30-1:00pm
- Truckee High School – The Wellness Center is located in Room WW132 Monday-Friday: 7:30-2:30pm

Target Population

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

Evaluation Activities and Outcomes

The Wellness Program collects evaluation activities for MHSA including demographic information on each individual receiving services. In addition, information on the type, date, location, and duration of group services is collected.

GOAL #1 - YOUTH:
Seventy-eight youth were trained in peer mentor and leadership skills to better support themselves and their peers, and to have authentic voices in shaping school and community initiatives.

OBJECTIVES:
1. The Wellness Program trained 78 youth in the Link Crew Peer Mentor Program.
    - North Tahoe High School - 32 attendees each day
    - Truckee High School - 46 attendees each day
2. The Wellness Program welcomed 332 incoming 9th graders to high school through fun, interactive, student-led Freshmen Orientation Days. Youth Leaders then followed up with 9th graders the first week of school and have been offering support and mentoring to them during their first year of high school.
3. The program provided an opportunity for 15 alternative education youth from Sierra High School to participate in the Community Collaborative Youth Forum. The purpose of the forum was to educate and inform community leaders about the experiences, perspectives and needs of the students who participate in the alternative education programs.

OUTCOME:
The Wellness Program was not able to administer an end of the year Link Crew survey this spring due to the COVID pandemic and TTUSD transitioning to distance learning.

GOAL #2 - SUPPORT:
A total of 122 unduplicated students received individualized support from Wellness Center Staff to improve their social, emotional and mental health. On average approximately 45 students used the Wellness Centers daily with over 700 students participating in Wellness Programming. Twenty-five students were referred to community resources. The total number of drop in participants was 2,015 at Truckee High School and 2,329 at North Tahoe High School.

OBJECTIVES:
1. The Wellness Program trained 16 partners from youth serving agencies in skills to help them better support and connect youth to community health resources. Some of the topics were: Social Media and Sexual Pressure on Youth, Supporting Youth with Anxiety, Building Authentic Relationships with Youth and Understanding Grief.
2. The Wellness Program created a safe space for youth to talk, seek support and get connected to outside community resources by offering Wellness Center Drop-In hours five days a

week/approximately six (6) hours a day. There were 119 groups offered with 1,464 attendees across the groups.

OUTCOME:
The Wellness Program was not able to administer an end of the year Wellness Center Perception of Care Survey this spring due to the COVID pandemic and TTUSD transitioning to distance learning.

Twenty-five unduplicated individuals received 27 total referrals. There was an 89% overall connection rate (23 of 27) averaging 8.6 days from the date of referral to connection to a resource. All students that were referred to mental health treatment were supported until they connected to the service provider and were encouraged to participate in the services at least once. Thirteen referrals were made to County Children's Mental Health Programs. Eleven of those were connected in an average of 11 days. Three referrals were made to non-county Mental Health Programs. All were connected in an average of 11 days. Sixteen students were identified as having untreated mental illness. The duration or untreated mental illness averaged 15.7 months for these students. Other agencies that received referrals from the Wellness Program were Child Protective Services (six referrals), community resources (three referrals) and Physical Health Providers (two referrals).

The Wellness Program also trained 349 school district staff in Know the Signs, Trauma Informed Schools, Mindfulness and Restorative Practices. These trainings helped to strengthen staff suicide prevention skills, better support traumatized students, understand how to use mindfulness strategies to support student self-regulation, develop stronger school cultures, manage conflict and repair harm by building authentic and caring relationships with students.

GOAL #3 - EDUCATION:
The Wellness Center offered 67 educational outreach activities to over 3,859 adult and youth attendees. Educational presentations covered topics such as: Heart Math, Mindfulness/Stress Reduction, Know the Signs/SOS, Link Crew, Transition to High School, Restorative Practices, Trauma Informed Schools, Grief, Anxiety, Social Media, Authentic Relationships with Youth, and Health Communication.

OUTCOME:
Ninety percent of students who participated in Health Class Workshops (Know the Signs/SOS and Heart Math) reported increased knowledge and skills of healthy wellness practices. Survey data was collected by Health Teachers.

Challenges, Solutions, and Upcoming Changes

The 19/20 school year was very challenging. Several unexpected events happen that impacted the Wellness Programming. The first event was the newly hired Truckee High School Wellness Liaison suddenly left the position in October without any notice. It was very difficult for the students and staff. Many students are slow to trust and had been displaced when the previous

Wellness Liaison left at the end of the previous school year. It created instability in the program which took a while to bounce back from. Luckily, a wonderful long-term counseling substitute was able to step into the position shortly after to provide consistency for the remainder of the school year. A new Truckee High School Wellness Liaison has recently been hired who seems like a great fit and has over 20 years of youth development experience. Additionally, the North Tahoe High School Wellness Center Liaison has been in the position for six years and has been able to mentor and support the new staff.

Another devastating challenge Truckee High School faced was the loss of a student to suicide. This loss shook the entire school community. It was a student the Wellness staff, Counseling Team and Coordinated Care Team had all been supporting. The student had been offered many mental health resources, so it was quite the blow when everyone learned about the suicide. The hardest part was that the program could only offer postvention services to students and staff for a few days following the death because the school district then went into shelter in place mode due to COVID-19. The Wellness Program continued to check in with students, staff and family members via distance learning, but the virtual platform made it difficult to connect with some of the students who needed the most support. In response, it was decided to enhance the suicide prevention efforts by implementing a new peer mentor suicide prevention program called Hope Squad in all the local middle and high schools. The program is exciting because it has a more robust curriculum than Sources of Strength and will hopefully re-energize students in the efforts of suicide prevention. This program will launch in the 20/21 school year.

The last and most obvious challenge everyone faced was the COVID pandemic shut down. Program staff did their best to reach out to students and offer virtual wellness programming, such as: Girls Group, Mindfulness Based Substance Abuse Treatment Groups, Link Crew and Wellness Check Ins but it was difficult. Many students were overwhelmed, had spotty Wi-Fi and were inundated by all the emails they were receiving from teachers and school staff. As a result, the end of year surveys were not able to be conducted. It was felt that the low response rate would not be an accurate reflection on the program.

Students were also hesitant to talk about their mental health challenges while at home, often surrounded by family members. The Wellness Program decided to contract with a local therapist to provide emergency counseling to 20 of the highest needs' students. The therapist was able to offer virtual and in person therapy in a safe socially distanced way. This fall the program will be adapted to a hybrid model to have more in person contact with students to offer Wellness supports.

Program Participant Story

A "regular" Wellness Center user began to open up about his home life as he spent more time in the Center. He was feeling depressed, so he was referred to the Tahoe Forest Hospital Youth Health Navigator to help identify a mental health provider who was covered by his family's insurance. In talking to his parents, the Youth Health Navigator learned that they were not supportive of him receiving counseling. The school also spoke to his parents about how therapy could support his depression, but they still refused.

The student continued to receive support through Wellness Programming and this year he was invited to join Boys Group at the Wellness Center. He was excited to be part of the group which gave him a safe place to talk about his feelings. While this was a great support for him, there also started to be some concerning shifts in his behavior. He was becoming more withdrawn and isolated. The Wellness Center Liaison met with him privately and learned that he was fed up with things at home and was having suicidal thoughts. He was immediately referred to the School Psychologist and collaboratively they conducted a suicide risk assessment. His parents were contacted, and they had him assessed by the Tahoe Forest Hospital Crisis Team. They created a safety plan which included daily Wellness Center check-ins as part of his support system. Wellness Program staff were able to talk to his parents about the seriousness of his suicidal thoughts and encouraged them to get him into therapy. They shared that they were also worried about him and agreed to try out a therapist. He began therapy and shared that having his parents support him made him feel like they truly cared about him and made him feel hopeful for his future. While he is still dealing with his depression, he now has a supportive team inside and outside of school. The therapist is teaching him the tools to communicate with his parents about how he is feeling. The Wellness Center played an important role in providing a space for him to explore his feelings and get connected to support services. By having an ongoing, trusting relationship the Wellness Program was able to notice the concerning behavioral changes and get him support right away.

PEI Project Name: Prevention Program

TAHOE TRUCKEE UNIFIED SCHOOL DISTRICT (TTUSD)
Teaching Pro-Social Skills in the Schools
Second Step for Early Learning

Program Description

Program Overview
Second Step is a social emotional learning educational research based program developed by the Committee for Children.

Target Population
The target population is students between preschool and 8th grade.

Evaluation Activities and Outcomes

During the 2019/2020 school year the Second Step Program was in full implementation for Tk (Transitional Kindergarten) through 8th grade, until March 14, 2020. At that point the schools were closed due to COVID-19. The Second Step program transitioned to distance learning.

During distance learning the program fell into crisis implementation mode. The Committee for Children implemented a COVID-19 Response Curriculum for teachers and parents during the Spring of 2020. These were selected lessons that teachers implemented targeting the SEL (Social Emotional Learning) lessons appropriate for distance learning. The lessons were recorded for Tk-5th grade. There was also a component for the middle school response to COVID-19 and a section for parents. Many families were able to take advantage of the lessons through distance learning and many teachers were accessing these important lessons as well.

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

Twenty-nine unduplicated individuals were served by this program in FY 19/20. Before the COVID crisis, one group was held with 28 attendees in the Tahoe/Truckee Region for a duration of one hour and 45 minutes.

Fourteen referrals were made to students in this program. Eight referrals (57%) were documented as connecting to the services to which they were referred. Below is a list of referrals and connections:

- 4 - undocumented referrals
- 4 - Counseling/School Counseling Services (3 connected)
- 2 - Outside Counseling Services (1 connected)
- 1 - Read Intervention (connected)
- 1 - Psychoeducational Assessment (connected)
- 1 - Behaviorist (connected)
- 1 - 504 plan (connected)

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

Challenges, Solutions, and Upcoming Changes

The Second Step program will continue in the Tk-5th grade with the materials that have been purchased and if more materials are needed, they will be purchased by each site.

The middle school program will continue through December 2020 then the streaming will need to be purchased by each individual site if they choose to continue with Second Step program.

The California Healthy Kids Survey will be implemented during the month of March 2021 if schools remain open.

Program Participant Story

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

PEI Project Name: Prevention Program

BIG BROTHERS, BIG SISTERS
Child and Youth Mentoring
Pals Program

Program Description

Program Overview

The Big Brothers, Big Sisters (BBBS) Pals Program utilizes high school students to mentor younger children in elementary and junior high who have been referred by the schools and identified as "at-risk". Each of the children are considered to be subject to mental health issues due to their environments. The mentors develop relationships with the children and assist them with their homework and encourage social emotional learning.

Target Population

Children ages 6-14.

Evaluation Activities and Outcomes

The beginning of the 19/20 year brought great hope for the continued success of the Pals Program. During late August and early September, 29 new MHSA matches were made in the program and another 12 had continued from the previous year. Early in the year BBBS of Nevada County was asked to merge with BBBS of El Dorado County. At that time BBBS National brought to the county's attention that the Nevada County matches did not meet some of the program standards

required by National. Unfortunately, to ensure the safety of the children and to comply with the company's insurance regulations, it was necessary to suspend of all Nevada County matches (41 total) during the merge with BBBS of El Dorado County. BBBS of Northern Sierra (combined name) encouraged the matches to continue and has worked hard to re-engage as many of those matches as possible while also serving additional children in the area.

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

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

Because site-based visits were no longer a viable option, BBBSNS has been working to transition the matches to a "site-based plus" format which allows for community outings. To date, four matches have been fully re-engaged under the new format and nine more are pending. Of the four matches that were re-engaged, no additional referrals to other agencies were made as the spring was used to strengthen the matches and no need for new referrals were required. Due to the merger and staff turnover prior to the merger there is no documentation available for previous referrals made.

All youth were given the Youth Outcomes Survey (YOS) prior to their match and annually. Youth Outcomes Surveys are completed by the youth and measure their life, moods and feelings, feelings of school, things they have done, and important adults in their life. Of the YOS's most were positive. The children stated they got along well with their family and other children, tried hard in school and felt good about themselves. Unfortunately, there were also negative answers to some of the surveys. Some children stated they didn't work hard in school and were receiving failing grades, didn't have a positive adult in their life and sometimes felt lonely, sad and unhappy and it is almost always hard for them to have fun. The YOSs are given to assist in creating a case plan for the child with goals for the year and it can be referred back to when the annual YOS is completed to see if there has been any progress for the child.

One SOR (Strength of Relationship Survey) was completed by a youth. The rest are due in August and September so they will fall under FY 20/21. Strength of Relationship Surveys are given three months post-match and annually to measure the successfulness of the match relationship. With the one completed SOR, the youth reports that the match is strong, and she feels connected to her Big Sister.

Additionally, all parents/guardians complete an RPI (Risk Protective Inventory) prior to the match. The RPI is given pre-match and annually to measure the program's success. The RPI also helps with case plans, goals and case management for the match.

Challenges, Solutions, and Upcoming Changes

One of the biggest challenges has been due to COVID 19. Because the schools were closed, neither the high school mentors (Bigs) nor the Elementary School (Littles) were able to meet. The solution was to encourage matches to stay connected utilizing virtual meetings, giving suggestions/ideas each week, or to become a "site-based plus" match allowing for community visits. Moving forward, this program will no longer be limited to high school mentors but will include other vetted community members as well. This will allow for a larger number of Littles who need services to be matched.

The other challenge was the atmosphere of the community with regards to the merge. Some community members were convinced that the merge was a "hostile takeover" and there was a huge distrust factor. Rumors circulated that offices were being closed and children were no longer going to be served. This has taken some time to overcome but thanks to some marketing in the area, community trust has started being rebuilt. The marketing efforts have included signage, used for community events, new business cards, program brochures, even letterhead and envelopes. Web-sites, Facebook pages, and databases have also been incorporated allowing newsletters to be delivered to all previous recipients (adding approximately 3,000 members). This could not have been managed this quickly without the funding afforded by MHSA and the re-allocation of funds. These efforts will further facilitate awareness of the program as a community resource and aid in the recruitment of both Bigs and Littles.

Program Participant Story

One of the new matches in Nevada County is between Big Brother (let's call him, Big) and Little Brother (let's call him, Little). Little, who lives at home with his single parent, is a tween and very withdrawn. He does not make friends easily and is hesitant to participate in new activities.

Recently, Little and Big played in a golf tournament and they were paired with the BBBS Case Manager and his former Little (a relationship that has lasted over 30 years). Little was very quiet in the beginning of the day, shy to meet new people (and there were many) and he was nervous because he had never played golf before. His Big Brother was patient, showed him a few golf techniques, and they all ate a BBQ lunch together. By the end of the day, they were all good friends, and Little felt proud of his newfound athleticism.

This was a huge step for Little. Not only did he have a new experience on the golf course, he was able to meet someone who used to be in his very situation and had grown with his own Big Brother. This showed Little his own potential by stepping out of his comfort zone. As Little and Big were leaving, Little turned back to wave good-bye and said "I can't wait to play again".

PEI Project Name: Access and Linkage to Treatment Program

NEVADA-SIERRA CONNECTING POINT PUBLIC AUTHORITY
211 Nevada County

Program Description

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

Target Population
211 Serves the entire population of Nevada County.

Evaluation Activities and Outcomes

Staff attended trainings in Housing First & Built for Zero, Suicide Prevention & Awareness, and educational presentations from local resource providers. Additionally, in-house trainings were held on Texting & Web Based Chat, Crisis Calls, and Coordinated Entry & Housing Resources.

Of the 16,593 total calls handled:
- 9,429 were unduplicated individuals
- 9,069 of those unduplicated were general Information & Referral callers
- 360 of those unduplicated were Coordinated Entry calls
- 1,369 were Follow Up Calls (approximately 8%)
- 1,492 calls ended with a "warm referral" direct connection to a resource (approximately 9%)
- 209 callers were referred to Nevada County Behavioral Health

A total of 19,800 referrals to resources were made. The top five agencies referred to were:
- AARP – Income Tax Assistance – 1,155 referrals
- Nevada County Office of Emergency Services – CodeRED – 1,015 referrals
- PG&E – Public Safety Power Shut Off Info – 906 referrals
- Listos California – Disaster Preparedness Info – 429 referrals
- Nevada County Social Services – CalFRESH food assistance – 388 referrals

No caller who identified with suicide ideation was let off the line without a warm-transfer to a crisis line and/or referral to suicide first aid resource(s).

Challenges, Solutions, and Upcoming Changes

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

Program Participant Story

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

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY SYSTEM OF CARE
Access and Linkage to Underserved Populations: Seniors, Disabled and Isolated, Homeless, Forensically Involved, Veterans, and Youth
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, Nevada County Behavioral Health (NCBH), Adult Protective Services, Hospitality House, Granite Wellness Center (GWC), Common Goals, National Alliance for the Mentally Ill (NAMI), SPIRIT Peer Empowerment Center, and other social service providers.

Target Population

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

Evaluation Activities and Outcomes

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

During FY 19/20, Forensic Outreach provided services to 202 unduplicated participants. The program provided 789 referrals to participants over the year, averaging 3.9 referrals per participant. See the table below for more detailed referral information.

Agency Referred To:	# of Referrals
Common Goals	136
CoRR	128
Hospitality House/Homeless Shelter	124
NCBH	110
Human Services (Benefits)	51
Employment (one-stop)/ CalWORKs	51
Crisis Stabilization Unit	29
Western Sierra Medical Clinic	24
Social Services Agency	23
Financial Assistance	20
SPIRIT	16
DVSAC	16
Chapa De	11
Therapist/ Psychiatrist (Private)	10
Freed	7
Insight Respite House	6
Food Bank	4
Veteran Services	4
211	4
Other	15
TOTAL:	**789**

Services: The Forensic Liaison received 211 requests for service. The average interval between the Request for Service and the First Face-to-Face Forensic Assessment was 0.26 days. In addition to initial requests for service, the liaison also contacted participants for an additional 369 follow-ups. Of the 110 referrals to NCBH, 32 were referrals for Substance Use Disorder (SUD) Assessments. Of the 32 SUD referrals 29 were authorized for services. The average time between the First Face-to-Face Forensic Assessment and the SUD Assessment or Treatment Start Date was 19 days.

Challenges, Solutions, and Upcoming Changes

Challenges/Solutions relating to COVID-19: For a month following the outbreak of COVID-19 the Forensic Liaison was unable to visit inmates face-to-face at Wayne Brown Correctional Facility (WBCF) while an internal safety protocol was established. During this time services were coordinated via phone, and the forensic worker focused on aiding the HOME Team with case managing some of their more challenging participants. After a month the forensic worker was allowed to resume visitation at WBCF. The major challenge that COVID-19 continues to pose is the impact on services available to inmates. Treatment facilities often close their doors during local flare-ups of COVID cases, adding an element of uncertainty to exit plans, and Hospitality House is not accepting clients daily, moving instead to a cohort quarantine system.

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

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

Outreach worker will be trained in ASAM (American Society of Addiction Medicine) assessments in order to streamline the flow of individuals going from the jail to local treatment facilities.

Program Participant Story

This individual has had very minimal interactions with the legal system. He was known for his work with at-risk youth and his kind, gentle demeanor. Last year however, he suffered a medical event which, according to those who know him and later seconded by medical professionals, radically affected his personality and cognitive functioning. Due to these impairments and prior to any treatment, he was involved in an assault when approached by a person who was suspicious of his unusual behavior, resulting in his arrest. Throughout his incarceration the jail medical staff were very concerned about his medical, emotional, and psychological well-being as he began to rapidly deteriorate on each of these levels. Through advocacy to the District Attorney, the Judge, and the Public Defender's office, the forensic outreach worker was able to arrange for him to be released to their custody for a trip to a residential facility, where the process of diagnosing and treating the cognitive impairments and medical issues he was and continues to face could begin in earnest. His criminal case has not yet closed however, due to the advocacy and communication on the part of the Forensic Outreach worker, he is now receiving the full and appropriate medical care he deserves and is staying safely at home where his psychological decline has halted.

PEI Project Name: Access and Linkage to Treatment Program

NEVADA COUNTY ADULT SERVICES
Access and Linkage to Underserved Populations: Seniors, Disabled and Isolated, Homeless, Forensically Involved, Veterans, and Youth
Social Outreach Program

Program Description

Program Overview

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

The number of visits and phone contacts varies with each person, based on need. Follow-up "check-in" calls are frequently conducted, and the participants are always encouraged to call if

a need arises. At times, consumers call after several months when they need assistance, circumstances change, or they need someone to talk to for support, which allows additional opportunities to link participants to long-term supportive services.

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

Target Population

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

Evaluation Activities and Outcomes

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

The Social Outreach Program delivered services to 87 unduplicated participants (27 Existing Social Outreach Participants and 60 new Social Outreach Participants) during FY 19/20.

During FY 19/20, the Program Coordinator made 365 referrals to other agencies/services. Of these, 50% or 182 successfully connected with the agency or service with an average connection time of 30 days (See Chart).

Agency	# of Referrals	# Connected	% Connected	Avg. Days to Connection
Connecting Point	63	50	79%	19.4
Crisis/Stabilization Unit	5	0	0%	
FREED	43	33	77%	18
Adult MH (non-County)	41	17	41%	21.5
Physical Health Provider	2	2	100%	88
SPIRIT	3	1	33%	14
County MH	3	0	0%	
Other	205	79	39%	19.6
TOTAL	**365**	**182**	**50%**	**30.1**

FY 2019-20 Goals and Outcome Measures:

Goal: 50% of the participants served who scored moderate-severe on the pre mood scale screening will score lower on the post mood scale screening, indicating decreased depression/ improved mood.

Outcomes:

- 22.5% of participants seen scored moderate-severe risk (16/71) on the pre mood scale screening, indicating moderate to severe depression.
- 67% of the participants served who completed a post mood scale screening scored lower on the scale indicating decreased depression/ improved mood (8/12). Four of the participants had no post-test scores at the end of the fiscal year.

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

Outcome: All participants served had seen their primary care physician within the prior 12 months, so this data point was not applicable. Additionally, two participants requested and received referrals to physical health providers and 100% connected with the referral.

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

Outcomes:

- 72% of participants scored lower on the post mood scale screening, indicating decreased depression/ improved mood (34/47).
- 87% of participants served who completed a post mood scale screening reported an increase in social activity or increased positive mood at follow-up (41/47).

Challenges, Solutions, and Upcoming Changes

A primary challenge for the Social Outreach Program this year was the COVID-19 pandemic. Due to the vulnerable nature of the participants served including people over the age of 60 years and people with disabilities, many with multiple pre-existing conditions, it became highly important to establish protocols to keep them as safe as possible from transmission of COVID-19. Following guidance from Nevada County Adult Services developed with information from national and regional health agencies, the program contact moved to primarily telehealth phone visits (most participants didn't have internet or didn't feel comfortable using technology). Protocol was also developed for circumstances requiring in-person visits to do so outside if possible, with six feet of distance and wearing face masks.

The COVID-19 pandemic created further isolation and barriers for participants regarding in-person socialization. Participants were encouraged to connect with phone based programs such as the FREED Phone Reassurance Program and Well-Connected. Additionally, information was provided regarding grocery delivery services and other supports for those unable or concerned about the risk of going out into the community. Those that were able to utilize technology were given information about web-based groups and support.

Many outreach opportunities were unavailable due to the pandemic, however, several of them moved to web-based groups and the Program Coordinator was able to continue community connections after a period of time.

A positive outcome of the COVID-19 pandemic was the allowance for mental health therapists to provide telehealth phone/computer sessions to participants in their home. Lack of in-home therapy access has long been a barrier to home bound participants and this change has allowed more participants to obtain mental health support.

Program Participant Story

The Social Outreach Coordinator connected with a new participant who was homebound and experiencing depression symptoms impairing their psycho-social functioning and life satisfaction. Additionally, the participant indicated she had few social interactions and was feeling lonely and isolated. Over a period of approximately two months the Social Outreach Coordinator provided assessments, built rapport, and connected the participant to long-term supports and services in alignment with their identified needs and interests. This included a therapist who was able to provide home-based visits twice a week for mental health support and social support such as Book Buddies and FREED's Phone Reassurance/Friendly Visitor program. At the end of the active support period this individual reported reduced depression symptoms and increased social activities and engagement though the referrals provided. This resulted in a positive outcome and increased life satisfaction for the participant. Furthermore, the individual reported that the Social Outreach Program was vital to their improved quality of life.

PEI Project Name: Access and Linkage to Treatment Program

HOSPITALITY HOUSE
Access and Linkage to Underserved Populations: Seniors, Disabled and Isolated, Homeless, Forensically Involved, Veterans, and Youth
Homeless Outreach

Program Description

Program Overview

Hospitality House is committed to ending homelessness by providing intensive case management services to all of its guests. Hospitality House also offers outreach services including Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) application assistance, birth certificate and California ID fee waiver assistance, referral services, transportation, clothing, and clothing vouchers, and food/drink. Hospitality House Homeless

Outreach staff works with social services, Public Health, Behavioral Health, churches, nonprofit organizations, service providers, family members, and other support systems of those who are homeless. Hospitality House strives to empower people who are homeless and help them develop the skills they need to overcome the barriers that prevent them from successfully obtaining and maintaining stable housing.

Target Population

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

Evaluation Activities and Outcomes

Hospitality House collected evaluation activities for MHSA, including demographic information on every individual receiving service. Additionally, information on individual services, referrals to outside agencies, and outreach activities were collected.

Goal 1: "90% of homeless and severely mentally ill individuals with no Social Security income (or other sources of income) will be offered assistance with a referral to the Social Security office and/or an application for benefits so that the individual can receive Social Security Income."
Outcome: Hospitality House identified one individual experiencing severe mental illness who was not connected to Social Security. This individual accepted the referral, and a connection to benefits was made. Goal was met: 100% of homeless and severely mentally ill individuals identified to have no sources of income were connected to Social Security Income.

Goal 2: "90% of individuals engaged by the Street Outreach Coordinator will be referred to HOME team services."
Outcome: 44% of engaged individuals were referred to the HOME team. This goal was not met for a variety of reasons:

- A number of individuals who were engaged by the Homeless Street Outreach program were unable to be located by the time the HOME Team, Homeless Management Information System (HMIS) program was accepting referrals. These individuals could have been unable to be located due to self-resolution, incarceration, and/or moving out of the area.
- Additionally, the HOME Team was short staffed and HMIS was not initially utilized as data management responsibilities were defined.

Goal 3: "90% of homeless and severely mentally ill individuals engaged by the Street Outreach Coordinator will be referred to mental health services."
Outcome: 48 of the 50 (96%) individuals who reported experiencing severe mental illness were referred to mental health services. Of those referred, 45 were sent to Nevada County Behavioral Health (NCBH). All 45 NCBH referrals were connected to services. The average interval between referral and connection to NCBH services was 19 days. Of those referred to county mental health programs 16% were not previously treated for the mental health symptoms they were exhibiting at the time of referral. The average duration of untreated mental illness for these individuals was 3.3 years.

Goal 4: "70% of individuals with a drug problem will be referred to drug treatment services."
Outcome: 62 individuals reported experiencing a substance abuse issue (either alcohol or drugs). Of these, 43 (69.3%) individuals were referred to either Granite Wellness or Common Goals.

Goal 5: "Refer a minimum of 10 individuals per year to mental health services."
Outcome: 48 individuals experiencing mental illness were referred to mental health services.

Goal 6: "70% of individuals who are referred engage in the referred service, defined as participating at least once in the service."
Outcome: Of the 211 referrals made during the performance period, 178 referrals were connected, defined as participating in the service at least once, a connection rate of 84%. The average interval between referral and engagement was 9.4 days. The top agencies that referrals were sent to were:

- HOME Team - 51
- Granite Wellness Center - 49
- Nevada County Behavioral Health - 45
- Utah's Place (Foothill House of Hospitality) - 19
- Common Goals, Inc. - 9
- Western Sierra Medical Clinic - 6

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

Service Type	# of Services
Case/Care Management	210
Local Automobile Transportation	39
Substance Use Disorder Services	39
Substance Use Disorder Counseling	34
Outreach Programs	26
Street Outreach Programs	20
Emergency Shelter	15
Mental Health Assessment and Treatment	14
Veterinary Services	14
Local Bus Fare	11
Housing Counseling	10

Challenges, Solutions, and Upcoming Changes

The biggest challenge faced during FY 19/20 was a combination of the COVID-19 pandemic and the departure of the PEI Outreach Case Manager, in April 2020. The Case Manager served as the agency's Certified Drug and Alcohol Counselor (CDAC), an essential resource for homeless community members struggling with substance use. His departure amid the COVID-19 pandemic led to Hospitality House evaluating its policies and procedures for Homeless Street Outreach

during the pandemic. To remedy this loss, Hospitality House hired a new Case Manager in June 2020, and has been working with him to prepare for the next contract year.

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

Program Participant Story

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

PEI Project Name: Access and Linkage to Treatment Program

SIERRA COMMUNITY HOUSE
Access and Linkage to Underserved Populations: Seniors, Disabled and Isolated, Homeless, Forensically Involved, Veterans, and Youth
Truckee Homeless Outreach (formerly Project Mana)

Program Description

Program Overview

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

- Promote Safety: engage with individuals experiencing homelessness in order to reduce the risk of harm and enhance safety (e.g., provide sleeping bags on cold nights); and stabilize acute symptoms via crisis intervention.
- Form Relationships: engage with individuals in a manner that promotes trust, safety and autonomy, while developing relevant goals.

- Learn Common Language Construction: attempt to understand individuals by learning the meaning of his or her gestures, words, and actions; promote mutual understanding; and jointly define goals.
- Facilitate and Support Change: prepare individuals to achieve and maintain positive change; explore ambivalence, reinforce healthy behaviors, develop skills, and create needed supports; and utilize Change Model and Motivational Interviewing Principles.
- Form Cultural and Ecological Considerations: prepare and support individuals for a successful transition to new relationships, ideas, services, resources, treatment, etc.

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

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

Target Population

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

Evaluation Activities and Outcomes

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

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

In FY 19/20, staff engaged in targeted outreach 72 times, averaging 1.2 hours per contact. See the table below for more detailed information.

Outreach	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
# Hours	126.8	283.6	214
# Contacts	169	165	181
Avg. Hours/Contact	**0.8**	**1.7**	**1.2**

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

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

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

Challenges, Solutions, and Upcoming Changes

Lack of available housing and lack of affordable, low income housing continue to be the biggest barriers for the homeless in the Truckee/Tahoe region. Community members who work part-time, low income jobs or are on SSI/SSDI simply cannot find housing in the area that they can afford. The need for good credit and rental histories are additional barriers that contribute to homeless individuals being unable to secure housing.

The COVID-19 Pandemic created additional barriers that directly impacted the health and wellbeing of this population. Precarious housing arrangements exacerbated the risk of getting infected and prevented safety precautions and safe conditions from being used. Namely, the lack of stable housing to quarantine in case of suspected or confirmed contagion has been one of the main challenges.

The overall lack of resources and the fact that the existing ones are geographically spread apart, represents another big challenge. There are no transitional housing units, respite centers, or full-time shelters in the area for men with alcohol and drug problems. So, the homeless often need to leave the region in order to get assistance.

Many find it a burden due to the distance, especially in the winter, to go to Truckee for the Emergency Warming Center (EWC) or the former Food and Resource Center (FRSC). Even

though outreach is done consistently, and transportation is offered to facilitate access to the EWC and FRSC, the burden of getting the Tahoe City and Kings Beach populations over to Truckee resources has resulted in more isolation and less willingness to receive help.

Snow and cold weather create dangerous situations where people can freeze to death and become stuck in their cars. Individuals who have campsites are sometimes hesitant to go to the EWC because a heavy snow can damage their tent and camp site. Extreme winter weather poses a constant threat to these populations in the region.

It's worth noting that, starting on April 7th, 2020, the FRSC evolved to become the Emergency Respite Day Center, located in a bigger facility in downtown Truckee, known as the Veterans Hall. This new space provides guests with a warm meal, shower, health "check in", access to counseling and community in addition to basic necessities and the laundry facilities. Opened Tuesday through Friday, from 10 am to 2 pm, the Day Center has resulted in increased services that help mitigate the spread of COVID-19, while providing a unique opportunity to meet with community members in need of services on almost a daily basis.

Program Participant Story

After almost three months of interaction with "Jane" (not her real name), going from slowly developing a trusting relationship to actually implementing a safe plan, the Outreach Coordinator could secure for her a move that could start to break a cycle of violence and mental illness.

"Jane" had been a victim of violence, which lead to losing her housing. She also had some mental health challenges that had been exacerbated by substance abuse. The Homeless Outreach Coordinator (HOC) met her for the first time at the hospital. After talking to her about resources they decided that a possible option to stabilize her situation could be to check in at a shelter in another town where she had stayed before. When it seemed that she had agreed to it, she changed her mind and decided she wanted to stay in her own community instead. The HOC had already shared with her the information about the Food and Resource Center, so they could meet there again.

When they met again, "Jane's" attitude towards the HOC had changed completely. She was totally distrustful and even aggressive, accusing the HOC of having deceived her into services she had never asked for. The HOC contacted "Jane's" volunteer helper to learn more about her possible needs and how a plan for her could be worked out.

When they met again, "Jane" had an injury and could barely walk. The volunteer nurse present that day recommended going to see a doctor, so the HOC offered "Jane" a ride and assistance connecting with care. She at first didn't want to, but finally accepted. After that day, every time the HOC would meet her, "Jane" was evasive, not wanting to engage in conversation to check in.

Finally, one day at food distribution, "Jane" asked for the HOC, whom wasn't there that day. "Jane" and the HOC connected later and "Jane" expressed that she was ready to move forward

with the shelter option. The HOC contacted her with the shelter and two shelter staff came to pick her up, after the HOC had carefully explained to her what the arrangements were. All ended well.

PEI Project Name: Access and Linkage to Treatment Program

Access and Linkage to Underserved Populations: Seniors, Disabled and Isolated, Homeless, Forensically Involved, Veterans, and Youth
NEVADA COUNTY VETERANS SERVICE OFFICE

Program Description

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

The Veterans Outreach and Linkage program began contracting with Nevada County PEI in July 2016.

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

Evaluation Activities and Outcomes

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

The VSO was active in outreach activities speaking at senior facilities, veterans' organizations, and county clubs. In all 4,607 veterans were reached during 25 different events, including four events in the Tahoe/Truckee region, 18 events in Western Nevada County, two events in Sacramento and one radio spot on local KNCO radio. Additionally, the VSO performs outreach on various social media platforms with over 530 followers and over 200 connections on LinkedIn. These efforts have proven to be successful in reaching veterans in different locations. Finally, the VSO produces a newsletter that is made available to local Veterans Services Officers, and the newsletter is added to the Nevada County CEO's newsletter to provide information to as many veterans as possible.

Challenges, Solutions, and Upcoming Changes

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

Program Participant Story

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

PEI Project Name: Access and Linkage to Treatment Program

Access and Linkage to Underserved Populations: Seniors, Disabled and Isolated, Homeless, Forensically Involved, Veterans, and Youth
WHAT'S UP? WELLNESS CHECK UPS

Program Description

Program Overview:
The mission of What's Up Wellness Checkups (WUWC) is to improve the quality of life and emotional health of teens and families in Nevada County. Program goals include: preventing youth suicide; increasing access to universal youth mental health screenings in high schools; increasing youth and family access/connection to mental health and other needed services; increasing coping skills and emotional resilience among youth; improving health of family systems by advocating access to services and parent support; identifying and filling gaps in the continuum of care of services for youth; promoting teen emotional health as a community priority; and decreasing mental health stigma in schools and community at large.

Target Population:
WUWC serves youth and families in Nevada County.

Evaluation Activities and Outcomes

WUWC collected evaluation information for MHSA including demographic data on each youth receiving mental health screenings and group services. Group data was collected via pre- and post-surveys. Linkage data was collected via referral to mental health treatment/resources data which included duration of untreated mental health symptoms for County referrals. Program outreach activity data was also collected.

Outreach**:** 21 outreach activities were conducted, reaching an estimated 18,772 people.

- Thirteen virtual activities: nine trainings/educational videos; three social media/web pages; one newspaper article.
- Six school presentations serving Western county.
- Two community presentations: one Western county, one Eastern county.

Performance Measure: A minimum of 300 high school students will be screened in Nevada County.
Outcome: 331 total students were screened: 301 in-person screenings; 30 virtual screenings.

Performance Measure: All students who screen positive (clinically significant levels of symptoms and/or impairment) will receive in-depth clinical interviews to assess the need for further evaluation/treatment.
Outcome: 100% of 78 total positive screens received clinical interviews.

Performance Measure: A minimum of two-thirds of students who receive clinical interviews will receive case management services if needed.
Outcome: 60 total students received case management services, 77% of total positive screens.

Performance Measure: A minimum of 20 prevention group meetings will be conducted at participating high schools.
Outcomes: A total of 25 group meetings: 21 in-school/face to face group meetings; four virtual meetings. A total of 61 unduplicated attendees in 25 groups; 331 attendees duplicated across all 25 group meetings.

Performance Measure: As a result of prevention groups 80% of the participants will report a decrease in suffering related to mental illness and/or an 80% increase in protective factors.
Outcomes: Mindfulness prevention groups offered content on both stress response recognition and identifying coping mechanisms. Data showed that groups were effective in delivering those with positive results. Data showed moderate increase in both markers of "awareness of how I respond to stress" and the "ability to use positive coping skills to deal with stress" from pre to post. Students reported an increase in the marker "awareness of how I respond to stress" from 26% to 42% from pre to post survey, a 3% overall change in reported decrease in suffering related to mental illness and a 7.5% overall change in reported increase in protective factors. Due to school closures, staff encountered challenges in collecting complete evaluations for Spring 2020 groups – see challenges below.

Performance Measure: 100% of individuals who received a referral and accepted Case Management services will receive services until they see the mental health service provider at least once.
Outcome: 100% of the 60 individuals who accepted case management, received services until connected to a provider at least once or until they no longer requested services.

Performance Measure: Once student and parent consent is in place, 100% of individuals who have untreated mental health symptoms will be referred to County mental health services.
Outcomes: Three students identified as having untreated mental illness and qualified for County services. 100% of the three students were referred and were connected to County mental health services. These individuals reported untreated mental illness symptoms that had lasted for an average duration of 32 months.

Performance Measure: 100% of individuals that are referred to mental health services and receive a service will be tracked and reported.
Outcomes: A total of 40 referrals were made to mental health services. Of the 13 referrals to in-school mental health providers, 12 individuals were successfully connected to mental health services (92%). Of the 27 county and private mental health referrals, 12 individuals were successfully connected to mental health services (44%). Seven of the 27 referrals were made to county mental health programs. Thirteen individuals were referred to and 13 individuals were successfully connected to prevention groups (100%).

Performance Measure: 100% of individuals who are referred to and engage in treatment will have the interval between referral and engagement in treatment tracked and reported.
Outcome: Of the 12 county and private mental health referrals identified as being connected to services, five (42 %) had follow up appointment dates recorded. Due to school closures, staff encountered challenges in contacting parents and schools for follow up appointment dates – see challenges below.

Challenges, Solutions, and Upcoming Changes

As expected, the main screening challenge in FY 19-20 was related to COVID-19, when participating school sites closed and in-person screenings and support groups were no longer an option for the 19/20 school year. In response, WUWC management began developing a virtual approach to screening students and providing prevention supports. Online screening tools were researched, virtual protocols were

developed, County partners were consulted and WUWC screening staff were trained in providing screenings using a new online platform. WUWC group facilitators replaced their in-person prevention groups with mindfulness support videos as a response to needs identified by screened youth. These videos were compiled into a WUWC YouTube Channel to be sent to screened students as easily-accessed online referrals.

Additional challenges due to COVID-19 involved data collection delays due to school closures and challenges in reaching parents/families struggling with pandemic-related stress. WUWC has responded to these challenges by following up on data collection once schools re-opened in 2020 and continues to follow-up to finalize data as thoroughly as possible. WUWC has responded to lack of returned parent contact by reaching out to parents via multiple platforms – calling, texting, emailing to increase access to student screenings, to complete case management data, and to share information on mental health and other supports/resources available for families during this time.

Upcoming changes include a revised format with increased school-based integration/collaboration for virtual screenings for the 20/21 school year until in-person screenings once again become an option. Other program changes include a significant increase in numbers of parent consents due to online enrollment consent forms, as well as collaborating with schools to create new strategies of integrating screenings into health classes for direct access to students during virtual learning.

Program Participant Story

WUWC screened an LGBTQ+ student who disclosed suicidal ideation and being bullied on campus– all previously unreported. After their clinical interview, this student's parents were immediately notified and were provided psychoeducation on youth suicide prevention and safety planning, were directed to LGBTQ+ suicide prevention websites/resources for support, and were provided a Release of Information for staff to contact a mental health provider as well as school staff that day to help link this student to services immediately. The following day WUWC staff met again with this student and accompanied them to meet with a school administrator to support reporting of their bullying incidents. WUWC staff linked them with the facilitator of a local youth LGBTQ+ support group and discussed with them in detail how to access community LGBTQ+ resources. WUWC staff continued to stay in touch via text with this student to follow up on referrals, and later coordinated with school staff on following up with the reported bullying. A month later WUWC staff met with this student again who reported a positive treatment connection, as well as a decrease in mental health symptoms and a reduction in suicidal ideation.

Participant responses from group evaluation question "What did you like most about this group?"
-"I like how she [facilitator] taught different techniques to teach us how to handle stress."
-"We were able to talk about things that stressed us without having to feel stressed about details"
-"The breathing exercises"

PEI Project Name: Stigma Reduction and Discrimination Reduction Programs

SIERRA COMMUNITY HOUSE
Promotora Program - Latino Outreach Services

Program Description

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

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

Workshops Offered

- **Desestres-Arte:** Desestres-Arte is a series of workshops meant to encourage the women who participate to express their emotions through craft-making and other art projects. Each class is two hours long, and classes are held once a week throughout the year.
- **Mas Fuerte que Nunca and Los 4 Acuerdos:** The mission of Arts in Wellness is to facilitate and promote personal and community health and harmony using art. Arts in Wellness welcomes everyone; artists and non-artists alike, to participate in confirming that their connection to their human experience is unique and valid, and to communicate with color in a way that perhaps they could never find in words.
- **Ninas Creativas:** Engagement workshops that include art and conversation for children ages 5 to 11 years old.

Target Population
The Sierra Community House 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

Performance Measures and Outcomes for the Latino Outreach program:

- Twenty-five individuals will receive education on mental health issues per year. In FY 19/20, 37 unduplicated individuals received direct services and completed demographic forms, and an additional 91 individuals received outreach and/or dropped in for group services.
- Eighty percent of individuals will demonstrate an improvement in attitudes, knowledge, and/or behavioral change related to mental illness that is applicable to the activity. In FY 19/20, 38 surveys were collected. Survey results below:
- Eighty percent of individuals will demonstrate an improvement in attitudes, knowledge, and/or behavior related to seeking mental health services that are applicable to the activity. In FY 19/20, 38 surveys were collected. Survey results below:

As a result of this training, I am MORE willing to:	**# w/ positive attitude toward MH**	**Percentage w/ positive attitude toward MH**
...live next door to someone with a serious mental illness.	18	47%
...socialize with someone who had a serious mental illness.	20	53%
...start working closely on a job with someone who had a serious mental illness.	17	45%
...take action to prevent discrimination against people with mental illness.	27	71%
...actively and compassionately listen to someone in distress.	26	68%
...seek support from a mental health professional if I thought I needed it.	32	84%
...talk to a friend or a family member if I was experiencing emotional distress.	31	82%

- Eighty percent of individuals that self-identify or are identified by a Promotora as having a mental health (MH) need will be referred to a mental health provider and offered a warm handoff. In FY 19/20, 14 individuals identified as needing MH referrals. Eleven were referred to the County MH Program and three were referred to other mental health agencies. Five individuals who were referred to County Mental Health had not been treated for these symptoms in the past. Their average duration of untreated mental illness was one to four years.
- Sixty percent of individuals that are referred to mental health services will engage at least once with the referred mental health service provider. Fourteen referrals to mental health services were made. Six of these referrals were connected (43%). Of the connected referrals four were identified as connecting with services on the same day
- Ten individuals will receive one-on-one support and consultation from the Family Advocate. Eighteen individuals received one-on-one support.

- Latino Outreach will hold at least 70 group services and/or meetings with the goal of destigmatizing mental health. Eighty-eight groups were held including nine virtual groups and 79 face-to-face groups. A total of 128 unduplicated individuals attended across all groups for a total of 146 group hours. One hundred percent of groups were offered in Spanish.

Challenges, Solutions, and Upcoming Changes

Due to the COVID-19 crisis all workshops, fitness activities and groups were moved online starting on Monday, March 15th, 2020. It was a real challenge for Promotoras to adjust to these new circumstances including familiarizing themselves with technology that they otherwise wouldn't need to use. During COVID the Family Support and Community Engagement team continued to provide information about resources and services to community members in need, as well as support the Hunger Relief, Legal and Crisis Intervention programs at Sierra Community House. The Promotora program is seen as a source of trusted information and an effective bridge to services. During COVID when all types of resources were needed, and the local health system was stretched, the Promotora program chose to serve the community and maintain their trust. Specifically, Promotoras served the community by educating people on how to implement prevention measures to protect their families. They were well prepared with knowledge on procedures and processes to help prevent the spread of COVID-19, following Placer and Nevada County health recommendations, and they continue to learn and incorporate the most up to date CDC guidelines.

A key activity of the Promotora program is providing current, correct, and useful information and resources. As questions and concerns are expressed from community members, information and resources are provided in the appropriate language and structure. Processes are in place to always adapt to the most urgent needs of this underserved population. As mentioned above, the CDC and county guidelines have been distributed, discussed, and emphasized with the whole team. They have been continuously monitored and updated. Telecommunicating is already a part of the team's daily activities. All these components are currently in place as part of the new procedures.

During the past few months, the Promotora's work has centered around shifting activities to on-line. All classes, groups, activities and services have now been successfully re-launched using virtual platforms. Using Zoom and other video technologies (Facetime, WhatsApp and Microsoft Teams) the Promotoras look forward to continuing to assist community members to build resiliency and adapt to all the changes and challenges they are facing.

Program Participant Story

Ceci, our Promotora, met "Jane*" a year or so ago when she moved to Truckee. Jane was encountering major changes that caused her to experience feelings of loneliness and depression. Ceci quickly invited Jane to attend a Promotora workshop, where she found support and connection with the group. Jane found the courage to share that she was going through a divorce

and didn't have support. The leader of the workshop, also a Peer Supporter connected with her in a one-on-one session. Jane explained her struggles and was referred to other Sierra Community House (SCH) Legal and Advocacy programs.

Jane was able to find a home and received assistance paying the deposit and first month's rent. Her children and herself are feeling more connected to Truckee and are thrilled to be part of such a supportive community. They are settling into their new home and the children are attending school. Jane has shared that SCH has been a blessing to her family, she continues to attend Promotora programs to receive encouraging support that helps her continue living a stable lifestyle through both the difficult and happy times.

**Name changed for privacy*

PEI Project Name: Stigma and Discrimination Reduction Program

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

Program Description

Program Overview

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

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

Target Population

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

Evaluation Activities and Outcomes

The Promotora/ 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. The Promotora provided varied services, such as: assistance with medical and dental appointments, school issues, individualized education programs (IEPs), and referrals for immigration and other family legal issues, translation assistance with medical applications and other documents. Also provided was an English as a Second Language (ESL) tutor and a Yoga Wellness Class with a certified instructor. Mental health awareness pamphlets were distributed.

Over the years, this program has worked in collaboration with many other organizations, schools and professionals including: Alcoholics Anonymous, Alta Regional Center, Anew Day, Nevada County Schools, Chapa-De, Child Protective Services (CPS), CHIP committee, Community Beyond Violence, Foothill Healthy Babies, local attorneys, Medical Professionals, Nevada County Behavioral Health, Spirit Peer Empowerment Center, Sierra Nevada Memorial Hospital (SNMH), SNMH Foundation, SNMH Emergency, SNMH Crisis Stabilization Unit, Western Sierra Medical Clinic, Suicide Prevention Task Force, and Equity & Inclusion Alliance.

During FY 19/20, the Promotora program made contact with 657 individuals including 70 participants in group and one-on-one services and 587 individuals through outreach efforts. There were 17 groups offered, consisting of six face-to-face groups and 11 virtual Skype groups. Thirty-five unduplicated individuals attended groups. There was an average of six participants attending each group.

Performance Measures and Outcomes were tracked and measured.

- Show a decrease in the negative feelings, attitudes, beliefs, perceptions, serotypes and/or discriminations related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services, and increase in acceptance, dignity, inclusion, and equity for individuals with mental illness and members of their families. Eleven Perception of Care Surveys were completed showing:
    - 4 of 11 = 36% report they know how to access community mental health resources.
    - 8 of 11 = 73% report they feel comfortable discussing mental health issues with others.
    - 9 of 11 = 82% report they would feel comfortable if others knew someone in their family had a mental illness.
- Fifty individuals receive education on mental health issues per year.
    - 69 unduplicated individuals served

Many of the outreach contacts were made at community-building events including:

- Nohemi's Retirement Social
- Kings Day Social
- Yoga y Bienestar - 17 sessions (Yoga classes were maintained as Skype sessions after COVID began)
- Distribution of grocery and gas cards for those adversely affected by COVID quarantine

The program provided direct mailing to help increase awareness of the activities and maintain contact with the Latino community during the COVID quarantine. Over FY 19/20 the Promotora program mailed over 200 informational postcards.

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

The Promotora program tracked referrals throughout the year. In FY 19/20, 35 referrals were given to 31 unduplicated individuals. Two of those were referrals to County Mental Health services, and both were successfully connected to services. Nineteen referrals were made to the Family Resource Center, and all connected to services. Of the 35 referrals made, 32 (91%) connected to services.

Challenges, Solutions, and Upcoming Changes

Challenges:

- A new Promotora was hired in FY 19/20 and getting to know the Latino community in Nevada County required time to gain trust. WRAP (Wellness Recovery Action Plan) trainings for the Promotora were not available until January. Once the COVID virus became an emergency, the response for safety/quarantine created an obstacle for the in-person presentation of any new programs. The Yoga y Bienestar program continued via Skype. The "shelter in place" and the closing of all non-essential businesses put the community in "survival mode." The school closures and lack of work for a large number of people in the Latino community caused widespread uncertainty. Any other previously scheduled programs had to be cancelled. There was confusion and lack of information early on with the "shelter in place" and there was no simple way to reach out to the Spanish speaking community so mailings with information on COVID health and safety , mental health and other updates were used as a mode of communication for the broader community. Phone call "check-ins" with families that had received services from the Promotora in the prior months were another way to maintain some connection.
- It continues to be difficult to provide services when resources for families and the need for housing assistance has not been adequately addressed.
- It continues to be a goal to reduce the time that it takes new families to integrate into the community and to bridge the gaps of service that come with these transitions.

Solutions:

- Create a plan for more effective rapid response communication with community members by building a phone tree.

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

Upcoming Changes:

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

Program Participant Story

A Spanish speaking young man (he will be referred to as J) had been attending one of the local schools since the beginning of the school year after he came to live with a local relative. J was finding it difficult to fulfill the many academic demands of his course work. He had prescribed medications that had run out due to a language barrier with the pharmacy staff. He was not able keep up with his daily dosage for several days and it became a huge problem that surfaced on a school day. The Promotora connected with staff at the school around this crisis. The Promotora had previously met J and was therefore called to help respond to J's suicidal statements. The Promotora got J connected with a local relative to take him to the Emergency Room where the Promotora assisted J's relative with the registration and interpreted for J as he went through the preliminary procedures and when he met with crisis personnel. The crisis staff were professional and caring with J and they felt it necessary to have him stay until his state of mind cleared. Then a plan to keep him safe once he was discharged could be established. The Promotora was asked to interpret and to assist in making a safety plan for J. Once the safety plan was in place J was discharged to a local relative. Since then, his medication has been balanced (the pharmacy confusion was corrected), and he has had an Individual Education Plan prepared to help him with his school needs. He is also enrolled with other local agencies for additional support. He will now have the services he was needing. The Promotora was integral in assisting with interpreting, translation and with contacting the necessary agencies to help J and his family come to a positive outcome.

PEI Project Name: Stigma and Discrimination Reduction Program

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CalMHSA)
Statewide PEI Project

Program Description

Program Overview

Counties collectively pooled local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the Statewide PEI Project. The Statewide PEI Project is publicly known as Each Mind Matters: California's Mental Health Movement, which represents an umbrella name and vision to amplify individual efforts from the county and other organizations that are taking place across California under a united movement to reduce stigma and discrimination and prevent suicides. In FY 19/20, more than 500 local county agencies were served by programs implemented under the Statewide PEI Project.

In FY 19/20, funding to the Statewide PEI Project supported programs such as maintaining and expanding public awareness and education campaigns, creating new outreach materials for diverse audiences, providing technical assistance and outreach to county agencies, schools and community based organizations, providing mental health/stigma reduction trainings to diverse audiences, engaging youth through the Directing Change program, and building the capacities of schools to address mental health, stigma reduction and suicide prevention.

Funding also supported the North Valley Suicide Prevention Hotline, a regional call center providing crisis line telephone support for regional callers who have reached out to the National Suicide Prevention Hotline.

Target Population

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

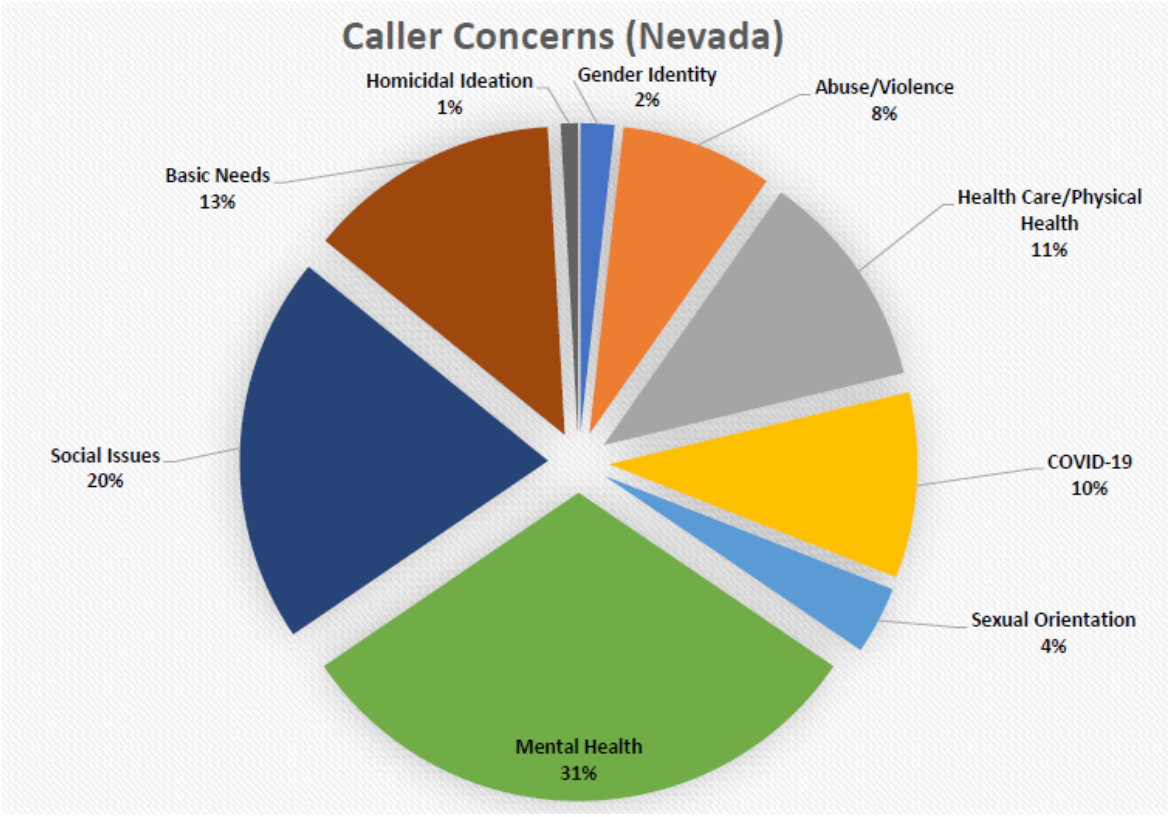
Evaluation Activities and Outcomes

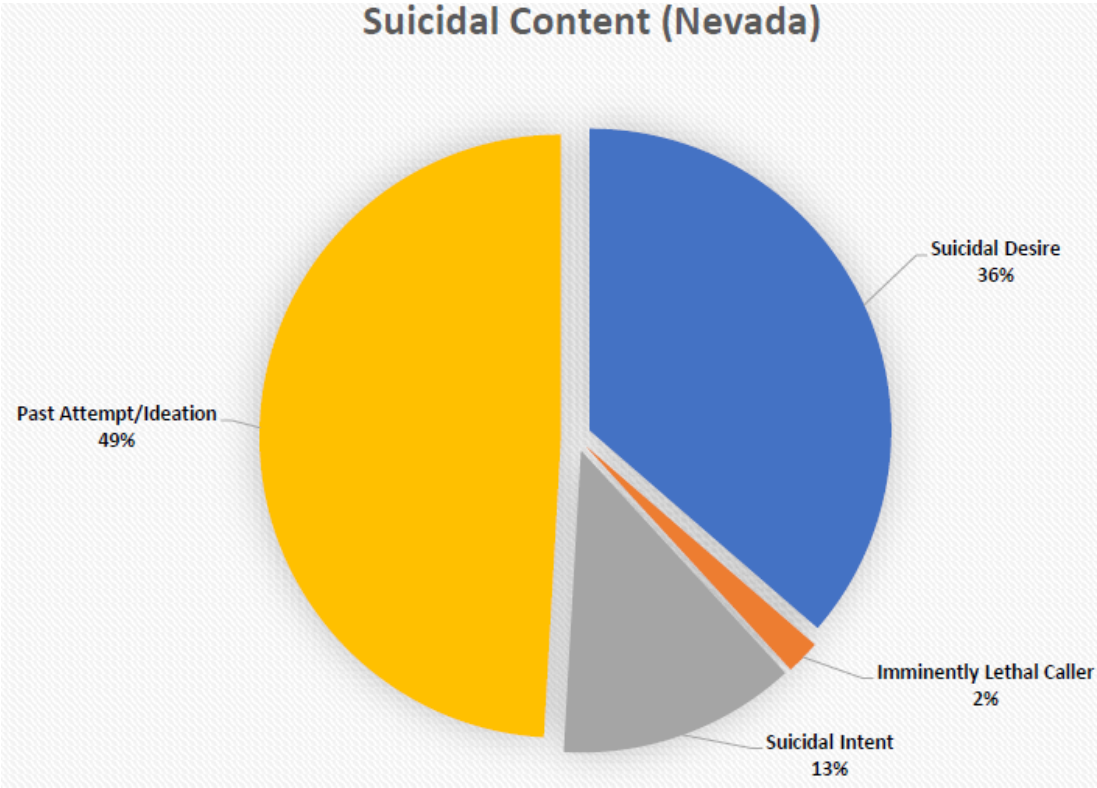
The effects of the Statewide PEI Project go beyond county lines. Influencing all Californians in the message of Each Mind Matters is critical for creating a culture of mental health and wellness regardless of where individuals live, work or play. Key statewide achievements of the Statewide PEI Project in FY 2019-2020 include:

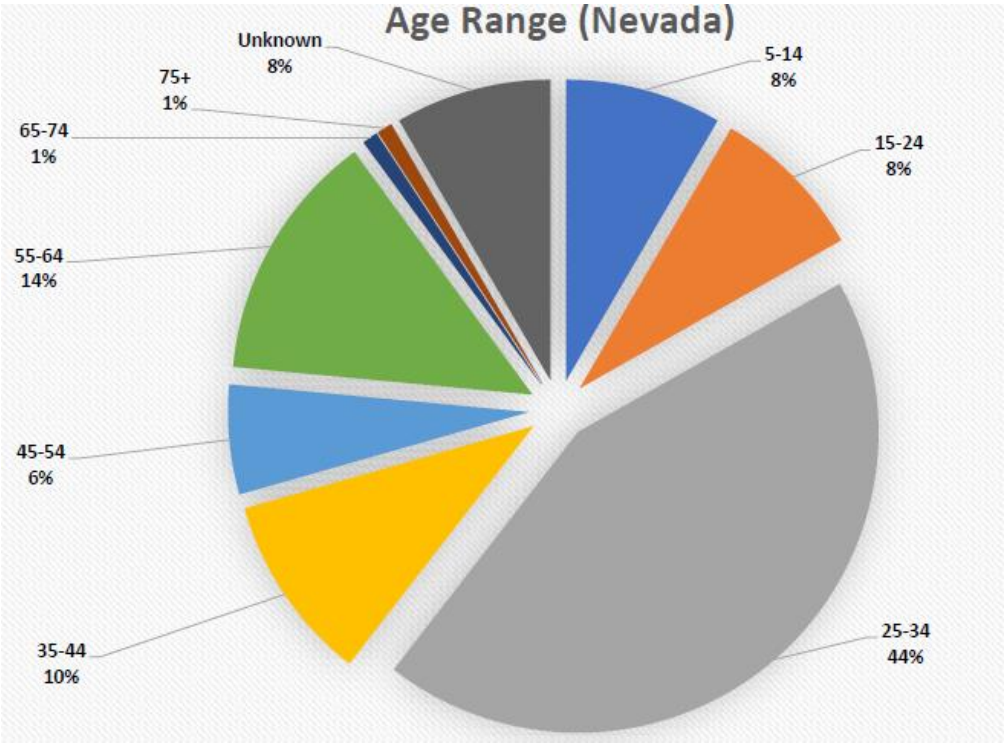
- Over 250,000 Lime Green Ribbons disseminated throughout the state
- Almost 1 million hardcopy materials were disseminated in counties, schools, and CBOs
- Over $80,000 in mini-grant funds were provided to CBOs, NAMI affiliates, Active Minds Chapters and Community Colleges to host community outreach events utilizing Each Mind Matters resources and messaging
- The Directing Change Program received over 1,000 videos submissions from almost 200 schools across California, engaging over 3,400 students
- 5 new Each Mind Matters culturally adapted resources were developed
- 29 news broadcasts, news articles and radio reports discussed programs implemented by the Statewide PEI Project

- Over 500 county agencies, schools, local and statewide organizations across California were touched by programs implemented by the Statewide PEI Project

In FY 19/20, the North Valley Suicide Prevention Hotline addressed 205 crisis calls from Nevada County residents, including 18 moderate or higher lethality calls, 7 active rescue callers, and 1 imminently lethal caller who was deescalated. Active Rescues are initiated to secure the immediate safety of a caller at risk if, in spite of the crisis line counselor's best efforts to engage the at-risk caller's cooperation, they remain unwilling and/or unable to take actions likely to prevent their suicide, or they remain at imminent risk/danger to themselves or others. Of Nevada County callers, 52% identified as male, 40% as female, and 8% were unknown. Most callers were between the ages of 25 and 34 (44%).




Suicidal Content (Nevada)
Suicidal Desire
36%
Imminently Lethal Caller
2%
Suicidal Intent
13%
Past Attempt/Ideation
49%


Age Range (Nevada)
Unknown
8%
5-14
8%
75+
1%
65-74
1%
15-24
8%
55-64
14%
45-54
6%
35-44
10%
25-34
44%

PEI Project Name: Suicide Prevention Program

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

Program Description

Program Overview

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

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

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

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

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

The coordinator also convenes the Suicide Prevention Task Force (SPTF) in Western Nevada County, supports the work of the Tahoe Truckee Suicide Prevention Coalition in Eastern Nevada County, and collaborates with many other organizations and agencies. Both the SPTF and the Tahoe Truckee Suicide Prevention Coalition are in the process of developing strategic plans to guide their work.

Target Population

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

Evaluation Activities and Outcomes

Evaluation activities include collecting demographic information on each participant in trainings as well as collecting data at the end of trainings to provide information on participant perceptions of the training and how much they learned (results shown below).

As a direct result of this training:	% in Agreement
I am better able to recognize the signs, symptoms and risks of suicide.	93%
I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide.	92%
I am more willing to reach out and help someone if I think they may be at risk of suicide.	92%
I know more about how to intervene (I've learned specific things I can do to help someone who is at risk of suicide).	92%
I've learned how to better care for myself and seek help if I need it.	82%

Please tell us how much you agree with the following statements:	
The presenters demonstrated knowledge of the subject matter.	94%
The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.).	93%
This training was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).	91%

SPP provided trainings to 149 unduplicated participants during FY 19/20 in various suicide prevention modalities. The coordinator hosted four Know the Signs trainings, four safeTALK trainings and one ASIST training. Additional trainings were scheduled, but in-person trainings were canceled beginning in March due to COVID-19 (see Challenges, Solutions and Upcoming Changes for additional details).

The Clinical Supervisor followed up with many suicide loss survivors, including relatives and other close relations. In addition, the clinical supervisor attended the National LOSS Conference in Tulare County in October to learn more about the LOSS model of postvention services.

Challenges, Solutions, and Upcoming Changes

The primary challenge in FY 19/20 was adapting to the COVID-19 pandemic. Many of the training modalities offered by the SPP are in-person only, which forced the cancellation of at least

two trainings, including an ASIST training planned for late April in the Truckee area of Eastern Nevada County.

Since March 2020, the county has relied exclusively on virtual Know the Signs trainings, since safeTALK and ASIST are in-person only. As a result, the number of community members trained is lower than it would have otherwise been.

The SPTF moved its meetings to a virtual format as a result of the pandemic. While the group continued to meet, the strategic planning process was put on pause while the group focused its efforts on responding to the immediate needs of the community during the pandemic.

Finally, SPP staff have added significant responsibilities related to COVID-19, which has taken some time away from suicide prevention activities.

Program Participant Story

Below are some quotes from training evaluation forms on participants' experience in suicide prevention trainings hosted by the county:

"Simple, straight-forward information taught in a safe way. [The trainer] was prepared and it felt safe." – September 16 safeTALK participant

"This training will help me in my field 100%. Thank you for this training and the trainers who were wonderful." – December 10-11 ASIST participant

"The training was extremely meaningful and confidence building." – December 10 ASIST participant

"Very open, kind. Extremely helpful and supportive. I feel more comfortable and confident talking about suicide and supporting individuals." - February 25 safeTALK participant

PEI Project Name: Suicide Prevention Program

SIERRA COMMUNITY HOUSE
Truckee Tahoe Suicide Prevention Coalition

Program Description

Program Overview

The Tahoe Truckee Suicide Prevention Coalition (TTSPC) formed in 2013 out of concern for the mental health and safety of the youth in the community. The goal of the TTSPC is to provide education, outreach, and strategies that will mobilize and support all members of the community while preventing future suicides. This is a collaborative effort involving a number of community agencies including local schools and the Tahoe Truckee Community Foundation.

Target Population

The target population that TTSC serves is North Lake Tahoe and Truckee Residents.

Evaluation Activities and Outcomes

The TTSPC served an estimated 3,627 individuals via trainings (1,034 people) and outreach (2,593 people) in FY 19/20. The program tracked roughly 60 events or activities throughout the year. A breakdown of some of these event types is shown below.

April - June 2020	**Events/Activities**
Community Outreach Events	14
Education/Training	17
Infrastructure Building	5
Media Outreach/Stigma Busting Work	13

Challenges, Solutions, and Upcoming Changes

A Suicide Prevention Coordinator for Truckee/North lake Tahoe was hired in April, a-midst the COVID-19 pandemic. TTSPC had to get creative to provided suicide prevention education during times of physical distancing. Know the Signs Trainings were offered on Zoom and staff began promoting the community trainings to local residents. TTSPC created a media calendar to target prevention work towards special populations going forward. The focus in April was starting up the social media platforms of Instagram, Facebook, and YouTube as well as getting TTSPC's website (www.TahoeLifeline.org) updated. In May the team focused on Mental Health Awareness. In June the focus was on Men's Mental Health, LGBTQ populations, and Minority Mental Health to support the social unrest and the Black Lives Matters movement. The program focused media attention & communications on COVID-19 and connectedness, which contribute to the reduction of stigma surrounding mental illness.

Innovation (INN)

Innovation Project Name: Integrated Tahoe/Truckee Services

NEVADA COUNTY BEHAVIORAL HEALTH & SIERRA COMMUNITY HOUSE

Program Description

Program Overview

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

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

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

Through one-on-one appointments at Sierra Community House, home visits and outreach through Promotora workshops, the SCH Family Advocate performed the activities under this Innovations project. This work was done with guidance from the bilingual Nevada County Behavioral Health therapist. Activities included outreach to local Latino community members, linkage and access to services regardless of which county the community members lived in, one-on-one support, referrals to a bilingual therapist, and attending meetings with Nevada/Placer County and Promotoras.

Target Population

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

Evaluation Activities and Outcomes

Sierra Community House, Family Advocate:
During FY 19/20, 16 individuals received one-on-one support and consultations from the Family Advocate to get connected with mental health services. The Family Advocate delivered a total of 41 hours of individual direct services (2.5 hours of services to each individual).

Five of those served received continued case management to stay connected, not only to mental health services but also to housing (one case involved an eviction process). This allowed the individuals to stay in the community through COVID-19 and continue to access services from Nevada County and Sierra Community House. The Family Advocate worked directly (through virtual meetings) with these community members so they could receive housing assistance, utilities credits, legal support, food and mental health services information.

Sierra Mental Wellness Group, Personal Services Coordinator (SMWG PSC):
The SMWG PSC position was vacant in FY 19-20. The PSC position was moved from SMWG to Victor Community Support Services (Victor) for Nevada County and to Uplift Family Services for Placer County. Due to program start up there were staffing vacancies. This shift also silos the intention of the position back to each county.

The innovation project encourages and tracks collaboration between agencies. Below is a comparative chart with the number of respondents on the Collaboration Survey per year. Placer County's participation in this program ended after FY 18/19 so the Placer agencies were less likely to respond to the Collaboration Survey after that. Due to the small number of agencies participating in the survey in FY 19/20, it was decided that the Collaboration Survey will not be collected for the last year of the program, FY 20/21.

	# of Respondents August 2018	# of Respondents February 2019	# of Respondents August 2019	# of Respondents May 2020
Unduplicated Number of Persons Responding	36	40	25	17

Challenges, Solutions, and Upcoming Changes

Due to small numbers of people accessing services in Tahoe/Truckee, SMWG's programs weren't fiscally sustainable so they ended most of their contracts in the Tahoe area, including the Innovation Case Manager role. In preparation for SMWG scaling down Placer and Nevada counties created a joint Request for Proposal (RFP) for Behavioral Health services in Tahoe, including Innovation Case Management for both counties. There wasn't an agency that applied that Nevada County wanted to contract with so instead they solicited Victor to do Truckee services

and Placer County contracted with Uplift. There was a lot of effort to continue the innovation and integration piece of the program, but due to the eligible applicants it didn't work out in the end.

During the FY 19/20, SCH worked on achieving the goals set for the "Innovation Family Advocate" role, in collaboration with Nevada County Behavioral Health and the in-house Promotora Program.

Different challenges arose from the organizational changes as a result of the merger with three other organizations, formally becoming Sierra Community House in July 2019. These changes continue to require staff to adjust to new internal processes and new team members, while avoiding any possible disruption in services.

At the same time, towards the third quarter of the fiscal year, COVID-19 hit and the stay at home order was established in California. This resulted in the need to close SCH offices to the public, beginning on March 16, 2020. Since then, staff has been working from home. This has created a whole new set of challenges and the need to adjust the service delivery model, traditionally built around the in-person interaction with community members. The use of electronic communications as well as meeting platforms such as Zoom has enabled the program to maintain, and sometimes even expand, the reach of services. However, there are still limitations encountered when trying to connect with community members, such as the lack of widespread access to reliable internet connection. This was sometimes a barrier for the Family Advocate that required a high degree of flexibility to accommodate community members' service needs.

Program Participant Story

"Daniel*" was referred to SCH and began receiving one on one support with the SCH Family Advocate through home visits. The Family Advocate started working closely with the behavioral health therapist and Tahoe Forest Hospital Community Health Advocate to better support and assist "Daniel". He had many health issues. The Family Advocate supported "Daniel" with medication monitoring, when he received a new device for checking his medication needs. The Family Advocate was able to meet with "Daniel" periodically to support him with using the device until he was comfortable with using it by himself. Although COVID-19 interrupted the continuation of home visiting, the goals for "Daniel" to become independent, be able to check his medication needs, and learn how to read and understand the monitoring device were met. The Family Advocate continues to support "Daniel" with biweekly check ins over the phone, aiding with care coordination and access to services every time a need arises.

**Not his real name*

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

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

Program Description

Program Overview

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

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

Target Population

Chronically Homeless residents of Nevada County

Evaluation Activities and Outcomes

HOME Team Services: A total of 4,327 services were provided to 322 unduplicated individuals in FY 19/20. A breakdown of the services is listed here:

Service Type /Service Description	# of Services
Case/Care Management	2,630
Local Automobile Transportation	767
Local Bus Fare	166
Housing Counseling	80
Employment Preparation	62
Clothing	45
Medical Equipment/Supplies	39

Food Banks/Food Distribution Warehouses	28
Long Distance Automobile Transportation	28
Housing Search Assistance	27
Homeless Motel Vouchers	15
Automotive Repair and Maintenance	11
Emergency Medical Care	10
Rental Deposit Assistance	8
Meals	7
Rent Payment Assistance	6
Outreach Programs	4
Crisis Intervention	3
Gas Money	3
Identification Card Fee Payment Assistance	3
Personal/Grooming Supplies	3
Clothing Vouchers	2
Identification Cards	2
Long Distance Bus Fare	2
Medicare	2
Moving Service	2
Pet Food	2
Benefits Assistance	1
Camping Gear	1
Community Shelters	1
Driver's License Fee Payment Assistance	1
Education	1
General Medical Care	1
Gift Card Distribution Programs	1
Health Care Referrals	1
Landlord/Tenant Dispute Resolution	1
Life Skills Education	1
Local Transportation	1
Long Distance Transportation	1
Motel Bill Payment Assistance	1
Non-Emergency Medical transportation	1
Pharmacies	1
Prescription Drug Lock Boxes	1
SSI Applications	1
TANF Applications	1
Total Services	**4,327**

Demographics: Demographics were collected for 116 individuals served by this program.
Outcome Measures:

- Number Engaged = 322 unduplicated individuals vs. a target of 150 per year. This includes linkages and service connections and limited case management.

- Number of SPARS Intakes Completed = 89 Intakes vs. a target of 80 per year. This refers to individuals who have completed an intake through the Substance Abuse and Mental Health Services Administration's Performance Accountability and Reporting System (SPARS).
- Number Receiving Intensive Case Management (ICM) = 113 unduplicated individuals. This is the cumulative number of individuals who have completed an intake and are considered "intensively case managed" by the HOME Team during the fiscal year.

Of those 113 HOME Team Participants receiving intensive case management:

- Number of Assessments Completed for Substance Use Disorders (SUD) = 31. Of these, 26 started treatment programs. This refers to placement in inpatient and/or outpatient treatment programs. Of the 26 that started treatment programs, 21 completed the program requirements.
- Number of Mental Health Assessments completed through Nevada County Behavioral Health (NCBH) = 42. Of those, 14 assessments were facilitated by the HOME Team following intake and 28 had previously completed assessments within the last two years.
- Number Connected to Behavioral Health Services = 41. Of the 42 individuals assessed through NCBH, 41 connected to services. The number placed in Behavioral Health treatment refers to all people on the HOME Team list that are connected to mental health services through NCBH, including Turning Point.

Housing by Location

	Permanent Housing Locations					Transitional Housing Locations					
	PSH	Private Pay	Family	Turning Point	Board &Care	Recovery Res.	Booth	Odyssey	B2H	P47	Sober Living
Home ICM	5	5	2	1	0	4	4	0	5	2	0
Home Engaged	1	2	0	4	2	2	0	3	0	0	1
Total	6	7	2	5	2	6	4	3	5	2	1

Housing Data:

HOME Team Housing FY 19-20

	Placed in Housing		Returned to Homelessness	
	Permanent	Transitional	Permanent	Transitional
Home ICM	13	15	0	9
Home Engaged	9	6	3	1
Total	22	21	3	10

Grants for the Benefit of Homeless Individuals (GBHI) Funds were used to assist 21 individuals to obtain or retain housing through flexible housing funds. Seven of the 21 individuals were HOME Team ICM beneficiaries. One of the seven is duplicated in the overall Permanent Housing Numbers for HOME Team. Funds were accessed 25 times. Funds were accessed 13 times to secure housing by paying the initial deposit and (if required) the first month's rent. Funds were accessed 11 times for rental assistance in order to maintain housing. Funds were accessed once to assist with cleaning an apartment for inspection.

The number of individuals who received Medical Engagement by HOME Team Nurse = 133. Of the 133 engaged individuals, 12 received ongoing intensive services from the HOME Team nurse. Of the 12 intensively case managed individuals, Emergency Room (ER) recidivism data was collected on 10 individuals. Eight individuals had data collected for six months prior to working with the HOME Team nurse and six months following working with the nurse. The eight individuals demonstrated a 64% reduction in ER visits following working with the HOME Team nurse, from a cumulative count of 39 days before HOME Team engagement to a cumulative count of 14 days after engagement. Seven of the eight individuals had an overall reduction in ER visits. Two individuals had data collected for three months prior to working with the HOME Team nurse and six months following working with the nurse. These individuals demonstrated a 55% reduction in ER visits, decreasing from a cumulative count of 11 ER visits before HOME Team engagement to a cumulative count of five ER visits after engagement.

Emergency Room Recidivism Data				
	# of Clients	**# of ER Visits Pre-Intervention**	**# of ER Visits Post Intervention**	**% Reduction**
6-Months Pre/Post Data	8	39	14	64%
3-Months Pre/Post Data	2	11	5	55%
Total	10	50	19	62%

Primary Medical needs of the 12 intensively case managed individuals were tracked and reported. Up to three medical needs were reported per person.

Medical Need	**# of Client's**
Wound Care	6
Nutrition	5
Chronic Health Condition	5
SUD	3
Medication Management	3
Pregnancy	2
Other Medical Need	2

Referrals: The HOME Team program made 938 referrals. Forty percent of referrals were connected to services. All 45 NCBH referrals were connected to services. Other agencies referred to and the count of individuals referred to each are listed below:

Referred-To Provider	**Count**
Nevada County Behavioral Health	176
Granite Wellness (Formerly CoRR)	146
Utah's Place (FHH)	136
Home Team (FHH)	56
Interfaith Food	53
Common Goals, Inc.	40

Food Bank Referral	33
Foothill House of Hospitality	27
Freed	27
Western Sierra Medical Clinic	24
Nevada County Dept. of Social Services	22
Stability Project (SPIRIT)	22
SOARWorks HDAP (Freed)	19
Referral Provider	18
Veteran Services Referral	18
AMI Housing, Inc.	17
Crisis Stabilization Unit	17
Chapa De	11
Sierra Nevada Memorial Hospital	8
CalWorks - Employment Services NevCo	7
Emergency Shelter (CBV)	7
Insight Respite	7
Bridges 2 Housing (AMIH)	6
Sierra Roots	6
Social Security	5
ARGP (FHH)	4
Coordinated Entry	4
HOME(ICM)	4
Employment Assistance Referral	3
Law Enforcement	3
Mental Health Referral	3
Bread and Roses	2
Business & Career Network (formerly One Stop)	1
CMSP (FHH)	1
Day Center (SPIRIT)	1
Pets of the Homeless Nevada County	1
Physician/MD Referral	1
Private Therapist	1
Regional Housing Authority of Sutter and Nevada Counties	1
Grand Total	**938**

Challenges, Solutions, and Upcoming Changes

Staffing- Due to staffing issues, the HOME Team Nurse was splitting her time between the HOME Team and Nevada County Behavioral Health throughout the fiscal year. As a result, she was

unable to dedicate her full time (40 hours per week) to HOME Team duties. As of June 2020, the Behavioral Health nursing position has been filled and the nurse assigned to the HOME Team is able to dedicate her full time to HOME Team beneficiaries and responsibilities.

Data Systems- Creating data sharing systems for overall HOME Team data integrity and fidelity became a focus during the fiscal year. A HOME Team Data Committee was created and met monthly in order to review data collection procedures, HOME Team outcomes, and to track fidelity. Additional county staff were trained in the Homeless Management and Information System (HMIS) in order to readily access, track, and report aggregate program data both internally and to partner agencies as needed.

An additional challenge was creating systems for tracking and storing medical data specific to the HOME Team Nurse. Due to HIPAA (Health Insurance Portability and Accountability Act) and Data sharing regulations, collecting, storing, and sharing beneficiary information pertaining to the medical work the HOME Team Nurse was doing with individuals, proved initially challenging. During the fiscal year tracking forms were created that the nurse was able to readily access and complete while working in the field. A secured data entry and storage cloud space was created on the County's SharePoint system specific to HOME Team Medical Engagement. This system allows for tight controls over who has access to the information, while maintaining the ability to readily pull aggregate de-identified data specific to medical engagement reporting.

Program Participant Story

When the HOME Team began, it met with several community providers including Sierra Nevada Memorial Hospital and local law enforcement agencies, to discuss the needs of the target population. During these meetings, there was an elderly individual that was brought to the HOME Team Nurse's attention. This individual had frequent hospital emergency department (ED) utilization, as well as repetitive, time consuming interactions with Law Enforcement. The Team was concerned for his health and wellbeing.

The HOME Team Outreach Nurse took over his care. In the seven months prior, the gentleman had multiple ED visits. Many times, he left the ED against medical advice, only to return days later. There were several medical holds written by law enforcement due the individual being unable to care for himself.

As the Nurse got to know this gentleman, she began to better understand his lifestyle and was able to do a medical case study which involved looking at his past ED and inpatient records, in order to figure out why there were so many visits and what exact medical problems needed to be addressed. The Nurse's assessment highlighted the main reason many local homeless individuals have high rates of ED admissions: lack of medication compliance and inconsistent medical follow up. The Nurse took over his daily medication management as well as provided wound care, temporary housing for respite and recovery, and supported his follow-up Primary Care Physician appointments.

In the one-year time span of receiving nursing case management services, the individual has been to the ED only two times. Each time the HOME Team Nurse was able to work with the hospital social workers and have him discharged to a facility where he resided for the majority of the year. This was no easy task; the Nurse sat at the side of his hospital bed multiple times working to understand that he needed a higher level of care than was offered by his current lifestyle. The gentleman is now in supportive placement, with the intention that he will continue to stay there for the foreseeable future. This is an example of the intensive medical case management and follow through that is needed to alleviate some of the burden on the local system of care while supporting the wellbeing and freedom of homeless individuals.