Nevada County Mental Health Services Act (MHSA) Annual Progress Report for Fiscal Year 2014/2015

Overall Implementation Progress Report on Fiscal Year (FY) 2014/2015 Activities

General Nevada County Information:

Nevada County is a small, rural, mountain community, home to an estimated 98,893 (2014 US Census Bureau estimate) individuals. According to the 2014 US Census estimate a little over 93% of the Nevada County residents identified their race as White, while over 3% of residents identified their race as African American, Asian, American Indian, Alaska Native, Native Hawaiian and Pacific Islander combined. Additionally, 3% identified themselves by two or more races. In regards to ethnicity, an estimated 85.6% of the population identified as Non-Hispanic or Latino and 9.2% of the population of Nevada County identified themselves as Hispanic or Latino. Therefore, Nevada County's one threshold language is Spanish.

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

MHSA Program Updates:

Community Services and Supports (CSS):

Full Service Partners:

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

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

   Demographics: In fiscal year 2014/2015, VCSS Grass Valley served 101 program participants representing 96 unduplicated individuals. [redacted]

[redacted]

Referrals: During this fiscal year 2014/2015, there were 39 referrals made, with 37 program participants opening (95%), one individual remaining pending at the end of the fiscal year, and one referral being denied. Three referrals pending from the previous fiscal year opened to services, bringing the total number of intakes to 40, excluding transfers between reporting units.

Barriers/Challenges: A major barrier to service was the difficulty of communicating with program participants. Individuals in the program and those being referred frequently lacked a phone or available phone-minutes, and cell phone service could be limited in rural areas. As a result, it could be hard to establish and maintain contact with referred individuals and program participants. To ensure program participants received service and support, VCSS occasionally provided reloadable cell phones for individuals in need.

Outcomes/Successes:

- Housing: During this reporting period, 93% of program participants remained in a community living situation and avoided a higher level of care. Seven individuals experienced a group home placement. Please note this does not include temporary juvenile hall placements, which are addressed below.
- Employment and Education:
  - VCSS achieved its contractual goal of ensuring at least 80% of parents report youth maintained a C average or improved on their academic performance. During this reporting period, 80% of parents surveyed reported they saw improvement in their child's academic performance. Additionally, based on the CANS item "Academic Achievement," 86% of program participants were maintaining at least a C average and were not failing any classes.
  - VCSS achieved its contractual goal of ensuring at least 75% of youth maintain regular school attendance or improve their school attendance, as 81% of discharged program participants 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; 75% of program participants did not experience a suspension or expulsion in this fiscal year.
- Criminal Justice involvement: VCSS achieved its contractual goal of ensuring at least 70% of youth have no new legal involvement (arrests/violations of probation/citations) between admission and discharge. In this reporting period, 90% of program participants had no new legal involvement while receiving services.
- Acute Care Use: Ninety-two percent (92%) of program participants served did not experience a psychiatric hospitalization during this fiscal year.
- Emotional and Physical Well Being:
  - Throughout the 2014/2015 fiscal year, VCSS Grass Valley successfully supported the strengthening and development of program participant, caregiver, and family members' emotional and physical well beings.
  - VCSS achieved its contractual goal of ensuring at least 65% of children were able to identify at least one lifelong contact. Based on the CANS item, "Relationship Permanence," 97% of program participants served were able to identify at least one lifelong contact.

  - VCSS achieved its contractual goal of at least 80% of parents/caregivers reporting an increase in their parenting skills. In this fiscal year, 93% of surveyed caregivers reported they learned additional strategies to address behaviors at home.
  - VCSS achieved its contractual goal of ensuring at least 75% of caregivers maintained or increased connection to natural supports, with 89% of surveyed caregivers reporting increased connections in the community.
  - VCSS achieved its contractual goal of ensuring at least 80% of program participants improved their scores on the Comprehensive Child and Adolescent Needs and Strengths (CANS) instrument between intake and discharge. During this fiscal year, 84% of program participants with a planned discharge improved in at least one of the following CANS domains: Life Functioning, Mental Health/Behavioral/Emotional Needs, Risk Behaviors, or Educational Needs. CANS outcomes for FY 14/15 planned discharges were strong, with 72% improving in Life Functioning, 68% improving in Mental Health/Behavioral/Emotional Needs, 45% improving in Risk Behaviors, and 56% improving in Educational Needs.
- Service Access and Timeliness:
  - Excluding transfers between reporting units, there were a total of 35 discharges in this fiscal year. For this time period, the average length of service (ALOS) for the discharge population was 14.5 months.
  - VCSS has a contractual goal of attempting initial contact with referrals within three (3) business days of receipt of referral. While initial contact was attempted for all program participants within three days, initial contact was successfully made with 65% of referrals in this period.
  - VCSS achieved its contractual goal of making face-to-face contact with 60% of referrals within ten (10) business days of receiving the referral, serving 75% of referrals within ten days.

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

   Demographics: Two-hundred and seventy-five youth have been admitted to EMQFF's Nevada County Wraparound Program since inception. [redacted]

   There were 80 youth served during the July 2014 to June 2015 timeframe, [redacted]

Service Intensity: For the 275 youth served since the inception of the Nevada County Wraparound Program, 251 youth were unduplicated and received an average of 16 service hours per youth, per month. For the 80 youth served during the July 2014 to June 2015 timeframe, 73 youth were unduplicated and received an average of 9.5 service hours per youth, per month was provided.

Community Responsiveness: For the July 2014 to June 2015 timeframe, 72% of youth and families received an initial contact within three business days of receipt of the referral. Forty-eight percent received face-to-face contact within ten business days of receipt of the referral.

Outcomes/Successes:

- **Length of Stay -** Since inception, the average length of stay, for the 202 youth who were enrolled for 60 days or more, is 14 months. For youth discharged during the July 2014 to June 2015 timeframe, 23 had a length of stay of 60 days or more, and had an average length of stay of 21 months.
- **Pro-social Behavior -** Since 2011, 99 matched pairs first completed/discharge Child and Adolescent Needs and Strengths (CANS) tool were available to analyze. Fifty percent of actionable items improved compared to non-actionable items on youth clinical condition and quality of life. During the July 2014 to June 2015 timeframe, 20 matched pairs first completed/discharge CANS tool were available to analyze. Forty-six percent of actionable items improved to non-actionable items on youth clinical condition and quality of life.
- **In Home or Foster Care -** Since inception, 83% of youth who participated in the Nevada Wraparound Program for at least 60 days were stabilized at home or in foster care at discharge. During the July 2014 to June 2015 timeframe, 79% of youth were stabilized at home or in foster care at discharge.
- **School Attendence -** During the July 2014 to June 2015 timeframe, 94% of youth maintained regular school attendance during participation in the Nevada County Wraparound Program.
- **School Behavior -** During the July 2014 to June 2015 timeframe, 92% of youth maintained no suspensions or expulsions in the three months prior to discharging.
- **Academic Performance -** In the July 2014 to June 2015 timeframe, 78% of youth with a history of academic problems improved their academic performance.
- **Legal Trouble -** During the July 2014 to June 2015 timeframe, 87% of discharged youth maintained zero arrests, probation violations, or days spent in custody in the three months prior to discharging. Twenty-five percent of discharged youth with prior legal involvement improved to have no new legal involvement at discharge.
- **Relationship -** During the July 2014 to June 2015 timeframe, 25% of youth established, reestablished or reinforced lifelong relationships with a caring adult while participating in the Nevada Wraparound Program.
- **Caregiver Self-confidence in Parenting -** During the July 2014 to June 2015 timeframe, 50% of caregivers reported an increase in their parenting skills at discharge that they learned while participating in the program.
- **Families Connecting to Natural Supports –** Fifty percent of youth and families maintained or improved natural supports during the July 2014 to June 2015 timeframe.
- **Discharge -** Since inception, 58% of youth with a length of stay of 60 days or more, discharged from the program because they met their treatment goals. For the 23 youth who discharged during the July 2014 to June 2015 timeframe, and had a length of stay of 60 days or more, 59% were discharged because they met their treatment goals.

- **Satisfaction -** Since inception, 76% of caregivers and 54% of youth indicated satisfaction with the program. During the July to June 2015 timeframe, 81% of caregivers and 44% of youth indicated satisfaction with the program.

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

Plan II: Adult Full Service Partnership (FSP)

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

   Demographics: In fiscal year (FY) 2014/15 a total of 118 individuals were enrolled in the Providence Center program. [redacted]

   Outcomes/Successes:
   - Program Discharge: A total of 45 individuals were discharged in FY 14/15. The top two discharge settings were Lower Level of Care at 44.4%, n=20; and Program Participants Discontinued Services at 24.4%, n=11.
   - Psychiatric Hospital Days: A total of 417 Psychiatric Hospital Days were reported for 17 individuals (14% of total individuals) in FY 14/15.

  - This represents a decrease of 156 days from the 573 psychiatric hospital days accrued by 18 individuals in the 2013/2014 fiscal year.
  - Overall, 86.0% (n=104) of the individuals served within the 14/15 fiscal year accrued zero psychiatric hospital days.
- Jail Days: Jail Days were reported as 1,077 (a 156 day increase from FY 13/14) for 23 individuals (19% of total individuals). Ninety-eight individuals (81%) accrued zero Jail Days.
- Homeless Days: Twenty-eight individuals (23%) accrued a total of 2,578 Homeless Days (665 days increase from FY 13/14). Ninety-three individuals accrued zero Homeless Days (77%).
  - Of the 20 individuals who had accrued homeless days within FY 13/14, 18 (90%) continued to receive services at Providence Center in the FY 14/15. Thirteen (72.2%) of those 18 individuals were reported as having a decrease in the total number of homeless days accrued. Additionally, 10 of those 13 individuals (76.9%) no longer accrued any homeless days in FY 14/15. The remaining three individuals showing a decrease in days accrued 112 (4.3%) of the 2,578 homeless days in FY 14/15. The remaining 2,466 days were accrued by individuals who had either accrued fewer homeless days in FY 13/14 or were new to Providence Center entirely.
  - Note that nine individuals alone accrued 2,053 (79.6%) of the total 2,578 days in FY 14/15; suggesting the presence of outliers.
- Emergency Interventions: Eighty-one Emergency Interventions were performed on 34 individuals (28%). This represents a slight increase of eight days from the 73 Emergency Interventions accrued by 32 individuals in FY 13/14.
- Milestones of Recovery (MORS): Scores of five (Poorly Coping/Engaged) (38.2%, n≈35.7) made up the majority of those scored across the past 12 months. Scores of six (Coping/Rehabilitating) made up the second highest frequency (27.3%, n≈25.5). A score of six is a favorable threshold of the MORS.
- Consumer Satisfaction Survey: Overall, the Providence Center program received a satisfaction rating of 84.1% on a scale from 0% – 100%. All seven domains had satisfaction rates above the favorable 80% threshold.
- Assisted Outpatient Treatment (AOT) Outcomes: The following outcomes are from data submitted to DHCS for the 26 individuals who were served by AOT in FY 14/15.

  AOT Hospital Days:
  - A total of 296 psychiatric hospital days were accrued by five individuals or 19.2% of the total 26 individuals observed. The majority of individuals (80.8%, n=21) did not accrue any psychiatric hospital days in the reporting period.
  - There was a decrease of 417 days or 64.6% post referral versus pre-referral. Ten of the 14 individuals (71.4%) who had accrued hospital days prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Eight of those 10 individuals (80.0%) no longer accrued any further hospital days post-referral.
  - In comparing the pre and post-referral data, there was a reported decrease of 207 days or 65.5%. Five individuals accrued the 316 psychiatric hospital days prior to their AOT referral. All five (100%) were reported as having a decrease in total days accrued post-referral. Four of the five (80.0%) no longer accrued any psychiatric hospital days after their referral.

  AOT Incarceration Days:
  - During the reporting period a total of 243 incarceration days were accrued by four individuals or 15.4% of the total 26 individuals observed. The majority of individuals (84.6%, n=22) did not accrue any incarceration days in the reporting period. Additionally, one individual accrued 143, or 58.8%, of the total 243 incarceration days suggesting the presence of outliers.

- There was a decrease of 303 days or 61.0% post referral versus pre-referral. All 3 (100.0%) of the individuals who had accrued incarceration days prior to their AOT referral no longer accrued any further incarceration days post-referral.
- In comparing the pre and post-referral data, there was a reported decrease of 32 days or 14.3%. Two individuals accrued the 224 incarceration days prior to their AOT referral and both no longer accrued any days within the 12 months after their referral.

AOT Homeless Days:

- During the reporting period, a total of 29 homeless days were accrued by five individuals or 19.2% of the total 26 individuals observed. The majority of individuals (80.8%, n=21) did not accrue any homeless days in the reporting period.
- There was a decrease of 649 days or 78.6% post referral versus pre-referral. Six (85.7%) of the seven individuals who had accrued homeless days prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Four of those six individuals (66.7%) no longer accrued any further homeless days post-referral.
- In comparing the pre and post-referral data, there was a reported decrease of 81 days or 97.6%. Of the two individuals who were court ordered and had accrued homeless days prior to their AOT referral, both (100%) no longer accrued any homeless days post-referral.

AOT Emergency Interventions:

- During the reporting period, a total of 24 emergency interventions were accrued by nine individuals or 34.6% of the total 26 individuals observed. The majority of individuals (65.4%, n=17) did not accrue any emergency interventions in the reporting period.
- There was a slight increase of three days, or 9.1%, post referral versus pre-referral. Despite this increase seven (43.8%) of the 16 individuals who had accrued emergency interventions prior to their AOT referral were reported as having a decrease in total days accrued post-referral. Six (85.7%) of those seven no longer accrued any emergency interventions in post referral. One individual continued to accrue the emergency interventions both pre-referral (12.1%, n=4) and the majority post referral (41.7%, n=15) suggesting the presence of an outlier.
- Just as there was for the entire AOT population observed, those who were court ordered also showed a very slight increase in the number of emergency interventions accrued pre referral in comparison to post referral (-12 days, 85.7%). Four of the six individuals (66.7%) who had accrued emergency interventions prior to their AOT referral date were reported as having a decrease in days accrued. Three of the four (75.0%) no longer accrued any emergency interventions.

AOT Milestones of Recovery (MORS):

- On average, at the time the first MORS score is assigned, the majority of program participants were at extreme risk (a score of 1) (42.4%, n=14). At the time of their most current MORS score assignment the majority were poorly coping but engaged with staff (a score of 5) (51.5%, n=17). Overall, 22 (66.7%) of the 33 individuals included in the analysis had an increase between their initial and most current MORS score.
- On average, program participants increased by approximately 2 scores between their initial and most current MORS score assignment. This shows that progress was made towards recovery once the Providence Center began providing services.

AOT Consumer Satisfaction Survey:

- Overall, the AOT program received a satisfaction rating of 79.1% on a scale from 0% – 100%. Four of the seven domains had satisfaction rates above the favorable 80% threshold. The other three domains had scores in the mid to high 70% range.

2. The **New Directions Program** in Nevada County Behavioral Health Department is a lite AACT program, which serves individuals with severe, persistent mental health issues and accompanying challenges to daily living. The program facilitates program participants transitioning from county services to independence and community living. [redacted] The New Directions team maintains a strong commitment to providing services which include Supported Independent Living, Supported Employment, educational and therapy groups, individual therapy and WRAP (Wellness Recovery Action Plans). During FY 14/15 New Directions provided services to 49 program participants across the three age categories.

   Demographics: Of the 49 participants served in FY 14/15, [redacted]

   Service Intensity: During the FY 14/15 service intensity varied by individual for the 49 participants served. The focus of increased services across all age categories is to decrease hospitalization by utilizing intense case management, temporary placement at Odyssey House transitional home, medication caddy services and daily delivery support in partnership with Turning Point, and nightly calls to the most high risk program participants. Comparing the year before partnership to the second year of receiving services through New Directions, the number of program participants in a Psychiatric Hospital decreased from six to three. The number of participants in an Emergency Shelter decreased from three to one. The number of individuals in Residential Placement decreased from six to four and the number of participants Supervised (in Congregate Placement or Community Care) decreased from four to three.

   Program Options:
   Housing:
   - *Self-Sufficient Support (S^3)* - Residents who are successfully capable of living independently with minimal support are classified as "self-sufficient." These participants receive support on an "as needed" basis from Personal Service Coordinators (PSC). The residents are able to handle and problem solve most basic daily situations of independent living. Comparing the year before partnership to the first year of receiving services through New Directions, the number of Independent Living days increased from 5,530 to 6,376 days. Also, comparing the year before partnership to the second year of receiving services through New Directions, the number of Homeless days decreased from 423 to 234 days.
   - *Supported Independent Living (SIL)* - Residents need regularly scheduled support to remain successful in independent living. Identified shared houses are supported by Nevada County Behavioral Health in the following manner:
     - Deposits are paid by MHSA flex funds.
     - If a room is vacant, MHSA funds are used to pay the monthly rent to maintain stability of the house until residents can locate a new housemate.
     - A "basic needs" list for residents is created by staff and obtained by program participants' resources, donations and/or MHSA flex funds.
     - PSCs provide support with medication, housemate conflict resolution, money management skills, paying bills, meal planning, budget planning, shopping, leisure skill planning and other daily living skills.
     - PSCs work with landlords to ensure support for both the resident and the landlord.

- New Directions continued support for the six SIL (Supported Independent Living) houses, housing 14people.
- Housing was provided for 35 homeless adults or previously homeless adults who struggled with severe and persistent mental illness using subsidies from the HUD Supported Housing Program grants. This included Winters' Haven house and scattered sites in the Summer's Haven and Home Anew Projects. See MHSA Housing section of this report for more details.
- *The Catherine Lane House (a joint venture with Turning Point)* - The Catherine Lane House offers 24/7 support services to residents with independent living skills challenges. This non-licensed house includes a focus on single room occupancy that facilitates residents in achieving their maximum level of independence. This house enables residents to live independently and keep their current community support network intact. In FY 14/15 the New Directions Program did not have any participants living at the Catherine Lane House.
- *The Willo House*- The Willo House is a program which provides intensive support services for participants who are on conservatorship or in need of one or more staff contacts per day. This setting provides participants an opportunity to live in the community with greater independence than an IMD (Institute for Mental Disease) or Board and Care facility. The Willo House is a three bedroom unit. In FY 14/15 the New Directions Program housed five participants in Willo House.

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

Employment/Volunteer Employment:

- *Snack Shack* - Vocational training is available through the Snack Shack program. The Snack Shack program is a collaborative effort between NAMI, the Behavioral Health Department and Program participants. It is an individual 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 program participants and an individual with bookkeeping experience balances the receipts. In FY 14/15, 14 participants volunteered to work in the Snack Shack program for a total of 1,697 hours.
- *Peer Support Training* - Peer Support Training is an eight to ten month program where program participants develop skills to counsel and support peers. The goal of the support services is to promote self-empowerment, independence and interdependence, facilitating individuals 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 two outcomes: 1) a certificate of graduation or 2) a certificate of participation. Program participants are then introduced to volunteer opportunities in the community. In FY 14/15, ten participants completed Peer Support Training and within the graduates of the program:
  - Two participants took the training for personal enrichment.
  - One participant is volunteering at the Behavioral Health Department.
  - Two participants are working for Respite Center positions.

  Peer support challenges continue. As peer support continues to expand, so does the need to find paid or volunteer community placements for program graduates. Ongoing outreach to community based agencies and groups is continually needed to provide options for graduates to utilize their skills. Additionally, once a Peer Supporter has a paid or volunteer position in the community they typically need intermittent support. Staff schedule an alumni meeting once a month to provide support for the individuals working in the community. Staff also

facilitate visits to other agencies to foster knowledge of future referral resources, as well as meet prospective employers.

Supportive Services:

- *Weekly Groups:*
  - Healthy Living - Healthy Living courses provide education to program participants and healthy options for independent living. Choices include coping and time management skills; nutrition, social and budgeting skills; leisure and development of Wellness Recovery Action Plans (WRAP) and social activities based in the community.
  - Saturday Adventure Outings - Saturday Adventure Outings serve high risk program participants who have a history of being isolated on weekends. The goal of the program is to engage these individuals socially with other peers that result in decreased symptoms of mental health issues and increased quality of life. The program participants organize the adventure and determine the activities each week. A peer staff member and an MFT intern trainee provide transportation utilizing Behavioral Health vehicles. The staff also provides support and referral services during the program. This creative solution has enabled individuals to access social interactions through activities they determine. In FY 14/15 the New Directions Program had 20 participants in the Saturday Adventure Outings program. The lead therapist/program team coordinator provided qualitative data in collaboration with the larger Behavioral Health clinical team indicating that this program had a direct role in reduction of symptoms and the need for more intensive services for program participants.
- *Therapy Support and Service Coordination:*
  - Therapy services are provided by interns through the intern program. The program offers an opportunity for interns to be trained in the mental health field while offering services to individuals who might otherwise wait or not receive individual therapy services. The long term benefit is quality services for the program participants and training for a new generation of clinicians who have developed skills which they will bring to a variety of community based settings.
  - The Interns are individuals in the process of completing or who have completed their Master's degree in psychology, sociology or a related field. Supervision is provided by a licensed therapist with the New Directions Program.
  - Program treatment options range from service coordination to providing mental health rehabilitation, including medication delivery.
  - Individual and group therapy provides participants the opportunity to further their goals of developing healthy life options, including choosing the abstinence or harm reduction model for recovery from substance use disorders as a component of their co-occurring disorder.
- *After Hour Services* - Nevada County is a small county and resource availability within the Behavioral Health Department is limited, given budget constraints. In order to meet the criteria of 24 hour/seven day a week services, the following adjunct supports have been developed for holidays, weekends and overnight coverage. Individuals have use of the 24 hour crisis line of Nevada County Behavioral Health as a contact resource. They have the further option of requesting contact with the program team coordinator or designee alternate for support in managing critical issues through the crisis line. For participants in New Directions utilizing daily medication deliveries, service coordinators from Behavioral Health make weekday morning deliveries. Through a partnership with Turning Point Providence Center, medication delivery services are provided at night, on weekends and holidays. During FY

14/15, nine individuals received daily medication caddie deliveries in collaboration with Turning Point for night and weekend coverage.

Outcomes: Notable community impact is reflected by these program outcomes.

- Decreased hospitalizations (listed above) were recorded.
- There was a decrease in legal issues (10 individuals with arrests prior to partnership, decreased to five partners with arrests during the first year of service).
- Independent Living was maintained or increased (listed above) which reduces the impact on community based homeless resources (decreased homelessness listed above).
- Programs focused on medication compliance, nutrition and physical health reduced utilization of emergency room services (17 individuals with emergency room visits before partnership, decreased to five partners during the first year of partnership).
- The employment program provided enrolled program participants with additional resources which they spent locally and thereby became financially contributing members of the local community.

General System Development:

1. In FY 14/15 **Intern Program Expansion** added service capacity, increased access, and broadened services in Nevada County. Interns and their clinical supervision were funded through CSS GSD. In FY 2014/2015 eleven interns provided 9,510 hours of services for Nevada County citizens. The interns provided services in both adults' and children's systems of care (3,657 hours for adults and 5,853 hours for children). Additionally, two individuals provided supervision to the interns. Of the total hours of supervision provided, 149 hours were funded by MHSA CSS GSD.

2. Nevada County Behavioral Health (NCBH) has licensed therapists, **Network Providers,** who work in the community at private offices. They see children, Transition Aged Youth (TAY), adults and older adults referred to them by NCBH. Nevada County Behavioral Health refers program participants with lower needs to the Network therapists. These are individuals who do not appear to need medication or a lot of case management. Network providers help to serve additional individuals and offer individuals and families a variety of specialties and locations that NCBH would not be able to offer otherwise. Network providers are funded under both the Adult and Children's programs within CSS.

Demographics: These therapists provided services to 238 individuals in FY 14/15. [redacted]

3. **Expand Adult and Child Psychiatric Services**

Nevada County Behavioral Health (NCBH) Children's Services provided Psychiatric services to 27 children with MHSA CSS funds in FY 2014/2015. Some of the children were being wrapped with Full Service Partner (FSP) providers. Some of these children continue to see the NCBH doctor individually and work with the WRAP team.

Demographics: [redacted]

Nevada County Behavioral Health Adult Services provided Psychiatry to Case Management/ Auxiliary, New Directions and Healthy Outcomes Integration Team (HOIT) program participants using General System Development funds. Expansion of psychiatry services and expansion of behavioral health services within the Adult System of Care included the same individuals. All Auxiliary, New Directions and HOIT program participants received both psychiatric and case management services.

Demographics: The program served 43 individuals [redacted]

4. The **Sierra Family Medical Clinic (SFMC)** provides therapy one day a week to underserved children, adolescents, adults and older adults. Therapy includes solution-focused, cognitive behavioral therapy, and other modalities that are evidenced-based/promising practices utilizing motivational enhancement/motivational interviewing counseling styles and techniques. Care coordination services are provided to high-need behavioral health patients to assure that care is patient-centered. Individuals with mental health conditions can have challenges prioritizing concerns when seeing a medical provider due to focusing and concentration difficulties. Providers may have a limited amount of time to address concerns in one appointment. The BH care coordinator meets with individuals to assist with this process and develop a multi-visit plan so that the program participants feel heard and valued. Connection with other community services is continually developed and supported so that program participants can access services in accordance with their abilities.

Demographics: In fiscal year 14/15, 163 unduplicated individuals were served by SFMC. [redacted]

[redacted]

Barriers/Challenges: Challenges were primarily addressing the needs of individuals with serious mental health conditions who required more intensive support than is possible through the clinic. Primary care providers were not able to address patients with complex psychiatric needs; tele-psychiatry was limited. Some individuals had chronic mental health conditions that could be debilitating at times and sufficient care management was not available.

Although managed care Medi-Cal recipients had transportation charges for medical appointments covered, it was sometimes limited and did not support obtaining prescriptions. The ability to receive assistance for food and social supports was also impeded due to lack of public transportation in the area.

A recurring challenge continues to be finding affordable housing and temporary housing for people who were not eligible for the current programs; some people continued to live in substandard housing and crowded conditions.

SFMC continues to problem-solve with Nevada County Behavioral Health to obtain treatment for individuals with psychiatric needs. The program also continues to collaborate with other community stakeholders on these issues.

Outcomes/Successes:

- Approximately 80% of individuals who entered treatment with suicide ideation were no longer experiencing suicidal thoughts after a course of treatment.
- Approximately 80% of individuals desiring reconciliation/re-connection with family members and personal supports experienced increased confidence and the ability to successfully repair relationships.
- These measures reduced the need for emergency department visits.
- Consistent with clinical practices, warm-handoffs from medical providers resulted in over 85% of patients continuing with behavioral health services.
- Anecdotal evidence included a person disabled by depression and anxiety unifying with his wife/children and obtaining employment; a young person who had been disabled by anxiety and depression was now able to go to school part-time.

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

within a framework of intensive provider collaboration both internally (within CoRR) and externally (within the greater system of care including EMQFF, Victor Services, Behavioral Health, Probation, Courts, Child Protective Services, etc.).

Demographics: Forty-six adults and children were served in FY 2014/2015, [redacted]

Barriers/Challenges:

- The number of youth referrals to the COD program was quite low this year. Other community youth services such as Probation and YES! Court also reported low youth referral numbers. In an already small program, this translates into less group services (group therapy, skill/rehab groups and parent group) for enrolled youth, and a shift to a primary emphasis on individual modalities. The same holds true in the adult services; gender specific group services suffer. Group services overall will be even more difficult next year, as the program has been cut by 50%. This means enrollments will be low making it challenging to offer robust groups with appropriate milieu match, beyond gender specific.
- This population experiences difficulty maintaining eligibility of their Medi-Cal benefits. In FY 14/15 there appeared to be an increase in a variety of issues for COD enrolled individuals (both adults and youth). This resulted in interruptions or discontinuations of their Medi-Cal benefits, which is the only funding the program can accept. On the bright side, CoRR now has greater access to a Medi-Cal eligibility worker resource.
- Access to psychiatric services continues to be a barrier. This service type is limited in Nevada County.

Outcomes/Successes:

- The COD program served 25 unduplicated adults and 21 unduplicated youth. This is above the contractually required minimum of 26 people. Of the youth enrollment, five remain enrolled, four were successful completions, six were transferred to other services/levels of care, two moved out of the area, three withdrew, and one lost their Medi-Cal funding. Of the 25 Adults, eight remain enrolled, four successfully completed the program, four were transferred, two lost their Medi-Cal funding, two moved out of the area, and five withdrew. The evidenced based practice (EBP) model of COD treatment implemented by the program is designed to meet individuals with COD 'where they are', and services are not time limited, therefore, a 75% completion rate (achievement of treatment goals within one year) is not in alignment with the implemented COD EBP model of care.
- The program did see an increase in the speed at which some individuals moved from the pre-contemplative stage to contemplative and action stages. This improvement of individuals moving more rapidly than expected from their initial stage of change, we believe is due to the influence of the environment within which most services are delivered, and the effective level of integration with staff. The service delivery setting has been primarily a specialty substance misuse/dependence treatment facility with a continuum of treatment programs. It has increasingly become a facility fully integrated with both substance use and

mental health services and a treatment philosophy that integrates mental health and wellness in addition to medical care. All services accessed onsite.

- The program tracked data that demonstrated decreases in homelessness and increases in employment and volunteerism for individuals in the COD program. Out of three adults and one youth reporting homelessness upon intake, all ended up with housing. Three youth became employed and one started a volunteer position. Five adults became employed and one obtained a volunteer position.
- In the adult population, there were 0% incarcerations for new offenses for anyone during their enrollment in services, and only one new offense (5%) for youth. Eight youth (38%) participated in either gainful employment, volunteer work or completed community service hours. Half of the adults (50%) served during their enrollment, either became gainfully employed, did volunteer work or completed community service.
- Additionally, 18 of the 25 adults served (72%) and six of the 21 youth (29%) participated in 12 step or self-help non-treatment groups in the community during enrollment in COD. For adults and children combined, 90% reported an increase in supportive connections. Some of those supportive connections resulted in safer and more stable living environments in the community, as well as employment opportunities.
- Ninety percent of enrolled adults either reduced the use of their drug of choice or were successful in adopting a program of recovery, understanding the need for abstinence from substances. The most prevalent drugs of choice for adults were alcohol and methamphetamine. Seventy percent of youth reduced their use of substances. For those meeting the criteria for addiction, 50% were able to adopt a program of recovery and achieve abstinence. The overwhelming drug of choice for the youth population was cannabis, while alcohol was the drug associated with the highest risk factors and addiction criteria for youth.
- Families engaged in services reported anecdotally improvements in family communication, increased parenting skills, improved ability to make and follow through with parenting/family decisions that resulted in increased problem solving and stability, and changes in family configurations done proactively.

6. **<u>Expand Adult and Child Mental Health Services</u>**

Nevada County Behavioral Health (NCBH) Children's Services provided Mental Health services to 55 children with MHSA CSS funds in FY 2014/2015. Some of the children were being wrapped with Full Service Partner (FSP) providers. Some of these children continue to see NCBH staff individually and work with the WRAP team.

Demographics: [redacted]

Nevada County Behavioral Health Adult Services were expanded in FY 14/15, to provide Case Management to Auxiliary, New Directions and Healthy Outcomes Integration Team (HOIT) program participants using General System Development funds. Expansion of psychiatry services and expansion of behavioral health services within the Adult System of Care included the same

individuals. All Auxiliary, New Directions and HOIT program participants received both psychiatric and case management services.

Demographics: The program served 43 individuals [redacted]

7. MHSA funding provides a **Crisis Worker Position and Crisis Support Team** onsite at the Behavioral Health office from 8am to 5pm during normal weekday hours. Also provided is a crisis support position for afterhours including weekends and holidays, and a crisis worker position to staff the local hospital's emergency department 24 hours a day, seven days a week. These services are exclusive to western Nevada County. Funding sources used to support these Crisis Services included Medi-Cal, Senate Bill 82 Triage Grant, 1991 Realignment funds, MHSA-CSS funds.

Crisis services are provided on location at Nevada County Behavioral Health's, Crown Point facility. The crisis workers provide direct crisis intervention services to program participants by phone contact and face-to-face evaluation. Crisis staff also responded 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 may be appropriate.

Demographics: In FY 14/15 MHSA Crisis Workers served 851 unduplicated individuals. [redacted] **Note: the demographic numbers for FY 13/14 were duplicated totals.*

Barriers/Challenges:
The main barriers faced in this program were lack of acute care services for program participants requiring hospitalization, and lack of follow-up services for individuals needing outpatient and other supportive care. Persistent efforts were made to access resources from other agencies, and crisis workers continued follow-up services until the crisis events were fully stabilized.

Outcomes/Successes:
- Service provision to program participants and families resulted in referrals to other agencies or hospitalization.
- Approximately 20% of program participant evaluations resulted in hospitalization.

- Contact was maintained with individuals until the crisis was stabilized.
- Services were provided to all age groups.
- Services included brief crisis intervention to resolution.
- Services provided on site at the Crown Point facility included: Crisis Intervention; 5150 Assessment; Collateral Support; and collaboration with families, behavioral health staff, and other support providers. Consultation with law enforcement, hospital staff, and community service providers also occurred.
- Many services were provided by phone including: brief crisis support, assessment and linkage and referral services.

8. **Truckee Outreach, Engagement and Liaison** is funded under other CSS and PEI (Prevention and Early Intervention) programs.

9. **Emergency Department Crisis Peer Counselor Program (SPIRIT ED)**, has Crisis Peer Counselors (CPCs) available for 10 hours a day, 7 days a week at the Sierra Nevada Memorial Hospital Emergency Department. Providing Crisis Peer Support in the hospital emergency department (ED), following up with individuals served in the ED, supporting community members in crisis to get connected with local resources and offering continued peer support to empower individuals to reach their wellness and recovery goals are the main services provided by this program. The overall goal of the program is to reduce the number of people going to the ED in crisis, and to reduce the number of recurring ED visits. Crisis Peer Counselors and Team Leaders coordinate and collaborate closely to support each other and community members in crisis.

   Demographics: The SPIRIT ED Program served 304 people in FY 14/15. [redacted]

   Barriers/Challenges:
   - Many of those served by SPIRIT do not have a phone for staff follow up calls, or the number is disconnected. When a person with no phone shows up at the SPIRIT Center, they are connected with the Free Government Phone application.
   - Frequently individuals are unsure where they will live once they are released from the hospital, as their current home environment is not supporting them. Nevada County now has a peer centered Respite Center where guests can take time to collect themselves and access resources to help them on their path to recovery.
   - Transportation is regularly a challenge in getting individuals to doctor's appointments and to the SPIRIT office. SPIRIT gives out bus passes for those needing transportation to important appointments.
   - At this time SPIRIT does not have a tool for outcome measures, however they are being trained and attending webinars that will help them measure outcomes in the future.

   Outcomes/Successes:
   - There were 55 requests to follow up with program participants from Crisis Workers and 248 requests to follow up with program participants from CPCs in FY 14/15.

- Completed follow ups numbered 116 for the year with 40 still pending at year end. Other follow up statistics included 48 people who refused contact, 44 who would not give permission to follow up, 46 who were contacted but did not return calls and 62 who were not available by phone.
- In FY 14/15 CPC's working with individuals developed 58 Action Plans, discussed Stress Reduction Techniques with 60 people, tracked Stress Reduction Techniques used by 40 people, made 513 referrals and provided resources to 38 individuals.
- The members of the ED Team, along with SPIRIT staff and community members, were trained by Lauren Spiro in Emotional CPR (eCPR). This was a public health education program designed to teach people to assist others through an emotional crisis by three simple steps: C = Connecting, P = emPowering, and R = Revitalizing.

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

Demographics: In FY 14/15, WHV served 50 veterans and family members [redacted]

Barriers/Challenges:

- Those Veterans being treated under VA funding may now remain under that funding umbrella with their local provider. However, WHV has also determined that there are a number of Veterans in Nevada County whose trauma, although incurred in the military, was not related to being in combat. Those Veterans were, and still are, not eligible for treatment in the county through VA funding. Yet they are often just as disabled by their PTSD and other diagnoses as the combat Veteran. WHV has been adding those Veterans to the target population as funding has been available, either through pro bono services, donations, fundraising or other short-term grants. With the renewal of the MHSA/CSS contract, WHV can use some of those funds to serve those non-combat Veterans now that the VA is continuing to fund treatment for combat Veterans within the county.
- There is still a pressing need to continue treatment of families of those Veterans who have PTSD, a need which has been met in the past by the MHSA/INN contract. That contract expired last year, and is not renewable, nor is there MHSA funding in another category with which to continue this program. Fortunately, NCBH has allowed a slight change in the wording of the CSS contract which has allowed family members as well as Veterans to be treated. Even though combat Veterans are now funded through the VA, the current amount of the CSS contract is not sufficient to fully cover treatment of families and of non-combat Veterans. Several WHV therapists are currently providing up to 40% of covered therapy on a

pro bono basis. WHV continues to seek other funding sources to cover this population, and are grateful for the County's investment in the mental health of Veterans and their families.
- As the WHV outreach numbers grow, the need for fundraising/new grants grows as well, since costs to provide services increase accordingly.

Outcomes/Successes:
- WHV provided a total of 117 group therapy sessions paid for by CSS funds. Therapists provided a further 51 sessions to WHV program participants on a pro bono basis. WHV Licensed Clinical Psychologists (LCP) provided 127 individual sessions funded by CSS, as well as donating 41 pro bono individual sessions. WHV Licensed Marriage and Family Therapists (LMFT) provided 143 individual therapy sessions funded by CSS, as well as donating 107 pro bono sessions. This emphasis on individual therapy reflects their ongoing attempt to move program participants to peer-led group sessions where feasible and appropriate, allowing WHV to focus resources on the most urgently needed services.
- WHV has been successful in reaching more Veterans in FY 14/15 than in the previous year.
- In addition, WHV has been gradually transitioning many of their longer-term program participants to a recovery model which features peer-facilitated support groups in place of therapist-led support. This model fits the needs of this chronically disabled population quite well. As program participants begin to achieve some of the goals they set, especially goals in the area of relationships with others, they become less dependent on the paid therapist and are able to engage in more social activities with peers – something many have not done since leaving the military. This model also allows WHV to allocate scarce resources to newer program participants who need therapist-led treatment.
- The year from July 2014 through June 2015 was WHV's first full year of Outreach & Engagement. The Outreach Coordinator reported almost 900 new contacts with Veterans throughout the year. Many of these Veterans are helped by WHV in ways additional to therapy, for example; help processing claims with the Department of Veteran's Affairs, referring Veterans to other agencies to help in locating the services they need, and even help with mundane issues such as a new appliance. During the year, relationships have been established with all local law enforcement agencies, local community agencies, Sierra College, and most local non-profits that work with Veterans. As a result of these collaborations, Welcome Home Vets has been able to exchange referrals with these agencies on behalf of mutual populations.

11. **Housing and Supportive Services to the Severely Mentally Ill Homeless** was provided through the MHSA Housing program, the Roseville/Rocklin/Placer-Nevada Continuum of Care; the lead agency identified as administrator is the Homeless Resource Council of the Sierras (HRCS) and the Nevada County Coordinating Council (NCCC) to End Homelessness.

MHSA Housing includes:
Housing Choice Vouchers (HCV) (formally known as Section 8): The Housing Choice Vouchers list opened last fiscal year. The Personal Service Coordinators from Behavioral Health and contracted service providers helped program participants complete the HCV Pre-Application form. Many of Behavioral Health and contracted service providers program participants were placed on the Housing Choice Voucher wait list. During FY 14/15 Personal Service Coordinators assisted individuals on the wait list to secure additional required documents to verify what they had put on the HCV Pre-Application form, complete the rest of the HCV Application, look for and secured housing that could be used by a voucher and move into their new homes.

Second MHSA House: Nevada County Housing Development Corporation (NCHDC) entered into escrow for a second MHSA funded house. Escrow was to close in August 2014, but due to NIMBY (Not in My Back Yard) issues with 46 neighbors, the escrow did not close and the home was not purchased.

Nevada County Housing Development Corporation (NCHDC): A landlord that remodeled a large Victorian home into nine apartments approached the County to master lease the whole building from him. The County has partnered with NCHDC, to master lease the building and sub-lease the apartments to Behavioral Health program participants.

Winters' Haven: NCHDC purchased a five bedroom house in Grass Valley in October 2011. They renovated the house in FY 2011/2012. The first tenants moved into the House in December 2012 and by June 2013 the house was full with five tenants.

For FY 14/15 there were six tenants in the house. One person left the house mid-year for another permanent supported housing opportunity and another person moved in. [redacted] Three individuals came from Emergency Shelters; two came from a place not meant for habitation and one person transferred over from another housing program. All six tenants had a source of income at the end of the fiscal year, [redacted] Lastly, all six tenants were housed for six months or longer.

Winters' Haven had its second California Housing Finance Agency (CalHFA) housing inspection and the inspection resulted in no negative findings.

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

In FY 14/15 the SHP vouchers were utilized by 18 households consisting of 21 individuals. [redacted] Most of the tenants had physical or mental health conditions: [redacted] The Residence prior to program entry varied: four from emergency shelters, 14 from a place not meant for habitation, and two from another permanent supportive housing program. [redacted] All households had a source of income except three. Sources of income included earned income, SSI, SSDI and General Assistance. The only individual to leave the program passed away during the fiscal year. The average length of stay for the tenants was 541 days. Of the 21 adult program participants 20 were enrolled in the program for at least 6 months (housing stability measure).

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

Home Anew: The Behavioral Health Department submitted an application to HUD for three additional Permanent Supportive Housing grant vouchers for chronically homeless individuals with a serious mental health condition in FY 13/14. The Behavioral Health Department was awarded the grant for $20,270 for two vouchers in FY 14/15.

In FY 14/15 the Home Anew vouchers were utilized by two households consisting of one individual each; [redacted] The program started less than six months ago so cannot measure housing stability yet.

Homeless Count January 26, 2015: A Homeless Count was conducted on the night of January 26, 2015 for individuals in Emergency shelters (sheltered) and people living outside, in cars, and in places not meant for human habitation (unsheltered). A Homeless Connect Event happened on January 27th. At the Homeless Connect Event the homeless participants were surveys on where they slept on the night of January 26th. At the Homeless Connect Event food, warm clothing, entertainment, and support from local businesses and community based organizations were provided. A street count was also conducted and individuals who did not come to the Homeless Connect Event were asked to complete the survey.

Below are some of the results of the survey:

- A total of 279 individuals were homeless, 101 were in shelters and 178 were unsheltered.
  - Two hundred and eleven households were homeless, 71 were in shelters and 140 were unsheltered.
  - Forty-two children under the age of 18 were homeless, 25 were in shelters and 17 were unsheltered.
  - Thirty-one young adults (18-24) were homeless, six were in shelters and 25 were unsheltered.
  - Twenty-one people 60 years or older were homeless, eight were in shelters and 13 were unsheltered.
  - One hundred and eighty-five individuals were between the ages of 25-59, 62 of these were sheltered and 123 were unsheltered.
- Ninety-two females (33%) were homeless and 187 (67%) males were homeless.
- Length of time in Nevada County: More than five years = 59.9%; 1-5 years = 15.6%; and less than a year = 24.5%.
- What is the main reason you live here: have family or friends here = 46.4%; originally from here/grew up in the area = 24.6%; job opportunities/employment 7.7%; attended school here = 3.3%; all other responses (other, just passing through, better social services, legal issues) = 17.9%.
- Chronically Homeless individuals (homeless for a year or longer or homeless four times in three years) = 109, 33 sheltered and 76 unsheltered.
- Homeless Veterans = 22: three were females and 19 were males; eight sheltered and 14 unsheltered; 14 were chronically homeless veterans.
- Disabilities (individuals self-identified whether they had a disabling condition and if it severely interfered with their life): Individuals could mark that they had more than one condition.

  - Chronic Depression, Post-Traumatic Stress Disorder and Serious Mental Health Issues = 50.6%; Substance Use = 28.5%; Development Disability = 11%, Traumatic brain injury = 9.3%, Chronic health condition = 22.8%, Physical Disability = 19%.
- Ninety-one adults or 38.4% of participants said they had experienced dangerous or violent situations (including domestic violence, sexual assault, stalking, or dating violence) at some time in their life.
- Twenty-four adults or 10% said of participants said they had lived in a foster home or a group home.
- 50.3% of households reported no income; 15.2% reported Social Security income; 10% reported CalWORKs; 9.3 % reported General Assistance income; and Other Sources (other, family and friends, unemployment and Child Support) were reported by 17.9%.
- Un-obtained Service Needs (individuals could make more than one service need request): Supported Housing/vouchers = 58.1%; Dental/vision = 41.9%; Transportation = 41.9%; Financial Assistance = 39.5%; Mental Health services/counselling = 33.7%; Emergency shelter = 31.4%; Food = 25.6%; Legal = 20.9%; Job Training = 20.9%; Drug and alcohol services = 14%.

In order to apply for and receive Homeless Continuum of Care (CoC) funding, the United States Department of Housing and Urban Development (HUD) requires that a community establish an effective Homeless Continuum of Care. Nevada County is a member of the **Roseville/Rocklin/Placer-Nevada Continuum of Care;** the lead agency identified as administrator is the **Homeless Resource Council of the Sierras (HRCS).** The **Nevada County Coordinating Council (NCCC) to End Homelessness** is one of three regional groups that provide feedback, support and information to the HRCS for planning and collaboration purposes. The other two regional groups are located in Tahoe-Truckee and in western Placer County. The Behavioral Health Department is an active member of the HRCS and the NCCC.

Outcomes/Successes: MHSA funds were used to help fund the HRCS Coordinator position. The HRCS Coordinator in FY 14/15 completed the following:

- Developed the HUD Homeless Assistance applications that were submitted to HUD in October 2014. The Coordinator assisted the Nevada County project applicants in the development of their applications.
  - Summer's Haven: This permanent supportive housing program is funded annually at $110,841 to provide 13 housing units for individuals with severe mental illness enrolled in an MHSA Full Service Partnership program.
  - Homelessness Management Information System (HMIS): The HMIS Lead Agency and The Salvation Army Grass Valley Corps submitted two proposals to fund a full-time HMIS Systems Operator for the HRCS and to purchase user licenses. An applicant must be using HMIS to receive HUD Homeless Assistance funds or Emergency Solutions Grant funds.
- Coordinated the application, evaluation and Annual Progress Report process for the HRCS's 14 HUD grants that annually total $1,200,571.
- For the December 2014 round of Emergency Solution Grant (ESG) funding, the California Department of Housing and Community Development required that the CoCs assign up to 100 Need Points to each applicant. However, the points assigned to each application needed to be at least five points apart. The Coordinator facilitated the process to develop an unbiased HRCS Committee to review the ESG applications and assign points. Five Nevada County ESG applications were reviewed. Four applications from Nevada County were funded:
  - Hospitality House was awarded two grants for a total of $400,000.

  - The Salvation Army was awarded two grants for a total of $190,515.
- Conducted the January 2015 Sheltered and Unsheltered Homeless Count and Housing Inventory Chart.
- Facilitated the following HRCS-wide committees/task forces:
  - Nevada-Placer Governance Committee
  - Grant Evaluation Committee
  - Homeless Count Coordinating Committees
  - Coordinated Assessment

Outreach and Engagement:

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

   Demographics: NAMI served 97 individuals in FY14/15. [redacted]

   Barriers/Challenges: The Peer-to-Peer and NAMI Basics programs were not offered due to instructor issues.

   Outcomes/Successes:
   - In FY 14/15 NAMI provided educational information regarding their resources to members of the Unitarian Universalist Community of the Mountains Church (UUCC). This set the foundation for building a relationship which resulted in bringing the Inside Mental Illness program to the church in the subsequent fiscal year. NAMI members are members of the UUCC congregation, so in working with the UUCC leadership, NAMI was granted access to the congregation. The leadership was welcoming and open to this collaboration.
   - Inside Mental Illness training with Community Legal Inc. resulted in NAMI being asked to formalize a community partnership agreement to provide quarterly trainings to Community Legal's constituency. Community Legal training was attended by attorneys and mediators. This session included information about mental illnesses, communication strategies to use when individuals are struggling, Our Voices Matter perspectives and linkage to community resources. The training was presented on June 23, 2015 by four program participants/family members and addressed personal experiences as well as providing information to 24 attendees.

- NAMI Family to Family Educational (evidenced based) program comprised of 12 weekly sessions for family members of individuals with mental illnesses was provided. The class filled quickly after conducting outreach through NAMI membership, support programs and The Union Newspaper. The Family to Family program was held from January 15, 2015 through April 2, 2015 and 17 people were enrolled for the 12 week course.

2. **Full Service Partnership Agencies and Other Contract CSS Service Providers** conducted outreach and engagement services throughout the fiscal year. These services were done for individuals, families, and other stakeholders through Turning Point, New Directions, Victor, EMQ, Welcome Home Vets and Sierra Family Medical Center. Outreach and engagement activities were provided to 1,741 individuals in FY 14/15. This number does not include services provided by the individual programs listed separately in this section of the report.

3. **SPIRIT Peer Empowerment Center (SPIRIT)** serves visitors 18 years and older. The program serves people with severe, moderate and mild mental illness including the homeless population, offering 13 different support groups. These groups cover topics such as: Dual Diagnoses, WRAP (Wellness Recovery Action Plan), Bi-polar Group, Men's Group, Women's Group, LGBTQ Group, Peer Support, Group Facilitation and Basic Computer 101 Group.

   Demographics: In FY 14/15, SPIRIT Center served 696 individuals [redacted]

   Barriers/Challenges: It has been difficult to penetrate the community with the SPIRIT message. SPIRIT is getting more articles in the newspaper and is planning a campaign to work with doctors in the community showing them how SPIRIT can be a resource for their patients. At this time SPIRIT does not have a tool that is used for outcome measurement, however staff are attending trainings and webinars that will help them to measure outcomes in the future.

   Outcomes/Successes:
   - In FY 14/15 SPIRIT Center provided a total of 5,301 services.
   - SPIRIT Center provided Peer Counseling in the isolated community of North San Juan (NSJ). Peers either met individuals at the Resource Center in NSJ or at the individual's home. [redacted] unduplicated program participants were served in NSJ in FY 14/15. This service was provided by two of SPIRIT's NSJ local Peer Counselors. They are husband and wife and have lived in the community for years so they know the culture in NSJ well. A SPIRIT board member does additional outreach in NSJ.
   - Offering group support and one-on-one peer support has helped individuals to get well and reach out for support to other community resources. SPIRIT provided 696 unduplicated services in FY 14/15 including 655 Peer Support visits. SPIRIT groups were accessed 1,280 times in the year.
   - SPIRIT supports the homeless population by supplying showers and laundry facilities. This enables the homeless to be presentable when they go out and look for employment. Showers were accessed 244 times and the laundry facility was used 99 times in FY 14/15.

- Serving a hot lunch on Saturdays has helped individuals socialize and break free from their isolation. SPIRIT provided 806 bags of food and 1,040 Saturday brunches in FY 14/15.
- SPIRIT tracked 5,662 volunteer hours and were open a total of 1,309.50 hours in FY 14/15.
- SPIRIT Center is an active participant in the MHSA Steering Committee and Innovation Subcommittee, CoC, Cultural Competency/WET as well as, NAMI, Forensic Task Force, Suicide Prevention Task Force and Mental Health Board.

Prevention and Early Intervention (PEI): Access to Services

Activity 1: Suicide Prevention Intervention (SPI) Program

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

- Gay-Straight Alliance (GSA) Leadership Summit: Sponsored by Parents and Family of Lesbian and Gay (PFLAG) of Grass Valley, this event is an opportunity for high school and college students and staff to meet, network, and participate in workshops designed to help everyone better understand and advocate for Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) students
- Sources of Strength (SoS) Peer Leaders
- Tahoe Truckee Suicide Prevention Coalition (TTSPC) Steering Committee
- Know The Signs (KTS) Media Forum: Responsible suicide reporting and do no harm media messaging. 5,000 by 2015! Campaign.
- Youth Mental Health First Aid (YMHFA) Train-the-Trainer Workshops: Certified Instructor Workshops.
- Applied Suicide Intervention Skills Training (ASIST) Workshop: Two days
- Crisis Response (Tahoe Truckee)
  - Multi-County Health Officer Health Alert Letter – Formal announcement to heighten health care providers awareness of vulnerable patients seeking help services – Lake Region (El Dorado, Tahoe & Truckee).
  - Tahoe – In March & April, several suicide deaths occurred within a small geographical area. The lake community was stunned and grief stricken.
  - Greif Workshop / Parent & Community Forum – North Tahoe

Demographics: In FY 14/15 the SPI Program served 1,750 individuals. [redacted]

Barriers/Challenges:

- MHFA Workshops: Several adult workshops were canceled due to low registration numbers. Staffing changes impacted promotion efforts. Slight variations between MHFA & YMHFA may cannibalize the limited market for this workshop. Maintaining instructors is cumbersome especially when workshops do not fill and classes are cancelled.
- Multiple suicides weigh heavily on the community and community leaders. Grief, fears of contagion and clusters, as well as feelings of overwhelm, exhaustion and caregiver fatigue are present among stakeholders.

Solutions to Barriers:

- MHFA Workshops: Secure training space a year in advance. Develop MHFA/YMHFA workshop flyer for dissemination. Announce workshops many months in advance via NCBH e-list serves. Consult with MHFA-USA about difficulties maintaining dual training statuses in MHFA & YMHFA.
- Multiple suicides: Outreach to KTS State Representatives for rural community response strategies. Strengthen bi-county ties and promote self-care for the Tahoe Truckee community and especially for the TTSPC steering committee members.

Outcomes/Successes:

- GSA Leadership Summit: Forty LGBTQ regional youth attended, ages 18-24.
- Sources of Strength Peer Leaders promoted connectivity, school bonding, peer-adult partnerships, and help-seeking behaviors.
- Tahoe Truckee Suicide Prevention Coalition hired an Outreach Facilitator (10 hrs. /wk.) with areas of focus, 1. Awareness, 2. Access to Care, 3. Stigma Reduction, 4. Advocate & Disseminate Healthy Supports.
    - Maintained email contact data base for Youth Suicide Prevention Coalition.
    - Supported monthly Youth Suicide Prevention Task Force Steering Committee meetings.
    - Spearheaded the Know the Signs Campaign and provided related training to local community groups.
    - Assisted with planning and advertising quarterly Youth Suicide Prevention Coalition Meetings.
    - Developed Tahoe Truckee Suicide Prevention page on the Truckee Tahoe Unified School District website.
    - Established a relationship with the Sierra Sun newspaper to submit monthly articles for publication, focusing on stigma reduction and mental health and wellness.
- KTS endeavored to reach 5,000 people by 2015 (5,000 by 2015!). Over 4,000 received a face-to-face KTS in-service training in Truckee.
- Approximately 120 Nevada Joint Union High School District Non-Classified Staff were trained in YMHFA.
- Approximately 92 people were trained in MHFA including Sierra Community College.
- ASIST workshops were provided in Grass Valley and Tahoe Truckee. Forty-five people were trained in suicide intervention skills, including Nevada County Crisis workers.
- SoS Bear River High School (BRHS) SuicideTALK gave an hour and a half presentation to SoS Peer Leaders. SuicideTALK encourages open and direct talk about suicide.
- SoS BRHS and BRHS GSA co-sponsored an educational performance at a school assembly called “Dis/Connected” by New Conservatory Theater. “Dis/Connected” looks at the dynamics of friendship, peer pressure, diversity, labeling, stereotypes, harassment, and growing up in this highly technological age. (200 students)

- Community Outreach, Counseling, Support and Education in Tahoe Truckee: Community meetings, a multi-county Public Health Officer letter, media stories of resiliency, letters to the editor about living with mental health illness - especially depression, guest speakers on suicide, death, and grief, how to talk to your kids, and the psychology of happiness and resiliency are some of the topics that were covered in FY 14/15.
- Greif Workshop/Parent & Community Forum in North Tahoe: Supporting Ourselves and Our Children in Difficult Times, a community discussion about mental health and community resources was held. Speakers addressed topics ranging from how to talk to your children about suicide to depression, to self-care during grief and sadness. The workshop featured Dr. Kim Bateman, Jackie Hurt-Coppola and a panel of community mental health experts. (200 people attended)
- Mental Health in the Mountains: A six session educational series on mental health was held in Tahoe Truckee. Sponsors included Youth Suicide Prevention Coalition, Tahoe Forest Health System's Wellness Neighborhood, North Tahoe Family Resource Center, Family Resource Center of Truckee, Tahoe Truckee Unified School District, UC Davis Tahoe Environmental Research Center, Sierra College and the Community Collaborative of Tahoe Truckee. The first session, held in Tahoe City was on The Science of Happiness and included a lecture, Q&A, and a Screening of the film "Happy". This program focused on positive psychology and building up resiliency.
- Crisis Response (Tahoe): A regional approach to working closely with local governments and Health Officers in El Dorado, Placer and Nevada counties was provided. This activity was provided to alert, without alarming, health care providers, including mental health professionals, about supporting our most vulnerable community members.

Activity 2: Integrated Behavioral Health (IBH) Training for Primary Medical Care Providers – No activity in FY 14/15. Plans are being made to remove this from the plan.

Activity 3: First Responder Training

Mental Health First Aid (MHFA) Training is an evidence based, community proven training provided to first responders. "First Responders" may respond to an individual in crisis in their home, on the streets, at school, on the job, at church, etc. "First Responders" are often the facilitators of mental health services for people in the community. The MHFA Training provided increased first responder's ability to care for and properly refer individuals who may not otherwise receive mental health services. In fiscal year 2014/2015 two Law Enforcement and two Adult focused Mental Health First Aid Trainings were held. A total of 52 individuals were trained.

First Responder Training - Crisis Intervention Training (CIT) is provided to patrol officers, correctional staff and juvenile hall staff who may work with mentally ill individuals in crisis. The intent is to increase knowledge and skill levels in this area. During fiscal year 2014/2015, eight separate Crisis Intervention Trainings were provided to 117 attendees in Nevada County.

Trainings focus on understanding and working with high risk program participants who encounter law enforcement frequently or during intense events, while incarcerated or on the street. Emphasis is on effective response to deescalating agitation and reducing risk of injury to individuals and first responders. Other focal points in the training are on conducting more accurate field evaluations of suicide risk and identifying acute symptoms. Resources and referral options are also provided to trainees. Trainings are conducted by a licensed mental health professional,

teamed with a law enforcement instructor. Peace Officer Standards and Training (POST) hours are provided to the sworn officers.

Demographics: All 117 individuals served were [redacted] Trainings were provided to 25 juvenile hall and correctional staff. Other trainings were provided to 92 sheriff's department patrol and correctional staff.

Barriers/Challenges: Organizing training times to meet law enforcement shift work and mandatory existing training schedules was challenging. Arranging and accessing training facilities and preparing materials and presentations to meet specific training requests was also at times demanding.

Solutions to Barriers: Working with training providers, law enforcement administration and training officers was helpful in overcoming barriers. Providing consistent efforts to interject Crisis Intervention Training into administrative scheduling, as well as allowing adequate time for training preparation has also been beneficial.

Outcomes/Successes:

- The program reduced fear and anxiousness and increased knowledge and skills for training participants.
- Participants learned the basics of mental illness.
- Individuals trained have more skills in de-escalating a crisis.
- Participants learned how to avoid injuries to themselves and others.
- Trainees learned to recognize the signs of mental health distress.
- Training results in avoidance of participant deaths (suicide prevention).
- Staff were trained about referrals and how to link mentally ill individuals to appropriate resources.
- Further requests for additional trainings were received.
- Training was provided to over 100 individuals in formal training events.
- Training plans for future first responder events were established.

Activity 4: Nevada County 2-1-1

2-1-1 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. 2-1-1 Nevada County serves the entire population of Nevada County. By dialing 2-1-1 Nevada County residents can access health information, community services, and disaster services throughout Nevada County. This program offers assistance in multiple languages, and is accessible to people with disabilities. Utilizing a comprehensive computerized database of more than 1,282 nonprofit and public agencies at 1,739 different locations in Nevada County, trained information and referral specialists give personalized attention to each caller. Specialists can refer callers to a variety of services to best meet their needs.

On July 1, 2014 2-1-1 Nevada County began taking calls locally on a 24-hours-a-day, 365-days-a-year basis. Prior to that date, 2-1-1 Nevada County contracted with 2-1-1 Sacramento to handle calls after regular business hours. During this fiscal year, total call volume increased by 76% over the prior year. Increased call volume can also be attributed to specialized programs such as screening callers for emergency assistance services and providing CalFresh outreach and

education. 2-1-1 Nevada County's 2014/15 web search totals were up more than 44% from the prior year. People in search of resources can also contact 2-1-1 Nevada County through instant messaging on the website or by texting their zip code to TXT211.

Demographics: Of the 7,292 calls answered, [redacted]

Barriers/Challenges: Callers experiencing homelessness or on the verge of homelessness report high levels of stress, anxiety and agitation. A lack of sufficient affordable housing, both emergency and long-term, frequently presents challenges to call agents when they are unable to provide referrals to assist individuals with fulfilling this basic need.

Call agents are sometimes challenged with serving the needs of callers who may appear to be in need of behavioral health services, but aren't specifically seeking this type of referral. Instead they may be seeking other solutions to a web of problems they report. Although 2-1-1 Nevada County doesn't receive many suicidal callers, such calls do have the potential for raising the stress level for call agents during these brief, emotionally intense calls.

Solutions to Barriers: Training for call agents is being secured to better prepare them for handling behavioral health crisis calls, including suicidal callers. This will increase call agents' confidence in handling these calls and reduce their stress levels. The call center manager attended QPR (Question, Persuade, Refer) training and has been a resource to agents on this subject. The Resource Specialist recently attended Mental Health First Aid training. In addition, staff will be attending the safeTALK training in August and future offerings of Mental Health First Aid.

Outcomes/Successes:

- The total number of service calls as they relate to MHSA Prevention and Early Intervention in FY 14/15 were 7,292.
- In addition 105,555 web searches were conducted by individuals on the 2-1-1 Nevada County website.
- A total of 11,673 behavioral health resources were accessed by callers and web users during this period.
- At the conclusion of each call, the call agent requests that the caller call back if the referral(s) received doesn't work out for him or her, so additional referrals may be made.
- A warm hand-off option was instituted this year and is routinely offered to callers to directly connect them with the resources needed. Behavioral health crisis calls are always warm transferred to a crisis line. Non-crisis callers appreciate the ease of connection this affords. Those who struggle to navigate automated phone menu options also appreciate the additional customer service received from 2-1-1 through the warm transfer option. During the past year, callers accepted offers of warm transfers 697 times.
- Because there is no charge to dial 2-1-1 from a pay phone, callers are able to access 2-1-1 and can then request transfer directly to county Social Services or Behavioral Health.

- Call Agents made 84 follow up calls to individuals this year.
- Through telephone calls, web searches on 211nevadacounty.org, instant messaging and texting, 2-1-1 Nevada County program participants and agencies seeking services for individuals received referrals to behavioral health services at any time, day or night, 365 days a year.
- The primary resources most searched for by 2-1-1 Nevada County users during the year were Housing & Shelter (1,343 calls and 20,869 web searches), Aging & Disability Resources (722 calls and 16,199 web searches), and Medical Services (740 calls and 12,088 web searches).
- 2-1-1 Nevada County provided a total of 11,673 resources to individuals requesting Behavioral Health services as follows:
    - Counseling Services – 3,840 referrals
    - Substance Use – 3,041 referrals
    - Support Groups – 2,936 referrals
    - Domestic Violence Services – 1,463 referrals
    - Crisis Hotline – 393 referrals
- Healthcare referrals provided by 2-1-1 in FY 14/15 were as follows:
    - Clinics & Hospitals – 6,419
    - Personal Care – 1,924
    - Pharmacy – 1,525
    - Physician – 1,245
    - Public Health – 817
    - Insurance – 763
    - Vision – 683

Prevention and Early Intervention: Outreach Projects

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

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

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

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

The Friendly Visitor Program impacts the community in three distinct ways: 1) It brings members of the community to an individual, reducing isolation and improving mental health; 2) It mitigates and prevents, in many instances, the reliance on more costly services and complements other mental health programs such as the Senior Outreach Nurse by providing social contact and; 3) It

connects individuals who are isolated and at risk of depression, anxiety, and suicide to other mental health and community services so that they can remain living safely in the community.

Referrals are received through a variety of agencies and family members. The Friendly Visitor Coordinator meets with the program participants in their home and gets to know their needs and interests, and then matches them with an available volunteer. All volunteers have completed applications, interviews, back-ground and reference checks and are expected to spend a minimum of an hour a week visiting with their matched program participants. Many volunteers spend several more hours each week then is mandated. Volunteers attend an orientation on consumer-centered services as well as regular monthly trainings and volunteer support groups.

Demographics: In fiscal year 2014/2015, 43 unduplicated program participants received services.

[redacted]

Barriers/Challenges: Monthly volunteer support groups and trainings were poorly attended.

Solutions to Barriers: Monthly meeting going forward will be held on a regular day and time based high attendance last year, the fourth Tuesday of each month. This should help reduce scheduling conflicts.

Outcomes/Successes:
Program participants:
- There were 43 volunteer- program participants matches made.
- There were 76 individuals served.
- There were 957 home visits made.
- There were 118 phone calls made.
- There were 1,430 hours of in-home visitation.
- The consumer survey reported:
  - 85% of program participants contacted, participated in the survey.
  - 100% of respondents felt their quality of life had improved because of the visits.
  - 100% indicated that they felt less depressed due to receiving visits.
  - 95% said that they felt less anxiety because of the weekly visits.

Volunteers and Volunteer Training:
- Volunteers are interviewed and have reference and background checks and are given orientation training.
- This year, 46 active volunteers participated in the program.
- There were six volunteers in the Truckee area, but no program participant referrals for the program in Truckee. Some of the Truckee area program participants may live in Placer County and be receiving services there, while others may require a Spanish speaking volunteer. Some Truckee area volunteers are willing to be matched with western Nevada County program participants.
- Monthly Volunteer Support Group Meetings were held.
- FREED provided four group trainings to volunteers in FY 14/15. Topics covered included:
  - Companioning Skills
  - Depression Among Older Adults
  - Older Adults and Substance Use

  - Hoarding
  - Suicide Prevention
  - Honoring Memories
  - Workshop on serving people with disabilities, seniors and the low- income population.
  - Workshop on the new managed care Medi-Cal Program.
- The volunteer survey reported:
  - 66% of volunteers contacted, participated in the survey. Rate was low due to several pre-scheduled vacations.
  - 95% of volunteers felt that the quality of their life improved by participating in the program.
  - 95% of volunteers felt comfortable talking directly about depression with the person they visited.
  - 100% of volunteers felt comfortable talking directly about anxiety with the person they visited.
  - 90% of volunteers felt comfortable talking directly about suicide with the person they visited.

Focus for Fiscal Year 2015-2016:

- The Friendly Visitor program would like to shift focus to younger people who have disabilities and are socially isolated. Staff is working closely with [redacted] Special Ed teachers at the high school level who have students who are at least 18 years old.
- Another goal is to successfully provide support groups and ongoing training for volunteers, rotating on different days/times to accommodate different schedules.
- The program would like to offer more Peer Support groups for program participants at FREED.

***Social Outreach Nurse Program*:** This program is funded by the Mental Health Services Act, working with the Falls Prevention Coalition as a component of the Prevention and Early Intervention (PEI) Program. The program is in its sixth year and continues to be recognized as an important resource that benefits the senior and disabled populations in the local community.

The Social Outreach Nurses do a Mental Health/PEI Screening on all new program participants unless the individual has dementia. They also visit seniors and disabled adults primarily in their homes, where the vast majority live alone. Some of the many challenges they are dealing with are: isolation, loss of independence, grief, declining health issues, limited financial resources and family conflicts.

The Social Outreach Nurse assesses for depression, anxiety, and fall risk while building rapport with the individuals. Part of the depression assessment may include a Geriatric Depression Scale (Yesavage). The nurse provides support by listening, advocating and making referrals to various public and private services. The number of visits and phone contacts vary with each person based on need. Follow up "check in" calls are frequently done and the participants are always encouraged to call if any needs arise. Program participants sometimes call after several months when they need assistance, circumstances change or they need someone to talk to.

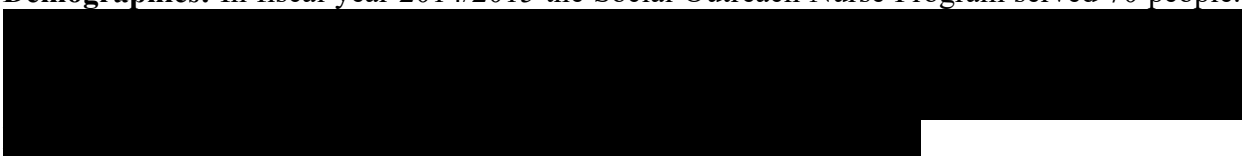
An integral part of this program is Outreach. This happens through networking with other individuals and organizations. This year the Social Outreach Program initiated a monthly presentation at a senior apartment complex. Each month a different topic, chosen by the residents, was presented by various guest speakers. Topics included, Aging - What to Expect and Resources

Available, Advance Directives, Assisted Living and Caregiver Options, and next month's presentation will be on the In-Home Supportive Services (IHSS) and Adult Protective Services (APS) programs presented by County Social Workers. These Presentations have been very well received as they not only provide valuable information and opportunities for questions and answers, but they also bring neighbors together.

As part of the on-going Outreach and Education the Social Outreach Nurses attend meetings, trainings, seminars and workshops.

- Meetings: Falls Prevention Coalition, Adult Services Unit Meetings, Social Outreach Nurse's Meeting, Elder Care Provider's Coalition (ECPC), Community Networking Meetings, MHSA Steering Committee, Truckee Community Collaborative Meetings.
- Presentations: Grass Valley Ladies Relief Luncheon, Beginning in the 40, conducted monthly Presentations at a Low Income, Apartment Building for residents on various topics around aging and resources available.
- In-services/Classes Attended: HIPAA Training, Child Abuse Mandatory Training, Hospice Liaison Donna Brown, Healing Journey's at Sierra Nevada Memorial Hospital, Six Week Stress Management class with Marge Kaiser MA CHT through IHSS.
- Seminars/Trainings: SBIRT - Screening, Brief Intervention and Referral for Treatment and Motivational Interviewing, ASIST - Applied Suicide Intervention Skills Training, PESI - Hoarding Disorder, ECPC The Caregiver's Journey Continues … Alzheimer Conference.
- Online Trainings: UC Davis Extension: Civil Rights Division 21- Nevada County 2015.

Demographics: In fiscal year 2014/2015 the Social Outreach Nurse Program served 70 people.



Barriers/Challenges: The lack of available psychiatrists in the local area is a challenge.

Solutions to Barriers: This program utilizes Licensed Clinical Social Workers who, in some cases are able to make home visits. This is a tremendous benefit that reaches program participants that would not have access to therapeutic services otherwise.

Outcomes/Successes:

- There were 70 individuals served in FY 14/15.
- This fiscal year the nurses screened 137 program participants and referred 21 to the Social Outreach Program. Other referrals came from Adult Protective Services, Social Workers from Sierra Nevada Memorial Hospital and Home Care Agencies, FREED, In Home Supportive Services, Public Authority, as well as families and individuals themselves.
- 100% of the individuals served were under the care of a primary physician and were seen within the past year. Many were being followed by specialists as well.
- There were 26 Geriatric Depression Scale (Yesavage) screenings done;
    - Two of the participants were within the normal range; four indicated moderate to severe depression and the remaining had mild depression.
    - Two who indicated moderate to severe depression, with increased socialization and counseling were later screened again and indicated mild depression.
    - One participant continues to have moderate depression as a result of numerous challenges. She is currently responding to counseling and making changes in her life.

  - The fourth person who indicated moderate to severe depression did not have a follow up screening but did verbalize that he is doing better and declined various referrals.
- Most of the program participants whose general well-being improved were utilizing various resources, including counseling, Friendly Visitor Program, and/or Caregivers.
- Improvement was also seen in individuals who were working on family relationships and who had increased socialization.
- The response from the six participant surveys returned indicated:
  - 100% benefited emotionally from the social visit
  - 100% looked forward to the visits
  - 100% would recommend the program to a friend
  - The referrals that program participants said they benefited from included: counseling, Social Outreach Nurse, Friendly Visitor, Falls Prevention Event, IHSS, Meals on Wheels (MOW), Domestic Violence and Sexual Assault Coalition (DVSAC), and Primary Care Physician.

Activity 2: Latino Outreach

Latino Outreach:

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

In FY 14/15 the program conducted psycho-educational meetings to increase knowledge and reduce stigma related to mental health. Family Resource Center Promotora staff facilitates the use of appropriate community resources by helping with translation, scheduling appointments, and initiating referrals. Staff collaborated with local community agencies to translate services for participants.

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

Western County Demographics: In FY 14/15 NCBH's Latino Outreach therapists served 19 people in Grass Valley. [redacted]

In FY 14/15 NCSOS's Latino Outreach program served 234 individuals. [redacted]

[redacted]

Barriers/Challenges:

- There is still a language barrier for participants to access and integrate into the educational and health care systems. Mental health still has a negative cultural connotation.
- Many participants don't know about health care resources, and those that do may have difficulty accessing resources.
- Outreaching to new audiences, as well as gathering and maintaining the interest in discussing mental health disorders with the existing audience is challenging.

Solutions to Barriers:

- Staff make the psycho-educational meetings attractive by addressing how lifestyle impacts mental health. i.e., diabetes and mood, exercise and depression, or they present the meetings as a prescription for wellness.
- The program finds Spanish speaking professionals to present mental health topics.
- The team stays up-to-date on trends in healthy lifestyle and pairs them with mental health.
- Staff serve the community through translation, applications, information, and referrals.

Western County Outcomes/Successes:

- The Exercise Club is self-sustaining, meeting bi-weekly with five to ten members. The Promotora met with the club six times in "Sanamente Conversation Starters" in FY 14/15.
- The Latino community rallied to collect food for two refugee families not eligible for any aid.
- The Partners Family Resource Center provided 177 services this year.
- Psycho-educational meetings were held 26 times with a total attendance of 206, excluding children. Sixteen participants in the groups or individually made WRAP plans in three sessions, meeting 13 times.
- Knowledge of the symptoms of depression, anxiety and mania were increased. A meeting on Food and Mood dealt with depression, nutrition and diabetes. Several meetings dealt with anxiety and stress reduction through the practice of Yoga. Another meeting dealt with stress and anxiety relating to child abuse. Not only did these meetings increase the participants' knowledge, but also their comfort level in speaking and sharing their concerns about these issues. A post-test response from one participant in the Yoga meeting was: "This has helped me relax and reduce back pain due to stress." Another said: "I can sleep better".
- There was an increase in knowledge of substance use and treatment resources available in Nevada County. During the meetings there is time for announcements when the availability of treatment and resources is advertised. At large meetings, a resources sheet and blank cards are passed out. Requests for referrals are left in a slotted box for discretion. People feel comfortable to share their concerns about alcohol abuse in the community and/or in their families with the Promotora. One person felt so comfortable and supported that she referred her mother for detox.
- Participants demonstrated a knowledge of mental health treatment resources available in Truckee and Nevada County. The Nevada County Emergency Resource Numbers sheet was available and given out at a11 the meetings. On one occasion, since the sheet did not include

the 1-888 number for Spanish Suicide Prevention, the number was added by the participants to the sheet using a memory game to aid in memorization.

- There was increased comfort in talking about depression, anxiety and mania. For example a "Conversation Starters" in Spanish from "Each Mind Matters" was used in the Exercise Club. This facilitated a lively discussion where stigma of mental illness disappeared and comfort in speaking about these disorders increased.
- The level of comfort in talking about suicide was enhanced. "Know the Signs" materials were used to outline the warning signs, find the words, and reach out to find help for those with suicidal thoughts. Thirteen people attended and felt comfortable enough to open up and talk about their own experiences with relatives and others. They even stayed past the time of the meeting dismissal.
- [redacted] Spanish Speaking referrals were made to a Nevada County Mental Health Bilingual professionals for treatment in FY 14/15. Some individuals were transported and accompanied to their first appointment as a warm hand-off, while others received help in making their first appointment. Additionally, with the education and information shared during meetings, some people felt comfortable self-referring, setting aside the stigma of mental health and reaching out for help.
- One hundred and twenty-two individuals received mental health education and/or resources through the many meetings held during the year.

In **Eastern Nevada County** the Family Resource Center of Truckee (FRCoT) Promotoras continued to see success in their outreach and education work in the Latino Community during the 2014/2015 fiscal year. The Promotoras are all dedicated to, and passionate about, serving the local Latino community. The program provides mental health education/stigma reduction workshops. Promotoras participate in capacity building trainings based on health and mental health outreach and education, including Chronic Disease Self-Management and Crisis Intervention. Latino Outreach promotes and supports the Family Room as a place to build networks of peer support and to break out of the isolation of parenting. The FRCoT provides referrals for community members to local mental health providers and the Family Advocates of the FRCoT.

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

Eastern County Demographics: In FY 14/15 NCBH's Latino Outreach therapist in Truckee served 53 program participants. [redacted]

In FY 14/15 FRCoT's Latino Outreach program served 41 individuals. [redacted]

[redacted]

Barriers/Challenges:

- There is little local access to diverse mental health resources.
- Transportation is an ongoing challenge.
- Cultural barriers and differences keep individuals from seeking treatment and/or opening up.
- Promotoras are not always available when needed.

Solutions to Barriers:

- Referrals were made to a local community parenting consultant and home visitor with Truckee-Tahoe Healthy Babies for peer counseling.
- NCBH staff provided bilingual services at the FRCoT.
- Public transportation programs were utilized as much as possible.
- Promotoras divided up their tasks to help cover for one another.

Eastern County Outcomes/Successes:

- Four mental health education/stigma reduction workshops were provided to a total of 41 participants.
- Increased knowledge of mental health issues in the Latino Community: The Promotoras evaluate the success of their workshops by assessing program participants' knowledge of mental health and local resources before and after the Promotora Workshop. By using an informal testing model based on conversation, the Promotoras are able to gain an honest narrative through a means that is not intimidating or daunting. The Promotoras complete a pre-workshop evaluation that consists of a group conversation in which questions are allowed to be asked and discussion is encouraged. Through this initial evaluation, staff gains a sense of the knowledge base that each participant holds; areas of interest and gaps in knowledge can be identified and addressed. At the end of each workshop, the Promotoras conduct an evaluation through informal small group discussions. The purpose of the discussion format is to provide a comfortable atmosphere for participants to express the knowledge that they have gained from the workshop. The Promotoras use a template of questions to gauge the increase in knowledge of their participants.
    - The result of this fiscal year's pre and post workshop conversations was that 100% of regular participants (who came to three or more sessions) increased their knowledge of mental health issues.
    - Throughout the duration of each workshop, group participants write down questions, issues, concerns or recommendations and submit them anonymously at the end of each session. This method helps the Promotoras to assess group needs and participant understanding of topics covered. The Promotoras in conjunction with FRCoT staff use the information gathered through these anonymous questions and those raised during discussions to determine indicators and select outcomes.
- Increased networks of peer support and increased confidence and ability: Family Room – Final evaluations at the end of the year reflected that all participants felt more connected to peers, other families and resources through their participation in the Family Room.
- Consumer Satisfaction Surveys showed 58% of individuals specifically mentioned new friends as the greatest benefit of the workshop.
- 100% of participants present for the post-workshop conversation reported feeling more confident, able, and connected.

- Narrative reports provided by the Promotoras from program participants reflect the benefits of a peer network of support. They speak to alleviating the isolation of parenthood for many community members and the increase in comfort maneuvering within the Truckee community and utilizing the resources available to them.
- Increased capacity of Promotoras:
  - Three Promotoras completed five days of Crisis Intervention Training with Tahoe Safe Alliance.
  - Four Promotoras completed six sessions of the Chronic Disease Self-Management Program in Spanish, Tomando Control de su Salud. They will be trained as leaders this September. There is a chronic mental health component to the Program.
  - Three Promotoras completed the Paraprofessional Development Series as a part of the North Tahoe Family Resource Center (NTFRC)/FRCoT and Tahoe Forest Hospital regional Promotora project.
- The program continues to grow and stabilize as its structure and capacity improves with the Promotoras.
  - One new Promotora was brought on-board.
  - Two additional new Promotoras are in the contract process.
  - There is increased participation and increased involvement in the Family Room.
  - Expansion of Promotora programs have been offered, including additional health workshops and community programs.
  - Collaboration and partnership with NTFRC, Tahoe Forest Health District (TFHD), and Placer PEI.

Activity 3: Homeless Outreach

The **Homeless Outreach Program** provided by Hospitality House Homeless Shelter (HH) also known as Utah's Place serves unsheltered individuals through many routes of engagement; social networking at food banks, bus stops, homeless camps, libraries and public parks, word of mouth referrals, law enforcement referrals, shelter guests and community referrals. This Access and Linkage Program utilizes an Outreach Coordinator to go where the homeless are to engage with them in order to reduce their risk of harm and enhance safety (e.g., provide sleeping bags on cold nights); to stabilize acute mental health symptoms via crisis intervention; and to offer other referrals as needed.

Demographics:

HH provided services to 249 individuals in FY 14/15. [redacted]

Barriers/Challenges:

Hospitality House received a number of calls/complaints regarding homeless encampments located on both public and private lands. It continues to be a challenge to manage these calls as most reporting parties are motivated by a desire to evict and convict the campers, which is not a role that HH Outreach is available to play.

Solutions to Barriers:
The willingness of the Outreach Coordinator to respond quickly to these calls does a lot to minimize the fears and concerns of the community at large.

Outcomes/Successes:
- In FY 14/15 2,300 contacts were made with homeless on the streets or in the camps.
- Transportation was provided 524 times in the form of bus passes and/or rides to needed appointments.
- There were a total of 195 referrals made to individuals and families including:
  - Salvation Army - 34
  - Public Defender - 27
  - Hospitality House Housing Program - 21
  - Western Sierra Medical Clinic/Sierra Nevada Memorial Hospital - 17
  - Behavioral Health - 14
  - Social Services - 14
  - Other - 12 (outside substance use recovery centers)
  - Common Goals - 10
  - CoRR - 8
  - DMV - 8
  - Spirit Center - 6
  - Social Security Administration - 4
  - Veteran's Services - 1
- 100% of individuals received services from the referred agency: 195.
- 60% of chronically and severely mentally ill individuals received psychiatric services: 14 out of 23.
- 25% of homeless individuals and families found stable permanent housing: 48.
- 95% of chronically and severely mentally ill were assisted with Social Security applications by the Outreach Coordinator (those not already receiving benefits).
- 80% of those with a drug problem were offered drug treatment services.

Activity 4: Forensic Outreach

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

Demographics: During FY 14/15 there were 46 people served under this program. [redacted]

[redacted]

Outcomes/Successes:

- There were a total of 23 referrals in FY 14/15.
- Of all individuals seen this year:
    - Ten were assessed for services
    - Two were ineligible for services
    - Three engaged in services
    - Twelve refused, declined or did not call back
    - Three had medical treatment
    - Four had mental health treatment
    - Two received help with Social Security
    - Eleven received substance use treatment
    - Thirteen were given help with housing
    - Three received warm handoffs
    - There were a total of 29 follow-ups made by Forensic staff

Activity 5: Wellness Center: Peer Support and Outreach Services

Wellness Center – Truckee Tahoe Unified School District (TTUSD) provides Peer Support & Outreach. The TTUSD Wellness Program is a collaborative project between the TTUSD, Placer and Nevada Counties, Community Collaborative of Tahoe Truckee partners and youth designed to help high school students build protective factors, reduce risk factors/behaviors and increase access to a broad spectrum of mental health services. The program is financially supported by both Nevada County and Placer County and is comprised of Wellness Centers at Truckee High School and North Tahoe High School and individualized wellness programming at Sierra High School. The Centers serve as hubs for high school students to talk with caring adults, connect to community resources and learn new skills to develop sustainable wellness practices.

Key Services include:
1. YOUTH VOICE: a peer mentor program at the three high school sites provides students with skills to better support themselves and their peers. This service gives students an authentic voice in shaping school and community initiatives.
2. SUPPORT: trained Wellness staff and volunteers from community agencies listen to, support and connect students to community health and wellness resources.
3. EDUCATION: Wellness Workshops provide students with practical tools to improve their overall health. Topics cover the range of social, emotional, mental and physical healthy choices and lifestyle tools, such as: Healthy ways to deal with stress, Heart Math, Suicide Prevention Training, Being the Change, and Bullying Prevention.

The Sources of Strength Program (SOS) helps prepare adolescent, peer leaders to change school norms, and connects suicidal youth to capable adults at school and within their community. Trained “peer leaders” change student norms regarding the acceptability of suicide throughout these Truckee schools. The program enables help-seeking and youth-adult communication by conducting a set of well-defined messaging activities with ongoing adult mentoring. Trainings and weekly clubs are facilitated where students get together to organize meaningful activities that educate and support their peers.

Demographics: In fiscal year 2014/2015 TTUSD's Wellness Program at the Wellness Center served 1,098 students. [redacted]

Barriers/Challenges:
The primary barrier was receiving referrals and staying in close communication with some of the school counselors. Counselors were very busy and did not have a lot of time to meet with Wellness Staff to coordinate services and communicate about students. At times, the Wellness Center felt disconnected from the rest of the school.

There were some scheduling challenges for the SOS trainers to present to students. It was a struggle to find dates that worked well for the trainers and the students. At Truckee High School, an SOS training was scheduled, but unfortunately not enough students returned their permission slips so the training had to be cancelled.

Solutions to Barriers:
Student Care Coordination Teams have been created to improve communication between Wellness Staff, School Counselors, School Psychologists and relevant community service providers, such as Nevada County's What's Up? Wellness Checkups Program. The plan is to meet regularly to case manage and provide a continuum of support for the highest need students. This is part of a new initiative to expand the Wellness Centers into Wellness Hubs to truly create a single access point for students to connect with peer mentors, health screening, school-based behavioral health, health coverage, primary care and reproductive health services. This initiative is being spearheaded by Tahoe Forest Hospital and is closely linked with Nevada County and Placer County Behavioral Health Services. The overall goal is to expand current Wellness Programming to make it more integrated in the school and community health systems.

Next year, all of the SOS training dates will be scheduled ahead of time so the trainers will have them calendared and can appropriately plan for them.

Outcomes/Successes:
- OUTCOME #1 - YOUTH: The program surpassed the contractual goal of training 50 youth. A total of 76 youth were trained in peer mentoring and leadership skills to better support themselves and their peers, as well as have authentic voices in shaping school and community initiatives. Activities included:
  - Creating opportunities for 21 youth to speak/share their voice at county and community meetings.
  - Training 44 youth in peer mentoring and helping skills.
  - Training 73 youth in leadership skills at the Youth Leadership Summit.
  - Supporting students in designing and leading their own projects, such as 9th Grade Peer Mentor Groups and Pathways presentations.
- OUTCOME #2 - SUPPORT: The program again, surpassed the contractual goal of linking 50 youth to community resources. New connections and/or support was given to 540 students at Truckee High, North Tahoe High, Sierra High and Community School through assemblies, workshops, groups, clubs, peer mentoring, tutoring and lunch time socialization.

  - In-depth work was done with 53 students to listen to, support and help them improve their social, emotional and mental health.
  - Linkage to outside community resources was provided to 18 students including referrals to: EMQ FamiliesFirst therapy, Nevada County Behavioral Health, Child Protective Services, Teen Clinic, What's Up? Wellness Checkups, Adventure Risk Challenge (ARC), Family Resource Center and Boys and Girls Club.
- OUTCOME #3 - EDUCATION: The program successfully surpassed the contractual goal of teaching practical tools to improve overall health and well-being to at least 200 youth. Thirty-five educational presentations were offered to 329 youth and adults on the following topics: Heart Math, Mindfulness/Stress Reduction, Self-Empowerment, Know the Signs (of Suicide), Healthy Kids Survey, and LGBTQ.
- The SOS program served 558 individuals in FY 14/15.
  - At Truckee High and North Tahoe High:
    - Staff trained 29 Truckee High and 22 North Tahoe High students in peer helping skills.
    - Staff trained 13 students in the Middle School SOS curriculum.
    - Ten SOS students attended the Community Collaborative Youth Café and engaged in meaningful conversations with community leaders about mental health and substance use issues for youth.
    - SOS students launched a school-wide Love Campaign to promote the message of treating each other with respect and kindness.
    - SOS students organized a Positive Messaging Campaign during Valentine's Week.
    - Seventeen students attended the REACH Leadership Conference in Chico, Ca. The students spent three days learning about themselves and how to be leaders.
    - SOS students helped design the Youth Leadership Summit and recruit students to attend. Students also participated in a follow-up group to determine next steps and generate ideas for next year.
    - SOS students designed and launched a new website where students can anonymously ask questions. Many conversations revealed that young people don't always feel safe asking for help face to face. It was felt that more students might seek help if they could ask for it online and anonymously.
    - Students created signs about "Asking for Help" and "Not Being Alone" with a link to the new website. The signs were posted all over the school.
  - At Sierra High:
    - The SOS club focused on creating a positive school climate. The group met at least twice monthly throughout the quarter, more often if a particular event was happening. Club members checked-in regarding: status, atmosphere at school and any concerns. Members brainstormed about how to keep school cohesive, safe and fun.
    - Fifteen students were trained in SOS.
    - A positive messaging Holiday Party and Easter celebration were held.
  - At North Tahoe School:
    - The SOS group met every other month. The students discussed school culture and ways to better support their friends. Instead of organizing school-wide activities, the group focused on having thought provoking conversations and providing individual support for its members.
    - Twenty students were trained in SOS and engaged in meaningful conversations.
  - At Alder Creek Middle School:
    - The SOS students focused on spreading the message of SOS school-wide and building a stronger, more supportive school community.
    - Twenty-five students were trained in SOS.

  - An SOS booth was organized and run at the Wellness Fair.
  - Students supported Kindness Week by organizing fun kindness activities and getting the word out to their peers.
  - Students organized a school-wide Movie Night for 58 kids to build and strengthen the school community.
  - An end of the year party was held.
- Cumulative Retrospective Survey Results (Surveys conducted at the end of 4th Quarter - 58 students):
  - 72% of students reported that they have an improved sense of safety and well-being from having the Wellness Centers on campus.
    28% of students reported that they had an improved sense of safety and well-being at certain times but not always.
  - 72% of students reported have improved feelings of self-worth by participating in Wellness Program activities.
    23% of students reported having improved feelings of self-worth at certain times by participating in Wellness Program activities.
  - 78% of students were able to meet new people and make new social connections through the Wellness Center.
    17% of students were able to make new social connections at certain times but not always.
  - 72% felt like they have more support in their life as a result of the Wellness Center.
    24% felt like they had more support at certain times.
  - When asked what is your biggest Sources of Strength:
    70% said Healthy Activities
    33% said Friends
    20% said Family
    9% said School
    4% said Other (computer, internet, myself)
  - 100% of students experienced a positive environment when they were in the Wellness Center.
  - 97% of students felt like the Wellness Center staff listened to them and treated them with respect.
  - 74% of students reported that they felt the Wellness Centers provided them with appropriate outside resources.
  - 26% of students felt this was not applicable to them.

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

Activity 1: Teaching Pro-Social Skills in the Schools

The **Nevada County Superintendent of Schools** brings the **Second Step** Curriculum into preschools of the Western Nevada County Region as a component of the County's MHSA Prevention and Early Intervention (PEI) Plan. This program brings Second Step social and emotional learning curriculum to preschools and transitional kindergartens.

Demographics: In FY 14/15, 540 children, [redacted] and 15 adults (teachers), [redacted] participated in Second Step at both new and continuing schools. [redacted]

[redacted]

Barriers/Challenges:
The first challenge is getting the initial commitment from schools to participate. Another challenge is scheduling the training sessions since preschool teachers, especially those at private centers, can have incredibly long days and often there is no extra money to pay for time beyond the normal schedule. The high teacher turnover rate in early learning presents another challenge to the program.

Solutions to Barriers:
Second Step staff met in person with prospective participants to present the program in such a way that they understood its incredible value and importance. Staff also showed how it is possible to add another piece into teachers' already very busy day. Trainings are held on site and at whatever times work with the teachers' schedules. Sometimes multiple trainings are held at the same site in order to reach everyone. Second Step also returns to retrain new teachers at schools where there has been teacher turnover.

Outcomes/Successes:
- In FY 14/15 540 children in 28 early learning classrooms, both new and continuing, participated in Second Step.
- Second Step curriculum was brought into seven new classrooms through teacher training and program modeling.
  - There were nine on-site trainings given to a total of fifteen teachers.
  - Second Step staff delivered the first two weeks of daily lessons in each of the seven classrooms. The teacher(s) were present so staff could model the program in the teacher's classroom with their children, working with their schedule.
  - Second Step staff met with the teachers at the end of each unit to support them, check-in with their progress and deliver curriculum-recommended storybooks for upcoming lessons.
- Second Step met at least twice with the twenty-one continuing sites started in past years.
- Second Step also meet with sites that were on hiatus (for various reasons) from the program.
- 99% of the children showed some growth in the social-emotional and self-regulation areas measured on the knowledge assessments.
- As a whole, improvement on the twelve knowledge assessment measures ranged from 66% to 86%.
- Of the teachers who could quantify a percentage, disciplinary issues were reduced by 48%.
- On a scale of 1 to 5, teachers rated the children's overall self-regulation growth as 4.1 and their social-emotional growth as 4.1. The second Step program overall was rated at 5.

Tahoe Truckee Unified School District (TTUSD) is entering its fifth year of implementation of the updated Early Learning-5 **Second Step** Curriculum, a curriculum that teaches social and emotional learning for children from preschool to 5th grade that was introduced in FY 10/11 into

Eastern Nevada County elementary schools. With significant outcomes in FY 12/13 at Glenshire Elementary, the first elementary school to implement Second Step, this contract will continue to support all teachers, school staff and students at all elementary schools with the goal of full implementation in Early Learning-5 classrooms.

In FY 13/14 TTUSD piloted the Second Step Middle School Curriculum, "Student Success through Prevention," in two classrooms at the 6th, 7th and 8th grade levels at Alder Creek Middle School with the goal of full implementation of the middle school curriculum in succeeding years. Leveraging the familiar Second Step concepts and vocabulary that students experienced in elementary school provided a familiar framework and smooth transition for middle school students who, research shows, are especially challenged in the realms of social change and pressure. During these years, students witness and take part in more problem social behaviors than at any other time in their educational careers.

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

The five themes in the middle school curriculum include: empathy and communication; bullying prevention; emotional management; action steps for problem solving, decision making and goal setting; and substance use prevention. The universal classroom-based program uses high-interest, interactive lessons to addresses the core competencies and problematic behaviors that have been shown to affect students' success in school and throughout their lives.

Early Adolescence is a key time for school staff to structure students' opportunities to think and talk with peers about social behavior. Research suggests that this may also be a good time to affect norms and values related to behavior. Evaluation of a previous version of the Second Step middle school program showed that Second Step lessons were associated with changes in student attitudes about aggression. Specifically, students who received these lessons were less tolerant of aggression than students who did not, and it was easier for them to use social emotional skills than students in the comparison group.

Outreach to the local pre-schools continues to occur at a slow but steady pace, with 75 pre-school students receiving the benefits of this program weekly. TTUSD's Transitional Kindergartens (TK) are seeing the benefit of this early social-emotional learning. The students enter already knowing about empathy, self-regulation, problem-solving and skills for learning, which help them deal with the higher behavioral expectations that are expected in the TK year.

Alder Creek Middle School (ACMS) implemented the Second Step Curriculum with the entire student body, beginning in September of 2014. A whole school staff training was given in August of 2014. The teachers were enthusiastic and excited about the program. They could see the benefits of having these social-emotional conversations with their students. The TTUSD trainer also went to a staff meeting in October in order to answer questions that staff had after teaching the program for one month. Additionally, another training was held for the Latino parents at one

of their scheduled English Language nights, and the parents felt the program would help them with many of the parenting issues that were occurring in the home environment.

The decision was made to have every teacher take a small group of students for an advisory once a week and teach the program. This included music, PE, Spanish, etc. teachers as well. ACMS found that the bond between a student and a teacher that a student did not have for their regular curriculum was limited and this factor affected the impact of the program. Therefore, next FY 2015/16 the student's advisory teacher will also be one of their regular teachers in the day. The goal being that the connection with the teacher will enhance the material being taught, and allow the students to take it more seriously. The staff will all be wearing lanyards next year with "How to cope with stress," and "Staying in control." The staff decided these were the two most important Second Step concepts the students could benefit from at this time.

Transitional-Kindergarten through fifth grade continue to benefit from the Second Step Program. Both Glenshire Elementary School and Truckee Elementary School have 100% of teachers teaching the program. There was a refresher training for all teachers in August of 2014 and a new teacher training in September of 2014. Additionally, a refresher training was held for all paraprofessionals in June of 2015.

Demographics: In FY 14/15, TTUSD Second Step served 1,612 children. [redacted]

Barriers/ Challenges:

- There was high teacher turn over.
- The Project Coordinator changed from the beginning of the program year in 2014 to the end of reporting period in 2015.
- Few preschools are participating.
- The counselor had limited work hours.
- The counselor was not familiar with or involved in writing the original grant.
- The new Project Coordinator was not familiar with the preschools in the area.
- The person in charge of Early Childhood Education no longer works with this grant.

Solutions to barriers:

- Staying connected to schools and being informed about staff changes.
- Simplify data collection.
- Someone who works in a preschool can train the preschool teachers and do the follow up.
- Have more flexibility in counselor's schedule for site visits when the timing is best for each site; to complete as many as possible before October.
- Continue to train new teachers, bus personnel, and Boys and Girls club personnel.
- Replace materials as needed.
- Buy new materials for new teachers.

- Continue to keep teachers informed of changes to website. Have the Committee for Children continue to update the website and offer new things for teachers and individuals teaching the program.
- Continue training new teachers in early September.

Outcomes/Successes:

- 100% of K-5 classroom teachers at Glenshire Elementary fully implemented the curriculum in FY 14/15.
- 85% of K-5 classroom teachers at Truckee Elementary fully implemented the curriculum in FY 14/15.
- 85% of 6-8 grade classroom teachers at Alder Creek Middle School fully implemented the curriculum in FY 14/15.
- Teachers and school staff demonstrated they felt supported by ongoing training, support and technical assistance from the Counselor/Facilitator, Early Childhood Educators and the Early Learning Trainer.
- Second Step Curriculum Kits and supplies were ordered as needed.
- TTUSD explored high school social-emotional curriculum/programs for 9-12 grade.
- TTUSD collaborated with the Boys and Girls Club on implementation of Second Step in their afternoon child care program.

Activity 2: Mental Health Screening in the Schools

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

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

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

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

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

WUWC staff and Promotoras provided crisis management for some program participants. Because of the need for an immediate connection or referral, the WUWC staff serve as one of the primary, if not the only, support system for the student's family, providing both in-person and phone-based crisis intervention and referrals to local crisis agencies.

Demographics: In FY 14/15 WUWC served 342 individuals [redacted]

Barriers/Challenges:

- Significant numbers of students were unable to be screened. Consent forms were provided for students no longer in the NJUHSD or TTUSD districts or were consistently absent when requested for screening.
- TTUSD had lower consent rates this year resulting in lower numbers of students screened.
- Lack of available resources for students at "mild to moderate risk" for ongoing mental health support was a continuing challenge.

Solutions to Barriers:

- Staff worked with districts to locate missing students and determine whether they were eligible for screening. Letters were sent to those still in the district with consent forms for next year's screenings.
- WUWC worked with TTUSD on a plan for the 2015/16 school year to integrate consent forms into their enrollment packets, and to increase screenings from just 10th grade to both 9th and 10th graders.
- Additional group resources were created through the STARS program by offering Mindfulness Skills Groups at both NU and Bear River, and additional group offerings are being planned for the 2015/16 school year.

Outcomes/Successes:

- A total of 342 high school students were screened in Nevada County. This represents a 62% increase from the prior year.
- There was a 20% increase in returned parent consents from over the prior year.

- In-depth clinical interviews were provided to 105 students to assess the need for further evaluation/treatment.
- Referrals/ WUWC case-management services were provided to 70 students and their families.
- Seventeen students at Bear River and NU high schools participated in a Mindfulness Skills Group founded and designed by WUWC in response to the need for more support groups in the NJUHSD high schools.
- A new WUWC training structure was developed for current and future volunteers/interns.
- Outreach and education on the WUWC program and mental health issues were provided to approximately 85 people through fundraising events, youth groups and health fairs.
- With NAMI support, WUWC created a mental health stigma reduction presentation for high school classrooms.

Schools	Consent Forms Out	Consent Forms Returned	Yes Consent	Students Screened	Screened Positive	Case Management Provided	Screening Refusals
Bear River	600	186	82	[redacted]	[redacted]	[redacted]	[redacted]
Nevada Union	700	532	328	[redacted]	[redacted]	[redacted]	[redacted]
Silver Springs	150	46	43	[redacted]	[redacted]	[redacted]	[redacted]
Ghidotti	120	42	23	[redacted]	[redacted]	[redacted]	[redacted]
Northpoint	100	65	19	[redacted]	[redacted]	[redacted]	[redacted]
Truckee High	182	45	38	[redacted]	[redacted]	[redacted]	[redacted]
Sierra High	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
North Tahoe	96	14	11	[redacted]	[redacted]	[redacted]	[redacted]
TOTAL	**1,955**	**940**	**554**	[redacted]	[redacted]	[redacted]	[redacted]

*Consent forms can be obtained from other sources, so it is possible to have more forms returned than are sent out.

Activity 3: Child and Youth Mentoring:

The **Big Pal Program** has a long history of serving at-risk elementary and middle school youth, called Little Pals, by providing them with a Big Pal, or high school mentor, who helps them navigate the sometimes stormy path of growing up while also providing academic support. The program began in the Nevada City School District and was expanded by Big Brothers Big Sisters of Nevada County (BBBSNC) to the Grass Valley School District in the fall of 2009 with funding from the U.S. Office of Juvenile Justice and Delinquency Prevention. With the lack of funding from the Nevada City School District to support the program along with the retirement of their long-time Coordinator, BBBSNC consolidated the program and operated it for both school districts in the 2010-2011 school year. BBBSNC now operates the program exclusively.

High School juniors and seniors are matched with elementary and middle school students, grades three through seven, for a weekly mentoring meeting on the school campus. Students are referred by administrators/teachers from one of four schools: Scotten, Lymon Gilmore – Grass Valley School District, Deer Creek, and Seven Hills – Nevada City School District. High School Big

Pals are recruited from the following schools: Nevada Union High School, Forest Charter School, and Bitney Prep Charter. The Pal Program Coordinator recruits, screens, trains and matches all children and teens, conducts match support meetings on a bi-monthly bases and works closely with the schools and teachers to set goals and review progress towards those goals throughout the school year. For the school year 2014/2015 39 matches were successfully completed.

Demographics: In fiscal year 14/15 39 children [redacted] were served. [redacted]

Barriers/Challenges: The main challenges are recruiting enough High School students (especially males) to volunteer as "Bigs". There are many more "Littles" referred to this program from the schools, than Bigs who volunteer.

Solutions to Barriers: This year, the Big recruitment efforts were expanded to include the alternative High Schools (Bitney Charter and Forest Charter). These students have greater flexibility and are new to the program so they are excited about the opportunity to serve the community. This will be an ongoing effort, as it was very well received by both High Schools and the word has spread. In addition there is support from the administration and encouragement from the teachers for students to participate.

Outcomes/Successes:

- Based on the Youth Outcome survey, the following progress was reported by the Littles at the end of the 2014/2015 school year:
  - 20% more of the students are now very sure they will graduate from high school.
  - 50% more of the students are very sure they will go on to college and graduate from college.
  - 10% more of the students believe it is not okay to skip school without permission.
  - 70% more of the students improved their grades in school.
  - 30% more of the students believe it is not okay to engage in risky behaviors (tobacco, drug or alcohol use).
  - 10% more of the students have a better relationship with their parents.

Activity 4: Early Intervention for Referred Children and Youth

In FY 14/15 no children were served through this funding stream.

Innovation (INN):

Work Plan #1 - Veterans' Family Wellness – FINAL REPORT:

- **Innovation Project Name: <u>Welcome Home Vets (WHV) or Veterans' Family Wellness Project</u>**

- **Brief Summary of the Priority Issues related to Mental Illness**
  This project was designed to create and deliver a continuum of mental health care specifically geared to family members of veterans who are afflicted with Military-Related Psychological Trauma (MRPT), such as Post Traumatic Stress Disorder (PTSD), Major Depression, etc. Several diagnoses may result from traumatic experience, with PTSD being the most common. Although studies have demonstrated that family members of veterans who suffer from PTSD have a higher incidence of mental health and social problems than the families of veterans without PTSD, there are few resources dedicated to their unique mental health needs. When these family members are offered treatment, it is generally not delivered any differently than for the general population, usually meaning individual therapy in a therapist's office without interaction with others who have similar issues and with a therapist who may not be competent in military culture. However, treatment with veterans who have PTSD in a continuum of care consisting of individual therapy, group therapy and adjunctive social activities has been demonstrated to be very effective. Therefore, this project will demonstrate the effectiveness of a continuum of care for family members. Furthermore, this project will demonstrate the value of input from multiple sources in creating program design, including the prospective program participant. In order to design a continuum of care for family members, input from veterans, family members and professionals who treat veterans with PTSD was integrated into a conceptual programmatic whole. Their input, through focus groups, was a moving force behind the final design.

- **Description of Any Changes**
  Change #1:
  -As a result of the information gathered from focus groups in Phase I, an educational component was added to the proposed continuum of care, with funding re-allocated from Therapy to the Educational component. This curriculum was divided into four classes meeting weekly for four weeks, open to veterans and spouses. The cost of $1,500 to create the curriculum and $450/month to implement was transferred from funds originally allocated to psychotherapy. The resulting curriculum was well received by new program participants, both veterans and family members, and helped them understand the problems they were experiencing, according to class evaluations.
  -The Initial period of authorization for individual therapy for new program participants was reduced from 6 sessions to 3 sessions. This was an encouragement to therapists to move program participants into group therapy early in treatment, and justification for not entering group therapy was required of therapists. This was felt to be important based on feedback from the focus groups. Most therapists complied with the idea of getting program participants into group as soon as possible.
  -A requirement was adopted that the Vet and family member were to come together for a couples or family session every 3-6 months at a minimum. This proved difficult to enforce, as vets and family members were usually assigned different therapists and setting up joint meetings for contracted therapists in private practice was generally unsuccessful. Monitoring compliance was also extremely difficult.

-The Flanagan Quality of Life scale was adopted as an evaluation tool, to be used in addition to the BASIS-24 required by the contract. This was done in order to assess which instrument was best for reflecting change in family members.

Change #2:

-Due to several obstacles in completing Phase I of the project in a timely manner, $19,082 allocated to Year One was not spent. As implementation of actual treatment proceeded in Year Two, it became evident that Year Three would exceed budgeted expectations in terms of numbers of program participants to be served. Therefore, the unspent funds from Year One were re-allocated to Year Three.

- **Program Information collected during the Reporting Period**
  Quarterly and annual reports were collected which included: the unduplicated number of program participants served by month, individual's age and services provided by month (Individual, Group, Couple's/Family Therapy). Also, collected were the number of individuals served by age, race and ethnicity, primary language, and culture on an annual basis.

- **Final Evaluation Results**
  - **Description of the evaluation methodology.**
    Upon admission, every program participant was administered the BASIS-24 (Behavior and Symptom Identification Scale) and the Flanagan Quality of Life Scale. Attempts were made to obtain these measures again at the end of treatment, but generally it was found that there was no formal end to treatment in most cases; the program participants just stopped coming when they felt like they are done. Mailings to all program participants of these questionnaires, along with a Consumer Satisfaction Survey, resulted in only fourteen (14) program participants returning the completed packet, although they were sent to each of the sixty-seven (67) program participants who had participated in the program.
  - **Outcomes of the Innovative Project including those related to the selected primary purpose, with a focus on whatever was new or changed compared to established mental health practices.**
    - Areas of Individual Improvement on BASIS-24:
      There were improvements on every item of the BASIS-24, but only two items received a number of responses that approached significance:
      Item #1: "During the past week, how much difficulty did you have managing your day-to-day life? 36% showed improvement.
      Item #2: "During the past week, how much difficulty did you have coping with problems in your life? 36% showed improvement.
    - Areas of Individual Improvement on Flanagan Quality of Life Scale:
      There were improvements on several items on the Quality of Life Scale, but only four items received a number of responses that approached significance:
      Item #3: "Relationships with parents, siblings & other relatives – communicating, visiting, helping." 21% showed improvement.
      Item #5: "Close relationships with spouse or significant other." 21% showed improvement.
      Item #11: "Work – job or home." 14% showed improvement.
      Item #13: "Socializing – Meeting other people, doing things, parties, etc." 14% showed improvement.
    - Significant comments from Consumer Satisfaction Survey:

- The Four Introductory Classes:
  -"Enjoyed the classes very much."
  -"Awesome! Difficult to bear, but very well done presentation."
  -"The classes were very helpful."
  -"Excellent classes – more detail is far always useful."
  -"Very informative."
  -"(Instructor) did an awesome, thorough and interesting presentation for each class."
- The individual therapist:
  -"It means a lot to be able to talk to her about my feelings."
  -"She has been a real life saver and the best counselor I've ever experienced."
  -"Being in therapy has helped me on so many levels. It has been a huge part of getting me through hard parts of dealing with issues dealing with getting through life after a vet with PTSD."
  -"Very insightful and has a very caring and has a profound effect on my well-being."
  -"He really makes you think and open up!"
  -"She is a life saver! I have experienced lots of emotional growth and healing due to her skill and guidance. So thankful for her wisdom!"
  -"Very little attention paid to what I had to say, though my son was helped by being heard at the VA hospital."
  -"(Therapist) listened and counseled me with kindness and understanding."
  -"(Therapist) has been an enormous support, a wise guide, a nurturing presence in my life. I am ever grateful for her and for Welcome Home Vets."
- Group Therapy:
  -"I still feel uncomfortable in group setting. I don't enjoy or look forward to it. But hope it will be doing me some good."
  -"Going to group with women who understand what I've been through has been a big part of helping me."
  -"Very cohesive group, we care deeply about each other, and are close."
  -"Even with different styles, both (therapists) ran excellent groups."
  -"Some sessions better than others."
  -"Sometimes don't feel safe to share. Don't know if it's me or what makes it so unpleasant. Do not look forward to it like others seem to do."
  -"Therapist allowed one person to do all the talking. I requested help with grief as my husband was dying but she never addressed it! I felt frustrated."
- Overall Satisfaction with the Family Wellness Program:
  Participants were asked to rate the program on a scale of 1 to 5, with 1 being totally dissatisfied and 5 being extremely satisfied.
  Results: 5 = 45%; 4=36%; 3=9%; 2=9%, with 1% not rating the program.
  Significant Comments:
  -"I am so thankful for this program, especially the individual counseling."
  -"I feel I have most benefitted from the classes and the personal/individual counseling. Also my husband has better coping skills and support system in place."
- Those no longer participating in the Family Wellness Program and comments:
  36% of the respondents indicated that they were no longer participating in the Family Wellness Program. Reasons included:
  -"I felt that I had received the max."

-"Group therapy too difficult emotionally; do better in individual therapy."
-"No improvement."
-"Therapist quit." (Referring to one therapist who left as a provider; her program participants were offered the opportunity to see another program provider.)

- **Any variation in outcomes based on demographics of participants, if applicable.**
  The only significant variation in demographics of participants has to do with age. Most (78%) of those who responded to the evaluation tools were spouses of Vietnam-era veterans. This group also tended to remain in treatment for longer periods of time than younger spouses. One spouse of [redacted] veteran actually enrolled in the program twice but never attended a program activity; like many of the younger participants, she only sought help when there was an acute issue, but when that issue resolved, she did not follow through with getting help.
- **Assessment of which activities or elements of the Innovative Project contributed to successful outcomes.**
  Contracted therapists were unanimous in their feeling that all components of the program (education, individual therapy, group therapy, couples/family therapy) were important in contributing to success. However, they acknowledged that group therapy was not for all program participants for various reasons. A small percentage of program participants reported that group therapy was not comfortable for them.
- **Explanation of how the evaluation was culturally competent.**
  All contracted therapists were required to demonstrate competence in military culture through experience or completion of an on-line or in person course on military culture. Military culture was one of the classes that family members enrolled in the program were required to take, and their input through both written evaluation tools and a consumer satisfaction survey was the primary source of information for the evaluation process.
- **Explanation of how stakeholders contributed to the evaluation.**
  Contracted therapists gave verbal feedback on their evaluation of the program. Program participants completed the BASIS-24, Flanagan Quality of Life Scale, and a Consumer Satisfaction Survey.

- **Sustainability of the Innovative Project**
  Due to funding constraints, the County was not able to continue the Innovative Project. However, an existing contract through MHSA/CSS for treating veterans was expanded in scope to include family members, but no additional funds were provided. The contractor, Welcome Home Vets, is attempting to continue serving families with a full continuum of treatment through billing insurance when available.

- **Key Outcomes and Lessons Learned**
  <u>Expected Outcomes:</u>
  - *Specific needs of veterans' families and loved ones in Nevada County will be formulated through focus groups of veterans, family members and loved ones.*
    This outcome was successfully accomplished, with additional input from professionals who worked with veterans and family members, meeting twice as a group to help design the program and to offer focused responses to the needs of family members. There were then five focus groups conducted with veterans and family members in separate homogeneous groups.

- *The target program participants will be introduced to psychotherapy for themselves in group, individual, couples, child and/or family therapy as deemed clinically appropriate after assessment by a licensed psychotherapist.*
  This outcome was also successfully accomplished, aided by a requirement that therapists begin to justify keeping a program participant in individual therapy alone after three treatment sessions. Although the therapists in this project were aware of the benefit of group therapy for this cohort of program participants, there was an early tendency to maintain them solely in individual therapy for an extended period of time. (It needs to be noted that there is a financial incentive to do so, as individual therapy is billed at a higher rate than group therapy; the effect of this factor on actual practice is undeterminable within the context of this project).
- *Through the process of psychotherapy, potential peer counselors and support group leaders will be identified. Those who desire further involvement will be trained, in conjunction with NAMI training programs or other appropriate training resources.*
  This anticipated outcome was never fully realized. Three different individuals, all spouses of veterans, were identified as potential peer group facilitators at different times, but all dropped out of the training due to personal issues unrelated to the project.
- *Once peer counseling and support groups are in place, veterans' families and their loved ones in the program will be referred to those modalities as clinically appropriate.*
  This anticipated outcome was never realized, due to lack of trained peer group facilitators/counselors as stated in #3 above.
- *An evaluation of program participant functioning using a standardized instrument, will be accomplished at admission to the project, at discharge from a modality or transfer to a new modality, and annually in the support group setting.*
  Partially met; all were administered the BASIS-24 and the Quality of Life (QOL) scale upon admission to the project. However, the reality of operations made this goal unrealistic as far as administering those instruments at changes of modality, especially with only three sessions of the individual therapy modality required before entering into the group therapy modality. This brief period of time did not realistically allow for any significant changes to take place in the program participants. Other modalities, such as couples or family therapy, were integrated into the individual and group phases of treatment in such a way as to make any "change of modality" artificial. The instruments were administered at the end of one year in treatment and/or at discharge, but the reality was that program participants rarely were "discharged" by their therapist, they just stopped coming when they felt done. Therefore, all follow-up assessments through these instruments was sought via mailing to the former program participant, with a very low rate of return.
- *Results of the project will be reported through MHSA channels and published in an appropriate clinical journal.*
  All quarterly and annual reports have been submitted through MHSA channels as required. Unfortunately, a realistic appraisal of the clinical outcomes, due to low rate of return of the instruments of evaluation, make final results of this project inappropriate for publication in a journal.
- *There will be no divorces during the time program participants are in treatment.*
  Perhaps the most important goal in terms of program participant centered outcomes, and a goal that was met. There were no divorces of anyone in the program during their time in treatment.

- Summary of what was learned:

  A continuum of care which includes education, individual therapy, group therapy and couples/family therapy when appropriate is beneficial for family members of veterans who suffer from MRPT. However, there needs to be some flexibility in terms of treatment modality, particularly group therapy, which was not appropriate for everyone.

  Managing provision of care through contracted therapists in private practice is difficult, both in terms of consistency of quality and in compliance with program requirements. For example, instead of being able to gather information for program evaluation at the time of discharge, contractors rarely formally discharged anyone; the program participant usually just stopped coming with no follow-up by the therapist as to why or to get the evaluation tools completed.

- **Dissemination of Results**
  Locally, the Veterans' Family Wellness Project outcome data was shared at MHSA Steering Committee meetings and at Mental Health Board meetings. Information about the Veterans' Family Wellness Project outcomes was included in MHSA Annual Progress Reports. In addition, the results of Veterans' Family Wellness Project are available to the public on the Nevada County Behavioral Health Website and by contacting the Behavioral Health Director, Rebecca Slade, at Rebecca.Slade@co.nevada.ca.us, (530) 470-2784.

- **Additional Relevant Data**
  None

Work Plan #2- Rehabilitation and Behavioral Health Collaborative – FINAL REPORT:

- **Innovation Project Name: Department of Rehabilitation (DOR) and Nevada County Behavioral Health (NCBH) Collaborative:**

- **Brief Summary of the Priority Issue Related to Mental Illness**
  This program supported counseling services from Nevada County Behavioral Health (NCBH) for Department of Rehabilitation (DOR) clients, all of whom were Nevada County residents and Transition Aged Youth (TAY) who were attending Sierra College's Truckee campus. Individuals served by this program voluntarily participated in individual counseling services provided by NCBH and were referred by the Department of Rehabilitation's Senior Vocational Rehabilitation Counselor (SVRC) for the Truckee/Tahoe area.

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

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

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

- There was a lack of vocational training options in the Truckee area. It was hoped that the collaborations would provide a stronger voice to advocate for the development of additional programs that could benefit the programs' mutual clients.

- **Program Information Collected During the Reporting Period**
  The program served 10 individuals in its entirety. [redacted]

- **Final Evaluation Results and Lessons Learned**
  Counseling was recommended for a number of students who appeared to be able to benefit from these services, but many were resistant to therapy. It was thought that the program would be utilized by a greater number of DOR clients. In some cases, TAY disregarded the agreement contained in their Rehabilitation Plan to continue with counseling. There is a dramatic drop-off of services available to TAY once they leave high school. Effectively connecting TAY to adult services was one of the challenges of this collaborative. Because the focus was on the TAY population in Truckee, there was more awareness of the multiple stressors and challenges they face. The benefits of individual therapy were continually seen for those that participated in this program. In some cases a history of emotional trauma was not diagnosed by the school system because of that system's focus on learning problems. However, the emotional problems that come out of childhood emotional trauma constitute a major barrier to success for these individuals and this program was successful in addressing these issues.

- **Sustainability and Key Outcomes**
  The DOR/Sierra College collaboration, augmented by this program, continues to provide quality support for increasing numbers of DOR clients attending Sierra College's Truckee campus. Clients in the program receive an increased level of support than would be available without this partnership. Throughout this collaboration, all of the clients/students stayed connected to DOR following their separation from the college. This is a significant finding compared to the high level of DOR-sponsored TAY who stopped communicating after failing to succeed in other schools. The extra layer of support provided by this collaboration fills a service gap by offering more personal support than is available through disability resource departments alone. This finding illustrates the need for more support services that can address the psychological needs of the TAY population.

- **Additional Relevant Data**
  None

Work Plan #3 - Primary Care Mental Health Integration – FINAL REPORT:

- **Innovation Project Name: <u>Integrating Primary Care and Behavioral Health Services or Healthy Outcomes Integration Team (HOIT)</u>**

- **Brief Summary of the Priority Issue Related to Mental Illness**
  The vision of the Nevada County Behavioral Health (NCBH) Innovation Project was to

build and support healthy futures in people with a Serious Mental Illness (SMI). To assist individuals to achieve wellness and recovery, strategies were developed for integrating health care services with mental health and substance use treatment services. To achieve this vision, local mental health, primary care, and substance use treatment providers, community partners, program participants, and family members formed a consortium and developed a collaborative system of care for adults with an SMI. This collaboration created the ability to develop an integrated health care system.

This MHSA-funded project was expanded and strengthened with a three-year Health Resources and Services Administration (HRSA) grant to fully develop the Healthy Outcomes Integration Team (HOIT). HOIT was comprised of a Registered Nurse (RN) and three part-time Service Coordinators, as well as staff from each of the consortium agencies. HOIT staff identified and linked program participants to services and worked collaboratively with consortium agencies to achieve the goals of the project.

The organizations in the consortium who were actively involved in implementing HOIT included NCBH as the lead agency; Western Sierra Medical Clinic, a Federally Qualified Health Center (FQHC); and Sierra Family Medical Clinic, an FQHC Look-Alike. In addition, two agencies, Community Recovery Resources (CoRR) and Common Goals, Inc., offered substance use treatment services to HOIT program participants who had co-occurring substance use disorders. This integrated team delivered coordinated services to SMI adults, with an emphasis on improving access to health care, identifying chronic health conditions, and improving health outcomes.

The priority focus of the Innovation Project was to create a supportive environment to help program participants access primary health care services; identify chronic health conditions; and develop a support system to help program participants effectively manage their chronic health conditions and improve their health outcomes. The second priority was to develop and enhance collaboration and coordination of services across partner agencies to improve services and improve program participant outcomes. This enhancement included developing the capacity to reconcile medications across agencies; coordinate treatment; and develop shared goals to support each person’s wellness and recovery.

HOIT also provided leadership to improve system outcomes including bi-directional, co-location of primary care at the Behavioral Health (BH) clinic. This strategy helped to improve access to health care services for program participants who were reluctant to see a primary care provider. Subsequently, program participants experienced improved health indicators. HOIT was instrumental in developing strategies to coordinate services across providers through the development of a shared Multi-Party Agreement. This collaborative document formalized this consortium of providers through clear identification of roles and responsibilities.

Individuals with an SMI who were served by HOIT had access to a range of effective health services, supports, and resources to promote wellness, manage chronic health conditions, and improve overall health outcomes. The HOIT RN coordinated services with the Primary Care Physician and RN from the FQHCs to reconcile medications for program participants, identify any discrepancies in health care, and developed an Individual Treatment Plan (ITP) to promote health and wellness. To further integrate health care services, one FQHC brought their mobile van to the BH outpatient clinic one day a week to deliver primary care services

to the BH program participants. The FQHC medical staff met with BH staff and the BH Psychiatrist prior to seeing the program participants. This strategy created the opportunity to discuss complex situations, fully coordinate care, and identify any specialized needs of each individual.

The collaboration between HOIT, BH staff, and the FQHC primary care providers created important outcomes for program participants. These outcomes included linking all individuals with a primary care provider and developing a person-centered health care home. This approach helped to reconcile medications for shared program participants and improve coordination and continuity of care for these high-risk individuals. HOIT activities also improved participants' health outcomes, including blood pressure, Body Mass Index (BMI), breath Carbon Monoxide (CO), fasting glucose, Hemoglobin A1C (diabetes), Triglycerides, and cholesterol. Participants learned how to manage their chronic health conditions, through exercise, improved diet, and healthy choices in meal preparation. This model has been effective at improving continuity of care, and other Behavioral Health systems are highly encouraged to develop an integrated service delivery model to support positive health and wellness outcomes for program participants.

- **Description of Any Changes**
  It was originally planned to have the two FQHCs identify a primary care physician who would deliver integrated primary and behavioral health care services at the NCBH outpatient clinic to adult participants. However, in order for the FQHC to be reimbursed for their primary care services at the FQHC rate, an extensive application process with HRSA and the Center for Medicaid and Medicare Services needed to be completed, including a change of scope and certification. This application process would have taken between one and two years to complete, based upon similar applications for other FQHCs. The FQHC began looking at alternative opportunities to this co-location model.

  Western Sierra Medical Clinic (WSMC) determined that they could utilize their existing mobile van to deliver the needed primary care services outside of the NCBH outpatient clinic. This strategy would allow program participants to conveniently receive primary care services on the grounds (in the parking lot) of the BH outpatient clinic, and the FQHC could be reimbursed for all primary care services delivered to the BH program participants. This approach created the capacity to obtain reimbursement for services without submitting 1-2 years of paperwork in order to be paid for the primary care services delivered at NCBH.

  This change in service model, using the mobile van, allowed NCBH to bring primary care services to our adult program participants, in a location that was comfortable to them. Program participants appreciated having a primary care provider and being able to see the physician on the same day as their scheduled mental health services.

- **Program Information Collected During the Reporting Period**
  The evaluation team collected information on a number of different key health indicators to track health status improvement as a result of integrated services. The selected indicators were consistent with the Federal Healthy People 2020 initiative, including reduced weight for overweight individuals; reduced chronic pain; reduced number of suicide attempts; reduced number of persons who smoke; improved access to treatment for co-occurring disorders; and improved access to primary care.

The RN and Service Coordinator worked together to complete an intake assessment for each individual upon enrollment in HOIT and periodically throughout the project. In addition, each participant enrolled had lab work completed at intake and periodically. Each participant's health data was analyzed, graphically displayed, and shared with the individual and staff in an easy-to-understand format. This format provided information on each health indicator, the "normal" range for each measure, and whether the individual's information was at risk for becoming a chronic health condition (e.g., pre-diabetic; high blood pressure; high cholesterol).

The evaluation team also utilized the county's Electronic Health Record (EHR) to collect information on participant demographic and service utilization data. This information was used to evaluate the amount of services delivered to each participant.

- **Final Evaluation Results**

Individuals with an SMI who were served by HOIT had access to a range of effective health services, supports, and resources to promote wellness, manage illnesses, and improve overall health outcomes. The HOIT RN coordinated services with the Primary Care Physician and Registered Nurse from the FQHC and FQHC Look-Alike to reconcile medications for program participants; identify any discrepancies in health care; and developed an ITP to promote health and wellness. To further integrate health care services, the FQHC brought their mobile van to the Behavioral Health (BH) Outpatient Clinic one day a week to deliver primary care services to the BH participants. The MD and RN met with BH staff and the BH psychiatrist each morning, prior to seeing the BH participants. This strategy created the opportunity to discuss complex situations, fully coordinate care, and identify any specialized needs of the individual.

This integrated model supported both staff and program participants to improve management of chronic health conditions as well as reinforce positive outcomes. In addition, the HOIT RN and Service Coordinators offered a number of different classes to individuals, to help them develop skills in managing their chronic health conditions, lose weight, stop smoking, and manage their stress. A number of individuals were managing their chronic pain by taking prescription medications. Utilizing a coordinate team approach, many of these individuals were able to manage their pain without medications and utilized relaxation and medication to reduce their dependence on pain medications.

National data was used to identify the need for integrating physical health and mental health care for NCBH program participants. Research has shown that individuals with an SMI face an increased risk of having chronic medical conditions and die, on average, 25 years earlier than other Americans, largely due to treatable medical conditions. Data shows that some of the most common health issues for adults with an SMI are diabetes, hypertension, depression, obesity, heart disease, autoimmune disorders, and high cholesterol. Older adults are also at risk of having depression, arthritis, chronic pain, and limited mobility. Substance use is more common for adults with an SMI, including alcohol addictions and inappropriate use of prescription medications. In addition, many individuals smoke cigarettes, which increases the probability of developing heart disease, asthma, and/or certain types of cancer. Some individuals also have a chronic cough and/or chronic obstructive pulmonary disease (COPD) as a result of smoking, or living with a person who smokes.

A number of different key health indicators were selected to help track program participant's

improvement in health status as a result of these integrated services. The selected indicators are also consistent with the Federal Healthy People 2020 initiative.

Several different data collection instruments were used to collect data on each program participant enrolled in HOIT. An RN interviewed each individual at baseline, every six months, and at discharge. The RN also collected the individual's blood pressure; height and weight to calculate the Body Mass Index (BMI); and waist circumference. The RN used a Breath Carbon Monoxide (CO) monitor to measure the impact of smoking on the program participant's lungs. Breath CO monitoring provides an easy and low cost method of determining smoking status without relying on an individual's self-report alone to determine whether or not they smoke.

In addition, each program participant had lab work completed at baseline and annually. The lab work provided values on Fasting Plasma Glucose; Hemoglobin A1C (diabetes); Total Cholesterol, and Triglycerides.

The Service Coordinators (Case Managers), some of whom are persons with lived experience, also collected data for the project, including demographic at baseline and mental health and substance use information from each program participant at baseline, every six months, and at discharge. This information provided data on each individual's education, employment, and functioning, and was collected through an interview process with the individual.

Data sources included lab reports at baseline and annually. The RN collected key health information at baseline, every six months, and at discharge. This information was included in the "Nurse Packet" to report blood pressure, BMI, waist circumference, and CO level. The Service Coordinator collected information at baseline, every six months, and at discharge. The "Service Coordinator Packet" was collected through an interview with the participant. In addition, Nevada County Behavioral Health routinely collects participant demographic and service-level information on each individual through the EHR. This service-level data was utilized to support the evaluation activities.

The data process and analysis included several different strategies. The Evaluator analyzed the data from the EHR, lab work, Nurse Packet, and Service Coordinator Packet to report data on the national Performance Indicators Measures (PIMS). In addition, the Evaluator collected information on each individual's progress on improving a number of different health conditions, and analyzed the data to produce an Individual Wellness Report (IWR) for each participant at baseline and every six months. The IWR was developed to provide ongoing information to participants and staff regarding the identified core health indicators. A number of different measures were analyzed for persons at risk for the following health conditions: Blood Pressure, BMI, Breath CO, Fasting Plasma Glucose, Hemoglobin A1C, Total Cholesterol, and Triglycerides. The IWR was generated at baseline, and data was added every six months to reflect new information over time. This strategy allowed the program participant and staff to see areas of improvement on each health indicator, celebrate success, and identify new goals for those conditions showing "at risk" indicators. The EHR data was also used to provide information on program participant demographics and service utilization. This information was analyzed to determine access and linkage to services.

Collecting lab work was the most complex component of the evaluation. Program

participants were asked to fast eight (8) hours prior to visiting the lab. Some individuals forgot to fast, so the individual and Service Coordinator needed to reschedule a time to draw labs. In addition, many of the program participants did not like needles and were reluctant to get their blood work drawn. The Service Coordinators were creative in developing incentives when participants completed their lab work. Otherwise, there were no limitations to the data.

The Innovation Project achieved excellent outcomes on a number of measures over the period of the project. Data follows:

- The Project served 84 individuals.
- Nearly 75% of the participants stayed in the project for at least six months. There were 23.8% who stayed 6-11 months, 31% who were in the project for 1-2 years, and 17.9% who were in the project for over 2 years.
- Participants showed an improvement in their identified health indicators (e.g., diabetes, depression, hypertension, cholesterol, etc.). Data was analyzed by identifying individuals who were "at risk" at baseline, and determining the number and percent who showed improvement while in the project. The key outcome data is shown below:
  - *Measurement: The number of overweight HOIT participants who improved their Body Mass Index during the grant period.*
  - Outcome:
  - *Measurement: The number of HOIT participants who had a Breath CO above 6 and showed improvement during the grant period.*
  - Outcome:
  - *Measurement: The number of HOIT participants who had an 'at risk' Systolic Blood Pressure at baseline and showed an improvement (decrease) in Systolic Blood Pressure during the grant period.*
  - Outcome:
  - *Measurement: The number of HOIT participants who had an 'at risk' Diastolic Blood Pressure at baseline and showed an improvement (decrease) in Diastolic Blood Pressure during the grant period.*
  - Outcome:
  - *Measurement: The number of HOIT participants who had an 'at risk' Fasting Plasma Glucose at baseline and showed an improvement in Fasting Plasma Glucose during the grant period.*
  - Outcome:
  - *Measurement: The number of HOIT participants who had an 'at risk' Total Cholesterol at baseline and showed an improvement in Total Cholesterol during the grant period.*

- Outcome: [redacted]
- *Measurement: The number of HOIT participants who had an 'at risk' Triglycerides at baseline and showed an improvement in Triglycerides during the grant period.*
- Outcome: [redacted]
- *Measurement: The number and percent of HOIT participants who received services from a primary care provider.*
- Outcome: [redacted]
- *Measurement: The number and percent of HOIT participants with diabetes whose condition has been diagnosed.*
- Outcome: [redacted]
- *The number and percent of HOIT participants who participated in local health and wellness programs.*
- Outcome: [redacted]
- *The number and percent of HOIT participants who set goals to enhance health outcomes.*
- Outcome: [redacted]
- *The number and percent of HOIT participants who remain living in the community and are not admitted to a psychiatric inpatient hospital.*
- Outcome: [redacted]

Individuals were successfully engaged in coordinated services. The Service Coordinators supported participants to attend a range of activities (e.g., nutrition groups, teaching how to cook healthy meals, walking groups, meditation and relaxation) to help improve their health indicators. In addition, individuals enrolled in HOIT were given memberships to the local gym. These memberships were paid for as long as the individual visited the gym at least 10 times per month. This incentive was a powerful one for participants who maintained this level of involvement. These individuals experienced improved health outcomes, as a result.

Participants reported excellent satisfaction with services. They were pleased to see their progress on improving their health indicators, reduced hospitalization, and stability in their daily lives (e.g., stable housing, improved social supports). Participants also reported satisfaction with having a Primary Care Physician and visited regularly with their providers. They also reported satisfaction in receiving services from the FQHC mobile van that came to the Behavioral Health Outpatient Clinic to deliver primary care services.

- **Sustainability of the Innovation Project**
  It is planned to continue this project by funding the positions through CSS.

- **Key Outcomes and Lessons Learned**
  The HOIT project was extremely successful. Individuals enrolled in the project were adults ages 18 and older who had an SMI. Initially, many of these individuals did not have a primary care physician and/or did not access primary care services. Similarly, the

Behavioral Health program did not collaborate on a daily basis with the local FQHCs to coordinate services for the SMI program participants. Initially, both Behavioral Health and FQHC staff did not feel that they had the time to participate in weekly calls to discuss shared program participants, reconcile medications, and coordinate care. However, within a few short weeks, staff from these agencies realized that, at times, program participants were being prescribed duplicate medications, family members were sharing medications, and medications were not being taken as prescribed. Through frequent phone calls and meetings to coordinate medications and services, participant's health conditions were greatly improved. As a result, a strong, collaborative, trusting relationship was developed across these agencies. As a result, staff initiated phone calls and consulted on shared program participants, as needed and on a daily basis.

The collaboration between the HOIT team, Behavioral Health staff, and the FQHC primary care providers created important outcomes for program participants. These outcomes included linking all individuals with a primary care provider and developing a person-centered health care home. This approach helped to reconcile medications for shared program participants and improve coordination and continuity of care for these high-risk individuals. HOIT activities also improved participants' health outcomes, including blood pressure, BMI, Breath CO, fasting glucose, A1C, and Cholesterol. Participants learned how to manage their chronic health conditions, through exercise, improved diet, and healthy choices in meal preparation.

HOIT also provided leadership to improve system outcomes including bi-directional, co-location of primary care at the Behavioral Health clinic. This strategy helped to improve access to health care services for program participants who were reluctant to see a primary care provider. Subsequently, participants experienced improved health indicators and learned how to manage their chronic health conditions. HOIT was also instrumental in developing strategies to coordinate services across providers through the development of a shared Multi-Party Agreement. This collaborative document helped to formalize this consortium of providers through clear identification of roles and responsibilities and delivery of bi-directional, integrated health care services by co-locating primary care services at the NCBH clinic and similarly co-locating behavioral health services at the primary care clinics in the community to meet the needs of program participants. This strategy also created a continuous Quality Improvement process that developed the capacity to share information across programs to improve program participant care and services over time.

Individuals with an SMI who were served by HOIT had access to a range of effective health services, supports, and resources to promote wellness, manage illnesses, and improve overall health outcomes. The HOIT RN coordinated services with the Primary Care Physician and Registered Nurse from the FQHC and FQHC Look-Alike to reconcile medications for program participants, identify any discrepancies in health care, and developed an ITP to promote health and wellness. To further integrate health care services, the FQHC brought their mobile van to the Behavioral Health (BH) Outpatient Clinic one day a week to deliver primary care services to the BH program participants. The MD and RN met with BH staff and the BH psychiatrist each morning, prior to seeing the BH program participants. This strategy created the opportunity to discuss complex situations, fully coordinate care, and identify any specialized needs of the individual.

This integrated model supported both staff and program participants to improve management of chronic health conditions as well as reinforce positive outcomes. In addition, the HOIT RN and Service Coordinators offered a number of different classes to individuals, to help them develop skills in managing their chronic health conditions, lose weight, stop smoking, and manage their stress. A number of individuals were managing their chronic pain by taking prescription medications. Utilizing a coordinate team approach, many of these individuals were able to manage their pain without medications and utilized relaxation and medication to reduce their dependence on pain medications.

- **Dissemination of Results**
  Locally, the HOIT outcome data was shared at MHSA Steering Committee meetings and at Mental Health Board meetings. Information about the HOIT project outcomes was included in MHSA Annual Progress Reports. In addition, the results of the HOIT Project are available to the public on the Nevada County Behavioral Health Website and by contacting the Behavioral Health Director, Rebecca Slade, at Rebecca.Slade@co.nevada.ca.us, (530) 470-2784. In addition, the Behavioral Health Director has provided information on the results of this project at state meetings and conferences.

  Due to the positive impact of the HOIT project, which was funded by both federal grants and state MHSA allocations, NCBH has been nominated to be added to the HRSA Rural Health Models and Innovations Hub located on the Rural Community Health Gateway (https://www.raconline.org/communityhealth). The Rural Community Health Gateway showcases programs that can help other organizations who are interested in building effective community health programs. This website is an excellent opportunity to disseminate the HOIT strategies and successes.

- **Conclusion**
  The success of the HOIT project created the foundation for NCBH to obtain two California MHSA-funded grants. One grant expands the NCBH crisis services to be co-located 24/7 at the Emergency Department (ED) of the local hospital. It also expands the number of hours for Crisis Peer Counselors, who are program participants and family members employed by SPIRIT Peer Empowerment Center, to go to the ED and support program participants and family members while experiencing a crisis. This grant also funded the development of a four-bed Peer-Run Respite Center, to help support program participants to resolve their crisis in a community setting and/or provide additional support following a crisis or psychiatric inpatient hospitalization. A second CA MHSA grant funded the development of a Crisis Stabilization Unit on the grounds of the local hospital. Both of these MHSA grants support the development of an exemplary crisis continuum of care in Nevada County to help program participants to remain in the community, whenever possible.

  The integration of primary care and behavioral health has a significant impact on the health and well-being of persons with a Serious Mental Illness. Many individuals do not access primary care and/or know how to manage their chronic health conditions. Similarly, Behavioral Health staff do not typically understand chronic health conditions or have the skills needed to help program participants improve their health functioning. Through coordinated, integrated health, behavioral health, and substance use treatment services, program participants can improve their health conditions and achieve positive outcomes. This model has been effective at improving continuity of care and other behavioral health systems are highly encouraged to develop an integrated service delivery model to support

positive health and wellness outcomes for program participants.

Workforce Education and Training (WET)

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

1. **Workforce Staffing Support:** The MHSA Coordinator worked on the implementation of the plan including providing updates as required to the Mental Health Board and the MHSA Steering Committee. The MHSA Coordinator participated in the state-wide WET conference calls and meetings, and provided leadership for ongoing trainings, WET activities and development. Clerical staff supported the ongoing administration for the MHSA Coordinator, Behavioral Health staff, contractors, program participants and families as related to WET implementation. A total of 239.25 hours was billed to Workforce Staffing Support in FY 14/15.

2. **Training and Technical Assistance:** Numerous training events have been offered by the County for staff, service providers, and stakeholders, including program participants and family members. When appropriate, MHSA PEI and WET funds were utilized for training opportunities. For FY 14/15 events/conferences/trainings included: Adult Behavioral Health (BH) Training, Advanced Applications in Cognitive Therapy, Advancing Behavioral Health Care in your Hospital, California (CA) BH Policy Forum, CA Hospital Association, County Behavioral Health Directors Association of California (CBHDA) Meetings, Child Abuse & Incest Reporting Laws & Treatment, California State Association of Counties (CSAC) Institute - Managing Conflict, CSAC Yearly Registration, Data Collection and Reporting (DCR) System Training, Emergency Mental Health - Crisis Assessment & Treatment, Full Service Partnership (FSP) Enhanced Partner-level Data (EPLD) Template Training, Governing Board Strategic Planning Meeting, Hoarding Disorder Training, Integrating Substance Use with Mental Health and Primary Care, Know the Signs - Suicide is Preventable, Law & Ethics Training, Living Works Training, Making Sense of Anxiety Training, Mental Health First Aid, Mental Health First Aid for Law Enforcement, Mental Health America (MHA) Recovery Oriented Practice Training (Immersion), MHA Recovery Training, MHSA WET Mental Health Board Training, Motivational Interviewing to Facilitate Family Change, PsychCeli.com Courses, Risk Assessment and Treating Clients in Crisis, Superior Region WET Meeting, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Booster Training, and Understanding & Using Acceptance and Commitment Therapy (ACT) in the Treatment of Eating Disorders.

   Purchases continue to be made to expand the training library. Staff and providers are welcome to check materials out and use these resources as it fits their schedules. Continuing Education Units (CEU) are available for some of the materials.

   Demographics: A total of 234 individuals attended a training conference or event in FY 14/15.

3. **Mental Health Career Pathway Programs:** In FY 11/12, it was decided to utilize $15,000 in Mental Health Career Pathway funds to further support the Wellness Recovery Action Plan (WRAP) Facilitators in Nevada County. Eighteen individuals were either trained to be a WRAP Facilitator or had a booster training. These individuals were representatives of a wide range of organizations/groups. Individuals from SPIRIT Peer Empowerment Center, The Alliance for Wellbeing, Grass Valley PARTNER Family Resource Center, Family Resource Center of Truckee, Community Recovery Resources, Women of Worth, Domestic Violence and Sexual Assault Coalition, and New Directions (a Nevada County Behavioral Health Full Service Partner provider) participated in the training. These individuals included: program participants, peer support specialists, young adult peer supporters, Promotores, drug and alcohol counselors, domestic violence counselors/employees, and therapists. The County continues to support the WRAP Facilitators by providing training, meeting space and materials to conduct WRAP Facilitator Support Meetings. WET funds are also used to provide WRAP Facilitation Group implementation materials. In FY 14/15 the county purchased these additional resources for the ongoing program using WET funds: 30 WRAP books, 20 WRAP For Addictions books, 70 My WRAP books, 35 Wrap for Veterans and People in the Military books, and one WRAP for Veterans & People in the Military DVD set.

4. **Expansion of Nevada County's Internship Program:** This program was primarily funded under CSS in FY 14/15. See CSS section above for details.

5. **Financial Incentives:** Our Voices Matter (OVM) continues to be an essential program participants/family-run speaker's bureau that provides the opportunity for program participants/family members to give voice to their experiences living with mental health conditions. Telling stories can be very effective in addressing the stigma and discrimination that individuals with mental health conditions face. The program is actively supported by NAMI Nevada County and SPIRIT Peer Empowerment Center, however Nevada County Behavioral Health WET funds are no longer used for this program.

Individuals Served by MHSA in FY 2014-15

Program: MHSA Totals

Age Group	# of individuals
Children & Youth (0-15)	
TAY (16-25)	
Adults (26-59)	
Older Adults (60+)	
Unknown	
Total	**18559**

Ethnicity	# of individuals
Hispanic or Latino as follows:	
Caribbean	
Central America	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South America	
Other Hispanic/Latino	
Unknown	
Hispanic or Latino Subtotal:	**1726**
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic/Non-Latino	
Unknown	
Non-Hispanic/Non-LatinoSubtotal:	**3452**
More than one ethnicity	
Ethnicity Unknown	
Total	**18559**

Race	# of individuals
American Indian or Alaska Native	
Asian	
Black of African American	
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Unknown	
Total	**18559**

Primary Language	# of individuals
English	
Spanish	
Arabic	
Cambodian	
Cantonese	
Farsi	
Hmong	
Mandarin	
Russian	
Tagalog	
Vietnamese	
Other	
Unknown	
Total	**18559**

Sexual Orientation	# of individuals
Lesbian	
Gay	
Bi-sexual	
Transgender	
Questioning	
Unknown	
Total	**342**

Gender Identity	# of individuals
Female	
Male	
Trans-Female	
Trans-Male	
Both	
Neutral	
Unknown	
Total	**18559**

Culture	# of individuals
Veterans	
HIV/AIDS	
Homeless	
Disabilities	
Criminal/Legal System	
Latino/Hispanic	
Substance Abuse	
Domestic Violence	
Other:	
Total	**7427**

Individuals Served by MHSA in FY 2014-15

Organization: Adult System of Care

Program: Community Services and Supports

Age Group	# of individuals
Children & Youth (0-15)	
TAY (16-25)	
Adults (26-59)	
Older Adults (60+)	
Unknown	
Total	**3770**

Ethnicity	# of individuals
Hispanic or Latino as follows:	
Caribbean	
Central America	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South America	
Other Hispanic/Latino	
Unknown	
Hispanic or Latino Subtotal:	**59**
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic/Non-Latino	
Unknown	
Non-Hispanic/Non-LatinoSubtotal:	**937**
More than one ethnicity	
Ethnicity Unknown	
Total	**3770**

Race	# of individuals
American Indian or Alaska Native	
Asian	
Black of African American	
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Unknown	
Total	**3770**

Primary Language	# of individuals
English	
Spanish	
Arabic	
Cambodian	
Cantonese	
Farsi	
Hmong	
Mandarin	
Russian	
Tagalog	
Vietnamese	
Other	
Unknown	
Total	**3770**

Sexual Orientation	# of individuals
Lesbian	
Gay	
Bi-sexual	
Transgender	
Questioning	
Unknown	
Total	**2**

Gender Identity	# of individuals
Female	
Male	
Trans-Female	
Trans-Male	
Both	
Neutral	
Unknown	
Total	**3770**

Culture	# of individuals
Veterans	
HIV/AIDS	
Homeless	
Disabilities	
Criminal/Legal System	
Latino/Hispanic	
Substance Abuse	
Domestic Violence	
Other:	
Total	**2107**

Individuals Served by MHSA in FY 2014-15

Organization: Children's System of Care

Program: Community Services and Supports

Age Group	# of individuals
Children & Youth (0-15)	
TAY (16-25)	
Adults (26-59)	
Older Adults (60+)	
Unknown	
Total	**858**

Ethnicity	# of individuals
Hispanic or Latino as follows:	
Caribbean	
Central America	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South America	
Other Hispanic/Latino	
Unknown	
Hispanic or Latino Subtotal:	**73**
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic/Non-Latino	
Unknown	
Non-Hispanic/Non-LatinoSubtotal:	**491**
More than one ethnicity	
Ethnicity Unknown	
Total	**858**

Race	# of individuals
American Indian or Alaska Native	
Asian	
Black of African American	
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Unknown	
Total	**858**

Primary Language	# of individuals
English	
Spanish	
Arabic	
Cambodian	
Cantonese	
Farsi	
Hmong	
Mandarin	
Russian	
Tagalog	
Vietnamese	
Other	
Unknown	
Total	**858**

Sexual Orientation	# of individuals
Lesbian	
Gay	
Bi-sexual	
Transgender	
Questioning	
Unknown	
Total	**0**

Gender Identity	# of individuals
Female	
Male	
Trans-Female	
Trans-Male	
Both	
Neutral	
Unknown	
Total	**858**

Culture	# of individuals
Veterans	
HIV/AIDS	
Homeless	
Disabilities	
Criminal/Legal System	
Latino/Hispanic	
Substance Abuse	
Domestic Violence	
Other:	
Total	**169**

Individuals Served by MHSA in FY 2014-15

Organization: Outreach Projects

Program: Prevention & Early Intervention

Age Group	# of individuals
Children & Youth (0-15)	
TAY (16-25)	
Adults (26-59)	
Older Adults (60+)	
Unknown	
Total	**1853**

Ethnicity	# of individuals
Hispanic or Latino as follows:	
Caribbean	
Central America	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South America	
Other Hispanic/Latino	
Unknown	
Hispanic or Latino Subtotal:	**771**
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic/Non-Latino	
Unknown	
Non-Hispanic/Non-LatinoSubtotal:	**996**
More than one ethnicity	
Ethnicity Unknown	
Total	**1853**

Race	# of individuals
American Indian or Alaska Native	
Asian	
Black of African American	
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Unknown	
Total	**1853**

Primary Language	# of individuals
English	
Spanish	
Arabic	
Cambodian	
Cantonese	
Farsi	
Hmong	
Mandarin	
Russian	
Tagalog	
Vietnamese	
Other	
Unknown	
Total	**1853**

Sexual Orientation	# of individuals
Lesbian	
Gay	
Bi-sexual	
Transgender	
Questioning	
Unknown	
Total	**11**

Gender Identity	# of individuals
Female	
Male	
Trans-Female	
Trans-Male	
Both	
Neutral	
Unknown	
Total	**1853**

Culture	# of individuals
Veterans	
HIV/AIDS	
Homeless	
Disabilities	
Criminal/Legal System	
Latino/Hispanic	
Substance Abuse	
Domestic Violence	
Other:	
Total	**1195**

Individuals Served by MHSA in FY 2014-15

Organization: Access to Services

Program: Prevention & Early Intervention

Age Group	# of individuals
Children & Youth (0-15)	
TAY (16-25)	
Adults (26-59)	
Older Adults (60+)	
Unknown	
Total	**9211**

Ethnicity	# of individuals
Hispanic or Latino as follows:	
Caribbean	
Central America	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South America	
Other Hispanic/Latino	
Unknown	
Hispanic or Latino Subtotal:	**149**
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic/Non-Latino	
Unknown	
Non-Hispanic/Non-LatinoSubtotal:	**124**
More than one ethnicity	
Ethnicity Unknown	
Total	**9211**

Race	# of individuals
American Indian or Alaska Native	
Asian	
Black of African American	
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Unknown	
Total	**9211**

Primary Language	# of individuals
English	
Spanish	
Arabic	
Cambodian	
Cantonese	
Farsi	
Hmong	
Mandarin	
Russian	
Tagalog	
Vietnamese	
Other	
Unknown	
Total	**9211**

Sexual Orientation	# of individuals
Lesbian	
Gay	
Bi-sexual	
Transgender	
Questioning	
Unknown	
Total	**302**

Gender Identity	# of individuals
Female	
Male	
Trans-Female	
Trans-Male	
Both	
Neutral	
Unknown	
Total	**9211**

Culture	# of individuals
Veterans	
HIV/AIDS	
Homeless	
Disabilities	
Criminal/Legal System	
Latino/Hispanic	
Substance Abuse	
Domestic Violence	
Other:	
Total	**2962**

Individuals Served by MHSA in FY 2014-15

Organization: Child, Youth & Families at Risk

Program: Prevention & Early Intervention

Age Group	# of individuals
Children & Youth (0-15)	
TAY (16-25)	
Adults (26-59)	
Older Adults (60+)	
Unknown	
Total	**2548**

Ethnicity	# of individuals
Hispanic or Latino as follows:	
Caribbean	
Central America	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South America	
Other Hispanic/Latino	
Unknown	
Hispanic or Latino Subtotal:	**673**
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic/Non-Latino	
Unknown	
Non-Hispanic/Non-LatinoSubtotal:	**853**
More than one ethnicity	
Ethnicity Unknown	
Total	**2548**

Race	# of individuals
American Indian or Alaska Native	
Asian	
Black of African American	
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Unknown	
Total	**2548**

Primary Language	# of individuals
English	
Spanish	
Arabic	
Cambodian	
Cantonese	
Farsi	
Hmong	
Mandarin	
Russian	
Tagalog	
Vietnamese	
Other	
Unknown	
Total	**2548**

Sexual Orientation	# of individuals
Lesbian	
Gay	
Bi-sexual	
Transgender	
Questioning	
Unknown	
Total	**27**

Gender Identity	# of individuals
Female	
Male	
Trans-Female	
Trans-Male	
Both	
Neutral	
Unknown	
Total	**2548**

Culture	# of individuals
Veterans	
HIV/AIDS	
Homeless	
Disabilities	
Criminal/Legal System	
Latino/Hispanic	
Substance Abuse	
Domestic Violence	
Other:	
Total	**970**

Individuals Served by MHSA in FY 2014-15

Program: Innovation

Age Group	# of individuals
Children & Youth (0-15)	
TAY (16-25)	
Adults (26-59)	
Older Adults (60+)	
Unknown	
Total	**85**

Ethnicity	# of individuals
Hispanic or Latino as follows:	
Caribbean	
Central America	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South America	
Other Hispanic/Latino	
Unknown	
Hispanic or Latino Subtotal:	**0**
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic/Non-Latino	
Unknown	
Non-Hispanic/Non-LatinoSubtotal:	**38**
More than one ethnicity	
Ethnicity Unknown	
Total	**85**

Race	# of individuals
American Indian or Alaska Native	
Asian	
Black of African American	
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Unknown	
Total	**85**

Primary Language	# of individuals
English	
Spanish	
Arabic	
Cambodian	
Cantonese	
Farsi	
Hmong	
Mandarin	
Russian	
Tagalog	
Vietnamese	
Other	
Unknown	
Total	**85**

Sexual Orientation	# of individuals
Lesbian	
Gay	
Bi-sexual	
Transgender	
Questioning	
Unknown	
Total	**0**

Gender Identity	# of individuals
Female	
Male	
Trans-Female	
Trans-Male	
Both	
Neutral	
Unknown	
Total	**85**

Culture	# of individuals
Veterans	
HIV/AIDS	
Homeless	
Disabilities	
Criminal/Legal System	
Latino/Hispanic	
Substance Abuse	
Domestic Violence	
Other:	
Total	**23**

Individuals Served by MHSA in FY 2014-15

Organization: Training & Technical Assistance

Program: Workforce Education & Training

Age Group	# of individuals
Children & Youth (0-15)	
TAY (16-25)	
Adults (26-59)	
Older Adults (60+)	
Unknown	
Total	**234**

Ethnicity	# of individuals
Hispanic or Latino as follows:	
Caribbean	
Central America	
Mexican/Mexican-American/Chicano	
Puerto Rican	
South America	
Other Hispanic/Latino	
Unknown	
Hispanic or Latino Subtotal:	**1**
Non-Hispanic or Non-Latino as follows:	
African	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic/Non-Latino	
Unknown	
Non-Hispanic/Non-LatinoSubtotal:	**13**
More than one ethnicity	
Ethnicity Unknown	
Total	**234**

Race	# of individuals
American Indian or Alaska Native	
Asian	
Black of African American	
Native Hawaiian or other Pacific Islander	
White	
Other	
More than one race	
Unknown	
Total	**234**

Primary Language	# of individuals
English	
Spanish	
Arabic	
Cambodian	
Cantonese	
Farsi	
Hmong	
Mandarin	
Russian	
Tagalog	
Vietnamese	
Other	
Unknown	
Total	**234**

Sexual Orientation	# of individuals
Lesbian	
Gay	
Bi-sexual	
Transgender	
Questioning	
Unknown	
Total	**0**

Gender Identity	# of individuals
Female	
Male	
Trans-Female	
Trans-Male	
Both	
Neutral	
Unknown	
Total	**234**

Culture	# of individuals
Veterans	
HIV/AIDS	
Homeless	
Disabilities	
Criminal/Legal System	
Latino/Hispanic	
Substance Abuse	
Domestic Violence	
Other:	
Total	**1**

RESOLUTION No. 17-106

OF THE BOARD OF SUPERVISORS OF THE COUNTY OF NEVADA

RESOLUTION APPROVING THE NEVADA COUNTY MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL UPDATE TO THE THREE-YEAR PROGRAM AND EXPENDITURE PLAN FOR FISCAL YEAR 2016/17 AND ANNUAL PROGRESS REPORT FOR FISCAL YEAR 2014/15

WHEREAS, the Mental Health Services Act (Proposition 63), adopted by the California electorate on November 2, 2004, created a new revenue source for the transformation and enhancement of public mental health services; and

WHEREAS, the goal of MHSA is to reduce the long-term impact on individuals/ families and the community from untreated serious mental illness; and

WHEREAS, the Behavioral Health Department developed the Fiscal Year 2016/17 Annual Update and the Fiscal Year 2014/15 Annual Progress Report based on the MHSA Annual Update Instructions developed and issued by the Mental Health Services Oversight and Accountability Commission (MHSOAC); and

WHEREAS, the Annual Update contains descriptions of MHSA-funded programs and activities, as well as numbers served and program updates; and

WHEREAS, consistent with statutory requirements, the Draft Fiscal Year 2016/17 MHSA Annual Update and Annual Progress Report for Fiscal Year 2014/15 was posted for 30-day public review and comments, and the County has engaged in a comprehensive stakeholder and community input process to involve all interested individuals, consumers and collaborative partners in the identification of community needs and priorities; and

WHEREAS, the primary components of the MHSA Plan are: Community Services and Support (CSS), Workforce and Training (WET), Prevention and Early Intervention (PEI), and Innovation (INN), and the estimated program expenditures under the County's MHSA Plan are: $5,481,500 for Fiscal Year 2014/15; $5,106,500 for Fiscal Year 2015/16; and $6,123,452 for Fiscal Year 2016/17; and

WHEREAS, Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the County Board of Supervisors, to the Mental Health Services Oversight and Accountability Commission within 30 days after Board of Supervisor adoption.

NOW, THEREFORE, BE IT HEREBY RESOLVED that the Board of Supervisors of the County of Nevada, State of California, approves the Nevada County Mental Health Services Act (MHSA) Annual Update to the Three Year Program and Expenditure Plan for Fiscal Year 2016/17 and Annual Progress Report for Fiscal Year 2014/15; and

FURTHERMORE, the Board of Supervisors authorizes the County Behavioral Health Director to sign and certify the MHSA County Compliance Certification which is included in the Fiscal Year 2016/17 Mental Health Services Annual Update.

PASSED AND ADOPTED by the Board of Supervisors of the County of Nevada at a regular meeting of said Board, held on the 28th day of February, 2017, by the following vote of said Board:

Ayes: Supervisors Heidi Hall, Edward Scofield, Dan Miller, Hank Weston and Richard Anderson.

Noes: None.

Absent: None.

Abstain: None.

ATTEST:

JULIE PATTERSON HUNTER
Clerk of the Board of Supervisors

By: Julie Patterson-Hunter

Hank Weston

Hank Weston, Chair

2/28/2017 cc: BH*

The foregoing instrument is a correct copy of the original on file in this office.
Resolution 17-106
ATTEST: March 2, 2017
Julie Patterson Hunter, Clerk of the Board
County of Nevada
BY: