NEVADA COUNTY
CALIFORNIA

Behavioral Health

BEHAVIORAL HEALTH COMMUNITY NEEDS ASSESSMENT

2025

Assessment Conducted and Prepared By

EVALCORP
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TABLE OF CONTENTS

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Introduction

Behavioral Health Services Act

The Behavioral Health Services Act (BHSA), enacted following the approval of Proposition 1 in March 2024, seeks to reform California's approach to mental health and substance use disorder services. This legislation replaces the 2004 Mental Health Services Act (MHSA), expanding its scope to include services for substance use disorders and prioritizing housing interventions for individuals with mental illness and/or substance use disorders who are experiencing homelessness.

Statewide Goals. As part of the implementation of BHSA, known as Behavioral Health Transformation (BHT), the California Department of Health Care Services (DHCS) *has identified 14 statewide behavioral health goals aimed at improving well-being and reducing adverse outcomes. These behavioral health goals will inform state and county planning and prioritization of BHSA resources, and DHCS will continuously assess statewide and county progress toward these goals.*[1] A list of the statewide goals is provided in Appendix 1.

Integrated Plan. *The BHSA requires counties to submit Three-Year Integrated Plans (IPs) for Behavioral Health Services and Outcomes*. The Integrated Plans are intended to provide a *global spending plan that describes how county behavioral health departments plan to use all available behavioral health funding, including BHSA* funds. The Integrated Plans are completed based on a template provided by the DHCS and include programs and strategies for addressing the Statewide Goals.

Community Program Planning Process

Similar to the MHSA, the BHSA requires county behavioral health departments to collaborate *with local stakeholders to develop each element of their Integrated Plan. Counties are required to demonstrate a partnership with constituents and stakeholders through a process that includes meaningful stakeholder involvement*. Meaningful stakeholder engagement *requires that counties conduct a community planning process that is open to all interested stakeholders and provides opportunities for stakeholders to voice feedback on key planning decisions*. Examples of meaningful partnerships with stakeholders may include education, listening sessions, town hall meetings, focus groups, surveys, key informant interviews, or other methods.

Required Stakeholders. Twenty-four distinct stakeholder groups are required for engagement, as well as participation from six additional groups of individuals. These groups are listed in Appendix 2.

The purpose of this report is to summarize the feedback received from stakeholders as part of the Community Program Planning Process for the Integrated Plan covering the three years beginning July 2026 (i.e., starting Fiscal Year 26/27).

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[1] NOTE: *italicized text* in the Introduction and Methods section is taken verbatim from the BHSA County Policy Manual

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Methods

Data Collection

Stakeholder engagement for the Integrated Plan primarily consisted of data collection, which took place between late August and early November 2025. Data collection methods included 16 focus groups, eight key stakeholder interviews, one survey, and one demographic form. A detailed summary of respondents is provided in the next section (Stakeholders Engaged), and a list organized by required stakeholder categories is provided in Appendix 2.

Organization of Results

Stakeholder feedback from the focus groups and interviews was organized thematically and is presented in the context of the Statewide Goal or component of the behavioral health continuum of care in which it most directly corresponds. Focus group, interview, and survey questions, for the most part, directly corresponded to one component of the continuum of care. Following the overview of stakeholders engaged, results are presented in the following order:

- Stakeholders Engaged
- Stakeholder Survey Results
- BHSA Goals
- Crisis Services
- Housing
- Severe Mental Illness (SMI)
- Substance Use Disorder (SUD)
- Workforce

Note that the Stakeholder Survey Results are reported separately, with results summarized by question. The interview and focus group results are integrated across the five themes, which are further divided into subthemes (generally, Strengths, Limits of Services, and Recommendations).

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Stakeholders Engaged

Focus Groups

Sixteen focus groups were conducted during September through early November 2025. A brief description of the groups conducted is provided in Table 1 below. There was a total of 210 participants across the 16 focus groups.

Table 1. Focus Groups Conducted (N=210)

#	Host Organization/Site	# of Participants	Format	Language
1	Adult Mental Health Consumers in Western County	10	In-person	English
2	Adult Mental Health Consumers in Truckee	3	In-person	English
3	Adult Mental Health and Substance Use Advisory Board	9	In-person	English
4	Youth Consumers' Family Members	8	In-person	English
5	Youth Consumer Providers	3	In-person	English
6	Behavioral Health Providers	28	Virtual	English
7	NCBH All Staff Meeting	47	In-person (staff facilitated)	English
8	Tahoe Truckee Providers	11	In-person	English
9	Youth Early Intervention Providers	3	Virtual	English
10	Criminal Justice Partners	9	Virtual	English
11	Educators in Western County	7	Virtual	English
12	Health Care Providers	17	Virtual	English
13	Spanish Speaking Consumers in Truckee	13	In-person (staff facilitated)	Spanish
14	Spanish Speaking Providers in Truckee	10	In-person	Spanish
15	Unhoused	20	In-person	English
16	Overdose Prevention Coalition	12	In-person (staff facilitated)	English

Focus Group Demographic Form

This section summarizes demographic data for participants who completed a demographic form after participating in a 2025-2026 CPP Nevada County Stakeholder Focus Group. Below is a summary of responses.

Demographic data were analyzed using descriptive statistics. Across the 16 focus groups conducted, a total of 152 out of 210 individuals completed a demographics survey at the conclusion of their participation. This discrepancy is normal, as completing a demographic survey is encouraged but not required. A snapshot of participants' demographic and background characteristics are outlined below and presented in Table 2.

- 66% White or Caucasian, 15% Hispanic or Latino, seven percent multiracial, three percent American Indian or Other Indigenous group, two percent Asian or Asian American/other Pacific Islander, one percent Black or African American, and six percent preferred not to answer.
- 70% female
- 78% of focus group participants were adults between the ages of 25 and 59, followed by older adults (21%), and transitional age youth (1%).
- 84% of focus group participants primarily spoke English at home, 11% spoke Spanish, three percent spoke English and Spanish, and one percent spoke English and Tagalog. One percent preferred not to answer this question.

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Table 2. Demographic Data for Individuals Who Completed the Focus Group Demographic Survey (N=152)

Demographics		Percent*
Race N=152	White or Caucasian	66%
	Hispanic or Latino	15%
	Multiracial	7%
	American Indian or other Indigenous Group	3%
	Asian or Asian American/other Pacific Islander	2%
	Black or African American	1%
	Prefer not to answer	6%
Gender N=152	Female	70%
	Male	27%
	Gender Non-conforming/Gender Fluid	1%
	Prefer not to answer	2%
Age Group N=150	Adults (25-59)	78%
	Older Adults (60+)	21%
	Transition Age Youth (TAY, 18-24)	1%
Language Spoken at Home N=151	English	84%
	Spanish	11%
	English and Spanish	3%
	English and Tagalog	1%
	Prefer not to answer	1%

*Column percent was calculated based on valid response rates.

Roles That Focus Group Participants Represented

Table 3 shows that "community member" was the most common role that focus group identified with, followed by "mental health consumer/client" and "mental health service provider (32% each), "family member of a mental health consumer/client"(22%), "Member of a community-based organization" (22%), and "County Employee" (20%). See Table 3 for additional roles indicated applied to focus group participants. Two focus group participants indicated they were criminal justice system partners, and two reported the role of a Judge.

Table 3. Roles that Nevada County Focus Group Participants indicated that Applied to Them (n=152)

Fields/Sectors Represented	Count	Percent*
Mental health consumer/client	48	32%
Family member of a mental health consumer/client	33	22%
Mental health service provider	48	32%
Substance use consumer/client	12	8%
Family member of a substance use consumer/client	16	11%
Substance use service provider	14	9%
Unhoused	18	2%
Family member of someone who is unhoused	9	6%
Service provider for the unhoused	12	8%
Community Member	66	43%

NEVADA COUNTY CALIFORNIA | Health & Human Services Agency

County Employee	31	20%
Law Enforcement	0	--
Educator/Teacher	11	7%
Advocate	18	12%
Member of a faith-based organization	20	13%
Member of a community-based organization	31	20%
Healthcare provider	7	5%
Other	21	14%
Other types of community health worker/case mgr.	10	7%
Peer support specialist	4	3%
Justice system partner (2)/Judge (2)	4	3%
Other (school board trustee, data analyst)	2	1%
Licensed marriage and family therapist	1	<1%

*Column Percent exceeds 100% as 96 survey respondents reported multiple roles.

Key Stakeholder Interviews

Eight Key Stakeholder Interviews were conducted between October and early November 2025. A brief description of the interviews conducted is provided in Table 4 below.

Table 4. Interviews Conducted

#	Group Description
1	Tribal and Indian Health Designees
2	Area Agencies on Aging
3	Independent Living Centers
4	Representatives from Youth from Historically Marginalized Communities
5	Representatives from LGBTQ+
6	Victims of Domestic Violence and Sexual Abuse
7	Representatives from Veteran Organizations
8	NCSOS

Stakeholder Survey

A stakeholder survey was conducted between mid-September and early October 2025. The stakeholder survey gathered further insight from key partners and stakeholders of Nevada County Behavioral Health. An overview of participants who completed the stakeholder survey is provided in the tables and figures below.

A total of 119 surveys were partially or fully completed. Of these, 94 were completed, and 25 were partially completed.

Upon further inspection, five of the partially completed surveys had data that could be included in the summary analysis, while 20 were excluded from the analysis due to a high rate of non-response.

NEVADA COUNTY CALIFORNIA | Health & Human Services Agency

Stakeholder Survey

This section summarizes the demographic and service characteristics of stakeholders who participated in the 2025-2026 CPP Nevada County Stakeholder Survey. Below is a summary of findings organized by survey question.

Fields and Population Represented

Table 5 shows that Mental/Behavioral Health was by far the most represented sector, with nearly three-quarters (72%) of respondents working in this field. Social Services was the second most common sector at 17%, followed by Child Welfare at 8%. Substance Use Disorder Treatment (6%), Healthcare (5%), Education (4%), and Housing (4%) represented smaller but substantial portions of the workforce. No representation was reported from Faith-based Organizations, Labor Representative Organizations, Disability Insurers, Law Enforcement, or Public Guardian roles, suggesting potential gaps in these sectors or limited involvement in the survey.

Table 5. Fields/Sectors Nevada County Stakeholder Survey Respondents Reporting Working In (N=99)

Fields/Sectors Represented	Count	Percent*
Mental/Behavioral Health	71	72%
Social Services	17	17%
Child Welfare	8	8%
Other: Substance Use Disorder Treatment	6	6%
Healthcare	5	5%
Education	4	4%
Other: Housing	4	4%
Corrections/Probation	3	3%
Courts/Judicial	3	3%
Other: Public Health	3	3%
Other: Non-Profit/NGO (Youth Services, Homeless)	3	3%
Other: Veterans	2	2%
Other: Tribal(Health & Welfare/Social Services)	2	2%
Other: Family Resources	2	2%
Emergency Department	1	1%
Other: Fiscal	1	1%

*Column Percent exceeds 100% as 19 survey respondents reported working in multiple fields/sectors.

Figure 1 shows that early one-fifth (9%) of respondents worked across multiple fields/sectors, indicating cross-sector collaboration.

Figure 1. Nevada County Behavioral Health Stakeholder Survey Respondents Reported Number of Field(s)/Sector(s) They Work in (N=99)
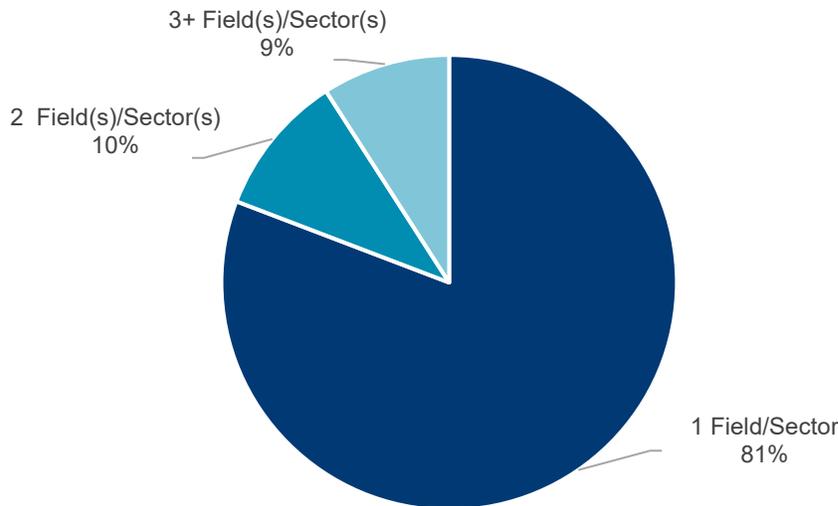

Figure 2 displays the participants' organizational affiliation with Nevada County Behavioral Health. The results show that 88% of respondents considered their organization part of Nevada County Behavioral Health (NCBH), while 12% did not. This distribution suggests NCBH utilizes county-affiliated and independent community providers.

Figure 2. Nevada County Stakeholder Survey Respondents Affiliation to NCBH (N=99)
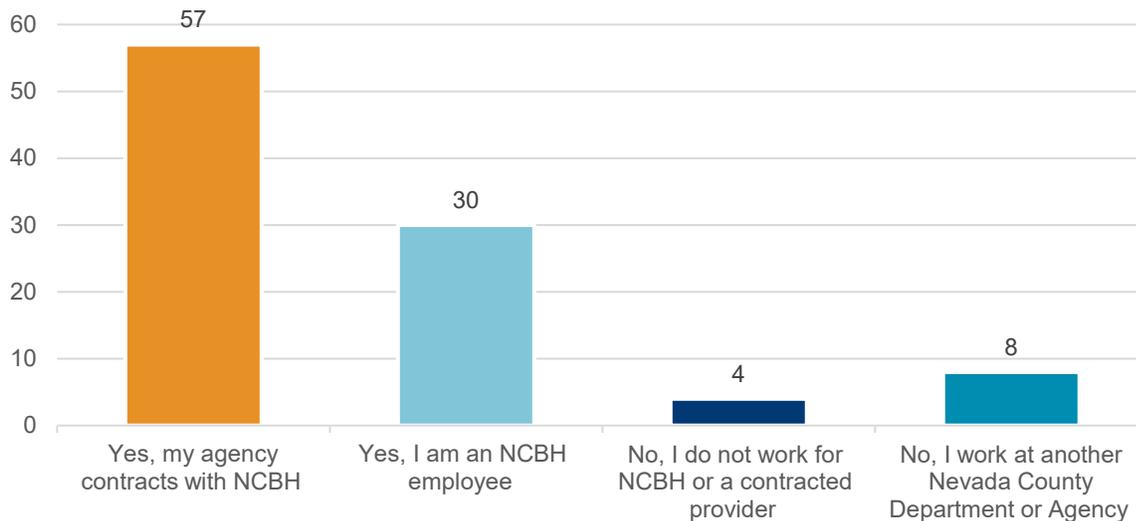

Figure 3 details the age groups served by Nevada County Behavioral Health. Adults (26-59 years) represented the largest primary service population at 64%. One-fifth (20%) primarily served Youth and Young Adults (16-25 years), reflecting a focus on this critical transition period. Older Adults (60+ years) comprised 4% and Children (0-15 years) comprised 12% of the primary populations served.

Figure 3. Age Groups Nevada County Stakeholder Survey Respondents Work with the Most (N=99)
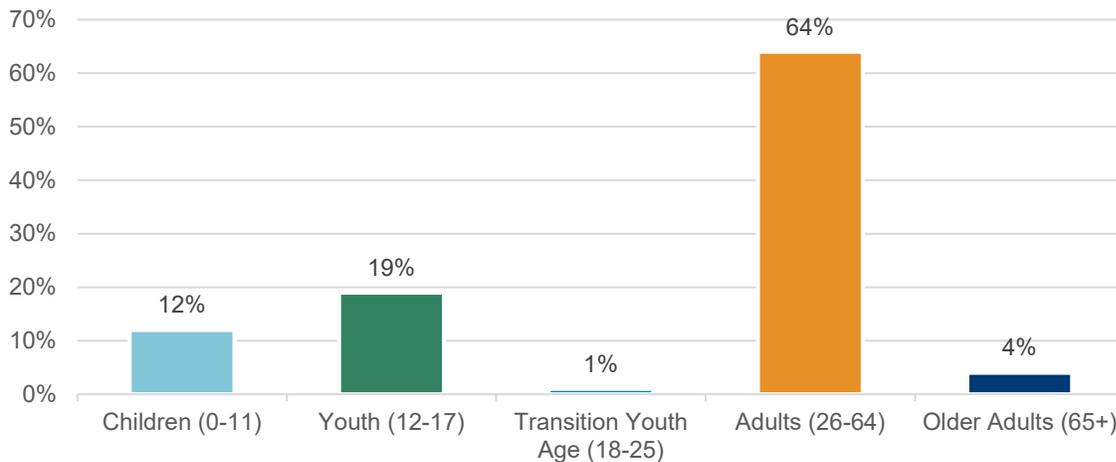

Figure 4 shows the priority populations served among the survey respondents. Individuals at risk of or chronically experiencing homelessness were the most commonly served priority population, with more than two-thirds (68%) of respondents providing services to this group. More than half (57%) served individuals at risk of, currently in, or recently exiting the justice system. More than one-third (35%) served those at risk of institutionalization. Less than one-quarter (24%) indicated they served none of these priority populations. The high overlap suggests many providers work with individuals experiencing multiple, intersecting risk factors, reflecting the complex challenges faced by Nevada County's residents.

Figure 4. Number of Nevada County Stakeholder Survey Respondents Who Reported Providing Services to Adult and Children Priority Populations (N=99)*
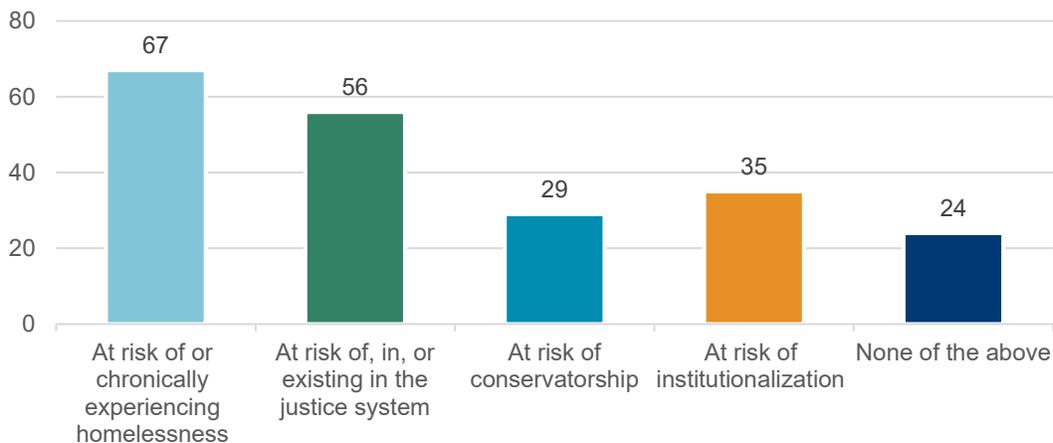
* Survey Respondents were instructed to select all priority populations that applied.

Table 6 displays the percentage of "targeted" and "culturally specific" services provided by the respondents. People with Disabilities were the most frequently served population receiving targeted services (39%), followed by LGBTQIA+ individuals (33%) and Latinx communities (28%). Nearly one-quarter (23%) of respondents provided services specifically targeting the Truckee geographic region. Veterans (16%) and Indigenous People (17%) also received culturally specific services from notable proportions of providers. Around one-quarter (24%) indicated they did not provide targeted services to any of the listed populations,

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possibly reflecting potential gaps in culturally specific programming. Additional populations identified included homeless individuals (5%), youth and families (5%), elderly/seniors (2%), and individuals with mental illness (2%).

Table 6. Populations Nevada County Stakeholder Survey Respondents Report Providing "Targeted" or "Culturally Specific" Services (N=99)

Population Descriptions	Count	Percent*
Veterans	16	16%
People with Disabilities	39	39%
LGBTQIA+	33	33%
Latinx	28	28%
Indigenous People	17	17%
Truckee (geographic region)	23	23%
Other, specified:		
▪ Individuals with Mental Illness	2	2%
▪ Elderly/Seniors	2	2%
▪ Homeless	5	5%
▪ Youth and Families	5	5%
▪ Substance Use Population	1	1%
None of the Above	24	24%

*Column Percent exceeds 100% as survey respondents were instructed to check all populations that applied.

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Behavioral Health Services Act-Related Services

Table 7 shows that Mental Health Services were provided by the vast majority (71%) of respondents, closely aligning with sectoral representation. More than one-quarter (27%) provided Substance Use Disorder Services. Youth-Specific Services (25%) and Housing (23%) were also commonly provided services. Very few respondents (6%) indicated they provided none of these BHSA-related services. The overlap in services suggests many providers offer integrated support to clients.

Table 7. Behavioral Health Services Act-related Services Primarily Provided by Nevada County Stakeholder Survey Respondents (N=99)

Behavioral Health Services Act-related Services	Count	Percent*
Mental Health Services	70	71%
Substance Use Disorder Services	27	27%
Housing	23	23%
Youth-Specific Services	25	25%
None of these	6	6%

*Column Percent exceeds 100% as survey respondents were instructed to check all BHSA-related services that applied.

Table 8 shows the Components of Care. Outpatient or Intensive Community-Based Services represented nearly two-fifths (39%) of primary service provision, indicating a strong commitment to community-based care. One-fifth (20%) of respondents primarily provided Prevention or Early Intervention Services, reflecting investment in upstream interventions. Field-Based Services (10%), Residential Treatment Services (9%), Housing Intervention Services (7%), and Crisis Services (5%) comprised smaller portions of the care continuum. Other services included fiscal management, advocacy, peer support, tribal support, and navigation services.

Table 8. Components of Care Services Nevada County Stakeholder Survey Respondents Reporting Primarily Providing (N=98)

Components of Care Services Provided	Count	Percent
Prevention or Early Intervention Services, Including Education	20	20%
Outpatient or Intensive Community-Based Services	38	39%
Field-Based Services	10	10%
Housing Intervention Services	7	7%
Residential Treatment Services	9	9%
Crisis Services	5	5%
Inpatient/Hospital Services	0	--
Other, specified:		
▪ Fiscal	1	1%
▪ Advocacy	1	1%
▪ Peer support	1	1%
▪ Tribal support	2	2%
▪ Not a provider	2	2%
▪ Navigation/independent living skills	1	1%
▪ Multiple services listed	1	1%

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Behavioral Health Service Effectiveness

Table 9 details the top housing needs among Nevada County Medi-Cal Recipients. Community-Based Supportive Housing was identified as the top housing need, with nearly half (47%) of respondents selecting this option. Transitional housing programs were the second most identified need at 23%. Housing Coordination/Navigating Services represented 17% of responses. Emergency Shelter (5%) and Transitional Housing Programs (5%) were less frequently identified as top priorities. Low-income Permanent Housing represented 4% of responses. Youth residential and Residential SUD/Recovery Housing each represented only 1% of responses.

The strong emphasis on community-based supportive housing aligns with the high need for housing services identified in the mental health and substance use service questions, reflecting a preference for housing models that integrate wraparound support services.

Table 9. Top Housing Needs Among Nevada County Medi-Cal recipients as Identified by Nevada County Stakeholder Survey Respondents (N=94)

Population Descriptions	Count	Percent
Emergency Shelter	5	5%
Transitional Housing Programs	22	23%
Community-Based Supportive Housing	44	47%
Housing Coordination/Navigating Services	16	17%
All of the Above	1	1%
Other, specified:		
▪ Low Income Permanent Housing	4	4%
▪ Youth residential	1	1%
▪ Residential SUD/Recovery Housing	1	1%

Figure 5 shows the rate of need for mental health services among Medi-Cal Recipients. Housing services showed the highest rate of need, with an overwhelming majority (92%) of respondents rating the need as high and no respondents rating it as low. Early intervention services demonstrated a strong need, with nearly three-quarters (71%) rating the need as high and only 2% rating it as low. Crisis intervention/stabilization services also showed substantial need, with more than two-thirds (69%) rating the need as high and 4% as low. Outpatient/community-based services showed that more than half (59%) rated the need as high, and 2% rated the need as low. Peer support services and intensive community-based services showed moderate-to-high need patterns, with 43% and 53%, respectively, rated the need as high. The lowest perceived need was for inpatient hospital services.

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Figure 5. Rate of Need for Mental Health Services Among Nevada County Medi-Cal Recipients
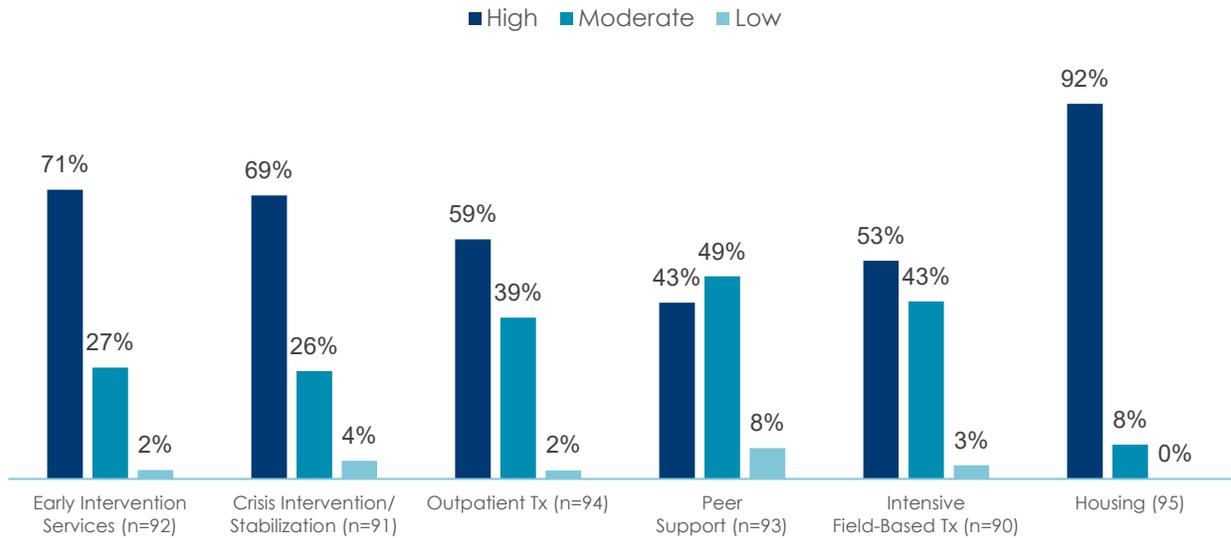

Figure 6 details the rate of need for substance use services among Medi-Cal Recipients. Housing services again emerged as the highest-priority need, with 84% of respondents rating the need as high and only 1% rating it as low. Residential treatment services showed nearly three-quarters (72%) rated the need as high, and 1% rated the need as low. Early intervention services and outpatient/SUD treatment both demonstrated a strong need, with 69% and 65%, respectively, rating the need as high. Recovery support services showed 63% rating the need as high and 3% as low. Medication-assisted treatment and intensive community-based services both showed more than half (58% and 63% respectively) rated the need as high. Across all substance use service categories, very few respondents rated the need as low (ranging from 1% to 4%), indicating overall substantial service gaps for substance use.

Figure 6. Rate of Need for Substance Use Services Among Nevada County Medi-Cal Recipients

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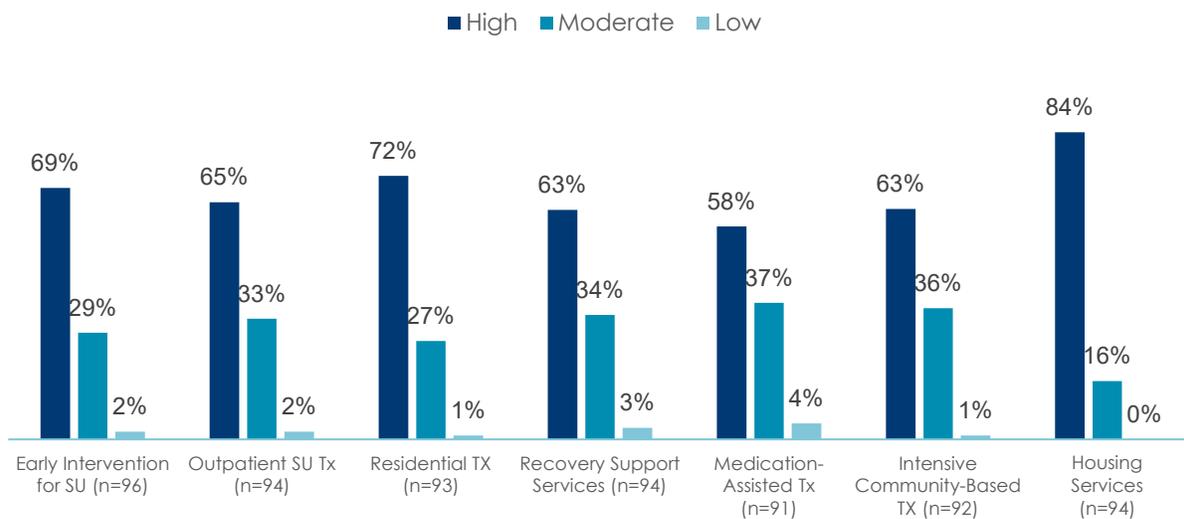
Barriers

Table 10 presents the barriers that respondents have observed their clients and the community face. Perceived lack of transportation emerged as the most critical barrier to accessing behavioral health care, with 83% rating it as "somewhat" or "a lot" of a barrier. Local services not available were the second-highest concern at 69%, followed by excessive delay in getting an appointment at 58% and the cost of care at 57%. Moderate barriers included the inability to take time off work (54%) and the lack of educational outreach (49%). In contrast, discrimination/unfriendliness of providers (12%), language barriers (33%), and concerns about quality of care (28%) received relatively lower ratings. The data indicate that access challenges are more structural and systemic rather than interpersonal or quality-related issues.

Table 10. Barriers for People Accessing Behavioral Health Care in Nevada County

Statements	N	None	A Little Bit	Somewhat	A Lot
Cost of care	90	23%	20%	29%	28%
Lack of transportation	92	4%	13%	38%	45%
Inability to take time off work for an appointment	90	16%	31%	37%	17%
Lack of educational outreach and awareness	91	19%	32%	36%	13%
Language barrier/communication difficulties with providers	90	31%	36%	21%	12%
Discrimination/unfriendliness of providers	90	49%	39%	10%	2%
Concerns about the quality of care or diagnosis	90	33%	38%	24%	4%
Excessive delay in getting an appointment	90	16%	27%	29%	29%
Local services not available	86	14%	17%	29%	40%

Agreement on System Capacity Statements

Displayed in Table 11 (Appendix 3), Nevada County stakeholders were surveyed regarding various aspects of behavioral health system capacity, revealing a gap between provider knowledge and system performance. Respondents strongly agree and agree ratings in knowing where to refer clients for mental health services (82%), substance use disorder treatment (76%), and housing support (75%). However, confidence that these referrals would result in successful service delivery decreased. Only 45% believed clients would receive needed mental health services, 47% for substance use disorder services, and just 42% for housing services.

Providers understand the referral landscape but have learned through experience that knowing where to refer does not guarantee access to services for their clients. The housing system emerged as the area of greatest concern, with the lowest confidence rating across all survey statements. Additionally, only 53% of respondents reported having effective follow-up processes for referrals to Nevada County Behavioral Health, with 12% expressing no opinion, the highest uncertainty rate for any question, suggesting inadequate closed-loop referral systems.

Respondents expressed confidence in their organizations' inclusive service capacity (88%) and telehealth adoption (77%), indicating progress in modernizing individual service delivery. However, 77% agreed that behavioral health education gaps exist in the community, citing insufficient prevention and early intervention programs. The data reveal a system where individual providers are knowledgeable and equipped, but system-level coordination, capacity, and follow-through remain notable challenges.

Qualitative Analysis of Priority Improvement Areas

Finally, an open-ended question asked respondents to identify the most important actions to improve behavioral health care quality and availability. Sixty-six stakeholder responses revealed four priorities. Care coordination emerged as the dominant concern (35% of responses), with stakeholders calling for better collaboration across agencies, simplified system navigation, closed-loop referrals, and improved outreach.

Respondents emphasized that the current system is too complex for both clients and providers to navigate effectively, despite the existence of many individual services.

Staffing challenges were reported in 23% of responses, with stakeholders emphasizing not only hiring more providers but also improving retention through competitive pay, manageable caseloads, and opportunities for advancement. Bilingual and culturally competent staff were specifically identified as a need, particularly Spanish-speaking providers. Housing concerns were reported in 20% of responses, with an overwhelming emphasis on supportive housing models that include wraparound services rather than shelter alone. Multiple respondents noted that housing instability undermines all other behavioral health interventions, with long wait times (2-3 years for some programs) creating critical gaps. Transportation barriers appeared in 9% of responses, consistently described as a notable obstacle in Nevada County's rural geography.

NEVADA COUNTY CALIFORNIA | Health & Human Services Agency

BHSA Goals

Introduction

The Behavioral Health Services Act requires counties to meet six priority goals: 1) Access to Care, 2) Homelessness, 3) Institutionalization, 4) Justice Involvement, 5) Removal of Children from Homes, and 6) Untreated Behavioral Health Conditions. For each goal, there are primary indicators that counties can use to compare their performance to state-level performance.

Furthermore, the Behavioral Health Act outlines additional goals that counties can choose to meet. The additional goals of interest to Nevada County Behavioral Health are 1) Overdoses and 2) Care Experience. As with the priority goals, county performance is compared to **state-level** performance.

This section will provide qualitative insight into the priority goals and additional goals on which Nevada County Behavioral Health is underperforming. The analysis will begin with qualitative findings relevant to underperforming primary measures of priority goals and conclude with qualitative findings relevant to selected underperforming primary measures of selected additional goals.

Primary Goals

Of the six priority goals, there were only qualitative insights into one indicator on which Nevada County was underperforming. This indicator, "People Experiencing Homelessness," was for the priority goal of Homelessness. The data show that Nevada County had a higher rate of people experiencing homelessness than the state.

Homelessness: High Rate of Homelessness

Across a wide range of focus groups and key stakeholder interviews, participants discussed what they perceived to be the *high rate of homelessness* that Nevada County is experiencing. For example, in the Youth Consumer Caregiver focus group, not enough housing for those with a serious mental illness was described as "a constant challenge," with a participant explaining that "the housing situation is dire." More broadly, in the Healthcare Provider focus group, when discussing the unhoused, participants described how "there are no places for them to go." Furthermore, a breakout session of the Nevada County Behavioral Health Staff focus group, a participant described how a "persistent lack of housing remains a major issue." Finally, an interviewee described how for the LGBTQ+ community, "homelessness is a huge risk…because of family rejection."

The issue was also present in Truckee, as the Truckee Adult Mental Health Consumer focus group described how "finding housing is a joke" and that there were no "temporary place[s] to sleep at night in Truckee." A participant from the same focus group described how they perceived a lack of "places for animals and people," noting that individuals with pets were often denied access to shelters.

These findings highlight what participants saw as a need for housing in Nevada County. Participants from both the Western and Eastern parts of the county described homelessness as a notable issue. These findings reinforce the quantitative findings on the high levels of homelessness in Nevada County.

Additional Goals

The additional goals of interest to Nevada County Behavioral Health are 1) Overdoses and 2) Care Experience. For the additional goal of Overdoses, the qualitative data provided insight into the indicator of "The Rate of All Drug-Related Overdose Deaths." For this indicator, Nevada County had a higher rate than the state. For the Care Experience goal, the qualitative data provided insight into the indicator of "Adult Perception of Cultural Appropriateness," on which Nevada County scored lower than the state.

Overdoses: Drug-Related Overdose Deaths

The qualitative data provide insight into the issue of *drug-related overdose deaths*. The theme of overdoses was discussed three times in the data. One participant discussed steps that can be taken to prepare those in the support systems of individuals who have a substance use disorder, while two other participants discussed steps that can be taken to enhance the continuum of care for those who overdose.

First, feedback was shared regarding steps that can be taken to prepare those in support systems of individuals with a substance use disorder. In the Western County Educators focus group, when asked about feedback regarding services for individuals with a substance use disorder, one participant shared that they wanted to see "families and teachers being prepared to administer [Narcan] when [an] overdose occurs."

Second, participants discussed steps that can be taken to enhance the continuum of care for those who overdose. A participant in the Truckee English-speaking providers focus group shared that they wished to see "services to support individuals" who overdosed. Furthermore, in the Overdose Prevention Coalition focus group, a participant shared that in their experience, there was "no comfortable place for unhoused people to stay after an overdose."

Taken together, this feedback recommends that NCBH combat overdose deaths through a multi-pronged approach. On the one hand, NCBH can train those in the support system of individuals with a substance use disorder on how to use Narcan. On the other hand, the continuum of care could be enhanced with further services and resources to support those who overdose, including housing for unhoused individuals recovering from an overdose.

Care Experience: Perception of Cultural Appropriateness

Across a wide array of focus groups, as well as a key stakeholder interview, participants provided insight into their perception of Nevada County Behavioral Health as delivering care that could be **_more culturally appropriate_**. For example, one NCBH staff member described this as "a gap in support for Spanish-speaking adults." Another NCBH staff member described "services for immigrants, refugees, [and] Native Americans" as a gap in NCBH services. In more direct terms, an NCBH contractor said the "cultural competency" is a gap in services for those with a Serious Mental Illness.

Most of the feedback on this issue came from Truckee focus groups. One Spanish-speaking provider explained that from their perspective, there were "no services in Spanish." At a different point in the focus group, a participant described how there were "only two Spanish-speaking providers for the entire county." Furthermore, a Spanish-speaking provider explained that in Truckee, there is only one Spanish-speaking provider for Substance Use Disorder. Finally, a Spanish-speaking provider encouraged "bilingual service expansion."

These findings underscore the need, from both the perspective of providers and NCBH staff, for increased Spanish-language services and a greater number of bilingual providers. Insight was also provided on the perceived need to expand services to more vulnerable populations, such as refugees and Native Americans.

Conclusion

Qualitative findings provide key notable insights into Nevada County's underperformance on one priority goal and two additional goals. For the priority goal, the findings indicate the extent to which homelessness is a notable issue in the county, which could therefore become a funding priority. The findings on the additional goals highlight what participants saw as the importance of providing support for those who overdose, as well as culturally competent care.

Crisis services

This section focuses on qualitative feedback regarding Crisis Services, a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about Crisis Services. Next, it will discuss participants' feedback on the limits of Crisis Services. Finally, this section will conclude with recommendations that participants offered to improve Crisis Services.

Strengths

The biggest strength of crisis services, as emphasized by participants, is the ***existence and performance of the different crisis services and their staff***. From the Mobile Crisis Team, to the CSU, and the CIT, this theme was the most common among all themes across the focus groups and key stakeholder interviews. For example, NCBH staff said that "the mobile crisis team is working well and maintains good communication with staff when their clients engage with crisis services." Similarly, Western County Educators explained that "Mobile crisis unit is going well with response and having a mental health provider come and follow up with the parent on resources."

The Mental Health Advisory Board echoed these sentiments, explaining that the "Mobile Crisis Team is an asset" and that "CSU is a strength." Furthermore, a participant from the Truckee English-speaking providers explained that "having a mobile crisis team [Sierra Mental Wellness Group] at the hospital is working really well…[they have the] direct ability to respond." Finally, an interviewee explained that "The Mobile Crisis team is incredibly beneficial and needed." These findings indicate that across a wide range of community members and stakeholders, there is a perception that crisis services are highly effective and that the staff is doing an excellent job.

Limits of Services

Although crisis services were emphasized as a notable strength of the continuum of care, participants also discussed service issues, such as response times, as well as concerns with crisis lines.

First, participants discussed service issues such as "***response time***" and "follow-through" for crisis services, as some participants felt that services could be improved by being delivered in a more timely manner and with follow-up after care is delivered. For example, regarding response time, a participant in the Western County Educators focus group explained, "Response time isn't as quick, but I haven't had to call them in a while." Participants also described issues such as follow-through. For example, a participant in the Truckee Spanish-Speaking Provider focus group explained that, in their view, a limitation of crisis services was the lack of "no follow-up or sustained support after crisis." This was echoed by an NCBH staff member, who described how "when someone receives mobile crisis services, follow-up could be more seamless; as it's difficult, especially during late-night hours like 2am, clients may receive resources but not follow through."

Participants also described ***service issues they saw with crisis lines***, including issues with customer service and staffing issues. For example, a participant from the Mental Health Advisory Board explained that they believed people who answer crisis line hotlines "don't have much experience or wisdom," while another participant shared that "one time no one answered the phone" at a crisis line when they called. An Adult Mental Health Consumer focus group participant offered a similar assessment, explaining that there was "not enough time to talk" on the crisis line due to staffing issues. Later in this same focus group, a participant explained that the "crisis line seems overburdened."

Taken together, these findings indicate that while widely regarded as a valuable resource, crisis services have room for improvement. Such improvement, from the participants' perspective, would entail decreased response times, increased follow-through after crisis services, increased staffing at crisis lines, and improved crisis line customer service.

Recommendations

Participants offered two main suggestions to enhance crisis services. First, participants encouraged the county to increase outreach and education efforts around crisis services. Second, participants described how they would like to see crisis services expanded.

First, participants requested that the county ***increase outreach and engagement for crisis services***. This entails intensified efforts to raise public awareness of crisis services, as well as enhanced education about these services. For example, in the Criminal Justice focus group, one participant explained that "With mobile crisis, lots of people who don't know what it does, how to do it, and utilize it." Similarly, an interviewee described how there was a "bit of confusion on the types of crises."

To combat this type of confusion, a participant in the Truckee English-Speaking Provider focus group recommended a "Centralized resource directory for all behavioral health programs and providers" as a way to address any perceived public confusion around crisis services. In addition to public outreach, focus group participants also encouraged outreach and education of law enforcement. For example, a participant in the Unhoused focus group explained that they would like to see "training for law enforcement on mental health crises, suicide prevention, and appropriate response."

Second, participants described their ***desire to see crisis services expand***. An NCBH staff member explained that "a more robust Crisis Stabilization Unit (CSU) is needed for overnight stays; currently there are about four beds, and not everyone meets the criteria to stay, making it difficult for some to find a place to go." Similarly, a participant in the Western County Educators focus group explained that they "would like a local 988 call center – understanding is that 988 calls go to Sacramento right now so people who use it aren't receiving services about the local crisis unit in the county." Finally, a participant in the Unhoused focus group expressed a desire for "properly staffed mobile crisis team that responds immediately without wait times."

Taken together, these recommendations encourage the county to increase outreach and training efforts regarding crisis services, as well as expand these services. Suggestions for outreach ranged from a unified directory of all behavioral health services to increased training for law enforcement about mental health crises. Furthermore, recommendations for expanding crisis services discussed the need for additional staff, a local 988 call center, and increased capacity.

Housing

This section focuses on qualitative feedback on Housing Services, a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about Housing Services. Next, it will discuss participants' feedback on the limits of Housing Services. Finally, this section will conclude with recommendations that participants offered to improve Housing Services.

Strengths

For the strengths of housing services, participants discussed *specific housing programs*. For example, HOME Team was mentioned by various participants as a strength. An NCBH staff member explained how "HOME team's outreach and engagement efforts have increased client involvement when they do connect with services." Other programs that were mentioned as strengths include Sierra Outreach Services, Hospitality House, Spirit Center, Sierra Community House, The Stagecoach Project, and FREED.

Limits of Services

Participants emphasized two main limits of housing programs. First, they discussed negative service experiences. Second, they discussed the limits of the transitional process.

Participants discussed their *negative service experiences with housing services*. These negative experiences ranged from facing organizational barriers to navigating services, accessing services, and experiencing staffing issues, as well as delays in service delivery. For example, a participant in the Unhoused focus group explained how they have "been on the waiting list for apartments for less than a year - doesn't matter if you have a full-time job within two weeks of getting out of jail, still homeless." Later in the focus group, a participant described how they wished there was "better coordination between all organizations - have them meet with people with lived experience." These issues were also salient for NCBH staff and service providers. For example, an NCBH staff member explained how "it would be ideal to provide housing support while paperwork is collected, rather than requiring all documentation to be completed before housing can begin."

Next, a limit of service that participants described was the *transitional process*. This means that participants discussed the issues that people faced in transitioning from being unhoused to having permanent housing. This includes issues with transitional housing, care, coordination, and services. For example, a participant in the Mental Health Advisory Board focus group stated that we "need more transitional housing in our community." Similarly, an NCBH staff member described the need for "transitional housing, more places with longer stays, [and] better collaboration with Permanent Supportive Housing contractors to adjust to take people with increased need." Participants with lived experience echoed this theme. A participant in the Adult Mental Health Consumers focus group described a need for "more transitional and permanent affordable housing," as well as for "youth transitional housing." The participant described how homeless youth were "sleeping in the woods [and] couch surfing."

Taken together, these findings highlight the limitations of housing services in terms of service experience and services related to transitional housing. As NCBH transitions to the Behavioral Health Services Act, these are areas that it could prioritize.

Recommendations

Participants across focus groups emphasized two major themes for recommendations for housing services. First, they discussed the need for financial aid and housing for the unhoused. Second, they recommended more housing and integrated services for those with a serious mental illness, a substance use disorder, or a co-occurring substance use disorder and mental illness.

First, participants recommended an array of *financial and housing support for the unhoused*. For example, one NCBH staff member recommended "longer-term funding for transitional housing." Similarly, a participant in the Contractor focus group discussed how "finding permanent housing" for the unhoused should be a priority of the county. Those with lived experience voiced similar desires. One participant explained, "Financial aid or direct financial assistance to those who are incapable of starting somewhere doesn't exist and is needed." Finally, an interviewee recommended that NCBH "[build] more accessible housing."

NEVADA COUNTY CALIFORNIA | Health & Human Services Agency

Second, the qualitative data focused on ***providing housing for individuals with SUD, SMI, and co-occurring conditions***. In the Youth Consumer Caregiver focus group, participants reported a lack of housing options for individuals with SMI. The participant said that providing this housing is "a constant challenge…if they're not stable in housing, then there are a lot of other issues." The participant concluded by explaining how "the housing situation is dire" for those with SMI and SUD. Finally, a participant in the Adult Mental Health Consumer focus group explained how they wanted to see "more housing…[for] those with MH services. More than just a handful of apartment complexes, so much room for tiny homes."

Taken together, these findings emphasize what participants saw as the need for housing for the unhoused, those with an SUD, those with SMI, and those with a co-occurring SUD and SMI. These priorities align with BHSA priorities. The findings then reaffirm that priorities outlined by BHSA and suggest that NCBH could prioritize providing housing for these groups.

Severe Mental Illness (SMI)

This section focuses on qualitative feedback on Serious Mental Illness Services (SMI), which are a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about Serious Mental Illness Services. Next, it will discuss participants' feedback on the limits of Serious Mental Illness Services. Finally, this section will conclude with recommendations that participants offered to improve services for individuals with Serious Mental Illness.

Strengths

Participants highlighted two main strengths of services for those with serious mental illness. First, they emphasized the quality of services. Second, they discussed specific programs that they considered strengths.

First, participants described the ***experience and quality of services for those with a serious mental illness*** as a strength. For example, a participant from the Youth Early Intervention Providers focus group shared that the "county is doing a good job for SMI." Additionally, a participant in the Adult Mental Health Consumers focus group stated, "Case managers are doing a fabulous job." Finally, an interviewee explained that for staff treating SMI, "They are very busy and often overwhelmed, but they really do work well together."

Second, participants describe ***specific SMI programs that they believed were working very well***. Programs such as TTUSD Wellness Centers were highlighted by participants. One participant in the Overdose Prevention Coalition focus group explained that "TTUSD Wellness Centers and staff that are trained are doing a fantastic job. TTUSD is a leader in mental health services, staff, and specialists, and has grown incredibly. Having wellness centers in all our schools is not common." Tahoe Forest Hospital System and Odessey House were mentioned as strengths of SMI services.

Taken together, these findings show that the strengths of the Nevada County continuum of care for SMI include service experience and specific programs. This means that NCBH staff and providers, as well as programs such as TTUSD Wellness Centers and the Odyssey House, were highlighted by participants.

Limits of Services

While participants highlighted the strengths of the services, they also discussed the limitations of these services. The major themes that emerged among participants as limitations of services included issues with coverage for SMI services, as well as concerns about outreach and education.

Participants described what they perceived as a ***lack of coverage*** as a major theme. This was one of the most commonly observed themes throughout the qualitative data. "Lack of coverage" refers to participants' feelings that SMI services did not cover them or their loved ones. This often included a perceived lack of emphasis on prevention, as well as issues that participants had with NCBH's definition of "severe" when defining what a severe mental illness was. For example, one participant in the NAMI focus group explained that they tried to get help for someone who was starting to spiral and was showing signs of an episode. The participant wanted NCBH to intervene, but was told that the situation was not severe enough to warrant

NEVADA COUNTY CALIFORNIA | Health & Human Services Agency

treatment. The participants described how they were "knocking at the door" for help before things got worse, but "the gate still is closed rather than open." These findings show the potential for clearer eligibility criteria for county behavioral health services.

This was echoed in the Youth Consumer Caregiver focus group, as one participant said, "The word is severe. What defines severe?" The participant went on to explain that the problem is that NCBH only offers help for those with severe mental illness. Later, the participant explained that "This word 'severe' seems to rule the world. What seems severe to you might be different from what I look at." The participant concluded by explaining, "I have to prove how severe it is…I know what's going on, I know the signs, why won't you help me?"

Another prominent theme that was voiced often throughout the data was the **need for outreach and education**. For example, one NCBH staff member explained, "Some of the challenges may be educational, supporting family members to make a phone call, helping case managers take notes, and managing conflicts that may arise." Furthermore, a participant in the Adult Mental Health Consumer focus group explained that they wanted to see "more focus on education on diagnosis, understanding your own diagnosis and how to live with it." Finally, a participant in the Truckee Adult Mental Health Consumer focus group said that a limit was that there was "not enough promotion of services and knowledge shared, worried that making more money might lead to loss of services such as medical."

Recommendations

Finally, a major theme for recommendations for SMI services emerged from the data. Participants recommended increasing programs that aimed at stigma reduction.

Stigma reduction was the main recommendation that emerged from the data. Stigma reduction was deemed necessary by participants for the public, as well as for staff and law enforcement. In the Healthcare Providers focus group, one participant explained that they would like to see a partnership with NCBH "so hospital staff are not afraid of mentally ill patients." Similarly, participants discussed what they perceived as a need to reduce the stigma of parents of children with SMI. For example, a participant in the Mental Health Advisory Board focus group described how "Parents can be blamed for their child's mental illness."

This was echoed in the NAMI focus group, as one participant shared that "too often [the family] is blamed" for their child having an SMI. Later in the focus group, a participant described how "providers make parents feel like they are crazy. [They] lecture parents for being late when they are overwhelmed with taking care of SMI children. [There is a] lack of empathy among providers." A solution for reducing stigma, as identified by a NAMI focus group participant, was to involve parents: "Parents could be a huge part of the solution if they were educated and approached properly."

Substance Use Disorder (SUD)

This section focuses on qualitative feedback on Substance Use Disorder Services (SUD), which are a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about Substance Use Disorder Services. Next, it will discuss participants' feedback on the limits of Substance Use Disorder Services. Finally, this section will conclude with recommendations that participants offered to improve Substance Use Disorder Services.

Strengths

Participants highlighted **specific SUD programs** as strengths. In particular, participants discussed substance use navigators, community health workers, "telehealth options," "County SUD screening clinics," and County-contracted vendors as strengths of SUD services.

Limits of Services

Participants discussed the limits of SUD services. In particular, the two major themes that emerged were a perceived lack of services for minors and a perceived lack of services in Truckee.

Participants described how they perceived there to be a **lack of SUD services for minors**. For example, one NCBH staff member stated that "low-barrier SUD treatment for youth is needed." Moreover, a participant in the Mental Health Advisory Board focus group explained that there was a "gap in services for youth and youth with SUD…[youth have] two options and if neither of those options work out," they have no more options. They went on to explain that "With adults you can do SUD screening but not with youth…at the end of the day, there were no options presented because [the consumer was] underage." Finally, a participant in the Overdose Prevention Coalition focus group described how there was a gap in "youth treatment in general – what is available? How do referrals happen?" This feedback shows what participants perceived as the need for enhanced youth SUD services for minors that can serve an increased number of individuals.

Furthermore, participants described what they perceived to be a **lack of services in Truckee**. A participant in the Criminal Justice focus group said that "Truckee [is] very underserved" in the areas of SUD services. This was echoed by Truckee Spanish-Speaking Providers. They described how, for SUD services, they faced "geographic limitations." In particular, they described how "previous services in Kings Beach absorbed and withdrawn…[we] used to have an office with three people, one Spanish-speaking. Now nothing is available in the area."

Recommendations

Two major themes emerged from the data for recommendations for SUD services. Participants emphasized the importance of education and stigma reduction around SUD, as well as the need for a Detox Center and Residential Care.

One of the most prominent themes across all of the focus groups and interviews was the recommendation by participants for **more education and stigma reduction around SUD**. In the Healthcare Provider focus group, one participant described how there was substantial "stigma for someone [in the] mental health system or [with a] substance use disorder." They recommended "[addressing] both training and stigma through one training." The need for education was then emphasized by a participant in the Youth Early Intervention Provider focus group, who explained that they would like NCBH to find "a way to make it common knowledge for youth to easily access substance abuse services." In terms of educating consumers, an NCBH staff member suggested "teach[ing] clients how to manage their triggers from the very beginning." Finally, from the side of those with lived experience, a participant in the Adult Mental Health Consumer focus group expressed the desire to see "[a]dditional training and education with mental health."

Finally, participants stressed the **need for a Detox Center, as well as for expanded Residential Care**. Regarding a Detox Center, one participant in the Truckee English-Speaking Provider focus group explained that they perceived there to be a "lack in detox centers, and it is difficult to get into the beds." Similarly, an interviewee explained that "[t]here just are not enough treatment or detox facilities." A solution was suggested by the Criminal Justice focus group, where a participant said NCBH should "[a]dd a detox or sobering center."

NEVADA COUNTY CALIFORNIA | Health & Human Services Agency

Regarding expanding Residential Care, a participant from the Overdose Prevention Coalition focus group described how this perceived need extended to "SUD residential treatment for patients – [there] just doesn't seem to be enough." Similarly, a participant in the Healthcare Provider focus group suggested a solution: that there was a "[n]eed for sobering centers and residential treatment beds for the medical population/uninsured."

Workforce

This section focuses on qualitative feedback regarding aspects of the Workforce, a key component of the behavioral health continuum of care. This section begins by highlighting the strengths that participants discussed about the Workforce. Next, it will discuss participants' feedback on the limits of the Workforce.

Strengths

Focus group participants described two major strengths of the NCBH workforce. First, they described NCBH employees and collaborators as a strength. Second, they described the strong workplace culture of NCBH as an additional strength.

The second most common theme across all of the interviews and focus groups was that the ***NCBH workforce was a major strength***. Participants described NCBH staff, employees, case managers, management, volunteers, and board members as a major strength of the NCBH continuum of care. An internal perspective was voiced by an NCBH staff member, who said that NCBH is "a great team" and that their coworkers are "fantastic." Similarly, the Mental Health Advisory Board praised the "compassion" of the NCBH workforce and the "staff's ability to cooperate with consumers and other organizations." A participant added, "We think Phoebe is great! We have a great director." The participant went on to describe how the "state board has said that Nevada County is one of the most collaborative in the state." This sentiment was echoed by consumers as well. A participant in the Adult Mental Health Consumer focus group added that NCBH "offers more than most counties. [They] are already doing a fantastic job already between psychiatrists, peer support people, therapists doing a fantastic job with what they have."

The second major theme that emerged was ***praise for NCBH's workplace culture***. For this theme, participants described the strength of the NCBH workforce as characterized by a strong workplace culture that demonstrates coordination, innovation, and effective management approaches. For example, an NCBH staff member explained that NCBH's "safe, healthy work culture equips staff to serve the community better." Similar sentiments were echoed widely among the different NCBH staff focus groups. From an external perspective, an interviewee explained that they "feel good to partner with NCBH."

Limits of Services

Finally, the central theme that emerged across the interviews and focus groups regarding the limits of the NCBH workforce was the ***issue of staffing***. Participants discussed the perceived lack of staff, noted what they believed was high turnover, and expressed their concerns about the need for enhanced timeliness of services. In the Criminal Justice focus group, for example, a participant discussed how there were, in their opinion, "not enough behavioral health workers…NCBH should double the number of people helping out their clients." From the consumer perspective, the issue of turnover was noticeable. For example, a participant in the Youth Consumer Caregiver focus group explained that "[t]here's just so much turnover it's become quite the barrier to families receiving services."

Conclusion

The 2025-2026 Community Program Planning Process for Nevada County's Behavioral Health Services Act (BHSA) Integrated Plan engaged both system stakeholders and community participants between August and October 2025. Data collection included 16 focus groups with community members and individuals with lived experience, eight key stakeholder interviews with system partners representing the required stakeholder categories, one survey, and one demographic form. System stakeholders included representatives from mental and behavioral health agencies, social services, child welfare, substance use disorder treatment programs, healthcare providers, education, tribal organizations, veterans' services, LGBTQ+ advocacy groups, domestic violence services, independent living centers, and aging services. Community participants included mental health consumers, family members and caregivers, youth, unhoused individuals, Spanish-speaking community members, and various provider groups who shared their experiences and perspectives on behavioral health services in Nevada County.

Summary of Key Findings

CRISIS SERVICES

Crisis services, particularly the Mobile Crisis Team and Crisis Stabilization Unit (CSU), were identified as major strengths across stakeholder groups. Staff performance and coordination received consistent praise from educators, providers, and community members. However, participants noted what they saw as areas for improvement, including follow-through after crisis intervention, crisis line staffing, and an enhancement of the timeliness of services. Some callers reported difficulty reaching crisis lines or feeling rushed during calls. Stakeholders recommend expanding crisis service capacity, establishing a local 988 call center (calls currently route to Sacramento), increasing CSU bed capacity beyond the current four beds, and improving outreach to both the public and law enforcement. A centralized resource directory was also suggested to reduce confusion about available crisis services and how to access them.

HOUSING

Specific housing programs, including HOME Team, Sierra Outreach Services, Hospitality House, and Spirit Center, were recognized as strengths. However, housing emerged as the most critical need across all service areas, with 92% of survey respondents rating it as a high priority. Participants described a perceived need to enhance the timeliness of services, issues with documentation requirements prior to housing placement, and challenges with coordination between organizations. The transitional housing process was identified as an area in which participants perceived an opportunity for growth, with a perceived need for more options for youth and enhanced support during the transition to permanent housing. Stakeholders strongly recommend expanding community-based supportive housing with wraparound services, increasing transitional housing capacity, providing longer-term funding, and streamlining the application process. Housing for individuals with serious mental illness, substance use disorders, and co-occurring conditions was emphasized as a priority aligned with BHSA requirements.

SEVERE MENTAL ILLNESS (SMI)

Service quality and case management for SMI were praised, with TTUSD Wellness Centers, Tahoe Forest Hospital System, and Odyssey House highlighted as exemplary programs. However, participants highlighted what they perceived to be some issues with service eligibility criteria. Parents and caregivers expressed frustration that the definition of "severe" hindered the county's ability to intervene in situations before they escalated into crises. One participant described "knocking at the door" for services but being told the situation was not severe enough. These findings reveal the potential for enhanced clarity of county behavioral health services eligibility criteria. Outreach and education about SMI services were also identified as growth areas. Stakeholders recommend reducing stigma among hospital staff, law enforcement, and the general public. Parents of children with SMI specifically requested that providers approach families as partners. Finally, participants requested enhanced education for families about diagnoses and available services.

Nevada County California | Health & Human Services Agency

SUBSTANCE USE DISORDER (SUD)

Substance use navigators, community health workers, telehealth options, County SUD screening clinics, and County contracted vendors were identified as program strengths. Participants described what they perceived to be limitations in SUD treatment for minors, with participants noting that youth have limited options if initial referrals are unsuccessful. These findings highlight the perceived need for youth SUD services and the potential to develop enhanced SUD services for minors that can serve a greater number of individuals. Geographic disparities were also perceived by participants, with Truckee described as "very underserved," and previous Spanish-speaking SUD services in Kings Beach having been discontinued. Stakeholders emphasized what they perceived as a need for education and stigma reduction around substance use, noting that stigma affects both access to care and quality of treatment. The most frequent recommendation from participants was to establish a local detox center and expand residential treatment capacity. Participants also emphasized the potential to enhance the timeliness of services, highlighting the importance of "grab them when they are ready."

WORKFORCE

NCBH staff, case managers, volunteers, and leadership received widespread praise for compassion, collaboration, and effectiveness. The workplace culture was described as safe, healthy, and innovative. External partners reported positive collaboration experiences, and consumers noted that Nevada County offers more services than most counties. However, what participants perceived as staffing shortages were identified as an issue that participants thought affected service delivery across all programs. Participants described what they perceived as issues with staffing levels, which led to heavy caseloads and a perceived need for more timely services. Staff turnover, although perceived as lower than in other countries, was considered a barrier to continuity of care for families. The need for bilingual staff, particularly Spanish-speaking providers, was emphasized throughout the data.

Appendix 1 – Statewide goals

Goals *in red* are goals in which the county is performing *'worse'* (i.e., higher or lower, depending on the goal) on one or more primary measures compared to the average of all California counties.

Priority Goals

- Access to Care
- Homelessness
- Institutionalization[2]
- Justice-Involvement
- Removal of Children from Home
- Untreated Behavioral Health Conditions

Additional Goals

- Care Experience
- Engagement in School
- Engagement in Work
- Overdoses
- Prevention and Treatment of Co-Occurring Physical Health Conditions
- Quality of Life[3]
- Social Connection[4]
- Suicides[5]

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[2] Limited data available

[3] Performance on one primary indicator *negligibly* below state average

[4] Performance on one primary indicator *negligibly* below state average

[5] Performance on one primary indicator *negligibly* below state average

NEVADA COUNTY CALIFORNIA | Health & Human Services Agency

Appendix 2 – Required Stakeholders

A list of the required stakeholders, as presented in the Integrated Plan template, is provided in the table below.

Required Stakeholder/Group	Able to engage?	Reason not engaged?
Area agencies on aging	Yes	-
BHSA eligible adults and older adults	Yes	-
Community-based organizations serving culturally and linguistically diverse constituents	Yes	-
Continuums of care, including representatives from the homeless service provider community	Yes	-
County social services and child welfare agencies	Yes	-
Disability insurers	No	Attempted but did not receive a response
Early childhood organizations	Yes	-
Families of BHSA eligible children and youth, adults, and eligible older adults	Yes	-
Higher education partners	Yes	
Health care organizations, including hospitals	Yes	-
Health care service plans, including Medi-Cal managed care plans	Yes	-
Independent living centers	Yes	-
Individuals with behavioral health experience, including peers and families	Yes	-
Labor representative organizations	Yes	-
Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+) communities	Yes	-
Local education agencies	Yes	-
Local public health jurisdictions	Yes	-
Organizations specializing in working with underserved racially and ethnically diverse communities	Yes	-
People with lived experience of homelessness	Yes	-
Providers of mental health services	Yes	-
Providers of substance use disorder treatment services	Yes	-
Public safety partners, including county juvenile justice agencies	Yes	-

Nevada County California | Health & Human Services Agency

Regional centers	No	Attempted but did not receive a response
The five most populous cities in counties with a population greater than 200,000	No	Stakeholder group is not applicable to county
Veterans and representatives from veterans' organizations	Yes	-
Victims of domestic violence and sexual abuse	Yes	-
Youth from historically marginalized communities	Yes	-
Youths (individuals with lived experience), youth mental health organizations, or youth substance use disorder organizations	Yes	-

NEVADA COUNTY CALIFORNIA | Health & Human Services Agency

Appendix 3 – Additonal Survey Results

Table 11. Survey Respondents Agreement on Statements

Statements	Valid n	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	No Opinion or Don't Know
There are gaps in behavioral health education and wellness programming about behavioral health in my community.	95	1%	5%	13%	58%	19%	4%
My organization has provided me with adequate tools for providing services for diverse patients/clients in an inclusive way.	94	1%	0%	7%	49%	39%	3%
My organization utilizes remote/phone/video appointments with my clients/patients.	95	3%	4%	7%	40%	37%	8%
If a client/patient needed a higher level of care for their mental health, I know how and where to refer them.	94	3%	6%	5%	44%	38%	3%
If I refer a client/patient for a higher level of care for their mental health, I am confident that they will receive the services they need.	95	3%	26%	23%	32%	13%	3%
If a client/patient needed (additional) help with substance use services, I know how and where to refer them.	94	0%	7%	11%	46%	30%	6%
If I refer a client/patient for additional help with substance use services, I am confident that they will receive the services they need.	95	1%	18%	28%	34%	13%	6%
If a client/patient needed additional help with housing support, I know how and where to refer them.	94	1%	4%	16%	55%	20%	3%
If I refer a client/patient for additional help with housing support, I am confident that they will receive the services they need.	95	5%	17%	29%	38%	6%	4%
My organization provides an effective process for following up after referrals are made to NCBH when a client/patient needs additional help.	94	1%	10%	24%	35%	18%	12%