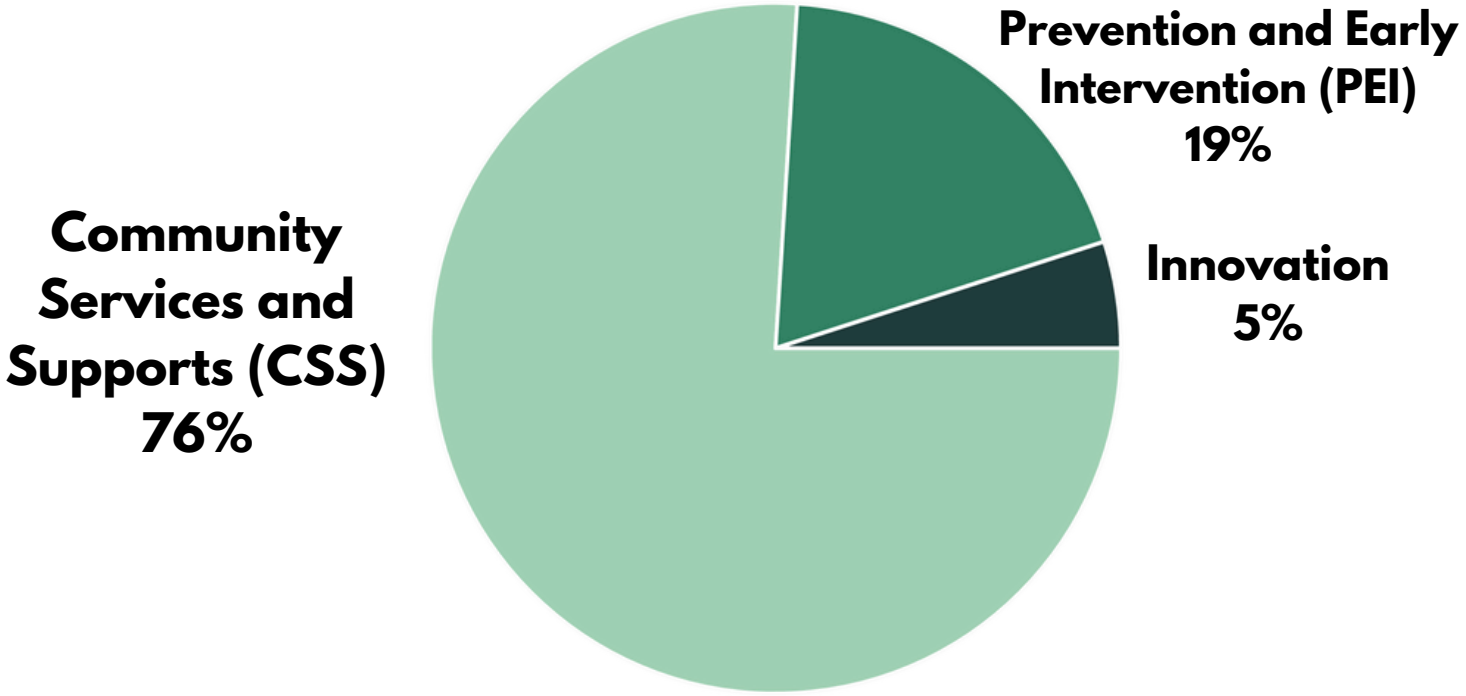
NEVADA COUNTY
MHSA ANNUAL PROGRESS REPORT
FISCAL YEAR 2023/2024

NEVADA COUNTY
CALIFORNIA

MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL PROGRESS REPORT FOR FY 2023/2024

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

MENTAL HEALTH SERVICES ACT (MHSA) COMPONENTS



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

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

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

ADULT FULL SERVICE PARTNERSHIP

Performance Outcomes July 2023 - June 2024

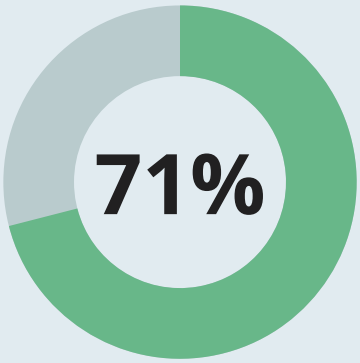
Adult Full Services Partnership (FSP) programs are designed for individuals 18+ years old who have been diagnosed with a severe mental illness and would benefit from a more intensive outpatient program. In Fiscal Year 2023/2024, Turning Point Community Programs was the primary Adult FSP provider in Nevada County.

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

104 INDIVIDUALS SERVED

17% *18 individuals* GAINED OR MAINTAINED EMPLOYMENT

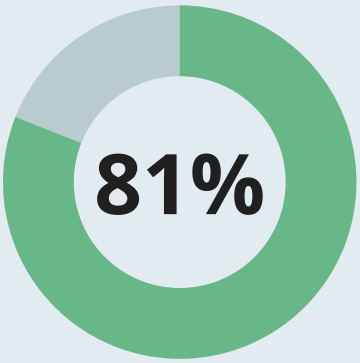
HOUSING & HOMELESSNESS



SUCCESSFULLY REMAINED HOUSED

74 individuals

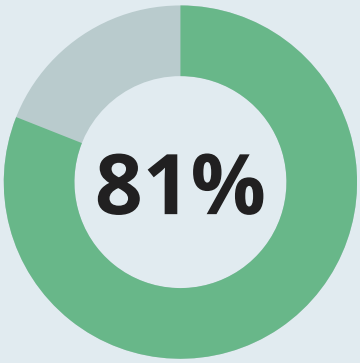
PSYCHIATRIC HOSPITALIZATION



AVOIDED PSYCHIATRIC HOSPITALIZATION

85 individuals

CRIMINAL JUSTICE INVOLVEMENT



AVOIDED ARREST OR INCARCERATION

85 Individuals

COUNTY OF NEVADA CALIFORNIA

TURNING POINT COMMUNITY PROGRAMS
A Path to Mental Health

CHILDREN'S FULL SERVICE PARTNERSHIP

Performance Outcomes July 2023 - June 2024

Children's Full Service Partnership (FSP) programs are intensive mental health treatment programs for children under age 21 diagnosed with a serious emotional disturbance or mental illness and their families. In Fiscal Year 2023/2024, Victor Community Support Services (VCSS) and Stanford Sierra Youth and Families (SSYAF) were the Children's FSP providers in Nevada County.

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

157 YOUTH SERVED

6% increase from previous year

98%
SUCCESSFULLY REMAINED HOUSED

91%
AVOIDED PSYCHIATRIC HOSPITALIZATION

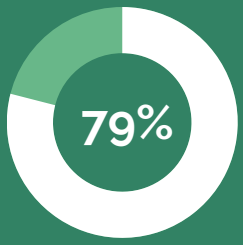
98%
AVOIDED NEW LEGAL INVOLVEMENT

ACADEMIC PERFORMANCE

- **81%** maintained a C average or improved their academic performance
- **92%** did not experience a suspension or expulsion
- **82%** of discharged youth reported regular school attendance or improvement in school attendance

CAREGIVERS

of caregivers reported increased connections in the community



of caregivers reported their parenting skills increased or improved

Stanford Sierra Youth & Families

County of Nevada California

Victor

COMMUNITY SERVICES AND SUPPORTS (CSS)

GENERAL SYSTEM DEVELOPMENT

Key Program Outcomes for FY 2023/24

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

87

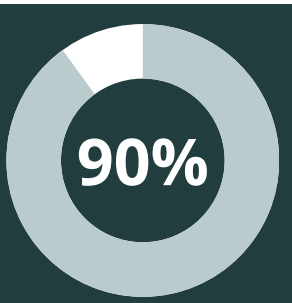
individuals utilized the Insight Respite Center for short term peer-centered respite care

1,423

Crisis assessments completed by SMWG Crisis Team

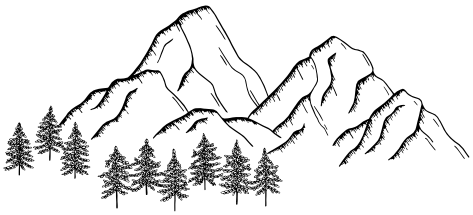
48

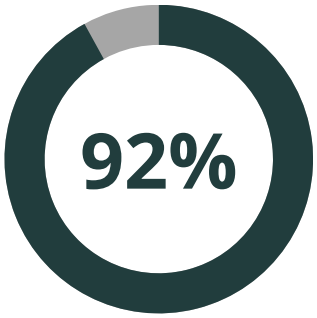
individuals in crisis received peer support at the Emergency Department or Crisis Stabilization Unit



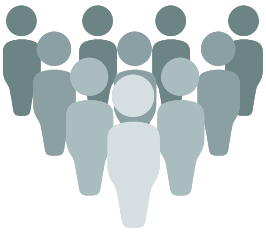
client satisfaction with treatment and progress made during their CSU stay

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





of the 156 children served by Stanford Sierra Youth & Families were stabilized at home or in foster care



NAMI provided family education and support including holding 48 group meetings and 10 educational meetings. 93% of participants stated their ability to manage their self-care had improved due to participation in NAMI.

- 14 individuals were served by network providers (3 children and 11 adults)
- Nevada County Behavioral Health provided expanded services to 781 individuals.

OUTREACH AND ENGAGEMENT

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

106

individuals served by AMI Housing

2,739

peer support sessions provided by SPIRIT Peer Empowerment Center

102

veterans referred to Sierra Family Therapy Center for mental health services

74

veterans and their families with mental health needs served by Veterans Services Office

11

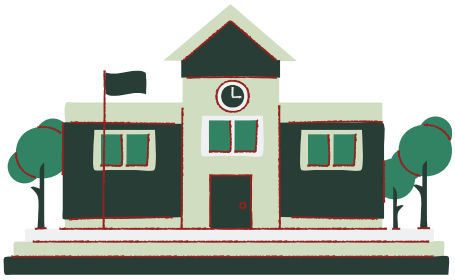
individuals served by embedded case manager at Hospitality House

PREVENTION AND EARLY INTERVENTION (PEI)

YOUTH OUTCOMES

519

Nevada County high school youth screened for mental health needs



428

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

All 17 mothers who completed 6 or more sessions in the Moving Beyond Depression program showed improvement in depression symptoms

43 individuals in the Truckee region experiencing homelessness received case management & referrals to services

94%

of 16 youth mentorships for elementary schoolers were sustained throughout the year

PREVENTION AND EARLY INTERVENTION (PEI)

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

120 youth participated in Boys and Girls Club activities in the Tahoe/Truckee region. 100% of participants reported positive changes in social/emotional well-being.

84% of the 261 Tahoe/Truckee families who participated in parenting classes reported increased feelings of acceptance related to seeking mental health services.

LATINX OUTCOMES

33

individuals received bilingual therapy

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

24

mental health referrals made by Promotoras

696

Referrals made by Promotoras to other community agencies

PREVENTION AND EARLY INTERVENTION (PEI)

OLDER & HOMEBOUND ADULT OUTCOMES

86%

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

79%

of older adults and homebound adults surveyed by the FREED Friendly Visitor program reported an improvement in their quality of life

OTHER PEI OUTCOMES

- 45 young adults in the Tahoe/Truckee region participated in Youth Empowerment groups
- 89 individuals attended Mental Health First Aid trainings
- Suicide prevention trainings provided to 148 individuals
- The SAFE (Stability-Access-Foundation-Empowerment) program served 140 youth experiencing housing instability, including 19 young families/pregnant youth.

Community Services and Supports (CSS)

Children's Full-Service Partnership (FSP):

VICTOR COMMUNITY SUPPORT SERVICES (VCSS)

Program Description

Program Overview

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

Target Population

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

Individuals are referred to Victor from the SMART Team, Children's Behavioral Health, Child Welfare Services, Probation, or school districts, including youth qualifying for Medi-Cal, and/or Katie A services.

Evaluation Activities and Outcomes

In FY 23/24, VCSS Grass Valley provided 148 youth with mental health and/or Wraparound services, a 6% increase over the total served in FY 22/23. Twenty-one (21) of these clients were served at VCSS Truckee and 128 were served at VCSS Grass Valley (including one client served at both sites.). The goals of these services are to reduce hospitalizations and recidivism for juvenile offenders, improve school performance, improve targeted behaviors, increase community connections, and provide effective services to ensure the most efficient, least restrictive, and most appropriate level of care for youth and their families.

Housing: During FY 23/24, 100% of the 148 clients served remained in a community living situation and avoided a higher level of residential care. No clients required a new group home placement in the year.

Employment and education: VCSS achieved its contractual goal of ensuring at least 80% of parents report youth maintained a C average or improved on their academic performance, as 81% of parents surveyed reported their child maintained a C average or saw improvement in their child's academic performance by discharge.

VCSS achieved its contractual goal of ensuring at least 75% of youth maintain regular school attendance or improve their school attendance, as 83% of discharged youth reported regular school attendance or improvement in school attendance (based on the CANS item "School Attendance").

VCSS achieved its contractual goal of ensuring that at least 70% of youth have no new suspensions or expulsions between admit and discharge; All 148 clients served did not experience an expulsion in this fiscal year, while 92% did not experience a school suspension.

Criminal Justice involvement: VCSS achieved its contractual goal that at least 70% of youth have no new legal involvement (arrests/violations of probation/citations) between admission and discharge. In FY 23/24, 98% of clients had no new legal involvement while receiving services, and only one engaged discharge client (2%) had an actionable need in the Legal item at discharge.

Acute Care Use: Ninety-one percent (91%) of clients did not experience a psychiatric hospitalization during the fiscal year.

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

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

VCSS achieved its contractual goal of at least 80% of parents/caregivers reporting that there was an increase in their parenting skills. In FY 23/24, 80% of surveyed caregivers reported their parenting skills increased or improved, while 74% of engaged discharges' caregivers reported no actionable needs in parenting knowledge upon engaged discharge.

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

Victor achieved its contractual goal of ensuring that at least 80% of individuals improved their scores on the Comprehensive Child and Adolescent Needs and Strengths (CANS) instrument between intake and discharge. During FY 23/24, 87% of individuals with a planned discharge (including the engaged discharge at VCSS Truckee) improved in at least one of the following CANS domains: Life Functioning, Behavioral/ Emotional Needs, Risk Behaviors, and/or Educational Needs; 1 of 2 engaged discharges at VCSS Truckee (50%) achieved this goal. Additionally, 90% of surveyed caregivers reported their child's targeted behaviors had decreased at time of survey.

Service Access and Timeliness There were 54 discharges this year, with 38 (70%) fully engaged in services. For FY 23/24, the median length of service for engaged discharged populations was 13.4 months for Grass Valley (n=36) and 17.0 months for VCSS Truckee (n=2).

VCSS nearly achieved its contractual goal of attempting initial contact with 100% of referrals (N=66) within three (3) business days of receipt of referral, as initial contact was *attempted* for 86% of referrals within three business days.

VCSS achieved its contractual goal of offering an appointment for face-to-face contact with 80% of children and families within 10 business days of receiving the referral, as 89% of eligible referrals were *offered* an appointment date in this time frame.

Challenges, Solutions, and Upcoming Changes

Victor continues to employ a team of clinicians, Facilitators, Parent Partners, and Family Support Counselors who all receive training and supervision specific to the wraparound model. During this fiscal year, a handful of VCSS's non-clinician staff received certification in Life Space Crisis Intervention (LSCI) to contribute more proactively with families experiencing acute crisis. Victor also sent a team to be trained and certified in PC-Cares, to meet the need of younger clients being referred to Wrap. Victor provided in-house training to all staff around the ARC framework, to build more knowledge and understanding around child, adolescent and caregiver complex trauma and attachment. Nurtured Heart Approach (NHA) training continues to be required for new staff. VCSS has also consistently increased the amount of Therapeutic Behavioral Services (TBS) being provided in Nevada County over the last year, both in clients served and overall service minutes. Emphasis has been placed on ensuring a well-trained team of behavioral specialists to meet the high needs of this population.

Hiring clinicians continues to be a challenge in this rural area. Across the state, Victor is utilizing a paid (stipend) Internship Program, where they provide on the job training, and meet interns' clinical needs and requirements. Victor has been very fortunate to work with interns that are aligned with agency values and come with strong experience.

A new Executive Director stepped into her role during the new fiscal year. Victor held a management working retreat to prioritize a cohesive leadership team, as well as plan and create a vision for the site and program needs and goals.

Victor is continuing to put time, energy and resources into developing a sustainable and stable staffing model and program in the North Tahoe and Truckee area. Victor has recently promoted a North Tahoe based clinician to program manager, overseeing the North Tahoe CSCO and ASOC programs, as well as Truckee Wraparound Services.

Victor remains committed to increasing connectedness for the clients and families served by continuing to add more group-based services, community-building activities and events, and further integrating the wraparound philosophy and teaming into processes in both virtual and in-person settings. During this year, Victor continued the Parent Caregiver Support group and made Nurtured Heart Approach (NHA) training available to all caregivers and staff. Through the increased inclusion of Parent/Peer partners on teams, Victor is emphasizing whole family unit

engagement in services via individual support and group support during the upcoming year. The anticipated length of stay will remain 8-10 months on average.

Program Participant Story

Client is a 14-year-old male who was referred to Victor TBS Services from NCCBH services who has been in and out of mental health services since he was 4 years old. Client came to us with disruptive behaviors, daily angry outbursts with aggression towards others and failed to respond to limit settings and other discipline. Client is the youngest of three children with his siblings being young adults and not living in the home. When client was refereed to VCSS the client was so burnt out on services, that he initially refused to meet. Introductory services started in the Victor parking lot. Client was hesitant but was given voice to choose where he would be most comfortable.

Victor provided services in all aspects of his life, including home services, school support, and community/field support. Relationship building was the main goal for the first few weeks; focusing on increasing trust between client and team, and to help client see that his team was behind him and believed in his healing process. The team met weekly to discuss updates and observations around the client and family. While supporting the family in the home, the team observed the lack of pictures and accolades given to the client; his siblings' awards, trophies and pictures adorned the family home. Staff met one on one with this mom to share observations and suggested that the client be given the same opportunity to showcase his achievements. The next session in the home the client was excited to show staff his awards and pictures that were now on display throughout the house. Family time was important to the client as it was just his mom and him now in the home. He shared his anger regarding his mom's ex-boyfriend and the abuse he was subjected to. Client was also hurt and angry with mom for stating several times that she regretted having her tubes untied to have him. Staff realized right away that they were going to be working with mom as much as the client; both needed to change for this to be successful. Victor decided to offer full WRAP services with TBS as an added service. It was perfect timing as the client trusted staff, he began to engage in therapy with a clinician, mom was offered a parent support staff, and the client was seen up to 3 times a week (including daily on some weeks) for his outbursts and crisis behaviors at school and at home.

Staff saw the changes in this family when mom was able to hear constructive feedback and make positive changes based on the guidance of the Wrap team. Mom was willing and able to change her ways by spending time with the client playing board games (his request) and following through with consequences no matter how hard holding the line would become. Team mirrored and role-played what this might look like in the beginning, and with consistency the payoff was huge. Staff helped the family make a schedule for the client to follow and helped design a rewards system to keep client motivated. During CFT's staff began to see a mom and a son who genuinely loved each other and enjoyed each other's company. They showed up respectful of each other's opinions, shared what was working, and were honest with what they still needed to focus on/areas that still required support and modification. The team got him involved with skating and helped develop an incentive around building a skateboard. Client was able to earn parts each week, and eventually he earned all the necessary parts to build the skateboard of his dreams. Sometimes, the client

requested that his therapy sessions were held with clinician at the skate park, where he felt comfortable and motivated.

During this time, when client was actively engaged in all services, the client's grandfather passed away. Client then struggled with the massive loss of a very important male figure in his life, he reported that his clinician was the only positive male role-model in his life. The team met and focused on how best to support the client, as staff were concerned with the possibility of behavior regression. Client worked through grief therapy with his clinician, TBS staff and the rest of his Wrap team. Through this support client was able to compose a beautiful letter to his grandpa, mentioning the things he would miss doing with him, and all the important lessons and things he learned from him. This client continued to progress, and titration was discussed. The Wrap team was hopeful, excited and sad to see this client step-down from services, as there was deep connection, joy and pride associated with this client's (and moms) journey and progress. During the course of treatment client made notable improvements including: taking more responsibility for his actions, better communication and less conflict at home, improved school accomplishments, better accord with peers, and more future oriented thinking. This case speaks to the power of Wrap, and importance of including the family and other support systems across all phases of Wrap. VCSS stepped in just when this family needed that extra support; they were open and willing to make changes, increase honestly within and as a family. During the client's graduation ceremony, without any prompt, the client expressed one positive thing about each VCSS staff that he appreciated and valued; staff were brought to tears.

Children's Full-Service Partnership (FSP):

STANFORD SIERRA YOUTH AND FAMILIES (SSYAF)

Program Description

Program Overview

Stanford Sierra Youth & Families (SSYAF) provides comprehensive specialty mental health services for children and their families throughout Nevada County. Specialty Mental Health Services provided are based on established medical necessity criteria for mental health services due to behavioral, emotional and functional impairments meeting Nevada County Behavioral Health (NCBH) Plan eligibility.

Target Population

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

Evaluation Activities and Outcomes

Goal	Objective	Fiscal Year 23/24
To prevent and reduce out-of-home placements and placement disruptions to higher levels of care.	80% of children and youth served will be stabilized at home or in foster care.	50% (2/4)
Youth will be out of legal trouble.	At least 70% of youth will have no new legal involvement between admission and discharge.	100% (4/4)
Youth will improve academic performance.	At least 80% of parents will report youth maintained a C average or improved on their academic performance.	75% (3/4)
Youth will attend school regularly	At least 75% of youth will maintain regular school attendance or improve their school attendance.	50% (2/4)
Youth will improve school behavior	70% of youth will have no new suspensions or expulsions between admit and discharge.	75% (3/4)
Caregivers with strengthen their parenting skills	At least 80% of parents will report an increase in their parenting skills.	50% (2/4)
Every child establishes, reestablishes, or reinforces a lifelong relationship with a caring adult.	At least 65% of children served will be able to identify at least one lifelong contact.	75% (3/4)
Caregivers will improve connections to the community	At least 75% of caregivers will report maintaining or increasing connection to natural supports.	100% (4/4)

Goal	Objective	Fiscal Year 23/24
Youth and Families improve functioning	80% of youth and families will improve their scores on the CANS 50 and the PSC-35 instruments between intake and discharge	75% (3/4)
Contractor is to be responsible to community needs	Contractor will make initial contact with youth and caregiver within 3 business days of receipt of referral from county	3.22 Days
Contractor is to be responsive to community needs	Contractor will have f2f contact with 60% of children and families within 10 business days of receiving the referral from request for services by the beneficiary.	67% (6/9)

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

The following CANS scores are for youth served in FY 23/24. Stanford Sierra Youth & Families served **9** unduplicated FSP youth and their families. As data collection and reporting strategies progress, data outcomes for individual domains will be shown. CANS Summary**: 100%** of individuals' CANS needs scores improved this fiscal year, with an average of a **1.40** reduction in needs scores from intake to discharge.

Challenges, Solutions, and Upcoming Changes

A primary challenge for the program in FY 23/24 was adapting to the multiple documentation and billing changes with the roll-out of CALAIM, as well as technological challenges with SmartCare's implementation as the new electronic health record.

A related challenge was staff productivity/service to families, impacted both by CALAIM changes to allowable billable services, and by other external factors. The Family Preservation team has historically done a significant amount of their work in the community, including family homes and client schools, and the inability to bill for travel time in a large, rural county impacted productivity across positions. As of the last analysis in April, the average lost billing time due to the inability to bill travel and documentation was 18% of all services billed. An additional challenge to meet productivity expectations during fiscal year 23/24 included limitations placed on service provision in the schools by several local school districts. This significantly compressed the available hours to provide services to clients, along with the fact that 46% of Family Preservation's clients are under the age of nine and therefore have earlier bedtimes and evening routines. In addition, over 10% of all scheduled sessions were cancelled by clients and families. Finally, billing productivity of the overall program was impacted by an average staff vacancy rate of 35%. The challenge of vacant positions and limited applicants in a rural workforce crisis was proactively addressed by the creation of a paid clinical student internship pathway to build workforce availability. However, this impacted productivity as well since student interns are held to a lower productivity expectation due to their increased learning and supervision needs. Overall, the team was able to utilize 75% of their total contract amount for fiscal year 23/24.

There were many additional solutions pursued throughout the fiscal year to increase billable service to families. This included an in-depth mid-year program analysis of challenges and potential solutions, county re-evaluation of rates for highest travel positions, close collaboration with schools to increase opportunities for daytime service provision, and a program-wide focus on increasing group activities and outings both after school and during school breaks. Through this initiative, the program was able to begin five weekly group opportunities for clients and families (an increase from 0 in the previous fiscal year), and schedule 16 group outings/activities during school breaks to maintain client engagement. As a result of these combined efforts, as well as increased staffing and client census, the program was able to significantly increase billable services in the second half of the fiscal year. An analysis of staff productivity from quarters three and four showed that 100% of full-time, non-intern staff met their contracted productivity expectation (35% for MHRS staff and 40% for clinical staff) when averaged across the second half of the fiscal year. Clinical student intern's average productivity for the second half of the fiscal year ranged from 27% to 37%, depending largely on length of time in internship. Both clinical interns have since

graduated and accepted full time clinician positions with the Family Preservation team, bringing the rate of hiring graduated clinical student interns to 83%. By the end of the fiscal year, the team's staff vacancy rate had reduced to 10%.

For the upcoming fiscal year, the Family Preservation program will continue to focus on staff training and retention. All Family Preservation clinicians will undergo formal training in Trauma-Focused CBT (TF-CBT), implementing this model consistently in their clinical practice to address high levels of trauma exposure and symptoms present in our client population. All paraprofessional staff will also undergo specialized trauma-informed intervention training to complement the clinical focus on TF-CBT. This is in alignment with the program's additional goal of continuing to prioritize close collaboration with the Child Welfare Services team to ensure families currently involved in the child welfare system, working on reunification, or at risk of removal receive evidence-based intervention to address trauma symptoms and stabilize at-risk families.

An additional priority will be the continued expansion of group services, including group therapy, social skills, groups, group community outings, and scheduled group activities during school breaks. This not only addresses client's needs for increased social and community connection but serves to increase client's engagement in services during typically low engagement service windows (e.g.: school breaks).

Program Participant Story

Reason for referral:
Fourteen-year-old bisexual Caucasian male with a history of exposure to domestic violence whose family recently resided in a local domestic violence shelter. The client was Referred by a managed care provider after multiple ER visits and hospitalizations, including a recent suicide attempt at school during the last week of middle school.

Services Provided:
This client became one of SSYAF's first Full Service Partnership clients, receiving individual therapy twice weekly, family therapy regularly, 24/7 crisis support, ICC, IHBS, case management, and linkage to psychiatry services. Treatment focused supporting the family in re-negotiating boundaries and roles following this traumatic event. The client worked on therapy on drawing boundaries with his father and expressing his wishes in court regarding custody. Family therapy also focused on shifting the client out of caregiver role for his mother and two siblings with special needs as well as working to define healthy peer boundaries and grow relationships supportive of his bisexual identity. Another critical aspect of services was trauma processing, through which the client was able to process his past trauma and shift his narrative of himself to view himself and his mother as separate from the trauma, and gain momentum towards his own future goals. Finally, treatment focused on targeting the client's impulsive suicidal ideation and attempts. This included supporting the client in managing triggers without reacting impulsively to injure himself, helping the client gain insight into understanding his triggers and slowing his reactions, exploring alternate options to manage overwhelming feelings, changing his negative thinking, teaching coping skills, supporting the client in expressing his feelings and needs before they grew overwhelming, and

interrupting the client's pattern of absorbing everyone's needs and stress until he would eventually reach his breaking point and attempt suicide.

Summary of Success Achieved:
As of the end of fiscal year 23/24, the client had received 11 months of services and was working towards graduation. After repeated hospitalizations, it had been 9 months since the client's last hospitalization. He was connected at school and thriving academically, on his school's basketball team, had a stable romantic relationship and supportive friend network, and reported he was motivated to attend college. The client was volunteering on the Nevada County Youth Mental Health Advisory Board, and hopes to help shape state and national mental health policy.

Adult Full-Service Partnership (FSP):

TURNING POINT COMMUNITY PROGRAMS
Providence Center

Program Description

Program Overview
Turning Point Community Programs (TPCP) - Providence Center promotes wellness and recovery, partnering with individuals 18 and older living with severe and persistent psychiatric disabilities. Clients are referred for individualized, locally based outpatient treatment. Assertive Community Treatment (ACT) and Assisted Outpatient Treatment (AOT) support individuals in achieving and maintaining a higher level of independence and quality of life within the community. Services strengthen community integration, mental and physical well-being, vocational and educational opportunities, healthy relationships and sense of independence.

Target Population
The AACT target population consists of individuals 18 years old and over with severe mental illness (SMI). Included in AACT services are individuals who may also meet criteria for Assisted Outpatient Treatment (AOT), designed for members who, in addition to having a severe psychiatric disability, may have committed an act of violence or made a serious threat of violence (within 48 months of the AOT referral) due to untreated mental illness.

Evaluation Activities and Outcomes

AACT:
In the FY 23/24, the Providence Center FSP served **104** individuals.

- **Housing**:
    - During FY 23/24, 74 (71.2%) individuals successfully remained housed in either temporary or permanent housing, avoiding homelessness. The remaining 30 (28.8%) individuals accrued a total of 2,818 homeless days.
    - A total of 82 individuals carried over from FY 22/23 and continued to accrue services in the FY 23/24. Of those 82 individuals, 67 (81.7%) either continued to avoid homelessness or decreased in the number of homeless days accrued.

- **Employment and education**:
    - **Employment**: Of the 104 individuals served within FY 23/24, a total of 18 (17.3%) individuals were reported as having some form of employment (paid or unpaid) at the end of the reporting period. When comparing to the Partnership Assessment Form (PAF), 15 individuals who were reported as being unemployed prior to their enrollment in the Providence Center were now employed at the end of FY 23/24.
    - **Education:** In FY 23/24 a total of 6 individuals were reported as having spent at least one day in school since enrollment. 3 (50.0%) of those 6 had not been attending school within the 12 months prior to their enrollment.

- **Criminal Justice involvement**:
    - During the FY 23/24, 85 (81.7%) of the 104 individuals avoided incarcerations or the accrual of jail days. The remaining 19 (18.3%) individuals accrued a total of 1,070 jail days.
    - Of the 82 individuals who carried over from FY 22/23 and continued to receive services through the Providence Center in FY 23/24, 72 (87.8%) either continued to avoid jail or decreased in the number of jail days accrued.
    - With regards to arrests, during FY 23/24, 85 (81.7%) individuals avoided arrests. The remaining 19 (18.3%) accrued a total of 28 arrests amongst them. Between FY 22/23 and FY 23/24, 6 (5.8%) individuals were reported as having accrued arrests in both fiscal years.

- **Acute Care Use**:
    - **Psychiatric Hospitalizations:** Within FY 23/24, 85 (81.7%) individuals avoided psychiatric hospitalizations. The remaining 19 (18.3%) accrued a total of 504 psychiatric hospital days. A positive outcome is that of the 82 individuals who carried over from FY 22/23 and continued to receive services, 60 (73.2%) continued to avoid psychiatric hospitalizations.
    - **Emergency Interventions:** Within FY 23/24, 73 (70.2%) individuals avoided the need for an emergency intervention. The remaining 31 (29.8%) accrued a total of 103 emergency interventions. A positive outcome is that of the 82 individuals who carried over from FY 22/23 and continued to receive services, 59 (72.0%) continued to avoid emergency interventions completely.

- **Emotional and Physical Well Being**:
  Turning Point continues to emphasize trauma informed care with those served. This allows participants to feel respected and cared for in their recovery process and allows staff the

opportunity to see people through trauma informed lenses. In the last year TP has added additional staffing of peer support, employment liaison, housing liaison and quality assurance which has enhanced services greatly for participants. With more auxiliary support in the program, it has also freed up clinicians in leadership to provide better clinical training and support to staff and provide individual therapy to more clients.

- **Stigma and Discrimination**:

In 23/24 TP has continued to enhance the role of peers. With the addition of the peer's certification through Medi-Cal the peer work force has received more training and validation for their roles. The validation of the peer workforce has supported a county level breakdown of stigma around people with lived experience in the workforce as well. Throughout the community, TP continues to support the individuals served in a strength based, respectful manner. Collaboration with community partners such as courts, law enforcement, hospitals, probation, and medical providers gives an opportunity to continue to educate people about SMI as well as for them to get to know the people TP serves, which also is helping to decrease the stigma. As Turning Point trains and supports individuals through employment and internship they go out and take other jobs in the community and continue to spread the message of destigmatizing mental illness and mental health services.

- **Service Access and Timeliness**:
    - 100% of non-urgent mental health services appointments were offered within 10-15 business days of the initial request for appointment.
    - In the 23/24 FY there were 27 psychiatric admissions accrued by 19 individuals. Only 4 (14.8%) of these 27 admissions were followed by a psychiatric readmission within 30 days during a one-year calendar period.
    - 100% of acute [psych IP and PHF] discharges received a follow up outpatient contact or IMD admission within 7 days of discharge.

- **AOT Summary**:
    - **6** individuals were served in the AOT Program on AOT orders, for the 23/24 fiscal year. There were 20 individuals referred under AOT in the 23/24 fiscal year. The individuals not requiring an order either voluntarily engaged in services or voluntarily engaged and were entered into another specialty court program.

- **Milestone of Recovery Scale (MORS)**

  The Milestone of Recovery Scale (MORS) is both a clinical and administrative tool. It allows staff to measure where individuals are in their journey of recovery and produce data that describes the journey of recovery over time.
    - A total of 63 individuals received a score at admission and at the end of the fiscal year or at discharge.
    - 19 individuals (30.2%) had a higher MORS score at the end of the reporting period, suggesting movement towards recovery including a lower level of risk, an increase in the level of skills and supports beyond program services, and an increase in the client's level of engagement with program staff.
    - 27 individuals (42.9%) remained at the same score. As many of our clients have higher MORS scores, a positive is stability in their current coping levels.
    - 16 individuals (25.4%) had a lower MORS score at the end.

- **Productivity**
  - **Objective A:** Minimum productivity standard of 70% of billable time for hours worked
    - ♣ Productivity average of 76% of billable time for hours worked
  - **Objective B:** 90% of all clients are Medi-Cal eligible
    - ♣ All TPCP clients for FY 23-24 were Medi-Cal eligible
  - **Objective C:** 5% denial rate for billed and audited services. Turning Point has not received any denial of billed services this year.
  - **Objective D:** Each Medi-Cal service provided must meet medical necessity guidelines and meet Medi-Cal requirements as described by service and activity/procedure code.
  - **Objective E:** Contractor shall document and maintain all clients' records to comply with all Medi-Cal regulations. Turning Point conducts chart reviews monthly, and reviews 8 charts per month.

Challenges, Solutions, and Upcoming Changes

During this last fiscal year, Turning Point continued to experience some employment challenges. Clinicians were still not applying for positions. TP has been accepting most interns that apply, which increases the pool of clinicians to hire, and often interns choose to stay at TP after their internship. Housing positions have also been difficult to fill to keep the houses fully staffed. There were a lot of applicants for the housing positions, but there was difficulty getting a hold of people, having people show up to interviews that were scheduled, and wanting pay or hours that were not available or reasonable. TP continued to keep reaching out to all applicants to offer interviews to find staff for the position. With these entry level positions TP does require basic job skills such as showing up to scheduled shifts, calling out sick with appropriate notice, interacting with peers, using a computer, in addition to the basic mental health worker skills such as appropriate boundaries, HIPPA and ethics. The benefit of training staff is TP has retained some very loyal staff that have stayed on with TP to pursue a career in mental health.

Another big challenge this year was the introduction of the state's payment reform, a new Electronic Health Record, and a new personnel management system for timecards and performance review tasks. This brought on significant changes for staff. Fortunately, TP had a very strong, loyal team that worked well though the changes with very little struggle or push back. Nevada County was a large part of TP support with rolling out the payment reform changes, as they spent a lot of time supporting and training those who were rolling this out to the team.
Office space became a challenge this year as TP outgrew the office with the addition of more staffing. With the additional staffing TP has had an increase in group activities provided for the peopled served which also has increased the volume of people in the building. TP has located a new office space that will fulfill all the needs as a program and allow staff to provide more enhanced services to those served such as more groups and a robust area for people to gather during the day and socialize and/or receive support.

Program Participant Story

One of the gentlemen TP serves was living in his own apartment and struggling significantly with mental health symptoms and using illicit substances, letting people who were homeless and using substances stay at his apartment. He thought getting a job was the solution to all his problems, but he never stayed at a job or kept a job more than 2 weeks, and there were many. He is a charismatic young man who was able to get hired places, but they never worked out. The visitors to his apartment got so bad that this gentleman was asked to leave his apartment. In time, and with the support of TP and his family, everyone collaboratively came up with a creative solution for his housing, as he and his treatment team identified his struggles in living alone. TP master leased a house that is owned by his brother, where he is the only permanent tenant and has a role of overseeing the house. The other rooms are used for people who are struggling and need an emergency placement. This gentleman is very loyal to his own family and values his brother's home as his own. He also has a lot of empathy and can get along with everyone, which makes him great at housing with people in crisis. In addition to this creative housing, this gentleman now has a job with the support of the Employment Liaison (EL). With the EL utilizing IPS, he has now been in the same job for going on 3 months. This is the longest time he has ever kept a job. Through having a job, this client has gained much more insight into his symptoms and is discussing them and how they affect his life. He is motivated to work on his recovery because of his employment and all of the work that he has done and is doing to keep this job. This gentleman has also remained clean and sober for the entirety of his job and living in the new housing situation.

General System Development:

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

Program Description

Program Overview

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

Target Population

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

Evaluation Activities and Outcomes

In FY 23/24, 14 unduplicated participants were served by Network Providers. This included 3 individuals served in the Children's System of Care and 11 individuals served in the Adult System of Care. Seven Network Providers are contracted with Nevada County Behavioral Health to provide these services: six for Adult Behavioral Health and one for Children's Behavioral Health. Children's Behavioral Health overall has less need for Network Providers than Adult Behavioral Health.

Challenges, Solutions, and Upcoming Changes

One previous challenge has been maintaining an adequate number of network providers in the system of care; however, NCBH has been maintaining an adequate number of providers during FY 23/24. Currently, the therapist team also does the full access and intake process. This includes fielding calls from the access line, scheduling intake appointments and follow-ups, and providing care coordination and referrals for people who do not meet behavioral health level of care. The volume of access work reduces the availability of therapists to provide treatment to clients. NCBH has managed this by adding network providers. Moving forward, NCBH plans to create a stand-alone Mobile Outreach and Access Team to support broader outreach efforts, intake assessments, and connecting people to appropriate care. This may lead to an increase in people accessing the behavioral health system; however, NCBH does not anticipate needing more Network Therapists at this time due to the increase capacity of the therapist team to provide these supports once Access has been removed from their scope of work.

For the first time Nevada County Children's Behavioral Health has added a group network provider this year. NCBH anticipates that this group will meet the network provider needs for the coming year. A minor ongoing challenge is getting and keeping Network Providers certified in CANS, but so far NCBH has worked with Network Providers to complete this state requirement for MHPs. In recent years NCBH has lost a few long-term Network Providers because of this requirement as an additional "hoop" to jump through.

General System Development:

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

Program Description

Program Overview
The Mental Health Services Act (MHSA) can be utilized to expand mental health services and/or program capacity beyond those services provided in 2004, referred to as "baseline services". This program encompasses expanded mental health and psychiatric services provided by Nevada County Behavioral Health (NCBH), as well as housing and flexible funds to support NCBH clients in meeting their treatment goals.

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

Evaluation Activities and Outcomes

In FY 23/24, Nevada County Behavioral Health provided 31,944 mental health and psychiatric services to 1,593 unduplicated individuals. Of these, 1,011 individuals were served by the NCBH Adult System of Care and 582 individuals were served by the NCBH Children's System of Care.

General System Development:

SIERRA MENTAL WELLNESS GROUP
Expand Crisis and Mobile Crisis Intervention Services
Crisis Workers, Crisis Support Team

Program Description

Program Overview
MHSA funding provides a Crisis Worker Position, a Mobile Crisis Position, and a Crisis Support Team at the Crisis Stabilization Unit (CSU) at the local Sierra Nevada Memorial Hospital (SNMH). The Crisis Worker, Mobile Crisis Team (MCT) and CSU support team are available 24 hours a day, seven days a week, while Mobile Crisis is available 7 days a week, 12 hours per day. These positions are exclusive to western Nevada County; however, the team serves clients from

anywhere within the county. Funding sources used to support Crisis Services included Medi-Cal, 1991 Realignment funds, and MHSA-CSS funds.

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

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

Target Population

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

Evaluation Activities and Outcomes

In FY 23/24 there were 745 unduplicated individuals served. In the prior fiscal year 22/23, the Crisis Workers performed a total of 1,934 evaluations. This fiscal year, Crisis provided 1,423 evaluations, 567 were performed in the Emergency Department, 483 were performed at the Crisis Stabilization Unit, 15 were performed at the Correctional Facility, 121 were performed in the field, and 181 services were performed in Truckee. There were 641 WIC 5150's written and 309 of those were placed at higher level inpatient psychiatric facilities.

The new mobile crisis program was implemented in Nevada county on December 31st, 2023. Since that time MCT has conducted 121 assessments and has been utilized as a resource to support clients with accessing the CSU along with providing a 24-hour service that clients utilize in the privacy of their own homes instead of utilizing the emergency room. There has also been positive feedback from not only community partners but also from Sierra Nevada Memorial Hospital who have stated they have had less individuals come to the emergency room for mental health concerns. Local schools in Nevada county have also appreciated having MCT as a resource for their students.

Challenges, Solutions, and Upcoming Changes

Much like the last fiscal year, this fiscal year has brought with it a bevy of changes. One of them has been the implementation of the new EHR system, Smartcare, and the steep learning curve that accompanied it. At the beginning of 2024 a new mobile crisis workflow was also implemented in

Smartcare which included a new evaluation document, a new service note document and a new safety plan document.

A whole new program isn't complete without new staff and training to implement it. Starting in October 2023, 14 new clinicians have been hired. These clinicians have been trained in both mobile and in house crisis. One challenge that accompanies a new 24-hour, 7 day a week program is scheduling. In December 2023 a new Administrative Assistant was hired who has been instrumental in streamlining the scheduling process to address all of the company's new scheduling needs. The new clinicians have also completed online MTAC trainings as part of their initial mobile crisis training.

There have also been leadership changes in Nevada County with the addition of a new Program Director. Her experience and dedication in the mental health field will be crucial in supporting the efforts to navigate these and future changes.

One program that had been rolled out during the last fiscal year was Xferall. This program is used to send 5150 referral packets electronically to contracted psychiatric facilities. Since its implementation more contracted facilities have signed up for this program which streamlines efforts to find placements for more acute and higher need clients, with some placements found within 45 minutes.

Program Participant Story

A client was served this year who was pregnant and suffering with multiple mental health concerns. This client struggled with explosive mood dysregulation and has had a history of 5150 holds and arrests. This client's behaviors caused them to be unable to access many community resources and there were concerns about how client might independently manage their pregnancy. Client was placed on a 5150 hold on 4/24/24 and the crisis team struggled to find them placement due to their pregnancy. However, because of the perseverance of the crisis team, placement was found for this client at a medical/psychiatric facility that would also provide post-pregnancy care.

General System Development:

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

Program Description

Program Overview

The Crisis Stabilization Unit (CSU) opened on December 14, 2015 to serve clients experiencing a mental health crisis or emergency. It is a 4 bed, unlocked unit, staffed by a mental health professional and a licensed medical professional on-site at all times. Psychiatrists are on-call 24 hours a day, 7 days a week. The CSU Supervisor works in close partnership with the Crisis Response Team Supervisor. They answer calls for any medical needs or operational questions. Clients may be admitted voluntarily for a maximum stay of 23 hours or while awaiting placement on a WIC 5150 hold. For the Fiscal Year of 23/24 the CSU has served 248 individual clients with 424 total admissions.

Per Medi-Cal requirements, clients are allowed to stay 23 hours. During that time the clients are assessed by the licensed medical professional, current medication interactions are investigated along with assisting clients in making appointments for a follow up with their primary care doctor. Upon client request the nurse may also help establish a primary care doctor or psychiatrist by assisting them with new patient forms for local offices and clinics.

Target Population

The CSU was established with the intention of reducing the need for psychiatric hospitalization when someone is in crisis due to exacerbation of symptoms resulting from a mental illness, or as a reaction to life stressors, or both. Medi-Cal clients on a WIC 5150 hold whose crisis can possibly be relieved by a 23 hour stay in the CSU with therapeutic and medical intervention, is the primary goal of the program. The program also serves and admits uninsured and privately insured individuals 18 years or older as a voluntary or WIC 5150 client if they meet admissions criteria. The target goal for FY 23/24 was 460 *individual* clients and was not reached.

Evaluation Activities and Outcomes

The CSU program has resulted in the rescinding of 0 of the 41 clients placed there on a WIC 5150 and 3 of the 41 WIC 5150 being able to expire during the FY 23/24 by stabilizing them and connecting them to local resources. This breaks down to 0 of the WIC 5150 holds being rescinded and 7% being able to safely expire. Collaboration by therapists with a client and their loved ones,

development of a personalized recovery plan and follow up appointments made by the CSU staff helped to stabilize clients to be able to rescind their holds or let them expire. The availability of the CSU offers the crisis staff an additional resource as part of the client's safety plan. For the client, it is a safe place away from the stressors that are often catalysts to their crisis and a way to be connected with a therapist, nurse and resources in the local community that can help them. There is also a mobile crisis team that brings clients to the CSU after evaluating them in the community. This has helped even more clients access services.

The CSU has been a success with clients. Satisfaction surveys were completed by 57% of individual clients that stayed in the CSU during the 23/24 fiscal year. They report a 90% degree of satisfaction with the treatment they received and the progress they made during their stay.

Sierra Nevada Memorial Hospital (SNMH) is also appreciative of the CSU. It provides a place for clients with a psychiatric need to receive care for those needs that are not traditionally provided in an emergency room setting. Clients evaluated in the emergency room, who meet CSU admissions criteria, are presented to the CSU and transferred to the CSU. This results in more beds being freed up for patients in the ED and clients being able to be helped in an environment that is calmer and has a therapist and nurse able to work with them individually to meet them where they are at in their crisis.

The county jail, NCBH, Granite Wellness, Hospitality House, FREED, Common Goals, therapists and local clinics often refer directly to the CSU. A working relationship continued with these stakeholders to communicate with crisis and CSU staff regarding client care. Work with the HOME team/ECM has continued to be successful for the clients who are homeless and not linked to any other county resources and ensures a warm handoff option for these clients.

Challenges, Solutions, and Upcoming Changes

SMWG has been working with staffing challenges by changing the nurses to 12-hour shifts, needing less staff this way. Cross training more crisis staff to work in the CSU has also helped... An upcoming change is implementing a new Acceptance Screening Tool that will decrease the clients' wait time between when they come to the door and when they are admitted to the CSU.

Program Participant Story

SMWG had a client this year with a recent dx of BP. While getting used to this dx and the medication that went with it, he was often on the cusp of decompensating. He began to use the CSU for support for coping and medication support, which resulted in stabilizing his current crisis/anxiety and often avoiding the need for hospitalization. He has expressed extreme gratitude for SMWG Crisis and CSU staff and continues to seek services when he needs a place to feel safe and supported.

In summary: The CSU serves clients with a mental health emergency in the most compassionate, therapeutic way possible while also serving all the stakeholders of the community and its residents.

General System Development:

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

Program Description

Program Overview

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

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

Services provided include the following:

- Crisis intervention
- Rehabilitation
- Guest advocacy
- Life skills
- Community Resource Referrals
- WRAP

Target Population

IRC serves guests 18 years of age and older, who have a mental illness, and because of the disorder, are at risk of needing a higher level of care. Guests could be at risk of needing psychiatric hospitalization, placement in an Institute of Mental Disease (IMD), Mental Health Rehabilitation Center, or Crisis Stabilization Unit. Guests may be recently discharged from one of these placements or experiencing a first episode or re-emergence of a psychotic break. Individuals must be assessed, medically cleared and approved by Nevada County Access Team, and then screened

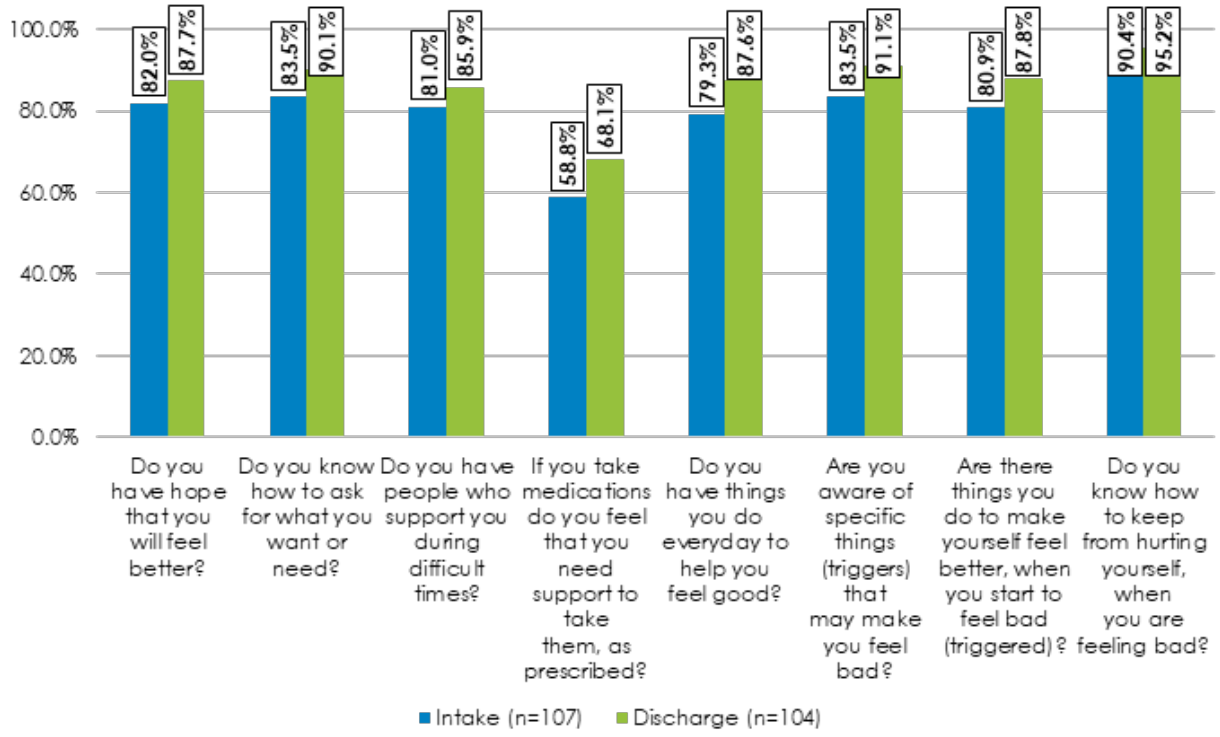
to determine appropriate fit by the IRC Leadership Team. Guests may not be under the influence of alcohol and/or illicit drugs and must be able to maintain acceptable hygiene. Guests are responsible for preparing meals and cleaning up after themselves. Guests must be able to understand and sign necessary documentation, be willing to follow the guest agreement upon entering the home and have a place to return to when leaving IRC, even if that is a homeless shelter.

Evaluation Activities and Outcomes

In the 23/24 FY:

- Referrals:107
- Duplicated individuals served:107
- Unduplicated individuals served:87
- Discharged individuals: 104
- Linkages made to community resources: 79
- Overall client satisfaction score:90.6%

Pre-Post Outcome Survey



Challenges, Solutions, and Upcoming Changes

FY 23-24 was an exciting year for peer support specialists at Insight Respite Center in that 95% of staff have become certified through the State of California as Medi-Cal Peer Support Specialists (MCPSS), and work to maintain certification through the established recertification process of

Continuing Education. IRC has successfully maneuvered changes brought forth by implementation of CalAIM and a new Electronic Health Record system.

Program Participant Story

"Being here gave me hope that I will be okay. Eleanor was very comforting. The grounds are beautiful, as I love nature. I saw a deer, wild turkeys and hummingbirds. I enjoyed all of the crafting and wonderful supplies that were provided. The food was amazing – very nutritious! You saved me from myself and I cannot thank you enough! This is a very special place, run by amazing people. I truly appreciate this experience."

General System Development:

STANFORD SIERRA YOUTH AND FAMILIES
Intensive Services for Youth

Program Description

Program Overview
Stanford Sierra Youth & Families (SSYAF) provides comprehensive specialty mental health services for children and their families throughout Nevada County. Specialty Mental Health Services provided are based on established medical necessity criteria for mental health services due to behavioral, emotional and functional impairments meeting Nevada County Behavioral Health (NCBH) Plan eligibility.

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

Evaluation Activities and Outcomes

Goal	Objective	Fiscal Year 23/24
To prevent and reduce out-of-home placements and placement disruptions to higher levels of care.	80% of children and youth served will be stabilized at home or in foster care.	94% (45/48)

Youth will be out of legal trouble.	At least 70% of youth will have no new legal involvement between admission and discharge.	98% (47/48)
Youth will improve academic performance.	At least 80% of parents will report youth maintained a C average or improved on their academic performance.	87% (40/46)
Youth will attend school regularly	At least 75% of youth will maintain regular school attendance or improve their school attendance.	95% (42/44)
Youth will improve school behavior	70% of youth will have no new suspensions or expulsions between admit and discharge.	93% (43/46)
Caregivers with strengthen their parenting skills	At least 80% of parents will report an increase in their parenting skills.	88% (37/42)
Every child establishes, reestablishes, or reinforces a lifelong relationship with a caring adult.	At least 65% of children served will be able to identify at least one lifelong contact.	85% (30/46)
Caregivers will improve connections to the community	At least 75% of caregivers will report maintaining or increasing connection to natural supports.	93% (39/42)

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

The following CANS scores are for youth served in FY 23/24. Stanford Sierra Youth & Families served **149** unduplicated youth and their families. As data collection and reporting strategies progress, data outcomes for individual domains will be shown. CANS Summary**: 81%** of individuals' CANS needs scores improved this fiscal year, with an average of a **3.48** reduction in needs scores from intake to discharge.

Challenges, Solutions, and Upcoming Changes

A primary challenge for the program in FY 23/24 was adapting to the multiple documentation and billing changes with the roll-out of CALAIM, as well as technological challenges with SmartCare's implementation as the new electronic health record.

A related challenge was staff productivity/service to families, impacted both by CALAIM changes to allowable billable services, and by other external factors. The Family Preservation team has historically done a significant amount of their work in the community, including family homes and client schools, and the inability to bill for travel time in a large, rural county impacted productivity across positions. As of last analysis in April, the average lost billing time due to the inability to bill travel and documentation was 18% of all services billed. An additional challenge to meeting productivity expectations during fiscal year 23/24 included limitations placed on service provision in the schools by several local school districts. This significantly compressed the available hours

to provide services to clients, along with the fact that 46% of Family Preservation's clients are under the age of nine, and therefore have earlier bedtimes and evening routines. In addition, over 10% of all scheduled sessions were cancelled by clients and families. Finally, billing productivity of the overall program was impacted by an average staff vacancy rate of 35%. The challenge of vacant positions and limited applicants in a rural workforce crisis was proactively addressed by the creation of a paid clinical student internship pathway to build workforce availability. However, this impacted productivity as well since student interns are held to a lower productivity expectation due to their increased learning and supervision needs. Overall, the team was able to utilize 75% of their total contract amount for fiscal year 23/24.

There were many additional solutions pursued throughout the fiscal year to increase billable service to families. This included an in-depth mid-year program analysis of challenges and potential solutions, county re-evaluation of rates for highest travel positions, close collaboration with schools to increase opportunities for daytime service provision, and a program-wide focus on increasing group activities and outings both after school and during school breaks. Through this initiative, the program was able to begin five weekly group opportunities for clients and families (an increase from 0 in the previous fiscal year), and schedule 16 group outings/activities during school breaks to maintain client engagement. As a result of these combined efforts, as well as increased staffing and client census, the program was able to significantly increase billable services in the second half of the fiscal year. An analysis of staff productivity from quarters three and four showed that 100% of full-time, non-intern staff met their contracted productivity expectation (35% for MHRS staff and 40% for clinical staff) when averaged across the second half of the fiscal year. Clinical student intern's average productivity for the second half of the fiscal year ranged from 27% to 37%, depending largely on length of time in internship. Both clinical interns have since graduated and accepted full time clinician positions with the Family Preservation team, bringing the rate of hiring graduated clinical student interns to 83%. By the end of the fiscal year, the team's staff vacancy rate had reduced to 10%.

For the upcoming fiscal year, the Family Preservation program will continue to focus on staff training and retention. All Family Preservation clinicians will undergo formal training in Trauma-Focused CBT (TF-CBT), implementing this model consistently in their clinical practice to address high levels of trauma exposure and symptoms present in our client population. All paraprofessional staff will also undergo specialized trauma-informed intervention training to compliment the clinical focus on TF-CBT. This is in alignment with the program's additional goal of continuing to prioritize close collaboration with the Child Welfare Services team to ensure families currently involved in the child welfare system, working on reunification, or at risk of removal receive evidence-based intervention to address trauma symptoms and stabilize at-risk families.

An additional priority will be the continued expansion of group services, including group therapy, social skills, groups, group community outings, and scheduled group activities during school breaks. This not only addresses client's needs for increased social and community connection, but serves to increase client's engagement in services during typically low engagement service windows (e.g.: school breaks).

Program Participant Story

Reason for referral:
Client is a 9-year-old Caucasian female who was referred for services after being placed in a new resource home following multiple failed placements due to her sibling's challenging behaviors. The client and her brother were placed with newly recruited resource parents who had no previous parenting experience and were unprepared to navigate the complex trauma symptoms that both siblings demonstrated, as well as the associated difficulties with behavior and emotional regulation that presented at home and at school. The Client was referred to Stanford Sierra Youth and Families' Family Preservation by the SSYAF Pathways to Permanency program, which placed the siblings with their resource family and provided additional support to the family during their time in services.

Services Provided:
Services offered were weekly therapy for client with her clinician, family therapy, 1-2x weekly rehabilitation services at school with a Family Support Specialist, and weekly parenting sessions with a parenting-focused Family Support Specialist. Although the family was actively seeking support from services, the resource parents were new to managing work and school schedules and were often too overwhelmed to meet weekly or consistently attend appointments. The treatment team chose to meet family where they were at, continuing to offer consistent appointments paired with understanding when appointments were less consistent due to the many other appointments needed for child welfare services. At times, therapy and/or rehab took place at the school or at the office to better accommodate the family's schedule or choice. Family therapy was provided whenever one or both parents were able to attend, and parenting support was flexibly provided to one or both parents. As services progressed, the client was able to open up and engage in therapy. She had previously taken on the identity of "the good girl, the helper, and the people pleaser" while her sibling took on the role of trouble-maker, taking up much of family's attention, energy, time, services.
One year into the placement and Family Preservation services, the resource placement was seriously at risk. The client's brother was being actively considered for placement in residential treatment, and the resource parents were considering ending the placement of both siblings as they dealt with significant grief and loss a they grabbled with their expectations of parenting as opposed to the reality, as well as their grief over losing the life they had prior to kids. The client was beginning to lose her "people pleaser" facade and express more feelings of anxiety and depression. Resource mom recognized that she felt little attachment to the client, and sometimes even experienced aversion. At this point, therapy shifted focus to attachment therapy. Resource mom and client's therapist began working on increasing her awareness of how her own childhood attachments were showing up in current relationships. Weekly conjoint sessions with client and resource mother were implemented instead of individual sessions, paired with homework assignments designed to strengthen attachment and increase opportunities for positive interactions. Parenting support focused on created a space for resource parents to grieve while also accepting their feelings rather than feeling crushed by guilt, and eventually this shift in thinking and acceptance helped the resource parent to relax in her parenting role and accept the client rather than try to change her. Consequently, the client experienced and increased sense of safety, resulting in an ability to present authentically and accept connection.

Summary of Success Achieved: Currently, the placement has stabilized and the client, her sibling and resource parents have developed a secure attachment and the resources to navigate challenges together. The client and her sibling recently changed their names to take on their resource parent's last name, and their adoption paperwork is pending with the court. The resource parent is serving represents the Resource Parent Voice on the Nevada County Foster Youth Advisory Board. The client is increasing her ability to express her needs, connect with her resource parents, and is eagerly anticipating her adoption day.

General System Development

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

Program Description

Program Overview

Outdoor Rehabilitation services shall be targeted to serve Nevada County children and their families. Child/Youth shall meet the established Nevada County criteria for identification as seriously emotionally disturbed or seriously mentally ill child/youth. Welfare and Institutions Code

Section 5878.1 (a) specifies that MHSA services shall be provided to children and young adults with severe mental illness as defined by WIC 5878.2: those minors under the age of 21 who meet the criteria set forth in subdivision (a) of 5600.3 - seriously emotionally disturbed children and adolescents. Services can be provided to children up through age 21.

Target Population

Children, youth, and families in Eastern and Western Nevada County.

Evaluation Activities and Outcomes

Gateway has served 4 youth and families in the Truckee region in the 23/24 fiscal year.
Active Services: 2
Discharged Mentees: 2

Service	**YTD**

Hours	77.91

- Outcome Measurements: GMC has had challenges with outcome measurements
    - As an organization GMC decided upon the Hello Insight SEL measurement tool that contained an outdoor component. After discussions with the County, it was deemed insufficient to measure outcomes for our PEI programs.
        - Hello Insight Reports
    - In partnership with Nancy Callahan and Team GMC finalized approval of the Youth Survey, CRAFFT Questionnaire and the continued use of the Perception of Care Survey.
        - Due to lack of ability to access the GMC Survey Monkey tool we have zero visibility of POC surveys completed and have not been able to add the new youth survey into the tool.
        - 2 CRAFFT Questionnaires completed
        - 5 youth Surveys completed

Challenges, Solutions, and Upcoming Changes

Primary Challenges have been limited referrals, staffing and outcome measurements.

- Referrals; GMC has received limited referrals from NCBH for CSS clients this fiscal year.
- GMC has made significant progress in staffing for both Qualified Mentors and creating a Peer Workforce
- GMC has struggled to get and review outcome measures.

General System Development

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

Program Description

Program Overview

For nearly 40 years, NAMI NC has provided individual and group support, mental health education, and mental health care system navigation to people of all ages in Nevada County who face mental health challenges. MHSA funding has allowed NAMI to expand services by providing financial support to expand the baseline of services. NAMI now provides support meetings for family members four times a month; a program for parents/caregivers of youth and young adults, monthly educational meetings on various topics with a range of speakers; individual support; and

individual navigation assistance for family members who are struggling with understanding and interacting in the forensic, education, social services, and treatment arenas.

Target Population

NAMI serves families of adults and children who are affected by mental health conditions, especially severe and persistent mental illnesses including schizophrenia, bipolar illness, major depression, severe anxiety disorders, post-traumatic stress disorder, and borderline personality disorder.

Evaluation Activities and Outcomes

The NAMI family support program is comprised of group meetings and individual assistance. The general family support group meetings consist of two in-person and two via Zoom each month for a total of 48 meetings annually. Additionally, this year NAMI added a support program for parents and caregivers of youth and young adults as the needs of families of that population can be very different. Parents have to learn to navigate education intricacies, developmental complexities, and treatment issues—all which can be overwhelming for families who are also struggling with understanding severe mental health conditions as previous norms typically do not work for these young people. The risk of suicide can be high, which also can be terrifying for parents. Parents, grandparents, and caregivers participate individually and in groups.

In addition to support, NAMI provides monthly general education meetings featuring various speakers on an array of topics. This past year NAMI held 10 educational meetings including: Tasha Loudon-LEAP (Listen, Empathize, Agree, Partner) Communication and Escalation Prevention; Laura Gravelle, LPC—Cognitive Behavioral Therapy; NAMI Panel Discussion on Surviving the Holidays; Todd Arvidson, Crisis Services and the new Mobile Crisis Team; Jennifer Morrill--SPIRIT Peer Empowerment Center; Julie Lang, LMFT—Self-care; Jennifer Price, CEO – AMI Housing; Stacy Green and Deputy Bryan—Co-Responder Mobile Crisis Team with law enforcement; Officer Ernesto Alvarado, GVPD—Crisis Response; Jared Merrill, Private Recovery Care Manager.

The Fall eight-week Family-to-Family Education course was well-attended and provided information and strategies for helping loved ones with a mental illness including problem-solving, stress management and self-care, how to support with compassion, up-to-date information on mental health conditions and how they affect the brain, crisis management, current treatments and therapies, the impact of mental health conditions on the entire family, and community resources. The group setting of NAMI Family-to-Family provides mutual support and shared positive impact—experiencing compassion and reinforcement from people who understand your situation. Through evaluations, participants rated their ability to manage their self-care had improved by 93% due to involvement in NAMI. Due to the needs of the Parents and Caregivers of Teens and Young Adults, NAMI has incorporated the educational materials within NAMI Basics in lieu of conducting a separate class. Community activities included participating in the Nevada Union Mental Health Night, speaking to the Grass Valley Rotary Club, Twin Cities Church and another church, NC

Mental Health and Substance Use Advisory Board, NC Adult Services, and a NAMI California Superior Region event.

Challenges, Solutions, and Upcoming Changes

As NAMI had increased funding, it had to make some adjustments internally and strengthen infrastructure. Most notably it became apparent that NAMI had to hire a bookkeeper in order to appropriately manage funds and was fortunate to find a professional who also had worked in the County's Auditor-Controller office. Another challenge was a change in consultants to provide assistance. As a result, NAMI was not able to offer a spring Family-to-Family course. NAMI also recognized the need to improve the website to make it more informative, engaging, and overall user-friendly. NAMI again was fortunate to contract with a company that works with both NAMI National and NAMI California so NAMI can link the website to those websites to effectively enhance our pages.

Program Participant Story

When parents of youth come to NAMI, they often express their goal is to help their child graduate from high school and turn 18 so they are no longer responsible. However, research shows that young people with serious mental health conditions are delayed in every area of psychosocial development, including cognition, moral reasoning, and social cognition. It is common for parents to become very frustrated as their now adult child is not able to manage on their own and can have numerous challenges with moving forward in their lives. This was true with one of the parents who took the Family-to-Family course and now participates in Parents and Caregivers of Youth and Young Adults support program learning NAMI Basics information. She recently remarked how she thought that everything would be different once her son graduated from high school—which he marginally did through a special program. Through her involvement in NAMI, she now sees how lost he is, how his focus is challenged, and how his ability to plan is impaired, let alone follow through—and how being able to drive a car is very concerning. She expressed that although she feels that she's sacrificing herself at times, she realizes it's worse for her son who is miserable. They had been in a wraparound program but it wasn't engaging for her son. Mom was able to get a diagnosis of bipolar since leaving the wraparound services, and he is willing to get help again. Mom will not give up on him. Nor will we.

Outreach and Engagement:

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

Program Description

Program Overview

In 2023-2024 NCHDC, the Nevada County branch of AMI Housing, operated 16 properties totaling 82 units. NCHDC programs include Permanent Supportive Housing, CSIG transitional housing and bridge housing. NCHDC also owns two homes (12 beds) operated by Turning Point, which provide 24-hour care for individuals requiring a higher level of care. NCHDC housing team consists of 3 FTE Service Coordinators who facilitate weekly house meetings, life skills support, transportation and case management services for clients with a history of homelessness and mental health diagnoses. NCHDC offers housing in shared homes and individual apartments.

NCHDC permanent supportive housing offers individuals long-term housing options within a shared housing setting or in individual apartment units. While permanent supportive housing is "permanent", clients are provided with case management and housing support to help them work toward one day living independently in their own housing unit in the community. We currently operate 12 shared houses, 2 apartment buildings and 2 scattered site locations throughout the community.

The CSIG program (known as Orchard House) serves clients who have experienced a high level of recidivism in the jail system and are referred from the Public Defender's office and probation.

NCHDC bridge housing program provides temporary housing for individuals experiencing homelessness who are awaiting other housing options such as a new apartment or residential treatment or those who need to stabilize before being considered for permanent supportive housing. The transitional housing is time limited to between 90 days and 24 months.

NCHDC facilitates both a property management component and a service component to ensure the properties and clients receive the care needed. The property management services include property/unit maintenance and repairs, unit/room turnover/prep for client move in/out and landscaping. Each location is assigned to one of the Service Coordinators who provides weekly case management services to ensure clients are supported and maintaining their housing. Service Coordinators collaborate with Behavioral Health and community partners in order provide wrap around support to clients and tenants. The team provided a significant amount of transportation for

clients including over a thousand rides to grocery stores for shopping, to local foodbanks, to medical appointments, places of employment and to other activities.

Target Population

NCHDC serves Nevada County's most vulnerable, low-income adults who, prior to participating in the program, have experienced homelessness. Clients served may have a mental health diagnosis and/or a history of substance or homelessness. NCHDC works closely with Nevada County Behavioral Health, FREED, Regional Housing Authority, Hospitality House and Turning Point Community Programs, to house clients with high vulnerability scores. Over 50% of the individuals in housing units have been chronically homeless in Nevada County.

Evaluation Activities and Outcomes

NCHDC utilizes HMIS data to observe and report on trends, discrepancies, and gaps in service. In FY 2023/24, NCHDC served 106 individuals. Of these individuals, 5 were children/youth (0-15), 4 were transitional age youth (16-25), 8 were veterans and 44 were identified as meeting criteria for "chronically homeless". The average length of stay of current residents in permanent housing is just over 3.5 years, and 20 individuals have been successfully housed in PH for over 5 years. Ninety-three persons served had a mental health disorder and 53 had either alcohol and/or drug use disorders. Fifty-four persons served have a chronic health condition. Prior to being permanently housed at NCHDC, 30 individual adults came from the shelter, 19 from transitional housing, 12 were either camping, sleeping in their vehicle, or in a place not meant for habitation, 1 was in a recovery residence, 3 were in a hotel, 6 were renting their own unit, and 3 were in a psychiatric facility or skilled nursing facility.

NCHDC direct care staff are trained in delivery of several evidence-based life skills curriculums and experienced with a variety of behavioral health interventions. Staff have weekly supervision to have support and advise to continuously provide the best possible support for their clients.

Challenges, Solutions, and Upcoming Changes

Nevada County continued to show a lack of inventory of affordable housing in 2023/24. The combination of heavy competition, high rents and the stigma associated with mental health, continue to be barriers to housing. Most clients are on social security disability or are considered extremely low income, making the possibility of affording a one-bedroom unit over $1200 per month unattainable. One major challenge faced is lack of housing vouchers that enable zero income or very low-income individuals to afford any type of housing. NCHDC was able to add 2 two-bedroom units and a four-bedroom home to the housing inventory. In the new fiscal year, the county will be adding the new ranch house project (six units).

Organizationally, staffing the on-site, live in positions has been a challenge. It can be difficult finding someone with the ability to maintain boundaries and uphold program rules who is willing to live in a shared housing setting with adults experiencing mental health issues. Fortunately,

NCHDC was able to fill all on site positions in the last fiscal year and able to remove the costs of a security guard. In addition, all positions in the program are now fully staffed and turnover has decreased by 26.4% since COVID ended. Overall, NCHDC has raised wages for all staff to attract qualified candidates, retain them and reduce turnover.

NCHDC has plans to renovate the apartment located at Badger Lane where the former offices were located. Renovating the apartment will allow NCHDC to locate the short-term housing program referred to as Purdon Program, at the same location as Empire Mine Courtyards where staff will be present 7 days a week and individuals placed at the Purdon Program can have more safety and supports. The renovation will also provide an additional studio apartment unit for a low-income individual to reside.

Program Participant Story

In the last fiscal year, NCHDC provided housing to a participant at the Orchard House. This person had been residing in his vehicle in Truckee for over five years. He was arrested and removed from his vehicle, which was impounded and lost to him while he was incarcerated. He lost everything he owned. After being released, he was referred to the Orchard program. There were a lot of doubts and concerns about how successful this person could be and whether he would accept the challenge to improve his life. After residing at the Orchard house for a few months, he started participating in a peer support training class at Nevada County Behavioral Health. He is scheduled to graduate in August. He was so inspired that he made the decision that he wants to be a peer counselor, so that he can share his story and guide others to improve their lives. This client has already begun using his training to help the other residents in his home. His story is an incredible reminder that everyone deserves a chance to start over and make different choices. The client is currently working hard to find employment with his peer certificate and is hopeful he will eventually find permanent housing. He has utilized all the opportunities the CSIG house provided to become a true success story.

Outreach and Engagement:
HOSPITALITY HOUSE
Case Management for Homeless Individuals with Mental Illness
Housing Assistance Program (HAP)

Program Description

Program Overview

Program Overview - The Contractor shall employ at minimum the positions described within this contract to engage people experience homelessness wherever they are and to coordinate with other service providers, medical organizations, and law enforcement to ensure access to services while promoting health, stability, and person-centered care for engaged households.

Target Population

Nevada County residents experiencing homelessness.

Evaluation Activities and Outcomes

Shelter Case Manager (MHSA CSS Funded):
Position Description:

1. The Shelter case manager will work inside the shelter to assist up to 60 unique clients per year.
2. The Shelter Case Manager will work with the Outreach Case manager and the ECM team to assist in transitioning unsheltered homeless households to shelter, monitoring the household's mental health and SUD needs while residing in the shelter and coordinating with the Outreach Case manager and ECM team staff for the referral and linkage to outside agencies.
3. Shelter Case manager shall:
    a. Communicate with other agencies connected clients to coordinate case management activities and monitor households transition from unsheltered to sheltered homelessness.
    b. Assist households in meeting expressed mental health related goals including assistance with medication management and establishing behavioral health care.
    c. Assist households in housing navigation, acquiring benefits and income, transportation, life skills, counseling and/or linkage to community providers who specialize in assisting with these services.

Outcome Measures:

(1) Provide case management services to at least 60 households per year.
- 142 clients served

(2) 80% of shelter stayers engaged will maintain in the shelter, in permanent housing or improve overall housing situation.
- 80% of shelter stayers maintained in the shelter, in permanent housing or improved overall housing situation

(3) 90% of program participants will have identified at least one service linkage or benefit acquisition that aids them in stabilizing in shelter or permanent housing.
- 100% of clients

(4) 80% of program participants report a decrease in symptoms attributed to suffering from Mental illness and/or report improved recovery in mental health, emotional support and/or relations with support systems.

(5) 80% of program participants report a reduction in risk behaviors/factors and/or an increase in protective/resiliency factors.

(6) 70% of referrals to outside services are followed up on by program participants.
- 632 referrals made
- 41 referrals were followed up on by the program participant
- 6% of referrals were followed up on by the program participant

Challenges, Solutions, and Upcoming Changes

Connecting homeless clients with NCBH services continues to be a challenge. The clients that are referred often come with substance use disorder which makes it difficult for the assessment team to determine whether or not the mental health issues are due to or exasperated by the substance use itself. The case manager has begun trying to give as much collateral information on the front end before the client is assessed. Furthermore, when appropriate the case manager has begun accompanying the clients that may have a difficult time accurately describing their symptoms. Another need that has been identified is the need for an imbedded therapist for guests at Utah's Place. In previous contracts HH had a part-time therapist come in 20 hours a week, and the guests found this support to be very helpful.

Program Participant Story

A long-term stayer at Utah's Place (the Shelter) has had many years of undiagnosed and untreated mental illness. This client would report hearing voices and having command hallucinations but was fearful and distrustful of medication or treatment. His case manager through trust and rapport building finally started to notice change talk from the client as he would often report "not being able to live like this anymore…I need help". The case manager seized this opportunity and immediately scheduled an assessment and personally drove the client to his first appointment. The client agreed to see the psychiatrist and begin medication. It has been several months since the client began treatment and with the help of the case manager has made great strides towards housing. The client has secured all of his vital documentation that has been missing for years, applied for social security, and has begun filling out apartment applications. All of this was not possible until his mental health was addressed.

Outreach and Engagement

SPIRIT
Peer Support Services &
Emergency Department Program (EDP)

Program Description

Program Overview

The SPIRIT Center is a wellness drop-in center, open six days a week for people seeking support with issues related to mental health and/or recovery. A significant number (about 85%) of those seeking services are unhoused. SPIRITs entirely peer-run Center offers one-on-one peer support to individuals and hosts a variety of support groups and classes. These include Diagnosis with Dignity, Depression and Anxiety, Women's and Men's Groups. Additionally, Steps to Home is a group focused on housing.

SPIRIT also offers many services intended to reduce suffering, and increase positive changes like Showers, Laundry, hot meals and access to a food pantry. The goal is to create pathways towards connection and creativity, in a way that meets each individual's interests and stage of growth. SPIRIT has a variety of planned activities throughout the week. Some of these include Peer Music, Beading for Wellness, Creative Expressions, and Gentle Yoga. Participants may also get their hands dirty tending the organic garden.

Housing Program: The Homeless Resiliency Program is designed to upgrade and expand on the existing homeless day service at the SPIRIT Center by providing weekly hot healthy lunches and increase daily hot showers and laundry. Education is offered regarding the positive effects of healthy lifestyle to increase the individual's positive state of mind, increasing the desire to make positive life choices. This better accommodates the Nevada County vulnerable population and builds in resiliency to lessen the impact on the homeless through Nevada County.

Through successful advocacy and collaboration with Nevada County agencies, the SPIRIT Housing Team can assist in the process of housing participants. Advocacy calls and in-person contacts are made on behalf of participants. In assessing participants' immediate and future goals, staff guide them to create a plan towards housing. The team also provides support in filling out applications and connecting participants to jobs available in the community. The Housing and Resiliency Specialists continue to offer new employees "coaching." This assistance builds relationships for future employment advancement and creates financial self-sufficiency.

Target Population

Adults with mental health issues who indicate that they would like to make positive changes in their life; this may include those with substance use issues, co-occurring conditions, or currently experiencing homelessness.

Evaluation Activities and Outcomes

Spirit Day Center

The increased volume of participants is attributed to the fact that SPIRIT opened a second location, which increased the name exposure to more folks who needed services. SPIRIT opened the Commons Resource Center for a limited time, from December 2023 through May 2024. This was an exciting experience for staff as well as long-term participants. SPIRIT saw an average of 25 people per day at the new location, and were able to engage them in additional services that were unknown to them.

SPIRIT Center Stats **F/Y 23-24**	(Q1) 23/24	(Q2) 23/24	(Q3) 23/24	(Q4) 23/24	**Year End Total 23/24**
Duplicated Visits (Walk-ins)	2212	2311	1847	3027	**9397**
# of Individuals each quarter	308	345	399	372	**N/A**
# of Unique Individuals Added Each Quarter	308	211	161	125	**805**
# New Participants to SPIRIT from EDP	7	0	0	0	**7**
Empower peers to engage in the highest level of work or productive activity appropriate as measured by:					
Volunteer hours spent maintaining the facility	162	124	83	121	**490**
Peer Support sessions	719	645	770	605	**2739**
Number of bi-lingual Support Sessions/Assistance	28	20	317	72	**437**
Peer Support training hours	190	14	15	146	**365**
Opportunities offered to peers to optimize productive activity (list hours for each service):					
Data Entry/Front Desk	442	434	408	576	**1860**
Group Facilitation	121	112	101	388	**722**
Reduce isolation of persons with mental illness as measured by:					
Support Groups per Quarter	77	58	57	46	**238**
-Support Group's Attendance	319	262	252	209	**1042**
Social Activities per Quarter	41	41	23	27	**132**
-Social Activity Attendance	247	246	140	180	**813**
Physical Movement Sessions per Quarter	8	13	1	0	**22**
-Physical Movement Attendance	31	25	6	0	**62**
# of people in SPIRIT sponsored structured educational class:					
Peer Support 101 (See narrative)					**0**
WRAP I (at CRC)				3	**3**
WRAP II					**0**

Improve quality of life of homeless individuals as measured by:					
# of Showers to homeless	532	522	339	680	**2073**
# of Loads of Laundry to homeless	234	218	155	336	**943**
# of Bags of Food given to homeless	303	333	256	414	**1306**
# of Meals given to homeless	395	426	468	447	**1736**
# of Homeless receiving basic services	246	355	472	319	**516 Unique**
# of homeless participants who obtained housing	15	3	4	3	**25**
# of peers who obtained employment	3	2	3	5	**13**
Survey Results - # of clients who improved in each of these areas: Note: Performed in 4th Qtr					
Help with Employment				18	**18**
Help with Housing				22	**22**
Building Life Skills/Coping Skills				48	**48**
Avoiding Hospitalizations				20	**20**
Avoiding Suicide				15	**15**
Court/Legal				22	**22**
Developing Education				20	**20**
Managing Substance Abuse				26	**26**
Feeling Better				42	**42**
Other Data to be collected:					
Fundraising (Holiday Letter, donations, outreach)	$1,080	$1,439	$9,652	$954	**$13,125**
Bus passes issued	185	126	256	487	**1054**
Number of public computer use sessions	67	62	32	81	**242**
Hours the Center was open	330	310	358	426	**1424**

SPIRIT Center - CRC Stats **F/Y 23-24**	(Q1) 23/24	(Q2) 23/24	(Q3) 23/24	(Q4) 23/24	**Year End Total 23/24**
# of Individuals each quarter		61	231	230	**522**
# of New Each Quarter		61	Included above	Included above	**61**
Duplicated Visits (Walk-ins)		140	1695	1751	**3586**
Hours the SPIRIT at the CRC was open		147	455	315	**917**
Peer Support sessions		25	673	695	**1393**

WRAP I		7	14	3	**24**

Emergency Department Program

Program Name: SPIRIT Emergency Department Program (EDP)
Program Overview: The Emergency Department Program (EDP) Crisis team serves clients over 18 years old in crisis at the Crisis Stabilization Unit (CSU) and Emergency Room at Sierra Memorial Hospital. Since 2012, The program has offered a valuable peer perspective to assist the client in the present moment of a current crisis and provided the bridge post-hospitalization to gently guide clients through follow-ups.

Evaluation and Outcomes: As we sunset The Emergency Department Program (EDP) on December 31st, 2023, The EDP Team is filled with gratitude mixed with sadness. The EDP program in collaboration with SPIRIT, has focused on and has achieved many solutions to meet the increasing demands for high level mental health peer support, housing resiliency, recovery goals, job search assistant, and referrals --- all these services have increased the number of ER/CSU clients that entered a long-term targeted program such as SPIRIT Peer Empowerment Center or one of the many other non-profits that work in collaboration with our population. Overall, the EDP Crisis services and referrals have improved client care, reduce the frequency, cost, and length of stay of emergency visits and to shift vital Nevada County Behavioral Health resources away from Emergency Care into effective community-based long-term solutions.

Continued Collaboration: The SPIRIT Peer and Housing Specialists will continue collaborate with the ER and CSU Teams and other agencies to provide Peer Support and Housing wrap around services, offer on-site case management at SPIRIT, advocacy, and facilitate groups aimed at helping individuals to better their own lives. Meeting basic needs with assistance is a necessary part of building a foundation for mental health and lowering the number and intensity of Emergency (ER) and Crisis stabilization Unit (CSU). The SPIRIT Team will continue provide information about the SPIRIT Program -- including keeping brochures and Support Group calendars stocked at the CSU. The team can also visit patients that are checked into the hospital to give Peer Support during their stay.

SPIRIT EDP DATA Q2 FY 23-24			
	Q1 July-September	**Q2 October-December**	**FY 23-24**
Total Served	26	22	48
Duplicates	0	0	0
Total unduplicated/yr.	26	22	48
CPC Follow-Ups	87	45	132
Action /Stress Plans Developed	22	22	44

Male/Female	13M 13 F	12M 10 F	25M F23
ER/CSU/SPIRIT	1ER 25 CSU	1ER 21 CSU	2ER CSU46
5150's	5	1	6

Challenges, Solutions, and Upcoming Changes

A long-standing challenge for SPIRIT has been the collection of data. SPIRIT is proud to announce that during tis fiscal year, staff were able to prepare to start gathering data electronically at the front desk. This is in preparation for the team to begin loading all of the data for the activities happening at our agency into the Homeless Management Information System (HMIS.) This simple act of going from hand-written data management to loading all data into an Excel Spreadsheet has ramped up accuracy, but more importantly, it has given much more readily available data regarding clients, so that SPIRIT can better serve their needs. This transition included some important training for staff, which has also increased confidence in staff. SPIRIT stands prepared to move to the next phase of purchasing more HMIS licenses as well as loading all data into this data system.

Program Participant Story

For the last six (6) years SPIRIT has worked diligently with a participant who has many mental health challenges, however her agnosia prevents her from knowing or accepting that she is ill. Through the work of many collaborations, and a lot of hard work on the case managers' part, she has been housed. Being housed has been an incredibly new and stress-inducing experience for her. SPIRIT is confident that through peer support, and post-housing support, she will feel more comfortable. Staff continue to visit her at home and help her navigate the new world of housing and getting along with others in her new environment.

Outreach and Engagement

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

Program Description

Program Overview
Nevada County is in the Sierra Nevada foothills of California with a person per square mile rate of 103, compared to 251 in California. The rural population of 102,240 lives across a 974-square-mile region that spans from the foothills, over the Sierra Nevada's and extending east to the California/Nevada border. The three incorporated cities (Nevada City, Grass Valley, and Truckee) comprise approximately 32,000 residents, leaving more than 66,000 persons living in very rural areas. Veterans comprise more than 10% of the county population.
Most Nevada County residents live 60-90 miles from the closest VA Medical Center. A small VA outpatient clinic in Auburn, CA is located 30 miles from Grass Valley. This clinic is where many Nevada County Veterans are seen for their primary care and where only a single psychologist is available. The clinic is associated with the Mather VA Medical Center, which is 56 miles away.
Sierra Family Therapy Veteran Counseling and Support Services provides comprehensive mental health and support services to veterans of all ages, helping them transition to civilian life, manage service-related issues, and enhance overall well-being. Services include individual and group counseling, family support, in person and telehealth options. Staffed by licensed and associate professionals and peer support specialists, the program ensures personalized care and community engagement and is dedicated to fostering resilience and long-term mental health for veterans and their families.

Target Population
Immediately upon separating from military service, many Veterans focus on providing for their family, starting a new career, or focus on continuing their education. During this new journey, many Veterans fail to file for benefits or seek treatment for the psychological trauma they experienced during their service. For some Veterans in Nevada County, it has been 30 years or more since they left the military. This same group of Veterans are just now coming to terms with their service and are seeking benefits and treatment.

The Nevada County Veterans Services Office provides services to veterans, their dependents, and surviving spouses in every era of conflict and peacetime.

Evaluation Activities and Outcomes

Evaluation Activities include conducting comprehensive intake evaluations to identify veterans' mental health needs and treatment goals as well as using standardized diagnostic tools and clinical interviews. Progress Monitoring includes regularly scheduled follow-up assessments using validated mental health questionnaires and self-report measures as well as continuous tracking of symptom changes and treatment adherence. The program keeps detailed records of treatment plans, session attendance, and therapeutic interventions.

Outcomes have shown a decrease in PTSD, depression, anxiety, and other service-related mental health symptoms as measured by standardized assessments and weekly charting of progress towards goals. As well as improved functioning and quality of life, including better family relationships, social interactions, and work performance.

The Nevada County Veterans Services Office (NCVSO) was successful in providing 102 referrals for mental health services to Sierra Family Therapy Center for treatment. Of these 102 referrals, 74 were seen for treatment of the symptoms for mental health by SFTC.

- VSO Outcomes:
  - Served 74 unduplicated individuals/families with mental health needs
    - Scheduled monthly meetings with service providers to ensure enrollment in services
  - Participated in a total of thirteen physical Outreach Events
    - Participated in the annual Truckee Air Show
    - Participated in Nevada County's annual Stand Down Event
    - Collaborated with Local American Legion to conduct bi-monthly elderly townhalls where up to 50 agencies who serve the elderly come together to share information
    - Presented on efforts of CVSO to Nevada County Board of Supervisors
    - Attend Vietnam Veterans of America Christmas Dinner for Active-Duty Airmen & Women from Beale AFB
    - Spoke to Nevada City Rotary Club
    - Participated in Grass Valley's Armed Forces Day
    - Monthly newsletters

Challenges, Solutions, and Upcoming Changes

Establishing trust and rapport in a veteran counseling program can be challenging, particularly during initial engagement. To address this, one SFTC directors personally oversees the initial contact with veterans, focusing on rapport building and trust establishment. By providing a welcoming and supportive first impression, the director helps veterans feel understood and valued. Additionally, the director assists veterans with completing necessary forms and navigating technology, ensuring a smooth and accessible entry into the program. This personalized approach aims to enhance comfort and engagement, setting a positive tone for ongoing therapeutic relationships.

The only upcoming changes are continued credentialing with a variety of insurances to be able to support a wider range of insurance plans. Sierra Family Therapy Center has also expanded to 9 additional offices in Nevada County to provide a greater capacity for in person sessions.

It will be essential that the VSO continues to focus on training, educating the public, and informing clients of current challenges within the VA and the difficulties service members encounter while transitioning to civilian life.

Last, inflation and operating during an election year, when political ideologies can be polarizing could lead to an increase in services. It is imperative that the VSO builds strong collaborative relationships with agencies that can assist clients to obtain jobs, write resumes, and receive training. Additionally, the continued financial stress of the economy's current inflation will bring greater requests for mental health services.

Program Participant Story

In January 2024, a recently discharged Marine who brought Lance Corporal Nicole Gee home, one of the final casualties during the withdrawal from Afghanistan, visited the Nevada County Veterans Services Office for assistance. The experience of bringing Nicole home and his thoughts that the US failed in Afghanistan led him to a deep-depressive state, close to divorce, and thinking of self-harm. This Marine was adamant that he did not want to become, in his opinion, part of the VA's cycle of dysfunction that would lead to multiple therapists and a life on medication.

When Sierra Family was presented as an option, he was enthusiastic because he would be seen by therapists in his community and who understood his way of life. Sierra Family Therapy's ability to bill outside insurance companies provided an opportunity for the veteran's whole family to be seen. Together, the family was able to gain a better understanding of what the Marine was going through and how they could assist him in his transition. Additionally, the individual members of his family (wife, two sons) were able to receive treatment for trauma that they had experienced through watching the Marine struggle post-service.

Today, the veteran is employed by a top software engineering company and earing over $100,000 per year. His two sons have begun to excel at school and his wife is now volunteering at the church.

Without, the treatment he received for SFTC, this would not have been possible. The veteran refuses to be seen by the VA for any medical needs and would not have engaged in the VAs mental health services.

Prevention and Early Intervention (PEI)

PEI Category: Early Intervention Program

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

Program Description

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

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

NCBH maintains good communication with these community agencies by:

- coordinating care of mutual participants
- funding programs at the SCH, including the Bilingual Peer-Counseling Program
- providing training to the SCH Peer-Counselors
- delivering quality service and treatment of participants referred from the SCH

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

Evaluation Activities and Outcomes

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

During FY 23/24, the program served 26 individuals. Of these individuals 13 were Children and 13 were Adults. A total of 658 services were provided in Spanish, 380 of those services were for children and 278 were for adults.

Challenges, Solutions, and Upcoming Changes

Challenges:

- Limited bilingual/bicultural staff across Western Nevada County, and a need for case management/in-person translation/advocacy
- Client's increased fear of contacting law enforcement and vulnerability to victimization
- Rumors, misinformation, and uncertainty around detentions/family separations are contributing to increased fear and impairment in functioning
- Fragmented services/limited capacity in Western Nevada County because we lack an agency dedicated solely to the LatinX or immigrant community (similar to Latino Leadership Council in Placer County)
- Burnout/compassion fatigue of community partners has recently intensified

Solutions:

- Bilingual/bicultural staff (e.g., case managers, peer support staff) who could work with youth and adult clients in Western Nevada County
- Agency or department dedicated solely to the immigrant population
- Coordinated messaging from law enforcement, county leadership, education, and health care. The Truckee community hosted an open and neutral Town Talk with the Family Resource Center and local law enforcement focused on navigating immigration rights and responsibilities in the workplace and community.
- Address the need for improved bilingual case management/translation services and support long-term growth of the bilingual/bicultural workforce. This can be done by creating a career path in social work/psychology for bilingual adolescents. Partner with Connecting Point (Youth Job Corps & IHSS programs), NCSOS/Partners FRC, and Sierra College. Connecting Point can support age-appropriate adolescents in obtaining peer support specialist and/or IHSS certifications and enrolling in Sierra College. Peer support specialists can bill for services and could potentially fit in with the BHSA Implementation Plan if that is approved. Through the bilingual provider meeting, we've made connections with enough programs to know that something like this is feasible and could significantly help the families we serve.

Program Participant Story

A 25-year-old Mexican woman, with a two-year-old and a four-month-old baby but no other family in this country moved to California about a year ago with a political asylum visa and was victim of interpersonal violence in the US. She lost her visa due to not able to attend follow up appointments, is currently undocumented, has no place to live, and does not have any income. She has been in treatment with NCBH since December 2024, and reported at that time symptoms of anxiety, psychosis and depression, including suicidal ideation when she first started treatment.
During the last month and a half, she was able to leave the interpersonally violent relationship, expressed feeling better, and denied suicidal ideation. She has connected with the Mexican consulate to address her migration status and has linked with resources to address issues related to

having no income like food, a place to live, clothes, diapers and other essentials. The main course of action has been addressing safety and helping this client to meet her basic needs as well as providing psychoeducation about the cycle of violence.
Client will continue to participate in individual therapy in the CBT modality, where she will learn relaxation skills; the relationship between thoughts, feelings and behaviors; coping skills, problem solving skills and recognizing her own strengths. She is motivated to learn English, find a job and permanent housing. She is convinced that she does not want to return to an interpersonally violent relationship again. She is grateful for the services received so far and would like to continue with services.

PEI Category: Early Intervention Program

NEVADA COUNTY PUBLIC HEALTH
Perinatal Depression Program
Moving Beyond Depression- Every Child Succeeds

Program Description

Program Overview

Moving Beyond Depression

Moving Beyond Depression (MBD) is a voluntary, evidenced-based program for women experiencing perinatal mood and anxiety disorders (PMADs) who are enrolled in a home-visitation program. MBD was developed by researchers at Every Child Succeeds and Cincinnati Children's Hospital and Medical Center. It is the only evidence-based treatment program specifically for mothers in home visiting programs. MBD offers In Home-Cognitive Behavioral Therapy in 15 weekly sessions and a one (1) month follow-up booster session. Therapy is provided by a licensed therapist.
MBD is in partnership with home visitation programs in Nevada County: Healthy Babies, Early Head Start, the Young Parents Program of the Nevada Joint Union High School District, the STEPP Program of TTUSD, Bright Beginnings, and the Nevada County Maternal-Child Public Health Nurses.
MBD is the only program within Nevada County with a treatment focus on maternal mental health. Although PMADs is the number one complication for perinatal women, there are many obstacles to mothers receiving evidence-based therapy and MBD is uniquely capable of providing immediate and effective support to mothers in Nevada County.

Becoming Us

The Becoming Us Prenatal Program is a psycho-educational program with a focus on the relationship between expecting parents. The program aims to develop a stronger and deeper bond between couples who are preparing for the birth of a child (1st or any subsequent sibling), to support individual and relationship health and well-being and to create an early foundation for

teamwork parenting. The program addresses a huge gap in current antenatal education which focuses mainly on birth.

Target Population

Moving Beyond Depression

This program is designed to meet the needs of all birthing individuals experiencing perinatal depression and anxiety. However, there is a higher incidence of PMADs in low-income, underserved parents, and this program is sensitive to their unique needs. Though mothers are the target population, the work of the program supports prevention and early intervention for infants and children.

As many as one-in-five, to one-in-three women experience Perinatal Mood and Anxiety Disorders (PMADs). In addition to internal referrals from Home Visiting Programs, the MBD program receives referrals from OBGYN Offices, Pediatrician and Primary Care Offices, and Birthing Hospitals which feeds into the Home Visiting services.

Becoming Us

More than 1 in 4 children live without a father in the home, that's 17.8 million according to the US census bureau 2023. All couples benefit from intentionally strengthening their relationship as they prepare for the postpartum stressors. Unlike Moving Beyond Depression, this program does not require a home visiting program for participants to qualify. The program serves expecting women and their partners or secondary caregivers. Good co parenting, a stable relationship and support from the other parenting partner are some factors that predict father involvement. These factors are a significant part of the Becoming Us program curriculum.

Evaluation Activities and Outcomes

Moving Beyond Depression

Multiple assessment tools are used to evaluate the effectiveness of the program. Perinatal and postpartum mothers receiving services complete an Edinburgh Postnatal Depression Scale (EPDS) completed at intake, at each session, and at discharge. The Prime MD (pre and post) assesses for Major Depression Disorder, Panic Disorder, Generalized Anxiety Disorder and Alcohol Dependence. Participants also complete Interpersonal Support Evaluation List-Short Form (ISEL-SF) to assess perceived social support at intake and discharge. The third assessment tool used is the Parenting Stress Index Fourth Edition Short Form (PSI-4-SF). This assessment is used to evaluate the parenting system. Data was also collected on the mother's Adverse Childhood Experiences (ACEs). Perception of Care surveys were collected at the end of services, as well as qualitative, narrative data. MBD collected demographic information for each mother receiving treatment and the children in the household. In addition, information on the dates of the services, referrals to community services, and home visitation information was collected.

The above data was all entered and managed using REDCap electronic data capture tools. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources.

The Moving Beyond Depression program has proven to be a resounding success, making significant strides in improving mental health outcomes for participants. Through its comprehensive approach, the program has effectively reduced symptoms of depression and enhanced overall well-being among its participants. By integrating evidence-based therapies, personalized support, and robust follow-up care, it has provided individuals with the tools and resources needed to manage and overcome depressive symptoms. The program's success is also reflected in the positive feedback from participants, improved engagement in daily activities, and increased access to ongoing mental health resources. This success underscores the program's effectiveness in creating meaningful, long-term improvements in mental health and quality of life. Over the years, Nevada County Public Health and Moving Beyond Depression have supported hundreds of families in linking to mental health resources. In that time 144 families have met the criteria to be evaluated by MBD's data collection and study.

Fiscal Year 21/22		**Fiscal Year 22/23**		**Fiscal Year 23/24**	
Referrals	17	Referrals	20	Referrals	27
Enrolled/Treated	11	Enrolled/Treated	23	Enrolled/Treated	23
Completed 6 sessions	7	Completed 6 sessions	14	Completed 6 sessions	17

During FY 2023-24, MBD offered services to 27 new referrals participants, and had an additional 6 continuing with ongoing services. Of the 27 offered services, 17 enrolled in the program, for a total of 23 mothers receiving treatment in the fiscal year. Of the 23, 17 completed at least 6 sessions by end of fiscal year, and 9 completed the program entirely.
By the completion of six sessions the average EPDS score had dropped by 26%. By the completion of the program, the EPDS score had improved by 47%
Participants who completed the MBD program showed overall improvement in both their EPDS, PSI-4-SF and ISEL-SF scores. A decrease in a client's EPDS score demonstrates a decrease in symptoms of depression.

EPDS Pre/Post FY 2023-2024 (n=17)			
	Average Pre-Score	Average Post-Score	% Change
EPDS	17.3	9.6	47%

FY 2022-2023 (n=10)			
	Average Pre-Score	Average Post-Score	% Change
EPDS	15.5	6	61.3%

FY 2021-2022 (n=3)			
	Average Pre-Score	Average Post-Score	% Change
EPDS	20	16	20%

Of the nine participants completing the program this fiscal year, nine met criteria for Major Depressive Disorder in their pre-assessment Prime-MD. Five of those participants also met criteria for Generalized Anxiety Disorder, three participants for Panic Disorder and one participant for Dysthymia. After completing the program, only two participants continued to meet criteria for any mental health diagnosis.

	PRIME MD Pre/Post FY 2023-2024 (n=9)			
	MDD	Gen Anxiety	Panic	Dysthymia
Pre	9	5	3	1
Post	1	0	0	1

Overall, addressing maternal depression not only supports the well-being of the mother but also has a cascading positive effect on her children's emotional, cognitive, and social development. Although the data collected is not longitudinal, it is important to remember that MBD treats a dyad, families, and 36 children were involved. Empirical data shows that when a mother's depression is managed effectively, it can lead to several beneficial outcomes for her child, including reduced risk of mental health issues, improved readiness for school, better emotional and behavioral outcomes, strengthened parent-child bond, and enhanced parenting skill. In upcoming years, MBD will be evaluating developmental measures between children and mothers with/without depression and treatment.

Becoming Us

In its inaugural year, the program has set a solid foundation for future success, marked by promising early outcomes and initial achievements. While still in its nascent stages, it has successfully established core processes and built a network of engaged participants and stakeholders. Key milestones include the completion of pilot projects, the collection of valuable feedback, and the development of critical partnerships. These early results provide a strong platform for refining the program's strategies and scaling its impact. As the program continues to evolve, the lessons learned from the first year will be instrumental in shaping its long-term trajectory and ensuring sustainable growth and effectiveness.

Challenges, Solutions, and Upcoming Changes

The Moving Beyond Depression is limited by the number of families that can be reached with just one therapist. Nevada County has an annual birth rate just under 900. Ideally there would be treatment options for all 180 families that would screen into the program. At the current capacity, the program is able to reach just a fraction of the population it aims to support. However, the future funding remains uncertain, so instead of looking at expanding to heal more families, the program is looking to find funding to sustain itself for future years. The program arguably has some of the most significant outcomes for reducing the impact of mental health on our communities. The MBD program is situated at a time in the lifespan that determines a life course. Ensuring newborns have the best chance at developing into productive community members is one of the most effective interventions. Leadership will continue to seek funding options should MHSA monies not continue due to the redirection of these funds from Proposition One. Additionally, should funding continue into the future, finding alternative monies will allow for expansion.

This last year MBD built the foundation and framework for the Becoming Us. Training was completed, locations were scouted and secured, promotional material was developed, and community partners were informed about the exciting opportunity for their clients. Overall, setting up the program was a success and excitement has grown around what Becoming Us has to offer. MBD looks forward to focusing on increasing the families served in the upcoming year.

Program Participant Story

A client grew up without a mother figure after her mother left the home when she was six. Her and her husband participated in the Becoming Us program's pilot session. Her daughter was born shortly after, and they are a thriving bonded family. She takes her daughter to weekly feeding support groups where she has made lasting connections to other mothers. "We've (father of the baby) been working together because it's new for both of us. It's been really nice to have direction on how things will change and how to work together on the changes. No one really gives you a handbook on how to have a kid."
"I appreciate MBD. It has helped me get back to my normal self. Because before I reached out, that's the lowest I have been, scary really."
"I have built confidence in parenting, social settings and body image. I am 100% better at coping with anxiety."
"I have more control of my emotions, decrease in mood shifts (I am not on a roller coaster anymore), and decreased depression."

PEI Category: Early Intervention Program

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

Program Description

Program Overview
There is a strong need in the Tahoe/Truckee region for crisis response and family support in cases of youth with early onset symptoms of mental illness or serious substance use disorder, specifically for those youth who do not qualify for County Behavioral Health services (i.e. who have private insurance). Due to limited provider availability in the region, families often wait weeks for support services after experiencing a crisis. Through this program, Gateway will:
• Engage youth and families in crisis through collaborations with the hospital and crisis system.
• Enroll referred youth in Whole Hearts program, including family counseling and support through social worker.
• Provide support over a 90-day period, while providing case management and discharge planning to the appropriate level of care (i.e. County behavioral health services or community mental health services).

Target Population
Whole Hearts serves high-need and under-resourced youth in crisis, ages 8 to 17, in the Tahoe/Truckee region.

Evaluation Activities and Outcomes

- Target Outcome 1:

Serve 15 youth/families per year across Nevada and Placer Counties.

  - Unduplicated youth served YTD: 21

- Target Outcome 2:

100% of youth will be discharged with adequate supports in place and/or to appropriate levels of long-term care as applicable

For YTD:

  - 10 were discharged from PEI funds.
    - 4 Successful Discharge to adequate support.
    - 1 Client Moved
    - 1 Client Referred to a GMC Clinician
    - 1 Administrative discharge due to lack of engagement
    - 3 Moved to a different funding source and continue in services (Not currently discharged)
  - Perception of Care Surveys Completed: Unknown
  - CRAFFT Questionnaires Completed: 2
  - Youth Surveys Completed: Unknown

Challenges, Solutions, and Upcoming Changes

- Outcome Measurements: GMC has had challenges with outcome measurements
    - As an organization GMC decided upon the Hello Insight SEL measurement tool that contained an outdoor component. After discussions with the County, it was deemed insufficient to measure outcomes for our PEI programs.
      - Hello Insight Reports
      - https://ins.gt/z5MDu0 Youth 8-12
      - https://ins.gt/QI4AiS Youth 12+
    - In partnership with Nancy Callahan and Team GMC finalized approval of the Youth Survey, CRAFFT Questionnaire and the continued use of the Perception of Care Survey.
      - Due to lack of ability to access the GMC Survey Monkey tool we have zero visibility of POC surveys completed and have not been able to add the new youth survey into the tool.
      - 2 CRAFFT Questionnaires completed
      - 5 youth Surveys completed

Program Participant Story

Case Study: Building Trust and Resilience Through Client-Centered Activities
Background:
The client, a young individual, was introduced to the program to help address challenges in building relationships and developing resilience. To establish trust and friendship, activities were selected based on the client's preferences and areas of familiarity.
Approach:
The mentor provided the client with autonomy and the freedom to make choices while maintaining a safe environment by keeping him within eyesight. This approach gave the client a sense of control and freedom, which helped ease tension and stress as the relationship developed.
Progress and Outcomes:
Throughout the sessions, the client demonstrated maturity by making satisfying decisions and choices during activities. He expressed joy and satisfaction with the chosen physical activities, successfully developing competencies and demonstrating resilience when faced with challenges.
Conclusion:
The client-centered approach of allowing autonomy and focusing on activities of interest helped build trust and rapport, leading to positive engagement and growth. By fostering a supportive environment, the client was able to develop resilience and gain confidence in his abilities.

Case Study: Empowering Decision-Making and Building Confidence Through Client-Centered Activities
Background:
The client, a young individual, was introduced to the program to enhance decision-making skills and build confidence. The approach involved engaging the client in activities of his preference to empower them and support their personal growth.
Approach:
The mentor encouraged the client to take the lead in choosing activities, providing him with autonomy and the freedom to make decisions. This empowerment fostered a sense of control and independence, reducing tension and stress as the client became more comfortable in the relationship.
Progress and Outcomes:
As the client engaged in these activities, he made mature and satisfying decisions, boosting his confidence and reinforcing his ability to make choices independently. He expressed joy and satisfaction, developing competencies and showing resilience when faced with challenges, which further enhanced his self-assurance.
Conclusion:
By prioritizing empowerment and decision-making, the program successfully built the client's confidence and autonomy. This client-centered approach not only strengthened his ability to make informed choices but also fostered resilience and personal growth, laying the foundation for continued success.
Here are a few individual efficacy statements:
Client Engagement and Self-Awareness:

"The client was highly engaged and eager to start, expressing a strong desire to gather information, have meaningful conversations, and enhance self-awareness. He was very open to discussing his past experiences with substance use."
Building Comfort and Connection:
"A young girl arrived at the car excited and engaged but appeared nervous about choosing a place to eat, suggesting she may not often make such decisions. During our lunch outing, we discussed her excitement for volleyball practice, and she shared openly with humor and comfort."
Expressive Activity and Shared Experience:
Facilitated a "boot dance experience on the deck to help the client manage stressors. This activity allowed her to express her unique self and resulted in a joyful experience, contributing to a meaningful shared moment between us".

PEI Category: Access and Linkage to Treatment Program

SIERRA COMMUNITY HOUSE
Homeless Outreach
Truckee Homeless Outreach

Program Description

Program Overview

The North Tahoe Truckee Homeless Services Outreach Program combines the Homeless Coordinator with other staff to create a team. Together they support unhoused and under-housed neighbors in the North Tahoe Truckee region. This team consistently spends 4 hours a week in the field outreaching to clients; Outreaches at the Sierra Community House food distributions in Truckee and Kings Beach; Outreaches 4 days a week at the Day Center; and supports with the Enrichment programs. When outreaching to clients in the field, they are working to meet basic needs, develop relationships, and encourage folks to access the Day Center, Emergency Warming Center in the winter and other available services. Additionally, they respond to calls from the community (police, hospital, business owners and community members) when there is an unhoused neighbor in need. While in the day center's office, they continue to develop relationships, getting to know each client's unique needs and challenges. They engage clients with motivational interviewing to help them identify and work towards their needs and goals.

The Tahoe Truckee Homeless Outreach Coordinator works alongside multiple agencies to assist these clients and engages in the weekly multi-disciplinary case conferencing meetings. They support connections to County Mental Health, Substance Use Supports and Medical providers along with providing access to CalFresh, MediCal, SSI, Veterans Services and more, to help improve everyone's quality of life. They help create housing plans by addressing barriers, looking for suitable housing options, along with researching rapid rehousing funds and housing vouchers that the client may qualify for.

Additionally, the program has added the support of a peer or other employee and are committed to building relationships along with health & wellness through enrichment opportunities for these clients.

Target Population

The Homeless Outreach Coordinator works with North Tahoe Truckee individuals who are currently unhoused and those at significant risk of losing their housing.

Evaluation Activities and Outcomes

The Homeless Outreach Coordinator completed an intake with everyone participating in this program. This included demographic details, date of the contact, location, and services provided. The coordinator also kept track of the number of referrals made to community agencies and the outcomes.

Outcomes for FY 21/22: The Homeless Outreach Coordinator served 60 individuals and made 101 referrals to other agencies / services. Of these, 46% or 46 successfully connected with the agency or service with an average connection time of 16 days.

Outcomes for FY 22/23: The Homeless Outreach Coordinator served 50 individuals and made 129 referrals to other agencies / services. Of these, 42% or 54 successfully connected with an average connection time of 12 days.

Outcomes for FY 23/24: The Homeless Outreach Coordinator served 43 individuals and made 51 referrals to other agencies / services. Of these, 49% or 25 successfully connected with an average connection time of 11 days.

	FY 2021-2022			FY 2022-2023			FY 2023-2024		
	# of Referrals Made	# of Referrals Connected	AVG # days for connection	# of Referrals Made	# of Referrals Connected	AVG # days for connection	# of Referrals Made	# of Referrals Connected	AVG # days for connection
Nevada County Behavioral Health	24	5	30	29	5	30	11	6	21
Other Behavioral Health	27	2	30	25	4	21	2	1	7
Physical Health Care Provider	22	12	30	23	11	7	14	10	30
Homeless Shelter	1	1	2	8	5	14	2	0	2
Sierra Community House	11	11	7	14	8	7	3	2	7
FREED	2	2	30	13	8	30	9	5	30
211/Connecting Point	10	10	1	13	12	1			
Crisis Srabilization Unit	2	1	1	3	0	1	8	0	24
Sierra Senior Services	2	2	14						
Placer County Visiting Nurse				1	1	7			
APS							1	1	2
AGM Advocacy							1	0	7
Totals/Average	**101**	**46**	**16**	**129**	**54**	**12**	**51**	**25**	**11**

Goal: Contractor shall serve a minimum of 36 individuals or families per year in Eastern Nevada County and North Tahoe (Eastern Placer County).
Outcome:

- FY 21/22: The Homeless Outreach Coordinator served 60 individuals.
- FY 22/23: The Homeless Outreach Coordinator served 50 individuals.
- FY 23/24: The Homeless Outreach Coordinator served 43 individuals.

Goal: 90% of homeless will be referred to the Coordinated Entry HMIS system.
Outcome:

- FY 21/22 : Of the 66 individuals served, 94% were referred to the Coordinated Entry.
- FY 22/23 : Of the 50 individuals served, 100% were referred to the Coordinated Entry.
- FY 23/24 : Of the 43 individuals served, 100%were referred to the Coordinated Entry.

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

- FY 21/22: The Homeless Outreach Coordinator worked with 5 individuals on their caseload that qualify for SSI. Of the 5 individuals, 100% have been referred.

- FY 22/23: The Homeless Outreach Coordinator worked with 5 individuals on their caseload that qualify for SSI. Of the 5 individuals, 100% have been referred.
- FY 23/24: The Homeless Outreach Coordinator worked with 9 individuals on their caseload that qualify for SSI. Of the 9 individuals, 55% were referred.

Goal: 90% of homeless and severely mentally ill individuals will be referred to mental health services.
Outcome:

- FY 21/22: Of the 66 individuals, 51 individuals qualify for mental health services, 100% were referred to services
- FY 22/23: Of the 50 individuals, 28 individuals qualify for mental health services, 79% were referred to services
- FY 23/24: Of the 43 individuals, 28 individuals qualify for mental health services, 75% were referred to services

***Goals added FY 23/24**

Goal: 70% of individuals with a substance abuse disorder will be referred to substance abuse treatment services.
Outcome:

- FY 23/24: Of the 43 individuals, 17 individuals qualify for substance abuse treatment services, 100% were referred to services.

Goal: NTTHS will offer a minimum of 24 enrichment opportunities and groups per year in Eastern Nevada County and North Tahoe (Eastern Placer County).

Outcome:

- FY 23/24: NTTHS has offered 88 enrichment opportunities and groups or 366% of the annual goal. NTTHS has offered 28 art groups, 1 MediCal/CalFresh day, 3 coffee groups, 12 social security benefits days, 13 game groups, 1 legal presentation, 1 Celebration of Life, 6 movie nights, 8 free phone days, 3 primary clinic days, 1 staff good-bye, 6 haircut days, and 5 legal days.

Challenges, Solutions, and Upcoming Changes

Over the past three years, NTTHS has continued to operate within a housing crisis. Many referrals are received for people losing their housing or people living in their vehicles, unable to find housing in their price range. The scarcity of affordable options and exceedingly long waitlists makes housing individuals very difficult. Also, a large portion of the unhoused we serve need limited Permanent Supportive Housing (PSH). AMI Housing and Placer County purchased and renovated a 12-unit motel in Kings Beach, the first PSH in this region. There are 7 individuals who have lived there this past year, with the final 6 units opening at the end of this month. Efforts are ongoing to refer clients to available mental health and SUD services and partner with community organizations to connect clients with other healthcare providers, despite logistical

challenges of limited providers in the Eastern parts of the county. This year with the elimination of COVID funding, and lack of a regional vision for homeless services, NTTHS struggled with uncertainty around the Emergency Warming Center and most recently the Day Respite Center which has closed. Through it all, the Outreach Coordinator will continue to meet clients where they are and support with connection to services and case management to improve their lives.

Program Participant Story

A client, a 56-year-old man, had been living outside for 10 years. When he first encountered the Homeless Outreach Coordinator, he was adamant about his disinterest in being housed. He had grown accustomed to his lifestyle and was wary of the restrictions and responsibilities that came with housing. Despite his initial reluctance, the Outreach Coordinator continued to check in with him regularly, offering support and building a rapport based on trust and respect. The Coordinator provided him with access to essential services, such as healthcare and mental health resources, and ensured he had food and warm clothing during the harsh winter months. Gradually, his perspective started to shift, he felt cared for and began to see the precariousness of his situation which led him to reconsider his stance on housing.
Eventually, with the help of the Outreach Coordinator, he learned about different types of housing, and navigated the application process which led to his acceptance into a supportive housing program. Since moving into his new home, he has experienced significant positive changes, his alcohol use has decreased notably, and his health is improving. Additionally, he has restarted the process of applying for Supplemental Security Income (SSI), which will help him support his basic needs and live independently. His story is a testament to the coordinator's ongoing support and the transformative power of stable housing.

PEI Category: Access and Linkage to Treatment

FREED
Senior, Disabled and Isolated Outreach Program
Friendly Visitor Program

Program Description

Program Overview

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

The Friendly Visitor Coordinator does a thorough intake either by phone or in the participants' home, gets to know their needs and interests, and matches them with an available volunteer. All volunteers have completed applications, interviews, background and reference checks. Volunteers

also attend an orientation on participant-centered services as well as regular monthly training and volunteer support groups. Volunteers are expected to spend a minimum of one (1) hour per week visiting with their matched participant, but many volunteers spend several hours more than the minimum.

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

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

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

Target Population

The FREED Friendly Visitor program serves individuals ages 60 and older, as well as persons with disabilities who are isolated in their homes. Participants are referred by family members and friends, or by a variety of local agencies.

Evaluation Activities and Outcomes

During the 2023-2024 year, FREED received 97 new referrals to the Friendly Visitor Program. There have been 40 new referrals to the PEARLS Program. This is a total of 137 new referrals. A year-end consumer phone survey was also done to gain information about the consumers quality of life and enhanced mental health as well as the ease and comfort level they have in sharing any feelings of depression, anxiety, or suicide ideation with their visitor. A year-end Volunteer Survey was also conducted by phone each year to gather information about volunteers' knowledge, ability and comfort level in identifying and directly addressing the symptoms of depression, anxiety, and suicide ideation.

Goals	2021-2022 Outcome	2022-2023 Outcome	2023-2024 Outcome
1 75 unduplicated individuals will	78 unduplicated individuals received	105 unduplicated individuals received	116 unduplicated individuals received

receive weekly calls or visits annually	weekly calls or visits annually	weekly calls or visits annually	weekly calls or visits annually
2 25 unduplicated individuals will participate in PEARL's	35 unduplicated individuals participated in PEARL's	36 unduplicated individuals participated in PEARL's	79 unduplicated individuals participated in PEARL's
3 75% of consumers will demonstrate improvement in depression symptoms Measured by the PHQ-2	82% of consumers demonstrated improvement in depression symptoms Measured by the PHQ-2	92% of consumers demonstrated improvement in depression symptoms Measured by the PHQ-2	88% of consumers demonstrated improvement in depression symptoms Measured by the PHQ-2
4 75% of PEARL's Participants will show improvements in depression symptoms measured by the PHQ-9	89% of PEARL's Participants showed improvements in depression symptoms measured by the PHQ-9	95% of PEARL's Participants showed improvements in depression symptoms measured by the PHQ-9	83% of PEARL's Participants showed improvements in depression symptoms measured by the PHQ-9
5 75% of consumers will report an improvement in quality of life and Mental Health	92% of consumers reported an improvement in quality of life and Mental Health	73% of consumers reported an improvement in quality of life and Mental Health	79% of consumers reported an improvement in quality of life and Mental Health
6 75% of Volunteers will feel comfortable talking about depression, anxiety with participants	88% of Volunteers feel comfortable talking about depression, anxiety with participants	88% of Volunteers feel comfortable talking about depression, anxiety with participants	93% of Volunteers feel comfortable talking about depression, anxiety with participants

During the 2023-2024 year, there were a total of 37 volunteers. Volunteers informed the participants of important events, information, and services such as: Emergency Preparedness for power outages, availability of Chromebooks, I-pads, low-cost phones and WiFi, HiCAP for Medicare Insurance Open Enrollment, PG&E Lifeline and CARE Programs, Vaccinations, Fire Evacuation Preparations, Heat Advisories and Cooling Centers, FREED's Referral List, Alzheimer's Outreach Events, Aging Well Events, Aging and Disability Device Access Program, Free Tax Preparation Service, Self-Care Tips, Grounding Techniques, and Nervous System Regulation, Depression and Dementia Workshop, Mental Health First Aid and Resources, Blue Zone Living, Grief Groups, Care-giver Workshops, Aging Well Magazine, Sudoku Class, Falls Prevention Conference, the Latina Festival, and the Veteran's Stand Down and many other services available in the County.

During 2023-2024, FREED offered 9 training opportunities for volunteers to attend via Zoom or live during this time:

- Mandated Reporting
- Community Resources and Services
- Volunteer Essentials
- Grief Support

- Suicide Prevention "Know the Signs"
- Pain Management- in person
- New Technology Programs and the Fix-it Program at FREED- in person
- How to be an Effective Peer Supporter
- Transforming Negative thoughts into Positive Ones

There was also an Appreciation Gathering for all volunteers at the Gold Country Inn, that included dinner and gifts in August and a cookie exchange social in December at FREED. FREED values the community members and acknowledgement is very important in the organization's culture.

Challenges, Solutions, and Upcoming Changes

The challenge to serve participants in the Friendly Visitor Program continues to be getting long term volunteers. FREED has a great group now, but the program keeps growing and more home visiting volunteers are needed. The Volunteer Coordinator is attending many more Outreach events and that is helping.

An upcoming change for the PEARL's Program is to have more participants participate in groups at the FREED office as an alternative to the one-on-one setting. FREED held an in-person group at Eskaton, but found it challenging to meet all the differing needs of the group members. Though there were initially 11 attendees, eventually all stopped attending. The group that met at the FREED office also encountered challenges with members physical health that made it difficult for people to attend and complete the program. The benefit of a group environment is that individuals get out into the community, can learn from each other, get a variety of different ideas, and make new friends and connections to the community. FREED hopes to be offering more groups in the future and plans for more advertising to increase enrollment numbers, so that if attendance is again an issue, there are still others engaged in the group.

Program Participant Story

A community member was referred to FREED because she was isolated and had symptoms of depression and anxiety. She attended 8 sessions one-on-one with the PEARL's Facilitator and made a great deal of improvement in her PH-Q and GAD-7 scores. She loved the process so much that she joined PEARL's group at FREED and has continued to grow and make important changes in her life that have significantly decreased her symptoms of depression and anxiety.

PEI Category: Access and Linkage to Treatment

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

Program Description

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

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

Evaluation Activities and Outcomes

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

The Social Outreach Program delivered services to 68 unduplicated participants FY 21-22, 69 during FY 22-23 and 58 during FY 23-24.

During FY 2021/22, the Program Coordinator made 217 referrals to other agencies/services. Of these, 64% or 139 successfully connected with the agency or service with an average connection time of 13.3 days, During FY 2022/23, the Program Coordinator made 191 referrals to other agencies/services. Of these, 70% or 135 successfully connected with the agency or service with an average connection time of 15 days. During FY 23/24, the Program Coordinator made 217 referrals to other agencies/services. Of these, 68% or 148 successfully connected with the agency or service with an average connection time of 18.5 days (see FY 23-24 PEI Year End Referral Summary Form).

FY 21/22, 22/23, 23/24 Goals and Outcome Measures:

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

- FY 21-22: 80% of the participants served who completed a post-screening tool scored lower (8/10).
- FY 22-23: 100% of the participants served who completed a post-screening tool scored lower (9/9).
- FY 23-24: 88% of the participants served who completed a post-screening tool scored lower (7/8).

Goal: 50% of the participants served who have not seen their primary provider in the past year will have made and kept an appointment.
Outcome:

- FY 21-22: 0% of the new participants served made and kept an appointment with their primary provider (0/3).
- FY 22-23: 60% of the new participants served made and kept an appointment with their primary provider (3/5).
- FY 23-24: 50% of the new participants served made and kept an appointment with their primary provider (1/2).

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

- FY 21-22: 97% of the participants served who completed at post-screening tool reported an increase in social activity or increased positive mood at follow-up (34/35).
- FY 22-23: 89% of the participants served who completed at post-screening tool reported an increase in social activity or increased positive mood at follow-up (25/28).
- FY 23-24: 86% of the participants served who completed at post-screening tool reported an increase in social activity or increased positive mood at follow-up (24/28).

Other Outcome Measurements:

1. Of the new individuals seen how many scored at a moderate-severe risk using the pre-screening tool?
    - FY 21-22: 34% of participants scored moderate-severe risk (19/56).
    - FY 22-23: 27% of participants scored moderate-severe risk (15/56).
    - FY 23-24: 29% of participants scored moderate-severe risk (12/42).
2. Of the new individuals seen how many hadn't seen their primary physician in the past year?
    - FY 21-22: 4% had not seen their primary physician in the past year (3/68).
    - FY 22-23: 7% had not seen their primary physician in the past year (5/69).
    - FY 23-24: 3% had not seen their primary physician in the past year (2/58).
3. Of the follow-up visits completed how many scored lower using the post-screening tool?
    - FY 21-22: 89% of the participants served scored lower (31/35).
    - FY 22-23: 89% of the participants served scored lower (25/28).
    - FY 23-24: 92% of the participants served scored lower (23/25).

Despite the challenges of impacted programs/therapists and the Program Coordinator's medical leave the outcome measurements were met or exceeded in FY 23-24.

Challenges, Solutions, and Upcoming Changes

The Program Coordinator was out on medical leave from 11/14/23 to 2/12/24 resulting in a reduced number of new participants (58 out of 60) as well as delays in service to existing participants. The Program Coordinator made efforts to support existing clients and engage new clients to reduce the impact to the participants' well-being and program outcomes as much as possible.

Therapists continue with impacted practices and fewer openings resulting in difficulty connecting participants with therapists in a timely manner or in some cases at all. The Program Coordinator utilizes increased case management time to support an individual's connection to a MH provider as well as providing additional referrals to supportive emotional programs during the interval period such as: warm lines, support groups, peer support, etc. Additionally, in order to provide participants with additional psychoeducation and emotional skills to improve participants' outcomes, the Program Coordinator completed a training in an emotional regulation modality. Furthermore, challenges remain with availability of services as many programs typically utilized for support for participants in the past continue to come back slowly from the pandemic in limited ways (or not at all). In addition, programs impacted by a high number of people seeking services results in longer wait times or clients giving up on connection with the service (see the trend in the average connection times for referrals). This resulted in the Program Coordinator being more creative and diligent in connecting participants to currently available and accessible long-term supports and services as well as engaging and encouraging development of additional natural supports where available.

The ongoing financial situation in the US has affected the most vulnerable citizens including the homebound seniors and people with disabilities on fixed incomes. The Social Outreach Programs client services budget continued to have a positive impact to meet participants' needs resulting in increased mental health and resilience this year. A request was to shift $2000 in funds from the Supplies and Postage budget line item to the Client Services line item for the FY 24-25 budget to grow the Nevada County Social Outreach Program's ability to meet ongoing increased participants' needs.

Program Participant Story

A referral from Nevada County APS resulted in the Social Outreach Coordinator collaborating with a participant experiencing severe depression, suicidal ideation, an anxiety disorder, active alcoholism, traumatic brain injury, and social isolation. This participant also experienced impairment in psychosocial functioning and challenging physical health symptoms limiting their quality of life. Despite a diagnosis of depression and anxiety earlier in her life and prior semi-recent treatment with a local therapist, the participant did not have mental health support in place at the time of engaging with the Social Outreach Coordinator. Barriers to connecting the participant

to supports and services were her mental health status, impaired communication skills, frequent intoxication, and lack of organization and motivation. Over a period of approximately two months, the Social Outreach Coordinator provided assessments, built rapport, provided psychoeducation and skill training, and connected them to long-term supports and services based on their needs and interests. This allowed the participant to begin to have hope and increased her motivation and actions toward addressing her situation. This included a therapist who was able to provide services weekly and a local SUD treatment center. Communication with her family improved with skills training and encouragement. Additionally, solutions to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) needs will be addressed with a pending IHSS case. The participant's second screen showed a reduction in their depression symptoms as well as increased socialization resulting in a positive outcome and increased life satisfaction.

PEI Category: Access and Linkage to Treatment

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

Program Description

Program Overview

What's Up Wellness Checkups (WUWC) is a suicide prevention program serving Nevada and Placer County youth and families since 2012. Modeled after TeenScreen, an evidence-based screening program developed by Columbia University, What's Up Wellness Checkups currently offers mental health screenings to primarily 9th graders (target population) in 10 high schools in Nevada and Placer counties. Screenings in 23/24 were also offered for the first time to 7th graders at Lyman Gilmore Middle School in Nevada County. These universal, no-cost, confidential screenings identify risk factors associated with suicide, depression, anxiety, eating disorders, PTSD, alcohol and substance abuse as well as other mental health conditions. Case management services are offered to families and students to assist in access and linkage to mental health treatment and other vital resources. WUWC prevention groups are provided on campuses teaching youth coping skills and ways to find resilience in their lives and in community.

Target Population

WUWC prevention groups are provided on high school campuses teaching youth coping skills and ways to find resilience in their lives and community at large.

Evaluation Activities and Outcomes

During FY 21/22, 481 total students were served. Out of those, 463 high school students received mental health screenings (Nevada County: 360, Placer County: 103). 171 students (37%) screened positive and received clinical interviews to assess the need for further evaluation or treatment (NC:

143, PC: 28). 141 students, 30% of total students screened, received WUWC case management services including referrals, screening summaries, consultations, in-person family meetings, and/or group services (NC:111, PC:30). 87 students, 19% of total students screened, received mental health referrals (NC:72, PC:15).

During FY 22/23, 520 total students were served. Out of those, 429 high school students received mental health screenings (NC: 301, PC: 128). 112 students (26%) screened positive and received in-depth clinical interviews to assess the need for further evaluation or treatment (NC: 83, PC: 29). 100 students, 23% of total students screened, received WUWC case management services including referrals, screening summaries, consultations, in-person family meetings, and/or group services (NC: 72, PC: 28). 69 students, 16% of total students screened, received mental health referrals (NC: 58, PC: 11).

During FY 23/24, 588 total students were served. Out of those, 519 high school students received mental health screenings (NC: 396, PC: 123). 151 students (29%) screened positive and received in-depth clinical interviews to assess the need for further evaluation or treatment (NC: 126, PC: 25). 166 students, 32% of total students screened, received WUWC case management services including referrals, screening summaries, consultations, in-person family meetings, and/or group services (NC: 143, PC: 23). 99 students, 19% of the total students screened, received mental health referrals (NC: 91, PC: 8).

FY	Total Students Served	Students Screened	Screened Positive	% Screened Positive	Students Referred to Mental Health Services	Students Referred To All Services
21/22	481	463	171	37%	87	141
22/23	520	429	112	26%	69	100
23/24	588	519	151	29%	99	166
TOTALS	**1589**	**1411**	**434**	**31%**	**255**	**407**

In FY 21/22 18 students were served in 14 prevention group meetings. 79% of participants providing evaluations reported moderate to significant increase in protective factors and/or decrease in suffering related to mental illness due to their participation. In FY 22/23 91 students were served in 24 prevention groups. 79% of participants providing evaluations reported a decrease in suffering related to mental illness and/or increase in protective factors. In FY 23/24 69 students were served in 22 prevention group meetings. 85% of the students providing evaluations reported a decrease in suffering related to mental illness and/or increase in protective factors.

Fiscal Year	21/22	22/23	23/24	TOTALS
Number of Group Meetings	14	24	22	**60**

Attendance	18	91	69	**178**

In FY 21/22, 130 mental health treatment referrals were made and 67 of these referrals were successful (51.5%). 19 students were referred to medical care or dentistry. Of the 19 students referred, 12 were successfully connected (66.6%). There were 47 students who were referred to local agencies/youth supports. Out of the 47 students referred to local agency/youth supports, 18 students/families were connected (38.2%). Screened students received 173 in-school support referrals this year. There were 115 successful in-school support connections out of 173 referrals (66.4%). Students received 68 referrals to LGBTQ+ supports both locally and virtually. 20 students were successfully connected out of 68 referrals to LGBTQ+ supports both locally and virtually (29.4%). Program clinicians provided 61 follow up meetings with higher risk students who faced ongoing barriers to accessing services.

In FY 22/23, 69 mental health treatment referrals were made with 36 known connections (53% connected). 19 students received youth-serving partner agency referrals with 5known connections (26% connected). There were 22 medical/dental care referrals with 11 known connections (50% connected). 87 LGBTQ+ support referrals with 24 known connections (27.5% connected). 204 school support referrals with 52 known connections (25% connected). Program clinicians provided 51 follow up meetings with higher risk students who faced ongoing barriers to accessing services.

In FY 23/24, 173 mental health treatment referrals were made with 62 known connections (36% connected). Students received 180 youth-serving partner agency referrals with 2 known connections (1% connected). 48 medical care or dentistry referrals with 11 known connections (29% connected). 317 LGBTQ+ support referrals with no known connections. 336 school support referrals with 56 known connections (17% connected). Program clinicians provided 78 additional follow up meetings with higher risk students who faced ongoing barriers to accessing services.

Referrals to Agencies and Services	**FY 21/22 # of referrals/ # connected (known)**	**FY 22/23 # of referrals/ # connected (known)**	**FY 23/24 # of referrals/ #connected (known)**	**TOTAL REFERRALS/ CONNECTION S**
Mental Health Treatment	130/67	69/36	173/62	**372/165**
Youth-Serving Partner Agencies	47/18	19/5	180/2	**246/25**
Medical and Dental Care	19/12	22/11	48/11	**89/34**
LGBTQ+ Resources	68/20	87/24	317/0	**472/44**
School Supports	173/115	204/52	336/56	**713/223**

Additional Clinician Meetings	61	51	78	**190**

In FY 21/22 outreach activities include partner agency presentations, collaborations and meetings (Teen Mental Health/Suicide Prevention Panel, NJUHSD board meeting, FRC, SCH, Know the Signs Training); partner schools program presentations and meetings (NJUHSD, TTUSD, STARS, SPED, Counseling Staff, Mental Health Club meeting, Bitney Prep. Reduced outreach events due to continued COVID restrictions.

In FY 22/23, outreach activities include partner agency presentations and meetings (BFFY, Mobile Crisis, CCTT, SPTF, CBV, CBH, SCH); partner schools program presentations and meetings (Wellness Centers, EHRMS, STARS, Superintendents, NJUHSD, TTUSD staff meetings); participation at community events (Truckee Health Fair, Latino Family Fest,
BFFY/SAFE Program's Teen Event, BR & NU Safety Nights); WUWC website overhaul; participation in Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP); participation on steering committee for County youth-led advisory board.

In FY 23/24 outreach activities include partner agency presentations, collaborations and meetings (BFFY, CCTT, CBV, CBH, SCH, GMC); partner schools program presentations and meetings (Wellness Centers, NCSOS, STARS, Superintendents, NJUHSD, TTUSD, Lyman Gilmore, Bitney Prep, SELS meetings); participation at community events (NSJ Cherry Festival, Lovewalk, NU Varsity Football Game, Pride Festival); WUWC website updates; participation in Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).

TOTAL YES PARENT CONSENTS	**NEVADA COUNTY**	**PLACER COUNTY**	**TOTAL CONSENTS**
FY 21/22	491	125	616
FY 22/23	421	147	568
FY 23/24	494	122	616
TOTALS	**1406**	**394**	**1800**

Challenges, Solutions, and Upcoming Changes

Program challenges this year include significant staffing changes mid-year creating disruptions to team screening schedules; not having prior experience with screening protocols in the middle school which created some difficulties for the school and screening team; group facilitators having to reduce their planned numbers of groups due to schedule conflicts. Solutions include reducing number of screening staff to a core team who can commit to the full school year; starting middle school screenings earlier in the school year with more thorough school planning meetings; and contracting with a new group facilitator in the spring to do anti-racism/anti bullying support group

which will continue in 24/25. Upcoming changes include reducing the # of core team staff and offering a BIPOC support group.

Program Participant Story

On the Diagnostic Predictive Scales, a student reported high levels of mental health symptoms and impairment. During their clinical interview, this student disclosed they were part of a high conflict custody dispute in which their father was requesting partial custody of them and their siblings. This student reported to the clinician that they and their siblings felt significantly uncared for when staying with their father. As details were disclosed, the information did not
indicate the need for a CPS report but there were areas of increased clinical concern. The case was then transferred to the WUW case manager who worked closely with the student's mom over a period of a few months on identifying needs, accessing support from community agencies, insurance access, and was finally able to find a successful connection for mental health treatment for this student. Later the student reported in their follow-up meeting with the clinician that they were feeling well supported by their new therapist, but asked for help on behalf of their mother to get legal support to address the custody issues. The case manager then contacted mom and referred her to the legal center at the family law court where she filed for custody. The mother later confirmed that the court ordered in favor of honoring the children's wishes after the screened youth gained confidence in therapy to speak up about their experience with their father which they reported to the court mediator. The mother extended her gratitude to WUW for helping alleviate the suffering in her children's lives and helping their family gain safety and freedom.

PEI Project Name: Access and Linkage to Treatment

BRIGHT FUTURES for YOUTH
Homeless Outreach

Program Description

Program Overview

The Bright Futures for Youth (BFFY) SAFE program provides access and linkages to comprehensive case management, housing navigation, mental and physical health care, as well as educational and career supports. The SAFE program provides youth with much needed support and guidance towards self-sufficiency by applying Bright Future for Youth's core values and impact areas, including self-advocacy, health and wellness, healthy relationships, goal setting, self-awareness, self-sufficiency, and community connectedness.

Target Population

The SAFE program serves marginalized, low-income youth ages 12-26 in Western Nevada County, supporting youth of all races/ethnicities, gender identities, and sexual orientations who are housing unstable/homeless unaccompanied minors and young adults, including young families.

Evaluation Activities and Outcomes

1. Goal: Program will serve 30 youth and families over three years.
    a. SAFE served 140 youth in the 2023-2024 reporting year alone, including 19 young families/pregnant youth. Over the last three years, SAFE has served a total of 239 youth experiencing homelessness/housing instability.
    2. Goal: Using the Youth Thrive survey as a baseline and post intervention tool, 80% of the SAFE Program Participants will report an increase in the protective and promotive factors of Youth Resilience, Social Connections, Knowledge of Adolescent Development, Concrete Support in Times of Need and Cognitive and Social-emotional Competence.
        a. SAFE plans to gather this information before the end of 2024 on active SAFE clients that are receiving case management services for a point in time snapshot on how they are doing with protective and promotive factors. However, BFFY has created a program that builds protective and promotive factors in our youth as follows:
            - The SAFE program expanded rapidly since opening the SAFE Drop-In Youth Navigation Center in October of 2022 in Grass Valley (at the BFFY headquarters). This Drop-In Center provides youth with needed concrete supports for basic needs, including food (both hot meals and shelf-stable food to keep) clothing, hygiene supplies, baby supplies, gas cards etc. Through the Drop-In Center, SAFE also provides youth with access to a hot shower and soon they will have access to a laundry facility on site. Youth are greeted at the Drop-In Center by a Peer Support Specialist, a young adult who has also experienced homelessness or housing instability in their lives. SAFE also has a Youth Support Partner who serves as liaison between SAFE and BFFY's NEO Youth Center program identifying NEO participants that are homeless or at-risk of becoming homeless, have mental health or other special needs, and providing case management to these youth. The other 3 SAFE case managers work with youth one-on-one to develop case plan goals and provide ongoing support and development in protective and promotive factors to help them obtain those goals.
            - In the 2023-2024 grant year, SAFE started a support group for young pregnant and parenting moms experiencing or at-risk of experiencing homelessness. This group setting provided clients with social connections and cognitive and social-emotional skills through regular meetings. Skill building was focused on parenting, self-care, healthy relationships, and financial stability.

- In the 2023-2024 grant year, SAFE has also provided concrete supports for 9 youth with a financial literacy workshop and one-on-one training on filing taxes.
- SAFE had a 61% connection to services rate for the 135 outbound client referrals made over the last year. Of these referrals, 32 (24%) were for mental health services. SAFE will work on improving this connection rate once BFFY's database is completed and able to track this information better. Since January 2022, SAFE has delivered 1,421 services to clients beyond outbound referrals. These services range from the provision of gas gift cards and hygiene products to obtaining documentation needed for employment and/or housing.

3. Goal: Improve housing stability for 40% of program participants

a. Through rental and deposit assistance, BFFY master-leased housing, housing choice voucher advocacy and application assistance, low-income rental application assistance, and landlord engagement, SAFE has helped 28 youth *obtain* housing and 26 youth *maintain* their housing in the 2023-2024 year. That totals 54 youth, or 39% of the youth served over the last year, in which SAFE provided housing stability to. All SAFE clients that are stably housed receive post-housing case management/aftercare to ensure sustainability of tenancy and ongoing personal growth.

b. Over the last three years, SAFE has helped a total of 110 (46%) youth improve their housing stability through the above direct services in addition to providing workforce development support and connection to resources like CalFresh and CalWorks that directly improve income stability.

c. SAFE helped an additional 31 clients with emergency and transitional housing by referring them to Hospitality House's emergency shelter (11 referrals), the Community Beyond Violence safe house if escaping domestic violence (7 referrals), and placement in BFFY master-leased housing to help them transition to permanent housing (13 youth total)

4. Goal: Program participants meet up to 60% of their case plan goals

a. All clients assigned a Case Manager formulate case plans, setting tangible goals in all life domains, including housing, employment, education, mental health, physical health, relationships, and community connections. Of the 147 youth that have received case management services over the last three years, 39 (27%) have exited the SAFE program meeting their case plan goals. Twenty-five (17%) youth currently receiving case management services in SAFE have met their case plan goals of being stably housed. Another 45 (31%) youth currently receiving case management services are working toward achieving their case plan goals.

Challenges, Solutions, and Upcoming Changes

The biggest challenges experienced by the SAFE program to date have been unexpected changes with staffing. The SAFE Program Director left the organization at the beginning of 2024, and the first SAFE Program Manager started a medical leave of absence Fall of 2023 and was unable to

return to work. The lead SAFE Case Manager and Intake Coordinator officially became the Program Manager in Spring of 2024 and has helped refine and formalize systems in the program to improve tracking of youth and their goal attainment. The Associate Director supervises the Program Manager and works closely with her to improve program tracking in the database so that BFFY has the most accurate information needed to help youth meet their goals and report on their progress.

Another big challenge recently discovered was that the BFFY program database that has been in the process of being developed by outside specialists was not developed correctly over the last two years. The organization found out the developers did not set up demographic and other important data fields to track history and changes in status. This resulted in the BFFY team having to go through paper files and written case notes to piece together the client history in the SAFE program.

Another ongoing challenge is the absence of emergency shelter providers for unaccompanied minors in the area, but also emergency shelter options for young adults where they feel safe and supported at the level they need.

Program Participant Story

H is a 21-year-old female who has been a participant of the SAFE program for 3 years. She has gone through many ups and downs during her time in the program and has struggled with her mental health, housing instability and domestic violence for years. In the beginning of 2023, the Bright Futures for Youth SAFE program assisted H in obtaining a Housing Choice Voucher (HCV) through the Regional Housing Authority. This allowed H to be housed in one of the BFFY master leased transitional houses, getting her out of the stressful living situation she was in. She had been living in a converted shed on her dad's property. Her dad has a history of drug abuse, and his unpredictable behavior was very difficult for H. Living in one of the BFFY transitional houses enabled her to have more support and get connected to the mental health services she needed. H has always been motivated to work and go to school, though took an extended break to focus on her mental health. Her case manager connected her to a therapist and psychiatrist. Group living also presented other problems, but H was able to work through them with assistance from her case manager, learning about herself and setting boundaries in the process. As she was able to gain rental history, H was able to obtain her own independent housing this year. In May of 2024, she signed her own lease on a 1-bedroom apartment. While she used her HCV for a few months there, she is now working full-time and is able to pay her rent without the assistance of the voucher. H works as a CNA at a local nursing home and is now completing classes at Sierra College to transfer to another college where she can pursue a nursing degree. H is doing very well on her own and has demonstrated incredible growth this past year. Even though she is doing well, the SAFE program team will continue to check in with her to ensure she maintains her housing, and she knows she can always reach out if there is anything she is needing help with. Bright Futures for Youth and the SAFE team are so excited to see what she accomplishes in the future!

PEI Project Name: Access and Linkage to Treatment

Gold Country Community Services
Senior Outreach

Program Description

Program Overview
Gold Country Senior Services, (GCSS) provides a range of programs and services that support the health, well-being and independence of older adults in Nevada County. The program serves approximately 500 older adults per year through their various programs and relies largely on volunteers to provide services. This year the MHSA PEI funds allowed GCCS to enhance and expand existing programming to add staffing, develop a standardized depression screening procedure for homebound Meals on Wheels program participants, and support the planning and outreach process for the opening of the Community Senior Center.

GCSS incorporated the PHQ-9 depression-screening tool into its current client assessment procedure and developed a proactive process for making the appropriate referrals to county mental health programs. Upon initiating the additional PHQ-9 question depression-screening tool, clients that demonstrate being at risk of or experiencing depression and high levels of anxiety, were provided the opportunity to participate in the PEARLS program. Should the client decide not to participate, the Case Managers will provide referral sources and educational materials.

Gold Country Senior Services expanded services to include a bilingual Case Manager. This Case Manager assisted in providing depression screenings, referrals to Mental Health and Well- Being programs throughout Western Nevada County. During the grant year, this Case Manager also provided community outreach activities and assisted in the development of educational materials and marketing materials to engage the Spanish speaking community. Because of the loss of the bilingual case manager, mid-year, this effort was not fully completed. The new part-time Program Director for the community senior center assisted the Case Management team in developing an educational session for the Meals on Wheels congregate dining community members at the Old Tunnel Road, Nevada City Apartments while the new senior center was undergoing construction. As the new Sierra Gold Community Senior Center opens on July 1, 2024, preparatory efforts were made during the grant year to identify transportation options to bring homebound clients to the center after it opens. A full socialization and activity scheduled was developed promoting key strategies from the PEARLS program was developed.

Target Population
Homebound Seniors in western Nevada County.

Evaluation Activities and Outcomes

The following outcome measures results were reported quarterly (see final report:

- Provide outreach, screening, and case management services via Bilingual Case Manager and Program Director. *Partially completed due to the loss of the Bilingual CM mid- year and the postponement of the senior center opening.*
- 3 Case Managers will complete PEARLS Training. *Completed*
- Develop assessment tool incorporating the 9 elements of the PHQ-9 screening tool. *Completed*
- Develop and put into use the contents, tools and flow of PEARLS program. *Completed*
- Develop and administer outreach, education, and awareness materials. *Partially completed for same reason as above.*
- Refer people who need mental health treatment to Nevada County Behavioral Health or other mental health providers in the community. *There is a current process for referrals.*
- Utilize evidence-based and -informed practices when working with seniors. *All Case Managers were provided with additional education in Options Counseling; attended supervision for PEARLS, and build skills as part of the monthly Case Management team meetings.*

Outcome data elements:

- Number of homebound seniors served
  - 480
- Number of homebound seniors educated
  - 330
- Number of congregate diner meetings
  - 118
- Number of unduplicated participants for homebound and congregate clients
  - 4
- PEARLS program Outcomes:
  50% of program participants will demonstrate improvement on the PHQ-9 screening tool pre/post
  - Between Quarters 1 and 2, 28 clients improved symptom scores by at least 1 point.
  - Between Quarters 2 and 3, 21 clients improved symptom scores by at least 1 point.
  - Between Quarters 3 and 4, 30 clients improved symptom scores by at least 1 point

  50% of program participants will show improvement in their participation in social and physical activities pre/post
  - (6/1/24) PEARLS Participant 1 has been enrolled for 3 weeks, they have already exceeded their daily exercise goals and have significantly improved physical

activities. When they started PEARLS they reported doing no physical exercise of any kind besides light stretching. They are now exercising daily and exceeding their exercise goals.

- (6/1/24) PEARLS Participant 2 reported doing physical exercise for less than 20 minutes a day or 3 days a week. He is focusing more on calling and reaching out to his daughter for socialization.
    - (8/1/24) Participant 2 has increased his exercise from 0 days to 3 days and finally 4 days of exercise a week, these include stationary bike and stair steppers.
- (8/1/24) Participant 3 was enrolled in April 2024 and reported doing little exercise, over the course of 8 weeks the participant has started walking more, swimming, and exercising in bed.
- (8/1/24) Participant 4 was enrolled in June 2024, they reported doing no exercise, Gold Country Community Services has just started the PEARLS Program with this participant and will have an update during the next reporting cycle.

50% of program participants will show improvement in their participation in pleasant activities pre/post.

- (6/1/24) Participant 1 does not participate in pleasant activities; they have identified pleasant activities to do. No data has been recorded on improvement yet, an update will be provided on the next quarterly report.
    - Enjoying a nice cup of coffee
- (6/1/24) Participant 2 sometimes participates in pleasant activities; they have identified pleasant activities to do. No data has been recorded on improvement yet, an update will be provided on the next quarterly report.
    - Listen to a Podcast
    - Relax outside
    - (8/1/24) After starting PEARLS, Participant 2 has been doing more and more pleasant activities helping to improve their mood
        - Listen to a podcast
        - Sit on Porch and get Sun
        - Relax Outside
- (8/1/24) As of the first PEARLS session, Participant 3 sometimes participates in pleasant activities; they have identified pleasant activities to do.
    - After completing PEARLS, Participant 3 has enjoyed sunshine, walked the dog to the park, and did water coloring. Improving their participation in pleasant activities pre/post PEARLS
- (8/1/24) Participant 4 has just enrolled in the PEARLS program and reports doing pleasant activities everyday, these include watering the garden and praying. An update will be given on the next reporting cycle.

50% of program participants will self- report improvement in their overall health status pre/post

- (11/1/23) Demographics sheet shows 0 participants for this quarter, Gold Country Senior Services' Case Managers are currently enrolled in PEARLS training and will start PEARLS program for clients next quarter. Next quarter will show more and active participants.
- (2/1/24) Finding participants that fit the criteria has proven to be difficult. If the clients score is too low, they do not need PEARLS training and if the clients score is too high, they are referred to Behavioral Health. All clients that have qualified to be offered PEARLS training have been offered the program and education. None of the screened clients have chosen to participate in the PEARLS program.
- (6/1/24) In March 2024, the Case Managers enrolled 2 clients in the PEARLS Program.
    - Participant 1 scored a baseline of 18 on the PHQ-9, after 2 weeks their score has improved to a 16. They improved interest in doing things and are not oversleeping as much. However, their appetite has decreased and are having more trouble concentrating.
        - Gold Country Senior Services are continuing treatment and will have a better update on the next report as Participant 1 has been in PEARLS program, only 3 weeks
    - (6/1/24) Participant 2 scored a baseline of 2 on the PHQ-9, after 2 weeks their score worsened to a 4. They improved interest in doing things but reported an increase in feeling depressed and staying asleep.
        - Gold Country Senior Services are continuing treatment and will have a better update on the next report as Participant 2 has been in PEARLS program, only 2 weeks
            - (8/1/24) Participant 2 has been enrolled in the PEARLS program for 8 weeks. At the end of Session 8 the Participants score PHQ-9 score improved to a 1 – reporting an improvement in their overall health status pre/post
    - (8/1/24) Participant 3 scored a baseline of 8 on the PHQ-9 in April 2024, after completing the 8 week PEARLS session, their baseline improved to a 1 – reporting an improvement in their overall health status pre/post.
    - (8/1/24) Participant 4 scored a baseline of 11 on the PHQ-9 in June 2024, an update will be provided on the next reporting cycle as this participant has just been enrolled in the PEARLS program

Challenges, Solutions, and Upcoming Changes

Challenges: It took longer than expected to hire the bi-lingual case manager and then to have to re-hire one after the first one left. Additional training time was needed to ready the case management team to begin to offer the program to homebound clients. The other challenge was that it takes time to establish trust before a client is comfortable with participating in the program.

Consequently, PEARL coaching was not implemented until this past spring. GCCS had also anticipated having the senior center open to allow for more community outreach and awareness. Transportation continues to be an issue to provide connection to the Senior Center for socialization.

Solutions: GCCS hired a new bi-lingual case manager this spring and are in the process of getting her trained in both Options Counseling and in the Pearls program. A position was created for 16 hour/mo that exclusively provides the PEARLS program and maintains a census of 3 participants in the program at all times. The Lead Case Manager also takes on clients as needed. The community Senior Center is now open and will be providing education and awareness materials at the center. The transportation issue will need to be resolved in collaboration with the county as part of the Master Plan on Aging. GCCS will actively participate in those efforts.

Upcoming Changes: GCCS will have a fully PEARLS trained coach by December 2024 and will have the outreach and marketing materials completed. GCCS is developing an outreach program to the Hispanic/LatinX community to expand the reach to homebound seniors with this need.

Program Participant Story

Why is the PEARLS program great for our seniors?

PEARLS stands for the Program to Encourage Active Rewarding lives for Seniors. An evidence-based program out of the University of Washington that works with people that have depression by teaching clients Problem Solving Therapy (PST). It provides useful tools and strategies that help in their everyday lives and helps with lowering the symptoms of depression.

Now, working as a PEARLS coach counselor, I have witnessed how this program truly helps others. One client in specific was suffering with depression and many other chronic medical conditions that limited his ability to care for himself. He felt hopeless and was angry with himself for not being able to do the things he used to be able to do. He lives alone and has no help. He cannot drive or cook for himself. Also being blind, he was unable to go many places outside of his home without help. He really felt like he was a burden to anyone that had to help him. After an assessment done for the Meals on Wheels program, a case manager from Gold Country Senior Services referred him to the PEARLS program.

As his PEARLS coach counselor, I worked with him once a week for about an hour and after a few sessions, I noticed that my client was already feeling less down and depressed. We worked on identifying problems, setting goals to solve his problems, and then we broke down his problems by coming up with solutions and steps to reach his goals. After a few more sessions, I found that he was able to solve many of the problems that contributed to his depression on his own and without any guidance. I was impressed and told him that he had used the tools for his problems he had learned on his own. I told him that he was developing the skills he had learned from the PEARLS program without knowing he had. He was excited! I was able to take the problems off his list as “solved”. Each week, I also conducted a depression screening with him, known as the PHQ9, and I noticed that some weeks his scores really dropped. He was feeling

better and very happy to have someone to talk with. Each week we set a pleasurable, physical, and social activity, to help him with feeling better. It really helped him out and by keeping up with completing most of his goals; he felt that he was in control of his life again. I especially was able to see the results from his social activities. Being social for him was not only enjoyable again but it really helped him feel less lonely. I also witnessed a better mood from him and he seemed happier overall. Doing his physical activity each week made his feel more strength in his legs and he felt he could walk a little better. His pleasurable activities also helped him enjoy the small things in life again. The PEARLS program had truly helped him.

This client has also described how the PEARLS program has really helped in his life. “PEARLS has taught me ways to help with the problems in my life that bring me down and feel depressed. I have learned tools and techniques that have helped me with my daily activities. I now set weekly goals for myself that can help me feel like I can accomplish things and solve my own problems. I feel a lot better and a lot less stressed. I especially find that when I come up with my weekly activities and I complete all or most of them, I have more enjoyment in my life. I enjoyed having a PEARLS coach counselor come to my house for each session, as it is hard for me to go outside my home. I definitely recommend the PEARLS program to anyone that has depression and wants to learn ways to reduce the symptoms and problems that go with it.”

PEI Project Name: Access and Linkage to Treatment

Nevada County Superintendent of Schools
Homeless Education

Program Description

Program Overview

The NCSOS Homeless Education (HE) program focuses on meeting families and students "where they are at" to overcome barriers to access services. Through a mobile service delivery model, the HE Case Manager is able to meet with clients on school campuses throughout Nevada County (including the North San Juan Ridge), and private or public locations chosen by the parent/guardian. Family needs are identified by the parent/guardian completing a Housing Questionnaire. The HE staff then work with schools and community partners to address those needs, which may include mental health services, basic needs, transportation support, service provision on campus by outside agencies, etc.

Target Population

Children aged 0-12th grade.

Evaluation Activities and Outcomes

265 children/youth (ages 0-18+) will receive services per year through the Homeless Education Case Manager.
Between August 2023 and June 2024, 256 individuals were identified through the education system in Nevada County or through Nevada County Schools, as experiencing homelessness for the 2023-2024 school year. At the end of the 2023-2024 school year (August 2023 to June 2024), 95 individuals from 50 families were referred to the Homeless Education Case Manager.

20% of program participants will be permanently housed when they exit the program.
Of the 50 families referred to the Homeless Education Case Manager in the 2023-2024 school year (August 2023 to June 2024) 31 families were actively engaged and participating. 45% of the engaged families exited the program and transitioned to permanent housing this school year.

70% of program participants will receive mental health referrals and resources via warm hand-off.
A total of 61% of the families actively involved in the NCSOS Homeless Education program received mental health referrals and resources via warm hand-offs.

Challenges, Solutions, and Upcoming Changes

The challenges faced continue to be overcoming the perceived stigma of homelessness and mental health issues. Some families do not want to discuss their housing situation due to fear and concern about legal issues that could arise from CWS or custody situations.

Many individuals were already connected to Mental Health support through various channels, making it difficult for us to refer them to Behavioral Health Services; however, referrals were successfully provided to other Mental Health (MH) resources and facilitated warm hand-offs within the community. Families without Medi-Cal coverage and ineligible for Behavioral Health referrals faced limited options. Long wait times for services were a significant obstacle. The scarcity of professional counseling services and providers compounded the issue.

Some families, particularly those in medical crises and lacking stable housing, found it burdensome to navigate the process of finding a provider and enduring lengthy wait lists.

The introduction of a new case manager posed a learning curve; however, with time they have developed a stronger foundation to assist both individuals and families. Building relationships and establishing connections with other agencies also proved essential for their effectiveness. Referrals made to the case manager are being tracked along with the referrals and resources that the case manager gives to those families that engaged in case management support. Last school year, the case manager received 50 referrals to provide resource connection and comprehensive support. Of these referrals, 107 connections to community agencies and resources were made.

It was learned that connection to resources and knowledge of available resources is still very much needed within the school system and within the greater community. Staff will continue to work on ways of disseminating information about available resources to site liaisons. The program will focus on sharing out community resources in monthly newsletters, email blasts, a community resources Padlet and review of available resources at each of the quarterly liaison meetings.

Staff have learned that site liaisons and school staff are not aware of all the available community resources, mental health resources and qualifications for various programs. The case manager position has proved to be an asset for site liaisons and school staff to utilize as a place to gain information about community resources. Further demonstrating the continued need for the case manager position.

Solutions Proposed

The HE case manager will continue to strengthen ongoing efforts to foster trusting relationships with families, ensuring their continued support and engagement through open dialogue, weekly communications and continuing to meet families wherever they are, with compassion and respect, devoid of judgment.

NCSOS HE case manager will also persist in destigmatizing homelessness and mental health issues through additional mental health training initiatives. The case manager received a Mental Health First Aid certification in 2024 and continues to attend mental health trainings and webinars. Mental Health flyers will be provided to every engaged family next year during the intake process.

The new case manager has undergone significant growth and is equipped with a more solid foundation to assist individuals and families. They have actively cultivated relationships and connections with other agencies, enhancing their effectiveness. The community involvement and collaboration, especially with the impending expiration of the American Rescue Plan Funds in September is essential and continuing to partner with local agencies is vital to discovering new resource opportunities.

Upcoming Changes

With the expiration of the American Rescue Plan Funds in September, there is a heightened urgency to collaborate closely with local community agencies to identify and utilize new resource opportunities.

Program Participant Story

A single mother and her son, facing physical disabilities and upcoming surgery, became homeless due to their family’s home foreclosure. After six months in a hotel, they finally found a permanent home. During this time, the son's school attendance suffered, likely due to the mother's mental health issues and the challenges they faced.

The case manager spoke with the mother about accessing health and mental health services. She was able to get a doctor's appointment and after adjusting her medication she experienced less migraines and her overall well-being improved. One day when the case manager and the mother connected, she was out walking and was proud that it was the second day in a row she had gone for a walk after taking her son to school. She sounded more optimistic and mentioned the possibility of getting an apartment soon. Shortly after, the case manager called the mother and she shared the good news—they had moved into their new apartment, giving her son a stable place to recover after surgery. The mother's upbeat attitude continued as she began applying for jobs. This story highlights the importance of stable housing and mental health support for families facing adversity.

PEI Project Name: Access and Linkage to Treatment

Hospitality House
Outreach Case Manager

Program Description

Program Overview

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

Target Population

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

Evaluation Activities and Outcomes

During the reporting period, the Street Outreach Team served a total of 249 individuals experiencing homelessness in Nevada County.

Aggregate Outcomes from FY 21/22 and FY 23/24:

i) Outcome Measures
(1) Provide case management services to at least 60 individuals/families.
- 249 individuals were served.

(2) 90% of program participants have identified at least one service or benefit that they need and have received.
- 100% of program participants received at least one service or benefit they needed.

(3) 80% of program participants show a decrease in prolonged suffering from mental illness by measuring reduced symptoms and/or improved recover, including mental, emotional, and relational function.
- 82.7% of participants received referrals to either Mental Health or SUD services.

(4) 80% of program participants show a reduction in risk factors, indicators, and/or increased protectives factors that may lead to improved mental, emotional, and relational functioning.
- 97% of participants gained access to shelter, housing, mental health, or medical care.

(5) 70% of referrals provided to program participants are followed up on by the program participants.
- 71% of referrals were followed up by program participants.

- Community Recovery Resources - 113
- Nevada County Behavioral Health - 93
- Medical Referrals -28
- Housing Referrals - 48

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

Service/ Need Type	Number of Services
Case/Care Management	1041
Transportation	640
Housing Search Assistance	375
Local Bus Fare	222

Relationship Development Intervention	193
Meals	134
Clothing	106
Outreach Programs	94
Benefits Assistance	75
Crisis Intervention	62

Challenges, Solutions, and Upcoming Changes

FY 21/22:

From July 1, 2021, to June 30, 2022, Hospitality House served 143 clients through its PEI program. Meeting outreach clients "where they are at" poses certain challenges that are not found in sheltered guests. With no fixed address, and most not having cell phones, ongoing case management can be challenging. The expansion of services through the HOME Team and Hospitality House Outreach team is a step in the right in the right direction if more meaningful case management is to occur. While most of Hospitality House's outreach clients have severe substance use or mental health issues, many of them are unwilling to engage in treatment or have engaged in the past and are unwilling to do so again. A lack of options in the community for super utilizers can create a "been there, done that" mentality from both providers and outreach clients. Some clients have voiced negative experiences with local treatment options and encouraging engagement for those who have been disappointed with the outcome creates a barrier for case management. Ongoing relationship and rapport building as well as a willingness from agencies to reengage clients is necessary for long term success in outreach.

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

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

FY 23/24:

From July 1, 2023 to June 30th, 2024, 106 clients were served through the PEI Program. The biggest challenge faced during FY 23/24 was the GBHI (HOME Team) contract expiring halfway through the fiscal year. This coincided with the beginning of the Behavioral Health Bridges to Housing (BHBH) program. Luckily staff were able to be

retained to support the PEI case manager with outreach efforts in the community. Another challenge was the loss of "flex funding" that was part of the GBHI contract. These flexible funds allowed for multiple client supports from rental assistance, motels, vehicle repair, and homelessness prevention. Though the BHBH program does fund motels, much of the client supports mentioned above had to be supplemented from other providers, donors, and Hospitality House's general fund.

Program Participant Story

In one case HH was called by Grass Valley Police Department (GVPD) to meet with a gentleman experiencing acute schizoaffective disorder symptoms. The gentleman was incarcerated at the time but would be released homeless with mental illness. We were able to assist the gentleman in not only obtaining Medi-Cal, but also in completing a Social Security application. HH also made connections to Behavioral Health for referrals so that he can exit jail with services; he was awarded Supplemental Security Income (SSI), and HH is currently working on housing solutions for him to avoid returning to homelessness. By proactively engaging someone before they are released and ensuring they receive medical treatment and housing support, this significantly reduces recidivism and improves housing, employment, financial health, mental health, and legal outcomes for people.

PEI Project Name: Access and Linkage to Treatment

California Heritage: Indigenous Research Project (CHIRP)

Program Description

Program Overview

The CALIFORNIA HERITAGE: INDIGENOUS RESEARCH PROJECT (CHIRP) is a 501(c)(3) organization founded in 2014 with the mission to preserve, protect, and perpetuate the history and Culture of the Nevada City Rancheria Nisenan (NCR) Tribe. The organization has grown in focus and capacity to serve the Tribe's goals and needs better and to advocate for the restoration of the Nevada City Rancheria's Federal Recognition. With financial and community support, CHIRP continues to create and offer programs that support the preservation, protection, and perpetuation of the Nisenan people and their Culture into the future. CHIRP also addresses the social determinants of health that have an impact on Tribal members, including historical and generational trauma affecting Indigenous People and supports the continued progress of cultural revitalization and connectedness.

CHIRP is establishing and piloting an Indigenous Mental Health and Wellness program as a new initiative. The program is staffed by an associate social worker (ASW, MSW), the Tribal Prevention and Intervention Specialist with the skills, experience, and cultural sensitivity to work effectively with Indigenous People residing in Nevada County. Tribal Prevention and Intervention Specialist has a clinical supervisor (LCSW) who supports their supervision. The program is also staffed by three Tribal Community Health Workers who have been hired this year and are undergoing training to better enable them to assist their Tribal community as peer supports.

The specialist serves as a liaison between the Tribe and county Behavioral Health and other providers for a) collaborative learning exchange, b) to increase the accessibility of services, c) build non-Indigenous mental health provider awareness of the impact of historical and generational trauma on mental health, d) assist with navigation of the mental health and treatment systems and e) identify programs, approaches, and evidence-based practices developed to address Indigenous mental health, wellness and treatment for implementation in Nevada County. The Specialist is also implementing strategies and supports to reduce stigma among Indigenous People while working closely with the Nevada City Rancheria Tribal Council to embed proper Cultural protocols into the program.

This staff person works to introduce and normalize conversations around wellness, harm reduction, and sharing of needs and dilemmas. They also help facilitate mental health screening (e.g. PHQ-9, GAD-7) for Indigenous People, provide case management assessment, including social determinants of health, develop individualized service plans, provide linkage to prevention and intervention services (group supports, substance use prevention education, suicide prevention, and mental health services) and linkage to services to address social determinants. As well as advocate for the use and inclusion of additional evidence-based Indigenous best practice models that will widen the scope and cultural competency of assessment, intervention, evaluation, and planning.

Target Population

Identifying who to serve is based on need as well as stability. In Indigenous evidence-based best practice bringing stable Tribal Community on as staff is key. This population within the Nevada City Rancheria Nisenan Tribal community are folks who already have built trust with and support other Tribal community members who have been identified as less likely to seek out or accept services.

Therefore, the populations CHIRP has oriented towards working (and training) within this initial first phase of building out a Tribal Wellness Program are Tribal Staff (Six total: Three Community Health Workers [called Tribal Health Workers], training funded through the Hear US Grant, two Tribal Staff working with Youth within the PEI grant and programming, and the Executive Director and Tribal Council Member), Elders within the Tribal Community (eight) and Tribal Community families (including 11 youth and TAY) as well as 12 Tribal family members.

This initial core Tribal community of 36 has been identified and engaged over the last two years as those interested, in need, and willing to support the build out and nurturing of community care

networking. All programming that Tribal Staff and Tribal Community supports outreaches beyond this number of 36, but at this time the organization is focusing on building strong organizational capacity, community trust and care, and deepening relationships and trust with providers. It feels imperative to do this work well and to get practiced systems into place including appropriate Tribal protocols so as there is more engagement with the Tribal Community, services are provided to them in a dependable, consistent, and practiced way.

Evaluation Activities and Outcomes

Goal: Increase in number of Tribal community members engaging in Tribal community mental health conversations, workshops, focus groups, and services.

- **Measurement:** Baseline assessment of number of Indigenous People from NCR connecting to Tribal community mental health conversations, workshops, focus groups, and services: 24 Tribal Members
- **Outcome:** Increase in programming and participation of Tribal Community Engagement and Programming (conversations, workshops, focus groups, and services. Chirp Tribal Intervention Specialist has engaged with 24 new Tribal Community members in the following ways.
    - Conversations/Focus Groups: 6 Focus Groups have been held with Tribal Elders, Tribal Community members, and Tribal Staff
    - Youth Gatherings: 1x monthly with 9 Tribal Youth
    - Tribal Community Health Worker Trainings: Over 41 trainings supporting at least Three Tribal Health Workers and oftentimes two Tribal Staff
    - Tribal Leadership Community Care Conversations: 1-3 Tribal Community members; 1x weekly over 32 meetings
    - One-on-one Tribal Community Assistance Meetings: 11 Tribal Community members ongoing as needed and regularly.
    - Fall Tribal Wellness Programming: Red Road To Recovery, Harm Reduction Series, Nurtured Hearts Series, Native Wellness Institute's Wellness in the Workplace trainings…
    - Youth Programming for Prevention and Early Intervention:
    - Cultural Art Workshops and Gallery Opening: 6-10 Tribal Elders and Council Members; weekly over 25 meetings leading to Art Show opening in 2025.

Goal: Increase the number of Tribal Community members from NCR connecting to Tribal Harm Reduction Programming

- **Measurement:** Baseline assessment of number of Indigenous People from NCR connecting to Tribal Harm Reduction Programming: 6 Tribal Staff engaged in programming and training
- **Outcome:** 60% increase in Tribal Community connecting to Tribal Harm Reduction Programming
    - **Harm Reduction educational series/conversation** (2-day series, 2x): confirmed for Nov and December 2024 with speakers from Public Health, Know Overdose, and Yuba Harm Reduction to be attended by Tribal Staff and other interested Tribal Community Health Workers: 6- 9 attendees.
    - **Nurtured Hearts Training:** one-day training for all Tribal Staff confirmed and scheduled for mid-December to support all staff in navigating psychosocial and emotional conversations from strengths-based and emotionally wise methods.
    - **Native Wellness Institute 2 Day Training** coming to Nevada City to support Tribal Staff and the greeted Tribal Community with a one-day Wellness in the Workplace training and another one-day Adult and Youth Leadership training: 18 will attend
    - **Traveling to Native Wellness Institute's Adults Working with Native Youth** conference in December 2024: 4 Tribal Staff

Goal: Increase the number of Tribal community members receiving Indigenous Medicine bags (traditional medicines and Narcan, test kits, etc).

- **Measurement:** Baseline assessment of number of Indigenous People from NCR receiving Indigenous Medicine bags (traditional medicines and Narcan, test kits, etc); 0.
- **Outcome:** 0% increase towards this goal
    - The leather for the medicine bags has been purchased, are in the process of making the medicine quote cards and collecting the local traditional herbal medicines to include within the bags. 5 Tribal Members participated in the gathering of medicine, 2 Tribal staff are involved with buying materials.
    - As CHIRP began to engage in this work, deeper needs were identified around organizational order of operations, SMART goals, follow through, and communication.
    - CHIRP pivoted from this being the goal to a goal of training Tribal Staff on SMARTIE goals, clear communication, and follow through.

Goal: Increase in training and focus group materials created by Tribal Community Health Workers that support culturally appropriate, evidence-based education, prevention, intervention, and treatment.

- **Measurement:** Baseline assessment of number of Indigenous People from NCR connecting to training and focus group materials created by Tribal Community Health Workers: 5
- **Outcome:** 500% increase in goal.
    - 6 Tribal Staff have and continue to engage in focus groups and trainings to brainstorm and learn about both Western and Indigenous best practices around mental health, community engagement, and personal and community safety.
    - As a result of this, organizational Tribal Protocols are being created and laid out with the support of Indigneous Tribal Advisor, Kenneth Hanover Sr., who supports us in building out foundational methods.
    - Tribal Staff are also engaging in the creation of the first phase of a larger Tribal Newsletter whose orientation is the larger NCR Tribal community. This newsletter will have ongoing events, invitations to Tribal Community Gatherings, etc.
        - A caveat here is making sure the Tribal Staff has the capacity to navigate and support future programming, community engagement, etc.

Goal: Increase in cross-generational programming through Elevate Youth Grant and MHSA grant based on culturally appropriate, evidence-based educational, prevention, intervention, and treatment.

- **Measurement:** Baseline assessment of number of Indigenous People from NCR connecting to cross-generational programming about Indigenous culturally appropriate, evidence-based educational, prevention, intervention, and treatment; quarterly reporting to demonstrate increase over baseline. 36.
- **Outcome:** 100% increase in this goal. PEI Elevate Youth Grant, MHSA Grant teams, and Hear US Grant team are working together and weaving programmatic goals together for more impactful and long-term outcomes.
    - Grant Coordinators meet bi-weekly to collaborate on work plans, trainings, and community gatherings.
    - First Tribal Wellness Series has begun where CHIRP is collaboratively bringing various trainers, facilitators, and behavioral health practitioners together to educate and facilitate conversation with Tribal Staff.
    - Youth programming has also offered events including Tribal adults and elders to support the weaving together of generational understanding of previous trauma and current wellness.

Goal: Increased engagement, familiarity, and trust with County providers through building a cross-cultural Tribal Service Provider Coalition.

- **Measurement:** Baseline assessment of number of Indigenous People from NCR connecting to cross-cultural Tribal Service Provider Coalition (building trust with County providers); 11.
- **Measurement:** Baseline assessment of number of NevCo providers receiving cultural humility training from Indigenous Providers: 60-80.
- **Outcome:** Increase in progress toward this goal.
    - After great efforts in building trust with various providers and providing deeper conversations around cultural humility and dignity: CHIRP has supported 11 Tribal Community Members in getting connected, sustaining connections, and minimizing complications when connecting to County Providers and Community Organizations.
    - These providers are: Chapa De, Sierra Nevada Memorial Hospital, Dept of Social Services (Medi-cal & Cal Fresh recertification), Adult Protective Services, United Way of Nevada County, FREED, Public Health, Medi-cal support therapists for two Tribal Members.
    - In the new year, CHIRP will also begin a semi-regular Tribal Health Worker and Tribal Staff gathering with Adult Behavioral Health Drug and Alcohol Counselor.
    - CHIRP is excited about the collaboration with Nevada County Behavioral Health in hosting Native Wellness Institute here in Nevada City. CHIRP will host two gatherings: Wellness in the Workplace and Youth Empowerment and NevCo Behavioral Health will host “Being an Ally in Indian Country”.
    -

Challenges, Solutions, and Upcoming Changes

CHIRP continues to stay curious about what are the most sustainable ways to build trust and engagement between Tribal Communities/Staff and Service Providers both Indigenous and Nonnative. Hope is something talked about often. Is it safe to create hope within this community and how to mitigate the systemic limitations of what is possible in seeking care. CHIRP is hopeful though that the humanity of those being worked with and building relationships with is what can be depended on.

While on the surface this grant is about providing enough resources to support Native community members in getting referred to county services it is clear that the deeper work being invested in is building relationships between County agencies and Community Organizations and then introducing those service providers to Tribal Staff.

This has been the biggest success thus far in the steps of bringing the Tribal Staff team together, building trust within the organization, and also building bridges to chosen Providers within County Departments.

This is the solution for now, to train Tribal Staff in gaining more skills, perspectives, and experience with Service Providers and methods and then bring them together to have meaningful conversations around important topics like: mental health, crisis intervention, SUD services, housing support, basic needs/skills trainings, etc.

As CHIRP supports Tribal Staff, the ripple effect reaches beyond them into the Tribal community. As this happens, the Tribal Community is turning towards CHIRP's work and getting curious. As this happens, CHIRP builds more supportive systems to engage with Tribal Community and plans events to engage them.

Two upcoming/ongoing changes to note: CHIRP officially purchased the 232-acre property at Yulića at the end of September and has begun moving Tribal Elders and families onto the land. This process is amplifying the work being done through this MHSA grant in that CHIRP is finally able to see how community needs impact other family members and how the old ways of family supporting family intersecting with receiving support from County agencies can be beneficial. Moving on to the land also allows community needs and crises to be very visible and hard to hide, so CHIRP is grateful to be doing this work together and that the Tribal Wellness Series is prepared and ongoing to support the community.

Secondly, the Community Care Coordinator (Tribal Intervention Specialist [ASW/MSW]) will be going on maternity leave in the middle of December and will be returning in mid-May. This will be a time when Tribal Staff within the Wellness Department will continue with their work and be supported by Clinical Supervision and the Tribal Advisor. It is also an opportunity to allow the Tribal Health Workers to engage at a deeper level with County providers and community organizations. CHIRP feels well supported and prepared for this time and also are curious as to what will emerge.

Program Participant Story

There is a significant distinction between an Elder within the Tribal community and a senior citizen. Elders are the wisdom keepers of cultural and traditional practices, sought after by the Tribe for guidance, care, and support. They play a critical role in passing down Tribal protocols, oral histories, and traditions from one generation to the next. Often, Elders hold a unique ancestral authority to engage with Tribal members in a way that fosters understanding and meaningful impact. In contrast, senior citizens are Tribal members who are elderly but may not actively uphold traditions or participate in sustaining the Tribe's cultural and communal continuity.

The resilience of today's Elders, who have survived the Gold Rush, boarding schools, adoption and removal from Tribal families, the banning of spiritual practices, poverty, discrimination, and

more speaks to their willpower and enduring commitment to the community. This Elder continues to show up and support future generations, making them essential to the survivance of the Tribal community and therefore Tribal Wellness.

The Community Care Coordinator (CCC) has been working with this Tribal Elder who is in their late 70s for four months now. CCC was connected with this Elder by a Tribal Health Worker and Tribal Staff member who expressed this Elder was being taken advantage of by the children of a "friend" that was living with them.

After several conversations and trips to the Elder's home it became clear that the Tribal Elder was being manipulated into caring for a very sick senior citizen who had been a friend (not a Tribal community member) and needed somewhere to go after getting out of the hospital three years ago. This senior citizen had serious health issues requiring critical care, medication, and visits to doctors and hospitals weekly. The Tribal Elder had been caring for this man because their children, now adults, would not and because they did not want to be "the reason they would be homeless".

CCC contacted Adult Protective Services after having built a meaningful relationship. They worked together to strategize how to support the Tribal Elder and after several weeks decided to open a case. Tribal Elder was assigned a case manager and together with the CCC they worked diligently for months to support the senior citizen in getting the support needed to be placed either with their children or in assisted living.

Eventually and after serious conflict with the senior citizen's family, APS and CCC created a safety plan and team consisting of a public health nurse and veteran, the case manager from APS, FREED, and a Social Worker at Auburn Faith Hospital. After a series of crises and threats from the senior citizen's family and with the help of the safety team the senior citizen was placed in housing.

The support of this team decreased the Elders anxiety, blood pressure, and depression. They felt cared for and that they had providers to call when they needed assistance. With the chaos and crisis gone from the Elders home, they were able to move onto the land purchased by CHIRP and begin caretaking for their oldest sibling who is now in the late stages of life.

Because this Tribal Elder now lives on the land, they are able to be with and support the transmission of oral history and cultural practices to their children and grandchildren and other Tribal youth that live on the land, as well as teach the songs and prayers that came from their mother.

The first year of the CCC's work of building relationships with County providers enabled CHIRP to know where to go and who to speak to in a time of urgent crisis that was deeply troubling for the entire Tribal community.

It allowed to engage in professional services and showcase to the Tribal Health Workers and Tribal Staff what collaboration and dignified care looks like. Building relationships with County service providers is a key strand of the braid we are weaving at the Wellness Program, because of this experience, another Tribal family member came forward seeking assistance with getting

their Tribal Elder's Medi-cal recertified and reactivating their Cal Fresh card that had over $2000 on it.

While this story is not about an immediate referral to SUD/MAT services within County agency, it is an example of the many steps being taken to build trust and provide examples of today's way service providers support care. With this grant CHIRP has begun the work of paving this path forward and building trust.

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

WHAT'S UP? WELLNESS CHECKUPS
Mental Health First Aid

Program Description

Program Overview
Mental Health First Aid (MHFA) is an 8 hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The evidence behind Mental Health First Aid demonstrates that it helps people to feel more comfortable managing a crisis situation and builds mental health literacy — helping the public identify, understand and respond to signs of mental illness. What's Up Wellness provides 3 types of MHFA trainings to community members 1) Mental Health First Aid teaches adults how to provide mental health first aid to other adults 2) Youth Mental Health First Aid teaches adults how to provide mental health first aid to youth 3) Teen Mental Health First Aid teaches teens how to provide mental health first aid to other teens.

Target Population
Community members, adults, and teens.

Evaluation Activities and Outcomes

In 21/22, two 8 hr MHFA training workshops with a minimum of 12 participants per workshop were provided. 14 participants attended Mental Health First Aid (Adult). 15 participants participated in a Youth Mental Health First Aid training. Teen Mental Health First Aid trainings were provided to 10th graders at both Ghidotti Early College High School and Bitney Prep High School with a total of 51 students attending.

In 22/23, three 8 hr MHFA training workshops with a minimum of 12 participants per workshop were provided. 23 participants attended the first Mental Health First Aid (Adult) offered for the year. An additional Mental Health First Aid Training (Adult) was provided with 22 participants attending. 13 participants participated in a Youth Mental Health First Aid training. Teen Mental Health First Aid trainings were provided to 10th graders at both Ghidotti Early College High School and Bitney Prep High School with a total of 59 students attending.

In 23/24, three 8 hr MHFA training workshops with a minimum of 12 participants per workshop were provided. 23 participants attended the first Mental Health First Aid (Adult) offered for the year. An additional Mental Health First Aid Training (Adult) was provided with 13 participants attending. 13 participants participated in a Youth Mental Health First Aid training. Teen Mental Health First Aid trainings were provided to 10th graders at both Ghidotti Early College High School and Bitney Prep High School with a total of 40 students attending.

# Participants	**Adult MHFA**	**Youth MHFA**	**Teen MHFA**	**Total Served**
21/22	14	15	51	80
22/23	45	13	59	117
23/24	36	13	40	89
TOTALS	**95**	**41**	**150**	**286**

In 21/22 in MHFA and YMHFA classes, 25 out of 29 adult participants responded to the evaluations, for those responding, 100% of 25 participants reported a positive change in attitude and/or knowledge about mental illness. For TMHFA classes, 42 out of 51 teen participants responded, for those responding, 88% - 97 % felt more confident in responding to a friend with a mental health challenge or crisis. 88% - 97% felt more aware of resources, mental health signs/symptoms, and coping skills. A total of four referrals were offered with one known connection.

In 22/23 in MHFA and YMHFA classes, 43 out of 58 adult participants responded to the evaluations. For those responding, 100% of 43 participants reported a positive change in attitude and/or knowledge about mental illness. For TMHFA classes, 43 out of 59 teen participants responded, for those responding, 93% -
97.7 % felt more confident in responding to a friend with a mental health challenge or crisis. 93% - 97.7% felt more aware of resources, mental health signs/symptoms, and coping skills.

In 23/24 in MHFA and YMHFA classes, 28 out of 49 adult participants responded ot the evaluations, for those responding, 100% of 28 participants reported a positive change in attitude and/or knowledge about mental illness. In TMHFA classes, 39 out of 40 teen participants responded, for those responding, 100 % reported moderate to significant increase in confidence in responding to a friend's mental health challenge or crisis as well as awareness of resources, mental health signs/symptoms, and coping skills. A total of
1 referral was made to SAFE at Bright Futures for Youth.

Challenges, Solutions, and Upcoming Changes

- TMHFA curriculum does not adequately engage students. It is clear that regionally in California teens have a higher level of mental health knowledge than much of what is offered in the

nation-wide curriculum. Facilitators continue to rework the material to try and create more interesting, dynamic presentations but are now researching and collaborating with other training facilitators to integrate more engaging curriculum options for the 24/25 year.

Program Participant Story

Adult participant feedback:

- This was a great training! It was thoughtful, informative, and I took a lot away from it.
- Great resources! I feel like I've learned some new things and am excited to look up resources and continue to learn more. I also feel assured that I've handled recent situations with someone in a mental health crisis in an appropriate manner. I feel better equipped and empowered to help and recognize the importance of self-care...
- I am feeling encouraged and excited to be a Mental Health First Aider, I am pleased with everything I learned.
- I feel more informed and enlightened with the information I received.
- A little overwhelmed because of all of the information on heavy topics, but really grateful for the opportunity to be able to attend this training, especially free of charge. Thank you so much for all the hard work that went into this!!

Teen participant feedback:

- Super informational!
- I really appreciate everything we learned.

PEI Category: Prevention
Spectrum Project
Youth Prevention

Program Description

Program Overview

The Spectrum Project, named for the band of colors as seen in a rainbow, is designed to support LGBTQ+ youth in co-creating safer, supportive spaces within Western Nevada County schools, as well as aiding both school staff and parents in helping to build an identity affirming environment where LGBTQ+ youth can thrive. The project will roll out in a series of phases all

built upon the foundation research and data collection of a robust first phase- focusing on three key areas: 1) Supporting students in the creation of and maintenance of GSA (Gender and Sexuality Alliance) clubs at schools. 2) Education and support for teachers, administrators, and school staff. 3) Education and support for parents and guardians of LGBTQ+ youth. Target population includes LGBTQ+ and questioning youth in Western Nevada County schools, Nevada County school staff, and parents/guardians of LGBTQ+ youth.

Target Population

LGBTQIA+ and questioning youth and school staff.

Evaluation Activities and Outcomes

Outcomes for FY 22-23

The inaugural year for Spectrum project was spent collecting data to best assess the needs of LGBTQ+ students and school staff to better understand how to effectively create safer and more affirming environments in Western Nevada County Schools.

In total, 113 students were surveyed in order to collect data on the experiences of LGBTQ+ students in Western Nevada County. This was 126% beyond the target goal of surveying 50 students.

Additionally, 27 school staff were surveyed, exceeding this objective by 8%. With 69 students and 15 school staff participating in a series of focus groups, the remaining 44 students and 12 school staff participated via an online survey.

A total of 49 school staff were trained on *Creating Affirming Environments of LGBTQ+ Students*, surpassing Spectrum's goal by 390%. 72% of staff reported increased knowledge of how to support and affirm LGBTQ+ students, and 57% of staff reported a change in knowledge about LGBTQ+ identities and experience.

Spectrum Project launched 2 brand new GSAs (Gender & Sexuality Alliances) and supported those programs throughout the school year. Spectrum also supported 3 previously existing GSAs at participating schools- 5 schools in all were served: Nevada Union, Nevada City School of the Arts, SAEL, Ghidotti, and Silver Springs.

FY	Total Students Served	School Staff Served	School Staff Trained	GSAs Launched	Existed GSAs Supported
22/23	113	27	49	2	3

Outcomes for FY 23-24

Based on the needs reflected in the data collected in year one, the second year of Spectrum Project was primarily focused on three tiers of support 1) **LGBTQ+ students** - Spectrum staff continued to support the creation and sustainability of GSAs as a safe and affirming space for LGBTQ+ students in Western Nevada County Schools 2) **School staff** – Spectrum staff created a regular virtual space for staff to ask questions, share resources, and offer support to one another

3) **Parents/Guardians of LGBTQ+ youth –** Spectrum staff created *Turning Pages: Education and Support Group for Parents/Guardians of LGBTQ+ Youth*.

Eighty-eight students were served through GSA creation and support, surpassing our fifty-student minimum objective. Twenty-six school staff were engaged through monthly supportive Q&A, listening sessions, and staff trainings, 100% of staff surveyed reported increased knowledge and a change in attitude and knowledge about LGBTQ+ identities and experience. 100% of participants report the group was helpful in building connections with the parents of other LGBTQ+ youth, as well as helpful in getting informed and educated on topics to support LGBTQ+ youth. With one participant stating "I learned a lot of terminology that I didn't even know existed. I really felt seen and heard by the other parents and the facilitators. This was such a valuable resource for me and my trans kid. We have grown closer since I participated."

Spectrum Project launched three new GSAs and offered ongoing support throughout the school year, while supporting six existing GSAs in building more sustainable school club programming. Eight schools total were served: SAEL, Ghidotti, Nevada Union, Bear River, Silver Springs, Lyman Gilmore 5th & 6th grades, Lyman Gilmore 7th and 8th grades, Nevada City School of the Arts, and Bitney Prep.

After holding a youth listening session with eight LGBTQ+ youth at the end of the 23/24 school year, the need for mentorship was unanimously reiterated by high school-age participants.

Through outreach efforts Spectrum staff has identified eight adults from the community as possible mentors for an upcoming intergenerational LGBTQ+ mentorship program. 100% of staff surveyed reported increased knowledge in how to better support and affirm LGBTQ+ students, as well as a change of attitude about LGBTQ+ identities and experiences.

Outreach included presentations at WUW staff meeting, Bright Futures for Youth and Rainbow Social. Collaboration with Nevada County Pride and Nevada County Art's Council's Acting Up! and Say Something!, continued participation in Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP); participation on steering committee for County youth-led advisory board.

FY	Total Students Served	School Staff Served	School Staff Trained	GSAs Launched	Existed GSAs Supported	Adult Mentors Identified
23/24	88	26	26	3	6	8

23.24 PROGRAM HIGHLIGHTS:

Turning Pages: Education and Support Group for Parents/Guardians of LGBTQ+ Youth.
Cohort One: January-February 2024, 8 Sessions
10 Individuals Served
Group sessions included presentations, journal prompts, small group chats, and whole group discussions. Slideshow modules spanned three topics: 1) Parental emotional support 2) Learning about LGBTQ+ vocabulary and mental and physical health factors 3) Practicing affirming skills and advocacy.

Turning Pages: Education and Support group for Parents of Transgender Youth
Cohort Two: May-June 2024, 6 Sessions
10 Individuals Served
Addition of new Trans-identified co-facilitator. Across both sessions: 100% of participants reported feeling less isolated in their parenting experiences, and glad for the opportunity to connect with other parents. 100% parents reported feeling more equipped to engage in advocacy on behalf of their youth in various arenas: educating extended family, addressing inclusion and anti-bullying policies in school and community settings, and engaging in civil discourse on legislation to promote equal rights for LGBTQ+ citizens.

Challenges, Solutions, and Upcoming Changes

Spectrum struggled with school staff participation in Q&A drop-in sessions, as well as in trainings. Many teachers and school staff referred to lack of time, rather than lack of interest in the topic of supporting LGBTQ+ students. Next year Spectrum will find opportunities to partner with NCSOS and school administrations to offer trainings as part of annual offerings, as opposed to additional offerings for seemingly over-burdened school staff. Additionally, a few school GSAs are struggling with participation- the needs of LGBTQ+ youth are vast and some clubs are unable to reach outside their own social cliques to diversify.

Spectrum staff will work with GSA leadership to expand and diversify outreach efforts to appeal to a wider LGTBQ+ audience. And finally, many youth have expressed interest in having extra-curricular events and offerings after school to create a multi-school coalition of LGTQ+youth community. Spectrum staff will work alongside GSA leadership to support youth in organizing community events and offerings.

Program Participant Story

Parents participating in Turning Pages: Education and Support Group Cohort One, decided to meet in-person for their final session and agreed to bring their children for this final meetup. Youth ranged in ages from 12 to 21. The final session was so successful that parents have continued to be in contact with each other, have attended LGBTQ+ family events, and even volunteer together. Two teenagers from that group began a friendship which has continued on their high school campus. Both have reported that they are "super grateful" for the support of a new friend with whom they have so much in common with.

PEI Category: Prevention

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

Program Description

Program Overview

The Boys & Girls Club of North Lake Tahoe offers year-round, out-of-school time enrichment programs for youth ages 4-18. All programs are age appropriate, support academic endeavors, compliment lessons learned in school, create community, teach new skills, and support children's social and emotional learning. Through the PEI MHSA funding, BGCNLT offers targeted social and emotional learning lessons to children through an evidence-based program called Positive Action.

Target Population

BGCNLT is targeting 30 elementary aged students (grades 1-4) from the Truckee Elementary School site, as well as 30 children (grades 1-4) from the Kings Beach Clubhouse.

Evaluation Activities and Outcomes

BGCNLT utilized an IDEA survey to gauge Club Members' feelings about the program. One of the success stories comes from the Truckee site. At first, member was very defiant about Positive Action, but over time, he began saying that Positive Action wasn't that bad and that he actually liked it. He has become a great listener and even encourages his friends to participate and pay attention. The program has proven to make a positive impact on the youth served. In the 23-24 school year, 100%

of participants showed some level of positive change on key indicators such as behavior, social and emotional character, and physical/mental health.

Challenges, Solutions, and Upcoming Changes

It was challenging to make some of the curriculum more relatable to individuals with various cultural backgrounds. Positive Action made a difference over time, teaching the importance of self-awareness and boosting confidence. Over the course of the year participants became more engaged with activities such as songs, worksheets, and volunteering to be involved in skits and excited for Positive Action.

Program Participant Story

A participant of Positive Action, who had a background of misbehaving, spent a few weeks in the program. In time, they helped develop the "Club Community Service", which promotes positive behavior within the club. This was achieved by working with staff, and these members helped with day-to-day tasks, promoting positive behavior within the organization and assisting with organizing and preparing for each activity.

PEI Category: Prevention

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

Program Description

Program Overview

The Tahoe Truckee Unified School District (TTUSD) Wellness is a collaboration between the school district, Placer and Nevada counties, Tahoe Forest Hospital and the Community Collaborative of Tahoe Truckee (CCTT) partners designed to provide a youth-friendly point of entry for students to connect to supportive adults and access community and school wellness resources. At the heart of the Wellness Program are high school and middle school Wellness Centers that serve as access points for students to ask questions, learn new skills, seek support, and link to a variety of school and community services.

Through the Wellness Centers, students can connect to a hub of supportive wellness programming, including health education workshops, peer mentoring programs, student empowerment groups, social emotional curriculums, school-based Mental Health Specialists, school-based mental health screenings, and linkages to critical community mental health resources. The TTUSD Wellness Centers offer three types of programming: Group Services, Drop-In, and Outreach. This program provides prevention services for middle and high school students to reduce risk factors and/or increase protective factors that lead to improved mental and emotional functioning.

Target Population

Nevada County MHSA funding supports middle school and high school TTUSD Wellness Centers, students ages 11-18 years. The majority of students seek out Wellness Center programming on their own, but the program also receives referrals from school counselors, psychologists, school administrators, teachers, and parents.

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

Evaluation Activities and Outcomes

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

Outcome #1 - At least 150 youth will be trained in peer mentor and leadership skills to better support themselves, their peers, and incoming 6th and 9th graders transition to school.

2021-2022: 163 youth leaders were trained as Peer Mentors in Link Crew, WEB (Where Everyone Belongs) and Hope Squad. 95% of Link Leaders reported that Link Crew provided them with the support to be a Peer Mentor, 95% reported feeling comfortable with their ability to actively listen to others, and 80% reported that they have the skills to support other people when they need help.

2022-2023: 222 youth leaders were trained as peer leaders in Link Crew, WEB (Where Everyone Belongs), and Hope Squad. Trained peer leaders improved the help seeking norms at their school sites. 93% of Link Leaders reported that Link Crew provided them with the support to be a Peer Mentor, 90% reported feeling comfortable with their ability to listen to others, and 90% reported that they have the skills to support others when they need help. 86% of 9th graders reported feeling safe at school and 78% reported that by participating in Link Crew they felt more connected at school.

2023-2024: 188 youth leaders were trained as peer leaders in Link Crew, WEB, and Hope Squad in the TTUSD middle school and high schools. 83% of Link Leaders reported that Link Crew provided them with the support to be a Peer Mentor, 93% reported feeling comfortable with their ability to listen to others, and 85% reported that they have the skills to support others when they need help. 72% of 9th graders reported feeling safe at school and 79% reported that Link Crew helped me recognize their resources at school.

Outcome #2 - At least 400 youth will receive individual support from Wellness Center Staff to improve their social, emotional and mental health and opportunities to access community wellness resources.

2021-2022: TTUSD Wellness supported 415 students through individual sessions and 434 students through participation in 220 group sessions at the four TTUSD Wellness Center sites. TTUSD Wellness served 12,853 (duplicated) student walk-in visits to the NTHS, THS, North Tahoe School, and Alder Creek Middle School Wellness Centers.

TTUSD Wellness made 53 referrals to outside mental health and community services.

2022-2023: TTUSD Wellness Specialists supported 428 students through in-depth interventions and 376 students participated in 220 groups at the four TTUSD Wellness Center sites. The TTUSD Wellness Program had 19,503 (duplicated) student walk-in visits during the 2022-2023 school year.

TTUSD Wellness made 162 referrals to school and community mental health services. This is a 33% increase from referrals made last year.

2023-2024: TTUSD Wellness supported 663 students through individual sessions and 528 students participated in 368 groups. The TTUSD Wellness Program had 18,154 student walk in visits.
TTUSD Wellness made 350 referrals to school and community mental health services for 197 students. This is the highest number of referrals TTUSD Wellness has completed to date. This is more than twice as many referrals as in the previous year.

Outcome #3: At least 500 youth will learn practical tools to improve their overall health and well-being.

2021-2022: TTUSD Wellness offered 61 educational workshops and trainings to 2,483 participants. 90% of students shared that they learned new stress management and suicide prevention skills to improve their overall health and well-being.

2022-2023: TTUSD Wellness offered 56 educational workshops and trainings to 1,233 students and 4,580 overall (duplicative students and adults) participants. 95% of students who participated in Health Class presentations shared that they learned new stress management and suicide prevention skills to improve their overall health and well-being.

2023-2024: TTUSD Wellness offered 55 educational workshops and trainings to 5,683 participants. 93% of students shared that they learned new stress management and suicide prevention skills to improve their overall health and well-being.

One of the primary data points for the TTUSD Wellness is facilitating supportive Student Groups, Peer Mentoring, and Club Activities, such as: Link Crew, WEB, Hope Squad, Pride Club, and Skill Building Groups. These activities require more commitment on the part of the student, to attend and to complete sign-ins and demographic forms. The unduplicated number of students who attended groups, participated in Link Crew and Clubs has increased across the years: in FY 2018-19, 92 students attended, in FY 2019-20, 126 students attended, and in FY 2020-21, 192 students attended. See the table below for 2021-22, 2022-23, and 2023-24 data.

Groups or Clubs (Link Crew, Pride Club, Hope Squad, Support Groups)	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**
# Meetings	234	236	368
Unduplicated Attendance	483	427	528

Challenges, Solutions, and Upcoming Changes

A success and challenge is that the TTUSD Wellness Program grew tremendously over the last three years. The program went from having two high school Wellness Centers to four high school and middle school Wellness Centers, four elementary Wellness Centers, five Mental Health Specialists placed at all the school sites, a new MSW intern program, and an expanded Social Emotional Learning (SEL) Program. TTUSD is successfully building a comprehensive system of mental health supports for students that has already improved student access to mental health services. As the program expanded, it experienced growing pains along the way and needed to strategically build relationships with school site admin and counselors to better align and integrate services. The biggest challenge for this upcoming school year will be setting up a MediCal billing system and leveraging the CYBHI multi payer fee schedule.

Program Participant Story

At one school site, their Coordinated Care Team identified high needs students who were struggling with their social and relational skills. Wellness staff connected with these students and started a weekly group centered around building social skills. The group's goals were to: create a positive community to discuss issues related to stress and anxiety, promote healthy relationships and communication techniques, increase positive self-worth, and empower youth to feel comfortable speaking out and modeling healthy lifestyles. One student in particular, who was initially resistant to participating in the group, now attends group weekly and utilizes the Wellness Center outside of group time as well. Previous to the group, he would keep his hood pulled tightly up over his head and generally avoid all interaction with students and staff. Since joining the group, he has expressed that he feels a stronger sense of belonging in the Wellness Center and at school. He regularly visits the Wellness Center and opened up to staff that he struggles with anxiety and depression. Wellness staff listened to him, taught him coping strategies to help him manage his anxiety, and referred him to their school Mental Health Specialist. He received therapeutic interventions to assess and support his depression. He has since been referred to the County Mental Health for ongoing treatment. He has shown drastic improvement and almost never has his hood pulled up over his face.

PEI Category: Prevention

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

Program Description

Program Overview

In the region, families face significant challenges such as isolation, tourism-dependent employment, high cost of living and limited resources. Free programs for families and parents are particularly scarce. To address these issues and strengthen protective factors within local families, Sierra Community House offers daily play groups, support groups and classes designed to reduce isolation, foster peer networks, and build parent skills and confidence. Programs like the *Parent Support Group for families with Children of Special Needs* and the *Family Room*, facilitated by staff trained in curricula such as Parent Project®, Loving Solutions®, and The Incredible Years, respond to community needs through group workshops and play groups.

The *Parent Support Group for families with Children of Special Needs* emerged out of the growing need in the community for a space where parents can share, learn, and navigate the complexities of raising children with special needs together. This model provides a space for learning and shared experiences and acknowledges that all community members have strengths and hold wisdom. Parents become central in the creation of their own solutions by participating in a reciprocal and

respectful process and thereby emerging parent leaders in the community. Driving forward the unified need for continued education, advocacy and stigma reduction.
Family Room is a bilingual play group program serving families with children aged 0–4 by with a particular focus on those who are economically and culturally disadvantaged and/or are English language learners. Anchored in play-based education, this program nurtures school readiness by integrating activities such as reading, music, singing, play, and crafts. It strives to instill a love for learning, enhance language and cognitive abilities, and bolster self-assurance among participants. Moreover, Family Room staff promote parent-child interaction, provide resources and referrals but most importantly, encourage peer connections that foster a community atmosphere of support and inclusivity.

These programs have had a substantial impact by providing essential resources and support to families, enhancing parents' abilities to navigate challenges, and promoting the development of strong, supportive communities.

Target Population

Families in the North Lake Tahoe/Truckee Area.

Evaluation Activities and Outcomes

Family Support/Parenting Classes Outcomes FY 2021 -2022:
SCH served 113 individuals through family support and parenting classes.
Family Support/Parenting Classes Outcomes FY 2022 -2023:
SCH served 249 individuals through family support and parenting classes.
Family Support/Parenting Classes Outcomes FY 2023 -2024:
SCH served 261 individuals through family support and parenting classes.
Family Support/Parenting Classes Outcomes:

- 76% percent of individuals will demonstrate an improvement in attitudes, knowledge, and/or behavioral change related to mental illness.
- 84% percent of individuals will demonstrate an improvement in attitudes, knowledge, and/or behavior related to seeking mental health services.
- 88% percent of individuals will demonstrate increased acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.

Challenges, Solutions, and Upcoming Changes

In this new post-pandemic era, there has been a shift in how people engage with programs, where once curriculum structured classes served to bring parents together in an educational model, now individuals are looking for a relaxed safe space to share and navigate the challenges of parenting together while finding understanding and connection among their peers. This led to reopening the dialogue with community members and collaborative partners around the needs of parents in the community. In response, SCH proposed a shift in approach to providing parent education classes under the agreement with the Campaign for Community Wellness (PEI) and contract with Placer

County. This shift utilizes many components of the existing Parent Project and Loving Solutions program and incorporates the Parent Café model into its approach.
A Shift:
The Parent Support Group for Families with Children with Special Needs was created to support programs and communities in engaging parents, building protective factors, and promoting deep individual self-reflection and peer-to-peer learning. The Parent Support Group is based on the principles of adult learning and family support and is a gateway to providing parent leadership opportunities. ** This model provides a learning experience that acknowledges that all community members have strengths and hold wisdom. Parents become central in the creation of their own solutions by participating in a reciprocal and respectful process. http://www.bestrongfamilies.net/build-protective-factors/parent-cafes/model
One key element of the existing program remains the same. Promotoras, trained facilitators of the Parent Project and Loving Solutions, continue to facilitate under the Parent Café model, bringing with them the content expertise and topics covered in the respective curricula. In addition, Promotoras will be joined by other community leaders with expertise in youth development and parenting, as co-facilitators. The change in the role of the Promotora is significant to the success of the parenting programs. Instead of serving as the holder of information to be imparted to participants, Promotoras will function as facilitators, helping parents move through targeted topics, ensuring discussions are inclusive of all participants, and landing on solutions and practices that are appropriate. They will essentially serve as guides helping participants find their own solutions.

Parent Support Group topics include:

- Emotional Support
- Resource Sharing
- Community Building
- Coping Strategies
- Education & Advocacy
- Reducing Stigma
- Parenting Strategies
- Balancing Family Life
- Workshops & Skill Building
- Goal Setting & Evaluation

Program Participant Story

From a Family Room participant:

A year ago, a mother brought her three-year-old son to the Family Room, where he struggled with attachment and socializing. Through regular attendance, he gained confidence and began interacting more comfortably with others. He expressed remarkable creativity in crafts, and it was discovered through his participation in this program that he had a learning disability.
Thanks to the Family Room, he was referred for evaluation by a speech therapist and school psychologist, and he now receives specialized education services. This support has led to significant progress; giving him a boost of confidence that he now rides the school bus alone, has

made many friends, and enjoys a sense of independence. His mother feels proud of his growth and has become more confident in seeking help and supporting him in social settings, which has also enriched their family's social life.
At the Family Room, staff use song, play and crafts to encourage a love for learning and to help develop social, communication and literacy skills. This has helped to pave the way for a better and brighter future by allowing him the opportunity to adapt, adjust and grow in a safe and creative space.

PEI Category: Stigma Reduction and Discrimination Reduction

SIERRA COMMUNITY HOUSE
LatinX Outreach
Promotora Program - Latino Outreach Services

Program Description

Program Overview

The Program primarily serves Latino families and individuals who could benefit from supportive services and assistance, connecting them to needed services in the community.

SCH's Latino Community Outreach program consist of workshops, support groups, and peer support services to provide mental health education and referrals to the service area's Latinx population. The workshop program is open to all members of the community, and all workshops are presented in Spanish. The participant group ranges from interested community members seeking to improve their lives to seasoned Promotoras—bicultural and bilingual paraprofessionals that help connect Latinx families to mental health resources and promote the well-being of the Latinx community in the Tahoe/Truckee region.

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

Through cultural Spanish workshops, support groups or peer support services, Promotoras connect Latino individuals to mental health education, resources, and support. The Promotora Program aims at increasing knowledge within the Latino community about the symptoms of depression and anxiety and normalizing open and honest discussions about mental health. The program focuses on reducing negative feelings and perceptions related to mental health and stigma related to accessing support and treatment.

Promotoras promote the well-being of the Latino community in the Tahoe/ Truckee region. Intensive workshops and support groups are offered through the Latino Leadership series. Groups and workshops are presented in Spanish by native Spanish speakers and cover four components: (1) Self Leadership for Latinos; (2) Latino Couples Leadership; (3) Latino Parent Leadership. Weekly support groups are offered to participants of the Latino Leadership Series. These groups provide additional support to the attendees and help strengthen the skills learned in the Leadership Groups. Culturally and linguistically appropriate referrals to mental health services are being offered to participants requiring additional mental health help.

The Peer Support Program is designed to inspire Latino community members to take an active role in their physical and mental wellbeing. The program offers guidance on how to learn to live a healthy lifestyle, helping improve physical, emotional, and spiritual wellbeing. It provides tools on stress management techniques and helps address any matters that are most important to them. Sessions are typically one on one and are 2 hours long. The program goal is to empower individuals to recognize their talents, build their self-esteem, improve communication skills, wellness knowledge and gain tools to become active leaders of their life and wellbeing.

Certified peers Monina Vazquez, Beatriz Schaffert, and Oscar Perez, PhD, provide peer support sessions in Spanish. These peers have been advocating for cultural competency, equality and social justice in the community for many decades. As peer supporters and educators, they have been working with the Promotora program for many years. Their leadership and advocacy for issues impacting local families and their advice and mentorship is sought by many.

Target Population

Latino community members of North Lake Tahoe/Truckee Area. The Program primarily serves Latino families and individuals who could benefit from supportive services and assistance to link them to needed services in the community.

Evaluation Activities and Outcomes

Latino Community Outreach and Intervention Outcomes FY 2021-2022:
SCH served 118 Latinx individuals annually with mental health education and support.
Latino Community Outreach and Intervention Outcomes FY 2022-2023:
SCH served 128 Latinx individuals annually with mental health education and support.
Latino Community Outreach and Intervention Outcomes FY 2023-2024:
SCH served 127 Latinx individuals annually with mental health education and support.

From the results of the survey assessing attitudes towards mental health that was administered to the attendees of the groups during the period, 82% of individuals demonstrate an improvement in attitudes, knowledge, and/or behavioral change related to mental illness that is applicable to the activity, and 80% of individuals demonstrate an improvement in attitudes, knowledge, and/or behavior related to seeking mental health services that are applicable to the activity.

Latino Community Outreach, Prevention and Early Intervention Outcomes:

- 84% of individuals demonstrated an improvement in attitudes, knowledge, and/or behavioral change related to mental illness that is applicable to the activity.
- 88% of individuals demonstrated an improvement in attitudes, knowledge, and/or behavior related to seeking mental health services that are applicable to the activity.
- 91% of individuals that self-identify or are identified by a Promotora as having a mental health need have been referred to a mental health provider and offered a warm handoff

Challenges, Solutions, and Upcoming Changes

Post-pandemic life does not look the same for everyone. Efforts to curb the spread of COVID-19 affected nearly every aspect of day-to-day life for people worldwide. Recovering from the upheaval that these changes created has been a difficult process as well. While many community members felt excitement and relief about getting vaccinated and returning to "normal life," not everyone felt the same elation about reverting to previous patterns. Some community members were eager to jump back into things, while others felt extremely worried or frightened about the transition. Many community members are still dealing with anxiety. For those community members who had a negative COVID experience in terms of personal loss and loneliness, found it harder to return to “normal” and their psychological journey was more complex. Ever since COVID restrictions were lifted, hybrid arrangements have been offered for meetings and workshops to slowly give individuals the space and time to readapt and at the same time give them options that would meet their needs. SCH is now transitioning to in person for all activities, so activities can be provided for the children of community members attending.

SCH expanded peer support services, offered through Latino Community Outreach to meet the increased community need. Peer support is offered by contracted, certified peer support specialists. In the first half of FY22-23, there has been a significant increase in demand for peer support specialists. Increased funding in this area will allow SCH to meet the need for culturally specific and bilingual mental health support in the service area. As stated in the 2022 Community Mental Health Needs Assessment, COVID-19 created an increased need for mental health support services: “depression and anxiety have increased by 25% and individuals with preexisting mental health conditions report worsening of symptoms” where mental health systems were already “under-resourced and strained”. In order to maintain support for the community’s increased need for professional mental health support, increased funding was requested for the Peer Support program.

Program Participant Story

Testimony of Latino Outreach Workshop:
"Ana" and "Peter" are immigrant parents who, similar to every other parent, strive for the best outcomes for their children. They work really hard to provide a good life for them, so they are safe and happy.
There had been a suspected abuse and/or neglect report referral for them from the Children System of Care - CSOC, with a Path 2 category assigned; however, this time the referral was different in the sense that there were no indications of actual violence at home. When staff met with "Ana" and "Peter", they did disclose being stressed and feeling overwhelmed for different issues they were going through. Both parents were working all days of the week. Mom only gets to rest one day, on Saturdays. And the children, both boys ages 11 and 8, were spending many hours a day by themselves, feeling depressed, getting behind in school and fighting with peers.

Nonetheless, "Ana" and "Peter" were willing to overcome these obstacles and try for improvement. Their place was clean and organized and children were overall alright. They were glad they had connected with SCH because they felt they needed support from outside to figure things out, as they put it. They wanted to work on reaching a better balance and a healthier relationship between all of them. They were referred to an SCH parenting group.

There they talked about the importance for Parents to allow for free, playful and recreational time with the kids and the idea of going out together and spending more time with them. The kids' behavior outside the home was somehow a way for them to cope with the situation they were living at home. "Ana" and "Peter" eventually agreed with the fact that they were working more than they should.
They were also offered Peer Support sessions at Sierra Community House and also were assisted by an Advocate with a Medi -Cal application, as they were uninsured at the moment. They were also connected to swimming lessons at the local Recreation Center. The boys had been living by Lake Tahoe and didn't know how to swim, as well as could be used as a shared an activity that would help them connect with each other at a different level.

Testimony of Peer Support client:
"I cannot thank you enough for the work we've done together in regard to peer support and co-parenting peer support. After working with many therapists and different counties hoops, and insurance or financial restrictions, you are such a blessing to me and all those whose lives you touch. Through your referrals, your listening, your curriculum, your expertise does not go unnoticed. You meet a need that is untouched by any other professionals for me as a parent and also a woman of color in a non-diverse region; your assistance helps move mountains. In addition to bridging a much-needed gap, your optimism and empathy have changed my life. I hope we get to work together in the future!!! You help a better world be possible for our families and communities. I appreciate you so much for being able to see and hear me."
Testimony, ExpresArte participant 2023:
I arrived to this the long-awaited country of opportunities, one year ago. Although this country has given me so many good things, I have also experienced a lot of hardships. I had my first baby eight months ago; he was born prematurely. Seeing such a small person connected to so many machines,

and beeping sounds is something that was very painful to have to endure as a first-time mom. I was struggling with depression, but someone once told me "It's a bad day, not a bad life there are good and bad days, and nothing lasts forever".

At the Sierra Community House ExpresArte workshop, I was able to meet and connect with other members of my community. Attending this weekly workshop became a part of my weekly routine. I would anxiously wait for Tuesdays to arrive, just so that I could attend and meet with the group of spectacular women, mothers with problems of their own but also full of virtues, strong and empowered women who made me feel like I wasn't alone.

They allowed me to see that many of the things that happened or were happening in my life, they too had experienced, and they managed to persevere despite everything. Today my life, my family and I are fine thanks to God and the group of people who I met through this workshop.
My depression is gone now I have friends I can count on, and I am happy to know that there are still very good people in this world".

PEI Category: Stigma Reduction and Discrimination Reduction

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

Program Description

Program Overview

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

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

Target Population

NCSOS Promotora/ Latino Outreach Specialists serve the Latino population in Western Nevada County. According to the Census Quick Facts from 2020, the Latino/Hispanic community

presently accounts for 10.4% of the population (10,416 people). This program serves children, transition age youth (TAY), adults, and older adults.

Evaluation Activities and Outcomes

Triennial: 21-22, 22-23, 23-24
The Promotora/ Latino Outreach Program collects evaluation activities for MHSA including information on individual demographics, outreach and referrals to community resources on each person receiving services. FRC interacted, or collaborated, with over 120 community resources such as Western Sierra Medical Center, Spirit Peer Center, Common Goals and Helping Hands also helped to support members of the Latino community.

The Promotora provided varied services, such as: assistance with medical and dental appointments, including transportation, school matters such as individualized education programs (IEPs), referrals for immigration, other family legal situations, and translation assistance with applications in a variety of agencies. Also provided was an English as a Second Language (ESL) instructor/classes, yoga wellness class with a certified instructor and Ritmos exercise class. Mental Health Awareness groups were enhanced, along with WRAP (Wellness Action Planning) for children and adults. This included a WRAP walk that was started to help participants develop a personal wellness plan by blending mental wellness with physical movement, and life coaching sessions with a certified Life Coach. During these sessions clients were given early intervention for the purpose of educating themselves to increase wellness and decrease the stigma surrounding mental health. Mental health support groups also included Promotra led book studies. Latino parenting support came in the form of book clubs in which clients read non-fiction parenting books in a group setting led by the Promotora. Other healthy living activities included drug overdose awareness workshop, nature appreciation movie night, walks on local trails, nutrition classes and farm-fresh berry picking field trip.

This year 2023-2024 FRC was able to hire a new half-time Promotora. With this increased funding and additional team member, services to the Latino community grew immensely as one can see from the comparison chart below. The following year the COVID Pandemic was very challenging for the community since they were in the process of reestablishing their work and living situations. Therefore, the chart displays a decrease in those served in the 2022/2023 year due to this transition. Beginning in 2023 services were matching family needs and the data shows this trend.

With the increase in Promotora staff, and the hiring of a full-time supportive coordinator, the planned and organized activities in the community increased. These activities included mental health and wellness programs as described above. Because promatora staff were able to feel the pulse of the community by informal surveys, they were able to plan timely access to valuable programs for this underserved population. A list of successfully executed activities and concrete services are listed below:

1. **Transit Services:** Bus tickets
2. **The Laundry Voucher Program:** Grass Valley Laundromat
3. **Gas Card:** Chevron Gas Station.
4. **Grocery Outlet Cards:** $20 Grocery Outlet card

5. **Latino Book Club:** in partnership with Sierra Nevada Children's Services
6. **Nutrition Classes:** The Family Resource Center in partnership with the Nevada County Public Health Department held nutrition classes for adults, teenagers, and children.
7. **Salmon Journey Workshop:** Artist and naturalist Monica Farbiarz, sponsored by the Upstate California Creative Corp. presented a lesson for children and family at one of the partner elementary schools.
8. **Screen-Free Week:** During the screen free week, the Family Resource Center Promotoras led two hiking activities at the Sierra College trail.
9. **Opioids:** The Family Resource Center invited the bilingual Community Overdose Prevention Efforts (COPE) team to speak to families.
10. **Movie Night:** in partnership with South Yuba River Citizens League (SYRCL) for the purpose of enjoying nature and learning about local habitats.
11. **Sierra College Tour and Picnic:** informative presentation and tour about the different programs and services offered by the Grass Valley Sierra College campus.
12. **Playgroups:** Throughout the school year, the Penn Valley, North San Juan and Grass Valley Family Resource Center.
13. **Yoga Class:** To enhance the mental health of the Western Nevada County Latino community, the Family Resource Center offered Yoga classes in 2 locations.
14. **RITMOS Exercise Class:** To help support the mental health of the Latino community, the Family Resource Center offered an on-going Zumba-like classes with a Promotora facilitating the weekly activity.
15. **ESL Class:** partnership of the 3-volunteer native English speaker teachers.
16. **WRAP (Wellness Recovery Action Plan) I:** FRC led 9 WRAP I sessions with Latino clients and collaborated with a local wellness center in their beautiful space.
17. **Life coaching sessions:** The Latino Outreach Specialist provided 8 life-coaching sessions to Latino clients.
18. **How to Overcome Depression Group:** The Latino Outreach Specialist led a group in a Depression Recovery Program.
19. **The Latino Family Festival** was held for the 2nd year. A fun event for Latino community and the community at large with 48 partner organizations tabled at this event along with music, fun, food, a drawing for prizes and activities for the children. There were 451 attendees.
20. **3 Kings Day** is an annual event to celebrate the new year and being together. Each child received gifts during this social event.

	FY21/22	**FY 22/23**	**FY 23/24**
Unduplicated Individuals Served Comparison Chart			
Overall Latino served	**228**	**181**	**281**
Children ages 0-15	**71**	**53**	**84**
TAY	**35**	**28**	**43**

Adults	**115**	**82**	**134**
Older Adults	**7**	**18**	**19**
Females	**146**	**118**	**167**
Males	**81**	**63**	**114**
Homeless	**0**	**8**	**21**
At risk of becoming homeless	**17**	**13**	**27**
Referrals			
Total referrals made	**262**	**202**	**696**
Nevada County Social Services	**19**	**26**	**25**
Nevada County Behavioral Health	**3**	**5**	**24**
Housing help/SPIRIT	**21**	**18**	**77**

Challenges, Solutions, and Upcoming Changes

Challenges: Housing is an ongoing challenge for the community in general, but the Latino community is now having an increased number of unhoused individuals and families. During COVID the apartment management were very lenient with the tenants. Now, all rules are being enforced, and this is causing people to lose their housing. To add to this challenge, many relatives of those that already lived here in Nevada County, and many others, have arrived in recent months. Many in the Latino community are undocumented and therefore, do not qualify for subsidized apartments and they cannot double up as they had hoped. It takes many hours to serve the varied needs of the growing community.

Solutions: Continue to work with the local apartment community and other local resources to develop a possible solution for housing the undocumented community.

Upcoming Changes: The help for individuals and families in the community will continue in every way possible. It is hoped that eventually there will be more staff to support the growing Latino community and their needs. Many mental wellness programs are planned for all age groups in the coming year.

Program Participant Story

WRAP I: Client C started WRAP I sessions on June 18, 2024, with one of the Promotoras. After studying the fundamentals of WRAP and brainstorming about the wellness toolbox, client C

designed her daily plan for wellness. On her third session she happily shared: “At home, I had a difficult situation to deal with today. After remembering that I am personally responsible for my well being and thinking about the different tools I can use to keep me calm and sound, I was able to handle the situation with respect and appropriateness to me and the people involved. Now that I have created my WRAP I, I can refer to it any time I need.” Client C also shared that the first time she met with the promatora, she felt great pressure in her chest and a strong need to cry. She mentioned that she had been feeling the same during her therapy sessions. However, after she designed her wellness plan, she had not experienced that anymore and since then, her therapy sessions have been more effective for her.

Financial Support: When client M came to the Promotra’s office for emotional support, they started a series of life-coaching sessions. During these sessions, the Promotora learned that PG&E had cut their services to the client’s home in the previous two months because they had a high bill debt. Because of lack of power, the client could not preserve her food, and her youngest child got scared at night time. The Promotora started to search for ways to support the family since winter was around the corner and the client was a single mom with 2 children. As a result of her search, the promotora shared with the mother that the Salvation Army could financially support them through their “Project Go” Program. After gathering all the information and putting all the requirements together, the client submitted her application form and a week later her electricity bill was fully paid. As a result, the client could preserve their food and stay warm all winter.

Immigration Services: * Client G came to the Promotora’s office on a Monday morning feeling despair. With tears in her eyes, she explained to the Promotora that she had only till Friday that same week to gather proof of paternity to send to USCIS. The immigration office had required affidavits and pictures that support her petition for her father. After calming her down, the Promotora suggested she call relatives and friends who were able to submit the affidavits in English and were willing to testify in court if they were asked to do so. While waiting for their response, the Promotora put together all the pictures of her father in childhood and teenagerhood and wrote a description for each one of them. On Thursday, after receiving all the affidavits via email, she printed them and the pictures. That same day, the client sent all the documents to the immigration department overnight. A month and a half later, the client got a letter from the USCIS department notifying her that her petition had been approved. The client was thankful because the Promotora helped her put the paperwork together and remained calm and hopeful through the process.
* Client D was referred to the Sierra Community House where she was assisted in applying for the work permit of all the members of her family – 7 in total, and they are in the process of obtaining them.

Safety and well being: A young lady and her mother escaped from a serious cartel violence situation in their country. The young lady had seen her fiancé shot and killed before her eyes. She was involved with a young man that had somehow crossed a cartel member and anything or anyone that had a part in his life was now a target, including her and her family. Her mother immediately found a way for them to secretly get out of their town and get as far away from the danger as possible. They landed in Grass Valley with their extended family. Despite being away from danger and safe here in Nevada County, they were traumatized and needed many types of help. An extended family member recommended they contact a Promotora to get help with enrolling in

MediCal so each of them could get therapy for their trauma. When they were first introduced to the Promotora they both had a very downcast demeanor. Mom was the one that really stood out because of her inability to make eye contact and difficulty remembering details needed for the applications. Eventually, all the details were completed on the applications and the process went smoothly. They were both referred to Behavioral Health and soon they were receiving therapy. The young lady got an excellent job in a safe environment. The mom was invited and began attending the on-going Zumba and ESL classes where she met people who have become her supportive social circle. She now is blossoming in her new safe and secure reality as she continues with therapy. Mom now has a stable job, and her demeanor has notably changed, and she appears happy, makes eye contact, and smiles a lot. She will be invited to participate in the new offerings for mental wellness so she can continue her positive changes.

All around success: A couple was referred to CPS when their baby was found to have drugs in her system after her birth. The baby girl was placed in foster care and her mom and dad were required to attend a variety of classes for an extended period before they could get their baby girl back in their custody. Unfortunately, there were no services available in Spanish for them and they began to flounder. They heard that there was a Promotora in Grass Valley that may be able to help them. They came to the then PARTNERS Family Resource Center in Grass Valley and explained their situation and requested help. They felt extremely comfortable with the Promotora specifically because she was a native speaker and understood not just their words but their culture and made sure to communicate that fact. FRC immediately scheduled CPS, Helping Hands, Common Goals, etc. so that they could rest assured that they would be able to understand and communicate freely at each of their required classes and meetings. After approximately one year and a half, they attended the last court session where the judge granted them full custody of their baby girl and congratulated them on all their hard work and efforts. At the end of all their classes, they felt they needed to continue in a support group and were referred to the Alcoholics Anonymous Spanish speaking group. They are now not just participants but have become leaders and supporters within the extended northern California and Nevada AA Spanish Groups.

PEI Category: Stigma Reduction and Discrimination Reduction

GATEWAY MOUNTAIN CENTER
LatinX Outreach

Program Description

Program Overview

Through this program, LatinX youth in the Tahoe/Truckee region will be recruited and nurtured to be peer mentors. Mindfulness Based Substance Abuse Treatment (MBSAT) is an evidence-based practice used to help individuals with SUD develop better strategies for managing stress and executive skills, and to develop exercise self-control and reduce reactivity to cravings.

Target Population

Older Transitional Age Youth to provide peer counseling to High School students.

Evaluation Activities and Outcomes

Latin X Youth and Transitional Youth Leadership Development Outcomes:

Youth Supported in working toward CPS &/or MBSAT Training:
Unduplicated youth served 2023/2024: 1
Unduplicated youth served 2022/2023: 1
Unduplicated youth served 2021/2022: 3

Youth supported in Peer Training 2023/2024: 1
Youth supported in Peer Training 2022/2023: 1
Youth supported in Peer Training 2021/2022: 0

Certified CMPSS TAY youth: 2

- Youth supported in CPS Training: 2
- Transitional Age Youth Receive Peer Counseling : 2
- Transitional Age Youth Receive Peer Counseling in: 2
- Peer Group Sessions Offered: 2023-2024: 2
    - One group in Alder Creek Middle School
    - One group in North Tahoe School
    - There is a group of youth coming in during their lunch break from Truckee High School. GMC offers snacks and drinks and 'mindful minutes' and most come every day. (These are counted as drop in's for YWC, so they are not duplicated here). The Peer team works collectively to engage and hold space for these students.

- Peer Group Sessions Offered: 2021-2023
    - MBSAT and Mindful Warriors Circles Group Attendance 2023-2024: 19
    - MBSAT and Mindful Warriors Circles Group Attendance 2022-2023: 89
    - MBSAT and Mindful Warriors Circles Group Attendance 2021-2022: 51

- Peer Group Sessions Offered: 9
- Youth participated in Hello Insight Data Collection: 1
- 2 Transitional Age Youth have completed the Peer Support Training and Certified as Medi-Cal Peer Support Services.

- Youth participated in MBSAT YTD: 2
- Youth completed CRAFFT survey YTD: 5

Challenges, Solutions, and Upcoming Changes

In 2023 GMC had a significant change in leadership for this particular programming. With this change some data collection was challenged and programming disrupted. Many of the MBSAT and Mindful Warriors Circles were entered as individual attendance as opposed to the number of groups provided.

GMC is currently using this funding in particular to recruit, hire and train transitional age youth to become Certified Medi-Cal Peer Support Specialists with preference and incentives provided for LatinX applicants. GMC has fully certified 2 TAY youth.

PEI Category: Stigma Reduction and Discrimination Reduction

SIERRA COMMUNITY HOUSE
Youth Empowerment

Program Description

Program Overview
Youth Empowerment Groups (YEGs) are designed to foster skill development and provide diverse opportunities for students. These groups cover topics such as creating positive environments and communities, promoting healthy friendships, relationships, and choices, and boosting positive self-worth. They also focus on empowering youth to speak out, model healthy lifestyles, and understand mental health stigmas. Through YEGs, students learn to identify personal strengths and supportive resources, develop new ways of thinking, and address both internal and external challenges. Facilitators build meaningful connections with participants, offering a supportive space for open discussion through various activities, writing, media, and art. Depending on the group's focus, different curricula are utilized, with the Young Men's Work and Young Women's Lives curricula frequently referenced.

Target Population
Staff facilitate Youth Empowerment Groups for students in grades four through twelve in the North Lake Tahoe-Truckee area. These groups are offered to female-identifying students, male-identifying students, or mixed groups of any gender. Students are referred by school counselors and teachers after being identified as potentially benefiting from the discussed topics and additional support, or as influential peer supporters who can carry these skills into their school community.

Evaluation Activities and Outcomes

Contractor will serve a minimum of 56 youth each year. 75% percent of individuals will demonstrate an improvement in attitudes, knowledge, and/or behavioral change related to mental illness.

In FY 2021/2022, 50 students were served in Youth Empowerment Groups. Of those participants, 19 were Placer County residents and 31 were Nevada County residents.

During this reporting period, 8 students completed the Stigma and Discrimination Reduction Survey (SDRS). Of those participants, 100% answered "Yes" to the question "I have a better understanding of how to access mental health resources in my community". Additionally, 4 participants answered the question, "I would be comfortable discussing mental health issues with others (family, close friends, doctor)," and 75% answered "Yes". Five participants answered the question, "If someone in my family had a mental illness, I would be comfortable if people knew about it," and 80% answered "Yes".

Of the 11 youth participants that completed the Participant Perception of Care (PPC), 67.2% answered "Agree" for all 12 questions, implying those students had a positive experience in group and saw a positive change in their social-emotional health. 100% of participants responded "Agree" to the question, "I have learned to use coping mechanisms other than alcohol and/or other drugs." Other notable responses of participants answering "Agree" at 80% or higher were, "I am better able to do things that I want to do", I am better able to deal with crisis," and "I do things that are more meaningful to me".

The majority of the Youth Empowerment participants were aged 11 and under and therefore did not complete either the SDRS or PCC, as they are for participants 12 and older.

In FY 2022/2023, there were a total of 64 youth participate in YEGs. There were 10 students aged 12+ that participated in a YEG able to complete the Participant Perception of Care (POC) and the Stigma Discrimination & Reduction Survey (SDRS). On the POC survey, questions that were answered above 70 percent as "Agree" were, "I have people with whom I can do positive things" and "Staff are sensitive to my cultural background". The question with the lowest percent answered as "Agree" was, "My housing situation has improved", which would not be expected for this program to impact. Additionally, 87.6 percent of all statements were responded to as "Agree" or "Neutral", whereas only 12.4% were answered as "Disagree". On the SDRS, seven out of ten students answered "Yes" to both, "I have a better understanding of how to access mental health resources in my community" and "If someone in my family had a mental illness, I would be comfortable if people knew about it". In a 4th grade Girls YEG, students were asked at the completion of group on an anonymous survey what they learned in group, and responses included; "to show kindness, to ask questions, to be a better friend, to be kind to others, to listen", and that they "learned about others in the group and about their own needs."

In FY 2023/2024, the Sierra Community House Prevention team reached 82% of their contract goal to serve a minimum of 56 youth annually. The team conducted 66 group sessions with a total of 45 group attendees.

19 Perception of Care and 20 Stigma Reduction Surveys were distributed to students and participants of our Youth Empowerment Groups. 66.67% of students filling out the survey report an improvement in attitudes, knowledge, and/or behavioral change related to mental illness, while

25% are "not sure". Additionally, 51.3% report an improved perception of care, while 30.70% remain neutral about improvement.

Challenges, Solutions, and Upcoming Changes

In FY 2021/2022, some challenges were related to new volunteer requirements implemented in the Tahoe-Truckee Unified School District (TTUSD), which led to not being able to provide in-person services until the month of November. Affected by the pandemic situation, schools arranging groups with at that time chose to wait for YEGs to meet with the students in-person, rather than starting them virtually. In addition, in January YEGs were once again refused access to the schools due to a spike in COVID-19 cases in the district. At this time, school staff chose to suspend groups until were able to come back in-person, rather than switch to virtual programming in the interim. Additionally, staffing changes occurred in April and May, leading to a few groups being cut short, and another group that was scheduled to start never happening.

During FY 2022/2023, challenges were related to school cancelations and delays, due to air quality and inclement weather. Many group sessions had to be canceled or made-up, and this led to a lack of consistency in many of the groups, as well as some groups being cut short by a session or two. This was very challenging for the group facilitators, school counselors, and youth participating. Another big challenge was when staff provided the POC survey and SDRS to school staff to provide/review with students, they said they would complete them, but even after reaching out multiple times, staff did not receive the results. As staff often have very limited time with students, depending on school staff to assist is crucial, and is limiting when there isn’t follow-through. Many of the YEG participants were aged 11 and under this reporting year and therefore did not complete either the SDRS or POC as they are for participants 12 and older.

For FY 2023/2024, challenges in meeting the total goal included several staff changes in key positions, which prevented the Prevention Team from taking on an additional youth empowerment group that would have increased the total youth served to 56. Additionally, staff faced numerous challenges this school year due to school cancellations and delays caused by inclement weather. Some group sessions had to be canceled or rescheduled, which was difficult for group facilitators, school counselors, and the youth participating. Also, many of the YEG participants this year were aged 11 and under and therefore did not complete the SDRS or POC assessments, which are intended for participants aged 12 and older.

Two new team members were onboarded. One was able to take on groups but only in a limited capacity while familiarizing themselves with the program and school environment. The other joined late in the school year and was not fully trained to lead groups independently. Also, the current Prevention Program Manager will begin maternity leave in August, with an anticipated return date in January 2025. During this period, the Prevention Team will operate with limited capacity

Program Participant Story

For FY 2021/2022, feedback provided on a 6th Grade Girls Group through an anonymous survey to group members on the last group session gave the idea of a successful group. Some of the responses have been consolidated into repeat answers:
What did you learn from the group? I loved how we talked about being girls. I learned to stand-up for myself. I learned from the other girls. I learned how to deal with bullies and recognize toxic relationships. I learned I'm not the only one that goes through bad things, and while I was at a group I could really tell and share how I was feeling. I learned different types of communication and ways to deal with stress and anger. I learned how to talk about how I am feeling.
What did you like about the group? Getting to know new people. The fun activities. Making new friends. The trust in the group. The pizza party. "The facilitator" and how she really listened to us.
What would have made the group better for you? If it was longer (all 6 participants present at the last session responded with this answer).
In FY 2022/2023, all participants in the year-long Youth Empowerment Group participated in a mental health overview training and showed increased knowledge of the topics during the meetings in the following weeks. Students asked a lot of follow-up questions and put their training to use during the school year by supporting each other in working through situations they encountered in their everyday lives. Additionally, the students were excited to bring the information and skills they learned by creating a video to educate their parents and community-at-large on topics that are important to them, such as anxiety, depression and eating disorders.
Over FY 2023/2024, staff continued to engage recurring students in the year-long Youth Empowerment Group, enriching their experience and extending their involvement. This year, students who participated in the group last year and again this year, took a leading role in the mental health overview training. Their deepened understanding of the topics was evident as they actively contributed to discussions and demonstrated increased knowledge during meetings. In addition to that, two standout students went beyond the scope of the group, using their engagement to explore future career opportunities in social work. Their involvement in the group has significantly influenced their career aspirations and college choices, as they explored how to connect their learning to their long-term goals.
Lastly, the addition of a male-identifying staff member allowed staff to meet the increased demand for groups tailored to male-identifying students. Staff successfully facilitated three of these groups this year and have more planned for the upcoming school year. The students in these groups have shown enthusiasm and engagement, reflecting the success of the group offerings.

PEI Category: Suicide Prevention

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

Program Description

Program Overview

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

The SPP's focus includes facilitating the Mental Health Matters Nevada County Coalition (formerly the Suicide Prevention Task Force), providing outreach, education and training on suicide prevention in the community, and coordinating postvention services for suicide loss survivors.

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

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

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

The coordinator also convenes the Mental Health Matters Nevada County Coalition in Western Nevada County, supports the work of the Tahoe Truckee Suicide Prevention Coalition in Eastern Nevada County, and collaborates with many other organizations and agencies.

Target Population

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

Evaluation Activities and Outcomes

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

As a direct result of this training:	**%Agree FY20/21**	**% Agree FY21/22**	**% Agree FY22/23**	**% Agree FY23/24**
I am better able to recognize the signs, symptoms and risks of suicide.	100%	100%	89%	90%
I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide.	100%	100%	100%	100%
I am more willing to reach out and help someone if I think they may be at risk of suicide.	99%	100%	78%	90%
I know more about how to intervene (I've learned specific things I can do to help someone who is at risk of suicide).	98%	100%	100%	90%
I've learned how to better care for myself and seek help if I need it.	89%	90%	67%	70%
Please tell us how much you agree with the following statements:				
The presenters demonstrated knowledge of the subject matter.	100%	100%	100%	100%
The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.).	88%	90%	89%	70%
This training was relevant to me and other people of similar cultural backgrounds and experiences (race, ethnicity, gender, religion, etc.).	90%	91%	100%	90%

**includes respondents answering "strongly agree" or "agree"*
*** FY20/21 = 393 participants (100 responses), FY21/22 = 204 participants (40 responses, FY 22/23 362 participants (9 responses), FY 23/24 148 participants (10 responses)*

Outcomes for FY 21/22
SPP provided trainings to 204 unduplicated participants in FY 21/22. As a result of the COVID-19 pandemic, all but one of the trainings took place virtually and all of the trainings were Know the Signs trainings. In addition, the SPTF hosted a virtual Suicide Prevention Town Hall in September 2021 that had 52 attendees and supported a Spanish Know the Signs training for the Truckee area. The Clinical Supervisor followed up with many suicide loss survivors, including relatives and other close relations.

Outcomes for FY 22/23
SPP provided trainings to 362 unduplicated participants in FY 22/23. As a result of the COVID-19 pandemic, most of the trainings took place virtually and all of the trainings were Know the Signs trainings. In addition, the SPP hosted a virtual Youth Suicide Prevention Event in September 2022 with 21 attendees and a virtual Community Know the Signs Training in May 2023 with 11 attendees. The Clinical Supervisor followed up with many suicide loss survivors, including relatives and other close relations.

Outcomes for FY 23/24
SPP provided trainings to 148 unduplicated participants in FY 23/24. Most of the trainings took place virtually with in-person trainings at middle schools and high schools with Knows the Signs training content tailored for adults, youth, and parents. In addition, the SPP program in coordination with What's Up Wellness hosted a virtual Know the Signs Presentation in May 2023 that had 8 participants. The SPP program also participated in various outreach events including the Latino Family Festival, Veteran's Stand Down Event, Nevada Union Mental Health Awareness Football Night, the Nevada County Senior Health Fair, and the Nevada County Armed Forces Day providing outreach to over 1,000 individuals. The Clinical Supervisor followed up with many suicide loss survivors, including relatives and other close relations.

Challenges, Solutions, and Upcoming Changes

The primary challenges were the continued impact of the COVID-19 pandemic and staff transitions in FY 21/22 and FY 22/23 and a lack of interest in Know the Signs Trainings in FY 23/24.

During the pandemic in FY 21/22, the SPP had gone almost exclusively to virtual trainings. Because a couple suicide prevention training modalities- *safe*TALK and *ASIST*- are required to be in-person, those trainings were not offered. All events were also virtual, including the Suicide Prevention Town Hall. SPP staff was also given responsibilities related to COVID-19 during the first half of FY 21/22, which took some time away from suicide prevention activities. Finally, in March of 2022, the Suicide Prevention Health Education Coordinator assumed a new role within the Public Health Department.

Similarly, in FY 22/23, trainings were still almost exclusively virtual with *safe*TALK and *ASIST* continued to not be offered in-person. All events were also virtual, including the Youth Suicide prevention Event and the Community Know the Signs Training. A new Health Education Coordinator started in August of 2022. With the fall in COVID cases in Nevada County, there were some opportunities for in-person trainings including at two local middle schools and one local high school. The SPP was also able to coordinate in-person lunchtime activity events to promote Mental Health Awareness Month in May at one local middle school, one local charter school, and one local high school.

The primary challenge in FY 23/24 was the lack of interest in Know the Signs trainings outside of Suicide Prevention Awareness month/the first couple months of the school year. While trainings were able to be held both in-person and virtually, participation counts were low. The Health

Education Coordinator has been working on building strong collaboration among organizations, schools, and individuals to bring Know the Signs Trainings to more participants including partnering with school health classes, Mental Health First Aid Trainings, and refresher trainings for organizations.

The SPP launched the Mental Health Matters Nevada County Campaign on May 1, 2024. This collaboration with Behavioral Health and community partners aims to increase the public's awareness, understanding, and access to mental health and suicide prevention resources. The key components of the campaign include a central website (Mentalhealthmattersnc.com), outreach materials, and social media posts. With the launch of this campaign, the Suicide Prevention Task Force has transitioned into the Mental Health Matters Nevada County coalition with more targeted efforts on coalition collaboration around mental health/suicide prevention outreach and education.

Program Participant Story

"Thank you so much for the great training you did for our volunteers"
"I thought it was good to raise awareness for the community and it's hard to cram a know the signs training in an hour. I did an all day training some years ago. It can be hard for people to commit that much time. I wasn't able to attend the whole training but thought it was informational!"

PEI Category: Suicide Prevention

The Speedy Foundation
Suicide Prevention

Program Description

Program Overview
The Speedy Foundation (SF) Suicide Prevention program will provide education, outreach, and strategies that will mobilize the community to provide postvention support after a death by suicide and prevent future suicides. Program will train community members about suicide awareness and intervention and provide outreach to the community with suicide prevention information. Suicide Prevention Coordinator will coordinate Suicide Prevention Coalition (SPC) meetings and manage SPC's website.

Target Population
The target population is the entire community; however, outreach and prevention strategies specifically target youth (age 12-24 years), seniors, and middle-aged males.

Evaluation Activities and Outcomes

During the 23-24 program year, Speedy Foundation offered 19 trainings to 217 individuals. SF was able to obtain participant data for 125 individuals who attended these trainings. SF also hosted or participated in 56 community events which reached an estimated 8,193 individuals.

The assessment evaluations for trainings are showing a growth in mental health literacy and decrease in stigma associated with mental illness. The goals were met and exceeded expectations in all areas except for number of training participants, which was short by 83 people. Trainings that were conducted that were less than an hour in length were counted as public speaking events. With the marketing efforts built over the last year, SF will easily train 300 community members in the coming year.

Challenges, Solutions, and Upcoming Changes

A major success for Speedy Foundation is getting community trainings off the ground and some amazing community outreach events. SF is excited about new marketing efforts to maximize outreach with recruiting folks to attend training. SF has begun attending chamber of commerce meetings to establish relationship and will be conducting outreach in fall to offer organizational trainings. The main challenge this year has been on administrative deliverables such as timeliness of reporting and submitting invoices.

Mental Health First Aid has updated their platform for participant evaluations. For the first three quarters SF was using paper evaluations and then made the switch to the new platform. This has been incredibly frustrating both on the administrative side and for participants. Training participants are not taking the time and consideration to fully engage with the information and that data has been lost. This has been incredibly frustrating and difficult to develop a plan to address. Instead, SF staff have been trained in Be Sensitive, Be Brave to be able to offer another option for folks who are considering MHFA.

Program Participant Story

"To make sense of my son’s suicide I had to understand my own relationship to mental health.

The Out of Darkness Walk in Reno NV was my first walk after my son's suicide. Right away I realized that I was not alone. I was met with love and support.

When I learned that Hike for Hope was here in my own neighborhood, I immediately wanted to share to others my experience I have had and to help bring people together to generate awareness for the cause, raising funds for suicide prevention for our local community and to share conversations. Bringing together public education and community programs like Hike for Hope

provides support for those affected by suicide.

I encourage you to come out and enjoy our beautiful location. You can make a difference to someone by building the strength within yourself. For me I wear my tears as armor.

You are not alone...You matter."

- Survivor of Suicide Loss and Hike for Hope Participant – 6/23/24 Truckee, CA