El Dorado County
Mental Health Services Act
Outcomes

FY 2016-17 Year End Results

HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH DIVISION

WELLNESS | RECOVERY | RESILIENCY

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Introduction

The Outcome Measures document accompanying the FY 2018-19 MHSA Plan Update provides outcome information for the projects included in the FY 2017-18 MHSA Plan.

As used within the MHSA Plan Update and this Outcomes Documents, the following regional definitions apply:

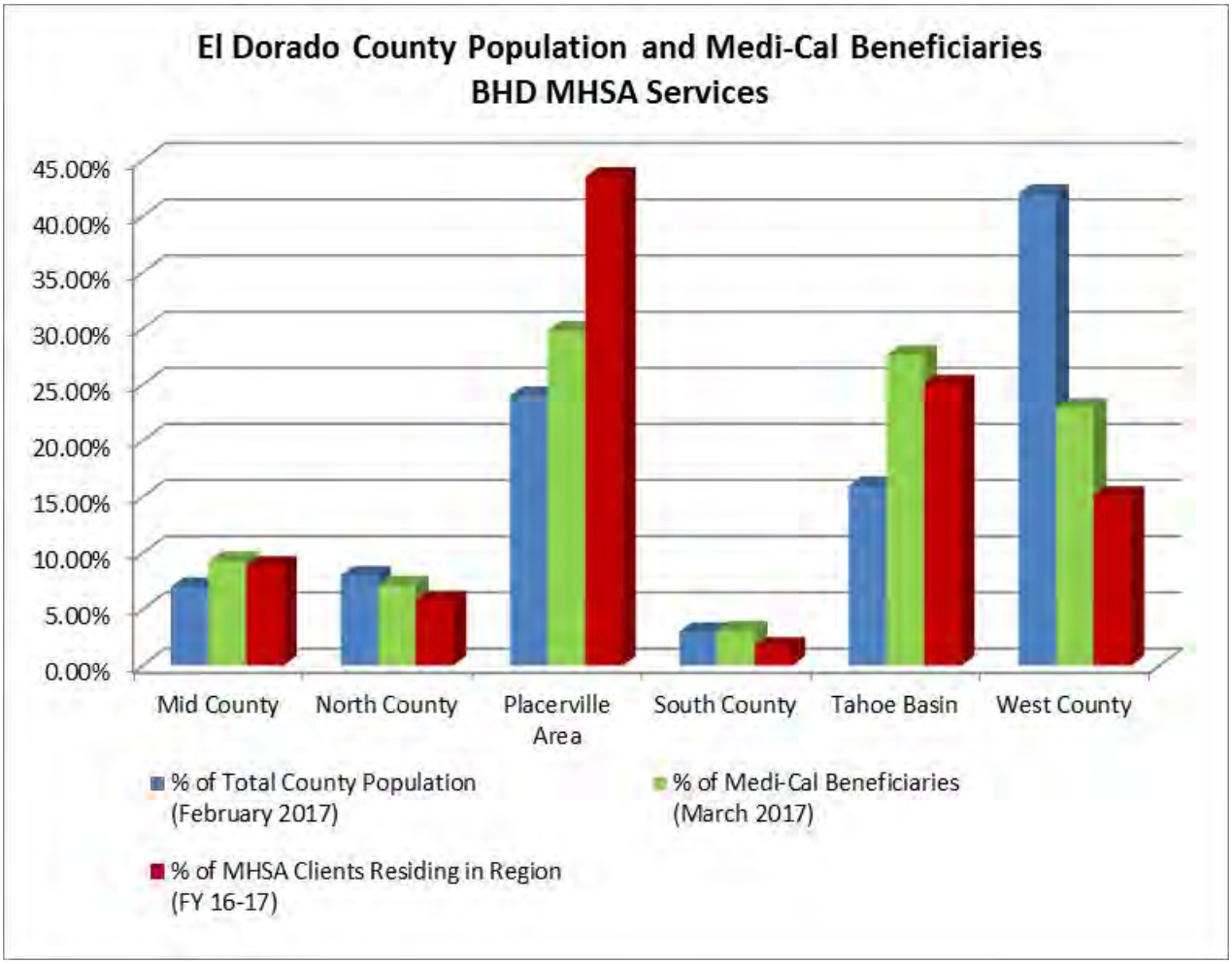
West County	Cameron Park, El Dorado Hills, Rescue, Shingle Springs
Placerville Area	Diamond Springs, El Dorado, Placerville, Pleasant Valley
North County	Coloma, Cool, Garden Valley, Georgetown, Greenwood, Kelsey, Lotus, Pilot Hill
Mid County	Camino, Cedar Grove, Echo Lake, Kyburz, Pacific House, Pollock Pines, Twin Bridges
South County	Fair Play, Grizzly Flats, Mt. Aukum, Somerset
Tahoe Basin	Meyers, South Lake Tahoe, Tahoma

Prevention and Early Intervention (PEI)

Please see Appendix A, *Annual Prevention and Early Intervention Program and Evaluation Report, Reporting Year: Fiscal Year 2016-17.*

Community Services and Supports (CSS)

MHSA programs represent only a portion of the Specialty Mental Health Services provided by the BHD. Non-MHSA funded services are not reported in this document.



Starting approximately three years ago and now as part of the BHD's ongoing Quality Improvement, the BHD has been re-assessing clients who are open for services to determine current medical necessity and identifying appropriate graduation goals. Graduation occurs when a client no longer requires the higher level of services provided through Specialty Mental Health Services and are safe to return to the care of their Primary Care Provider or other community-based provider for mental health services. However, other individuals may be discharged from BHD for lack of engagement in services, with all such cases reviewed by the client's treatment team and the Utilization Review team. Clients who graduate from the BHD can re-apply for Specialty Mental Health Services, or their Primary Care Provider can consult with a Medication Support Staff or make a new referral to BHD for higher level of services. It

is the continued goal of the BHD to allow clients to achieve the highest level of Wellness, Recovery and Resilience.

The expanded mild-to-moderate mental health services provided through the Managed Care Plans have allowed many clients to receive services in the community rather than rely on Specialty Mental Health Services. Additionally, the large Primary Care Providers (Marshall Medical Center, Barton Healthcare, Shingle Springs Health and Wellness Center, and El Dorado County Community Health Center) have been expanding their Behavioral Health services to provide mild-to-moderate services directly to their patients and it is only when the mild-to-moderate services are not helping a patient that the Primary Care Provider would refer the patient to Specialty Mental Health Services.

Outcome information for various BHD programs is posted on the BHD's Quality Improvement web page at: http://www.edcgov.us/Government/MentalHealth/QI/Quality_Improvement.aspx.

Full Service Partnership (FSP) Program

Children's FSP

Providers: New Morning Youth and Family Services, West Slope;
Sierra Child and Family Services, West Slope and South Lake Tahoe;
Stanford Youth Solutions, West Slope;
Summitview Child and Family Services, West Slope;
Tahoe Youth and Family Services, South Lake Tahoe;
CASA El Dorado, West Slope

Project Goals

- Reduce out-of-home placement for children
- Safe and stable living environment
- Strengthen family unification or reunification
- Improve coping skills
- Reduce at-risk behaviors
- Reduce behaviors that interfere with quality of life

Numbers Served and Cost

The expenditures and outcomes within this program include what was previously referred to as the Children's FSP and Enhanced Foster Care Programs. Data that was previously reported separately has been merged into a single reporting set, and as such, there may be some overlap between previous years (for example, a child in both Children's FSP and Enhanced Foster Care in the fiscal year would be counted twice rather than just once).

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$850,000	$750,000	$1,860,699
Total Expenditures	$757,790	$796,582	$1,009,637
Unduplicated Individuals Served	100	130	106
Cost per Participant	$7,578	$6,128	$9,525

Age Group*	FY 14/15	FY 15/16	FY 16/17*
0-15 (children/youth)	100	95	84
16-25 (transitional age youth)	23	27	23
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0

*Individuals who moved between age groups may be counted more than once

Gender	FY 14/15	FY 15/16	FY 16/17
Female	53	51	55
Male	70	71	51

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	20	12	10
Placerville Area	43	43	35
North County	6	3	8
Mid County	17	11	12
South County	3	1	0
Tahoe Basin	29	42	27
Unknown or declined to state	0	0	0
Out of County	5	10	14

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	6	3	1
Asian	0	0	1
Black or African American	2	2	2
Caucasian or White	96	97	88
Native Hawaiian or Other Pacific Islander	1	1	0
Other Race	16	16	8
Unknown or declined to state	2	3	6

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino	6	12	12
Other Hispanic / Latino	5	7	8
Not Hispanic	101	90	70
Unknown or declined to state	11	13	16

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	119	116	98
Spanish	1	2	0
Other Language	0	1	0
Unknown or declined to state	3	3	8

FY 14/15 through FY 16/17 Outcome Measures

- Measurement 1: Days of psychiatric hospitalization
- Measurement 2: Days in shelters
- Measurement 3: Days of arrests
- Measurement 4: Type of school placement
- Measurement 5: School attendance
- Measurement 6: Academic performance
- Measurement 7: Days in out of home placement
- Measurement 8: Child care stability

The majority of these outcomes come from reporting that is entered into ITWS, a database maintained by the State. Although an add-on database has been developed to interpret the data, the BHD has not yet been successful in obtaining the necessary data. However, contracted service providers continue to report on these "key events" for each child in services and the data is entered into ITWS by MHSA staff.

Information that is available is identified below.

Measurement 1 (Days of psychiatric hospitalization)

Children's FSP and Enhanced Foster Care	FY 14/15	FY 15/16	FY 16/17
Children Enrolled in this Program:			
Unduplicated Children Served	see below	see below	106
Unduplicated Children Hospitalized	see below	see below	8
Number of Hospitalizations	see below	see below	15
Average Length of Stay	see below	see below	7 days
All El Dorado County Children Medi-Cal Beneficiaries (under age 18): (whether receiving Specialty Mental Health Services or not)			
Unduplicated Children Hospitalized	see below	see below	55

Children's FSP and Enhanced Foster Care	FY 14/15	FY 15/16	FY 16/17
Number of Hospitalizations	see below	see below	75
Average Length of Stay	see below	see below	6 days

Children's FSP Only	FY 14/15	FY 15/16
Children Enrolled in this Program:		
Unduplicated Children Served	50	65
Unduplicated Children Hospitalized	4	2
Number of Hospitalizations	5	2
Average Length of Stay	not reported	10 days

Enhanced Foster Care Only	FY 14/15	FY 15/16
Children Enrolled in this Program:		
Unduplicated Children Served	73	57
Unduplicated Children Hospitalized	4	1
Number of Hospitalizations	6	1
Average Length of Stay	not reported	4 days

Transitional Age Youth (TAY) FSP

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- Decreased days of homelessness, institutionalization, hospitalization, and incarceration
- Safe and adequate housing
- Increased access to and engagement with mental health services
- Increased use of peer support resources
- Increased connection to their community
- Increased independent living skills

This project and the reported numbers include both TAY Wellness and TAY FSP. In the next MHSA Three-Year Plan, data for these two will be collected and reported separately.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget – Total	$342,387	$464,498	$714,707
Total Expenditures – Wellness and FSP	$101,242	$81,769	$84,742
Unduplicated Individuals Served	84	49	44
Cost per Participant	$1,205	$1,669	$1,926
Total Expenditures – MHBG First Episode Psychosis	$0	$11,656	$89,842
Unduplicated Individuals Served	0	2	6
Cost per Participant	$0	$5,828	$14,974
Total Expenditures – MHBG Dialectical Behavior Therapy (DBT) in Schools	$0	$199,040	$213,851
Total Expenditures – All TAY	$101,242	$292,465	$388,434

The following information reflects individuals receiving services in TAY Wellness, TAY FSP, and FEP

Age Group	FY 14/15	FY 15/16	FY 16/17*
0-15 (children/youth)	7	0	0
16-25 (transitional age youth)	77	51	50
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0

*Individuals who moved between age groups may be counted more than once

Gender	FY 14/15	FY 15/16	FY 16/17
Female	47	23	23
Male	37	28	27

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	13	11	10
Placerville Area	15	20	20
North County	1	2	2
Mid County	6	6	8
South County	1	2	1
Tahoe Basin	48	10	9
Unknown or declined to state	0	1	0

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	2	3	2
Asian	1	1	1
Black or African American	1	0	0
Caucasian or White	60	43	43
Native Hawaiian or Other Pacific Islander	1	0	0
Other Race	17	4	3
Unknown or declined to state	2	0	1

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino	15	6	4
Other Hispanic / Latino	10	5	3
Not Hispanic	53	36	40
Unknown or declined to state	6	4	3

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	81	50	50
Spanish	2	1	0
Other Language	0	0	0
Unknown or declined to state	1	0	0

FY 14/15 through FY 16/17 Outcome Measures

- Measurement 1: Number of days of institutional care placements
- Measurement 2: Number of days of homelessness / housing stability
- Measurement 3: Education attendance and performance
- Measurement 4: Employment status
- Measurement 5: Continued engagement in mental health services
- Measurement 6: Linkage with primary health care

The majority of these outcomes come from reporting that is entered into ITWS, a database maintained by the State. Although there an add-on database has been developed to interpret the data, the BHD has not yet been successful in obtaining the necessary data. However, BHD staff continue to report on these "key events" for each client in services and the data is entered into ITWS by MHSA staff.

Information that is available is identified below.

Measurement 5 (Continued engagement in mental health services)

Participants	FY 14/15	FY 15/16	FY 16/17
Unique Clients	84	51	50
Total Episodes	84	52	52
Episodes Opened:			
Total Episodes Opened	unknown	21	25

Participants	FY 14/15	FY 15/16	FY 16/17
New/Returning Client	unknown	20	23
Changed Program (same level of service)	7	1	0
Dropped Down in Level of Services	0	0	0
Increased Level of Services	0	0	2
Episodes Closed:			
Total Episodes Closed	57	26	22
Graduated / Exited Services	55	25	17
Decreased Level of Services	2	0	3
Increased Level of Services	0	0	2
Changed Program (same level of service)	0	1	0

Adult FSP

Providers: El Dorado County Health and Human Services Agency, Behavioral Health Division; Summitview Child and Family Services (for operation of an Adult Residential Facility)

Project Goals

- Reduction in institutionalization
- People are maintained in the community
- Services are individualized
- Work with clients in their homes, neighborhoods and other places where their problems and stresses arise and where they need support and skills
- Team approach to treatment

Numbers Served and Cost

Costs for this project include the Adult Residential Facility (ARF) and the Intensive Case Management (ICM) team, which bring individuals who have been placed in a locked facility out of county back to El Dorado County for continued treatment. These clients require a high level of staff support and the client to clinician ratio is low.

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$3,846,189	$4,050,000	$4,566,260
Total Expenditures	$3,210,260	$4,292,835	$4,375,139
Unduplicated Individuals Served	133	124	117
Cost per Participant	$24,137	$34,620	$37,394

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	1	0	0
16-25 (transitional age youth)	20	12	11
26-59 (adult)	101	100	94
Ages 60+ (older adults)	11	12	13
Unknown or declined to state	0	0	0

Gender	FY 14/15	FY 15/16	FY 16/17
Female	57	54	52
Male	76	70	65

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	10	8	9
Placerville Area	60	57	64
North County	1	2	1
Mid County	9	6	3
South County	0	0	0
Tahoe Basin	45	43	41
Unknown or declined to state	8	8	0

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	1	2	1
Asian	3	4	4
Black or African American	2	4	5
Caucasian or White	115	106	100
Native Hawaiian or Other Pacific Islander	1	0	0
Other Race	10	8	6
Unknown or declined to state	1	0	1

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino	3	2	2
Other Hispanic / Latino	7	7	9
Not Hispanic	119	110	95
Unknown or declined to state	4	5	11

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	130	122	114
Spanish	0	0	0
Other Language	0	1	2
Unknown or declined to state	3	1	1

FY 14/15 through FY 16/17 Outcome Measures

- Measurement 1: Key Event Tracking (KET) - As changes occur in a client's status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail
- Measurement 2: Achieving goals identified in the client plan
- Measurement 3: Continued engagement in services

The majority of these outcomes come from reporting that is entered into ITWS, a database maintained by the State. Although there an add-on database has been developed to interpret the data, the BHD has not yet been successful in obtaining the necessary data. However, BHD staff continue to report on these "key events" for each client in services and the data is entered into ITWS by MHSA staff.

Information that is available is identified below.

Measurement 3 (Continued engagement in services)

Participants	FY 14/15	FY 15/16	FY 16/17
Unique Clients	133	124	117
Total Episodes	139	134	123
Episodes Opened:			
Total Episodes Opened	not reported	60	58
New/Returning Client	not reported	19	17
Changed Program (same level of service)	not reported	1	4
Dropped Down in Level of Services	not reported	14	13
Increased Level of Services	not reported	26	24
Episodes Closed:			
Total Episodes Closed	not reported	69	61
Graduated / Exited Services	not reported	31	24
Decreased Level of Services	not reported	34	21
Increased Level of Services	not reported	3	12
Changed Program (same level of service)	not reported	1	4

Older Adult FSP

There are no FY 16/17 outcomes to report for this program.

Assisted Outpatient Treatment (AOT)

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- Reduction in institutionalization
- People are maintained in the community
- Services are individualized
- Team approach to treatment

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$125,000	$100,000	$200,000
Total Expenditures	$0	$0	$4,881
Clients Served	0	0	15*
Cost per Participant	$0	$0	$325

*For AOT, the number of clients served means the number of individuals who were referred to AOT for whom follow-up work was performed to determine if the individuals met criteria for AOT and/or engage the individual in outpatient Specialty Mental Health Services. When an individual becomes engaged in Specialty Mental Health Services, their services are provided through the appropriate outpatient team, generally the Intensive Case Management team (FSP level of services).

FY 14/15 through FY 16/17 Outcome Measures

- Measurement 1: Key Event Tracking (KET) - As changes occur in a client's status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail.
- Measurement 2: Reduction in institutionalization and incarceration.
- Measurement 3: Continued engagement in services, as needed, after discharge from AOT.

Data is not yet available for this program.

Wellness and Recovery Services Program

Adult Wellness Centers

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- Recovery and resiliency for participants.
- Participants gain greater independence through staff interaction, peer interaction and educational opportunities.
- Participants linked with community-resources.
- Increased engagement in mental health services.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$2,120,769	$2,500,000	$2,045,874
Total Expenditures	$2,331,867	$2,089,348	$1,912,671
Wellness Center Visits	10,500	7,200+	*
Cost per Visit	$222	$290	*
Wellness Program Clients Served	518	407	405
Cost per Client	$4,502	$5,134	$4,723

* Due to staffing changes, the data for the West Slope Wellness Center was not available until May 9, 2016, and there were 826 recorded visits between May 9 and June 30, 2016. Data for the Tahoe Wellness Center is not available for this time frame.

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	30	40	42
26-59 (adult)	228	324	316
Ages 60+ (older adults)	32	43	47
Unknown or declined to state	0	0	0

Gender	FY 14/15	FY 15/16	FY 16/17
Female	166	224	207
Male	124	183	198

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	38	51	62
Placerville Area	94	141	157
North County	8	14	22
Mid County	27	32	34
South County	6	12	10
Tahoe Basin	107	141	108
Unknown or declined to state	9	2	0
Out of County	0	14	12

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	5	5	4
Asian	4	2	3
Black or African American	5	4	6
Caucasian or White	460	360	369
Native Hawaiian or Other Pacific Islander	4	4	0
Other Race	37	29	20
Unknown or declined to state	3	3	3

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino	15	14	17
Other Hispanic / Latino	39	29	19
Not Hispanic	431	344	345
Unknown or declined to state	33	20	24

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	278	394	393
Spanish	7	8	5
Other Language	3	3	3
Unknown or declined to state	2	2	4

FY 14/15 through FY 16/17 Outcome Measures

- Measurement 1: Number of participants and frequency of attendance
- Measurement 2: Continued engagement in mental health services
- Measurement 3: Attainment of individualized goals

Measurement 1 (Number of participants and frequency of attendance)

Participants	FY 14/15	FY 15/16	FY 16/17
Unique Clients	518	407	405
Total Episodes	524	413	416
Episodes Opened:			
Total Episodes Opened	not reported	164	178
New/Returning Client	not reported	125	153
Changed Program (same level of service)	not reported	2	3
Dropped Down in Level of Services	not reported	19	17
Increased Level of Services	not reported	18	5
Episodes Closed:			
Total Episodes Closed	241	178	246
Graduated / Exited Services	229	154	145
Decreased Level of Services	3	6	78
Increased Level of Services	8	16	20
Changed Program (same level of service)	1	2	3

The large shift in the number of clients who decreased a level of service is a result of the establishment of the Medication Maintenance unit within the West Slope Outpatient Clinic. Clients who are in the process of transferring their mental health services to their primary care provider or who no longer require the more intensive individual therapy sessions are transferred to the Medication Maintenance unit. This unit is responsible for ensuring that clients continue with their medication and, when appropriate, facilitate the linkage with the clients' primary care provider.

Measurement 2 (Continued engagement in mental health services)

The process for gathering this information is being standardized. Data will be provided once it is available.

Measurement 3 (Attainment of individualized goals)
The BHD continues to work on a new report from Avatar to obtain this information.

TAY Engagement, Wellness and Recovery Services

See TAY FSP, above.

Community System of Care Program

Outreach and Engagement Services

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- To engage individuals with a serious mental illness in mental health services.
- Continue to engage clients in services by addressing barriers to service.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$1,055,798	$803,543	$802,578
Total Expenditures	$769,498	$736,552	$496,884
Requests for Services	1,852	1,607	1,406
Cost per Request	$415	$458	$353
Call Intakes (inquiries other than a Request for Service)	390	505	775

The following data reflects only Requests for Service (no Call Intakes):

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	578	491	441
16-25 (transitional age youth)	322	278	232
26-59 (adult)	856	781	654
Ages 60+ (older adults)	96	56	79
Unknown or declined to state	0	1	0

Gender	FY 14/15	FY 15/16	FY 16/17
Female	1,010	860	733
Male	842	747	673

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	311	300	231
Placerville Area	568	449	459
North County	107	102	72
Mid County	185	153	146
South County	51	36	19
Tahoe Basin	545	485	387
Out of County	0	68	92
Unknown or declined to state	67	14	0

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	37	32	15
Asian	16	4	14
Black or African American	38	28	33
Caucasian or White	1,533	1,285	976
Native Hawaiian or Other Pacific Islander	13	10	3
Other Race	158	133	105
Unknown or declined to state	57	115	260

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino	151	133	91
Other Hispanic / Latino	113	73	77
Not Hispanic	1,423	1,146	874
Unknown or declined to state	165	255	364

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	1,728	1,469	1,191
Spanish	63	41	30
Other Language	12	10	9
Unknown or declined to state	49	87	176

FY 14/15 through FY 16/17 Outcome Measures

	FY 14/15		FY 15/16	
	Number	Percent	Number	Percent
Opened to Outpatient BHD	453	24%	341	21%
Referred to Other Provider	167	9%	63	4%
Did Not Meet Medical Necessity	753	41%	701	44%
Other	479	26%	502	31%
Total	1,852		1,607	

	FY 16/17	
	Number	Percent
Opened to Outpatient BHD	289	7%
Referred to Other Provider	99	21%
Did Not Meet Medical Necessity	488	35%
Other	530	38%
Total	1,407	

There continues to be misunderstanding of the type of outpatient services provided by the BHD and the criteria for eligibility. The BHD will focus on more education and awareness regarding the available services and the criteria for medical necessity.

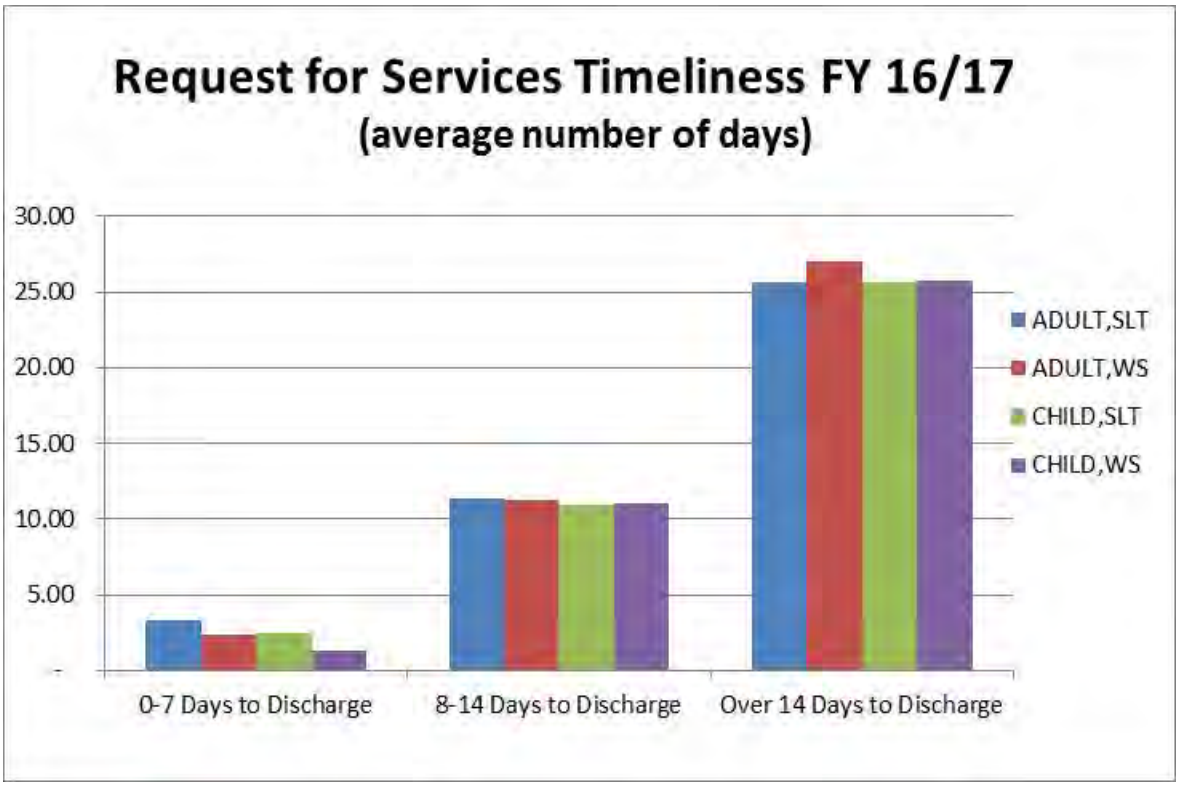
Additionally, in FY 16-17, there was staffing shortages on the Outreach and Engagement Team, which continued in to FY 17-18, that resulted in lower expenditures than anticipated.

Measurement 1 (Service Engagement)
The number of requests for services in FY 16/17 dropped by approximately 12.5% compared to FY 15/16. There are several factors which may contribute to this increase, including a higher rate of direct referrals (either self-referred or from Primary Care Providers) for mild-to-moderate services and an increased effort of the Access Team, who is responsible for responding to all requests for services, working with local Primary Care Providers to educate them on appropriate referrals to Specialty Mental Health Services. Additionally, the large Primary Care Providers (Marshall Medical Center, Barton Healthcare, Shingle Springs Health and Wellness Center, and El Dorado County Community Health Center) have been expanding their Behavioral Health services to provide mild-to-moderate services directly to their patients and it is only when the mild-to-moderate services are not helping a patient that the Primary Care Provider would refer the patient to Specialty Mental Health Services.

Measurement 2 (Days to Assessment)
The timeliness to assessment identifies how quickly individuals requesting services are assessed for eligibility for Specialty Mental Health Services. The BHD strives for a 14 day turnaround of requests for services.

During FY 16/17, and into FY 17/18, the BHD experienced a low level of staffing within on the Access Team despite several recruitments for qualified Mental Health Clinicians. As of April 2018, the Access Team is fully staffed and it is anticipated that the duration from initial request to service to "discharge" (making a determination as to whether the individual meets medical necessity for Specialty Mental Health Services) will decrease.

Once it has been determined whether or not an individual meets medical necessity, the BHD's Access Team will either open an individual to Outpatient Mental Health services or provide "resourcing", which includes referrals to Primary Care, Managed Care Plans and/or community-based organizations as needed to address an individual's needs.



Resource Management Services

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- Improve the number and quality of resources available to clients and their families.
- Improve access and service delivery.

- Improve project evaluation process.
- Improve client transitions between primary care providers and Mental Health.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$175,000	$75,000	$107,000
Total Expenditures	$20,336	$20,017	$46

FY 14/15 through FY 16/17 Outcome Measures

- Measurement 1: Update and expansion of resource list; dissemination of information to clients
- Measurement 2: Client wait time.
- Measurement 3: Client satisfaction surveys
- Measurement 4: Establishment of standard evaluation process for MHSA projects and dissemination of information
- Measurement 5: Results of EQRO annual review

Measurement 1 (Update and expansion of resource list; dissemination of information to clients)

The BHD continues its efforts in this area, as noted last year:

> *BHD managers meet with health care providers and Managed Care Plans on a regular basis to disseminate information, including the Community Health Center, Marshall Medical Center, Barton Health, California Health and Wellness, Shingle Springs Health and Wellness Center, California Health and Wellness, and other task forces and cooperatives. Additionally, the BHD hired a "Resource Specialist" in FY 2014-15 whose primary focus is identifying community resources for the benefit of clients, and includes assisting clients directly with identifying housing opportunities and other resource needs. The BHD has also developed a Resource List that clients and community members can keep in their wallet. The Resource List contains phone numbers to various community services, such as mental health, police, health centers, crisis/emergency lines, food closets, clothing closets, alcohol and drug programs, and advocacy services.*

Due to low staffing levels, limited Resource Management Services occurred in FY 16/17.

Measurement 2 (Client wait time)

See above under Outreach and Engagement.

Measurement 3 (Client satisfaction surveys)

The Consumer Perception Survey was administered in the Fall of 2016 and the Spring of 2017. Due to low staffing levels, the BHD has been unable to evaluate the outcomes.

Measurement 4 (Establishment of standard evaluation process for MHSA projects and dissemination of information)

The BHD continues to develop standard reporting formats that can be trended from year to year, which is the first time this has been largely available for MHSA programs. This ability is primarily due to the implementation of the electronic medical record Avatar, and the MHSA staff continuing to develop standardized reporting formats in response to public input and advancing technology.

Measurement 5
(Results of EQRO annual review)

The 2017 EQRO identified the following recommendations:

1. It is imperative that the MHP to take actions to stabilize staffing levels and reduce vacancies through examining and mitigating factors contributing to separations. The compensation study is one important opportunity for addressing this. Other options to consider as part of this staffing stabilization plan might include: (1) Consider adding funding to participate in State and National Health Services Corp loan forgiveness programs for hard to recruit licensed positions. (2) Consider entering into formal placement and internship agreements with colleges in northern California. (3) Consider putting critical hard to recruit positions on "continuous recruitment" and close lists when vacancies occur to immediately begin interviewing. (4) Consider use of provisional and temporary help appointments for qualified candidates while recruiting is going on to establish new lists and similar personnel strategies. Since resources are critical to solve and address many of the challenges discussed, it may be possible to enhance revenues through the following strategies:
   - Develop a business plan with Telecare to get the 16 bed acute care PHF Medicare certified via "deemed status" with the Joint Commission which they have done in a number of counties. This revenue restructuring can increase Medicare reimbursement significantly from disabled Medicare/Medi-Cal clients and reduce county general fund and realignment matching requirements.
   - Consider use of MAA revenues for transportation, enrollment in benefits, and linkage to other services. This is often used also to support these activities in the Wellness Centers. Many counties have used this successfully as supplemental revenue. It takes several years to get cash flow established but can still contribute to ongoing program stability.
   - Develop business plan to certify county-operated sites for Medicare Part B claim submission at least for medication and licensed clinician assessments. Consider reaching out to similar-size MHPs who use Avatar EHR to gauge their experience in navigating the Medicare site certification and claiming process.
   - Consider contracting with an FQHC clinic for some psychiatric, nurse practitioner, and LCSW behavioral health services capacity to serve clients with serious mental health needs who are have potential to become mild to moderate in stability. This also fosters service integration into the broader health system and supports other revenue options.

MHP Activities to Address this Recommendation

The MHP's South Lake Tahoe Clinic is fully staffed, and has been since approximately September 2017. However, the MHP's West Slope Clinic continues to face staffing challenges, although not from recent staff departures (the last Clinician separated September 15, 2017), but rather from the long recruitment process and lack of appropriate candidates. The MHP has recently hired two new Clinicians for the West Slope, and continues to recruit for two more. Additionally, the new Manager of Mental Health Programs for the West Slope outpatient programs is in the hiring process (that position has been vacant for approximately 10 months).

The MHP appreciates the suggestions from Behavioral Health Concepts regarding solutions to its staffing challenges. Here are the outcomes of the MHP's investigation into these suggestions:

Recommendation: **The compensation study is one important opportunity for addressing this.**

MHP Response: The County's Classification and Compensation Study continues to progress. Final action has not been taken. As a separate matter, the County and local bargaining units agreed to a one-time payout of funds for all staff that were employed with the County as of a specified date, and those funds were disbursed to employees as part of the standard payroll process on February 9, 2018.

Recommendation: **Consider adding funding to participate in State and National Health Services Corp loan forgiveness programs for hard to recruit licensed positions.**

MHP Response: Those programs are available for certain entities located in a Health Professional Shortage Area (HPSA). According to the Health Resources & Services Administration website (https://datawarehouse.hrsa.gov/tools/analyzers/geo/ShortageArea.aspx), the MHP's West Slope Clinic is not located in a HPSA. However, the South Lake Tahoe office is. As stated above, the South Lake Tahoe office is experiencing staffing stability.

Recommendation: **Consider entering into formal placement and internship agreements with colleges in northern California.**

MHP Response: The MHP works with California State University, Sacramento for these purposes. However, in doing so, the MHP receives candidates who are "associates" or working on their practicum. These entry-level staff require a high level of supervision and extensive training to gain the required knowledge to serve our high acuity clients. While the MHP does hire staff with this level of limited experience, it takes months to bring them up to a level able to handle a standard case load size. The MHP always appreciates interviewing candidates who are already licensed.

Recommendation: **Consider putting critical hard to recruit positions on "continuous recruitment" and close lists when vacancies occur to immediately begin interviewing.**

MHP Response: Pending the outcome of the current recruitment, the MHP will consider approaching recruitments in this manner provided doing so complies with County recruitment procedures.

Recommendation: **Consider use of provisional and temporary help appointments for qualified candidates while recruiting is going on to establish new lists and similar personnel strategies.**

MHP Response: The MHP has utilized "Extra Help" Clinician positions. At this time, we do not have any Extra Help Clinicians, however we are in the interview process for several.

Recommendation: **Revenue enhancements**

MHP Response: The MHP appreciates the revenue enhancements recommendations. However, revenues are not the issue. In FY 2017/18, MHSA Community Services and Supports (CSS) programs, the MHP started with a fund balance of approximately $5.6M (excludes the prudent reserve), an increase of approximately $1.2M from the previous fiscal year. Non-MHSA programs started with a fund balance of approximately $3.5M, an increase of approximately $1.3M from the previous fiscal year. The MHP continues to underspend each year and has been fairly unsuccessful in obtaining additional personnel allocations. CSS, Prevention and Early Intervention (PEI), and Innovation funds are potentially at risk of reversion due to underspending.

2. **Update the Cultural Competence Plan with a special focus on outreach and engagement to the Latino community and building on the MHSA programs to create clinics with a high degree of cultural competence.**

MHP Activities to Address this Recommendation

The MHP's Cultural Competence Plan was updated in December 2017, and the MHP initiated a workgroup comprised of community partners who work with and engage the Latino community in November 2017. Participants include a number of individuals who have long been considered key contacts within the Latino community in El Dorado County. A focus of the workgroup includes developing strategies for outreach and engagement of Latinos in accessing mental health services, whether through the MHP or community providers, as well as ensuring that individuals who are providing interpreter services are appropriately trained.

3. **Advance the current Concept Only PIPs to Active PIPs so that the next review has two Active PIPs in process.**

   MHP Activities to Address this Recommendation

   Clinical PIP: Short-Term Model of Care
   The MHP continues work on this PIP. However, as has been the case in previous years, the MHP has been short-staffed making it difficult to finally implement this PIP. Please see the submitted PIP documents for more information.

   Non-Clinical PIP: Collaboration with El Dorado County Community Health Center
   Feedback received from BHC after last year's review indicated the belief that there may not be an issue with Access timeliness and the MHP might want to consider a different PIP or modifying the current PIP. The MHP elected to change its non-clinical PIP. The MHP receives many referrals from the local FQHC, El Dorado County Community Health Center (CHC), that are not appropriate referrals for Specialty Mental Health Services. Additionally, the MHP has been advised by leadership at the CHC that many of their staff feel the MHP does not accept any individuals for services and therefore have stopped referring to the MHP. To address these issues, the MHP is proposing to a part-time co-location of a MHP Clinician at CHC for up to 8 hours per week to provide on-site assessments of medical necessity for Specialty Mental Health Services and to provide ongoing education for the CHC staff regarding medical necessity. Please see the submitted PIP documents for more information.

4. **Develop peer leadership to expand hours of the Wellness Center with peer stipends or salaries depending on scope of responsibilities.**

   MHP Activities to Address this Recommendation

   Effective February 5, 2018, the West Slope Wellness Center expanded its hours to 12:00 – 4:00 pm, Monday through Friday. It is anticipated that the extra hour of operations will benefit the clients by allowing clients time to sign in, socialize and have lunch prior to the daily curriculum starting. It was discovered that clients were not attending the early classes because they preferred to do the above-mentioned activities prior to classes.

   Further, the MHP is exploring opportunities to open the West Slope Wellness Center for Transitional Age Youth (TAY) one afternoon per week. It is anticipated that the extra hour of operations will benefit the TAY clients by providing enhanced opportunities for group work, psychoeducation and development of life skills. However, the program will begin by involving the TAY in the decision about the groups and other services available that day. A TAY peer leader will also participate in the planning and during the weekly TAY day. Potential groups for consideration include Employment and Job Connections, Budgeting, Looking for and Obtaining Housing, Cooking and Menu Planning, Substance Use, Cigarette Cessation, Activities of Daily Living, Goal Setting (WRAP or WHAM), Dialectical Behavior Therapy (DBT) Skill Building, Healthy Pleasures, Music Group and/or Dual Recovery.

Potential expansion of hours for the Lake Tahoe Wellness Center will continue to be considered pending the outcome of the West Slope expanded hours and the determined need. For example, there is not currently a high level of TAY clients in Tahoe and therefore a TAY-specific day may not need to be established in Tahoe. Additionally, daily attendance at the Lake Tahoe Wellness Center is generally lower than the West Slope Wellness Center due to the lower population in the Tahoe Basin than on the West Slope and the greater Placerville area.

The MHP continues to research stipends. While the MHP fully supports stipends and paying peer leaders for their time, we must first establish how the process would occur, the amounts, the responsibilities associated with the stipends, etc. In the meantime, we have been able to provide a token of appreciation for clients who participate in our Cultural Competency training through the provision of gift cards in the amount of $20 each to thank them for their time and for helping educate our staff.

Community-Based Mental Health Services

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- Improve community health through local services
- Increased access to and engagement with mental health services
- Decreased days of homelessness, institutionalization, hospitalization, and incarceration
- Increased connection to their community
- Increased independent living skills

Numbers Served and Cost

Due to limited funding and BHD staffing, this project is currently providing services only at the Community Corrections Center that serves individuals who qualify for services under AB 109.

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$157,613	$206,840	$230,761
Total Expenditures	$165,528	$186,107	$174,552
Unduplicated Individuals Served	67	46	61
Cost per Participant	$2,471	$4,046	$2,862

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	11	8	10
26-59 (adult)	54	37	51
Ages 60+ (older adults)	2	1	0
Unknown or declined to state	0	0	0

Gender	FY 14/15	FY 15/16	FY 16/17
Female	14	16	19
Male	53	30	42

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	17	14	13
Placerville Area	30	21	35
North County	4	9	6
Mid County	11	0	4
South County	2	0	0
Tahoe Basin	1	1	0
Unknown or declined to state	2	1	3

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	1	0	3
Asian	0	1	1
Black or African American	3	0	2
Caucasian or White	57	36	49
Native Hawaiian or Other Pacific Islander	0	0	0
Other Race	3	7	6
Unknown or declined to state	3	2	0

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino	2	6	6
Other Hispanic / Latino	1	2	3
Not Hispanic	57	34	48
Unknown or declined to state	7	4	4

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	61	42	59
Spanish	0	1	0
Other Language	1	1	0
Unknown or declined to state	5	2	2

FY 14/15 through FY 16/17 Outcome Measures

- Measurement 1: Continued engagement in mental health services
- Measurement 2: Days of homelessness, institutionalization, hospitalization, and incarceration
- Measurement 3: Linkage with primary health care
- Measurement 4: Levels of Care Utilization System (LOCUS)
- Measurement 5: Outcome measurement tools (e.g., ANSA)

Services through the AB 109 program are the primary focus of this project. At this time, the majority of the funding for this project comes from the Community Corrections Partnership with a small amount of MHSA funding for additional support.

The Community Corrections Partnership continues to develop program outcomes and those will be reported once they are available.

Housing Projects

Program Goals

- Acquire, rehabilitate, construct and support permanent supportive housing for individuals with serious mental illness and who are homeless or soon-to-be homeless.
- Support clients in maintaining tenancy.

West Slope – Trailside Terrace, Shingle Springs

MHSA Housing funds were utilized to provide for five units in Shingle Springs targeting households that are eligible for services under the Full Service Partnership project. All units are occupied and the BHD maintains a waiting list.

The funds for this program were transferred to California Housing Finance Agency (CalHFA) for administration of this program.

East Slope – The Aspens at South Lake, South Lake Tahoe

MHSA Housing funds were utilized to provide for six units in South Lake Tahoe targeting households that are eligible for services under the Full Service Partnership project. All units are occupied and the BHD maintains a waiting list.

The funds for this program were transferred to California Housing Finance Agency (CalHFA) for administration of this program.

Local Housing Assistance

These CSS-Housing funds include costs such as rental assistance, security deposits, utility deposits, other move-in costs, and/or moving costs.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$0	$11,858	$11,858
Total Expenditures	$0	$0	$11,705
Number of Clients Served	0	0	13
Average Cost per Participant	$0	$0	$900

Innovation (INN)

Restoration of Competency in an Outpatient Setting

Please see Appendix B, *Annual Innovation Program and Evaluation Report, Reporting Year: Fiscal Year 2016-17*.

Expenditures	FY 16/17
MHSA Budget	$355,000
Total Expenditures	$7,766

Community-Based Engagement and Support Services

Please see Appendix B, *Annual Innovation Program and Evaluation Report, Reporting Year: Fiscal Year 2016-17*.

Expenditures	FY 16/17
MHSA Budget	$641,000
Total Expenditures	$131,907

Innovation Administration

Activities performed under Innovation Administration include program development, implementation and monitoring, fiscal review, and provider meetings related specifically to Innovation.

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	n/a	n/a	$25,000
Total Expenditures	n/a	n/a	$2,812

Workforce Education and Training (WET)

Workforce Education and Training (WET) Coordinator

Program Goals

- Increase participation in regional partnerships.
- Identify career enhancement opportunities and variety of promotional opportunities for existing public mental health system workforce.
- Increased utilization of WET funding for local trainings.
- Increase number of bilingual / bicultural public mental health workforce staff.
- Increase number and variety of employment and/or volunteer opportunities available to consumers and their families who want to work in the mental health field.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$11,037	$11,000	$21,300
Total Expenditures	$8,767	$3,395	$27,941

FY 14/15 through FY 16/17 Outcome Measures

- Measurement 1: Increase the number of training opportunities for the mental health workforce.

Measurement 1:
Information about upcoming trainings applicable to Behavioral Health is distributed to BHD Managers and Supervisors, and to community-based organizations or the public depending upon the topic of the training. Additionally, contracts with training vendors continue to be established to ensure training can be scheduled when needed.

Workforce Development

Program Goals

1) Increase the number of training opportunities for the public mental health system workforce.
2) Identify career enhancement opportunities for existing mental health workforce.
3) Increase the retention rates for current mental health workforce staff.
4) Increase the number of new staff recruited into the mental health workforce.
5) Increase the number of bilingual / bicultural mental health workforce staff available to serve clients.
6) Increase the number and variety of positions available to consumers and their family members who want to work in the mental health field.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$49,825	$40,000	$12,000
Total Expenditures	$39,068	$5,396	$36,597
Number of Trainings	14	36	61

FY 14/15 through FY 16/17 Outcome Measures

- **Measurement 1: Increase the number of training opportunities for the public mental health system workforce, including staff, contractors, volunteers and consumers.**
- **Measurement 2: Increase the number of bilingual / bicultural public mental health workforce system staff in the County.**

Measurement 1

The information below identifies the 61 trainings that occurred in FY 16/17, many of which were provided at no charge to the WET program:

	Training Topic	Number of Attendees	Training Duration	Total Training Hours
1	Screening, Brief Intervention, and Referral to Treatment (SBIRT), Part 1	16	1.5	24
2	Treatment Planning Measurable, Attainable, Time-limited, Realistic and Specific (MATRS)	38	1.5	57
3	Dialectical Behavior Therapy Workshop	6	1	6
4	Dual Relationships	4	1.5	6
5	Dialectical Behavior Therapy Learning	8	1	8
6	SBIRT, Part 2	12	1.5	18
7	Dialectical Behavior Therapy Workshop	6	1	6
8	Neurocognitive Disorders	20	1	20
9	Ethics and Confidentiality, Part 1	19	1.5	28.5
10	Dialectical Behavior Therapy Learning	8	1	8
11	Dialectical Behavior Therapy Learning	5	1	5
12	Level of Care Utilization System (LOCUS) Training	4	3	12
13	Best Practices in Addiction Treatment	14	1.5	21
14	Treatment Plans	12	1	12
15	Clinical Documentation	27	1	27
16	LOCUS Training	6	3	18
17	Treatment Plan Development	12	1	12
18	Synthetic Drugs	25	1.5	37.5
19	Dialectical Behavior Therapy with Sabrina	1	6	6
20	LOCUS Training	11	3	33

	Training Topic	Number of Attendees	Training Duration	Total Training Hours
21	Dialectical Behavior Therapy Consultation	8	1	8
22	Somatic Symptom and Related Disorders	45	1	45
23	Difficult Clients/Red Flags	22	1.5	33
24	Veterans and Their Families	52	2	104
25	Dialectical Behavior Therapy Consultation	10	1	10
26	National Standards for Culturally and Linguistically Appropriate Services Standards	2	6	12
27	Ethics and Confidentiality, Part II	10	1.5	15
28	Mindfulness Techniques for Children & Teens	4	6.5	26
29	Addiction: The Layers of Complexities and Treatment	18	6	108
30	Dialectical Behavior Therapy Consultation	9	1	9
31	Manipulations & Character Disorders	6	6	36
32	American Lung Association Smoking Cessation Facilitator Training	1	8	8
33	Mental Health Restoration/Rehabilitation Treatment for Probationers/Parolees	33	2	66
34	Treatment Planning MATRS	10	1.5	15
35	Dialectical Behavior Therapy Consultation	12	1	12
36	Workforce Education & Training Summit	1	16	16
37	Cultural Competence Summit XX	1	16	16
38	Culture of Integrated Treatment	12	1.5	18
39	Early Interventions for Psychosis	3	6	18
40	Dialectical Behavior Therapy Consultation	4	1	4
41	Communication for the Behavioral Professional	1	1	1
42	Boundaries in Clinical Practice	1	1	1
43	Advanced Issues of Adult/Child Mental Health	1	12	12
44	Ethics & Confidentiality, Part III	9	1.5	13.5
45	Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 Anxiety Disorder Challenges	29	2	58
46	Dialectical Behavior Therapy Consultation	9	1	9
47	California Association of Social Rehabilitation Agencies (CASRA) Conference	5	8	0
48	Adult Needs and Strengths Assessment (ANSA) Training	24	4	96

	Training Topic	Number of Attendees	Training Duration	Total Training Hours
49	Cultural Competency and National Standards for Culturally and Linguistically Appropriate Services	10	1.5	15
50	NIATx (formerly the Network for the Improvement of Addiction Treatment, now just NIATx) Model of Process Improvement	11	1.5	16.5
51	Governance Leadership & Workforce	10	1	10
52	Clinical Training	36	2	72
53	Communication & Language Assistance	10	1	10
54	Recovery Support Technologies	10	1.5	15
55	Motivational Interviewing	10	16	160
56	Gay Boys: Coming Out in Middle School	1	1	1
57	Attention-Deficit/Hyperactivity Disorder (ADHD): A Controversial Subject	1	1.5	1.5
58	Patient's Rights	21	1.5	31.5
59	Addiction Counselor Ethics	1	1	1
60	Engagement, Continual Improvement & Accountability	10	1	10
61	Ethics-Confidentiality & Legal Issues	1	1	1
	TOTAL	**728**	**183**	**1519**

Post training surveys have been collected and the BHD is developing a more formal evaluation process to include surveys administered both immediately after the training and three months post-training.

Measurement 2

Recruitments resulted in additional bilingual / bicultural staff joining the BHD in FY 16/17, including a bilingual/bicultural Mental Health Clinician for the Psychiatric Emergency Services team.

Capital Facilities and Technology (CFTN)

Electronic Health Record System Implementation

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$185,686	$153,186	$213,186
Total Expenditures	$55,684	$49,671	$57,590

Funds were allocated to this program, but other costs for the Electronic Health Record were charged across the Behavioral Health Division rather than to this project specifically, resulting in lower than anticipated expenditures.

Telehealth

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$129,000	$10,000	$20,000
Total Expenditures	25,702	$0	$667

Expenditures were for small maintenance needs.

APPENDIX A

Annual Prevention and Early Intervention Program and Evaluation Report, Reporting Year: Fiscal Year 2016-17

El Dorado County
Mental Health Services Act (MHSA)

Annual Prevention and Early Intervention Program and Evaluation Report

Reporting Year: Fiscal Year 2016-17

HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH

WELLNESS | RECOVERY | RESILIENCY

Prevention and Early Intervention (PEI)

The MHSA Prevention and Early Intervention (PEI) programs are intended to prevent serious mental illness / emotional disturbance by promoting mental health, reducing mental health risk factors, and by intervening to address mental health problems before they occur, to the extent possible, or in the early stages of the illness.

This report incorporates the new metrics for recording demographics. As such, there may not be a direct correlation between FY 14/15, FY 15/16 and FY 16/17 because the categories have changed and/or the categories are new in FY 16/17. The MHSA Team continues to work with providers on adapting to the new, and significantly more detailed, demographics.

There is a noticeable trend within many programs where the responses to the demographics questions are "Unknown or declined to state". It is not possible to specifically identify the reason for the increased rate of completion, however it is believed that the number of potential responses to the many demographic questions may be too much information for individuals to review so they elect to leave the questions blank.

Prevention Programs

Latino Outreach

Providers: New Morning Youth and Family Services; South Lake Tahoe Family Resource Center

Project Goals

- Increased mental health service utilization by the Latino community.
- Decreased isolation that results from unmet mental health needs.
- Decreased peer and family problems that result from unmet health needs.
- Reduce stigma and discrimination
- Integration of prevention programs already offered in the community is achieved.
- Reduction in suicide, incarcerations, and school failure or dropouts.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$231,128	$231,128	$231,128
Total Expenditures	$213,301	$207,594	$167,699
Unduplicated Individuals Served	838	452	428*
Cost per Participant	$255	$459	$208*

*Data for South Lake Tahoe Family Resource Center only.

For the data from the South Lake Tahoe Family Resource Center, individuals may be listed under two or more categories due to multiple individuals having the same name and no unique identification field (e.g., client number or date of birth)

is provided with the data for one provider.

New Morning Youth and Family Services failed to provide the required year-end reports. Therefore, the demographic information below reflects only South Lake Tahoe Family Resource Center data. The contract with New Morning Youth and Family Services is being reviewed for compliance concerns and actions to be taken when a contractor does not comply with required elements of the contract.

In the event a new provider must be identified for the West Slope, a procurement process in compliance with the County Procurement Policy will be performed.

Age Group	FY 14/15	FY 15/16	FY 16/17*
0-15 (children/youth)	287	130	145
16-25 (transitional age youth)	127	51	4
26-59 (adult)	422	268	283
Ages 60+ (older adults)	2	3	0
Unknown or declined to state	0	0	1

Race	FY 14/15	FY 15/16	FY 16/17*
American Indian or Alaska Native	0	0	0
Asian	0	3	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	16	3	412
Other Race or Ethnicity	0	0	19
Multiracial	2	3	0
Unknown or declined to state	0	0	1

Ethnicity	FY 14/15	FY 15/16	FY 16/17*
Hispanic or Latino			
South American	--	--	1
Other	--	--	1
Specific ethnicity not indicated	828	443	411
Non-Hispanic or Non-Latino:			
Asian (specific ethnicity not indicted)	0	3	0
Other: White	16	3	0
More than one ethnicity	2	3	0
Unknown or declined to state	0	0	19

Primary Language	FY 14/15	FY 15/16	FY 16/17*
English	163	75	19
Spanish	674	376	416
Other Language	1	1	0
Unknown or declined to state	0	0	0

Sexual Orientation	FY 14/15	FY 15/16	FY 16/17*
Gay or Lesbian	--	--	0
Heterosexual or Straight	--	--	428
Bisexual	--	--	0
Questioning or unsure of sexual orientation	--	--	0
Queer	--	--	0
Another sexual orientation	--	--	0
Unknown or declined to state	--	--	0

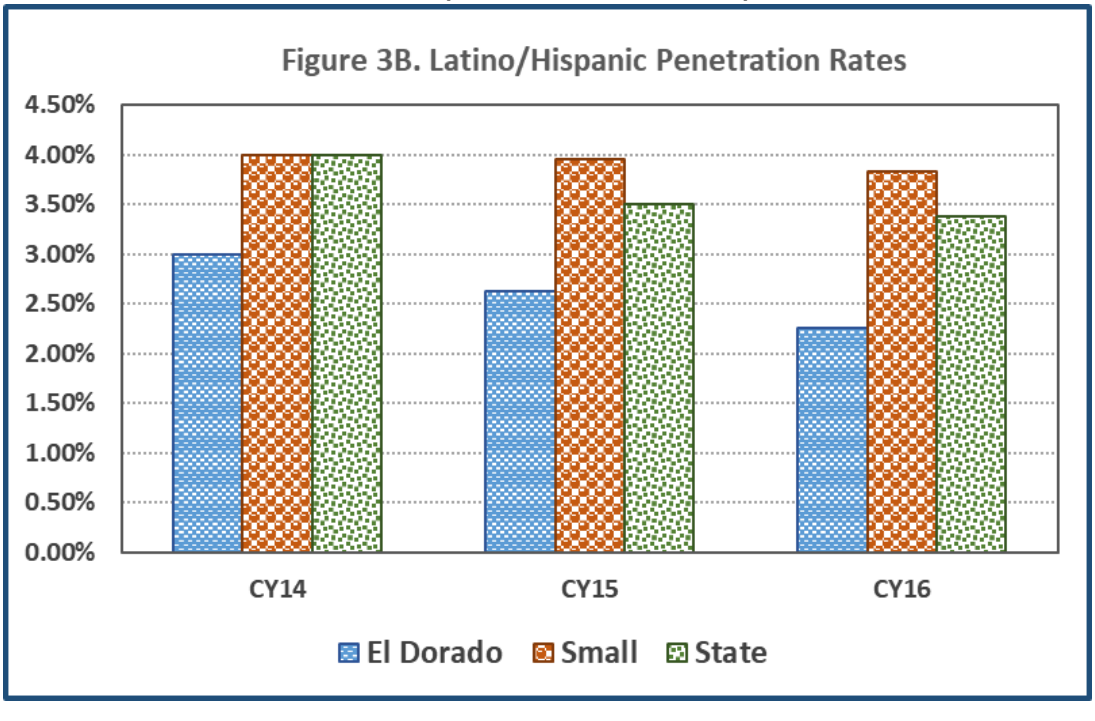
Gender	FY 14/15	FY 15/16	FY 16/17*
Assigned sex at birth:			
Male	--	--	132
Female	--	--	306
Unknown or declined to state	--	--	0
Current gender identity:			
Male	298	147	0
Female	540	305	0
Transgender	--	--	0
Genderqueer	--	--	0
Questioning or unsure of gender identity	--	--	0
Another gender Identity	--	--	0
Unknown or declined to state	--	--	428

Disability	FY 14/15	FY 15/16	FY 16/17*
Yes	--	--	0
Communication Domain	--	--	0
Difficulty seeing	--	--	0
Difficulty hearing, or having speech understood	--	--	0
Other (specify)	--	--	0
Mental domain not including a mental illness	--	--	0
Physical/mobility domain	--	--	0
Chronic health condition	--	--	1
Other (specify)	--	--	0
No	--	--	0
Unknown or declined to state	--	--	428

Veteran Status	FY 14/15	FY 15/16	FY 16/17*
Yes	--	--	0
No	--	--	428
Unknown or declined to state	--	--	0

Region of Residence	FY 14/15	FY 15/16	FY 16/17*
West County	58	47	0
Placerville Area	215	133	0
North County	28	11	0
Mid County	77	40	0
South County	10	8	0
Tahoe Basin	449	211	428
Unknown or declined to state	1	2	0

*Data for South Lake Tahoe Family Resource Center only.



Calendar Year	Medi-Cal Beneficiaries	Number Served	Penetration Rate
CY 2013	4,559	130	2.85%
CY 2014	5,366	138	2.57%
CY 2015	5,496	129	2.35%
CY 2016	7,211	163	2.26%

The penetration rate information is obtained from DHCS Approved Claims and MMEF Data provided annually during External Quality Review Organization (EQRO) session.

Although the penetration rates for Hispanics has dropped in the last three calendar years, the actual number of individuals provided with Specialty Mental Health Services has was higher in CY 2016. The

number of Hispanics served has not kept pace with the rate in which Medi-Cal beneficiaries are identifying as Hispanic.

It cannot be determined from the available data whether Hispanic beneficiaries are seeking mental health treatment through their primary care providers (via Managed Care Plans), however as noted in the Year End Report from the South Lake Tahoe Family Resource Center, Barton has increased its service assistance for Spanish-speaking clients and more clients are seeking services from Barton.
Year End Report

NEW MORNING YOUTH AND FAMILY SERVICES

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$96,000	$96,000	$96,000
Total Expenditures	$78,181	$88,552	$78,470
Unduplicated Individuals Served	389	250	Unknown
Cost per Participant	$247	$354	Unknown

Contractor did not provide required year-end reports.

MHSA Recommendation: Review contract for compliance concerns; provide technical assistance; and consider alternate provider.

SOUTH LAKE TAHOE FAMILY RESOURCE CENTER

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$135,128	$135,128	$135,128
Total Expenditures	$135,120	$119,042	$89,229
Unduplicated Individuals Served	449	202	428
Cost per Participant	$301	$589	$208

1) **Briefly report on how implementation of the Latino Outreach project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

The short term goals for this project are to increase mental health services utilized by the Latino community, thereby decreasing isolation and problems that arise from unmet mental health needs. The long term goals of this project include reducing stigma and discrimination associated with mental illness, the achievement of integration of prevention programs, and reduction of suicide, incarcerations, and school failure or dropouts.

During this reporting period FY16/17 the Family Resource Center focused on filling the tremendous need for counseling, food, clothing, and monetary assistance that was requested by clients. We served a total of: 7,274 duplicated clients. We offered two additional support groups with this funding. Average attendance at our support groups were nine, for a total of 489 duplicated clients.

We worked in the Bijou Community Garden with several classes of Kindergarten and Kindergarten through 3rd Grade and our "Parabajitos" groups, serving a total of 170 children. This afforded the children an opportunity to plant seeds and nurture them from seed to harvest.

In partnership with the Heavenly Epic Promise program we were able to offer four sessions of skiing/snowboarding. The sessions included free, lift tickets, lesson and equipment rentals. These sessions were attended by 80 underserved youth that otherwise would not have had the opportunity to enjoy local winter sporting activities. The Heavenly Epic Discovery offered Ropes Course access to 4 groups of 20 for a total of 80 children access to summer team building activities.

2) Briefly report on how the Latino Outreach project has improved the overall mental health of the children, families, and communities by addressing the primary negative outcomes that are the focus of the Latino Outreach project (suicide, incarcerations, prolonged suffering, homelessness, unemployment, school failure or dropout, and removal of children from their homes).

The Family Resource Center provided Promotora/advocacy/counseling services to 3,137 duplicated people this FY16/17 reporting period. These numbers include child care that is provided by Promotoras. The ability to have child care as a part of our support group offerings is vital to the ongoing success of the program. Without the ability to offer this component of the program we believe parents would be unable to attend the groups.

All clients surveyed reported 100% satisfaction with the services received. No negative or slightly negative comments were made; all were very positive receiving services in our bilingual-bicultural setting.

3) Provide a brief narrative description of progress in providing services through the Latino Outreach project to unserved and underserved populations.

We made presentations to seven local service clubs, explaining our roles and mission as well as the services we provide community wide. These presentations are crucial, not only to gather community support and inform community members about our mission but to seek information from our community regarding gaps in services.

We continue to conduct themed presentations to all the Cafecitos programs at three elementary schools, one middle school, and one high school; we presented information to 869 duplicated clients. With the support of our partner agencies and the community at large, this fiscal year we made a strong push to inform and educate participants about the services available in our community, thereby reducing barriers to seeking services that will help alleviate life's challenges.

We were able to serve an average of 3.5 people per day with one-on one and group counseling, with 99% identified as Latino. Attendance at our Mothers Support Group averaged 12 per session, all Latinas.

We served 7,274 people with food and 4 people per day with clothing. We do not ask who they are or where they live, but the vast majority of folks seeking food and clothing help are minorities (Latino, Filipino, Asian, African American).

We provided a wealth of brochures and pamphlets about programs and services in our community kiosks that have information regarding many community agencies. We continue to provide children's and young adult books, along with self-help books from our book store free of charge.

Through our partnership with the Lake Tahoe Community College (LTCC), we provide English as a Second Language (ESL) classes four days per week, three hours per day, during the LTCC school year. These classes attract many Spanish speakers as well as a broad variety of other racial and ethnic minorities. Other programs offered in Spanish through other partnerships include Foster and Kinship Care Education, in coordination with LTCC and the Bijou Community Garden adjacent to the Family Resource Center, native vegetation, fruit trees and perennial plants are all included in the garden. The children participating in our Parabajitos summer program will reap the benefits of the garden vegetables.

We provide a multitude of opportunities for people to give back to their communities through volunteering: parent involvement with kids' activities, helping with food distribution by picking up donations at our local supermarkets, bagging food for monthly Food Bank distribution, cleaning the center, cleaning the clothes closet, working special events such as Toys 4 Tots and Cinco de Mayo, as well as staffing our social enterprise called the Bookworks.

4) **Provide a brief narrative description of how the Latino Outreach services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

The Family Resource Center provided 103 oral and/or written translations this fiscal year, many related to health care, health access, court/justice/legal issues, and many also related to job seeking and service seeking endeavors. The Family Resource center also conducted two community meetings.

We also conducted a community meeting with the Tahoe Transportation District to discuss with the community the project proposal and how the project may affect the residents of our local community. The discussion centered around the housing issue and what accommodations may be made by the Tahoe Transportation District. We translated all the documents and provided immediate translation of the presentation to all in attendance. Total attendance 25 community members.

All of our programs and services highlighted above help reduce disparities across various topics, including mental health care and stigmas, public health topics, health insurance and access to quality care, environmental awareness issues, compulsory education, adult continuing education, transportation, nutrition, access to a variety of services and information that increases resilience and knowledge of cutting edge modalities and options.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

The Family Resource Center participates in our local Mental Health Cooperative meetings as well as the Community Health Advisory Committee with all of our community providers. At this meeting best practices are discussed along with discussions regarding the mental health service gaps that occur in our community.

The Family Resource Center participated in the following collaborations/teams: School Attendance Review Board (SARB); Child Parent Resource Team (CPRT); Lake Tahoe Collaborative (First 5); Drug Free Coalition; Regional Coordinating Council (Tahoe Transportation District); Community Behavioral Mental Health Collective (facilitated by High Bar Global, Michael Ward); Community Health Advisory Council (Barton Hospital); Maternal Child and Adolescent Health (MCAH; El Dorado County Public Health); South Tahoe Environmental Education Committee; Child Abuse Prevention Council (CAPC); TriO-SSS/UB/ETS Advisory Committee (LTCC); Gardens 4 a Healthy Tahoe (Lake Tahoe Sustainability

Coalition); Community Health Advisory Committee (Barton Hospital); Lake Tahoe Community College – Adult Education Block Grant committee; ADVANCE Program (LTCC)

6) Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Latino Outreach project are:

- **Measurement 1: Customer satisfaction surveys**
- **Measurement 2: Client outcome improvement measurements.**
- **Measurement 3: Increased engagement in traditional mental health services.**

The program staff work very hard to effectively advocate for the needs and issues of those seeking one-on-one and group support. Family Resource Center provides a wealth of programs and services to aid those in experiencing the greatest need, and works to instill resiliency so that when a crisis passes, clients do not backslide and instead provide support for others experiencing trauma or crisis.

Measurement 1
The current data collected demonstrates the effectiveness of our programs. Of the 22 clients who took the survey during this reporting period, 20 believe that they are able to manage their symptoms, with 22 reporting almost always. 22 reported feeling respected and welcomed at the Family Resource Center.

Measurement 2
20 were able to manage their symptoms, with 20 reporting almost always.

Measurement 3
Several clients have accessed traditional services from our largest provider of services, Barton Hospital. These clients have been very frustrated in Barton's inability to communicate effectively in regards to their diagnosis and follow up care. The general feeling of our clients towards local health care providers is their lack of understanding of the Spanish language. Barton Hospital in 2017 has addressed this deficit by hiring a bilingual translation coordinator and other bilingual staff to perform interpreter services and present information to the community. The Barton Hospital Bilingual staff have presented information at our regularly scheduled Cafecitos meetings at the schools.

7) Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

Not provided

8) Provide any additional relevant information.

n/a

MHSA Recommendation: Continue this project. Provide technical assistance for reporting and data validation.

Older Adults Enrichment Project

Senior Peer Counseling

Provider: Senior Peer Counseling through EDCA Lifeskills

Project Goals

- Clients demonstrate an increased number of "Therapeutic Lifestyle Changes" over the course of their counseling.
- Clients identify the primary issue of focus (presenting problem) for counseling.
- Clients achieve improvements in their feelings of well-being as shown on the Outcome Rating Scale (ORS) measurement tool.
- Clients are informed about other relevant mental health and support services.
- New volunteer trainings will be provided based on need for both Senior Peer Counselors and Friendly Visitors.
- Through the use of TLCs, clients improve their mental health and self-sufficiency.
- Clients ameliorate their distress as described in their presenting problem.
- Clients' mental health and satisfaction with life is increased as evidenced by scores on the ORS measurement tool.
- Clients know of, and successfully access, other needed mental health services.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget Rollover from FY 14/15	$35,000	$45,000 $20,000	$55,000
Total Expenditures	$25,351	$36,114	$33,710
Unduplicated Individuals Served	31	82	41
Cost per Participant	$818	$440	$822

New Enrollees Only in FY 16/17:

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	0	0	0
26-59 (adult)	4	6	0
Ages 60+ (older adults)	27	76	36
Unknown or declined to state	0	0	0

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	0	0	1
Asian	0	0	1
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	31	80	33
Other Race or Ethnicity	0	1	1
Multiracial	0	0	0
Unknown or declined to state	0	1	0

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino			
Mexican/American	--	--	1
Specific ethnicity not indicated	0	1	1
Non-Hispanic or Non-Latino:			
European	--	--	33
Chinese	--	--	1
Other Ethnicity	31	81	0
Unknown or declined to state	0	1	0

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	31	81	36
Spanish	0	1	0
Other Language	0	0	0
Unknown or declined to state	0	0	0

Sexual Orientation	FY 14/15	FY 15/16	FY 16/17
Heterosexual or Straight	--	--	35
Unknown or declined to state	26	62	1

Gender	FY 14/15	FY 15/16	FY 16/17
Assigned sex at birth:			
Male	--	--	1
Female	--	--	35
Current gender identity:			
Male	26	62	1
Female	5	20	35

Disability	FY 14/15	FY 15/16	FY 16/17
Yes	--	--	
Communication Domain	--	--	
Difficulty seeing	--	--	1
Difficulty hearing, or having speech understood	--	--	2
Other	--	--	1
Mental domain not including a mental illness	--	--	2
Physical/mobility domain	--	--	8
Chronic health condition	--	--	5
Other (specify)	--	--	0
No	--	--	17
Unknown or declined to state	--	--	0

Veteran Status	FY 14/15	FY 15/16	FY 16/17
No	--	--	21
Unknown or declined to state	--	--	15

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	7	21	10
Placerville Area	14	36	22
North County	1	3	4
Mid County	7	16	0
South County	2	6	0
Tahoe Basin	0	0	0
Unknown or declined to state	0	0	0

The majority of the costs for this project are due to training, supervision, and volunteers' mileage reimbursements.

This project began in August of FY 14/15, so the first year had higher costs due to volunteer training and supervision. A lower number of individuals were served due to lower numbers of volunteers initially.

Year End Report

1) Briefly report on how implementation of the Senior Peer Counseling project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.

Senior Peer Counseling served 41 individual clients (seniors). To date we have served a total of 960 clients in El Dorado County. We have designed and implemented three instruments:

1) Counseling outcome (outcome rating scale) "Senior Peer Counseling Client Evaluation";
2) Client satisfaction and quality control "12 Session Summary Worksheet"(a feedback worksheet that measures client satisfaction and quality control); and

3) "Lifestyle Hygiene" (a self-evaluation tool to measure level of engagement in therapeutic lifestyle activities).

We currently have 21 volunteers from various backgrounds and interests who are actively serving 27 individual clients. An additional 97 seniors were served by phone consultation. Four volunteers were served individually. 33 seniors were served by our Hospitality Liaison at Gold Country. 14 seniors were served in the Remembrance Group at Senior/Adult Day Care. We have also begun to serve seniors at the Senior Center in El Dorado Hills and the Cameron Park Community Services District. Many seniors are seen in the home for their first intake appointment. Our volunteers are an energetic, highly motivated group.

Our biggest challenges have been securing and maintaining enough volunteers to meet the demand for services as the senior population in our community continues to grow. Another challenge has been outreach, reaching out to various organizations in the community to make them aware of our services. Our volunteers complete a 50 hour training program and are asked to commit to a minimum of one year of service.

2) Briefly report on how the Senior Peer Counseling project has improved the overall mental health of the older adult population by addressing the primary negative outcomes that are the focus of the Senior Peer Counseling project (suicide and prolonged suffering). Please include other impacts, if any, resulting from the Senior Peer Counseling project on the other five negative outcomes addressed by PEI activities: (1) homelessness; (2) unemployment; (3) incarceration; (4) school failure or dropout; and (5) removal of children from their homes.

Our outcome data (Senior Peer Counseling Evaluation) indicate that seniors completing counseling services report overall improvement. They report improvement in their emotional well being, relationships, and social activities. They consistently indicated that they would recommend our services to other seniors. In addition, our clients received assistance through referrals either in counseling or by phone to services that they otherwise might not have found.

Senior Peer Counseling Outcome Surveys, June 2017

Mean Scores for Questions 1-6.

1. Please check one: My experience with a Senior Peer Counselor has been:
   a. From 0 to 10 (ie: 0 – least helpful, 10 – very helpful):
2. I would recommend Senior Peer Counseling to others: Yes No
3. How do you *feel emotionally*? From 1 to 10 (0-worse, 5-about the same, 10-better)
4. How would you rate your *close relationships* (family, partner)? (0-poor, 10-excellent)
5. How satisfied are you with your *social activities* (friends, hobbies, and clubs)? (0-not satisfied, 10-very satisfied):
6. Since you began Senior Peer Counseling, *overall* have you: Improved, stayed the same, gotten worse?

   N= 35

Question	Mean Score
1.	9.5 (N = 33)
2.	YES (N = 34)
3.	8.5 (N = 28)
4.	7.4 (N = 28)
5.	7.7 (N = 27)
6.	31 Reported improvement, 2 Stayed the same, 0 Felt worse (N = 33)

Comments:

- I found that my Senior Peer Counselor was very kind and caring concerning my problems. She took personal interest in trying to help me work out my difficulties.
- Please stay open.
- Counselor provided different perspectives and ways for me to handle my situation.
- Helpful in being able to discuss difficult events in dealing with widowhood.
- I have grown spiritually and gained confidence in myself.
- My counselor helped me realize I cannot face the future with a negative attitude.
- Aging is not easy, nor is learning how to transition from wife to caregiver.
- Counselor was a great listener. I gained emotional/practical support from her.
- Everything discussed was very helpful indeed!

3) Provide a brief narrative description of progress in providing services through the Senior Peer Counseling project to unserved and underserved populations.

Many of our seniors are on a fixed income and rely on Medicare for their medical and mental health needs. One problem in our community is that the majority of mental health providers do not accept Medicare insurance. In addition, the criterion to meet "medical necessity" according to most insurance carriers does not adequately fit the specific mental health needs of seniors. Therefore, many seniors may not meet the criteria for a psychiatric diagnosis and mental health services according to their insurance plans.

Senior Peer Counseling has been able to bridge the gap between seniors suffering from mental illness and those adjusting to life changes due to the aging process. While treating mental illness is outside the scope of our capabilities, we have successfully assisted seniors with mental illness in finding a mental health provider (therapist or psychiatrist). We are able to work collaboratively with the medical community to address the developmental needs of our clients so they can participate effectively in their medical/psychiatric treatment. This year we compiled two lists of mental health providers, one for the western slope and one for South Lake Tahoe, who accept Medicare or are willing to work on a sliding scale. Our volunteers make these lists available to any senior who may have mental health needs outside the scope of Senior Peer Counseling capabilities.

Some of our seniors are veterans or spouses of veterans. Our volunteers have assisted some of these clients by referring them to David Zelinski, Service Officer for the American Legion Post 119, and Veteran's Outreach, Only Kindness, Inc., to ensure they are getting the proper assistance with regard to military benefits. Because our services are provided by volunteer peers at the Senior Center, we are able to reach out to a vast number of seniors and provide valuable referral information in addition to our counseling support.

4) **Provide a brief narrative description of how the Senior Peer Counseling services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

Interestingly, our clients have been almost entirely Caucasian, however we have had a few Asian and Latino clients request our services. There has been a limited need for bilingual counselors; however, we do have Spanish and German speaking volunteers, and our office support coordinator speaks Spanish. We are anxious to train more bilingual volunteers and increase our cultural diversity.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

As referenced above, Senior Peer Counseling collaborates with a variety of community-based services, as well as other MHSA-funded programs. Seniors also receive assistance through other programs offered at the Senior Center to address legal, financial, and case management issues. Because Senior Peer Counseling is located at the Senior Center, interdepartmental referral and collaboration are very easy. We often refer clients to Senior Legal Services, Health and Human Services Agency, In-Home Support Services (IHSS), El Dorado Council on Alcohol (EDCA), and Senior Daycare. As a result, we have helped seniors deal with issues that often arise with their family members who are trying to help care for them.

The volunteers formed three committees to address outreach (Rack Cards and Brochures, Media, and Speakers Bureau).

- Rack cards and brochures have been distributed to various medical offices and businesses. Several volunteers have given presentations on our behalf in the community. We are also on Facebook.
- This year we published an article in the June 2017 addition of the Senior Times titled, "Combining Households/Combining Lives: Multigenerational Cohabitation". We also have an advertisement in several publications for Senior Peer Counseling titled, "Here to Hear".
- Our Speakers Bureau has set up several presentations for continuing education. Topics include Senior Legal Issues (Diana Steele), Residential Care Ombudsman (Debbie Johnston, MA), Senior Depression (Linn Williamson, LMFC and Jane Williamson, LMFC), Senior Cohabitation (Carolyn Sauer, Psy.D.)

6) **Provide the outcomes measures of the services provided. Outcome measures for the Senior Peer Counseling project are:**
   - **Measurement 1: Contractor will have peer counselors complete a pre- and post-rating form with the client to measure TLCs, primarily pro-health and pro-mental health activities and habits which have been shown to lead to positive physical, emotional and cognitive improvements in people of all ages. The categories to be measured are:**
     1. **Exercise**
     2. **Nutrition / Diet**
     3. **Nature**
     4. **Relationships**
     5. **Recreation / Enjoyable Activities**
     6. **Relaxation / Stress Management**
     7. **Religious / Spiritual Involvement**

8. Contribution / Service

- **Measurement 2: Volunteers will record the clients' self-reported improvement in the presenting problem selected by each clients at the start of peer counseling.**
- **Measurement 3: Outcome Rating Scale (ORS) measurement tool, which measures the following four psychological categories:**
  1. **Individually (personal well-being)**
  2. **Interpersonally (family, close relationships)**
  3. **Socially (work, school, friendships)**
  4. **Overall (general sense of well-being)**

Our measures were designed to assist our clients in learning about themselves and how their lifestyle habits can affect their sense of well being and happiness. As is common in any research project some data is lost due to attrition, however, by and large these measures have been well received by volunteers and clients.

Our outcome data (Senior Peer Counseling Evaluation) indicate that seniors completing counseling services report overall improvement (28 improved, 2 stayed the same). They report improvement in their emotional well being, relationships, and social activities. They consistently indicated that they would recommend our services to other (see item 2, above).

The results of the Lifestyle Hygiene among seniors completing more than one worksheet indicate that there is a rebalancing of activities over time. This may in part contribute to reports of overall improvement. The items on the Lifestyle Hygiene are all activities that have been empirically shown to improve mental health status.

Activity	Average	Minimum	Maximum
Exercise	3.79	0	9
Nutrition	4.64	1	10
Nature	4.8	1	10
TV/Video	5.77	1	10
Relationships	4.31	0	10
Recreation	3.86	0	10
Relaxation	3.77	0	10
Religious	4.42	0	10
Volunteer	3.33	0	8
Sleep	4.73	1	9

The data from the 12 Session Feedback Worksheet show an overall satisfaction among seniors with regard to their alliance with the peer counselor. The results indicate that seniors feel that they are being heard, that they feel their sessions are helpful, and that they feel better after their counseling session (see Summary-Feedback Worksheet).

Questions:

1. How well did you feel heard today? (0 not at all - 5 Very well)
2. How helpful was our session today? (0 not at all - 5 Very helpful)
3. How do you feel after our time today? (0 worse, 3 same, 5 better)*
4. Is there anything you can think of that would make our time together more helpful to you?

Mean Scores for Questions 1-3

	Heard	Helpful	Feeling state	Suggestions
N=59	4.9	4.6	4.5	
N=47	4.9	4.7	4.7	
N=42	4.9	4.6	4.6	
N=32	5.0	4.8	4.5	
N=31	4.9	4.8	4.7	
N=25	5.0	4.8	4.7	
N=23	5.0	4.9	4.7	
N=18	5.0	4.9	4.9	
N=15	5.0	5.0	4.8	
N=15	5.0	5.0	4.6	
N=15	4.9	4.9	4.7	
N=11	5.0	4.8	4.5	Meeting in the same room

Total # of sessions recorded = 333

*The range on question #3, was 2-5; two people reported feeling worse during one of their sessions out of a total N= 333.

7) Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

Expenditures in FY 2016-17 included volunteer supervision, general administration, training, mileage, equipment, and supplies.

Senior Peer Counseling receives donations from clients, businesses, and individuals in the community. We generally ask for a donation of $5.00 at each counseling session, but no client is turned away due to financial limitations. These donations have been used to support volunteer educational resources and attendance at regional meetings. This year Senior Peer Counseling received $3,025 in donations.

8) Provide any additional relevant information.

In addition to serving the seniors described in our grant, Senior Peer Counseling serves seniors in our community in other ways. For example, we provide information and referrals to seniors who call our office on the phone. We serve seniors in assisted living and the Senior Daycare program with information and support. Our volunteers are provided with the opportunity to receive one-on-one consultation with a licensed clinical psychologist. We are also working on more ways to provide personal growth activities to more seniors in residential facilities without compromising their confidentiality.

This year we began to investigate expansion of services for seniors to South Lake Tahoe. We have spoken by phone to members of staff at Barton Hospital and County Behavioral Health. In June 2017, our clinical supervisor attended the Mental Health Collaborative meeting in South Lake Tahoe to discuss the possibility of creating a peer support program for seniors. This is an exciting ongoing project.

Our volunteers are also investigating the possibility of designing and implementing a Friendly Visitor Program. We have been collecting literature and training materials.

MHSA Recommendation: Continue this program with sufficient funding to ensure adequate training costs and supervision are funded, and include potential expansion to South Lake Tahoe. Provide technical assistance regarding reporting.

Friendly Visitor

Provider: West Slope: Senior Peer Counseling through EDCA Lifeskills; South Lake Tahoe: TBD

Project Goals

- Clients demonstrate an increased number of "Therapeutic Lifestyle Changes" over the course of their counseling.
- Clients identify the primary issue of focus (presenting problem) for counseling.
- Clients achieve improvements in their feelings of well-being as shown on the Outcome Rating Scale (ORS) measurement tool.
- Clients are informed about other relevant mental health and support services.
- New volunteer trainings will be provided based on need for both Senior Peer Counselors and Friendly Visitors.
- Through the use of TLCs, clients improve their mental health and self-sufficiency.
- Clients ameliorate their distress as described in their presenting problem.
- Clients' mental health and satisfaction with life is increased as evidenced by scores on the ORS measurement tool.
- Clients know of, and successfully access, other needed mental health services.

Numbers Served and Cost
There is currently no provider for this service, although the program is being explored with Senior Peer Counseling and Barton.

Primary Intervention Project (PIP)

Providers: Black Oak Mine Unified School District; Tahoe Youth and Family Services

Project Goals

- Provide services in a school based setting to enhance access
- Build protective factors by facilitating successful school adjustment
- Target violence prevention as a function of skills training
- To decrease school adjustment difficulties at an early age and build protective factors to foster youth resilience and mental health

Numbers Served and Cost
The demographic data for FY 16/17 is for Black Oak Mine Unified School District only.

Tahoe Youth and Family Services failed to provide the required year-end demographic report. The contract with Tahoe Youth and Family Services is being reviewed for compliance concerns and actions to be taken when a contractor does not comply with required elements of the contract.

In the event a new provider must be identified for the Tahoe Basin, a procurement process in compliance with the County Procurement Policy will be performed.

The third provider of PIP, El Dorado Hills Vision Coalition, closed its operations and no data beyond Total Expenditures is reported.

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$212,700	$212,700	$212,700
Total Expenditures	$184,755	$120,815[1]	$151,705
Unduplicated Individuals Served (regardless of completion status)	214	133	53*
Cost per Participant	$863	$908	$1,428*

*Data for Black Oak Mine Unified School District only.

Age Group	FY 14/15	FY 15/16	FY 16/17*
0-15 (children/youth)	214	133	53
16-25 (transitional age youth)	0	0	0
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	7	4	6
Asian	9	7	1
Black or African American	4	5	2
Native Hawaiian or Other Pacific Islander	1	1	0
White	127	73	44
Other	2	0	0
Multiracial	6	1	0
Unknown or declined to state	58	42	0

[1] Total expenditures including EDCVC was $182,843.

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino			
Caribbean	--	--	0
Central American	--	--	0
Mexican/Mexican-American/Chicano	--	--	0
Puerto Rican	--	--	0
South American	--	--	0
Other	--	--	0
Unknown or declined to state	54	39	0
Non-Hispanic or Non-Latino			
African	--	--	0
Asian Indian / South Asian	--	--	0
Cambodian	--	--	0
Chinese	--	--	0
Eastern European	--	--	0
European	--	--	0
Filipino	--	--	0
Japanese	--	--	0
Korean	--	--	0
Middle Eastern	--	--	0
Vietnamese	--	--	0
Other	--	--	0
Unknown or declined to state	--	--	0
More than one ethnicity	--	--	0
Unknown or declined to state	--	--	53

Primary Language	FY 14/15	FY 15/16	FY 16/17*
English	172	106	53
Spanish	32	26	0
Other Language	5	0	0
Bilingual	4	0	--
Unknown or declined to state	1	1	0

Sexual Orientation	FY 14/15	FY 15/16	FY 16/17
Gay or Lesbian	--	--	0
Heterosexual or Straight	--	--	0
Bisexual	--	--	0
Questioning or unsure of sexual orientation	--	--	0
Queer	--	--	0
Another sexual orientation	--	--	0
Unknown or declined to state	--	--	53

Gender	FY 14/15	FY 15/16	FY 16/17
Assigned sex at birth:	--	--	
Male	85	57	0
Female	117	74	0
Unknown or declined to state	12	2	53
Current gender identity:	--	--	
Male	--	--	0
Female	--	--	0
Transgender	--	--	0
Genderqueer	--	--	0
Questioning or unsure of gender identity	--	--	0
Another gender Identity	--	--	0
Unknown or declined to state	--	--	53

Disability	FY 14/15	FY 15/16	FY 16/17
Yes	--	--	0
Communication Domain	--	--	0
Difficulty seeing	--	--	0
Difficulty hearing, or having speech understood	--	--	0
Other (specify)	--	--	0
Mental domain not including a mental illness	--	--	0
Physical/mobility domain	--	--	0
Chronic health condition	--	--	0
Other (specify)	--	--	0
No	--	--	53
Unknown or declined to state	--	--	0

Veteran Status	FY 14/15	FY 15/16	FY 16/17
Yes	--	--	0
No	--	--	53
Unknown or declined to state	--	--	0

Region of Residence	FY 14/15	FY 15/16	FY 16/17*
West County	45	0	0
Placerville Area	0	0	0
North County	63	40	53
Mid County	0	0	0
South County	0	0	0
Tahoe Basin	106	93	0
Unknown or declined to state	0	0	0

*Data for Black Oak Mine Unified School District only.

Year End Report

BLACK OAK MINE UNIFIED SCHOOL DISTRICT

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$61,478	$61,478	$61,478
Total Expenditures	$51,933	$61,476	$75,681
Unduplicated Individuals Served	39 (completed semester)	46 (completed semester)	38 (completed semester)
Cost per Participant	$1,332	$1,336	$1,992

1) Briefly report on how implementation of PIP is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.

A total of 4 part-time Aides served three elementary schools: American River Charter (two days per week), Georgetown (three days), and Northside (three days). We served a total of 53 students over two semesters. All students (with a few exceptions noted below) were evaluated by their teachers at the beginning of the session, and at the end using the Walker McConnell Survey (WMS) instrument. For the 38 clients with start and end scores, 30 children increased their WMS scores, and 8 had a drop.

A notable challenge this year was disruption at a school site because of sudden staff changes. One K-3 teacher, without warning, did not return to work after Winter break. The Principal at the same school was let go in mid-semester. By the end of the school year, school climate had improved and there is increased optimism for next year. We continue to have many families in crisis, be it from stressors such as parental incarceration, addiction and substance abuse, poverty, transience, or divorce. Additionally, 7 of our PIP students lost a parent due to death this year.

Another challenge we are seeking to address is the number of students who wish to stay in PIP beyond the 12-15 week semester. These children are especially in need of support, and the parents and teachers of these students request that they continue. We are working with our Community Health Advocate, Naomi Harris, to help us refer these students and their families to higher level interventions. We are very excited to be collaborating with the Georgetown Hub!

Our teachers and administrators are very supportive of the program because they see positive changes in the students, such as better focus in the classroom and improved peer relationships.

PIP continues to fill the need for many children and families who are either not eligible or unable to obtain more intensive interventions. PIP also introduces parents to mental health interventions that are less stigmatized and easier to accept than therapeutic models. For a family, PIP is often their first encounter with mental health services, and because it is such a positive experience for the child, it can make it easier to accept higher level interventions than may be necessary in the future.

We again incorporated a second assessment this year, the Adverse Childhood Experiences Survey (ACEs). ACEs are significant childhood traumas that result in actual changes in brain development.

- ACEs include: Abuse: physical, sexual and emotional, Neglect: emotional or physical, Family Problems: witnessing domestic violence, alcoholism, mental illness, or suicide in the home, incarcerated family member, loss of a parent due to divorce, abandonment or death.
- The science of ACEs shows the link between childhood trauma and higher adult risk of alcoholism and drug addiction, cancer, heart disease, suicide, mental illness and diabetes.
- Scores from the survey range from 0-10, zero meaning no adverse experiences prior to the age of 18, and one point given for each category of trauma experienced.
- The survey is meant to be self-administered, but because of the young age of PIP clients, the PIP Aide completed the survey based upon information voluntarily given from teachers, parents, and the child.
- Client privacy was ensured by the use of identifying codes.
- As would be expected with the targeted group of students with mild to moderate adjustment difficulties, ACE scores were much higher in this group than with the general student population.

We continue to serve children with more severe emotional and behavioral problems in the classroom. It is not clear at this time how we will use the ACEs Study to improve outcomes for our children. We are partnering with the El Dorado ACEs Collaborative and the Northern California ACEs Connection.

2) Provide a brief narrative description of how PIP services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.

The racial/ethnic demographics of BOMUSD is predominately White (87%), followed by Hispanic/Latino at 8%, and American Indian/Alaskan Native at 3%. All of the students served by PIP have been English speaking. If a parent is not fluent in English we have staff on site who can translate for Spanish speaking parents.

3) Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.

For families on the Divide, access to services is a critical concern. The distance to the nearest mental health services makes the children here an underserved population, on the whole. PIP helps to alleviate this problem by identifying issues when students are still young and serving them before there is a need for more intense intervention. Since PIP is offered on school campuses, during the school days, there is no transportation involved.

PIP also introduces parents to mental health interventions that are less stigmatized and easier to accept than therapeutic models. For a family, PIP is often their first encounter with mental health services, and because it is such a positive experience for the child, it can make it easier to accept higher level interventions that may be necessary in the future.

4) Identify whether PIP participants were provided with further referrals for services at the conclusion of the PIP semester, and if so, what type of referrals were made (e.g., mentoring programs, recreational programs, individual counseling, group counseling).

The PIP Coordinator and Aides work closely with the school counselor when referrals for more intensive services are warranted. We are working with our Community Health Advocate, Naomi Harris, to help us refer these students and their families to higher level interventions.

Some of our PIP students receive concurrent therapeutic counseling through private pay or MediCal, and our school counselors provide on-site group counseling.

5) Provide a copy of the data and analysis of the WMS for each PIP semester.

Identifying Number	ACE Score	WMS Start	WMS End	Difference
C1	6	155	163	+8
C2	5	145	150	+5
C3	4	140	151	+11
C4	6	119	133	+14
C5	8	140	152	+12
C6	5	135	144	+9
C7	4	138	153	+15
C8	7	136	148	+12
C9	2	152	155	+3
C10	4	188	181	-7
C11	6	121	134	+13
C12	3	143	144	+1
C13	5	143	149	+6
G1	unknown	122	155	+33
G2	1	129	111	-18
G3	8	87	93	+6
G4	6	105	140	+35
G5	8	125	168	+43
G6	5	132	115	-17
G7	3	172	n/a	n/a
G8	2	n/a	124	n/a
G9	5	181	183	+2
G10	3	101	n/a	n/a
G11	2	136	n/a	n/a
G12	3	123	156	+33
G13	3	81	74	-7
G14	6	91	84	-7
G15	6	183	157	-26

Identifying Number	ACE Score	WMS Start	WMS End	Difference
N1	1	117	174	+57
N2	8	< 6 sessions	-	-
N3	unknown	123	177	+54
N4	3	< 4 sessions	-	-
N5	5	168	202	+34
N6	6	162	155	-7
N7	unknown	149	129	-30
N8	5	206	n/a	n/a
N9	5	193	212	+19
N10	unknown	< 4 sessions	-	-
N11	1	119	130	+11
N12	unknown	174	n/a	n/a
N13	unknown	124	n/a	n/a
N14	unknown	128	157	+29
N15	unknown	< 4 sessions	-	-
N16	6	141	169	+28
N17	2	144	181	+37
N18	1	168	190	+22
N19	2	158	n/a	n/a
N20	2	159	177	+18
N21	2	160	183	+23
N22	6	< 6 sessions	-	-
N23	unknown	< 6 sessions	-	-
N24	4	< 6 sessions	-	-
N25	4	< 6 sessions	-	-

6) Confidential Teacher Questionnaire.

N=9

	YES	Mostly	No
Were the students picked up and returned on time?	9		
Did the students seem to enjoy the program?	8	1	
Were you involved in the selection of students for PIP?	8	1	

Do you feel you need more information about the program?			9
Would you like to meet with someone to discuss the program?	1		8

Please share a positive comment about PIP:

- One of my students this year had a very difficult time leaving Mother every day. Now the student comes to school every morning excited about learning and ready to participate in all our activities.
- Struggling students thrive going to it (PIP) and love working with PIP Aide
- Kids like it!
- Saw improvement in all students involved!
- This is a wonderful program for children who need connection to an adult separate from home/school. It is positive, affirming, and a respite for them.
- The children have a positive attitude regarding going to PIP.
- The program helps to boost the social awareness of my students!

Please share additional feedback about the program:

- Awesome PIP facilitator!
- Our PIP staff is wonderful and cares deeply for our students.
- For some of our children it is the only thing they can call their own … going to PIP empowers them and encourages them to keep coming to school.
- Our children are often under so much stress generated from the complications of home life and school expectations. This program gives them a time for positive contact with non-judgmental adults. So valuable.
- I have seen growth in children's social/emotional behavior.

Is there anything else you would like to share?

- Please keep this wonderful program in place at our school!
- Thank you for having this program for our in-need students.
- I appreciate the commitment that the PIP leaders have to the children and the program. Awesome people. Thank you.
- Hope we can keep and expand PIP!
- The Aide's caring and calm manner has greatly helped my students!

7) Provide total PIP expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

In-kind contributions were playroom facilities at the three schools.

MHSA Recommendation: The MHSA Team commends Black Oak Mine Unified School District for implementing the Adverse Childhood Experiences Survey (ACEs). Continue PIP through Black Oak Mine Unified School District, allow for an increase in funding if provider requests to serve more children due to popularity of the program and positive results. Provide technical assistance on reporting.

TAHOE YOUTH AND FAMILY SERVICES

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$87,986	$87,986	$87,986
Total Expenditures	$74,592	$59,339	$59,724
Unduplicated Individuals Served	106	97	79
Cost per Participant	$704	$612	$756

1) **Briefly report on how implementation of PIP is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

The PIP implementation is always challenging at the beginning of the school year. The teachers are under pressure to get to know their incoming students and assess their needs for referrals to the PIP program. Once teachers made the referrals and in coordination with the school Psychologist, we were able to begin seeing children in non-directed play. One of the PIP program challenges is to see children on a regular basis. At times, depending on the classroom schedule, teachers may not release a child on a particular day. The PIP program works best when the children are seen on a regular basis.

2) **Briefly report on how PIP has improved the overall mental health of the children, families, and communities by addressing the primary negative outcome that is the focus of PIP (school failure or dropout). Please include other impacts, if any, resulting from PIP on the other six negative outcomes addressed by PEI activities: (1) suicide; (2) incarceration; (3) unemployment; (4) prolonged suffering; (5) homelessness; (6) removal of children from their homes.**

The program allows children to feel supported in what, in certain circumstances, feels like a non-supportive environment due to many factors leading to the referral to the PIP program. Our PIP workers normally do not engage with parents (this function usually occurs with school staff).

3) **Provide a brief narrative description of progress in providing PIP services to unserved and underserved populations.**

PIP services to unserved and underserved populations is critical to the individual success of the participant. The program allows children to feel comfortable in their school environment thereby supporting their school success.

4) **Provide a brief narrative description of how PIP services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

The PIP program for our English Language Learners (EL) is delivered in the child's native language and supports their native culture. The program is focused on a non-directive play approach providing positive support for issues and/or situations the child brings up during the session.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

The PIP worker will discuss with school staff issues that are revealed during a session that are brought up by the child. The school staff will then follow up with linkages to other appropriate therapeutic services.

6) Identify whether PIP participants were provided with further referrals for services at the conclusion of the PIP semester, and if so, what type of referrals were made (e.g., mentoring programs, recreational programs, individual counseling, group counseling).

PIP participants are provided with information for other services that may be appropriate for the child. The PIP worker will provide the school staff with other agency information to refer to ie; after school Social Skills programs, Summer program run by other organizations etc.

7) Provide the outcomes of customer satisfaction surveys.

Copies of satisfaction surveys were provided with the majority ranging in the good to excellent range.

8) Provide a copy of the data and analysis of the WMS for each PIP semester.

Tahoe Youth and Family Services provided a full copy of the Early Intervention Program Local Evaluation Data Report prepared by Duerr Evaluation Resources. Below are summary tables and charts from the report.

Table 1
Changes in social competence and school adjustment (total scale) ratings for participants

School Name	n	Average Scores for Total WMS Scale							
		Before Participation		After Participation		Net Change and Significance Testing			
		Raw Score	%ile Score	Raw Score	%ile Score	Net Raw Change	Net %ile Change	Effect Size	P-Value
Bijou Community	32	140.8	24	157.6	38	16.8	14	0.63	<.001
Out of County School Included in Totals (not funded by MHSA)	10	115.5	7	126.8	13	11.3	6	0.59	0.055
Magnet School	14	100.7	3	131.6	17	30.9	14	0.93	<.001
Sierra House	12	105.7	4	133.5	18	27.8	14	0.86	<.001
Tahoe Valley	21	115.8	7	143.9	26	28.1	19	0.69	<.001
Project Total/Average	89	121.0	10	143.6	26	22.5	16	0.71	<.001
Statewide Total/Average	--	130.4	16	146.9	28	16.4	12	0.59	<.001

Effect size: As generally agreed among researchers, effect sizes lower than .30 are considered "small," Those in the range of .30 to .70 are considered "moderate," with effect sizes above .70 considered as "large."

P-Values: Values less than .05 are considered statistically significant, although this test is less sensitive with smaller sample sizes (n's).

Table 2
Changes in teacher-preferred social behavior (subscale 1) ratings for participants

School Name	n	Average Scores for WMS Subscale 1							
		Before Participation		After Participation		Net Change and Significance Testing			
		Raw Score	%ile Score	Raw Score	%ile Score	Net Raw Change	Net %ile Change	Effect Size	P-Value
Bijou Community	32	50.6	21	56.8	32	6.2	11	0.54	0.001
Out of County School Included in Totals (not funded by MHSA)	10	42.8	8	45.5	11	2.7	3	0.36	0.271
Magnet School									
Sierra House	114	38.4	4	49.1	17	10.6	13	0.89	<.001
Tahoe Valley	12	40.3	6	50.3	19	10	13	0.84	<.001
Project Total/Average	21	44.1	9	56	30	11.8	21	0.71	<.001
Statewide Total/Average	89	44.9	10	53.2	24	8.3	14	0.66	<.001

Effect size: As generally agreed among researchers, effect sizes lower than .30 are considered "small," Those in the range of .30 to .70 are considered "moderate," with effect sizes above .70 considered as "large."

P-Values: Values less than .05 are considered statistically significant, although this test is less sensitive with smaller sample sizes (n's).

Table 3
Changes in peer-preferred social behavior (subscale 2) ratings for participants

School Name	n	Average Scores for Total WMS Subscale 2							
		Before Participation		After Participation		Net Change and Significance Testing			
		Raw Score	%ile Score	Raw Score	%ile Score	Net Raw Change	Net %ile Change	Effect Size	P-Value
Bijou Community	32	56.2	24	62.6	40	6.3	16	.59	<.001
Out of County School Included in Totals (not funded by MHSA)	10	49.4	13	55.1	23	5.7	10	.71	.014
Magnet School	14	38.9	4	52.0	18	13.1	14	.95	<.001
Sierra House	12	41.3	5	52.5	19	11.2	14	.86	<.001
Tahoe Valley	21	47.2	10	57.8	28	10.6	18	.72	<.001
Project Total/Average	89	48.6	13	57.6	28	9.0	15	.73	<.001
Statewide Total/Average	--	51.7	18	58.9	31	7.2	13	.58	<.001

Effect size: As generally agreed among researchers, effect sizes lower than .30 are considered "small," Those in the range of .30 to .70 are considered "moderate," with effect sizes above .70 considered as "large."

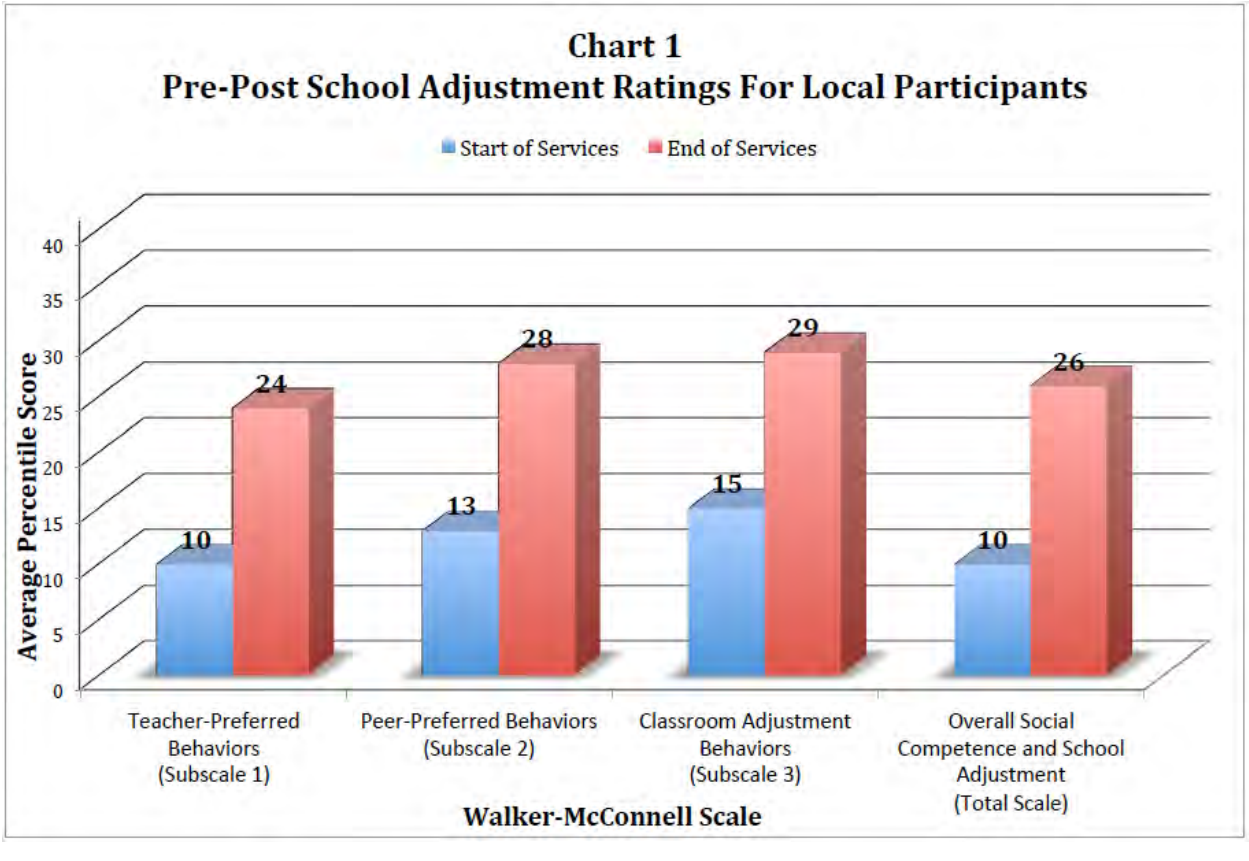
P-Values: Values less than .05 are considered statistically significant, although this test is less sensitive with smaller sample sizes (n's).

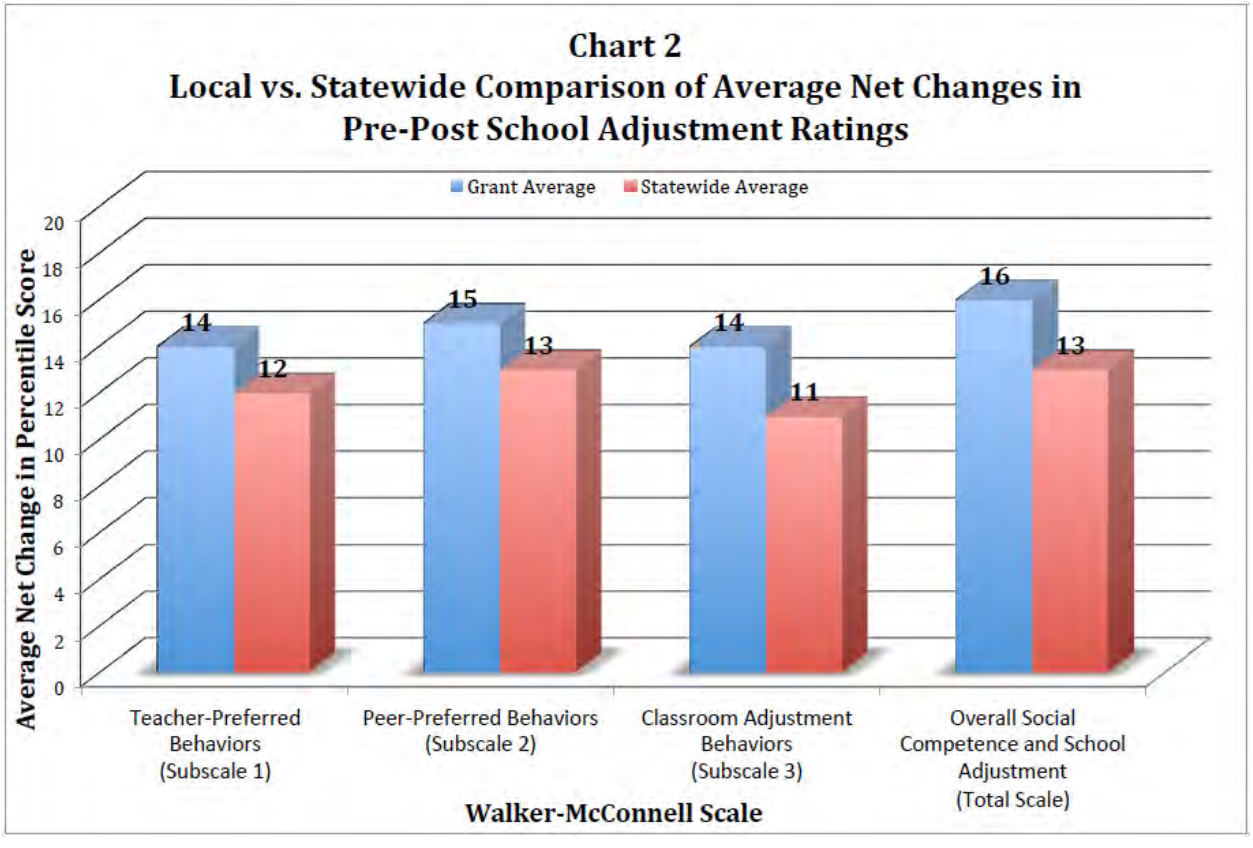
Table 4
Changes in classroom adjustment behavior
(subscale 3) ratings for participants

School Name	n	Average Scores for Total WMS Subscale 3							
		Before Participation		After Participation		Net Change and Significance Testing			
		Raw Score	%ile Score	Raw Score	%ile Score	Net Raw Change	Net %ile Change	Effect Size	P-Value
Bijou Community	32	34.0	32	38.2	44	4.2	12	.56	<.001
Out of County School Included in Totals (not funded by MHSA)	10	23.3	6	26.2	11	2.9	5	.48	.134
Magnet School	14	23.4	6	30.6	23	7.1	17	.91	<.001
Sierra House	12	24.0	8	30.7	23	6.7	15	.87	<.001
Tahoe Valley	21	24.4	8	30.1	21	5.7	13	.51	.016
Project Total/Average	89	27.5	15	32.7	29	5.2	14	.61	<.001
Statewide Total/Average	--	30.1	21	33.6	32	3.5	11	.48	<.001

Effect size: As generally agreed among researchers, effect sizes lower than .30 are considered "small," Those in the range of .30 to .70 are considered "moderate," with effect sizes above .70 considered as "large."

P-Values: Values less than .05 are considered statistically significant, although this test is less sensitive with smaller sample sizes (n's).





9) Provide total PIP expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

Leveraged resources were $20,816.49 in unrestricted monies with $39,400.00 of in-kind.

10) Provide any additional relevant information.

None provided.

MHSA Recommendation: Tahoe Youth and Family Services failed to provide the required demographic year-end report. MHSA staff met with the Financial Comptroller and new Executive Director to talk about services and contract requirements. The services and reporting will continue to be monitored.

In the event a new provider must be identified for the Tahoe Basin, a procurement process in compliance with the County Procurement Policy will be performed.

Wennem Wadati: A Native Path to Healing

Provider: Foothill Indian Education Alliance

Project Goals

- Increased awareness in the Native American community about the crisis line and available services.
- Improve the overall mental health care of Native American individuals, families and communities.
- Reduce the prevalence of alcoholism and other drug dependencies.
- Maximize positive behavioral health and resiliency in Native American individuals and families reducing suicide risk, prolonged suffering, and incarceration.
- Reduce school drop-out rates.
- Support culturally relevant mental health providers and their prevention efforts.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$125,725	$125,725	$125,725
Total Expenditures	$111,589	$117,364	$125,725
Unduplicated Individuals Served	270	344	318
Cost per Participant	$413	$341	$395

Individuals may be listed under two or more categories due to multiple individuals having the same name and/or no unique identification field (e.g., client number or date of birth) is provided with the data:

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	121	186	170
16-25 (transitional age youth)	29	33	43
26-59 (adult)	87	93	107
Ages 60+ (older adults)	30	30	2
Unknown or declined to state	3	2	0

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	225	300	308
Asian	0	0	0
Black or African American	1	0	0
Native Hawaiian or Other Pacific Islander	1	0	0
White	29	25	0
Other Race or Ethnicity	0	2	0
Multiracial	0	13	10
Unknown or declined to state	14	4	0

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino			
Mexican/Mexican-American/Chicano	--	--	5
South American	--	--	1
Other	--	--	3
Unknown or declined to state	14	0	
Non-Hispanic or Non-Latino			
African	--	--	10
Asian Indian/South Asian	--	--	2
Filipino	--	--	2
Other	30	25	23
More than one ethnicity	0	13	
Unknown or declined to state	226	304	299

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	262	328	316
Spanish	8	13	4
Other Language	0	0	0
Unknown or declined to state	0	3	7

Sexual Orientation	FY 14/15	FY 15/16	FY 16/17
Gay or Lesbian	--	--	1
Heterosexual or Straight	--	--	54
Bisexual	--	--	1
Questioning or unsure of sexual orientation	--	--	3
Queer	--	--	0
Another sexual orientation	--	--	0
Unknown or declined to state	--	--	260

Gender	FY 14/15	FY 15/16	FY 16/17
Assigned sex at birth			
Male	--	--	95
Female	--	--	209
Unknown or declined to state	--	--	13
Current gender identity			
Male	79	114	98
Female	185	225	216
Questioning or unsure of gender identity	--	--	4
Unknown or declined to state	6	5	2

Disability	FY 14/15	FY 15/16	FY 16/17
Yes			
Communication Domain	--	--	0
Difficulty seeing	--	--	0
Difficulty hearing, or having speech understood	--	--	0
Other (specify)	--	--	0
Mental domain not including a mental illness	--	--	7
Physical/mobility domain	--	--	4
Chronic health condition	--	--	2
Other (specify)	--	--	2
No	--	--	153
Unknown or declined to state	--	--	168

Veteran Status	FY 14/15	FY 15/16	FY 16/17
Yes	--	--	0
No	--	--	169
Unknown or declined to state	--	--	168

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	35	44	14
Placerville Area	165	209	53
North County	5	0	3
Mid County	29	45	0
South County	3	5	5
Tahoe Basin	1	1	5
Unknown or declined to state	32	40	263

Year End Report

1) **Briefly report on how implementation of the Wennem Wadati: A Native Path to Healing project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

Our Wennem Wadati program, which was designed to provide culturally specific Native American prevention and early intervention services in order to improve wellness and decrease health disparities experienced by this population, continues to be well received by the Native community. As with previous years with this program, we delivered services to more participants than originally anticipated in all the categories of service described in our program description and contract: Cultural Activities, Talking Circles, Crisis Response/Management/Referral, Outreach, Native Family Nights, and Leadership. We additionally added more cultural activities for students that raised resiliency factors.

Talking Circles were delayed due to School issues that could not be predicted: changes of Principals, and just in general the difficulty schools have integrating programs and logistics the first 6 weeks of school. We began in the second quarter and for the rest of the year, we delivered services to a much larger group of students in the schools than last year. We served students at Herbert Green, Indian

Creek, Blue Oak and Camerado. The total number of unique students we served with our talking circles was 62. We anticipate even more this next year, through the outreach efforts this year, and as we attempt to add a high school, and talking circles at Foothill Indian Education for high school students.

Crisis efforts increased, due to more outreach with various agencies, school referrals, referrals from more agencies, and prior clients' recommendations of our services. A major accomplishment was that through outreach with Probation, Native kids in Juvenile Hall in South Lake Tahoe are now allowed to be visited and supported through our Crisis/Support model. Native kids leaving Juvenile Hall in Placerville needing more support are also now able to access our services, through referrals and collaboration with Probation. Our next goal is for referrals for adult Natives on parole. We plan on providing possible talking circles and cultural experiences to prevent recidivism. This resource will assist with a variety of social services and support, including homeless help, school clothes and supplies assistance and more.

This is the fourth year that we have been using some parts of the new, but well studied concepts of "Photovoice". Photovoice is an educational action research tool that embraces visual communication through photography. Because many of our Native populations have a form of anxiety which may lead to excessive shyness, communication problems, and social phobias, we thought youth would be able to use photos as a way to express themselves, speak in public, and to have group interactions. During our leadership campout, we provided each youth with a digital camera to use throughout the trip. The photovoice process begins with the participating youth photographing relevant objects, items, or activities around them. Once the photographs are saved, each participant chooses a group of pictures to share. The youth will be invited to and expected to attend a series of scheduled meetings with the Wennem Wadati adult cultural specialists to prepare dialog about the photos. During a Family Activity Night, each participating youth will present their photos with a designated theme. The youth will then present a single photo that has relevance to their lives. This photo project allows participants to practice public speaking, appropriate self-disclosure, and use of creativity.

What we have recognized this year was that whatever point of entry a client participates with us leads to years of continued involvement in our programs and the local Native community. We have students who started in talking circles in K-1, and are still with us in high school. Many students continue to request that we offer talking circles at the next school they will attend.

Another accomplishment has been the development and implementation of an "Activity Evaluation" form, which has given us great feedback from participants, and ideas for possible changes.

A challenge that continues is using the Native Casey Life Skills Assessment for outcome measures on Talking Circle students. It is too long and complicated for all of the new younger students we added this year. It takes several full Talking Circles to complete these at both the start and end of each year. Despite lessening their Casey Life Skills Assessment to 2 pages rather than 4, it is still unmanageable, and we will be looking for an alternative in next year. We have no data analysis spreadsheet set up to maintain and/or capture the data, nor any member of our organization able to create such a document. So data results have to be hand counted for every question, for every student, for every school, then percents calculated from that. It is too time consuming as we reach larger and larger populations.

Another challenge is that most kids do not know their insurance, so that is difficult to complete on the Quarterly Reports.

2) **Briefly report on how the Wennem Wadati: A Native Path to Healing project has improved the overall mental health of the children, families, and communities by addressing the primary negative outcomes that are the focus of the Wennem Wadati: A Native Path to Healing project (suicide, incarcerations, prolonged suffering,**

homelessness, unemployment, school failure or dropout, and removal of children of their homes).

The aim of the Wennem Wadati program is to support and enhance the health and wellbeing of Native youth and families by improving school environment, increasing cultural opportunities, and increasing access to culturally appropriate services because research shows that being connected to ones culture and culturally specific wellness programs can have a positive impact on academic performances, educational outcomes and reducing high-risk behaviors.

Wennem Wadati was able to meet and exceed all of our goals through continuing established services. The negative outcomes we targeted, suicide, homelessness, unemployment, school failure or drop out and removal of children from their homes, are outcomes Native youth and Families historically and currently face at larger percents than non-Native populations.

Wennem Wadati has improved the overall Mental Health of our clients through serving more clients, referring more clients to other resources, both Native and non-Native, after gaining trust, and by increasing outreach efforts that resulted in additional referrals to us. We also improved our ability to engage clients for longer periods of time in our many programs, increasing their well-being. We also made efforts to add additional prevention work with teens. By adding confidence building, there was an increased ability of students to identify & express issues that were concerning them in both group and private conversations with adults.

3) **Provide a brief narrative description of progress in providing services through the Wennem Wadati: A Native Path to Healing project to unserved and underserved populations.**

By increasing collaborations with local tribal groups, Probation, New Morning, the schools, Food Give-Away at Foothill Indian Education, Victim Witness and Tribal TANF, we have engaged more previously underserved or underserved populations.

4) **Provide a brief narrative description of how the Wennem Wadati: A Native Path to Healing services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

As mentioned in other parts of this report, Wennem Wadati was designed to provide culturally specific services to Native youth and families. All the services, programs and activities have included Native American cultural competency. Talking circles are held in a traditional way, family activities involve Native American crafts/art, and Native American value systems are used. Our cultural Talking Circles participation continue to increase in size at the schools, compared to last year. Crisis referrals came in steadily. Outreach efforts for our population were well received, so more schools and agencies were supporting Native Cultural approaches, decreasing racial/ethnic disparities.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkage to medically necessary care, stigma reduction and discrimination reduction.**

This year, efforts were made to directly target outreach efforts to agencies beyond the school-based Principals and non-Native agencies. This was done to increase awareness of our culturally based programs, increase education of how and why our programs are successful, and increase referrals to our programs to improve outcomes for our population. This has resulted in a reduction of discrimination. By servicing a larger population each year, stigma towards mental health prevention and intervention through our Crisis/Support program has been reduced.

6) **Provide the outcome measures of the services provided and customer satisfaction surveys. Outcome measures for the Wennem Wadati: A Native Path to Healing project are:**
   - **Measurement 1: Casey Life Skills Native American Assessment, to be given when a student joins the Talking Circles and when they end their participation.**
   - **Measurement 2: Quarterly client registration which includes client demographic data as well as specific client issues to be address.**
   - **Measurement 3: Year-end annual report which will include a summary analysis of the Casey Life Skills Assessment, program accomplishments, community collaboration activities, program activities offered, and program outcome measures.**

See information in item 1, above.

7) **Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.**

Foothill Indian Education Alliance provided a meeting location for all Native family and youth programs and activities, as well as Foothill Indian Education Alliance staff time to advertise Wennem Wadati program activities, take phone calls, copy program forms and flyers, use Foothill Indian Education Alliance office and cultural supplies and materials, and use of Foothill Indian Education Alliance kitchen for family, community, and youth activities. Shingle Springs Behavioral Health Program provided fast track access to Tribal Health Clinic providers for our crisis clients. Title VII Indian Education Parent Committee and Foothill Indian Education Alliance's Board of Directors provide volunteer assistance at community activities and gatherings.

8) **Provide any additional relevant information.**

This year, several Native agencies joined us during our Wennem Wadati activities to see how we operate, so they can replicate what they've learned in their own programs. These agencies made several visits throughout the year.

Our ability to leverage resources from other agencies has increased the longer we do this project. Due to more collaboration & outreach, we have been able to better serve our population.

9) **Please provide the data and summary analysis from the Casey Life Skills survey for this time period.**

See information in item 1, above.

MHSA Recommendation: Continue this project in the FY 2018-19 MHSA Plan Update.

Early Intervention Programs

Children 0-5 and Their Families

Provider: Infant Parent Center

Project Goals

- Increased number of families within the target population who are accessing prevention/wellness/intervention services
- Strengthened pipeline among area agencies to facilitate appropriate and seamless referrals between agencies in El Dorado County
- Increased awareness of services available among families, health care providers, educators and others who may have access to target population
- Emotional and physical stabilization of at-risk families (increasing trust)
- Improved infant/child wellness (physical and mental health)
- Improved coping/parenting abilities for young parents
- Increase awareness and education of Domestic Violence and how it impacts families and young children
- Enhancement of programs serving children 0-5
- Decreased number of children removed from the home
- Decreased incidence of prolonged suffering of children/families
- Child abuse prevention
- Suicide prevention
- Increased cooperation and referrals between agencies
- Reduced stigma of mental health/counseling interventions among target population
- Improved trust of services as evidenced by an increase in self-referral by target group families
- Decreased cost of 5150 and hospitalizations by providing services in outpatient setting

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget Rollover balance from FY 2013-14	$125,000 +$117,500	$125,000	$175,000
Total Expenditures	$229,475	$125,000	$174,888
Unduplicated Individuals Served	189	91	150
Cost per Participant	$1,214	$1,374	$1,166

Higher expenditures and a higher number of individuals served in FY 14/15 were the result of available roll-over funding from FY 13/14.

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	93	49	81
16-25 (transitional age youth)	12	1	10
26-59 (adult)	29	41	59
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	55	0	0

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	2	1	4
Asian	0	0	0
Black or African American	2	6	7
Native Hawaiian or Other Pacific Islander	0	0	0
White	125	70	103
Other	2	1	11
Multiracial	16	2	16
Unknown or declined to state	15	2	9

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino			
Caribbean	--	--	3
Central American	--	--	4
Mexican/Mexican-American/Chicano	--	--	21
Other	--	--	5
Unknown or declined to state	27	9	0
Non-Hispanic or Non-Latino			
African	--	--	24
Asian Indian / South Asian	--	--	1
Eastern European	--	--	2
European	--	--	47
Other	--	--	21
Unknown or declined to state	--	--	22

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	162	87	139
Spanish	18	4	10
Other Language	0	0	0
Bilingual	9	0	0
Unknown or declined to state	0	0	1

Sexual Orientation	FY 14/15	FY 15/16	FY 16/17
Heterosexual or Straight	--	--	64
Bisexual	--	--	3
Unknown or declined to state	--	--	83

Gender	FY 14/15	FY 15/16	FY 16/17
Assigned sex at birth:	--	--	
Male	--	--	60
Female	--	--	84
Unknown or declined to state	--	--	4
Current gender identity:	--	--	
Male	67	37	58
Female	122	54	85
Unknown or declined to state	--	--	7

Disability	FY 14/15	FY 15/16	FY 16/17
Yes	--	--	
Communication Domain	--	--	
Difficulty seeing	--	--	0
Difficulty hearing, or having speech understood	--	--	0
Other (specify)	--	--	0
Mental domain not including a mental illness	--	--	12
Physical/mobility domain	--	--	0
Chronic health condition	--	--	3
Other (specify)	--	--	3
No	--	--	126
Unknown or declined to state	--	--	6

Veteran Status	FY 14/15	FY 15/16	FY 16/17
Yes	--	--	1
No	--	--	143
Unknown or declined to state	--	--	6

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	49	16	34
Placerville Area	92	48	74
North County	7	6	9
Mid County	23	15	15
South County	4	1	2
Tahoe Basin	0	0	10
Unknown or declined to state	14	5	6

Year End Report

1) **Briefly report on how implementation of the Children 0-5 and Their Families project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

MHSA funding continues to be instrumental to Infant Parent Center's ability to provide specialized services to families with young children in El Dorado County. Many of these children have endured severe trauma including: ongoing domestic violence, addiction, family conflict, child abuse and parents with severe and chronic mental illness. We are grateful for this funding and the opportunity to continue to serve these families in our community.

Major Accomplishments

Perinatal Mood and Anxiety Disorder (PMAD) - Infant Parent Center continues to raise awareness about PMAD, a condition affecting an estimated 25-30% of new mothers across all socio-economic and racial backgrounds. One of our accomplishments this past year was the production and distribution of a 9-minute video. This brief, accessible Mariposa Program video, which can be viewed on YouTube (https://www.youtube.com/watch?v=X6agAtpDaaw), features several women discussing their own experience with PMAD. The messaging in tandem with their stories is the urgency for self-care and family/professional support. This video, which had over 155 views in less than two weeks, can be viewed on any device, anywhere, which makes it a powerful tool when empowering a new mother to seek help. The video and our other efforts at outreach and education, which was additionally distributed to all MHSA clients and community providers, has led to an increase in PMAD referrals.

Infant Parent Center Services in South Lake Tahoe - Due to an increase in requests from community partners and a clear need for services in the Lake Tahoe area, Infant Parent Center launched a six-month pilot program to assess the feasibility of serving young families in the area on a more permanent basis. Within this trial period, Infant Parent Center was able to annex some treatment space from a small South Lake Tahoe agency. Infant Parent Center staff created new collaborations with area providers and agencies and filled the caseload of our Tahoe-based social worker. A few of these families have already achieved treatment completion. Our work in the area and client success prompted Infant Parent Center to secure a more permanent location effective July, 2017 and to hire another therapist to build our capacity to provide direct services to families in-need in the area.

Challenges

We continue to be challenged by a low follow-through (engagement) rate for women experiencing high-risk pregnancies. This has been especially true for patients referred by Marshall Hospital OB/GYN departments. There have been a number of cases where women initially referred during their pregnancy or postpartum period (who did not follow-through) were later referred to Infant Parent Center by Child Welfare Services (often with their infant/other children placed in foster care.)

We are addressing this challenge by continuing our collaboration and discussions with Marshall Medical staff, Public Health, Early Head Start, and Child Welfare Services in an effort to understand and address the possible barriers with initial engagement. Through continued problem solving with our partners we hope to develop new strategies to successfully engage families during pregnancy to help reduce trauma and harm to mothers, babies and families and prevent placement of babies in the foster care system.

We will also continue to utilize our perinatal video as one solution to this challenge in hopes that families will seek services sooner. This new permanent resource is designed to reduce shame and stigma associated with Perinatal Mood and Anxiety Disorders.

2) **Briefly report on how the Children 0-5 and Their Families project has improved the overall mental health of the children, families, and communities by addressing the primary negative outcomes that are the focus of the Children 0-5 and Their Families project (suicide, prolonged suffering, school failure or dropout, and removal of children from their homes). Please include other impacts, if any, resulting from the Children 0-5 and Their Families project on the other three negative outcomes addressed by PEI activities: (1) incarceration; (2) unemployment; and (3) homelessness.**

Infant Parent Center works with many families facing severe trauma and suffering. Loss of homes, poverty and separation of family members are intense negative impacts on families. These factors can keep families isolated, fearful and without effective interventions and support. The next generation often continues these harmful patterns of abuse, neglect and community harm. The Infant Parent Center provides the essential interventions to provide these families the opportunity to heal, grow and find new healthy paths for success and sustainable family wellness. Infant Parent Center IPC is grateful to be a part of these families' journeys.

Specific to the PEI Project areas of focus, Infant Parent Center reports the following:

Suicide: Seven families were served. Of these seven families, one pregnant mother was involuntarily held in a psychiatric institution; however, with effective services, the mother was able to achieve supportive housing, essential psychiatric support, therapy and the needed residential staff to assure medications were taken properly as well as consistent daily support to keep mother and baby safe.

Prolonged Suffering: Infant Parent Center continues to serve families with children already in the foster care system as a result of abuse or neglect. When children are removed from their homes, parents lose financial resources as well. The combination having their children removed from their home and increased financial stress often creates more harmful choices (addiction, trafficking, loss of housing, loss of transportation, etc.). Because all foster care cases are under Reunification, it is critical to have parents with some stabilization in order to maintain caring for their children after they return home.

Risk of Removal of Children from Home: 48 children were at risk of being removed from their primary caregivers. Per our communication with collaborative partners and to the best of our knowledge, none of those children have been removed from their homes. Infant Parent Center provided not only direct services, but also linkage and referrals to additional professional and permanent community resources to help families stay together and relieve the stressors and harm that cause these risks.

Incarceration to Mainstream: 16 families were served. Infant Parent Center staff supported a decrease of incarceration for many families who needed to address alcohol or drug issues by supporting recovery work and linking them to recovery and other services.

Homelessness/Unemployment: 67 families were served. Infant Parent Center provided direct services to families in homeless shelters and in transient housing. All Infant Parent Center offices are located on bus routes for easy access and therapists also provided home visits when appropriate. Infant Parent Center also linked families to various local housing organizations (such as Hope House, Mother Teresa's, HELP, etc.), CalWORKs, the Food Bank, and other basic needs resources. Infant Parent Center provided direct services to women and their children sheltering at Hope House, Mother

Teresa Homeless Shelter, and HELP. When appropriate, Infant Parent Center provides linkage to CalWORKs, Job One, etc.

School Dropout/Failure: Infant Parent Center provides reflective coaching to 10 home visitation Early Head Start teachers for the EL Dorado County Office of Education. Training and working with teachers individually every week provides teachers an opportunity process and better serve their families. By extension, a minimum of 122 additional families were served through this service. Reflective Coaching serves MHSA families through leveraged funds.

3) Provide a brief narrative description of progress in providing services through the Children 0-5 and Their Families project to unserved and underserved populations.

Infant Parent Center continues to serve isolated and transient communities and families. An array of services in Spanish is offered to monolingual Spanish speaking families in addition to home visitation for clients on the Western Slope. Continued collaboration with homeless shelters, recovery centers, home visiting programs and other programs serving at-risk families allows us not only opportunities to connect but be a part of families moving from high-risk challenges to greater resiliency and wellness. Many of these families have no transportation and live in isolated areas with little or no support systems.

4) Provide a brief narrative description of how the Children 0-5 and Their Families services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.

Infant Parent Center strives to treat all families from a place of humility in a culturally competent and sensitive way. This means we tailor our treatment plans to the unique needs of each family, engaging them in the treatment and solutions. We have to learn about culture by asking families what that means for them. We don't make assumptions, judgments or expectations. In an effort to become more competent when working with families we recently participated in a providers introduction to Substance Abuse treatment for Lesbian, Gay, Bisexual, and Transgender Individuals in collaboration with Mental Health to further learn and practice with greater sensitivity and awareness.

5) Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.

Infant Parent Center places a great importance on community collaboration and outreach. Successful linkage to permanent resources increases resilience and autonomy for the families we serve. In addition, our effective relationships with providers allow for clear communication and continuity of services. This connected community approach naturally reduces stigma and discrimination as we are all inclusive and working together.

6) Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Children 0-5 and Their Families project are:

- **Measurement 1: Clinical assessment and progress will include, but are not limited to, Parent Stress Index, Beck's Depression Beck's Depression and Anxiety Scale, Post-Partum Depression Scale, Ages and Stages, and Marshak Interaction Method.**

- **Measurement 2: Client satisfaction questionnaires, other provider questionnaires.**
- **Measurement 3: Tracking of referrals and engagement.**
- **Measurement 4: Decreased incidents of shaken baby syndrome.**
- **Measurement 5: Reduction of hospital emergency department visits.**

Measurement 1:

150 families served
133 families engaged in services
96 families achieved treatment success in at least two areas of concern

The initial response to the Infant Parent Center developed Mariposa Program video has been very encouraging. So far, we have tracked more than 155 views. The video has also been shared digitally and hard copies have been distributed to Public Health, Early Head Start, Mother Teresa's Homeless Shelter, Hope House Shelter, Marshall Hospital OB/GYN doctors and staff, Marshall Hospital Lactation Department, Birthing Center and First 5. These providers have stated the Mariposa Program video is a great permanent resource to reduce the stigma of Post-Partum Depression and provide normalization and opportunities to reaching out for help.

Marschak Interaction Method (MIM): Infant Parent Center conducted 51 MIM assessments during this period. Clients/caregivers displayed progress in one or more of the following areas:

- Increase in social-emotional development
- Decrease in trauma symptoms as evidenced by trust, reciprocity and engagement
- Increased ability to nurture, set appropriate boundaries and emotional safety
- Increased attunement with infant/child needs, cues and development
- Increase in caregivers reflective capacity

Prenatal Assessment: Infant Parent Center administered 11 prenatal assessments during this period with client displaying progress in one or more of the following:

- Identify perinatal mood and anxiety disorders
- Increase protective factors
- Strengthen relationship with baby in utero
- Process ambivalence, grief and loss
- Linking family to resources that can minimize risk factors and increase competency

Evidence Based Parent Education: 43 caregivers successfully completed our evidence-based parenting program specifically designed for children 0-5 years of age. Please note that when Parent Support and Education are the sole services, clinical assessments are not administered.

Parent Stress Index (PSI): 25 PSI assessments were administered. Infant Parent Center provided 32 additional clinical assessments that helped determined risk factors, treatment plans and interventions that would best serve the family system. Of the written assessments, Infant Parent Center finds the PSI to be an essential clinical tool to assess potential risk factors in child abuse, parent-child relational challenges, and parent's perception of their child's behaviors.

Measurement 2:

Client Survey Data – Infant Parent Center received 25 client satisfaction survey responses. We have a very high rate of engagement and completion of services. Families continue to identify Infant Parent Center as an important resource in the community.

Responses as of 7/28/2017

		Response %	Count
1	**How would you rate the quality of service you received?**		
	4 Excellent	100.0%	25
	3 Good	0.0%	0
	2 Fair	0.0%	0
	1 Poor	0.0%	0
2	**Did you get the kind of service you wanted?**		
	1 No, definitely not	0.0%	0
	2 No, I don't think so	0.0%	0
	3 Yes, generally	4.0%	1
	4 Yes, definitely	96.0%	24
3	**To what extent has our program met your needs?**		
	4 Almost off of my needs have been met	72.0%	18
	3 Most of my needs have been met	28.0%	7
	2 Only a few of my needs have been met	0.0%	0
	1 None of my needs have been met	0.0%	0
4	**If a friend were in need of similar help, would you recommend our**		
	1 No, definitely not	4.0%	1
	2 No, I don't think so	0.0%	0
	3 Yes, I think so	4.0%	1
	4 Yes, definitely	92.0%	23
5	**How satisfied are you with the amount of help you received?**		
	1 Quite dissatisfied	0.0%	0
	2 Indifferent or mildly dissatisfied	0.0%	0
	3 Mostly satisfied	4.0%	1
	4 Very satisfied	96.0%	24
6	**Have the services you received helped you to deal more effectively**		
	4 Yes, they helped a great deal	88.0%	22
	3 Yes, they helped somewhat	12.0%	3
	2 No, they really didn't help	0.0%	0
	1 No, they seemed to make things worse	0.0%	0
7	**In an overall general sense, how satisfied are you with the service**		
	4 Very satisfied	100.0%	24
	3 Mostly satisfied	0.0%	0
	2 Indifferent or mildly dissatisfied	0.0%	0
	1 Quite dissatisfied	0.0%	0
8	**If you were to seek help again, would you come back to our**		
	1 No, definitely not	0.0%	0
	2 No, I don't think so	0.0%	0
	3 Yes, I think so	4.0%	1

4 Yes, definitely	96.0%	24

Collaborative Partners Survey - Infant Parent Center received 8 partner surveys from Marshall Hospital, Public Health, Child Protective Services, Office of Education, Community Health and El Dorado County Library.

Responses as of 7/28/2017

** Note: Question 1 is Provider Identification*

	Response %	Count
2. How likely are you to recommend our agency to families or individuals in the future?		
1 - Definitely Not	0.0%	0
2 - Not Likely	0.0%	0
3 - Sort Of	0.0%	0
4 - Likely	0.0%	0
5 - Very Likely	100.0%	15
3. Did the Infant Parent Center respond within 24-48 hours of your referral?		
1 - Definitely Not	0.0%	0
2 - No	0.0%	0
3 - Sort Of	0.0%	0
4 - Yes	33.3%	5
5 - Absolutely	66.7%	10
4. Have you heard positive feedback from families with regard to services they received from IPC?		
1 - Definitely Not	0.0%	0
2 - No	6.7%	1
3 - Sort Of	0.0%	0
4 - Yes	26.7%	4
5 - Absolutely	66.7%	10
5. Did IPC services meet your client's needs?		
1 - Definitely Not	0.0%	0
2 - No	0.0%	0
3 - Sort Of	0.0%	0
4 - Yes	28.6%	4
5 - Absolutely	71.4%	10
6. How important are IPC services for the community?		
Extremely important	93.3%	14
Important	6.7%	1
Somewhat	0.0%	0
Not important	0.0%	0

7. Do you believe that family wellness improves after services with IPC?

Yes	100.0%	14
No	0.0%	0

Measurement 3: 40 families were self referred or referred by a family or friend. This represents an increase from last year. New partner collaboration has also resulted with an increase in professional referrals. There has also been an increase in referrals and engagement via our Mariposa Program video and distribution.

Measurement 4: Another main objective for Infant Parent Center has been decreasing the probability of Shaken Baby Syndrome, now known as Abusive Head Trauma (AHT). 23 babies were in homes that indicated high potential of being shaken or more severely abused. Of those 23 cases, no reports were provided stating the babies had been abused. In all cases, Infant Parent Center collaborated with multiple agencies to shore up resources, support and needed services to help caregivers achieve stability.

International long-term research has identified colic and fussy babies as the main reason for AHT. Even high functioning families with significant resources struggle severely with these stressors. When combined with complicating factors such as addiction, prolonged suffering, severe mental illness, isolation, low to no resources and language barriers the risk for AHT increase significantly. Therefore, it is essential that effective preventative services such those provided by Infant Parent Center are made available to these at- risk families to protect the most vulnerable infants in El Dorado County.

Measurement 5: IPC served 1 pregnant mother who was hospitalized involuntarily due to suicidality. Effective crisis intervention and case management as well as linkage to primary care services minimized the potential of the other 7 parents identified and referred to IPC as suicidal.

MHSA Recommendation: Continue project at current funding level.

Early Intervention for Youth in Schools

Provider: Minds Moving Forward

Project Goals

- Increase school-based mental health services.
- Increase knowledge of community resources.
- Raise awareness around early identification of the signs and symptoms of mental illness.
- Reduce stigma and discrimination.
- Improve student wellness and mental health.
- Improve the family relationship.
- Improve school culture as it relates to minimizing activities that may be risk factors for mental illness and encouraging positive mental health.
- Reduce suicidal ideation, attempted suicides and completed suicides.

- Increase academic success, which may not mean higher grade point averages, but could be other successes such as higher rate of completion of homework, increased academic confidence or increased willingness to reach out for academic assistance.
- Increase school attendance rates for participants.
- Decrease referrals for behavior problems or other disciplinary actions for participants.
- Improve results from the California Healthy Kids survey, which would show a reduction in the number of students with feelings of hopelessness or suicidal thoughts.
- Reduce substance use (alcohol, prescription drugs, marijuana, other illicit and life endangering drugs) and/or self-medicating.

Numbers Served and Cost

Expenditures	FY 16/17
MHSA Budget Rollover balance from FY 2013-14	$150,000
Total Expenditures	$15,059
Unduplicated Individuals Served	N/A General Outreach performed
Cost per Participant	N/A General Outreach performed

The demographic information below represents the total number of students who attend a school where this program may operate (Oak Ridge High School, Ponderose High School, Camerado Middle School and Charter Career Prep). Any of these students may be impacted by current general outreach, and more targeted services to address the needs of these students and their families in the future.

Age Group	Total Attendance
0-15 (children/youth)	1,933
16-25 (transitional age youth)	3,213

Race	FY 16/17
American Indian or Alaska Native	37
Asian	305
Black or African American	54
Native Hawaiian or Other Pacific Islander	8
White	3681
Other	770
Multiracial	285
Unknown or declined to state	6

Ethnicity	FY 16/17
Hispanic or Latino	
Unknown or declined to state	687
Non-Hispanic or Non-Latino	
Filipino	79
Unknown or declined to state	4,380

Primary Language	FY 16/17
Unknown or declined to state	5,146

Sexual Orientation	FY 14/15
Unknown or declined to state	5,146

Gender	FY 16/17
Male	2,689
Female	2,457

Disability	FY 16/17
Unknown or declined to state	5,146

Veteran Status	FY 16/17
Unknown or declined to state	5,146

Region of Residence	FY 16/17
Unknown or declined to state	5,146

Year End Report

1) **Briefly report on how implementation of the Prevention and Early Intervention for Youth in Schools project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

The Prevention and Early Intervention for Youth in Schools (PEI-YIS) project commenced on October 6, 2016. At the time of its inception, Minds Moving Forward began outreach by notifying relevant school district administration and campus-based leadership at each school that their campuses were chosen for participation in the PEI-YIS project. The first two quarters of the PEI-YIS project (fiscal year 2016-2017 quarters two and three) focused on outreach and collaboration with school district administration and school personnel. Outreach encompassed the identification of needs specific to each campus population including their student needs, caregiver needs, and needs of school personnel.

Minds Moving Forward completed assessments of school-based mental health services presently available on each campus and collaborated with school personnel and school district staff on identification of site-based service gaps. Also assessed were the methods currently in practice at each campus for early identification of the signs and symptoms of mental illness; as were their corresponding interventions. Through collaborative efforts, gaps and needs pertaining to early identification and effective intervention were identified. Additionally, various student groups were identified for participation in the PEI-YIS project. Fiscal year quarters two and three also included establishment of operational structures for program administration.

After inception mid-fiscal year 2016-2017, the PEI-YIS project encountered some unexpected delays. For example, the schools identified for participation in the PEI-YIS project experienced twenty-two days of previously scheduled holiday breaks and 5 days of total devotion to final exams within the first 12 weeks of the project's inception. The PEI-YIS project also encountered temporary challenges with compensation for services. Additionally, one of the schools identified for participation in the PEI-YIS project determined their students, staff, and families would be best served by implementing PEI programing in the 2017-2018 school year rather than the 2016-2017 school year due to the number of projects and resources already under implementation during the 2016-2017 school year.

Despite these challenges, the PEI-YIS collaborative efforts were successful in identifying specific needs of students, caregivers, and school staff at each campus. Collaborative teams also effectively assessed relevant interventions previously implemented at each campus, the perceived success of these interventions per school personnel and student reports, and evidenced-based options for addressing present needs.

2) **Briefly report on how the Prevention and Early Intervention for Youth in Schools project has improved the overall mental health of the children, families, and communities by addressing the primary negative outcomes that are the focus of the Prevention and Early Intervention for Youth in Schools project (suicide, prolonged suffering, incarcerations, school failure or dropout, unemployment, homelessness, and removal of children from their homes).**

As the PEI-YIS project was implemented midway through fiscal year 2016-2017, statistics are not yet available to describe impact on negative outcomes that are the focus of the PEI-YIS project. However, the project has contributed to bridging the segregations between mental health services that are available and the people who need them by increasing awareness and accessibility among educators who are often the youth and families' first opportunity for advocacy.

3) **Provide a brief narrative description of progress in providing services through the Prevention and Early Intervention for Youth in Schools project to unserved and underserved populations.**

Through implementation of the PEI-YIS project, the Charter Career Prep campus presented with the greatest need for unserved and underserved populations. Minds Moving Forward implemented collaborations with a variety of community service and social welfare providers to target family wellness needs, socio-economic needs, and others that likewise indicate potential risk factors for mental illness among the populations at this campus.

4) **Provide a brief narrative description of how the Prevention and Early Intervention for Youth in Schools services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

Minds Moving Forward via the PEI-YIS project provides racially and ethnically diverse professionals on school campuses. Groups and classes are facilitated through a culturally competent framework. Likewise, trainings are facilitated in a manner that encourage school personnel to self-assess using culturally aware filters. Additionally, Minds Moving Forward collaborates with linguistically diverse community partners such as mental health counselors, medical providers, peer support groups, and

faith-based communities for service-based referrals and otherwise meeting the mental health needs of the PEI-YIS target populations.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

In addition to collaborative efforts with school district personnel and campus-based leadership teams, the PEI-YIS project has facilitated numerous collaborative meetings with medical providers, mental health providers and social welfare providers including those who offer sliding fee-scales, services free of charge, cash-pay services, and managed care services. These efforts are designed to increase the youth and families' accessibility to medically necessary care and to bridge the gap between office-based mental health professionals and the reality of campus-based needs.

6) **Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Prevention and Early Intervention for Youth in Schools project are:**

Measurement 1:	**Continued engagement of students and parents in this project, including rate of attendance/missed appointments.**
Measurement 2:	**Self-assessments measuring pre-, interim- and post-participation self-perceptions, and pre-, interim- and post-participation assessments completed by the referring party, as allowed by law, to measure the referring parties' perceptions of the students enrolled in this project. May also include parental assessments.**
Measurement 3:	**Truancy rates/absences of the students enrolled in this project.**
Measurement 4:	**The number of referrals for behavior problems or other disciplinary actions for the students enrolled in this project.**
Measurement 5:	**The number of school dropouts within the students enrolled in this project.**
Measurement 6:	**The number of incarcerations within the students enrolled in this project.**
Measurement 7:	**The number of attempted or completed suicides by students enrolled in this project.**
Measurement 8:	**School-wide surveys to determine the level of knowledge about mental illness, available resources and willingness to discuss mental health concerns.**
Measurement 9:	**The California Healthy Kids Surveys will measure the long-range outcomes at the schools where this project is implemented as it relates to feelings of hopelessness and suicidal thoughts. The outcomes of this measurement may not be available annually or during the pilot period of this project.**

As the PEI-YIS project was implemented midway through fiscal year 2016-2017, implementation largely encompassed outreach efforts; collaborations on identifying needs of students, caregivers, and school personnel; identifying students for participation; establishing procedures, forms and documentation necessary for project implementation; and identifying gaps in school-based mental health services. Likewise, youth and caregiver enrollment in the project was not applicable during this reporting period.

7) Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

No leveraged resources or in-kind donations were utilized.

Stigma and Discrimination Reduction Programs

Mental Health First Aid

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- Raise personal awareness about mental health, including increasing personal recognition of mental illness risk-factors.
- Community members use the knowledge gained in the training to assist those who may be having a mental health crisis until appropriate professional assistance is available. Opens dialogue regarding mental health, mental illness risk factors, resource referrals, and suicide prevention. Work towards stigma and discrimination reduction in our communities and networks.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$120,000	$100,000	$117,000
Total Expenditures	$42,691	$37,063	$43,242
Unduplicated Individuals Served	249	219	320
Cost per Participant	$171	$169	
Number of Classes	17	14	17
Youth	*4*	*2*	*6*
Adult	*12*	*12*	*11*
Veterans	*1*	*0*	*0*
Cost Per Class	$2,511	$2,647	$2,544

In December of 2016, two new trainers were certified to teach the Adult version of Mental Health First Aid and began teaching shortly thereafter.

FY 14/15 through FY 16/17 Outcome Measures

- Measurement 1: Class evaluation provided to attendees at the end of each session.
- Measurement 2: Evaluation survey provided to attendees six months after taking the class, including information regarding application of material learned.

The Mental Health First Aid website was re-designed and access to necessary data is not currently available.

PFLAG Community Education

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division

Project Goals

- Reduction of stigma and discrimination associated with being lesbian, gay, bisexual, transgender or questioning.
- Education, in the form of presentations/discussions, to the general public regarding sexual orientation.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$5,000	$5,000	$5,000
Total Expenditures	$0	$0	$0

FY 14/15 through FY 16/17 Outcome Measures

Measurement 1: Number of informing material distributed.
Measurement 2: Number of people reached through presentations.

No materials were purchased and no presentation were provided.

Statewide PEI Projects

Provider: CalMHSA

Project Goals

- Reduce the stigma and discrimination associated with mental illness, prevent suicide, and improve student mental health.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$0	$9,471	$9,471
Total Expenditures	$0	$9,471	$9,471

The State contracts with CalMHSA for administration of this program. The FY 2016-17 Reach and Impact in El Dorado County report from CalMHSA states:

> *The Statewide PEI Project: Achieving More Together*
> In Fiscal Year 2016-2017, 41 counties collectively pooled local Prevention and Early Intervention (PEI) funds through the California Mental Health Services Authority (CalMHSA) to support the ongoing implementation of the Statewide PEI Project. The Statewide PEI Project is publicly known as *Each Mind Matters: California's Mental Health Movement*, which represents an umbrella name and vision to amplify individual efforts from the county and other organizations that are taking place across California under a united movement to reduce stigma and discrimination and prevent suicides.

Outcomes to Date

Since counties began pooling funds through CalMHSA to implement the Statewide PEI Project in 2011, the following short-term outcomes have been achieved. Given the outcomes so far, independent evaluators of the Statewide PEI Project, the RAND Corporation, have identified the following outcomes from the Statewide PEI Project:

- 15.4% more Californians exposed to Each Mind Matters turn to help for mental health challenges.
- Over 50% of Californians were exposed to Know the Signs.
- Individuals exposed to the Know the Signs campaign report higher level of confidence to intervene with someone at risk for suicide.[2]
- The Know the Signs campaign was rated by experts to be aligned with best practices and be one of the best media campaigns on the subject.[3]
- Students exposed to the Walk in Our Shoes website demonstrate significantly higher knowledge of mental health.[4]
- 63% of teachers and administrators who saw the Walk in Our Shoes performance started a conversation about mental health in the classroom.[5]
- 87% of students have a better understanding of mental illness and suicide after participating in Directing Change.[6]
- 97% of students who participated in Directing Change pledged to support a friend with a mental health challenge.[7]
- 87% of those who completed the Kognito training report that they are better prepared to identify, approach and refer students exhibiting signs of psychological distress.[8]
- 66% of California Community College faculty who completed Kognito training report an increase in the number of conversations they had with other faculty and staff about students that they were concerned about.[9]

Outreach for Increasing Recognition of Early Signs of Mental Illness Programs

Community Education and Parenting Classes

Parenting Skills

Provider: New Morning Youth and Family Services

[2] https://www.rand.org/pubs/research_reports/RR1134.html
[3] https://www.rand.org/pubs/research_reports/RR818.html
[4] http://walkinourshoes.org/content/NORCReportonWIOSWebsite.pdf
[5] http://walkinourshoes.org/content/NORCReportonWIOSWebsite.pdf
[6] http://www.directingchangeca.org/wp-content/uploads/CalMHSA%20DC%20Eval%20Report.pdf
[7] http://www.directingchangeca.org/wp-content/uploads/CalMHSA%20DC%20Eval%20Report.pdf
[8] https://www.rand.org/pubs/research_reports/RR954.html
[9] https://www.rand.org/pubs/research_reports/RR954.html

Project Goals

- Increase positive and nurturing parents
- Increase child positive behaviors, social competence, and school readiness skills
- Increase parent bonding and involvement with teachers/school
- Decrease harsh, coercive and negative parenting
- Increase family stability
- Increase emotional and social capabilities
- Reduce behavioral and emotional problems in children

New Morning Youth and Family Services failed to provide the required year-end reports. The contract with New Morning Youth and Family Services is being reviewed for compliance concerns and actions to be taken when a contractor does not comply with required elements of the contract.

In the event a new provider must be identified for the West Slope, a procurement process in compliance with the County Procurement Policy will be performed.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$50,000	$50,000	$50,000
Total Expenditures	$35,094	$50,000	$50,000
Unduplicated Individuals Served	42	52	unknown
Cost per Participant	$836	$962	unknown

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	0	2	unknown
16-25 (transitional age youth)	2	6	unknown
26-59 (adult)	38	33	unknown
Ages 60+ (older adults)	2	6	unknown
Unknown or declined to state	0	5	unknown

Gender	FY 14/15	FY 15/16	FY 16/17
Female	35	41	unknown
Male	7	11	unknown

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	4	10	unknown
Placerville Area	5	16	unknown
North County	9	2	unknown
Mid County	15	15	unknown
South County	3	1	unknown
Tahoe Basin	6	8	unknown
Unknown or declined to state	0	0	unknown

Race / Ethnicity	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	0	2	unknown
Asian	0	0	unknown
Black or African American	0	1	unknown
Caucasian or White	16	38	unknown
Hispanic or Latino	23	9	unknown
Native Hawaiian or Other Pacific Islander	0	0	unknown
Multiracial	2	2	unknown
Other Race or Ethnicity	1	0	unknown
Unknown or declined to state	0	0	unknown

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	25	45	unknown
Spanish	17	7	unknown
Other Language	0	0	unknown
Unknown or declined to state	0	0	unknown

Year End Report

Not submitted by contractor.

MHSA Recommendation: Review contract for compliance concerns; provide technical assistance; and consider alternate provider.

The Nurtured Heart Approach

Provider: Summitview Child and Family Services

Project Goals

- Improvement in the caregiver-child relationship
- Reduction in problematic behaviors at home, in school, and in the community
- Reduction in dollars spent on mental health services, special education, and criminal justice involvement

Numbers Served and Cost[10]

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget Rollover Funding	--	$19,500	$19,500 + $6,741
Total Expenditures	--	$12,759	$22,626
Unduplicated Individuals Served	--	84	125
Cost per Participant	--	$152	$181

[10] Contract began in January of FY 15/16.

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	--	0	0
16-25 (transitional age youth)	--	1	0
26-59 (adult)	--	82	0
Ages 60+ (older adults)	--	1	0
Unknown or declined to state	--	0	125

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	--	2	0
Asian	--	3	0
Black or African American	--	0	1
Native Hawaiian or Other Pacific Islander	--	3	2
White	--	70	75
Other	--	2	0
Multiracial	--	3	3
Unknown or declined to state	--	0	44

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino			
Unknown or declined to state	--	4	13
Non-Hispanic or Non-Latino			
Unknown or declined to state	--	--	0
More than one ethnicity	--	--	0
Unknown or declined to state	--	--	112

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	--	83	0
Spanish	--	0	0
Other Language	--	1	0
Unknown or declined to state	--	0	125

Sexual Orientation	FY 14/15	FY 15/16	FY 16/17
Unknown or declined to state	--	--	125

Gender	FY 14/15	FY 15/16	FY 16/17
Assigned sex at birth:	--	--	
Male	--	--	0
Female	--	--	0
Unknown or declined to state	--	--	125
Current gender identity:	--	--	
Male	--	10	0
Female	--	28	0
Unknown or declined to state	--	46	125

Disability	FY 14/15	FY 15/16	FY 16/17
Unknown or declined to state	--	--	125

Veteran Status	FY 14/15	FY 15/16	FY 16/17
Yes	--	--	0
No	--	--	0
Unknown or declined to state	--	--	125

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	--	29	0
Placerville Area	--	20	0
North County	--	5	0
Mid County	--	11	0
South County	--	6	0
Tahoe Basin	--	1	0
Unknown or declined to state	--	12	125

Year End Report

1) **Briefly report on how implementation of The Nurtured Heart Approach project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

Nurtured Heart Approach (NHA) day-long trainings were provided in 2016 on August 26 and November 12 and in 2017 on February 10, April 22, and May 19. All trainings took place in Placerville except the April 22, 2017 training that was offered in South Lake Tahoe.

There were approximately 125 total attendees at the five NHA trainings. The number is approximate since not all attendees were willing to complete the demographics sheet. Ninety-eight attendees provided demographic information.

NHA trainings have been enthusiastically received: 99% of participants responded "Yes" to the question on the presentation evaluation form "Would you recommend the Nurtured Heart Approach to family or colleagues?"

All those who attend the one-day training are offered 6 half-hour follow-up phone coaching sessions to support their use of NHA. Many participants sign up for follow-up coaching but it has been a smaller percentage who follow through with the calls. Those who do respond to emails offering to set up phone coaching commonly participate in one to two coaching sessions while a small minority use four to six sessions. During the fiscal year, a total of 78 phone coaching sessions occurred.

2) **Briefly report on how The Nurtured Heart Approach project has improved the overall mental health of the children, families, and communities by addressing the two primary negative outcomes that are the focus of The Nurtured Heart Approach project: (1) school failure or dropout and (2) removal of children from their homes. Please include other impacts, if any, resulting from The Nurtured Heart Approach**

project on the other five negative outcomes addressed by PEI activities: (1) suicide; (2) incarceration; (3) unemployment; (4) prolonged suffering; and (5) homelessness.

Not addressed.

3) Provide a brief narrative description of progress in providing The Nurtured Heart Approach project services to unserved and underserved populations.

There has been some success in reaching underserved populations in terms of socioeconomic status. Nineteen percent of attendees who provided demographic information indicated that they are in low to extremely low income brackets. Health insurance status also suggested that we are reaching people who are economically disadvantaged; 32% of respondents indicated that they either have Medi-Cal or no health insurance.

The demographics of training recipients closely mirrors the population of El Dorado County (as estimated by the US Census Bureau for El Dorado County as of 2016).

4) Provide a brief narrative description of how The Nurtured Heart Approach project services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.

The presenter Jennifer Lotery, Ph.D. (who is also the provider of follow-up Nurtured Heart Approach coaching sessions) is a Clinical Psychologist who was trained at UCLA, where she received specialty training in the areas of developmental and community psychology. (Community psychology training is focused on providing psychological tools and support in a culturally sensitive manner and empowering community members to be agents of positive change in improving mental health and the functioning of their families and communities.) The presenter has worked with El Dorado County residents from various ethnic groups and socioeconomic backgrounds for thirty years.

The Nurtured Heart Approach materials and the examples which are given during the training are designed to be applicable to a variety of cultures and backgrounds. The videos shown of the approach in action feature people of various races and ethnicities.

The follow-up phone coaching sessions provide the opportunity to individualize feedback and suggestions in a manner sensitive to the participant's cultural background.

5) Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access I linkages to medically necessary care, stigma reduction and discrimination reduction.

The availability of Nurtured Heart Approach trainings was communicated to a variety of agencies and organizations throughout El Dorado County including mental health agencies, the head of Foster and Kinship Education, and educators who can share the information with students' parents.

A several hour Nurtured Heart Approach presentation was made to the local juvenile court judge, CASA workers, and others involved in juvenile justice in El Dorado County.

There has been outreach to the El Dorado Community Health Center staff so that they can publicize the trainings to the families they treat.

Data provided by participants in terms of how they heard about the Nurtured Heart Approach training breaks down as follows:

Therapist or mental health agency	39%
School personnel or school district	13%
Saw a flyer posted	13%
"Word of mouth"	13%
Juvenile judicial system	9%
Foster/Kinship Education or foster care agency	4%
Children's Protective Services	2.5%
Alta Regional Center	2.5%
Other (Health and Human Services, Kaiser, church)	4%

6) Provide outcomes measures of the services provided. Outcome measures for The Nurtured Heart Approach project are:

- **Measurement 1: Pre- and post-Conners Comprehensive Behavior Rating Scales (CBRS) assessments**
- **Measurement 2: Participant surveys**

Measurement 1: Multiple attempts were made to have participants complete pre- and post-training Conners Comprehensive Behavior Rating Scales. The response rate was minimal and too low to provide meaningful data. An attempt was made to locate a different measurement tool for the next fiscal year as this one seems to be too extensive to produce adequate cooperation in terms of completion rates.

Measurement 2:

- Participants rated the presentation materials on a scale of 1 to 10. The average score was 9.26.
- Participants rated the presenter's delivery on a scale of 1 to 10. The average score was 9.28.
- Participants were asked to circle Yes or No regarding whether the presentation met or exceeded their expectations and 95% of respondents circled Yes.
- Participants were asked to circle Yes or No regarding whether they would recommend the Nurtured Heart Approach to family or colleagues and 99% circled Yes.

7) Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.

There were no leveraged resources or in-kind contributions.

8) Provide any additional relevant information.

None.

MHSA Recommendation: Continue project. Provide technical assistance on reporting.

Community Information Access

Measuring the use of this site was not possible by the MHSA Team. However, it was determined through the community planning process that the site was not utilized by the public. This project was discontinued in the FY 2017-18 Plan and the funds re-allocated to other PEI projects. No data is available for this project.

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$12,000	$16,000	$16,000
Total Expenditures	$7,770	$10,166	$10,166

Mentoring for Youth

Provider: Big Brothers Big Sisters of El Dorado County

Project Goals

- Determine if child or family has organically or environmentally induced mental illness concerns and develop a case plan for the child.
- Conduct parent workshops.
- Through skill building activities, mentors will develop coping mechanisms with the child.
- Through education and training, mentors normalize mental health conditions helping reduce stigma
- Mentors reduce the effects of parental mental health issues affecting the child
- Child will utilize skills learned to increase social and emotional development, increase academic performance, and increase socialization skills in school and public
- Prevention of adult / senior depression and other mental health concerns.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget Rollover balance from prior fiscal year	$75,000 +$50,000	$75,000 +$25,000	$75,000
Total Expenditures	$100,233	$94,462	$74,742
Unduplicated Individuals Served	4	16	11
Cost per Participant	$25,058	$5,904	$6,795

Of the 6 new referrals in FY 16/17:

Age Group	FY 14/15	FY 15/16	FY 16/17
0-15 (children/youth)	4	16	6
16-25 (transitional age youth)	0	0	0
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0

Race	FY 14/15	FY 15/16	FY 16/17
American Indian or Alaska Native	0	0	0
Asian	0	1	0
Black or African American	0	1	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	2	10	6
Other			
Multiracial	0	0	0
Unknown or declined to state	0	0	0

Ethnicity	FY 14/15	FY 15/16	FY 16/17
Hispanic or Latino:			
Specific ethnicity not indicated	2	4	0
Non-Hispanic or Non-Latino:			
Asian (specific ethnicity not indicted)	0	1	0
Other	2	11	6

Primary Language	FY 14/15	FY 15/16	FY 16/17
English	4	15	6
Spanish	0	1	0
Other Language	0	0	0
Unknown or declined to state	0	0	0

Sexual Orientation	FY 14/15	FY 15/16	FY 16/17
Declined to State	--	--	6

Gender	FY 14/15	FY 15/16	FY 16/17
Assigned sex at birth:			
Male	3	10	3
Female	1	6	3
Declined to answer the question			
Current gender identity:			
Male	3	10	3
Female	1	6	3

Disability	FY 14/15	FY 15/16	FY 16/17
Yes	--	--	0
No	--	--	0
Unknown or declined to state	--	--	6

Veteran Status	FY 14/15	FY 15/16	FY 16/17
No	--	--	6

Region of Residence	FY 14/15	FY 15/16	FY 16/17
West County	0	4	1
Placerville Area	4	6	0
North County	0	1	2
Mid County	0	1	1
South County	0	0	0
Tahoe Basin	0	4	2
Unknown or declined to state	0	0	0

Year End Report

1) **Briefly report on how implementation of the Mentoring for 3-5 Year Olds by Adults and Older Adults project is progressing (e.g., whether implementation activities are proceeding on target and as described in the County's MHSA Plan), and any major accomplishments and challenges.**

In FY 2016-17, Big Brothers Big Sisters of El Dorado County [BBBS] made 6 new successful Big/Little matches. This number includes 3 from the Western Slope and 3 from the South Lake Tahoe Basin. Total children served in FY 2016-17 is 11 children. The additional 5 children had been matched with their Big Brother or Big Sister in the previous funding year and still receive match support services from Big Brothers Big Sisters.

General Recruitment Challenges
The need for mentors for children ages 3-5 continues to be great. The challenge has been to fulfill the need with volunteers wanting to work with that young of children.

When the program began in 2014, the specified age range of children served was 3-5- years old. This constraint significantly stifled the number of eligible children and thus the efficacy of the program.

To address this challenge, the program was adjusted in the FY 2017-18 MHSA Plan to allow for all ages of children, with a focus on children who have or are at risk of having a mental health need.

While we still serve the 3-5-year-old population, this increase has allowed us to serve more children with the funding from MHSA. Since the adjustment in October 2017, we have served an additional 12 children between the ages of 6-18 and 4 additional in the 3-5 population. On average, BBBS is matching 2-5 new children with funding from MHSA.

It is important to note that MHSA funding is used throughout the length of the match, not just to initially "match" a child with a Big. Each match is individually and professionally supported by a Big Brothers Big Sisters Case Manager throughout the duration of the match. Case Management is done at least monthly with the Big, Little and parent/guardian for as long as the match remains opens with BBBS. Since the inception of this contract, 24 matches remain open and require ongoing regular support.

South Lake Tahoe Recruitment Challenges
BBBS continues to run into challenges in the South Lake Tahoe basin for volunteer recruitment. Based on the needs of the at-risk population, the demand for mentors is very high however, the population of South Lake Tahoe is somewhat "transient". Research has shown that matches lasting less than one-

year is actually harmful to a child therefore, BBBS does not accept any volunteer that cannot commit to a relationship for at least one year. While we receive interest from volunteers wanting to help the children living in Tahoe, some find it difficult to adhere to the one-year commitment.

To address this challenge, BBBS has adjusted the recruitment process to focus on long-time residents of the area (teachers, etc.). Through selected advertising and purposeful outreach, we are now targeting those individuals who are more likely to remain in the area and have the ability to make the necessary time commitment.

Program Effectiveness Measures Challenges
Based on the original measurements of the contract, the outcomes did not give a clear picture of program effectiveness.

To address this challenge, measurements were re-written in the FY 2017-18 MHSA Plan. The measurements will include strength of relationship surveys, pre- and post-risk assessments (done pre-match and annually) and teacher assessments (done annually).

While the reporting methods in the contract have not painted a clear picture, BBBS has the ability to track and measure program effectiveness based on standard practices that are required by our National organization. A few notable outcomes, based on our internal measurements, are as follows:

- 80% Retention rate from BBBS matches funded by MHSA. The BBBS retention rate is measured by a 12-month threshold.
- 97.4% of the children served have improved in the area of Social Acceptance
- 76.8% of the children served have improved in the area of Scholastic Competency
- 81.7% of the children served have reduced Risky Behaviors

2) **Briefly report on how the Mentoring for 3-5 Year Olds by Adults and Older Adults project has improved the overall mental health of the children, adults, older adults, families, and communities by addressing the primary negative outcomes that are the focus of the Mentoring for 3-5 Year Olds by Adults and Older Adults project (school failure or dropout, removal of children from their homes, and prolonged suffering). Please include other impacts, if any, resulting from the Mentoring for 3-5 Year Olds by Adults and Older Adults project on the other four negative outcomes addressed by PEI activities: (1) homelessness; (2) unemployment; (3) incarceration; and (4) suicide.**

From the matches that have been made and that BBBS continues to support, there has been great improvement for overall mental health. Teachers and parents have reported less negative behaviors in the class and at home, and the children look forward to the time with their Big. For all of the children matched, they lack stability, consistency and positive role models in their life. With the regular visits from their Big Brother or Big Sister, the child receives these important essential pieces of life. The volunteer Big Brothers and Sisters continue to be "partners" with the parents and teachers. They play an integral role in assisting with negative behaviors and help the parents navigate the stresses of parenting by being there to help them.

3) **Provide a brief narrative description of progress in providing services through the Mentoring for 3-5 Year Olds by Adults and Older Adults project to unserved and underserved populations.**

There continues to be a large gap of services for the 3-5 year group. BBBS can help close the gap by providing the services of a mentor to this age group of children. While children enrolled in Head Start and State Preschool receive their education, they don't get the important 1-on-1 time with an adult that is so important to their development.

However, as noted above, recruiting for the 3-5 year old range has been challenging despite the need, and in the FY 2017-18 MHSA Plan, this program was extended to include all children, not just the 3-5 year old age range to address the recruitment challenges.

4) **Provide a brief narrative description of how the Mentoring for 3-5 Year Olds by Adults and Older Adults services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.**

Prior to being matched, all volunteer Big Brothers and Sisters receive mandatory training on cultural competency, expectation, "how to be a Big", boundaries, safety and ethics. These trainings are interactive to help gage the volunteer's understanding of the material. BBBS also offers ongoing training for volunteers to take while they are matched. This includes trainings regarding ACEs, substance use, ADHD, and many other topics. All Big Brothers Big Sisters program staff received cultural competency training at the beginning of their employment and ongoing trainings to assist in combating disparities among the clients and families served.

5) **Provide a brief description of activities performed related to local and county-wide collaboration, outreach, access/linkages to medically necessary care, stigma reduction and discrimination reduction.**

BBBS staff is well connected with El Dorado County Office of Education Child Development staff and the Head Start and State Preschool teachers, and has positive and strong working relationships. To better serve the 3-5 year old population, BBBS is involved in countywide resource meetings and collaboratives, including Georgetown Ready by 5 and Western Slope Community Strengthening Coalition funded by Ready by 5. For volunteer recruitment, specific to Start Early, BBBS is involved in Friends of the Library, Kiwanis, Friends of Seniors, Tahoe Young Professionals, and the local Chambers of Commerce. In addition, many local advertising efforts have been made in the Mt. Democrat, The Windfall, The Clipper, The Tahoe Mountain Lab and The Tahoe Tribune.

6) **Provide the outcomes measures of the services provided. Outcome measures for the Mentoring for 3-5 Year Olds by Adults and Older Adults project are:**
   - **Measurement 1: Pre/Post Surveys**
   - **Measurement 2: Evaluations**
   - **Measurement 3: Behavioral Evaluation**
   - **Measurement 4: Documented Skill Building**
   - **Measurement 5: Rating Sheet**
   - **Measurement 6: West Slope: Big Brothers Big Sisters Youth Outcomes Survey (YOS) and Strength of Relationship survey (SOR)**
   - **Measurement 7: Recommended Adult Surveys and Evaluation Tools**
   - **Measurement 8: Testimonials**

Measurement 1: Twelve Littles were referred by Head Start and State Preschool for enrollment in the Start Early Program from El Dorado County, with 3 referred at the end of the school year which will be carried over to the next year.

They were all assessed at intake for program effectiveness and 6 Littles were matched with a Big Brother or Big Sister. The remaining 3 will be matched the following school year, none were evaluated out.

Measurement 2: 10 Volunteer Bigs applied to be a Big Brother or Big Sister. All 10 were interviewed, screened, trained and accepted based on their evaluation for program participation.

6 of the Volunteers were matched with a Little Brother or Little Sister. 2 volunteers didn't complete the screening process before the end of the school year and will be matched at the beginning of the next school year and the other 2 were unable to continue in the process to be matched with a Little Brother or Sister.

Measurement 3: Based on the behavioral evaluations completed at the beginning of the match, in conjunction with the referring teachers, 100% of the kids referred needed a positive role model because of either a chaotic home-life, little attention at home and/or medical reasons. 100% of the kids matched with a Big Brother or Big Sister struggled with school performance or in class behaviors either relating with other peers or listening to the teachers. 65% were referred stating low self-esteem or "other" reasons.

Based on the Annual Teacher Evaluation (given at the end of the school year) the kids matched with a Big Brother or Big Sister have increased their socialization and communication skills. Since being matched with their Big Brother or Big Sister, the average rating of self-confidence (10 being the highest) was 9, the average rating of classroom behavior was 8, and the average rating for relationships with peers was 7.5.

Measurement 4: Based on match support conducted with Bigs (monthly support conversations/visits) throughout their match individual Littles have:

- Acquired more developed social skills;
- Better focus during 1-on-1 conversations and class time;
- Become more talkative, open and respectful with teachers and peers;
- Behaviors that became calmer and more appropriate during class time;
- Noticeably happier and upbeat presentation.

Measurement 5: 100% of the parents were sent rating sheets to rate their perceptions of BBBS and the matching of their child. Of the 6 sent 50% were returned. 100% of the rating sheets returned stated they were very satisfied with the program and strongly agreed their child has had a positive experience.

100% of the Volunteer Bigs were sent rating sheets to rate their perceptions of BBBS and their overall experience of being a Big. Of the 6 sent 100% returned. 100% felt the agency was easy to work with and friendly and have had a positive experience being a Big.

Measurement 6:
From the YOS survey completed pre-match:

0% of the kids were not able to complete the survey because of lack of attention
55% said it was OK to be mean to other kids
85% could not identify a favorite adult in their life

From the YOS survey completed at the end of the school year:
100% said it was not OK to be mean or hit other kids
80% said they had a favorite adult in their life
All of the Littles (kids in program) stated their Big Brother or Big Sister makes them happy.

From the SOR survey completed 3 months post-match:
100% said they liked their Big
100% said they liked when their Big visits them
0% stated their Big made them feel bad
100% felt they were close to their Big

From the SOR survey completed at the end of the school year:
100% said they liked their Big
100% said they liked when their Big visits them
0% stated their Big made them feel bad
100% felt they were close to their Big

Measurement 7:
From the SOR survey completed 3 months post match:
15% of Bigs were overwhelmed by their Little's difficulties
90% felt well matched with their Little
10% felt frustrated that not much had improved with their Little
0% felt it was hard to find time to be with their Little

From the SOR survey completed at the end of the school year:
5% felt overwhelmed by their Little's difficulties
100% felt they were well matched
0% felt frustrated that not much had improved with their Little
25% felt it was hard to find time to be with their Little

Measurement 8:
"Todd is very nice to me and I like doing things with him."
-Little Brother

"He has really made huge changes at school. He's amazing me."
-Big Brohter

"She has become part of our family. I am so grateful for what she has done for my child."
-Mom

"While he still struggles occasionally in the classroom, his behavior is night and day from when before he was matched."
-Teacher

MHSA Recommendation: Continue this project in the FY 18/19 MHSA Plan.

Access and Linkage to Treatment Programs

Community-Based Outreach and Linkage

The focus of this program changed in the FY 2017-18 MHSA Plan because the previous programs under this category did not successfully launch.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$20,000	$31,125	$15,000
Total Expenditures	$1,237	$303	$2,960
Unduplicated Individuals Served	0	0	0
Cost per Participant	--	--	--

Starting in FY 2017-18:

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division and El Dorado County Sheriff's Office

Project Goals

- Raise awareness about mental health issues and community services available.
- Improve community health and wellness through local services.
- Improve access to medically necessary care and treatment.

Numbers Served and Cost

The Memorandum of Understanding between Health and Human Services Agency and the El Dorado County Sheriff's Office was executed effective January 4, 2018, so there were no services provided in FY 2016-17.

Suicide Prevention Program

Suicide Prevention and Stigma Reduction

Provider: Tahoe Youth and Family Services via its subcontractor Suicide Prevention Network

Project Goals

- Increase awareness of mental illness, programs, resources, and strategies.
- Increased linkage to mental health resources.
- Reduce the number of attempted and completed suicides in El Dorado County.
- Change negative attitudes and perceptions about seeking mental health services.

- Eliminate barriers to achieving full inclusion in the community and increase access to mental health resources to support individuals and families.

Tahoe Youth and Family Services failed to provide the required year-end demographic report in a timely manner for inclusion in this report. Starting in FY 18-19, the Suicide Prevention services will be provided by Suicide Prevention Network.

Numbers Served and Cost

Expenditures	FY 16/17
MHSA Budget	$30,000
Total Expenditures	$30,000
Unduplicated Individuals Served	unknown
Cost per Participant	unknown

Age Group	FY 16/17
0-15 (children/youth)	unknown
16-25 (transitional age youth)	unknown
26-59 (adult)	unknown
Ages 60+ (older adults)	unknown
Unknown or declined to state	unknown

Gender	FY 16/17
Female	unknown
Male	unknown

Region of Residence	FY 16/17
West County	unknown
Placerville Area	unknown
North County	unknown
Mid County	unknown
South County	unknown
Tahoe Basin	unknown
Unknown or declined to state	unknown

Race / Ethnicity	FY 16/17
American Indian or Alaska Native	unknown
Asian	unknown
Black or African American	unknown
Caucasian or White	unknown
Hispanic or Latino	unknown
Native Hawaiian or Other Pacific Islander	unknown
Multiracial	unknown
Other Race or Ethnicity	unknown
Unknown or declined to state	unknown

Primary Language	FY 16/17
English	unknown
Spanish	unknown
Other Language	unknown
Bilingual	unknown
Unknown or declined to state	unknown

FY 14/15 through FY 16/17 Outcome Measures
Measurement 1: Project quality will be measured by interviews and surveys about the project.
Measurement 2: Documentation of changes in attitudes, knowledge and/or behavior related to mental illness and seeking mental health services.
Measurement 3: Long-term success will be measured by the school-wide California Healthy Kids Survey, conducted every other year.

None reported.

Veterans Outreach

Provider: Only Kindness and Associate Providers

Project Goals

- Provide outreach and linkage to services for approximately 100 Veterans and families annually
- Develop a single point of entry for homeless Veterans to receive needed services
- Assist Veterans to secure permanent and affordable housing
- Reduce the number of homeless Veterans in our community

Numbers Served and Cost
This program was introduced in the FY 2017-18 MHSA Plan and the contract was executed effective March 6, 2018. Therefore there were no services provided in FY 2016-17.

PEI Administration

Activities performed under PEI Administration include contract development, implementation and monitoring, invoice review, vendor meetings and meetings with community providers and/or the public related specifically to PEI.

Numbers Served and Cost

Expenditures	FY 14/15	FY 15/16	FY 16/17
MHSA Budget	$175,000	$250,000	$65,000
Total Expenditures	$41,517	$26,350	$10,539

APPENDIX B

Annual Innovation Program and Evaluation Report, Reporting Year: Fiscal Year 2016-17

El Dorado County
Mental Health Services Act (MHSA)

Annual Innovation Program and Evaluation Report

Reporting Year: Fiscal Year 2016-17

HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH

WELLNESS | RECOVERY | RESILIENCY

BACKGROUND

The El Dorado County Mental Health Services Act (MHSA) Innovation Plans were approved by the Board of Supervisors on June 13, 2016, and approved by the Mental Health Services Oversight and Accountability Commission on August 25, 2016.

As of June 30, 2017, the programs had been in process for less than one year, therefore the available data is limited.

There are two approved Innovation Projects in El Dorado County:

Community-Based Engagement and Support Services

Community Hubs will leverage the best practices in early childhood, health and community building to inform systems change and increase access to health care, social services and behavioral health services for pregnant women and families, including children birth through 18 years of age. This systems change will offer a local point of access for services and outreach to isolated families in surrounding communities. Hubs will be established at libraries located in the five Supervisorial Districts within El Dorado County. Community Hubs differ from single services in that they foster more effective, accessible, and coordinated services and actively work to take down silos. While many service systems have been designed to meet a specific need using narrowly defined service criteria, a Hub offers an opportunity to understand and support individual and family strengths and needs comprehensively. The Hubs will offer health prevention activities including support groups, educational classes and engagement opportunities for the purposes of building resiliency within the community. Community Health Advocates will be assigned to each Hub, charged with engaging isolated pregnant women, families and children birth through eighteen, assisting them in health navigation that may include insurance, medical homes and accessing services. Using a trauma-informed approach, Public Health Nurses will provide case management, health screening, mental health screening, alcohol and drug screening, and assist clients in accessing services to meet individualized needs, including referrals to contracted mental health partners.

Restoration of Competency in an Outpatient Setting

The Restoration of Competency in an Outpatient Setting project will provide necessary services in a community setting. Misdemeanants will have an opportunity to receive Restoration of Competency services and Specialty Mental Health Services from County Mental Health. These services include, but are not limited to, the assignment of a Mental Health Clinician and a Mental Health Worker trained in Restoration of Competency, Psychiatric services as indicated, and Wellness Center Staff to provide Wellness Activities in a social setting. Wellness Activities may include, but are not limited to, managing emotions, exercise group, conversation skills, healthy pleasures for sober living, smoking cessation, self-care, life skills, and mindfulness skills. Participating individuals will have the opportunity to attend the Mental Health Division's Wellness Center activities as part of the treatment process. If an individual loses housing and is no longer medication compliant, or otherwise unsafe to maintain in an outpatient setting, they may be appropriately hospitalized (i.e., through the 5150 process)

or returned to jail for the Restoration of Competency services provided in the jail setting, or to wait for an available inpatient Restoration of Competency bed.

COMMUNITY-BASED ENGAGEMENT AND SUPPORT SERVICES

The commonly used name for this project is "Community Hubs" or "Hubs".

Learning Goals and Objectives:

- Will a library based access point for services, different than the multi-access point of the Oregon Model, facilitated by a Public Health Nurse using trauma-informed approach, be successful in the rural areas of the County?
- Does providing services at the Library reduce stigma?
- Does increasing access to prevention and early Intervention reduce long term mental health costs?
- Does improving coordination and integration of physical and behavioral health services increase the number of clients accessing mental health services?
- Does case management by a Public Health Nurse increase client screening and treatment for mental health services?
- Does a trauma-informed approach assist in reaching the hardest to serve mental health clients?
- Can Community Hubs be sustained through local planning and leveraging of resources?

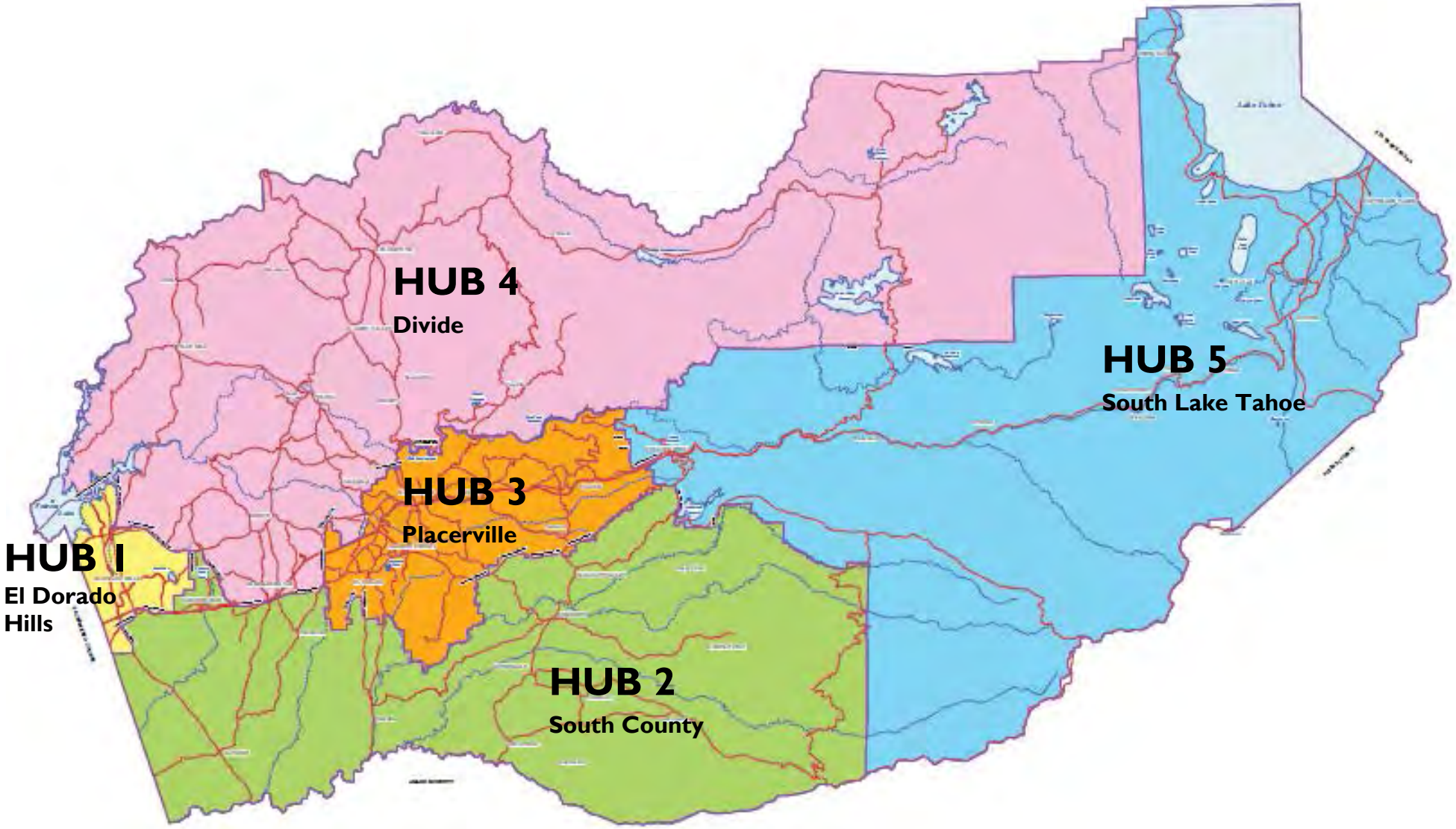
The Learning Objectives of the Community Hubs Innovative project have long-term effects that are not measurable during the review period of the previous fiscal year.

Program Timeline and Activities for Fiscal Year (FY) 2016-17

The first partial year of implementation involved significant time recruiting and training Public Health Nurses, developing written materials regarding the Hubs, and performing outreach regarding the availability of the services. Direct services started May 1, 2017.

Each Supervisorial District is considered a region for one Hub. There are five Districts in El Dorado County, and therefore there are five corresponding Hubs.

Regional Designations for the Five Community Hubs



The timeline for implementation activities in FY 2016-17 were:

- Sept. 2016 – Hired Supervising Public Health Nurse as program coordinator for Hubs and beginning of simultaneous recruitment of 5 Community Health Advocates and 5 Public Health Nurses; development of Hub staff orientation and professional development plan; logistical preparation; and began development of metric tracking mechanisms for client services.
- January 9, 2017 – Three Community Health Advocates begin transition into positions for Hubs 1, 3 and 4 while continuing to provide coverage to other public health programs.
- January 23, 2017 – First Public Health Nurse joined Hubs and began orientation for Hub 1.
- February 6, 2017 – Fourth Community Health Advocates joined Hubs and began orientation for Hub 2.
- February 21, 2017 – Fifth Community Health Advocates joined Hubs and began orientation for Hub 5.
- Mid-April 2017 – New Public Health Nurse from other Public Health Program began providing partial coverage for Hub 2. Finalized metric tracking mechanisms. Selected and purchased all Hub health team supplies for client services and outreach activities.
- May 2017 – Referral criteria updated and began soft roll-out for acceptance of referrals to Hubs for pregnant women and families with at-risk/low-risk health risk factors. Experienced Public Health Nurse in South Lake Tahoe providing coverage for Hub referrals for Hub 5.
- May 1, 2017 – Second Public Health Nurse for Hub 3 began orientation.
- June 26, 2017 – Third Public Health Nurse for Hub 5 began orientation.

Activities performed include:

- Recruitment of 1 Supervising Public Health Nurse, 4 Public Health Nurses and 5 Community Health Advocates for the Community Hubs, including 4 health staff members who are bilingual for Spanish.
- Development of updated PHN referral criteria as well as processing of incoming referrals to include at-risk or low-risk case criteria previously not accepted by the MCAH program.
- Health staff completed outreach inside library settings and at community events that are family friendly, devised concept of office hours for health staff to be available for families at the library for connection to resources and assistance with access to health care needs.
- Professional Development of all Health Staff including training on Maternal Mental Health through Postpartum Support International webinars; Cultural competence training through Public Health Training Center; Trauma-Informed Services: Excellence Through Safety, Self-Regulation and Self-Care local conference and ongoing participation in the ACEs Community Collaborative to reinforce understanding of trauma-informed approach and resiliency.
- Collaboration with Program Manager from EDC Behavioral Health to identify Behavioral Health and Substance Use assessment tools for use in PHN home visiting, including: Edinburgh Post-Partum Depression Scale, Beck's Depression Inventory, AUDIT, DAST and ACEs Questionnaires.
- PHN training in use of Hawaii Early Learning Profile (HELP) Developmental Assessment tool as an alternative to Denver II Developmental Screening to aid in referral process to local early intervention and developmental services. Building on existing collaborative relationship with Infant Development Program and ALTA Regional Services.
- Began Community Needs Assessment by completion of Windshield Surveys of the County's geographic composition and available resources through a health-focused lens as well as interviews with key informants to identify isolated populations and inform the outreach plans for each Community Hub. The surveys of the communities and interviewing processes are being led by the public health nurses (PHN) for each Community Hub.

- Community Health Advocates (CHAs) from Community Hubs 2 and 3 completed a 15-minute lesson and activity on Stress Reduction and Grounding Techniques to 18 classes at the Health and Wellness Event for El Dorado High School on April 4th sharing information with over 580 freshmen and sophomore students.
- Community Health Advocates and Public Health Nurse provided blood pressure readings, and health education on stress reduction strategies and building resiliency at a Family Engagement-focused event targeting fathers or male caregivers planned by Hub 3 multi-disciplinary team on June 24th.

Project Changes

There were no significant changes to the program in FY 2016-17.

Evaluation Data (including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes)

Evaluation Period: May 1, 2017 through June 30, 2017

First 5 El Dorado County Client Satisfaction Survey Responses

- 13.6% of Hub Program participants report an increase in protective factors associated with family functioning and resiliency.
- 9.4% of Hub Program participants report an increase in protective factors associated with concrete support in times of need.
- 16.7% of Hub Program participants report an increase in knowledge of parenting and child development.
- 11.2% of Hub Program participants report an increase in protective factors associated with social emotional supports.
- 7.8% of Hub Program participants report an increase in protective factors associated with nurturing and attachment as measured by First 5 EDC Client Satisfaction Survey.

Referrals Received and Client Contacts

Data Measure	Hub 1	Hub 2[1]	Hub 3	Hub 4	Hub 5[1]	Total
Hub Referrals Received and Assigned	N/A	N/A	N/A	N/A	N/A	41
Community Health Advocates Linkage Requests	1	0	5	119	5[2]	140
Home Visits or Significant Contact with PHN or Community Health Advocates	7	49	30	5*[2]	60	168

[1] FY 2016-17 data measures are underrepresented due to Public Health Nurses providing coverage to Hubs and other Public Health Nursing programs using different data tracking logs without detailed referral information.
[2] Loss of detailed referral data for Hub 4 and 5 Community Health Advocates due to poor off-site connection to secure EDC network as well as inconsistencies when entering data due to inexperienced staff. Increased training, resolution of IT concerns and increased quality assurance have corrected this issue moving forward.

Community Health Advocate Linkage Requests by Type and Source

Linkage Request by Type:	
Dental	57
Medical	18
Insurance	24
Community Resources	101
Linkage Request Source:	
1-800 MCAH line	3
Self-referral	98
Internal/External Partner	5

Referrals Made by Health Staff by Hub

Referrals from PHN staff to:	**Hub 1**	**Hub 2**	**Hub 3**	**Hub 4[3]**	**Hub 5[3]**	**Overall**
Mental Health Services	1	0	4	0	9	**14**
Services Received	-[4,5]	-[4,5]	2	-[4,5]	2	**4**
Primary Care Physician	1	3	3	0	7	**14**
Services Received	-[4,5]	1	3	-[4,5]	3	**7**
Dental Provider	2	28	5	0	11	**46**
Services Received	1	1	-[4,5]	-[4,5]	3	**5**
Insurance Coverage	0	0	4	0	9	**13**
Services Received	-[4,5]	-[4,5]	2	-[4,5]	1	**3**
Developmental Services	0	5	1	0	1	**7**
Services Received	-[4,5]	-[4,5]	-[4,5]	-[4,5]	1	**1**
Other PHN programs	0	0	0	3	0	**3**
Services Received	-[4,5]	-[4,5]	-[4,5]	-[4,5]	-[4,5]	**0**
Other Community Based Resources	1	2	8	2	34	**47**
Services Received	-[4,5]	-[4,5]	-[4,5]	-[4,5]	13	**13**

[3] Loss of detailed referral data for Hub 4 and 5 Community Health Advocates due to poor off-site connection to secure EDC network as well as inconsistencies when entering data due to inexperienced staff. Increased training, resolution of IT concerns and increased quality assurance have corrected this issue moving forward.

[4] Results of some referrals not captured in FY 2016-17 data due to operational status beginning late in fiscal year during 4th quarter.

[5] "Services Received" means that client completed an appointment with a provider only, does not reflect clients that had an appointment scheduled at the time of discontinued follow-up.

Challenges Faced

- Continued recruitment of health staff concurrently with development of operational procedures and logistics of the program requires significant time, effort and flexibility from all involved.
- Planning the logistics of service delivery required flexibility and problem solving as staff learned to use new technology and data tracking mechanisms, as well as building professional working relationships with Hub partners. Staff experienced technology challenges including a loss of service level data due to poor connectivity to the El Dorado County network while working at the Library sites. Increased technology support and knowledge of technology and data requirements has corrected this issue.

Demographics

Due to the technology challenges addressed above, the demographic data for the first months of operation were not available. MHSA staff will be meeting with the Public Health Nursing staff to problem solve.

RESTORATION OF COMPETENCY IN AN OUTPATIENT SETTING

Learning Goals and Objectives:

- Will the Restoration of Competency in an Outpatient Setting be successful in a rural County?
- Will family and friends be willing to house an individual ordered to Outpatient Restoration?
- Will transportation be an issue/barrier to completing the Outpatient Restoration services?
- Will participants be able to complete the Outpatient Restoration services?
- Will participants in the Outpatient Restoration program experience a reduction in recidivism?

Program Timeline and Activities for Fiscal Year (FY) 2016-17

- During FY 2016-17, the Restoration of Competency Program Operation Guidelines and curriculum were developed.
- One participant was Court-ordered to participate in the Outpatient Restoration of Competency program.

Project Changes

There were no significant changes to the program in FY 2016-17

Evaluation Data (including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes)

Potential participants identified by the Courts	1
Potential participants who met program eligibility criteria	1
Percentage of potential participants who located appropriate housing	100%
What was their housing status prior to incarceration?	100%: Independent Housing
Number of days held in the Jail until ordered to Restoration to Service	0 (individual was not in jail at time Restoration ordered)
Number of days from the order for Restoration to release from the Jail	N/A
Number of days from the release from the Jail to the Outpatient Restoration program	N/A
For those individuals found not eligible for the Outpatient Restoration program, track the number of days from the order for Restoration to placement in a facility	N/A
During the Outpatient Restoration program:	
What percentage of participants face transportation barriers, and what is done to overcome those barriers?	100% Transportation provided by Behavioral Health Division staff

Attendance rate for Outpatient Restoration services, including Psychiatric appointments.	75% for Psychiatry Appts. / Extremely limited participation in Restoration services
Identify the number of participants who sign Release of Information to allow family and/or friends participate in their services.	1
Percentage of individuals who successfully complete their Restoration Services in an Outpatient Setting	0%
Number of days from the start of the Outpatient Restoration of Competency program to the completion of the Restoration	N/A
Percentage of successful participants who experience a reduction in recidivism or experience no recidivism after 3 months, 6 months, 1 year, 2 years.	N/A
Percentage of successful participants who continue with mental health services after they have been restored to competency	N/A
Percentage of clients hospitalized and/or re-incarcerated who did not complete the Outpatient Restoration process	100%
If a participant is not successful in completing the Outpatient Restoration, what barriers to success were faced by the participant and how can they be overcome?	Substance use/abuse that impacts mental health symptoms
Were the barriers client specific or due to program design?	Client-specific
If due to program design, how can the program be changed to avoid these barriers in the future?	N/A
If possible to collect, what percentage of unsuccessful participants experience recidivism?	0% (participant was hospitalized)
If possible to collect, what percentage of unsuccessful participants will see mental health services upon release?	100%

Challenges Faced

- Lack of referrals for Outpatient Restoration of Competency.
- The one Court-ordered participant for the Outpatient Restoration of Competency program arrived at the Behavioral Health Division's clinic before the paperwork was submitted from the Court. The participant was not in Jail at the time the services were ordered. The Behavioral Health Division worked with the Jail and Court regarding the process for future referrals to the program.

Demographics

(A) Age Groups	
1. 0-15 (children/youth)	0
2. 16-25 (transition age youth)	0
3. 26-59 (adult)	1
4. Ages 60+ (older adults)	0
5. Declined to answer the question	0

(B) Race	
1. American Indian or Alaska Native	0
2. Asian	0
3. Black or African American	0
4. Native Hawaiian or other Pacific Islander	0
5. White	0
6. Other	0
7. More than one race	1
8. Declined to answer the question	0

(C) Ethnicity	
1. Hispanic or Latino as follows	
a. Caribbean	0
b. Central American	0
c. Mexican/Mexican-American/Chicano	0
d. Puerto Rican	0
e. South American	0
f. Other	0
g. Declined to answer the question	0
2. Non-Hispanic or Non-Latino as follows	
a. African	0
b. Asian Indian/South Asian	0
c. Cambodian	0
d. Chinese	0
e. Eastern European	0
f. European	0
g. Filipino	0
h. Japanese	0
i. Korean	0
j. Middle Eastern	0
k. Vietnamese	0
l. Other	0
m. Declined to answer the question	0
3. More than one ethnicity	0
4. Declined to answer the question	1

(D) Primary Language	
1. English	1
2. Spanish	0
3. Other Non-Threshold Language	0

(E) Sexual orientation	
1. Gay or Lesbian	0
2. Heterosexual or Straight	1
3. Bisexual	0
4. Questioning or unsure of sexual orientation	0
5. Queer	0
6. Another sexual orientation	0
7. Declined to answer the question	0

(F) Disability	
1. Yes, report the number that apply in each domain of disability(ies)	
a. Communication domain separately by each of the following	0
(i) Difficulty seeing,	0
(ii) Difficulty hearing, or having speech understood	0
(iii) Other (specify)	0
b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	1
c. Physical/mobility domain	0
d. Chronic health condition (including, but not limited to, chronic pain)	0
e. Other (specify)	0
2. No	0
3. Declined to answer the question	0

(G) Veteran status	
1. Yes	0
2. No	1
3. Declined to answer the question	0

(H) Gender	
1. Assigned sex at birth:	
a. Male	0
b. Female	1
c. Declined to answer the question	0
2. Current gender identity:	
a. Male	0
b. Female	1
c. Transgender	0
d. Genderqueer	0
e. Questioning or unsure of gender identity	0
f. Another gender identity	0
g. Declined to answer the question	0