MHSA OUTCOMES

Emerald Bay, Lake Tahoe

El Dorado County
Mental Health Services Act (MHSA)
Outcomes

FY 2019-20 Year End Results

Reported with the FY 2021-22 MHSA Annual Update

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Impact as a Result of the
Public Health Emergency/Coronavirus Pandemic:
Fiscal Year 2019/20 Outcomes

In mid-March, 2020, California was faced with a new dilemma of how to continue to provide vital mental health services, in the face of the Public Health Emergency associated with the Coronavirus Pandemic. El Dorado County's Behavioral Health and our contracted service providers recognized the importance of continuing to provide services and did their best to adapt, and if necessary, transition to new and innovative service models.

It is also important to note that due to the various gathering and interaction restrictions as a result of the Public Health Emergency, some Outcome demographic data may represent "*contact* with individuals". Counties across the State agreed that while it is important to gather as much meaningful data as possible, during this unique time, it was crucial to have contact with individuals to assess their needs and resiliency. At times, that may have meant collecting the myriad of required data, was not practical. This is especially true of data gathered during the end of the third quarter and all of the fourth quarter (i.e., from March 2020 – June 2020).

Prevention and Early Intervention (PEI) Projects

Introduction

Prevention and Early Intervention (PEI) Projects 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 Outcome Measures Report accompanying the Fiscal Year 2021/22 MHSA Three-Year Program and Expenditure Plan provides outcome information for the PEI projects included in the Fiscal Year 2019/20 MHSA Annual Update.

Pursuant to Title 9 California Code of Regulations Section 3560.010(a)(1): "The first Annual PEI Report is due to the Mental Health Services and Oversight Accountability Commission on or before December 30, 2017 as part of an Annual Update or Three-Year Program and Expenditure Plan. Each Annual PEI Report thereafter is due as part of an Annual Update or Three-Year Program and Expenditure Plan within 30 calendar days of Board of Supervisors approval but no later than June 30 of the same fiscal year whichever occurs first. The Annual PEI Report is not due in years in which a Three-Year PEI Report is due."

Section 3560.010(a)(2): "The Annual PEI Report shall report on the required data for the fiscal year prior to the due date." Therefore, this Outcomes Report is due no later than June 30, 2021 and is to report the required data from fiscal year 2019/20 (i.e., July 1, 2019 through June 30, 2020).

Further, this for each PEI Project, this PEI Report includes all the elements outlined in Section 3560.010(b).

This report reflects the responses as reported by the Project provider. In some cases, the reported data may not equal the number of unduplicated client counts.

Consistent with previous PEI Reports, there is a noticeable trend within many programs where the responses to the demographics questions are "Unknown or decline to state". It is not possible to specifically identify the reason for the increased rate of this response, 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.

Additionally, with the Public Health Emergency related to the Coronavirus Pandemic, some PEI service providers had to record number of "contacts" versus capturing all the required demographics.

MHSA Year-End Progress Report

Latino Outreach Project

Provider: South Lake Tahoe Family Resource Center FY 2019/2020

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 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$135,150	$135,150	$135,150
Total Expenditures	$67,273	$125,702	$135,150
Unduplicated Individuals Served	446	509	369
Cost per Participant	$151	$247	$366
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	88	202	152
16-25 (transitional age youth)	9	74	31
26-59 (adult)	349	221	178
Ages 60+ (older adults)	0	12	8
Unknown or declined to state	0	0	0
Race	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	0	0	0
Asian	0	0	0
Black or African American	1	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	25	32	0
Other	421	477	369
Multiracial	0	0	0
Unknown or declined to state	0	0	0

Ethnicity by Category	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	444	0	369
Caribbean	0	0	0
Central American	0	3	0
Mexican/Mexican-American/Chicano	0	491	0
Puerto Rican	0	0	0
South American	0	1	0
Other	0	14	0
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	0	0
Multi-ethnic	0	0	0
Unknown or declined to state	2	0	0
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	25	62	62
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	440	447	369
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	0	0	0

Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	0	0	0
Heterosexual or Straight	0	126	369
Bisexual	0	0	0
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	0
Another sexual orientation	0	0	0
Declined to State	446	383	0
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	162	213	129
Female	284	296	240
Declined to answer	0	0	0
Current gender identity:			
Male	162	213	129
Female	284	296	240
Transgender	0	0	0
Genderqueer	0	0	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	0	0	0
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	0	0	0
Difficulty hearing or having speech understood	0	0	0
Mental disability including but not limited to learning disability, developmental disability, dementia	10	3	0
Physical/mobility	1	3	0
Chronic health condition/chronic pain	10	3	0
Other (specify)	0	0	0
Declined to state	425	500	369

Veteran Status *Collection of this information from a minor younger than 12 years of age is not required.*	FY 2017-18	FY 2018-19	FY 2019-20
Yes	0	0	0
No	0	183	369
Unknown or declined to state	446	326	0
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	0	0	0
Placerville Area	0	0	0
North County	0	0	0
Mid County	0	0	0
South County	0	0	0
Tahoe Basin	446	448	369
Unknown or declined to state	0	61	0
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	0	0
Very low income	unknown	285	0
Low income	unknown	218	369
Moderate income	unknown	6	0
High income	unknown	0	0
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	0	0
Medi-Cal	unknown	469	369
Medicare	unknown	0	0
Uninsured	unknown	40	0

Annual Report FY 2019/20

Please provide the following information for this reporting period:

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 Latino Outreach project is performing well for the South Lake Tahoe community & the Family Resource Center (FRC). We are serving new clients every month, as well as keeping the community informed with our Engagement and Outreach activities at numerous locations including schools in the Lake Tahoe Unified School District (LTUSD) with our Cafecito's program(s). Fiscal Year 2019-20 has been challenging due to the COVID-19 pandemic and the closure of the LTUSD and Lake Tahoe Community College (LTCC). This has forced the FRC to re-evaluate our operation. We have gone to

a virtual platform for our counseling services on a HIPAA compliant platform and we are conducting our Parenting classes over ZOOM. Our counselor has made great strides in providing therapy in this method.

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, prolonged suffering, school failure or dropout, incarceration, unemployment, homelessness, and removal of children from their homes).**

   The overall health of community is strengthened by the Latino Outreach by providing group and individual therapy as well as community participation in parent support groups that are focused on topics of mental health and family dynamics. This year, beginning in March 2020 with the onset of COVID-19, we have moved to an on-line secure platform to continue to provide counseling services and parenting classes for our clients.

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

   By providing Outreach to schools in the Lake Tahoe Unified School District, as well as at Lake Tahoe Community College, the Family Resource Center informs the community of the Latino Outreach project and new clients continue to seek our services. The Foster & Kinship (FKCE) and English as a Second language (ESL) programs affords us the opportunity to provide information and services to a wider range of clients.

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.**

   All staff at the FRC are bilingually, culturally, and linguistically competent. All of our programming is in Spanish and provides opportunities to the community to further develop skills that empower them and their families to become self-sufficient. We meet individually with parents to assist them in overcoming their fears in communicating with their families, employers and schools.

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 FRC Executive Director and/or designee participate in committees such as: South Lake Tahoe Behavioral Health Network, Barton Hospital's Community Health Advisory Committee, El Dorado County School Attendance Review Board (SARB) and the Lake Tahoe Collaborative. We participate in all community events to further disseminate information to the community.

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.**

     The survey indicates that longer duration counseling services are desired by some clients.

   - **Measurement 2: Client outcome improvement measurements.**

None stated

- **Measurement 3: Increased engagement in traditional mental health services.**

  Some clients will be referred to El Dorado County MHSA to seek other long-term services that the limited English proficiency (LEP) does not provide. Others may be referred to local providers in the South Shore community.

7) If known, the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.

One (01) client was referred to county mental health for psychiatric services.

8) If known, the number of individuals who followed through on the referral and engaged in treatment.

Unknown.

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

Total Project expenditures: $135.000

10) Provide any additional relevant information.

The COVID-19 Pandemic has created a level of fear in our community that is difficult to overcome. The stress associated with COVID-19 is huge. So many of our families are not able to work and those that have begun to return to work are not being given enough hours to support themselves and families. Our clients are also in fear of contracting the virus at work, as most of our clients are working in service industry jobs and are being overrun by tourists in the workplace. The community is having difficulty paying rents that are past due and now they are concerned about being evicted from their place of residence. Food insecurity is a growing concern. We have distributed food and food cards for our community and we plan to do more food distribution.

MHSA Year-End Progress Report

Latino Outreach Project

Provider: New Morning Youth and Family Services

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 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$96,000	$96,000	$96,000
Total Expenditures	$80,356	$88,579	$93,445
Unduplicated Individuals Served	427	350*	433
Cost per Participant	$188	$253	$216

*Fiscal Year 2018/19: There is a discrepancy from New Morning Youth and Family Services electronic client case files that indicates Latino Outreach had 483 clients. However, the monthly Client Registration Demographics provided by the *Promotoras* did not represent all the clients that were assisted, so data is based upon 350 individuals being served.

Age Group	FY 2017-18	FY 2018-19	FY 2019-20
0-15 (children/youth)	145	146	150
16-25 (transitional age youth)	50	45	66
26-59 (adult)	220	144	199
Ages 60+ (older adults)	12	15	18
Unknown or declined to state	0	0	0
Race	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	0	0	0
Asian	0	0	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	406	344	421
Other	0	6	8
Multiracial	0	0	0
Unknown or declined to state	21	0	4

Ethnicity by Category	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	379	0	422
Caribbean	0	0	0
Central American	0	8	10
Mexican/Mexican-American/Chicano	0	328	422
Puerto Rican	0	0	0
South American	15	8	1
Other	21	6	0
Unknown or declined to state	12	0	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	0	0
Multi-ethnic	0	0	0
Unknown or declined to state	0	0	0
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	117	156	196
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	199	188	237
Tagalog	0	0	0
Vietnamese	0	0	0
Other language	4	6	0

Unknown or declined to state	0	0	0
Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	0	0	0
Heterosexual or Straight	0	350	433
Bisexual	0	0	0
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	0
Another sexual orientation	0	0	0
Declined to State	427	0	0
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	155	123	114
Female	272	227	319
Declined to answer	0	0	0
Current gender identity:			
Male	155	123	114
Female	272	227	319
Transgender	0	0	0
Genderqueer	0	0	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	0	0	0
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	0	0	0
Difficulty hearing or having speech understood	0	0	2
Mental disability including but not limited to learning disability, developmental disability, dementia	0	5	6
Physical/mobility	2	1	4
Chronic health condition/chronic pain	1	0	3
Other (specify)	10	0	0
Declined to state	414	344	1

Veteran Status *Collection of this information from a minor younger than 12 years of age is not required.*	FY 2017-18	FY 2018-19	FY 2019-20
Yes	0	0	0
No	427	350	433
Unknown or declined to state	0	0	0
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	0	74	102
Placerville Area	221	175	221
North County	7	10	8
Mid County	92	89	102
South County	6	0	0
Tahoe Basin	0	0	0
Unknown or declined to state	0	2	0
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	0	123	159
Very low income	0	96	134
Low income	0	125	135
Moderate income	0	6	5
High income	0	0	0
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	0	9	7
Medi-Cal	0	228	248
Medicare	0	4	7
Uninsured	0	109	171

Annual Report FY 2019/2020

Please provide the following information for this reporting period:

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.**

   Promotoras continue to provide a wide range of services including: advocacy, community outreach (Kids' Expo), interpretation, crisis support, home visitation, and linkage to other programs/resources (mental health services, domestic violence services, support for immigration status, referral and support for health services, referral to victims services, community Hubs, First 5 El Dorado, etc.).

   Since March (COVID-19) all of these services and supports were provided through a tele-health modality. In some circumstances, when interpretive services are needed for special cases, *Promotoras* abide by social distancing and masks.

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, prolonged suffering, school failure or dropout, incarceration, unemployment, homelessness, and removal of children from their homes).**

   The *Promotoros* continue to advocate for the youth that are struggling in school and accompany parents to school meetings (SST and IEP) for interpretation and clarification. They assist in making referrals at schools for counseling services. In addition, Ruth Zermeno provides services for the Wellness Centers located at each El Dorado Union High School District site. During the school closures due to COVID-19, the *Promotoras* continue to offer assistance with parents struggling to help their children with their school work at home. Ruth and Angie Olmos have been providing them with additional resources to assist families.

   Latino Outreach continues to address a variety of needs that affect the family unit as a whole. During this period, Latinos were worried in regards to any public assistance they received would be reported under the new “public charge” rule published under the Department of Homeland Security. This new rule went into effect in February 2020, but many Latinos had already declined services in advance. Even more concerning, due COVID-19, the Latino Population that do not have insurance, are not seeking medical assistance due to the cost and fear of being reported.

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

   Latino Outreach continues to increase services to unserved/underserved populations, especially to engage Latino families’ greater access to culturally competent medical and mental health services. Angie Olmos provided information about our services to a diabetes group that meets weekly in Pollock Pines. Likewise, Ruth Zermeno collaborated with Jesus Cordova (HUBS) at a meeting in Camino where she spoke about depression and offered tools and resources.

   New Morning Youth and Family Services (NMYFS) continued to provide Latina women with additional skills to increase their independence and self-worth due to cultural factors. In November, December, and January, we had a three week self-advocacy group to encourage their personal growth and self-confidence. Some of the topics discussed included the effects of trauma, resiliency/adversity, self-advocacy skills, and family relationships and dynamics. NMYFS provided free child care to participants.

   NMYFS identified 24 Latino families (multi-generational in some households) that were struggling financially and were unable to provide enough food for their children. We referred them to Markham Middle School for Friday vegetables/fruits. However, they needed more substantial food sustenance. For this reason, NMYFS purchased $1,500 in grocery gift cards to help the identified families purchase food. Two of the families were grandmothers (*abuelas*) who were responsible for their grandchildren (a total of eight children).

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 *Promotoras* provide all their clients with respect; mindful that the Latino population has a mixture of diverse cultures, linguistics (Spanish dialects), nationalities, and spiritual beliefs. NMYFS provides information through social media to reduce racial/ethnic disparities.

The *Promotoras* attend community events hosted by non-profit organizations and county departments to increase cultural awareness and reduce racial/ethnic disparities. In addition, this year both *Promotoras* attended the "9th Women's Leadership Conference of Northern California" and '*Ventanilla de Salud'* located at the Consulate General of Mexico in Sacramento. Furthermore, Angie attended "Closing Wounds," a weekly training at the Consulate General of Mexico in Sacramento. The *Promotoras* attended a prevention and instruction training called "Fighting Tobacco Use in Gold Country Latino Communities" on the increase of tobacco use.

This year, NMYFS realized that our brochures did not specifically address how we could assist the Latino population. We revised the NMYFS Latino Outreach brochures in February to be more linguistically relevant and specific in the services we provide to the Latino population.

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 *Promotoras* collaborate with county and non-profit organizations in outreach events to support the Latino population. This quarter, we specifically reached out to locally-owned and operated family Mexican restaurants and Latino markets to post our services to help provide assistance to the Latino community. Angie was able to converse with approximately 25 Latino families at the Markham Middle School food bank on Fridays.

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.**
  95% of clients were satisfied with the assistance they received.

- **Measurement 2: Client outcome improvement measurements.**
  85% of clients indicated that there were improvements.

- **Measurement 3: Increased engagement in traditional mental health services.**
  There are 4 to 6 clients a month that are referred to mental health services.

- **Measurement 4: Number of Clients referred to County Behavioral Health, if known.**
  7 to 9 clients a year are referred to County Behavioral Health.

- **Measurement 5: Client self-report on the duration of untreated mental illness.**
  Unknown

- **Measurement 6: If known, the average interval between referral and participation in treatment.**

For mental health services, the interval is determined upon the client's 'level of care.' If the client requires prompt intervention, then 1-3 days. Likewise, a lower 'level of care' could be up to two months.

- **Measurement 7: A description of the methods Contractor used to encourage Client access to services and follow-through on referrals.**
  The *Promotoras* prefer to accompany their clients to the resources because of language barriers and biases. If for any reason (COVID-19) they are not able to accompany their clients, the *Promotoras* contact the resource to obtain specific instructions that client will need to know when client arrives at resource. Every client continues to receive follow-up and support until the client has resolution.

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

NMYFS continues to utilize community volunteers to provide additional educational services to Latino families. Furthermore, we provide counseling services in English or Spanish that are referred by Latino Outreach.

8) Provide any additional relevant information.

NMYFS has updated our electronic client case files to capture the demographic information required for MHSA. The demographic information is transferred to an Excel spreadsheet for Latino Outreach Client Registration.

MHSA Year-End Progress Report

Senior Peer Counseling Project

Provider: 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 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$55,000	$40,000	$48,000
Total Expenditures	$53,087	$34,493	$44,973
Unduplicated Individuals Served	43	83 total / 45 new added in FY 18/19. Data in FY 18/19 is based upon the new clients only.	69
Cost per Participant	$1235	$416 (based on 83 total clients)	$652
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	0	0	0
26-59 (adult)	5	3	5
Ages 60+ (older adults)	38	42	64
Unknown or declined to state	0	0	0

Race	FY 2017-18	FY 2018-19	FY 2019-20
American Indian or Alaska Native	0	2	3
Asian	0	0	2
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	40	43	63
Other	3	0	0
Multiracial	0	0	1
Unknown or declined to state	0	0	0
Ethnicity by Category	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Hispanic or Latino	0	0	1
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	2	0	0
Puerto Rican	0	0	0
South American	0	0	0
Other	0	0	0
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	43	62
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	1
Middle Eastern	0	0	0
Vietnamese	0	0	1
Other	0	2	1
Multi-ethnic	0	0	3
Unknown or declined to state	0	0	0

Primary Language	FY 2017-18	FY 2018-19	FY 2019-20
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	42	45	68
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	1	0	1
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	0	0	0
Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	0	0	1
Heterosexual or Straight	42	45	67
Bisexual	0	0	1
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	0
Another sexual orientation	0	0	0
Declined to State	1	0	0
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	7	8	14
Female	36	37	55
Declined to answer	0	0	0
Current gender identity:			
Male	7	8	14
Female	36	37	55
Transgender	0	0	0

Genderqueer	0	0	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	0	0	0
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	1	3	5
Difficulty hearing or having speech understood	2	0	16
Mental disability including but not limited to learning disability, developmental disability, dementia	0	0	2
Physical/mobility	0	9	33
Chronic health condition/chronic pain	0	4	14
Other (specify)	1	0	0
Declined to state	0	0	0
Veteran Status ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Yes	2	2	6
No	39	43	63
Unknown or declined to state	2	0	0
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	12	15	14
Placerville Area	26	18	34
North County	2	6	12
Mid County	2	5	8
South County	1	1	1
Tahoe Basin	0	0	0
Unknown or declined to state	0	0	0
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	10	15
Very low income	unknown	14	19
Low income	unknown	4	12
Moderate income	unknown	17	12
High income	unknown	0	11
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	1	4
Medi-Cal	unknown	1	6
Medicare	unknown	43	61
Uninsured	unknown	0	2

Annual Report FY 2019/20

Please provide the following information for this reporting period:

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 other major accomplishments and challenges.**

   Senior Peer Counseling, (SPC), is happy to report that implementation of all program goals are being met and activities are proceeding on target and as specified in the MHSA Plan. This year saw many accomplishments in the Senior Peer Counseling program as well as some challenges. First with the challenges. In late February, the pandemic COVID19 spread to our county and by early March, the clinical supervisor made a decision to stop weekly group supervision meetings and in-person counseling. At that time, SPC was also in the midst of training nine (9) new peer counselors, which had to be halted temporarily. Because of COVID19, our intakes of new counselees were greatly impacted with much fewer than normal in the months of February through June 2020. The pandemic also prevented us from continuing with in-person outreach activities. Another challenge was that sadly, we lost our only Admin Support person to cancer, so the Clinical Supervisor did some of her duties while others were left to be caught up on when a new person could be hired. During this fiscal year we also lost six (6) volunteer counselors, due to personal or health problems.

   Now, the accomplishments. Immediately in response to the pandemic COVID19 shelter-in-place orders, SPC transitioned to providing phone sessions to all existing clients as normally scheduled and weekly supervision was provided for each counselor via phone with the clinical supervisor. Within 30 days, online video conferencing via the Zoom platform was in place providing weekly group supervision for the counselors. This helped ensure seamless services for our clients and retention and cohesion of the SPC counselors as a group. Our program was modified to enable us to continue receiving intakes of new clients via a phone intake appointment. We also started the use of "Doxy.me", which is a HIPAA compliant, privacy protected video conferencing platform online, so that counselors could now meet with their clients online instead of just by phone. This is a Telehealth option which we were able to offer all existing and new clients, so that counseling services were not interrupted by the pandemic shelter-in-place orders.

   At the start of the pandemic, we also started offering an additional new service to all adults 55 and over. A "One Time Counseling Session" call was started to address the additional anxiety, isolation and distress being experienced due to the shelter-in-place orders, and the economic and social unrest. We were asked to provide such a service by the El Dorado County Senior Center Program Manager, and our volunteers quickly responded to the needs being seen by the Senior Center staff in Placerville. A resident can call our office, requesting to talk to a counselor, and with this service, a counselor will be provided via phone the same day. Residents accessing this service are also able to request ongoing counseling if needed. We continue providing this service currently to the entire county, including the Tahoe Basin.

   This year, even amid the pandemic, SPC was able to complete a training program for nine (9) new peer counselors. The 45-hour training program was started mid-February and had to be stopped mid-March due to the governor's stay-at-home orders. But that didn't stop us for long. During that break in training, the SPC clinical supervisor worked to acquire a group video conferencing online program, (Zoom), arrange for cancelled speakers to make presentations for the group online,

revamp the training program to allow for virtual learning and interactions and keep the momentum going for the enthusiastic new volunteers wanting to come on board to serve the senior population's mental health needs. All nine (9) trainees completed the program with flying colors and are now a valued part of the team helping to energize the entire program. We now have a staff of 22 excellent and enthusiastic volunteer counselors, one (1) new and amazing Administrative Support person, one (1) grateful Licensed Clinical Supervisor, and one (1) wonderful substitute Licensed Clinical Supervisor.

During this fiscal year, SPC provided in-service training to counselors by staff at Adult Protective Services. Counselors were trained on and/or had a refresher course on all the criteria for Elder Abuse and Neglect Reporting, how to collaborate with Adult Protective Services staff, reducing stigma about reporting and increasing safety measures, all in service of the older adult population. Another in-service training was provided by a CEU accredited trainer on working with difficult clients and the importance of mindsets. This training was a six (6) hour training on the basics of Cognitive Behavioral Theory as applied to counseling entitled, "Changing How We Feel by Changing How We Think". Ongoing training was also provided on how to talk about and assess for suicide in clients, implement safety protocols, connect to emergency psychiatric services, refer and link to a higher level of care, and provide follow up.

Another accomplishment was that one of our volunteer counselors did statewide research and wrote a proposal for a Friendly Visitor Program, to be used as an adjunct to the Senior Peer Counseling program. This is a vitally needed program for those seniors that don't quite reach the level of need or desire for goal-oriented counseling, but whose mental health is suffering or at risk for deterioration due to loneliness and isolation. The Friendly Visitor Program proposal was accepted and will start formally for the fiscal year 2020-2021.

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.**

One of the ways SPC has been able to improve the overall mental health of the older adult population is our quickness in engaging clients in counseling and referral services. We are able to accommodate all requests for services without a wait time, intake is provided almost immediately and the client is connected with a counselor within one (1) week. Referrals to community resources are made as the need becomes known throughout the counseling process, and if the client is determined to need a higher level of care by the clinical supervisor, the counselor works with the client to link to other mental health providers. By responding quickly, we give the message that clients are valued and important, setting the stage for their recovery and the accomplishment of their goals. The client establishes goals for counseling, related to their mental health needs, and become the focus of the counseling work.

Statistics from our data assessment measure at intake shows that when clients start counseling with us, 59% have been experiencing Emotional, Mental and/or Relationship distress for 2 years or more. This is prolonged and untreated suffering in the older adult population we serve. The other 41% has experienced distress for less than 2 years. Data at the end of counseling shows that counselees report a significant increase in their ability to cope with their lives having a more positive mindset,

increased social interactions and engagement in their communities, improved family relationships and a skillset for better management of their mental health in the future. Our counselors achieve this by the work they do to focus clients on improving the elements of therapeutic lifestyle habits, which when in balance, we know to produce good mental health. Counselors focus on connecting with their clients on a relational level, providing eye contact, using reflective listening skills, providing validation and normalization of their experiences, helping them see that they are not alone, and providing skills such as mindfulness and positive thinking to boost self-esteem and self-sufficiency. A lot of what our program does to reduce and relieve prolonged suffering in the older adults we serve is to provide hope and connection. Connection to a counselor, then to self, family, friends and community.

This past year we have had several clients who were suicidal either upon intake or during the course of counseling. We also have clients whose close family members have died by suicide, impacting them personally and increasing their own risk. Through our work, we have been able to successfully prevent any suicides from occurring. When a client discloses that they may be feeling suicidal, the clinical supervisor is immediately called and many supports are then put in place for that client. Preventing suicide is our first priority and we have been successful accomplishing that through our protocols and interventions, including but not limited to, connecting them with professional mental health treatment while we continue to support them. Providing connection, empathy, and hope is our greatest strength in this area. Counseling provides an opportunity for socialization starting with one and broadening out to becoming a part of one's community again. This reduces the negative impact of isolation that so many of our seniors face and greatly improves mental health.

Other negative outcomes to be prevented or addressed that we have dealt with have been homelessness, unemployment, underemployment and the financial instability of living on a low fixed income. We address those issues by providing a bridge and linkage to available community resources, providing emotional support, encouragement to take steps on one's own to improve the quality of their lives through action, empowerment through the building of positive thinking skills and true caring for another human being. Although we don't measure these areas of issues, I can report that through supervision of the counselors working with these individuals, I have learned that homelessness has been prevented or ameliorated, employment has been found and resources have been connected with from the community.

One of the best ways of expressing how SPC has improved the overall mental health of the older adult population is to share with you some of the comments they themselves have written on our Data Outcome measurements. Here's a sampling of what they have said:

- *"It is extremely helpful to talk things out with someone who can bring an objective point of view to help me find my own solutions. This is an incredible service. I hope our county can continue to support a very useful service. In the future should there be any fundraisers, I would love to volunteer to help."*
- *"My counselor was a helpful and caring person who helped me get through a difficult adjustment period. She always answered my calls and was a great listener."*
- *"I was given the tools needed to have a better life with my wife and others."*
- *"My counselor helped bring perspective to me and my attitude improved little by little."*
- *"The sessions were very helpful. My counselor was caring, knowledgeable and provided helpful material to read that helped."*

- ❖ *"My counselor is a great listener. She empathizes and provides meaningful suggestions. My husband received his diagnosis during the time we were meeting and she helped me to process the diagnosis and start to establish a new routine. I am very grateful to her."*
- ❖ *"My counselor offered new ways to look at situations that helped me manage my responses and not go down the rabbit hole. She helped me accept the way I was feeling which allowed me to move on from it. Thank you for the program being here."*
- ❖ *"My counselor made me feel very comfortable and did not judge me. She made me see things in my family that I would not think of, which I really respect her for. Gave me ideas of what to do on days when things seem to get low with me, which I still do thanks to her. She has helped me more in the short time I was with her than the many years with a so-called counselor from Kaiser."*
- ❖ *"The Senior Peer Counseling Group was responsive to my needs and always followed through with any of my concerns."*

3) Provide a brief narrative description of progress in providing services through the Senior Peer Counseling project to unserved and underserved populations. Underserved is defined in California Code of Regulations 3200.300 as "clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided with the necessary opportunities to support their recovery, wellness, and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, or other serious consequences."

Seniors make up a significant percentage of the population of El Dorado County. Most of those seniors' mental health needs go unserved or underserved. This is due to a variety of reasons. One of which is the fact that there is a shortage of Medicare contracted mental health providers in our county, the fact that in order to qualify for Medicare mental health treatment, one must meet "medical necessity" meaning a required psychiatric diagnosis. Many of our senior's problems don't rise to that level but are still negatively impacting their quality of life, self-care and physical health, connection with the community, and ability to stay in their own homes. Other factors that contribute to them being underserved is the lack of ability to drive, inability to pay out of pocket, generational stigma about asking for help and talking about mental health, and the fact that there is no community-based or publicly funded mental health clinic that provides services to seniors.

Goals for further expansion to underserved subgroups within the older adult population in general would be to increase access for veterans, the Latino and the LGBTQ communities.

Senior Peer Counseling is able to meet the needs of this underserved population by providing professionally trained peer counselors to residents 55 and older who are unable to access mental health services in our community. We do so at no cost to the recipient. Senior Peer Counselors address the mental health needs of the older population by providing prevention and early intervention strategies.

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.

The population of El Dorado County lacks very much in racial and ethnic diversity, and this is true of the referrals and clients we serve as well. 88% of our new clients this year have been Caucasian,

which matches the most recent census numbers for El Dorado County. We have had no clients that were not English speakers. This year we had one (1) client each from Korean, Vietnamese, Hispanic and Native American ethnicities. We will try to match clients to counselors who are of, or have knowledge and experience with, like cultures and ethnicities. When that isn't possible, our counseling strategy is one of humble learners about the clients' unique culture and ethnicity. Education is sought out about how to best support clients in the way that works best for them and within their culture, family system and beliefs.

Our counselors represent some diversity themselves and share their own knowledge and experience with cultural and ethnic differences with the group regularly. We have one (1) German speaking counselor, and one (1) Spanish speaking counselor, and a mix of religious and ethnic differences that bring value to understanding the disparities that are faced in the greater population.

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.**

Because our trained counselors are peers and the fact that they are volunteers, this greatly reduces the stigma associated with accessing mental health care for the older adult population. Our clients report feeling understood and not judged, being able to relate to a counselor who has experienced many of the same things they have related to ageism, loss of mobility and health, children moving away from them, disconnection with community, grief and loss, and so on. Through weekly group supervision meetings, ongoing training is provided to counselors on the topics of inclusiveness, acceptance of all as equals, understanding our underlying inherent biases, and eliminating discrimination, racism and sexism in any way.

Senior Peer Counseling has collaborated with the staff from the Senior Centers in Placerville and El Dorado Hills, as well as the Cameron Park Community Center, to provide on-site counseling services on an ongoing or one-time only basis. We have collaborated with various case managers and social workers from the medical community, residential care facilities to provide outreach and receive referrals. Until the pandemic started, representatives from SPC were attending the Green Valley Church Community Leadership Luncheons and Trainings, to educate many local nonprofits who attend, about our program and services and to learn about the trends and needs in our communities. During one of these, we participated in a training about understanding one's own underlying biases about topics such as homelessness, LGBTQ, drug addiction, domestic violence, suicide and ethnic differences. One of our counselors is also a member of the Area Agency on Aging and collaborated with them on the needs of older adults in our county and what our program provides for improving the mental health of this population. A presentation about Senior Peer Counseling was made by two (2) of our volunteer counselors to a Georgetown United Methodist Church. We have also collaborated with and offered presentations to residents at Gold Country Retirement Community. Our volunteers spread the word about SPC through one-on-one local and personal interactions in their own neighborhoods and communities, as well as placing our advertising rack cards in many local businesses. In the latter part of the fiscal year with the pandemic in full swing, we have taken to outreach phone calls to spread the word that we are still operating at full capacity. SPC also advertises in the Mountain Democrat newspaper, The Clipper advertising paper, The Senior Times, and some other local neighborhood papers. This fiscal year, SPC applied for and is now included in the new 211 local phone information line which helps with outreach as well.

Through weekly supervision provided by a licensed therapist, counselees who are identified to need more care than we can provide are referred to and linked with a professional therapist. They are followed by a peer counselor until the connection has been made and have the option of continuing to receive supportive counseling from SPC as well. We are in contact with local therapists who are willing and able to accept Medicare patients. We also have the protocol to refer clients suffering from depression, anxiety or trauma to their primary care physician for a complete physical and evaluation of their mental health. Counselors provide encouragement and linkage support to get seniors connected to these vital medically necessary services.

6) **Provide the outcomes measures of the services provided. Outcome measures for the Senior Peer Counseling project are:**

Due to the COVID19 pandemic between the months of February - June 2020, this has greatly impacted our ability to collect data we would normally collect during in person sessions. Our counselors have been providing phone or online sessions but have not been able to collect the normal data on Measurements 1 and 2, and Measurement 3 has reduced number of completed self-report forms.

- **Measurement 1: Contractor will have peer counselors complete a pre-and post-rating form with the client to measure Therapeutic Lifestyle Changes, 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: Exercise, nutrition/diet, nature, relationships, recreation/enjoyable activities, relaxation/stress management, religious/spiritual involvement, contribution/services.**

  This outcome tool we have titled "Lifestyle Hygiene" and it measures the therapeutic lifestyle habits of clients. This measure is given to clients at the beginning, every three months, and at the end of the counseling process. Results below show improvements in these pro-mental health areas, showing overall clients have become more interested in engaging with their communities and in attending to their own healthy self-care habits.

  Data Results: N=30 Rating Scale: 0=Deficient, 5=Just Right, 10=Excessive

  (Results are shown as pre and post number averages)

Exercise: 2 to 4	Recreation/Enjoyable Activities: 3 to 6
Nutrition and Diet: 3 to 5	Relaxation/Stress Management: 2 to 5
Nature: 5 to 7	Religions/Spiritual Involvement: 2 to 5
Relationships: 3 to 5	Contributions/Volunteering: 1 to 4

- **Measurement 2: Volunteers will record the clients' self-reported improvement in the presenting problem selected by each client at the start of the peer counseling.**

  This instrument measures the client's self-reported improvement in the presenting problem and goal chosen by them at the outset of counseling. We use it at the end of every session until goals as met and counseling ends. Data results show that overwhelmingly clients made improvements, found solutions to their problems and reached their preset counseling goals. This represents a huge increase in their self-efficacy, reduced suffering and improved mental health.

Data Results: N= 84 sessions
Questions Asked:

1. How well did you feel heard and understood? 0=not at all, 5=well understood
   Average score: 4.95 (score of 5= 80, score of 4=4)

2. How helpful was our session today? 0=not helpful, 5=very helpful
   Average score: 4.73 (score of 5=64, score of 4=18, score of 3=2)

3. How do you feel after our session today? Worse, same, better
   Average score: Better (Better=89%, Same=10%, Worse=1%)

4. Do you believe there has been improvement in your original problem/s? Yes/No
   Average Score: Yes (Yes= 98%, No=2%)

- **Measurement 3: Outcome Rating Scale (ORS) measurement tool, which measures the following four psychological categories: Individually (personal well-being), interpersonally (family, close relationships), socially (work, school, friendships), and overall (general sense of well-being)**

  This is an outcome tool that is given at the end of the client's counseling to measure four (4) realms of psychological health. They are: Individual, Interpersonal, Social, and Overall Wellbeing. It also asks the client to rate how well the volunteer did as their counselor. The results, as stated below, prove that SPC is improving older adults' quality of life with statistical significance. It shows that not only are problems with mental health being prevented from becoming severe and disabling, but that there is an overall improvement at the end of the counseling experience.

  Data Results: N=11

  Individually (personal wellbeing): 0=worse, 5=the same, 10=better
  Average Score: 8.64

  Interpersonally (family, close relationships): 0=poor, 10=excellent
  Average Score: 7.91

  Socially (work, friends, groups, community): 0=not satisfied, 5=satisfied, 10=very satisfied
  Average Score: 7.18

  Overall (General Sense of Well-Being): Gotten worse, Stayed the same, Improved
  Average Response: Improved (9 were Improved, 2 Stayed the same)

7) Report on unduplicated numbers of individuals served, including demographic data.

Please reference the demographics table at the beginning of this report.

8) Report on the reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational-functioning.

Our outcome measurement tools given at the end of counseling, (Outcome Rating Scale called The Termination Evaluation), measures life suffering in the areas of Individual, Interpersonal and Social functioning, as well as their Overall or general sense of Well-being after receiving Senior Peer Counseling services. Upon intake, clients are asked how long they have been suffering emotionally, mentally and in their relationships. This fiscal year, the average length of time suffering at intake was more than 6 months. Average length of counseling is 1 year. Risk factors of suicide, loneliness, poor physical health, deteriorating mental health and social isolation were greatly reduced or eliminated. Results for the Outcome Rating Scale show Individual or Personal Well Being at 86%, Interpersonal Well Being, (Family and Close Relationships), at 79%, Social Well Being, (work, friends, groups, community), at 71%, and their Overall Sense of Well Being as Improved. This demonstrates an increase in protective factors for their future due to acquiring learned skills with positive personal mindsets, connections with community and improved relational communication skills, all resulting in improved self-efficacy.

9) If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.

Four clients were referred to private licensed therapists in the community, but none were referred to County Behavioral Health.

10) If known, the number of individuals who followed through on the referral and engaged in treatment.

Unknown

11) If known, provide the average interval between mental health referral and participation in treatment.

Unknown

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

<u>Expenditures from MHSA Budget</u>

- The cost of Weekly Supervision of the Volunteers: $ 13,290
- The cost of General Administration: $ 15,180
- The cost of Administrative Support: $5,341
- The cost of Training: $ 10,230
- The cost of Mileage for Volunteers: $596
- The cost of General Expenses: $367

Total MHSA Expenditures: $45,004

Donations Received

- Client Donations: $980[1]
- Foundation Donations: $1,000

Expenditures from Donated Monies: $ 1,523

13) Provide any additional relevant information.

Although not exciting, this year several forms and documents were rewritten, updated, and improved. Among them was the Informed Consent form which was rewritten to adhere to all legal and ethical considerations for the services being provided. The staff of volunteers was retrained on how to deliver, discuss and obtain Informed Consent for Counseling. Ethical and legal issues related to counseling has been on ongoing topic for discussion and training by the Clinical Supervisor. The volunteer counselors continue to grow in their knowledge and professionalism. This translates into better and more effective mental health counseling provided to the older adult population.

Despite the pandemic and the challenges it has presented to our program, staff and the counselors themselves, we have managed to provide seamless ongoing services to our clients, deliver meaningful and productive sessions to them, and they have reported how participating in the counseling has made improvements to their lives. Senior Peer Counseling is proud to be able to serve the older adult population in El Dorado County.

[1] SPC receives donations from clients, businesses and individuals in the community. Although a $5 donation per session is suggested at the outset of counseling, no one is ever turned away for inability to donate. These donations are used to pay for ongoing trainings for our volunteers and general office supplies.

Project: Senior Link

Senior Link is a partner program to the "Partnership Between Senior Nutrition and Behavioral Health" Innovation project, which was approved by the Mental Health Services Oversight and Accountability Commission in January 2020. An RFP is under development, therefore there is no data to report for the Senior Link project in FY 19/20.

MHSA Year-End Progress Report

Primary Intervention Project

Provider: Black Oak Mine Union School District (BOMUSD)

Project Goals

- Provide services in a school-based setting to enhance access.
- Build protective factors by facilitating successful school adjustment.
- Target violance 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

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$77,000	$77,000	$77,000
Total Expenditures	$72,952	$73,278	$68,177
Unduplicated Individuals Served	57	72	78
Cost per Participant	$1,280	$1,018	$874
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	57	72	78
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 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	2	5	2
Asian	2	2	0
Black or African American	6	4	1
Native Hawaiian or Other Pacific Islander	0	0	2
White	47	60	73
Other	0	1	0
Multiracial	0	0	0
Unknown or declined to state	0	0	0
Ethnicity by Category	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**

Hispanic or Latino	0	0	4
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	0	0	0
Puerto Rican	0	0	0
South American	0	0	0
Other	0	0	74
Unknown or declined to state	0	1	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	0	0
Multi-ethnic	0	0	0
Unknown or declined to state	53	0	0
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	56	71	77
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	1	1
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	1	0	0

Sexual Orientation ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	NA	NA	NA
Heterosexual or Straight	NA	NA	NA
Bisexual	NA	NA	NA
Questioning or unsure of sexual orientation	NA	NA	NA
Queer	NA	NA	NA
Another sexual orientation	NA	NA	NA
Declined to State	NA	NA	NA
Gender ***Collection of gender identity information from a minor younger than 12 years of age is not required.**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	37	45	39
Female	20	27	39
Declined to answer	0	0	0
Current gender identity:			
Male	NA	NA	NA
Female	NA	NA	NA
Transgender	NA	NA	NA
Genderqueer	NA	NA	NA
Questioning / unsure of gender identity	NA	NA	NA
Another gender identity	NA	NA	NA
Declined to answer	NA	NA	NA
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	0	0	0
Difficulty hearing or having speech understood	0	0	0
Mental disability including but not limited to learning disability, developmental disability, dementia	0	0	0
Physical/mobility	0	0	0
Chronic health condition/chronic pain	0	0	0
Other (specify)	0	0	0
Declined to state	57	72	78

Veteran Status *Collection of this information from a minor younger than 12 years of age is not required.*	FY 2017-18	FY 2018-19	FY 2019-20
Yes	NA	NA	NA
No	NA	NA	NA
Unknown or declined to state	NA	NA	NA
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	0	0	0
Placerville Area	0	0	0
North County	57	72	78
Mid County	0	0	0
South County	0	0	0
Tahoe Basin	0	0	0
Unknown or declined to state	0	0	0
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	unknown	unknown
Very low income	unknown	unknown	unknown
Low income	unknown	unknown	unknown
Moderate income	unknown	unknown	unknown
High income	unknown	unknown	unknown
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	unknown	unknown
Medi-Cal	unknown	unknown	unknown
Medicare	unknown	unknown	unknown
Uninsured	unknown	unknown	unknown

Annual Report FY 2019-20

Please provide the following information for this reporting period:
Note, in FY 2017-18 and 2018-19, this Project was known as the Primary Intervention Project and only served children in kindergarten through third grade. In FY 2020, this Project was adapted to the Primary Project and children in transitional-kindergarten through third grade were eligible.

1) **Briefly report on how implementation of Primary Project (PP) 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 four (4) part-time Aides served three (3) elementary schools: American River Charter (one day per week), Georgetown School of Innovation (four days per week), and Northside STEAM School (four days per week). We served a total of 78 students over two (2) semesters. Unfortunately, our

year was cut short when the shelter-in-place order closed all schools on March 17, 2020 (public health pandemic), which was about six 6 weeks into the second semester.

However, the year started as our best so far!

Accomplishments: We were able to fill most of our available client time slots within a week of starting. In past years, it normally took a few weeks to obtain teacher recommendations and parent permissions. I recognize a couple factors that precipitated this:

Firstly, teachers and parents increasingly want PP services because of the positive changes seen in the children who experience the program, such as better focus in the classroom and improved peer relationships. When our PP semester began, about three (3) weeks after the start of school, we were able to achieve the results of screening procedures and recommendations more efficiently than in past years.

Secondly, because our elementary schools are serving more children with school adjustment issues, the demand is higher.

We served the most students than any previous year!

Challenges: Obviously, the biggest challenge this year (and trending into the next) was the closure of schools for in-person learning. Our team considered how we could continue to serve our clients. Our model is based on one-to-one, in-person, child-directed play. We could not meet physically with our children. We chose to hand write letters, with pictures and simple activities, and send them by mail to the students who were not able to complete the semester.

A second challenge was starting the year without a playroom at American Charter School. (ARCS). The Child Aide assigned to be there one (1) day/week, instead, added a day to Georgetown School, where demand was very strong for PP. However, by the time second semester arrived, ARCS had remodeled a classroom into a new playroom just for PP!

2) **Briefly report on how PP has improved the overall mental health of the children, families, and communities by addressing the primary negative outcome that is the focus of PP (school failure or dropout). Please include other impacts, if any, resulting from PP 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 following was written in January 2020, by a First Grade teacher at Northside STEAM School. She has over 25 years of teaching experience:

"D. is a 6 year old boy who had anger, lack of trust, stealing, destructive and lying issues when he first started the year in first grade. He was often getting into physical and verbal altercations, in and out of the classroom, as well as before and after school on the bus, taking things and destroying school property. Often he would take flight from the scene of the altercation making it necessary for his safety and well-being to require administrative assistance to help bring him back both in physical location as well as emotional state of being. I received many complaints from students as well as other adults regarding the safety of other students and personal items. That's when I sought assistance through our counselor and our PIP providers. The relationships that D. has been able to

develop with his PIP advisor helped him to feel more connected to school. She has given him individual, one-on-one time that he truly needed through a supportive and encouraging risk-free environment. Her keen and genuine interest has encouraged him through discussion and play scenarios to become more trusting, compassionate with others, greatly reducing confrontations and has helped him tremendously to be more open and engaged in learning in the classroom setting. Where once a boy who found it hard to trust, ran away from conflicts, was disinterested in participating in class both in class discussions and producing any written tasks, is now working at grade level in all areas, trying to complete tasks in a timely fashion, no longer feels the need to run from conflict, and now cares so much for others that he looks for ways to jump in and help whenever possible. In his six (6) short years of life, he has had so many traumatic events happen to him and yet with support and encouragement can begin to change the direction of his life. Programs such as PIP help so many children make positive connections to school, simply because someone shows that they care."

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

   Increasing PIP services to unserved and underserved populations is addressed in answers to Question 5, below.

4) **Provide a brief narrative description of how PP 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.

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.**

   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.

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

   Unknown

7) **Provide the outcomes measures of the services provided. Outcome measures for the Primary Project are:**

- **Measurement 1: Administer Walker Assessment Scale (WAS) assessment tool to students at the time student is selected to enter the program and again when the student exits the program (contracted vendor will be responsible for procuring use of the WMS tool).**

2019-20 PIP Walker-McConnel Scale (WMS) Scores (BOMUSD)

Note: A score of zero (0) indicates that a survey was provided, but due to the abrupt "shelter-in-place" due to the Public Health Emergency, the survey was not able to be collected.

"Unknown" means the Contractor was not able to provide the end survey because the child had only been in the program for a few visits before the "shelter-in-place" due to the Public Health Emergency.

Therefore, for these reasons, the "Difference" was not calculated for some individuals.

Identifying Number	WMS Start	WMS End	Difference
G1	61	0	
G2	151	0	
G3	156	0	
G4	68	0	
G5	124	0	
G6	124	0	
G7	99	0	
G8	127	0	
G9	150	182	32
G10	181	184	3
G11	135	0	
G12	169	188	19
G13	213	213	0
G14	126	139	13
G15	107	0	
G16	128	0	
G17	112	0	
G18	113	0	
G19	131	0	
G20	118	0	
G21	100	96	-4
G22	215	Unknown	
G23	0	Unknown	

G24	0	Unknown	
G25	202	Unknown	
G26	0	Unknown	
G27	0	Unknown	
G28	0	Unknown	
G29	0	Unknown	
G30	0	Unknown	
G31	201	Unknown	
G32	215	Unknown	
G33	0	Unknown	
G34	0	Unknown	
G35	0	Unknown	
G36	115	Unknown	
G37	0	Unknown	
G38	0	Unknown	
G39	0	Unknown	
G40	0	Unknown	
G41	0	Unknown	
G42	0	Unknown	
G43	150	Unknown	
N1	117	150	33
N2	159	149	-10
N3	167	176	9
N4	111	129	18
N5	130	173	43
N6	126	136	10
N7	116	143	27
N8	106	121	15
N9	0	124	
N10	93	79	-14
N12	180	204	24
N13	115	173	58
N14	169	205	36
N15	145	204	59
N16	153	206	53

N17	158	166	8
N18	135	126	-9
N19	141	154	13
N20	120	181	61
N21	115	177	62
N22	112	Unknown	
N23	120	Unknown	
N24	132	Unknown	
N25	147	Unknown	
N26	152	Unknown	
N27	207	Unknown	
N28	154	Unknown	
N29	197	Unknown	
N30	150	Unknown	
N31	136	Unknown	
N32	180	Unknown	
N33	0	Unknown	
C1	0	Unknown	
C2	0	Unknown	
C3	0	Unknown	
C4	0	Unknown	

- **Measurement 2: Completion of service delivery report to the County on a PP semester basis showing number of students served.**

  Completed in separate documents

- **Measurement 3: Completion of year-end progress report to the County showing annual number of students served and pre- and post- WAS scores, identifying program successes, challenges faced and post-PP participation outcomes for the children.**

  See above measures

8) **Report on unduplicated numbers of individuals served, including demographic data.**

   Submitted in separate document

9) **Report on the reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational-functioning.**

Primary Project is a prevention and early intervention model. Increased protective factors:

- "… coping skills like compassion, self-regulation, self-confidence, the habit of active engagement, and the motivation to learn and be literate cannot be instructed. They can only be learned through self-directed experience (i.e. play)" -Susan J. Oliver, "Playing for Keeps"
- Early engagement and success in school. PIP students overwhelmingly are enthusiastic about coming to school
- Positive relationships with trusted adults
- Express him/herself symbolically
- Succeed at new things
- Practice skills that may be perceived by the child as being too difficult
- Experience a calm and positive environment
- Recreate experiences and change outcomes
- Experiment and find strengths
- Try new behaviors and play other roles
- Learn things for themselves that can't be taught

10) If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.

Unknown

11) If known, the number of individuals who followed through on the referral and engaged in treatment.

Unknown

12) If known, provide the average interval between mental health referral and participation in treatment.

Unknown

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

Total expenditures: $72,246.00
In-kind contributions: Dedicated playrooms and office equipment at three (3) school sites**.**

14) Provide any additional relevant information.

Many of the WMS scores are missing because of the shelter-in-place due to the Public Health Emergency interruption in the second semester. The WMS score is not considered valid if the student only participated for a few weeks.

MHSA Year-End Progress Report Fiscal Year

Primary Intervention Project

Provider: 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 violance 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

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$88,000	$88,000	$88,000
Total Expenditures	$47,977	$28,940	$13,740
Unduplicated Individuals Served	42	43	24
Cost per Participant	$1,142	$673	$573
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	24	43	24
16-25 (transitional age youth)	0	0	0
26-59 (adult)	18	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0
Race	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	0	2	0
Asian	0	0	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	0	17	15
Other	13	0	4
Multiracial	15	0	0
Unknown or declined to state	14	0	5
Ethnicity by Category	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**

Hispanic or Latino	0	0	0
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	7	21	4
Puerto Rican	0	0	0
South American	1	0	0
Other	7	0	0
Unknown or declined to state	0	1	20
Non-Hispanic or Non-Latino			
Non-Hispanic or Non-Latino	13	0	0
African	0	2	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	1
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	0	1
Multi-ethnic	0	0	0
Unknown or declined to state	14	0	18
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	33	31	15
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	1	0
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	5	0	9

Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	0	N/A	N/A
Heterosexual or Straight	16	N/A	N/A
Bisexual	0	N/A	N/A
Questioning or unsure of sexual orientation	0	N/A	N/A
Queer	0	N/A	N/A
Another sexual orientation	0	N/A	N/A
Declined to State	26	N/A	N/A
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	14	N/A	14
Female	28	N/A	10
Declined to answer	0	N/A	0
Current gender identity:			
Male	14	N/A	N/A
Female	28	N/A	N/A
Transgender	0	N/A	N/A
Genderqueer	0	N/A	N/A
Questioning / unsure of gender identity	0	N/A	N/A
Another gender identity	0	N/A	N/A
Declined to answer	0	N/A	N/A
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	1	1	0
Difficulty hearing or having speech understood	0	1	0
Mental disability including but not limited to learning disability, developmental disability, dementia	0	0	0
Physical/mobility	0	0	0
Chronic health condition/chronic pain	2	0	0
Other (specify)	5	0	0
Declined to state	34	0	24
Veteran Status ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**

Yes	1	1	N/A
No	35	0	N/A
Unknown or declined to state	6	42	N/A
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	7	0	0
Placerville Area	23	0	0
North County	1	43	0
Mid County	2	0	0
South County	3	0	0
Tahoe Basin	4	0	24
Unknown or declined to state	2	0	0
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	2	1
Very low income	unknown	2	2
Low income	unknown	15	4
Moderate income	unknown	9	7
High income	unknown	0	1
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	10	4
Medi-Cal	unknown	12	7
Medicare	unknown	0	unknown
Uninsured	unknown	0	unknown

Annual Report FY 2019-20

Please provide the following information for this reporting period:
Note, in FY 2017-18 and 2018-19, this Project was known as the Primary Intervention Project and only served children in kindergarten through third grade. In FY 2020, this Project was adapted to the Primary Project and children in transitional-kindergarten through third grade were eligible.

1) **Briefly report on how implementation of Primary Project (PP) 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.**

   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 the children in non-directed play. However, there were no challenges with the children as we moved through the semester.

Tahoe Youth & Family Services had several challenges. Prior to starting this school year, Tahoe Youth & Family Services had to hire a new PIP worker. She started out doing a great job but by December began being inconsistent with her attendance in seeing the children. This Executive Director also struggled with her doing her paperwork correctly and timely. This Director provided significant training to her but with little improvement. This Director believes there was a language barrier and she did not want to admit that she did not understand. Once school started back up after the Christmas break, her attendance was again poor. When this Director spoke with her about it, she immediately resigned and said the job was too stressful.

This Director immediately advertised for another PIP worker. Once trained, she worked one (1) week and then resigned and said it just was not going to work out. This Director, with the resignation of two (2) PIP workers in a row, tried to meet with them to see what went wrong and why they resigned but with no avail. They would not return my phone calls. Two (2) days later, the schools closed-down because of the COVID-19 Public Health Pandemic and never reopened for the rest of the school year.

The plan had been to allow the new person to see those students for an additional two (2) weeks to make up for the lost time they had with the first PIP Worker, but this was unable to happen since the schools closed. The teachers were unable to complete the POST Walker-McConnell Scale (WMS) forms for those students attending Sierra House, Tahoe Valley and Magnet, so they are not included in the Duerr Evaluation.

During this first semester the only school that completed the first semester post WMS forms was Bijou, for a totally 19 students. Teachers were in the process of getting permission slips signed for the second semester of students when the schools closed due to COVID-19.

Accomplishments:
There were some positives from this school year that occurred. The schools are still very supportive of this program and do not blame Tahoe Youth & Family Services for what happened with our staffing issues. They really want this program to continue and see a huge need for their students for this program.

This Director has a viable candidate who is bilingual who is very much interested in this position for this coming Fall. This individual contracted with me for four (4) months providing community outreach and did a fabulous job, so I have no doubt she will be excellent in this position.

The children who successfully completed the program from Bijou evaluations results were very positive.

2) **Briefly report on how PP has improved the overall mental health of the children, families, and communities by addressing the primary negative outcome that is the focus of PP (school failure or dropout). Please include other impacts, if any, resulting from PP 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.**

At Bijou elementary school, our PIP Worker was able to build a bond with three (3) of the children. These three (3) children were very shy at the beginning of the semester and as time went by the

children really looked forward to attending PIP on a weekly basis. The PIP worker saw a positive accomplishment on how the three (3) children were more talkative while playing and were less shy.

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

The majority of children that are served by the PIP program are from the underserved populations in Tahoe. Tahoe Youth & Family Services have made every effort to hire a PIP Worker who is Hispanic and is bi-lingual and bi-cultural since in the Tahoe community the Hispanic children have the greatest need. This can be challenging but when we find a bi-lingual, bi-cultural individual we see the greatest improvement in the children.

As you can see, the students we served from Bijou Elementary school made significant improvement according to Duerr Evaluation Services. This means they will be more likely to succeed as they move forward in school.

4) **Provide a brief narrative description of how PP 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 the 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 if necessary.

The 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 (i.e., after school Social Skills programs, Summer programs run other organizations such as the Boys and Girls Club etc.).

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

No referrals were made this year for PIP children for additional resources.

7) Provide the outcomes measures of the services provided. Outcome measures for the Primary Project are:

- **Measurement 1: Administer Walker Assessment Scale (WAS) assessment tool to students at the time student is selected to enter the program and again when the student exits the program (contracted vendor will be responsible for procuring use of the WAS tool).**

19 children from Bijou Elementary school completed this program. In Bijou elementary school the teachers administered the Pre and Post WMS Assessment.

In Bijou, one student moved out of the area.

- **Measurement 2: Completion of service delivery report to the County on a PP semester basis showing number of students served.**

  19 students completed this program successfully. Five (5) children were given the pre-WMS Assessment and were provided services but did not complete the post WMS form due to COVID-19.

- **Measurement 3: Completion of year-end progress report to the County showing annual number of students served and pre- and post- WAS scores, identifying program successes, challenges faced and post-PP participation outcomes for the children.**

  The Duerr Evaluation is attached to this report.

8) **Report on unduplicated numbers of individuals served, including demographic data.**

   There are no duplicated numbers in this report.

9) **Report on the reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational-functioning.**

   No response was provided.

10) **If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.**

    To my knowledge there were none.

11) **If known, the number of individuals who followed through on the referral and engaged in treatment.**

    I have no knowledge of this information.

12) **If known, provide the average interval between mental health referral and participation in treatment.**

    To my knowledge there were none.

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

    TYFS spent $13,789.30 in staff salaries with an additional $198.97 for toys for the children, which equals total expenditures of $14,107.43.

14) Provide any additional relevant information.

No additional information was provided.

The MHSA Team will provide technical assistance to the Contractor to enable responding to Question 9.

EARLY INTERVENTION PROGRAM
LOCAL EVALUATION DATA REPORT

2019/20

prepared by:
Duerr Evaluation Resources

under contract to:
Tahoe Youth and Family Services

Project Coordinator: Karen S. Carey

<u>School(s) Included in Report:</u>
Bijou Community

PROJECT SUMMARY

During 2019/20, many schools providing mental health program services contracted with Duerr Evaluation Resources to assist in collecting and reporting evaluation data. The goal of local programs was to identify, select, and provide services to children who were experiencing mild-to-moderate school adjustment difficulties in terms of social behaviors related to peers and teachers, or with classroom study behaviors. Once students were identified through a systematic selection process, parents were contacted, informed of the program, and asked to provide written permission for their child to participate. To provide outcome evaluation information regarding the impact of project services, teachers were asked to rate their students who participated in the program both before and after services.

For purposes of this report, complete evaluation data was received for a total of 19 participants from Bijou Community school within the Tahoe Youth & Family service area. The evaluation data for this project revealed that teachers felt that 62 percent of participants showed some level of improvement in overall school adjustment. Teacher ratings of teacher-preferred social behaviors, such as sensitivity, empathy, cooperation, and self-control, among participants before entering services was an average percentile score of 24 and after services it was 42. Teachers' ratings of appropriate peer-related social behaviors among participants, such as interaction with peers, helpfulness, ability to make friends, leadership, perceptiveness, communication, and sharing with others, changed from an average percentile score of 23 to 40, respectively. Teachers' ratings of the classroom work habits of participants, such as study habits, listening skills, participation, responsiveness, and quality of work, changed from an average percentile score of 38 at the beginning of services to 48 at the end of services. The combined teacher ratings for overall school adjustment and social competence changed from an average of 25 to 43 on a pre- to post-participation basis.

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I. INTRODUCTION

Instrument and Methods

The Walker-McConnell Scale (WMS) was completed by teachers for each participating student in their class on a pre- and post-participation basis in order to show the impact of the services on various school adjustment factors. The instrument is described in additional detail, as follows.

Walker-McConnell Scale of Social Competence and School Adjustment

The WMS consists of 43 positively worded descriptions of adaptive behavior and interpersonal social competence. The first two subscales measure social skills, and the third measures adaptive behavior required for success in classroom instructional settings.

The WMS was used to evaluate the impact of local-funded projects on participants' adaptive behavior and interpersonal social competence. Adaptive behavior refers to the set of skills necessary to function independently in a classroom instructional setting. Interpersonal social competence refers to the skills necessary to maintain adequate social interactions with others. The advantage of this instrument is that it is completed through the observation of student behaviors that are easily identifiable in the day-to-day classroom setting. A brief description of each subscale is presented on the following page.

SUBSCALE 1
TEACHER-PREFERRED SOCIAL BEHAVIOR

This subscale consists of 16 items to measure the social behaviors that are highly valued or preferred by teachers during non-instructional interactions with students. Items in this subscale reflect levels of sensitivity, empathy, cooperation, self-control, and socially mature forms of behavior in peer relations.

SUBSCALE 2
PEER-PREFERRED SOCIAL BEHAVIOR

This 17-item subscale measures social behaviors that are highly valued by peers in terms of peer dynamics and social relations in free play settings. The behavior content of items in this subscale reflect levels of interaction with peers, helpfulness, ability to make friends, leadership, perceptiveness, communication, and sharing with others.

SUBSCALE 3
CLASSROOM ADJUSTMENT BEHAVIOR

This 10-item subscale measures adaptive social-behavioral competencies highly valued by teachers in classroom instructional contexts. The content of this subscale reflects student competencies which teachers feel are necessary to be effective in the management of instructional environments in areas such as student study habits, listening skills, participation, responsiveness, and quality of work.

Classroom teachers completed the WMS for all students who received parental consent to participate in the project. Teachers filled out a WMS within one week before students started the project and again within one week after students exited the project. These data were then analyzed to determine whether changes in school adjustment factors had occurred during the period of time that participants received services.

Uses of Evaluation Data

There are a variety of uses for the data contained in this report. These materials can be used to identify strengths and weaknesses of the project, efficacy of student selection and service delivery, and project impact. Parents, teachers, principals, and project staff usually welcome information regarding changes in school adjustment among individual students. The aggregate data contained in this report can also be very useful for presentations to school boards, parent groups, teachers, media, and other stakeholders to help build support for the project and for extending district funding beyond the three-year grant period. To help in presenting the local project evaluation "picture," colorful and easy-to-understand charts are attached. These charts are presented on a full page to simplify reproducing overheads or hand-outs for such presentations.

II. OUTCOME EVALUATION INFORMATION

This section of the report examines the changes in school adjustment characteristics participants exhibited over the period of time they received local-funded services before outcome data is presented, short definitions of the statistics used to report the findings should be reviewed.

n:	For purposes of reporting local project evaluation information, “participants” are defined as those students who completed four or more sessions and for whom teacher completed WMSs on a pre- and post-participation basis.
Average Raw Score:	The average (mean) score.
Average Percentile Score:	The percentile equivalent score for the average (mean) raw score.
Net Raw Change:	This difference between the average post-WMS and the average pre-WMS scores. [Post minus Pre equals Net Change.] A positive value indicates improvement.
Net Percentile Change:	This difference between the percentile equivalent score for the average post-WMS and the percentile equivalent score average pre-WMS scores. [Post minus Pre equals Net Change.] A positive value indicates improvement.
Effect Size:	A measure of the strength of the association between the effects of program participation and pre-post changes on school adjustment measures. Effect sizes are independent of sample sizes, which make comparisons of changes between different sized groups of participants possible (i.e., school- or grant-level changes). Effect sizes can take values from 0, or no effect, to 1, or maximal effect. As generally agreed upon 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-Value:	The probability that the difference in pre-to-post averages was not due to random chance. Data were analyzed using a t-Test to determine probabilities at the 95% confidence level. Generally, P-Values of less than .05 are considered statistically significant.

Pre- and Post-Participation Ratings of School Adjustment

Figure 1 shows the total average WMS scores before and after services for all 2019/20 participants at each of the sites funded under this grant. In addition, the percentile equivalent scores are presented in order to show the relative school adjustment status of participants in comparison to all K-3 grade students nationally. Percentile equivalents indicate the percentage of all students throughout the nation who would score lower on the WMS (i.e., higher scores are better). Figure 1 also shows magnitude of the pre- to post-participation changes in terms of the “Net Raw Change,” the “Net Percentile Change,” the “Effect Size,” and “P-Value”. Positive scores in the “Net Raw Change” and “Net Percentile Change” columns indicate improvement in school adjustment behaviors, while negative scores indicate a worsening in school adjustment behaviors as measured by the WMS. (See page 4 for definitions.)

FIGURE 1
CHANGES IN SOCIAL COMPETENCE AND SCHOOL ADJUSTMENT RATINGS FOR PARTICIPANTS

School Name / Scale	n	Average Scores for WMS Scale: Before Participation Raw Score	Before Participation %ile Score	After Participation Raw Score	After Participation %ile Score	Net Change and Significance Testing: Net Raw Change	Net %ile Change	Effect Size	P-Value
Bijou Community	13								
Teacher-preferred		52.7	24	61.2	42	8.5	18	.46	.009
Peer-preferred		54.6	23	62.5	40	7.9	17	.54	.046
Classroom Adjustment		36.1	38	38.8	48	2.7	10	.43	.121
(Total) Overall WMS Scale		143.4	25	162.5	43	19.2	18	.54	.046

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).
Also see page A for expanded definitions of column headings.

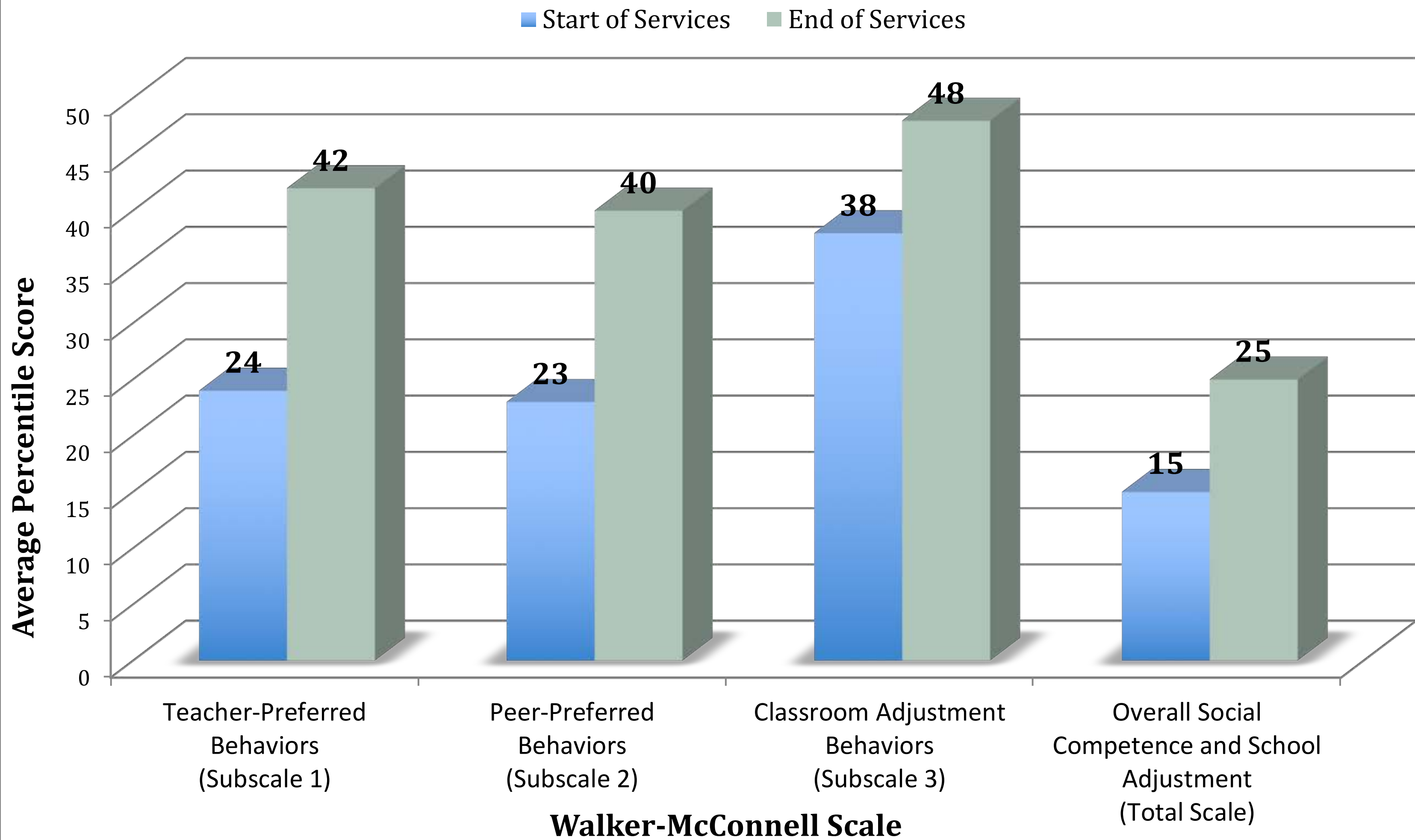


Figure 2
Pre-Post School Adjustment Ratings For Local Participants
Start of Services
End of Services
Average Percentile Score
0
5
10
15
20
25
30
35
40
45
50
24
42
23
40
38
48
15
25
Teacher-Preferred Behaviors (Subscale 1)
Peer-Preferred Behaviors (Subscale 2)
Classroom Adjustment Behaviors (Subscale 3)
Overall Social Competence and School Adjustment (Total Scale)
Walker-McConnell Scale

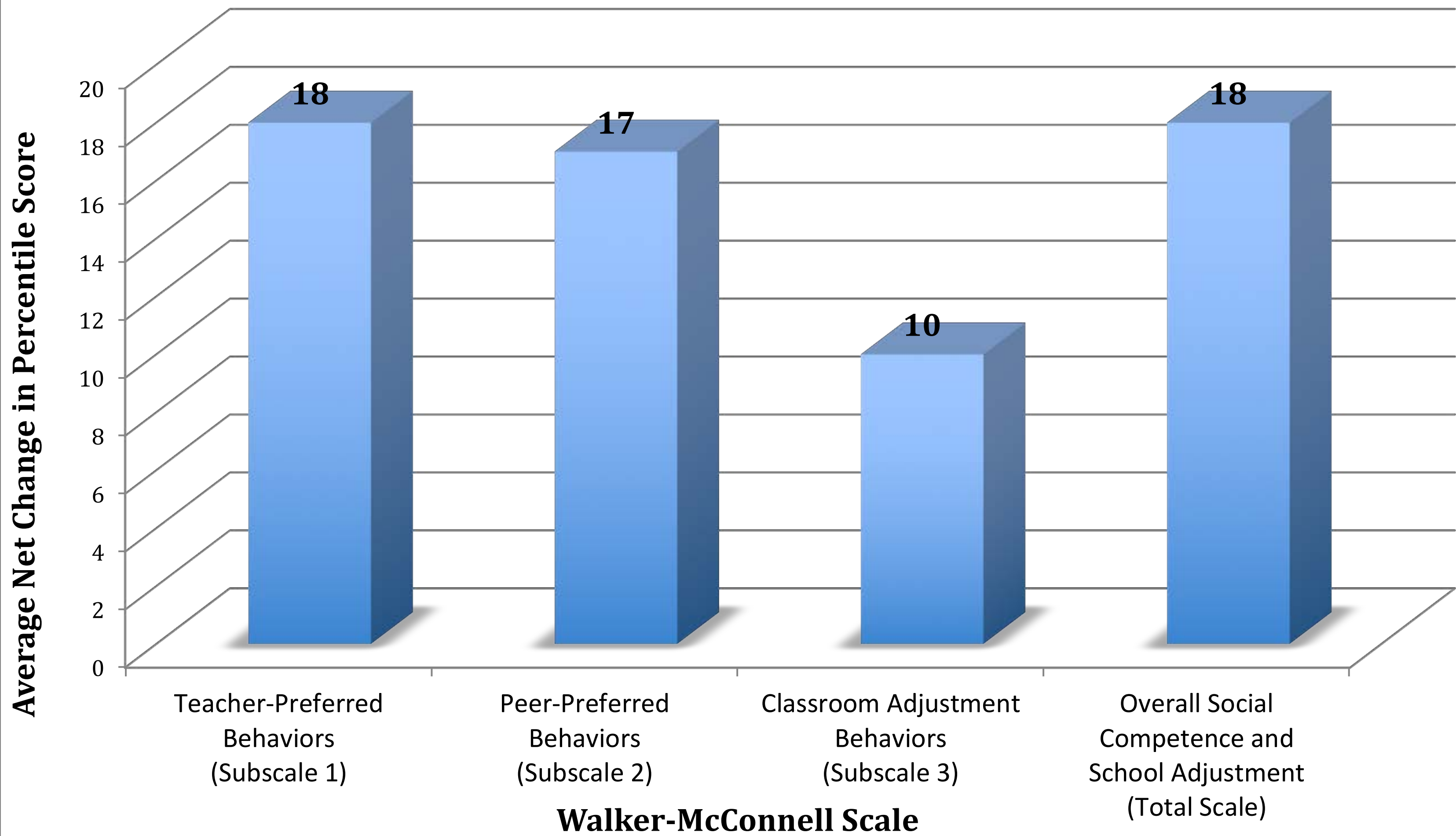


Figure 3
Average Net Changes in Pre-Post School Adjustment Ratings
Average Net Change in Percentile Score
0
2
4
6
8
10
12
14
16
18
20
18
17
10
18
Teacher-Preferred Behaviors (Subscale 1)
Peer-Preferred Behaviors (Subscale 2)
Classroom Adjustment Behaviors (Subscale 3)
Overall Social Competence and School Adjustment (Total Scale)
Walker-McConnell Scale

MHSA Year-End Progress Report

Wennem Wadati: A Native Path to Healing Project

Provider: Foothill Indian Education Alliance

Project Goals

- Increase 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 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$125,750	$125,750	$125,750
Total Expenditures	$119,175	$87,639	$89,776
Unduplicated Individuals Served	unknown	374	301
Cost per Participant	unknown	$234	$298
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	unknown	242	88
16-25 (transitional age youth)	unknown	82	72
26-59 (adult)	unknown	28	28
Ages 60+ (older adults)	unknown	22	19
Unknown or declined to state	unknown	0	94
Race	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	unknown	346	301
Asian	unknown	0	0
Black or African American	unknown	0	0
Native Hawaiian or Other Pacific Islander	unknown	0	0
White	0	28	0
Other	unknown	0	0
Multiracial	unknown	0	0
Unknown or declined to state	unknown	0	0
Ethnicity by Category	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**

Hispanic or Latino	unknown	0	0
Caribbean	unknown	0	0
Central American	unknown	0	0
Mexican/Mexican-American/Chicano	unknown	0	0
Puerto Rican	unknown	0	0
South American	unknown	0	0
Other	unknown	0	0
Unknown or declined to state	unknown	0	0
Non-Hispanic or Non-Latino			
African	unknown	0	0
Asian Indian/South Asian	unknown	0	0
Cambodian	unknown	0	0
Chinese	unknown	0	0
Eastern European	unknown	0	0
Filipino	unknown	0	0
Japanese	unknown	0	0
Korean	unknown	0	0
Middle Eastern	unknown	0	0
Vietnamese	unknown	0	0
Other	unknown	346	0
Multi-ethnic	unknown	0	0
Unknown or declined to state	unknown	28	0
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Arabic	unknown	0	0
Armenian	unknown	0	0
Cambodian	unknown	0	0
Cantonese	unknown	0	0
English	unknown	374	301
Farsi	unknown	0	0
Hmong	unknown	0	0
Korean	unknown	0	0
Mandarin	unknown	0	0
Other Chinese	unknown	0	0
Russian	unknown	0	0
Spanish	unknown	0	0
Tagalog	unknown	0	0
Vietnamese	unknown	0	0
Unknown or declined to state	unknown	0	0

Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	unknown	0	0
Heterosexual or Straight	unknown	0	0
Bisexual	unknown	0	0
Questioning or unsure of sexual orientation	unknown	0	0
Queer	unknown	0	0
Another sexual orientation	unknown	0	0
Declined to State	unknown	374	301
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	unknown	0	104
Female	unknown	0	197
Declined to answer	unknown	374	
Current gender identity:			
Male	unknown	0	104
Female	unknown	0	197
Transgender	unknown	0	0
Genderqueer	unknown	0	0
Questioning / unsure of gender identity	unknown	0	0
Another gender identity	unknown	0	0
Declined to answer	unknown	374	0
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	unknown	unknown	unknown
Difficulty hearing or having speech understood	unknown	unknown	unknown
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	unknown	unknown
Physical/mobility	unknown	unknown	unknown
Chronic health condition/chronic pain	unknown	unknown	unknown
Other (specify)	unknown	unknown	unknown
Declined to state	unknown	374	unknown

Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Yes	unknown	18	17
No	unknown	356	284
Unknown or declined to state	unknown	0	0
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	unknown	0	68
Placerville Area	unknown	0	129
North County	unknown	0	15
Mid County	unknown	0	17
South County	unknown	0	14
Tahoe Basin	unknown	0	0
Unknown or declined to state	unknown	374	58
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	unknown	0
Very low income	unknown	unknown	44
Low income	unknown	unknown	145
Moderate income	unknown	unknown	105
High income	unknown	unknown	7
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	unknown	unknown
Medi-Cal	unknown	unknown	unknown
Medicare	unknown	unknown	unknown
Uninsured	unknown	unknown	unknown

Annual Report FY 19/20

Please provide the following information for this reporting period:

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.**

   Over the years, our staff has declined from five (5) to three (3) staff members. The decline was due to staff members passing away. We were vey lucky in the beginning of our Wennem Wadati program to recruit very qualified and dedicated Native staff. As staff was lost, we have struggled to find people with the same skills and dedication to the goals of our program and our Native community. We continue to look, but our staff positions are not full time and we move forward with the three (3) staff positions we currently have. Our activities are still being offered, but we struggle to cover all activities with a limited staff.

Our talking circles declined because we were seldom able to have two (2) staff at each circle. Changes in Administrative staff at several target schools made out start up difficult and this affected the number of students we served.

We continued to provide after school cultural activities for students and weekend family activities up until schools were closed in 2020, due to COVID-19 restrictions. Our outdoor family activities continued until April with all the COVID-19 precautions. When schools closed, talking circles and after school cultural activities ceased for a time. Weekend family activities also ceased due to COVID-19. Rose, our Cultural Specialist, continued to receive and respond to crisis calls.

We began to receive calls to the Center requesting information about food bank sources as well as emotional and cultural support. James Marquez, Executive Director, began compiling a list of Elders and families that had called or that we had information that support was needed. Some elders were suffering from isolation and were afraid to leave their homes for food or medications. We organized a small group of volunteers that would shop and make pick-ups and deliveries for Elders. James would make regular support calls to those Elders as well as families that were struggling. This often led us to other families that were referred for support. With persistence and regular contact, we were able to provide support that proved invaluable. We received calls from family members that their older families members had shown a remarkable improvement in their outlook and demeanor. We continue to offer this regular contact and support. This was never designed as a part of our Wennem Wadati Program, but grew quickly as a response to the COVID-19 epidemic and its impacts on the local Native community.

We began to explore the use of Zoom to provide talking circles and after school cultural activities. It was determined that talking circles would not be feasible as students would be joining from home with parents and siblings around, which would not provide much privacy. The after school cultural activities proved to be successful using Zoom. Staff prepared cultural kits for students, and parents came by the center to pick them up. The students joined the Zoom class for cultural instruction and were also able to see other students that they communicated with regularly when they were coming to the Center after school. That was valuable and a way to stay connected during the COVID-19 isolation.

Of Course, our annual Summer student leadership field trip was cancelled.

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).**

Most of our Wennem Wadati program components rely on face to face contact. With the COVID-19 epidemic, our program was basically turned upside down. We had to retool quickly to address the immediate needs of our Native community. We worked with the Shingle Strings Tribal health, the Food Bank of El Dorado County, and the Board and Parent Committee of our local Indian Education programs. We addressed the most pressing issue in the community such as Elder and family isolation, food shortages, student and family support. Many of the other issues that regularly impact the Native community were put on hold for the time-being due to COVID-19.

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.**

Wennem Wadati staff continued to pursue additional qualified Native staff for our program. Program progress was set aside to address the most pressing needs of our COVID-affected Native community.

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.**

Wennem Wadati activities have always been presented in a culturally competent manner using cultural values, cultural art, teachings of the medicine wheel, stories of strength and resilience.

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.**

The past year has been difficult to maintain a lot of our outreach and collaborations in our area due to the COVID-19 stay-at-home orders and the measures we all took to reduce the spread of the virus. However, we were still able to meet via zoom for several of our meetings with the county, tribal programs, and courts. We continues to have monthly activities using the new health and safety standards we have put in place at the center.

6) **Provide the outcome measures of the services provided and customer satisfaction surveys.**

- **Measurement 1: Casey Life Skills Native American Assessment, or other assessment tool to be determined by contractor, to be given when a student joins the Talking Circles and when they end their participation.**

  The Casey Life Skills was not completed as our talking circles stumbled to get going in the beginning and were then cut off as school closures occurred. In school talking circles were not available again during the 2019/20 Wennem Wadati program year.

7) **Report on unduplicated numbers of individuals served, including demographic data.**

Total unduplicated number is 301.

Age group numbers are:
0-15yrs = 88
16-25yrs = 72
26-59yrs = 110
60+yrs = 19

Most participants live in and around the Placerville area, but we served from as far away as Grizzly Flats, Georgetown, El Dorado Hills and Pollock Pines. Our clients come to us because they identify as Native American. Some may be a mix of other ethnicities, but they do not identify that to us. There were many choices to choose from, if people wanted to identify with any of them. I did find it interesting that white was listed as a race, but were not asked to identify their ethnicity as everyone else was.

8) **Report on the reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational-functioning.**

The consequences of non-treatment for serious mental illness are devastating. With untreated mental illness, we will often see more homelessness, incarceration, episodes of violence, victimization, and suicide. According to the results of 2019 and 2020 annual needs assessment of the Shingle Springs Rancheria, the Native American families we work with have shown an increase in protective factors such as employment, insurance coverage, improved grades, structured family homes with rules, presence of mentors, and ceremonial activities. It will be interesting to see the results of the 2021 assessment to see the effects of the past stay-at-home orders and other COVID-19 related issues.

9) **If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.**

This is not known at this time. All persons contacting Rose Hollow Horn Bear with crisis calls were most likely referred to behavioral health at the Shingle Springs Tribal Health program. Rose would have kept this information confidential unless there was a need to know.

10) **If known, the average duration of untreated mental illness.**

Not known at this time.

11) **If known, the number of individuals who followed through on the referral and engaged in treatment.**

Not known at this time.

12) **If known, provide the average interval between mental health referral and participation in treatment.**

Not known at this time.

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

2019/20 Wennem Wadati Expenditures

Personnel: $85,648.50
Supplies/materials: $ 3,659.09

Total Expenditures for 2019/20 fiscal year: $89,307.59

Leveraged Resources

Foothill Indian Education Alliance, Inc – Briw Road, Placerville

Used Indian Education facility for Wennem Wadati meetings, talking circles, student after school cultural activities, weekend family cultural activities, and family community dinners. Provided chaperones for student activities, day trips, student leadership activities and summer leadership field trips (canceled due to COVID-19) (approx. value -$10,500).

El Dorado/Amador County Indian Education Project – Provided cultural support and chaperones for leadership activities, field trips, and speakers at community gatherings. (approx. value -$4,500).

Shingle Springs Rancheria – Provided free transportation for leadership activities and field trips for Wennem Wadati students. Provided entrance fees, a Red Hawk shuttle van and lunch for 25 students and 6 chaperones to attend a Native art exhibit at the Crocker Art Gallery in Sacramento. Also provided lunch for participants attending two weekend Wennem Wadati cultural activities that were usually potluck (pre-COVID-19) (approx. value -$8,500).

14) Provide any additional relevant information.

The COVID-19 pandemic had a major impact on our program. Our numbers were down. We normally would have seen an increase in numbers during the first 2 quarters of 2020. As COVID-19 reared its head, people stopped going out and participating. It took us a period of time to figure out how to continue providing services while keeping everyone safe, including staff and clients.

Our program served a total of 301 unduplicated clients.

Our crisis call line served 94 unduplicated clients. Fifty seven of those clients made multiple contacts. Our Weekend Family Cultural Gatherings served 110 unduplicated clients. Many of those were regulars at each activity. Participants ranged in age from 5 years old to 75 years old.

Our afterschool weekday Cultural classes served 25 unduplicated participants. All were 15 years or younger. Many attended regularly and participated in 8 or 9 classes.

With the onset of COVID-19, many of our Native families began to struggle financially and food, shelter and clothing became more difficult to come by. We received many calls early on asking for information and referrals to agencies or food banks that might provide assistance. We provided information and contacts with many services that are available in our area that could help our families get through unexpected unemployment, food shortages, eviction threats, etc. School closures and a quick change to remote learning was not easy for many students and families. We assisted families acquire laptop computers, internet service and hot spots so they could try to keep up with their schooling. Our tutoring services (not county funded) were able quickly adapt to a Zoom environment where they could continue to provide tutoring for our students. Over many months we have made regular contacts with many families that were struggling, not just financially or with housing, we provided an important link to the community as many were suffering from isolation and were becoming hopeless. We stayed in touch via phone and email, but sometimes would deliver food, supplies, and even firewood to families and elders. This was an extremely important service that we provided.

We served, and continue to serve 72 families and Elders with regular contact and support.

MHSA Year-End Progress Report Fiscal Year 2019/2020

Children 0-5 and Their Families Project

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 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$250,000	$250,000	$300,000
Total Expenditures	$242,975	$250,000	$300,000
Unduplicated Individuals Served	162	181	215
Cost per Participant	$1,500	$1,381	$1,395
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	85	76	73
16-25 (transitional age youth)	0	16	17
26-59 (adult)	76	87	117
Ages 60+ (older adults)	0	1	0
Unknown or declined to state	1	1	3

Race	FY 2017-18	FY 2018-19	FY 2019-20
American Indian or Alaska Native	0	1	1
Asian	0	2	2
Black or African American	6	0	4
Native Hawaiian or Other Pacific Islander	0	3	1
White	105	145	186
Other	12	6	0
Multiracial	18	2	4
Unknown or declined to state	21	22	12
Ethnicity by Category	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Hispanic or Latino	13	34	0
Caribbean	0	1	1
Central American	5	5	1
Mexican/Mexican-American/Chicano	23	25	41
Puerto Rican	0	0	1
South American	0	0	3
Other	0	3	0
Unknown or declined to state	0	33	0
Non-Hispanic or Non-Latino			
African	11	6	6
Asian Indian/South Asian	0	2	1
Cambodian	0	0	1
Chinese	0	0	0
European	0	97	127
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	1
Vietnamese	0	0	0
Other	2	9	6
Multi-ethnic	0	0	0
Unknown or declined to state	31	55	21

Primary Language	FY 2017-18	FY 2018-19	FY 2019-20
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	144	170	195
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	12	10	15
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	6	1	0
Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	0	0	0
Heterosexual or Straight	65	90	110
Bisexual	1	0	4
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	0
Another sexual orientation	0	0	0
Unknown or declined to state	96	91	22
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	54	45	12
Female	107	127	119
Unknown or declined to answer	1	9	6
Current gender identity:			
Male	54	45	12
Female	107	127	121
Transgender	0	0	0
Genderqueer	0	0	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Unknown or declined to answer	1	9	4

Disability	FY 2017-18	FY 2018-19	FY 2019-20
Difficulty seeing	1	1	0
Difficulty hearing or having speech understood	0	0	8
Mental disability including but not limited to learning disability, developmental disability, dementia	0	9	7
Physical/mobility	0	0	0
Chronic health condition/chronic pain	2	3	1
Other (specify)	12	1	4
Declined to state	14	9	15
Veteran Status **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Yes	3	1	5
No	149	171	116
Unknown or declined to state	10	9	16
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	39	53	43
Placerville Area	70	58	77
North County	6	6	13
Mid County	7	16	21
South County	6	7	2
Tahoe Basin	30	28	29
Unknown or declined to state	4	13	19
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	16	17	24
Very low income	5	2	28
Low income	70	81	84
Moderate income	38	46	54
High income	28	20	1
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	31	41	52
Medi-Cal	120	119	129
Medicare	0	0	0
Uninsured	3	1	7

Annual Report FY 2019-20

Please provide the following information for this reporting period:

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.**

   The Infant Parent Center (IPC) is grateful to the MHSA program staff and funding as an integral component to our growth and success. IPC has had a great year in terms of significant increases in expansion of services and ability to effectively adjust and serve families during the COVID-19 pandemic. The Infant Parent Center was able to successfully transition early as the agency had already implemented a HIPAA compliant Telehealth platform which allowed for a seamless transition for clinicians and clients.

   Major accomplishments

   - Infant Parent Center received a significant increase in self-referrals as well as increased referrals from Marshall Hospital, new doctors, and nursing staff.
   - Infant Parent Center provided an increase in services in the Georgetown Divide area as well as home visitation and services to monolingual Spanish speaking families.
   - IPC increased couples therapy for families in transition during pregnancy and after birth. In addition, there was an increase in working with couples transitioning during separation and divorce. Healthy communication and transitions are critical for these major life shifts. IPC is excited with the successes in the services we provided for these families.
   - With the realities of the pandemic this year, IPC was able to seamlessly serve families via secured video services. IPC also provided linkage and directive services for families experiencing basic needs crisis, including connection to financial grants, employment services, housing, food and diaper services.
   - IPC has achieved an increase in staff to provide more services to isolated and underserved families. We now have three (3) bilingual and bicultural therapists as well as a therapist located in and specifically serving the Georgetown Divide area.
   - Our continued efforts and dedication to the perinatal population has increased services and effective interdisciplinary collaboration for more preventive care for mothers, fathers and infants.

   Challenges:

   The occurrence of a pandemic creates a collective anxiety and impacts the community at large. Although we were equipped to provide secure video services immediately, remote therapy is more difficult, particularly with young children. The intensity of the increased stress also created new needs of financial supportive services, basic needs linkage and more social work provision. IPC was able to effectively serve families with these increased needs and collaboration with community partners.

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.

Overall, Infant Parent Center has continued to provide immediate response to referrals and community collaboration. Our referral base continues to expand with significant increase in successful treatment outcomes. Due to the unique complications of COVID-19, we have seen an intense increase in anxiety, depression, couples' conflicts, obsessive/compulsive behaviors and other indicators of increased emotional distress. Consequently, IPC has gone above and beyond to provide increased services, parental support, social services linkage and basic needs linkage including grant applications.

Specific to the PEI Project areas of focus, IPC reports the following:

Suicide: Six (6) clients were served. All six (6) reported feelings of suicidality. IPC clinicians provided crisis intervention, implemented a safety plan, and collaborated with medical staff to ensure support systems were in place. As a result, no hospitalizations were required.

Prolonged suffering: As stated previously, the pandemic created a distinctive new layer of stress, anxiety, financial stress, and basic life challenges. Consequently, many, if not all, families served could qualify as enduring prolonged suffering. As noted previously, IPC has identified prolonged suffering as enduring the pain and suffering of long term abuse, neglect and other forms of trauma. Accordingly, one hundred nineteen (119) families qualified under that criterion.

Risk of Removal: Fifty-two (52) children were referred with potential risks of being taken into foster care. IPC continues to effectively collaborate with all community providers with the purpose of minimizing risk factors and to support family resilience.

Incarceration to Mainstream: Ten (10) families were involved with the legal system this year. IPC works closely with families to help support transition and stabilization during these difficult situations, decreasing stress and potential trauma that often occurs during separation between caregivers and children during incarceration as well as reunification services after release.

Homelessness/Unemployment: Thirty-two (32) families served were enduring homelessness. This is a 50% increase since last fiscal year. The pandemic created a significant increase in unemployment. IPC expanded our services to directly collaborate with local resources to help families complete applications and achieve financial support through the various COVID-19 Relief Funds available. Continued effective collaboration and linkage with Hope House, Mother Teresa's Shelter, HELP, CalWORKs, Nomadic Shelter, and local churches provided greater opportunities to achieve temporary and permanent housing for families.

School dropout/failure: IPC provided support for several new teachers during the COVID-19 pandemic to aid them in their work with families who were struggling. The supportive services to teachers provide an opportunity to increase their reflective capacities at work and offer a holding space to process strengths and risk factors that many of their families are facing.

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.**

Due to increased bicultural staff, we were able to provide more services to isolated families. As a result of the addition to telehealth services, IPC was also able to serve an increase in families and

providers in need. Specifically, we provided a new local resident in the Georgetown Divide area to provide easy access to home visitation and school site services.

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.**

IPC continues to provide cultural humility to all families, providing a safe, non-judgmental environment with recognition of their unique culture and journey. IPC provides diversity in all services incorporating literature, play therapy toys including dolls of all racial backgrounds, special needs and medical processes. We strive for all families to be seen and honored. Additionally, IPC will increase needed capacities for unique cultural needs. IPC provides services in Spanish by bicultural, bilingual therapists. IPC does not provide any outsourced translation services.

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

As always, IPC places great importance on community collaboration and linkage. IPC works diligently to find the best additional services for families to not only address current needs, but to also serve permanent family wellness. IPC does not require medical necessity in order to access services. Because of this proactive approach, many of our families who would traditionally sit on a waiting list, receive access to preventive care and are linked to additional supports for greater continuity and wellness.

Based on the increase in referrals and engagement in the perinatal population, more and more families are seeking services during pregnancy and postpartum. Where both mothers and fathers were previously suffering in silence due to stigma, they are now receiving services and increasing self-care and greater family system health.

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.**

  - 210 families served
  - 187 families engaged in services
  - 91 families achieved treatment success in at least two (2) areas of concern
  - 64 families are currently in services

It is important to note that IPC was able to continue assessments, some modified, during the COVID-19 lockdown and continued pandemic. Families were, therefore, able to maintain effective assessments and services during the entire year. We provided a total of three hundred twenty-three (323) assessments for the entire year.

Marschak Interaction Method (MIM) - IPC conducted eighty-nine (89) 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

Play Room/Observation and Evaluation - IPC provided seventy-seven (77) playroom observation and evaluations for children served. The Playroom Evaluation/Observation is a systematic assessment provided for every child and caregiver. The assessment provides client-directed as well as therapist-led activities for greater observation of the child's presenting needs as well as opportunities to observe indicators of other areas of need.

Perinatal Assessment - IPC administered seventy-two (72) perinatal assessments during this period with clients displaying progress in one (1) 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 - We provide this program individually to support each caregiver's relationship with his/her child(ren). This evidence-based practice enhances awareness, attunement, connection and consistent containment which are essential components for a secure attachment and optimal development for children. Many of our families receive parent support in addition to their therapeutic services and were also provided Parent Education and Support through additional services.

Additional Assessments - IPC provided an additional seventy-nine (79) assessments. These include, but not limited to: The Parent Stress Index (18), Beck's Depression Anxiety and Depression Scales (26), and Edinburgh and Post Partum Depression Scale (21). Because IPC staff has additional specialized trainings and certifications, other instruments are also available and provided when clinically appropriate:

- **Measurement 2: Client satisfaction questionnaires, other provider questionnaires.**

  Client Survey Data - We received twenty-seven (27) client satisfaction survey responses. Due to the pandemic and technology, we were not able to obtain as many surveys as we would have liked. However, we have a very high rate of engagement and completion of services. Families continue to identify IPC as an important resource in the community. Charts of the client responses are attached at the end of this report.

  Collaborative Partner Survey - This year's increase in service areas has provided new opportunities for collaboration with new partners. IPC sent the survey to every partner connection. IPC received eighteen (18) surveys with supportive responses. As the charts at the end of this report exhibit, partners find IPC an essential service to the community. Our commitment to high quality service and collaboration will continue and hopefully grow this next fiscal year. The following agencies responded to our Provider Survey: Choices for Children (SLT), Marshall Medical OB/GYN, El Dorado County Office of Education (EHS), Lake Tahoe School

District, Child Protective Services (Western Slope), El Dorado County HHSA Health Departments, El Dorado County Behavior Health Substance Use Disorder Services, El Dorado County Mental Health, and marriage family therapists (MFTs).

- **Measurement 3: Tracking of referrals and engagement.**

  Fifty-one (51) clients were self-referred or referred by a family or friend. This represents an increase of almost 50% from the previous year. We are continuing to see significant increases each year in self-referrals. IPC is excited to see the growth in community awareness of our agency as well as the confidence in referring friends and families to our services.

- **Measurement 4: Decreased incidents of Abusive Head Trauma (formerly known as "shaken Baby Syndrome).**

  The Infant Parent Center worked successfully with thirty-four (34) infants who were at risk of Abusive Head Trauma (formerly known as Shaken Baby Syndrome). Because of the intense multigenerational trauma, we recognize the complexity of this risk and the sensitivity to caregivers' stress, yet also the essential need of safety for the infants. IPC has had great success through collaboration with Public Health, Early Head Start and Child Protective Services to increase safety measures and effective services for families.

- **Measurement 5: Reduction of hospital emergency department visits.**

  IPC served six (6) caregivers who reported suicidal ideation or active suicidality. All caregivers were effectively linked to crisis intervention services that included collaboration with medical and psychiatric services. No caregivers needed to be hospitalized and were able to remain with their children and continue services.

7) If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.

IPC provides referrals to County Behavioral Health, Community Health and other facilities taking insurance for caregivers and older children. We are committed to tracking all referrals to Behavioral Health going forward.

8) If known and if applicable, provide information on Client self-report on the duration of untreated mental illness.

IPC does not track the duration of untreated mental health issues for adults. IPC works diligently to identify, collaborate, and to encourage clients to access individual therapy and services as soon as possible. Some caregivers recognize needs for individual therapy and recovery services, however, we have also had many who have been untreated for PTSD, Bi-Polar, Personality Disorders, and Psychotic Disorders. Unfortunately, some of these caregivers struggle in connecting or following through with medication or their own treatment. However, IPC has been providing an increase in individual services for parents, especially during the perinatal period to provide greater opportunity for stabilizing and safety for the family. Infant Parent Center provides family services for many adults with co-occurring disorders such as mental illness and substance use. Unfortunately, many of the adults we referred to County Behavioral Health did not meet the medical necessity for services.

Specific to this past four (4) months of the COVID-19 pandemic, we are seeing a greater increase in stress, anxiety, PTSD, domestic violence, child abuse, substance and process abuse and obsessive-compulsive symptoms. Consequently, caregivers are reported as being highly triggered due to the social stressors. This is significantly impacting adults with untreated mental health and/or co-occurring disorders.

9) **If known, provide the average interval between mental health referral and participation in treatment.**

IPC does not track the time span between a referral we give to a family and the time it takes for them to receive the service.

For Infant Parent Center referrals, all potential clients are contacted within 24 hours with a therapist assignment offered within 48 hours. We do find that some referrals do not respond very quickly and may take up to a month to respond. IPC is sensitive to the stigma of mental health and resistance at times, particularly for the perinatal families. IPC, therefore, makes the effort to follow-up on referrals several times. We also follow up with referring agencies to ensure best practices and collaboration.

10) **If known, the number of individuals who followed through on the referral and engaged in treatment.**

IPC does not track this data.

11) **If known, provide a description of the methods Contractor used to encourage Client access to services and follow-through on referrals.**

IPC strives to provide warm, non-judgemental support to caregivers needing additional services. Our continued positive relationships with other providers gains easy access to linkage and referrals with specific identified people or agencies that caregivers can contact. Additionally, IPC continually provides interdisciplinary collaboration throughout the time we serve families and even refer and link families to services outside the area.

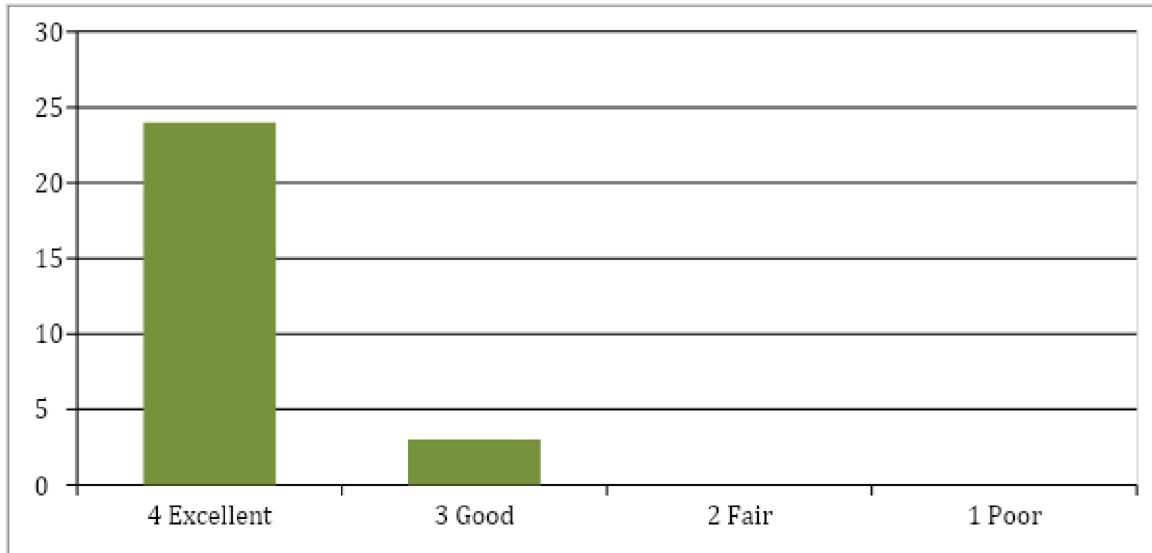
12) **Provide total project expenditures and the type and dollar amount of leveraged resources and/or in-kind contributions.**

IPC used all funds allocated in conjunction with additional contracts. Due to the increased collective anxiety that our community has experienced during the pandemic, IPC provided a one-time donation of $4,870 to ensure families continued to receive seamless services, linkage to basic needs, financial support and resources.

Infant Parent Center Client Satisfaction Survey
Fiscal Year 2019/2020

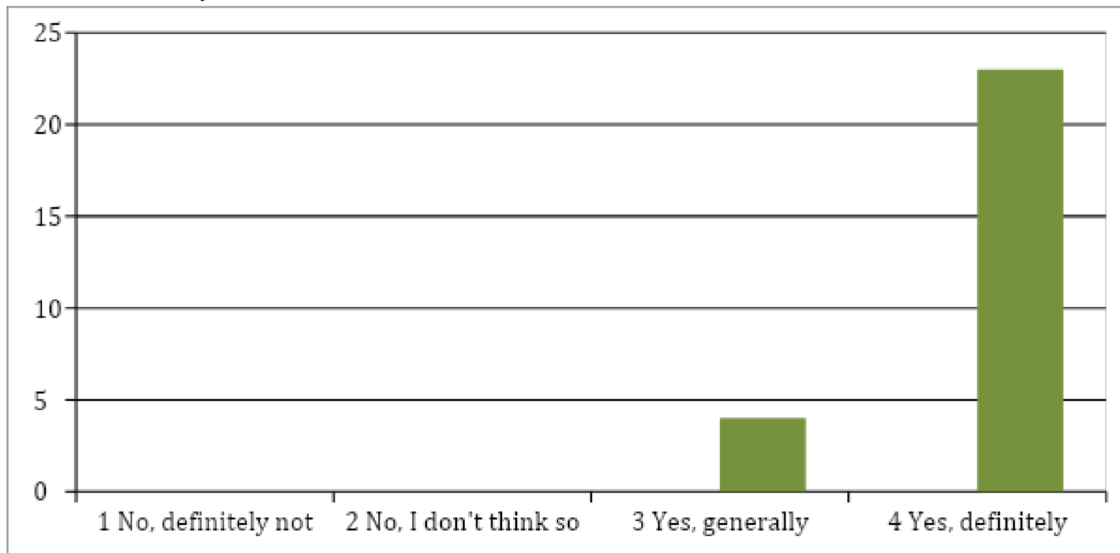
How would you rate the quality of service you received?

4 Excellent	80.0%	24
3 Good	20.0%	3
2 Fair	0.0%	0
1 Poor	0.0%	0



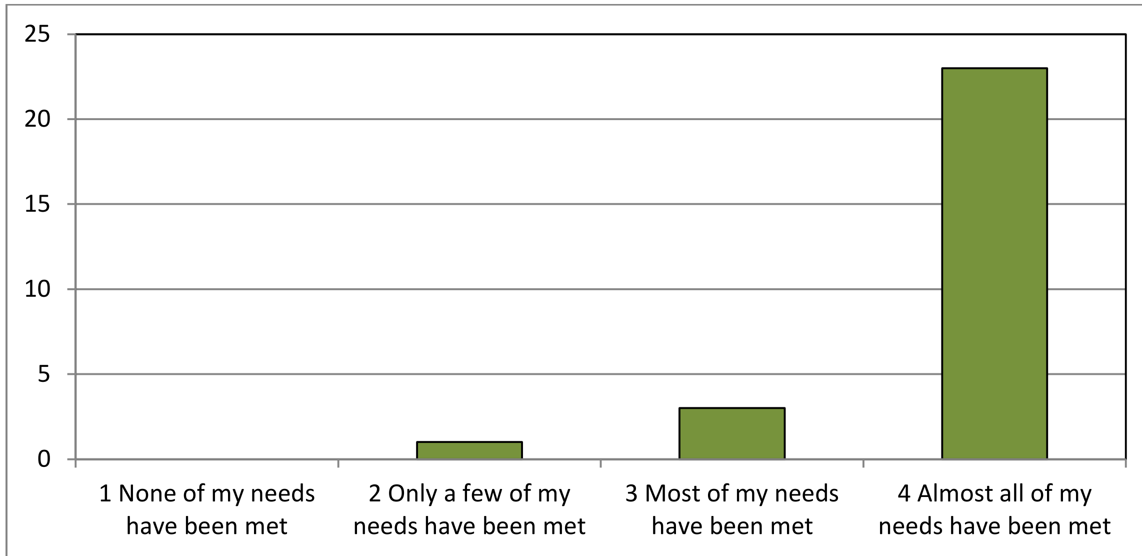
Did you get the kind of service you wanted?

1 No, definitely not	0.0%	0
2 No, I don't think so	0.0%	0
3 Yes, generally	26.7%	4
4 Yes, definitely	73.3%	23



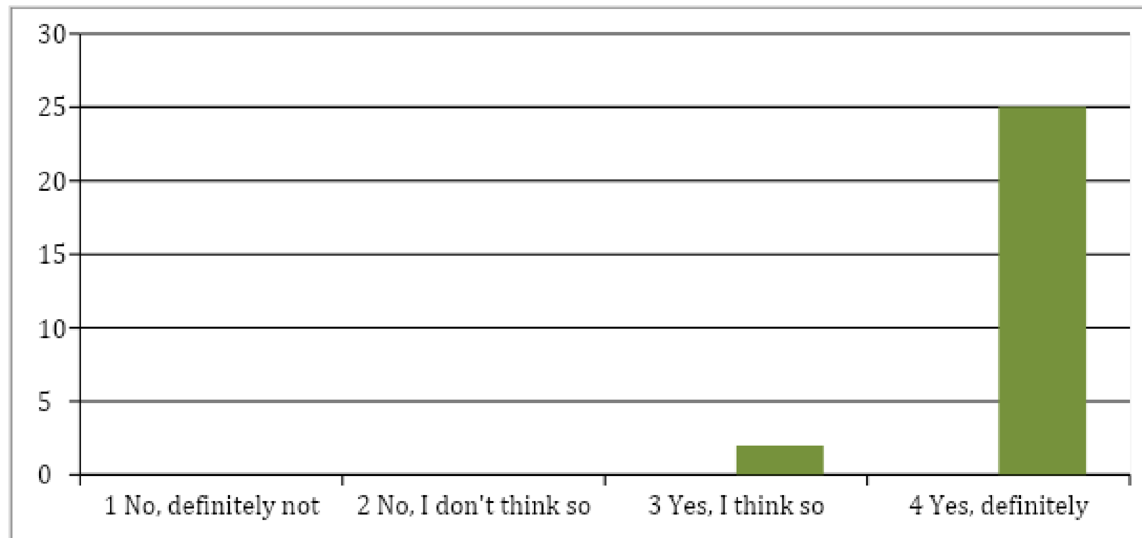
To what extent has our program met your needs?

4 Almost all of my needs have been met	73.3%	23
3 Most of my needs have been met	20.0%	3
2 Only a few of my needs have been met	6.7%	1
1 None of my needs have been met	0.0%	0



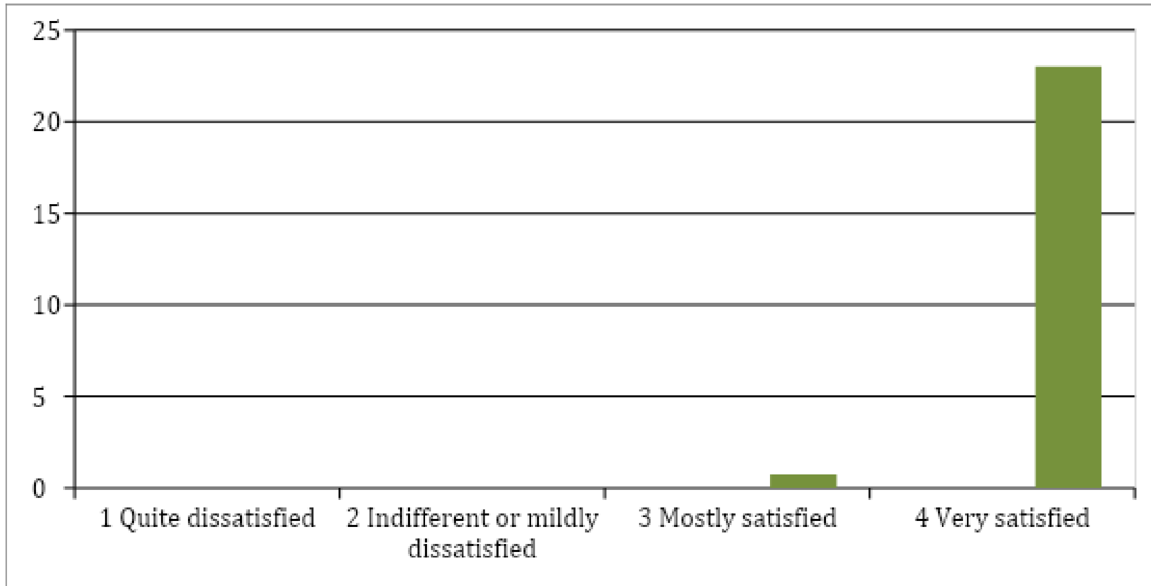
If a friend were in need of similar help, would you recommend our program to him or her?

1 No, definitely not	0.0%	0
2 No, I don't think so	0.0%	0
3 Yes, I think so	13.3%	2
4 Yes, definitely	86.7%	25



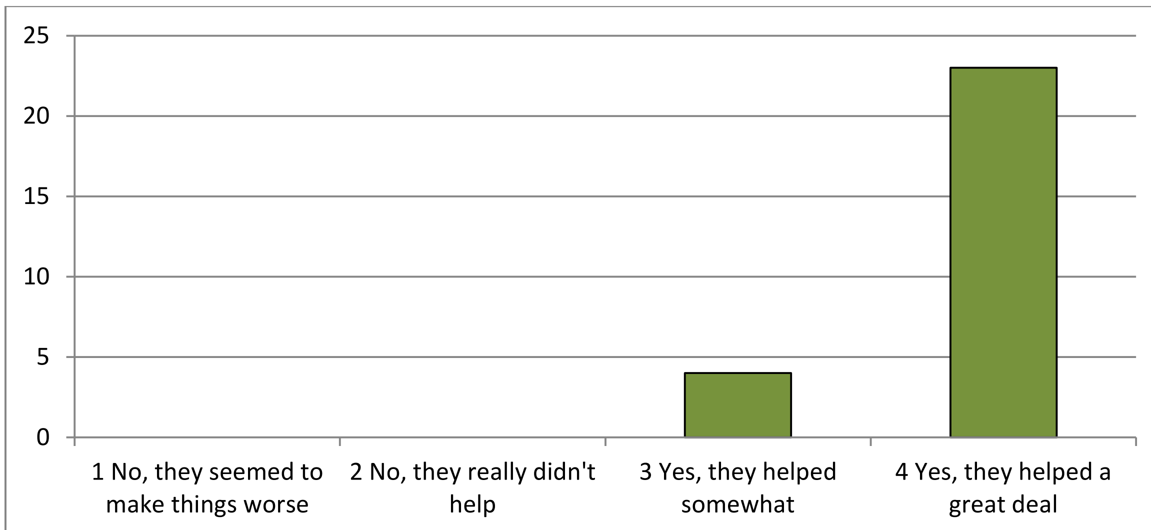
How satisfied are you with the amount of help you received?

1 Quite dissatisfied	0.0%	0
2 Indifferent or mildly dissatisfied	0.0%	0
3 Mostly satisfied	26.7%	4
4 Very satisfied	73.3%	23



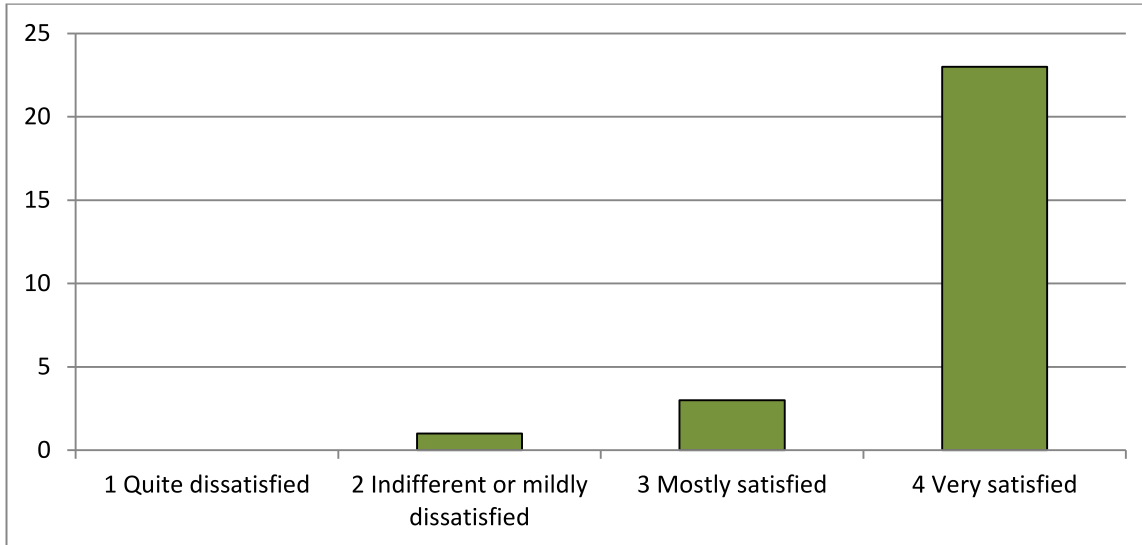
Have the services you received helped you to deal more effectively with your problems?

4 Yes, they helped a great deal	73.3%	23
3 Yes, they helped somewhat	26.7%	4
2 No, they really didn't help	0.0%	0
1 No, they seemed to make things worse	0.0%	0



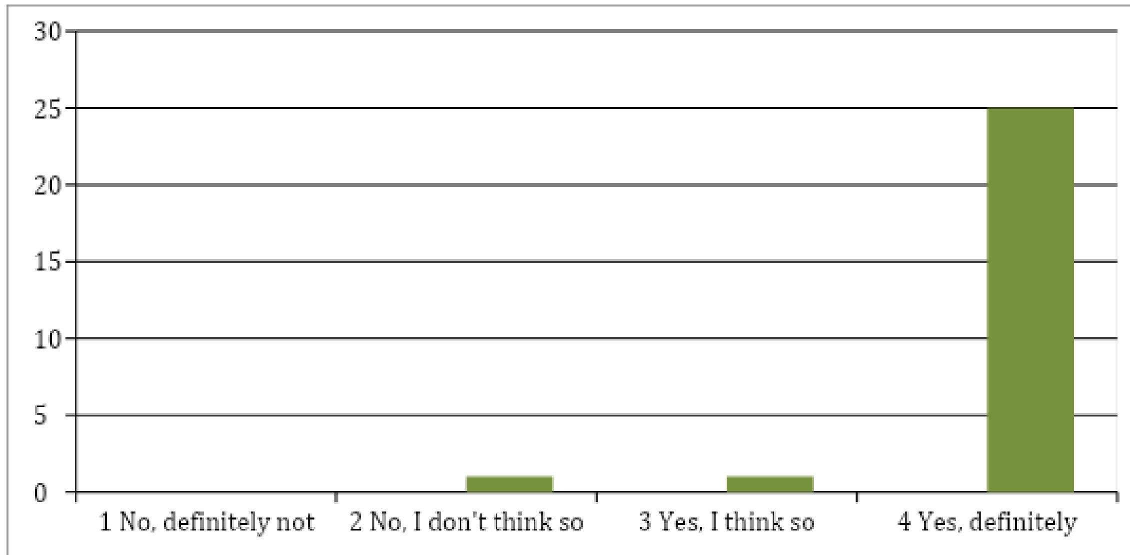
In an overall general sense, how satisfied are you with the service you received?

4 Very satisfied	73.3%	23
3 Mostly satisfied	20.0%	3
2 Indifferent or mildly dissatisfied	6.7%	1
1 Quite dissatisfied	0.0%	0



If you were to seek help again, would you come back to our program?

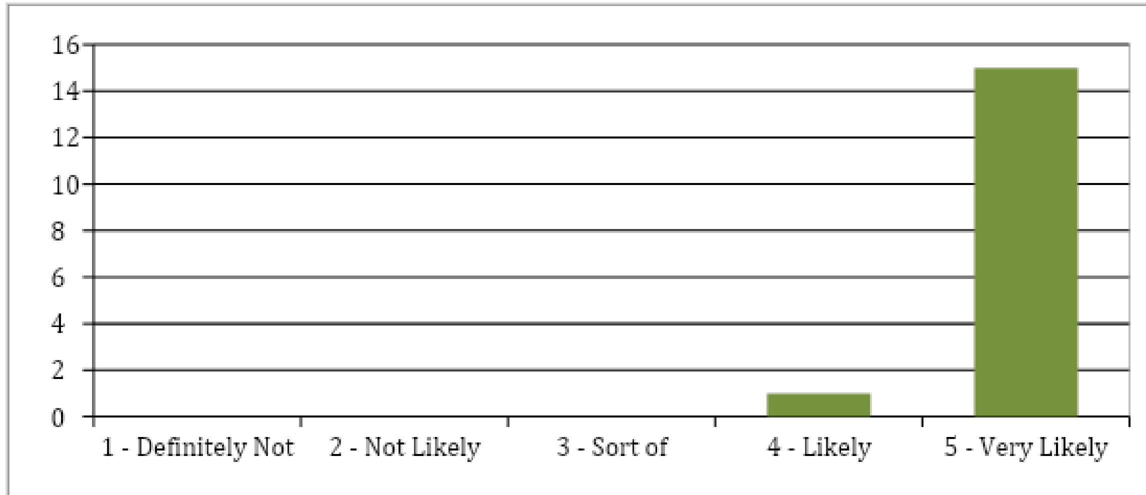
1 No, definitely not	0.0%	0
2 No, I don't think so	6.7%	1
3 Yes, I think so	6.7%	1
4 Yes, definitely	86.7%	25



Infant Parent Center Provider Survey
Fiscal Year 2019/2020

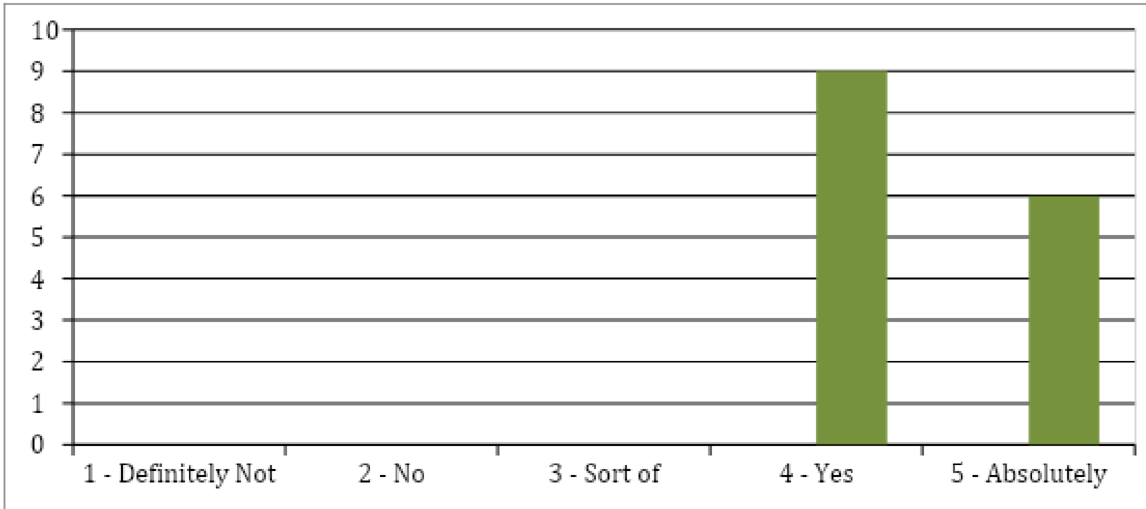
How likely are you to recommend our agency to families or individuals in the future?

1 - Definitely Not	0.0%	0
2 - Not Likely	0.0%	0
3 - Sort of	0.0%	0
4 - Likely	6.2%	1
5 - Very Likely	93.8%	15



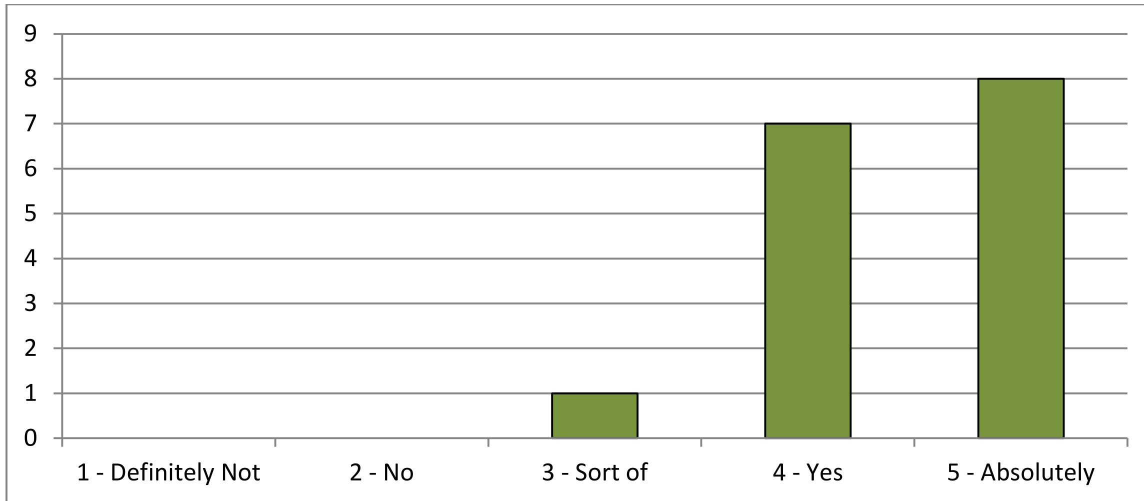
Did the Infant Parent Center respond within 24-48 hours of your referral?

1 - Definitely Not	0.0%	0
2 - No	0.0%	0
3 - Sort of	0.0%	0
4 - Yes	60.0%	9
5 - Absolutely	40.0%	6



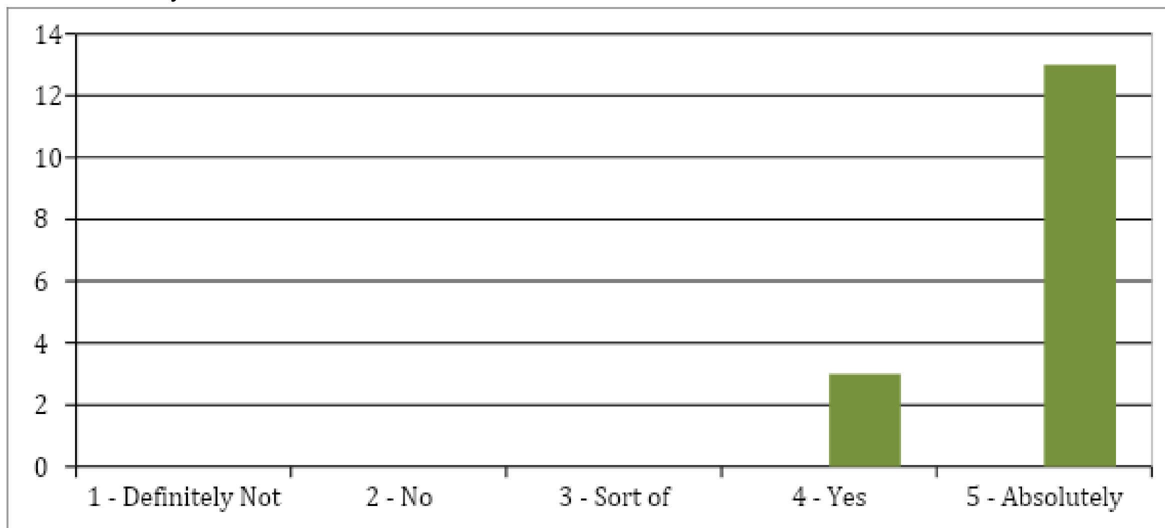
Have you heard positive feedback from families regarding services they received from IPC?

1 - Definitely Not	0.0%	0
2 - No	0.0%	0
3 - Sort of	6.2%	1
4 - Yes	43.8%	7
5 - Absolutely	50.0%	8



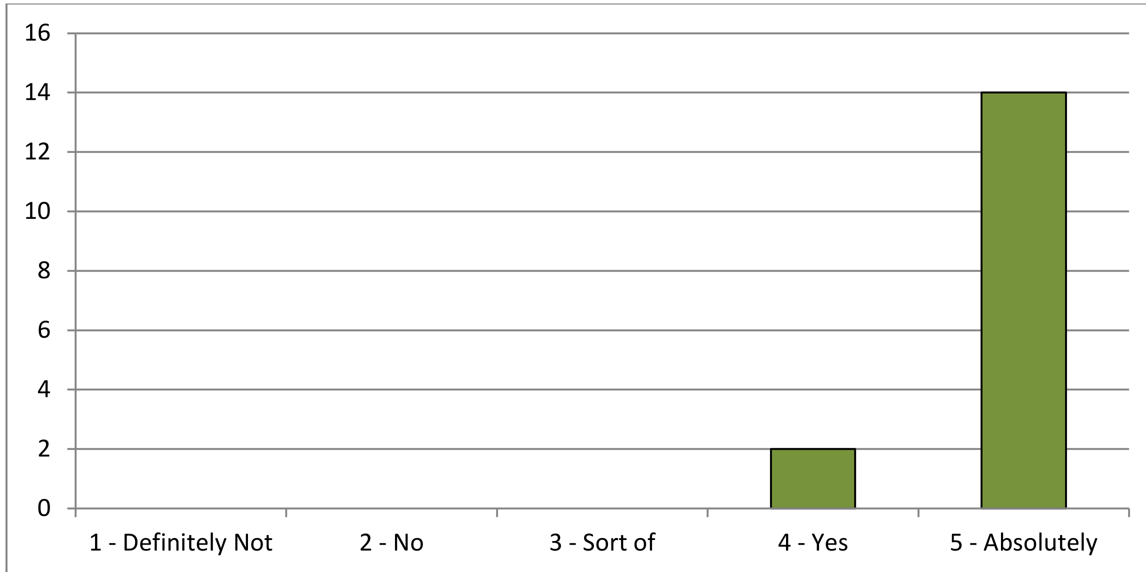
Do you believe that family wellness improves after services with IPC?

1 - Definitely Not	0.0%	0
2 - No	0.0%	0
3 - Sort of	0.0%	0
4 - Yes	18.8%	3
5 - Absolutely	81.2%	13



Do you find the Infant Parent Center's services essential for the community?

1 - Definitely Not	0.0%	0
2 - No	0.0%	0
3 - Sort of	0.0%	0
4 - Yes	12.5%	2
5 – Absolutely	87.5%	14



MHSA Year-End Progress Report

Prevention Wraparound Services: Juvenile Justice Project

Provider: Stanford Sierra Youth & Families

Project Goals

- Improve the array of services and supports available to children and families involved in the child welfare and juvenile probation systems.
- Engage families through a more individualized casework approach that emphasizes family involvement.
- Increase child/youth safety without an over-reliance on out-of-home care.
- Improve permanency outcomes and timeliness.
- Improve child and family well-being.
- Prevent involvement in the juvenile justice system.

Numbers Served and Cost

Expenditures	FY 2019-20	FY 2020-21
MHSA Budget	$550,000	
Total Expenditures	$103,918	
Unduplicated Individuals Served	15	
Cost per Participant	$6,928	
Age Group	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	2	
16-25 (transitional age youth)	13	
26-59 (adult)	0	
Ages 60+ (older adults)	0	
Unknown or declined to state	0	
Race	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	0	
Asian	0	
Black or African American	0	
Native Hawaiian or Other Pacific Islander	0	
White	14	
Other	0	
Multiracial	1	
Unknown or declined to state	0	
Ethnicity by Category	**FY 2019-20**	**FY 2020-21**
Hispanic or Latino	0	
Caribbean	0	
Central American	0	

Mexican/Mexican-American/Chicano	1	
Puerto Rican	0	
South American	0	
Other	1	
Unknown or declined to state	0	
Non-Hispanic or Non-Latino		
African	0	
Asian Indian/South Asian	0	
Cambodian	0	
Chinese	0	
European	11	
Filipino	0	
Japanese	0	
Korean	0	
Middle Eastern	0	
Vietnamese	0	
Other	2	
Multi-ethnic	0	
Unknown or declined to state	1	
Primary Language	**FY 2019-20**	**FY 2020-21**
Arabic	0	
Armenian	0	
Cambodian	0	
Cantonese	0	
English	14	
Farsi	0	
Hmong	0	
Korean	0	
Mandarin	0	
Other Chinese	0	
Russian	0	
Spanish	0	
Tagalog	0	
Vietnamese	0	
Unknown or declined to state	1	
Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	0	
Heterosexual or Straight	13	

Bisexual	0	
Questioning or unsure of sexual orientation	0	
Queer	0	
Another sexual orientation	0	
Unknown or declined to state	1	
Gender ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:		
Male	11	
Female	3	
Unknown or declined to answer	1	
Current gender identity:		
Male	11	
Female	3	
Transgender	0	
Genderqueer	0	
Questioning / unsure of gender identity	0	
Another gender identity	0	
Unknown or declined to answer	1	
Disability	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	unknown	
Difficulty hearing or having speech understood	0	
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	
Physical/mobility	unknown	
Chronic health condition/chronic pain	unknown	
Other (specify)	1	
Declined to state	0	
Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**
Yes	N/A	
No	N/A	
Unknown or declined to state	N/A	
Region of Residence	**FY 2019-20**	**FY 2020-21**
West County	2	
Placerville Area	4	
North County	1	
Mid County	0	

South County	0	
Tahoe Basin	5	
Unknown or declined to state	3	
Economic Status	**FY 2019-20**	**FY 2020-21**
Extremely low income	2	
Very low income	2	
Low income	3	
Moderate income	4	
High income	4	
Health Insurance Status	**FY 2019-20**	**FY 2020-21**
Private	7	
Medi-Cal	7	
Medicare	1	
Uninsured	0	

Annual Report FY 2019/20

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Prevention Wraparound Services: Juvenile Service 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 Wraparound program has been in implementation phase of the project since July 2019 where referrals reached capacity for the program of ten (10) youth by mid-October 2019. During quarter 2, our census was filled and we implemented a waitlist for services. By the end of the fiscal year 2019-2020, we had a total of 22 referrals (nine from Child Protective Services and 13 from Probation). Though a high percentage of the referrals we received this year were in need of higher level or different services, we were able to support our referring partners and families in accessing the more appropriate services. In total we saw seven (7) youth successfully through the program in reaching their goals and the eighth (8) youth is set to complete the program August 2020.

   Due to COVID19 it is worth noting that we saw a decrease in referrals quarter three (3) and quarter four (4). We worked diligently with our referring partners through this and learned that they were also seeing a significant decrease in referrals. Quarter four (4) is where we began to see more referrals made that were better suited to be served through county behavioral health.

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

The Prevention Wraparound team has continued to work with referring partners prior to referral to discuss the nature and appropriateness of the referral. During the intake and assessment process, our team assesses for mental health related needs utilizing tools such as the CANS-50; CSE-IT; CAFAS; PSC-35; CODA; and a comprehensive Core Assessment evaluating biopsychosocial history, risk assessment, and mental health history. Utilizing this information we are able to screen for higher mental health needs and potential negative outcomes (suicide, self-harm, prolonged suffering, school failure or dropout, incarceration, trauma, homelessness, or removal of children from their homes) and have referred to Specialty Mental Health Services when appropriate. Utilizing the High Fidelity Wraparound process we are able to create a comprehensive plan with the family, referral partner, and treatment team to address identified priority needs.

We have collaborated at our cross-systems monthly meeting to determine extensions for prospective discharge dates for youth needing additional time/support to complete recommended tasks. Lastly, we have remained open to ensure linkage for youth with alternative or higher level needs identified, supporting with that linkage and offering in-person support if needed.

3) **Provide a brief narrative description of progress in providing services through the Prevention Wraparound Services project to unserved and underserved populations. Underserved is defined in California Code of Regulations 3200.300 as "clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided with the necessary opportunities to support their recovery, wellness, and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, or other serious consequences."**

Throughout the first year we had a total of seven (7) youth who did not open due to higher level of needs determined within the referral process for which our team supported the referring party in linking to more appropriate services and closing out. Through the year we opened the remaining 15 clients referred and of these youth three (3) were determined in the initial assessment phase to need higher level of services (Specialty Mental Health), two (2) youth were detained for further probation violations mid-program and two (2) youth were determined to need higher level residential support mid-program.

To address the challenge at hand of identifying appropriate referrals for this program in order to ensure families are linked with the appropriate level of services we worked collaboratively with Child Protective Services (CPS) and Probation to educate their staff and to be available to discuss potential referrals before they're made. Additionally we developed a screening tool by the end of the fiscal year to support Probation staff in screening out potential Specialty Mental Health needs. The hope is that with initial screening tool(s) and conversation that we can link youth and families to the services they need sooner.

Additionally we also had received referrals for a couple of youth who had identified Specialty Mental Health Services, but due to Medi-Cal ineligibility could not access the level of services offered by County Behavioral Health. For these youth we were able to obtain permission from MHSA to provide them services that they otherwise would not have access to.

With the services provided, the team has supported youth and families in identifying strengths, becoming medication compliant, and creating a plan to support with the transition to the new placement, thus minimizing out-of-home placement or hospitalization.

4) Provide a brief narrative description of the number of youth who have reduced the number, duration, and repetition of in-patient psychiatric hospital care admissions.

No youth were admitted for in-patient psychiatric hospital care admissions during their services with the program. There were several youth referred for services who either through the referral or assessment process frequent/recent hospitalization determined a higher level of need for Specialty Mental Health services and they were linked for more appropriate support.

5) Provide a brief narrative description of the number of youth who have had reduced contacts with law enforcement, the Juvenile Justice system, and/or Child Welfare.

During the second (2) quarter we had three (3) youth detained for various probation violations, of these youth two (2) were released home with the support of prevention wraparound services. One (1) of the youth released home completed the program successfully, one (1) youth violated probation again and was detained resulting in discharge, and the youth who was not initially released from custody was discharged from the program due to the nature of the additional charges requiring long-term detainment. In regards to contact with Child Welfare Services, one (1) youth was placed in an out-of-state placement to support with ongoing safety risks and commercially sexually exploited child (CSEC) related concerns. One (1) youth referred by CPS was supported by the team with creating a transition plan for transition to long-term placement with a natural support with hopeful intention of adoption. A third youth involved with CPS was likely a better fit for Specialty Mental Health Services in retrospect and the team had some challenges in providing services due to the youth's long stay at the New Morning Youth Shelter and then abruptly being placed in an IFC home in South Lake Tahoe in order to better meet their needs.

6) Provide a brief narrative description of the number of youth who maintain integration or have been reintegrated into a permanent family-based setting and in the community.

Of the 11 youth served in the program, three (3) were in the Juvenile Treatment Center (JTC) detained for further probation charges, one (1) youth was removed from birth parents and placed in out-of-state placement, one (1) youth moved from the shelter to a resource home, two (2) maintained living with relatives, one (1) was placed with a legal guardian after the loss of their parent, one (1) youth obtained their own independent living, one (1) is actively in an independent living program, and one (1) was with their birth family.

7) Provide a brief narrative description of how the Prevention Wraparound Services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.

All staff hired for our Prevention Wraparound program receive cultural competence training and are prepared to support youth and families as appropriately indicated. During our assessment process, our team assesses any needs related to cultural accommodations, language needs, ADA or Indian Child Welfare Act (ICWA)-related accommodations. We have bilingual (Spanish speaking) staff who

can provide services in Spanish, as well as the capacity to utilize interpreter services if needed. At this time we have had no need for language accommodations. Additionally, at the time of assigning staff or adding additional team members, we utilize information known about the youth and family to best match the needs and comfort of the family. A specific example of this match consideration could be applied with our adding of youth advocates and family partners to some of our family teams; the team met and discussed the family dynamics and cultures in order to identify team members who'd best fit family culture and be able to best address the needs identified utilizing their lived-experience. Throughout services we continue to assess with any need for cultural or language accommodations. At this point in serving families for quarter four (4), there were no reported accommodations culturally or linguistically reported.

8) 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.

Our team has partnered with our referring partners of CPS and Probation to provide training and facilitate conversation around our services and create an open dialogue to best support with coordination of care. We have a monthly cross-systems meeting where we discuss the current census, the needs of the youth and families, any critical incidences or significant concerns, and plans for transition as clients near the end of services. We discuss each referral with the referring partner prior to calling caregivers to set up intake in order to gather pertinent information around needs and potential mental health concerns. In the event that a youth requires Specialty Mental Health Services, our team is able to support the referring partner and the caregiver in navigating the referral process. In regards to access/linkage to medically necessary care, we identify primary care physicians for each of our youth and complete a Child Health Questionnaire (CHQ) to identify any needed linkage/support medically, with this information we support youth and families in accessing care within their county and plan.

9) Provide the outcome measures of the customer satisfaction surveys.

The program does not have a developed customer satisfaction survey and we are working to implement the wraparound fidelity index (WFI). Currently we are utilizing the CANS scores to monitor and measure progress within the program.

10) If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.

We had eight (8) youth this fiscal year who's referral or services were closed in order to link the youth/family to county behavioral health for support with specialty mental health services and permanency/placement support.

11) If known and if applicable, provide information on Client self-report on the duration of untreated mental illness.

In quarter one (1) five (5) youth admitted reported having had history with mental health services. One (1) youth reported having begun receiving services at the age of six (6) for symptoms of ADHD and had been hospitalized multiple times for suicide attempts and self-harm. This particular youth was one of the youth who was not eligible for Medi-Cal and could not be referred to County

Behavioral Health. This youth is also the youth who was placed in out-of-state care to manage safety risks. Four (4) of the remaining youth in quarter one (1) reported being linked and actively seeing therapists for mild to moderate needs.

In quarter two (2), at least seven (7) youth served reported some level of untreated mental health. Some youth reported having historically received mild-to-moderate therapy services, two (2) youth reported concurrent mild-to-moderate therapy with one (1) of those youth receiving support to maintain and continue the support. Three (3) youth during this quarter were referred out for the higher level need for Specialty Mental Health Services.

In quarters three (3) and four (4), we had several youth who were not opened due the referral clearly noting the higher mental health needs. Additionally we opened or received referrals for two to three youth who were currently linked to Specialty Mental Health Services and due to COVID-19 had just ceased receiving services due to not wanting to engage in telehealth. Due to their still evident high needs, they were closed and linked back to the Specialty Mental Health Provider through the referring partner (CPS or Probation).

12) If known, provide the average interval between mental health referral and participation in treatment.

Information regarding mental health referral to date of open when youth are referred out is unknown. The average time between referral to prevention wraparound to intake averaged about 13.6 days. This is with the consideration of two (2) outliers of 26 and 35 days due to the referral being placed by the referral partner later than intended or circumstances with the family. Removing the outliers, the average was 8.7 days from referral to opening and beginning services.

13) If known, the number of individuals who followed through on the referral and engaged in treatment.

Upon receiving referral, our facilitator calls the referring partner (CPS Social Worker or Probation Officer) to discuss the referral and gather any pertinent information before contacting the caregiver. The facilitator then calls the identified caregiver on the referral and provides information about the program and their role as the facilitator. At this time they explain the intake assessment and planning process in order to answer any questions the caregiver may have and they set up a time for intake. Our facilitator also provides a reminder call or text (depending on caregiver's preference) prior to the appointment. We have a streamlined intake and assessment process in order to be able to develop a plan for services with the family's voice and choice at the forefront by the second or third appointment, allowing active services to begin by week three (3) or four (4).

14) If known, provide a description of the methods Contractor used to encourage Client access to services and follow-through on referrals.

Engagement begins when we receive the referral and assign the referral to our team members who then call the referral partner to confirm receipt and gather any pertinent information before calling the family. We call the family typically within 24 business hours of receiving the referral to introduce the program, explain how our teaming works, and to explain the intake and assessment process. When a family has consented to beginning services, our team begins with intake, which requires the youth and at least one caregiver to be present, during this time they gather information

about the youth and family, ensure that the family fully understands the expectation of the program, and determine when and where would be best for the family to receive our services.

When it is difficult to reach families or to attain attendance and completion of intake, we partner with our referral partners (Child Protective Services and Probation) to ensure that they are aware of our attempts and to verify that we have the correct information. Additionally we send letters to the home in an attempt to reach the family in case they are experiencing telephone issues. When a youth or family disengage mid-service, we rely on team members and natural supports who may have stronger connections or more frequent contact. We may also attempt to pay an in-home visit if safe to do so, and always collaborate with our referral partners to identify the challenges in order to overcome them.

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

The project expenditures totaled $131,247.10. The dollars leveraged for the project were $27,329.58.

16) Provide any additional relevant information.

No additional information provided.

MHSA Year-End Progress Report

Expressive Therapies Project

Provider: Arts & Culture El Dorado

Project Goals

- Decrease prolonged suffering related to unresolved grief due to the separation from a foster or adopted child.
- Improve parent mental health and resiliency.

Numbers Served and Cost

Note: This contract was executed on December 10, 2019. It took time to develop and implement the project. Further, the Public Health Emergency related to the COVID-19 pandemic required all workshops to cease in March 2020. Therefore, there is little data available for FY 19/20.

Expenditures	FY 2019-20	FY 2020-21	FY 2021-22
MHSA Budget	$100,000	$	
Total Expenditures	$ 10,650	$	
Unduplicated Individuals Served	5		
Cost per Participant	$ 2,130		
Age Group	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
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	5		
Race	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
American Indian or Alaska Native	unknown		
Asian	unknown		
Black or African American	unknown		
Native Hawaiian or Other Pacific Islander	unknown		
White	unknown		
Other	unknown		
Multiracial	unknown		
Unknown or declined to state	5		
Ethnicity by Category	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**

Hispanic or Latino	unknown		
Caribbean	unknown		
Central American	unknown		
Mexican/Mexican-American/Chicano	unknown		
Puerto Rican	unknown		
South American	unknown		
Other	unknown		
Unknown or declined to state	5		
Non-Hispanic or Non-Latino			
African	unknown		
Asian Indian/South Asian	unknown		
Cambodian	unknown		
Chinese	unknown		
Eastern European	unknown		
Filipino	unknown		
Japanese	unknown		
Korean	unknown		
Middle Eastern	unknown		
Vietnamese	unknown		
Other	unknown		
Multi-ethnic	unknown		
Unknown or declined to state	5		
Primary Language	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
Arabic	unknown		
Armenian	unknown		
Cambodian	unknown		
Cantonese	unknown		
English	unknown		
Farsi	unknown		
Hmong	unknown		
Korean	unknown		
Mandarin	unknown		
Other Chinese	unknown		
Russian	unknown		
Spanish	unknown		
Tagalog	unknown		
Vietnamese	unknown		
Unknown or declined to state	5		
Sexual Orientation ***Collection of this information from a minor***	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**

younger than 12 years of age is not required.			
Gay or Lesbian	unknown		
Heterosexual or Straight	unknown		
Bisexual	unknown		
Questioning or unsure of sexual orientation	unknown		
Queer	unknown		
Another sexual orientation	unknown		
Declined to State	5		
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
Assigned sex at birth:			
Male	unknown		
Female	unknown		
Declined to answer	5		
Current gender identity:			
Male	unknown		
Female	unknown		
Transgender	unknown		
Genderqueer	unknown		
Questioning / unsure of gender identity	unknown		
Another gender identity	unknown		
Declined to answer	5		
Disability	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
Difficulty seeing	unknown		
Difficulty hearing or having speech understood	unknown		
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown		
Physical/mobility	unknown		
Chronic health condition/chronic pain	unknown		
Other (specify)	unknown		
Declined to state	5		
Veteran Status ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
Yes	unknown		

No	unknown		
Unknown or declined to state	5		
Region of Residence	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
West County	unknown		
Placerville Area	unknown		
North County	unknown		
Mid County	unknown		
South County	unknown		
Tahoe Basin	unknown		
Unknown or declined to state	5		
Economic Status	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
Extremely low income	unknown		
Very low income	unknown		
Low income	unknown		
Moderate income	unknown		
High income	unknown		
Health Insurance Status	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**
Private	unknown		
Medi-Cal	unknown		
Medicare	unknown		
Uninsured	unknown		

Annual Report FY 2020

Please provide the following information for this reporting period:

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

   This has been a challenging year for everyone, and like many public programs and services, the Expressive Therapies program was severely impacted by the quarantine order. (Arts and Culture El Dorado suspended all public programs, including Expressive Therapies, on March 13, 2020.) We did undertake preliminary program development, meeting with artists and therapists and matching them together. These teams went on to develop the program sessions to be offered. Once the contracts were signed, we began marketing the program to the public and ultimately scheduled six (6) sessions between February and June 2020. We were enthusiastic about offering these programs to persons who qualified as caregivers to a child not their own.

   The first program was Masks: Adornment and Storytelling. Participants were to learn a brief history of mask use and construction, appropriate adornment techniques, and performance aspects. Each week a new topic of persona would be explored while decorating various masks. Personal and fictionalized stories and narratives would be explored while refining a final mask-centric performance piece. However, only four (4) sessions of this program were offered before the

declaration of the Public Health Emergency and consequent shelter-at-home orders due to COVID-19.

In addition to the Masks workshop, we developed five other workshops: Knitting and Crochet as a Healing Medium; Collage and Mixed Media; Guided Visual Journal; Painting as Meditation; and Nature Drawing. We are currently considering how to offer these programs virtually or electronically.

2) **Briefly report on how the Expressive Therapies project has improved the overall mental health of the older adult population by addressing the primary negative outcomes that are the focus of the Friendly Visitor project (suicide and prolonged suffering). Please include other impacts, if any, resulting from the Friendly Visitor 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.**

   We are unable to provide this information due to the abrupt cancellation of the sessions.

3) **Provide a brief narrative description of progress in providing services through the Expressive Therapies project to unserved and underserved populations. Underserved is defined in California Code of Regulations 3200.300 as "clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided with the necessary opportunities to support their recovery, wellness, and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, or other serious consequences."**

   To our knowledge, none of the five (5) participants in the Masks workshop would be described as underserved according to 3200.300. Once we begin this program again, further attempts will be made to identify and engage with this population.

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

   Arts and Culture El Dorado's programs are always provided in accordance with the tenets of DEIA (diversity, equity, inclusion, and access) as set forth by the California Arts Council, for whom we serve as the State-Local Partner. Artmaking by definition lends itself to cultural equity and we hold our programs to the highest of standards in this regard.

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.**

   We are unable to provide this information due to the abrupt cancellation of the sessions.

6) **Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcomes for the Expressive Therapies project are:**

- **Measurement 1: Report on the unduplicated numbers of individuals served, including demographic data.**

  5 unduplicated individuals served

- **Measurement 2: Parent satisfaction surveys of completion of a visual analog survey at the end of each session.**

  Due to separation of staff who managed the project, we are unable to locate this information. It will be included in future workshops.

- **Measurement 3: Parent self-report of increased coping mechanisms associated with secondary trauma experience by Parents of adopted or foster children (decreased prolonged suffering).**

  Due to the separation of staff who managed the project, we are unable to locate this information. It will be included in future workshops.

- **Measurement 4: Number of Parents referred to County Behavioral Health and the type of treatment to which Parents were referred, if known.**

  Unknown

- **Measurement 5: Parent self-report on the duration of untreated mental illness, if known.**

  Unknown

- **Measurement 6: If known, the average interval between referral and participation in treatment.**

  Unknown

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

   Total expenditures: $10,650
   No in-kind contributions

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

   In addition to the cancellation of workshop activities, Arts and Culture El Dorado found it necessary to downsize our staff in order to deal with economic reality. The staff person serving as Program Manager was also serving as Expressive Therapies Coordinator and he is no longer on the Arts and Culture team. However, we have identified another individual who is enthusiastic about serving as

Expressive Therapies Coordinator. She has been engaged to begin developing new strategies for Expressive Therapies for the coming year. We will work diligently to implement a new approach to this important program.

Suicide Prevention of Yolo County

2019-2020 Year End Report

El Dorado County

North Valley Suicide Prevention Hotline Report

Suicide Prevention of Yolo County (SPYC) shall provide crisis line telephone support for callers who have reached out to their crisis lines. This service shall be provided seven (7) days per week, twenty-four (24) hours per day, to the community. SPYC will operate the North Valley Suicide Prevention Hotline with specialized support and outreach provided to (but not limited to) the following contributing counties: Yolo, Butte, El Dorado, Humboldt, Nevada, Sacramento, Shasta, Solano, and Sutter-Yuba.

The following report details call contacts identified as having originated from El Dorado County, California.

North Valley Suicide Prevention Hotline

Suicide Prevention's crisis line counselors are trained extensively on deescalating caller situations with the least invasive interventions.

Active Rescues are initiated to secure the immediate safety of a caller at risk if, in spite of the crisis line counselor's best efforts to engage the at-risk caller's cooperation, they remain unwilling and/or unable to take actions likely to prevent their suicide, or they remain at imminent risk/danger to themselves or others.

42 Moderate or Higher Lethality Incoming Calls

5 Active Rescue Callers

1 Imminently Lethal Callers Deescalated

Cost Avoidance (July 2019 – June 2020)

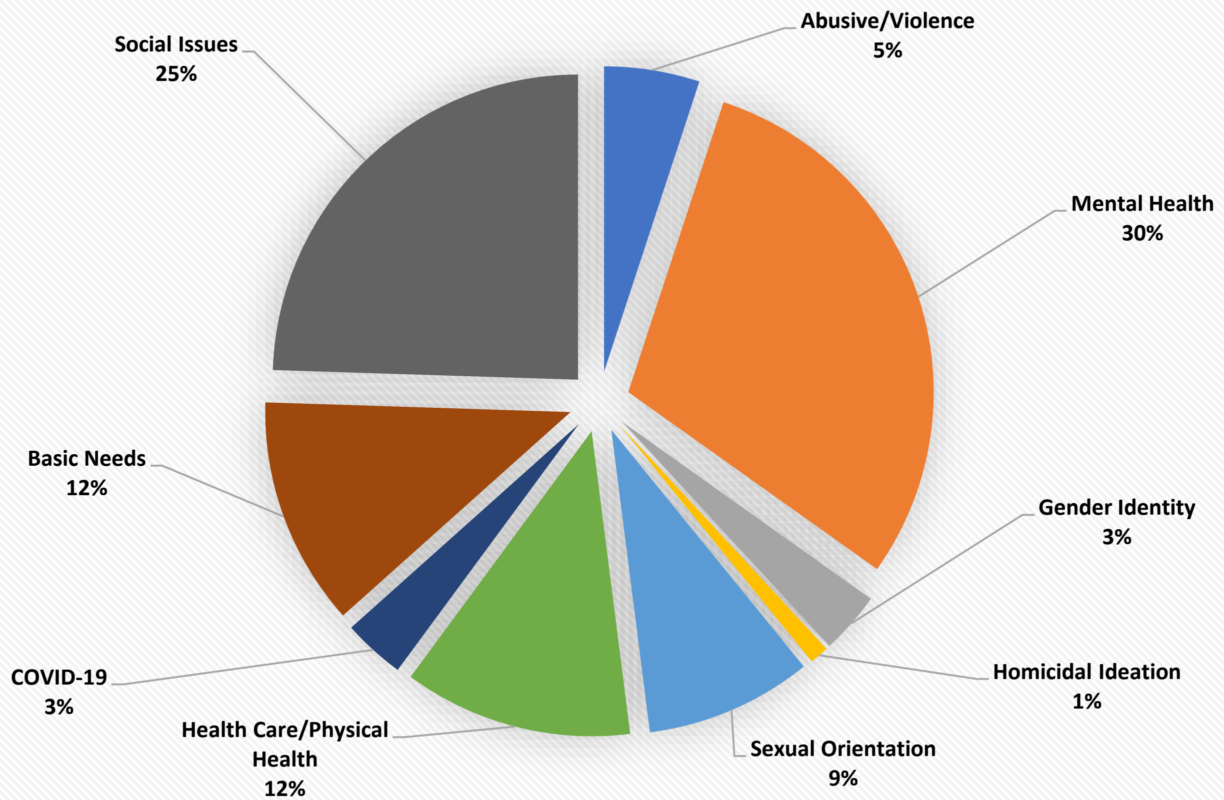
Most crisis line callers have few healthcare options and resources; therefore, when individuals escalate into imminent lethality, costs for emergency services or other limited resources are usually covered by the county.

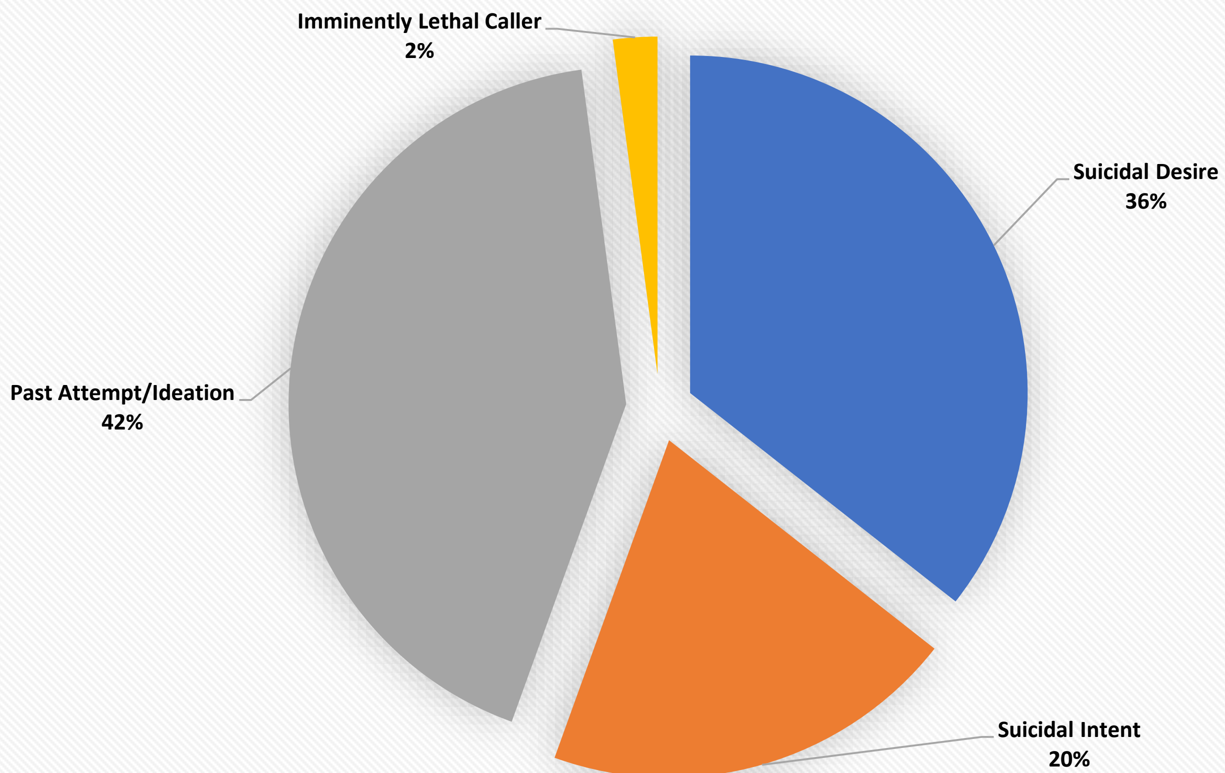
Emergency Services*	Costs to System
Ambulance Transport	$590
Law Enforcement/In-Person Crisis Intervention	$6/minute MediCal = $360/hr
Psychiatric Admission	$1,000 - $1,800/day

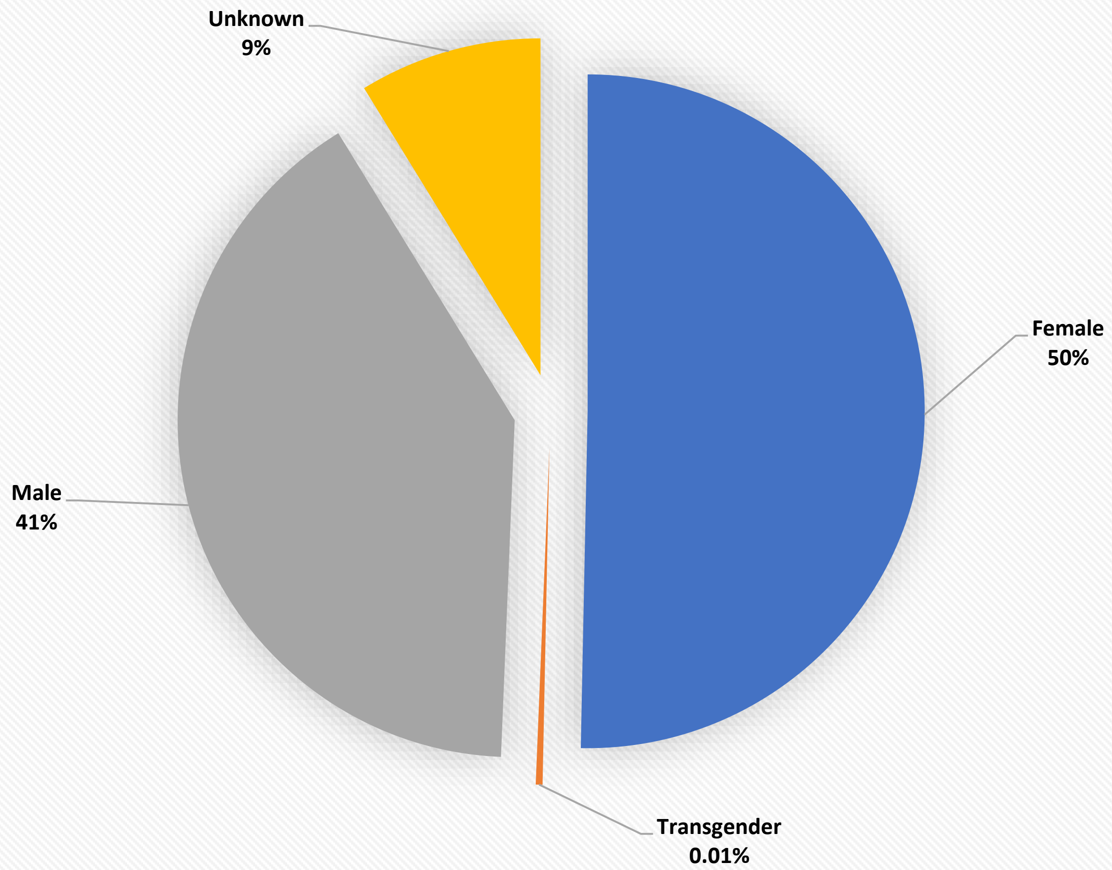
With access to critical crisis lines like ours, callers at moderate or high lethality can avoid costly psychiatric hospital stays (or more serious consequences) as they are able to receive immediate support and deescalate from emotional crises before the situation turns into an emergency.

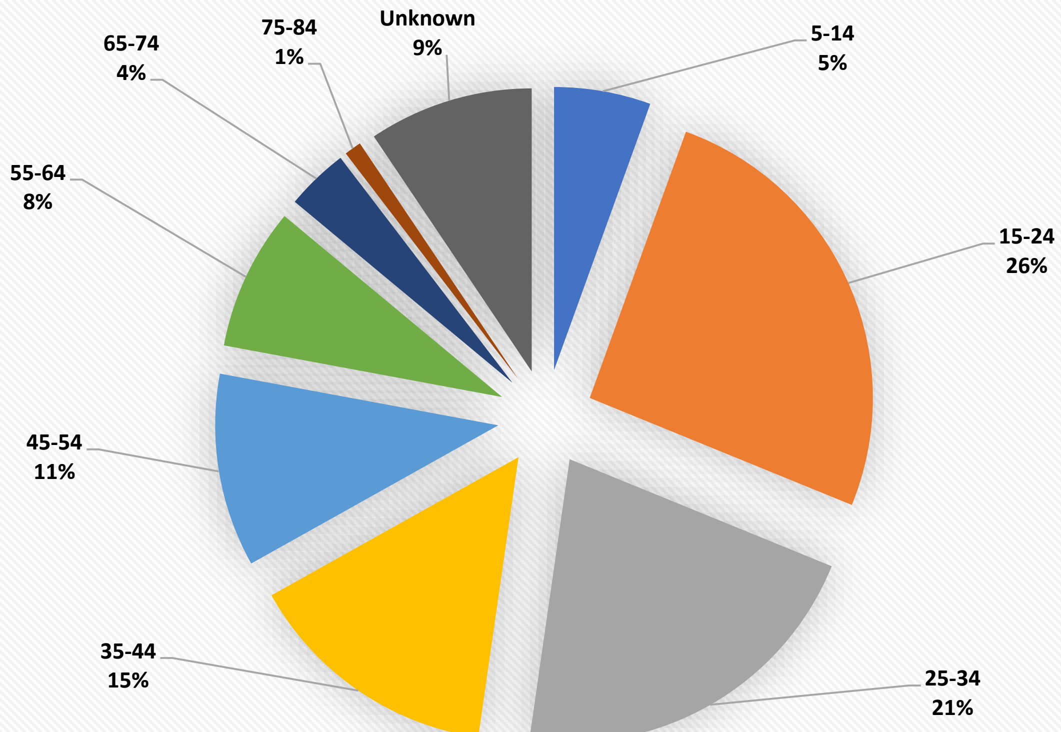
**This chart does not include additional potential costs of deploying extra law enforcement time or officers, mental health professionals and psychiatrists, any medications or medical procedures administered following an attempt, a 5150 hospitalization, a 5250 hospitalization, any additional medical procedures, or any additional referrals or placements for a patient discharged from the hospital to a different level of care.*

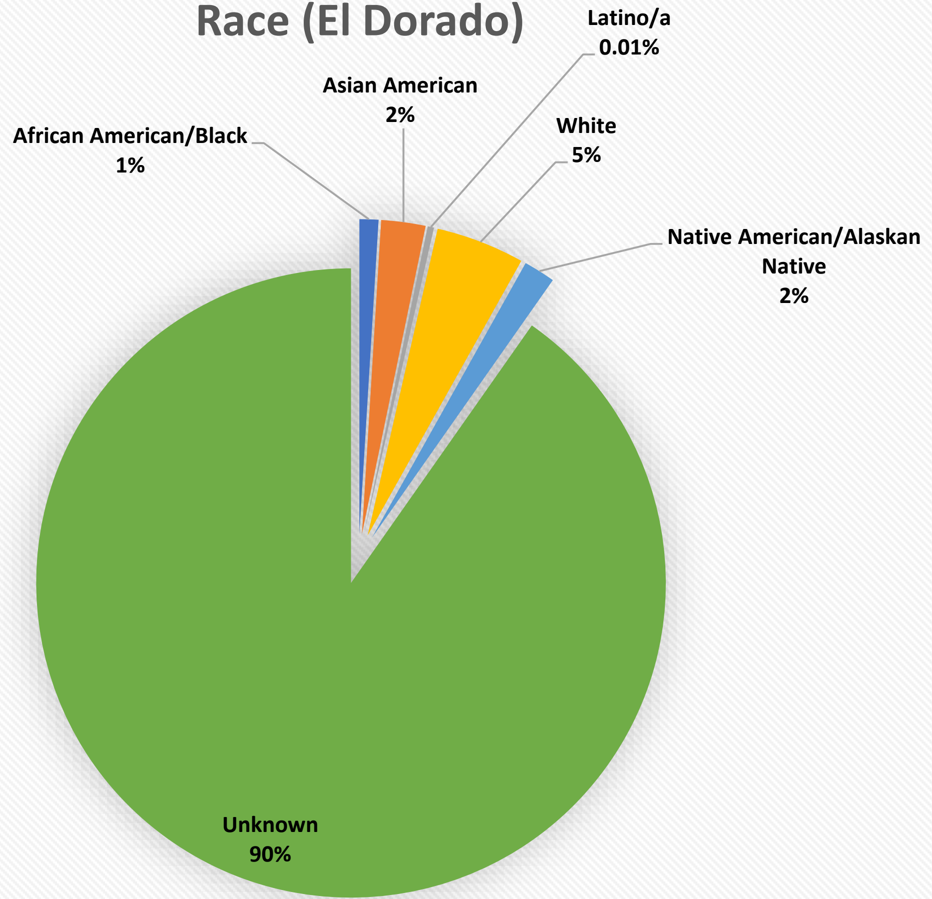
TOTAL EL DORADO CALLERS FROM 7/2019-6/2020: 296


Caller Concerns (El Dorado)
Abusive/Violence
5%
Mental Health
30%
Gender Identity
3%
Homicidal Ideation
1%
Sexual Orientation
9%
Health Care/Physical
Health
12%
COVID-19
3%
Basic Needs
12%
Social Issues
25%


Suicidal Content (El Dorado)
Imminently Lethal Caller
2%
Suicidal Desire
36%
Suicidal Intent
20%
Past Attempt/Ideation
42%


Gender (El Dorado)
Unknown
9%
Female
50%
Male
41%
Transgender
0.01%


Age Range (El Dorado)
Unknown
9%
75-84
1%
65-74
4%
5-14
5%
55-64
8%
15-24
26%
45-54
11%
35-44
15%
25-34
21%


Race (El Dorado)
Latino/a
0.01%
Asian American
2%
White
5%
African American/Black
1%
Native American/Alaskan
Native
2%
Unknown
90%

MHSA Year-End Progress Report

Mental Health First Aid and Community Education Project

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 us 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 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$120,000	$120,000	$120,000
Total Expenditures	$15,341	$30,207	$29,907
Unduplicated Individuals Served	191	274	119
Cost per Participant	$80	$110	$251
Number of Classes			
Youth	3	6	54
Adult	7	11	65
Veterans	1	0	0
Cost per Class	$1,295	$1,777	$251

Outcome Measures

- **Measurement 1: Class evaluation provided to attendees at the end of each session.**

- **Measurement 2: Evaluation survey provided to attendees six (6) months after taking the class, including information regarding application of material learned.**
  Outcome information is not currently available.

Note: Five (5) classes (four adult and one older adult) were scheduled between March and June 2020 when the Governor instituted the stay-at-home order due to the Public Health Pandemic. These classes had to be cancelled. The certified trainers are now working on being certified to teach the classes virtually.

LGBTQIA Community Education Project

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 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$5,000	$5,000	$10,000
Total Expenditures	$0	$82	$0

Outcome Measures

- **Number of informing material distributed.**
  327 Informing materials were distributed

- **Number of people reached through presentations.**

  One (1) presentation was provided.

- Each Mind Matters regularly sends El Dorado County MHSA new LGBTQIA informing materials.

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 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$55,000	$55,000	$60,000
Total Expenditures	$58,060	$58,253	$60,000

MHSA Year-End Progress Report

Parenting Classes Project

Provider: El Dorado County HHSA, Social Services Division/Child Welfare 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

Expenditures	FY 2019-20	FY 2020-21
MHSA Budget	$100,000	$
Total Expenditures	$24,917* *See response to question #1 below	$
Unduplicated Individuals Served	34	
Cost per Participant	$733	$
Age Group	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	0	
16-25 (transitional age youth)	3	
26-59 (adult)	28	
Ages 60+ (older adults)	1	
Unknown or declined to state	2	
Race	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	4	
Asian	0	
Black or African American	0	
Native Hawaiian or Other Pacific Islander	1	
White	15	
Other	3	
Multiracial	0	
Unknown or declined to state	11	

Ethnicity by Category	FY 2019-20	FY 2020-21
Hispanic or Latino	unknown	
Caribbean	unknown	
Central American	unknown	
Mexican/Mexican-American/Chicano	unknown	
Puerto Rican	unknown	
South American	unknown	
Other	unknown	
Unknown or declined to state	2	
Non-Hispanic or Non-Latino		
African	unknown	
Asian Indian/South Asian	unknown	
Cambodian	unknown	
Chinese	unknown	
Eastern European	1	
Filipino	unknown	
Japanese	unknown	
Korean	unknown	
Middle Eastern	unknown	
Vietnamese	unknown	
Other	unknown	
Multi-ethnic	unknown	
Unknown or declined to state	31	
Primary Language	**FY 2019-20**	**FY 2020-21**
Arabic	0	
Armenian	0	
Cambodian	0	
Cantonese	0	
English	34	
Farsi	0	
Hmong	0	
Korean	0	
Mandarin	0	
Other Chinese	0	
Russian	0	
Spanish	0	
Tagalog	0	
Vietnamese	0	
Unknown or declined to state	0	

Sexual Orientation ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	unknown	
Heterosexual or Straight	4	
Bisexual	unknown	
Questioning or unsure of sexual orientation	unknown	
Queer	unknown	
Another sexual orientation	1	
Declined to State	29	
Gender ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:		
Male	13	
Female	14	
Declined to answer	7	
Current gender identity:		
Male	13	
Female	14	
Transgender	unknown	
Genderqueer	unknown	
Questioning / unsure of gender identity	unknown	
Another gender identity	unknown	
Declined to answer	7	
Disability	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	1	
Difficulty hearing or having speech understood	0	
Mental disability including but not limited to learning disability, developmental disability, dementia	2	
Physical/mobility	2	
Chronic health condition/chronic pain	1	
Other (specify)	1	
Declined to state	5	
Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2019-20**	**FY 2020-21**
Yes	1	
No	29	
Unknown or declined to state	4	

Region of Residence	FY 2019-20	FY 2020-21
West County	8	
Placerville Area	10	
North County	4	
Mid County	unknown	
South County	unknown	
Tahoe Basin	3	
Unknown or declined to state	11	
Economic Status	**FY 2019-20**	**FY 2020-21**
Extremely low income	unknown	
Very low income	unknown	
Low income	5	
Moderate income	4	
High income	unknown	
Health Insurance Status	**FY 2019-20**	**FY 2020-21**
Private	6	
Medi-Cal	19	
Medicare	1	
Uninsured	unknown	

Annual Report FY 2019/20

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Parenting Classes 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 original start date of the group was delayed several times (approximately three weeks) due to PG&E Public Safety Power Shutoff power outages in our county. In addition, the facilitators struggled to get an adequate number of clients referred to the group who met the participant requirement: A current open case with CPS and who were willing to attend. Once the group actually began, the facilitators offered the group with a consistently scheduled time, day and location. To address the relatively low number of clients initially attending the group, the facilitators requested Emergency Response Social Workers refer parents at the time of the detention hearing rather than wait for Ongoing Social Workers to engage parents in services. This served two purposes: 1) increased referrals and 2) reduced wait times for parents to begin the group. As stated, this relatively simple change reduced unnecessary wait times for the parents as well as increased participation.

   In March of 2020, the Governor issued stay-at-home orders due to COVID–19 and once again, the continuity of program operations were negatively affected. While this order presented a challenge to the facilitators' ability to meet in-person safely, they were able to restart the group after only a one-week break by using Zoom technology. The Zoom platform allowed us to continue to provide a service for our clientele while following the state mandates to maintain social distancing.

Additionally it enabled us to expand our group to include parents from the Lake Tahoe Basin, a previously underserved population. The Agency continually assesses whether the video-conferencing format used to offer this class meets the needs of our clients. At this time, given the continued uncertainty and rise in COVID-19 cases, it does appear to be an effective, safe and prudent way to deliver course material.

2) **Briefly report on how the Parenting Classes 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 Parenting Classes project: (1) school failure or dropout and (2) removal of children from their homes. Please include other impacts, if any, resulting from the Parenting Classes project on the other five negative outcomes addressed by PEI activities: (1) suicide; (2) incarceration; (3) unemployment; (4) prolonged suffering; and (5) homelessness.**

More than half of the parents participating in the CPS parenting classes are involved in Dependency Court and have an open Family Reunification case. These parents had their children removed due to abuse and neglect concerns that were unable to be mitigated without the removal of their children from their care. Some parents maintain custody of their children and are involved in other types of cases with the Agency, such Voluntary or even court order Family Maintenance cases. This parenting program helps parents learn age-appropriate developmental milestones, expectations, and consequences for their children as well as parental behaviors, parenting techniques and supervision necessary for safe and healthy parenting. Parents gain knowledge of the parenting skills presented in the class and these assist them to avoid a recurrence of maltreatment: Future cases with the Agency and should reduce re-entry into the Child Welfare System and the associated trauma when families are separated from one another.

It is also important to explore the impact that positive community support plays in these parents' journey with CWS. The parents in this group receive support from the facilitators while in the group and on an individual basis throughout the duration of the class. Additionally, parents receive support from each other. They are able to share details of their situations in confidence and without judgement as their peers in the group are involved in CPS as well. In theory, this level of support reduces participants' risk of suicide, incarceration, and prolonged suffering.

3) **Provide a brief narrative description of progress in providing the Parenting Classes project services to unserved and underserved populations.**

Parenting classes that address the specific needs of the families served by the Agency are difficult to find and often not available on a drop-in basis. Because of this, parents must wait until the next class series begins, creating a barrier to services for families experiencing crisis, anxiety or are in a high time of need. This class starts at the time of detention (when a child is removed and the Court case begins) or when a Social Worker opens a case for Voluntary Services. All that the facilitators require to have parents participate is an email from the Emergency Response Social Worker with contact information for the parents. The Agency does the rest and actively engages the parents in what they need to know about this class and why it can benefit them personally and in their relationship with their child(ren). Additionally parents that need to miss class for work can make up the class rather than being penalized (missing a class or more commonly – being removed from the group). The facilitators work with each parent to identify his/her needs and adjusts individual schedules accordingly to allow for missed classes and unexpected changes to schedules. Finally, as

mentioned, this group is now available using Zoom so any parent with a cell phone or computer access can attend the group, regardless of their current location.

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

The CPS parenting class addresses the specific needs of each individual family. Two (2) facilitators lead the classes: A male who is a bilingual Social Worker Supervisor and a female who is a licensed Marriage and Family Therapist and an Intake Social Worker. Great effort and intention is made to identify parents' strengths as well as problem areas and to take into account cultural customs and beliefs while working within the Child Welfare System. Additionally, translators can be provided if needed.

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 parenting group was started after a countywide collaboration between CWS, our local Community Hubs and counseling agencies. This group identified the need for a parenting program that only served CPS participants in hopes it would reduce stigma for families with CPS involvement. In other parenting groups, it can be hard for families to discuss CPS involvement due to perceived judgment by other participants or lack of shared experiences that can lead to shame, humiliation and an increase in feelings of isolation and stigma. By limiting participation to these families, this group provides much needed space to discuss CPS involvement and other issues unique to these parents' needs.

Parents' needs often go unaddressed because they are unable or reticent to convey what is honestly behind the issues that led to CPS involvement in their lives. They avoid topics of parental drug use, child abuse, neglect and domestic violence for fear of Agency involvement. This parenting group, however, is able to address these very issues because the parents all share one thing in common: CPS involvement. In addition, the facilitators are able to communicate and collaborate with all other agencies working with the parents to ensure that the parents are addressing the issues at hand.

6) **Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Parenting Classes project are:**

- **Measurement 1: Pre and Post Conners Comprehensive Behavior Rating Scales (CBRS) assessment.**

  No information was provided. The Agency will assess ability to implement the CBRS assessment next year.

- **Measurement 2: Participant surveys.**

  Post-class surveys were nearly impossible to obtain. A number of factors contributed to the difficulty with outcome assessments and surveys. First, only two (2) individuals completed the course before the COVID-19 "Shelter in Place Order" was issued. When groups were conducted

in-person, facilitators handed surveys to the parents at the beginning of the group and collected them at the end, taking care to ensure confidentiality. Outside these two (2) individuals, all other parents who have completed the course since the Shelter-in-Place were emailed the survey. Unfortunately, this limits confidentiality so if one (1) had negative feedback it is less than an ideal way to solicit honest feedback. Additionally, because parents completed the course and were not incentivized to submit a survey, the return rate was minimal.

From surveys received, however, there was positive feedback about the group. One (1) parent reported that s/he liked the food provided and that the class felt more like a conversation, which he enjoyed. Another parent shared that s/he did not feel judged and liked that we had a smaller group format. One individual identified that s/he liked the guidance and information shared by the facilitator. Lastly, another stated s/he learned great techniques.

The parents also provided some constructive feedback for future groups. Two (2) requested the addition of information related to co-parenting and one (1) requested information on drugs but made no further comments. One (1) stated that the slides could use updating while another shared they would prefer in-person groups. Finally, one (1) parent felt that the facilitators could use better IT support when it came to rooms and equipment use (it should be noted that this is a response to the facilitators being bumped from their regularly scheduled room on multiple occasions and placed in a room with limited technology, which required all to share a laptop). Information Technology or the group facilitators did not cause this situation nor could they do anything to stop it. It has since been resolved.

All but one parent noted improvement in their use of parenting techniques presented in Nurturing Parenting. The one parent who did not show improvement had already given himself the top score at the beginning of class so clearly there was no room for improvement from his perspective.

7) Unduplicated numbers of individuals served, including demographic data.

See above.

8) The number of potential responders engaged. Potential responders include, but are not limited to, families, employers, primary health care providers, visiting nurses, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel, emergency medical service providers, people who provide services to individuals who are homeless, family law practitioners such as mediators, child protective services, leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health services.

Child Welfare staff administer the program, but there may be other responders engaged with the families. The focus of this project is merely providing a parenting class to families involved in the Child Welfare system.

9) The setting(s) in which the potential responders were engaged.

Child Welfare staff provide the services at the County Health and Human Services building; or since COVID-19, virtually.

10) **The type(s) of potential responders engaged in each setting (e.g., nurses, principles, parents).**

No information provided for this year.

11) **If known, the number of individuals with serious mental illness referred to treatment and the kind of treatment the individual was referred to.**

Unknown

12) **If known, the number of individuals who followed through on the referral and engage in treatment.**

Unknown

a. **If known, the average duration of untreated mental illness.** Unknown
b. **If known, the interval between the referral and participation in treatment.** Unknown

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

The MHSA-approved budget was $100,000. As of the end of the Fiscal Year, projected expenses equate to $24,916.94. HHSA's Fiscal Team is still in the process of submitting the Q4 County Expense Claim so it is possible that this amount will increase slightly once all documents are posted. Expenses by quarter are as follows:

Q1 : $823.74
Q2: $5,234.55
Q3: $4,707.28
Q4: $14,151.37 (Estimate)
Total: $24,916.94

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

El Dorado County Health and Human Services Agency, Child Welfare Services appreciates the opportunity made available through MHSA funding to provide this parenting program to its population. As mentioned, this is a unique group that is often embarrassed, angry or experiencing a myriad of feelings that interfere with true engagement in other local parenting programs. The CPS Nurturing Parenting class enables parents to come together in a nonjudgmental environment to explore ways to improve their knowledge about child development, how their actions created an unsafe environment for their child(ren) and to begin the important steps to make changes that will improve the lives for themselves and their families.

Community Education and Parenting Classes Project

Parenting Skills
Provider: New Morning Youth and Family Services

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.

Numbers Served and Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$50,000	$50,000	$50,000
Total Expenditures	$31,050	$18,295	$8,115
Unduplicated Individuals Served	22	29	7
Cost per Participant	$1,411	$631	$1,159
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	1	0	0
16-25 (transitional age youth)	7	4	1
26-59 (adult)	14	25	6
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0
Race	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	0	1	1
Asian	0	1	0
Black or African American	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0
White	0	27	6
Other	18	0	0
Multiracial	0	0	0
Unknown or declined to state	0	0	0

Ethnicity by Category	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	4	0	0
Caribbean	0	0	0
Central American	0	1	0
Mexican/Mexican-American/Chicano	0	2	1
Puerto Rican	0	0	0
South American	0	0	0
Other	0	0	0
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	0	0	0
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	1	1
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	18	0	4
Multi-ethnic	0	0	0
Unknown or declined to state	0	0	0
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	18	27	6
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	4	2	1
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	0	0	0

Sexual Orientation ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	unknown	0	0
Heterosexual or Straight	unknown	22	6
Bisexual	unknown	2	1
Questioning or unsure of sexual orientation	unknown	0	0
Queer	unknown	0	0
Another sexual orientation	unknown	1	0
Declined to State	unknown	4	0
Gender ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	14	18	1
Female	8	11	6
Declined to answer	0	0	0
Current gender identity:			
Male	14	11	0
Female	8	18	6
Transgender	0	0	0
Genderqueer	0	0	0
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	0	0	0
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	unknown	1	1
Difficulty hearing or having speech understood	unknown	0	0
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	0	1
Physical/mobility	unknown	0	0
Chronic health condition/chronic pain	unknown	2	1
Other (specify)	unknown	0	0
Declined to state	unknown	0	0

Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Yes	unknown	0	0
No	unknown	29	6
Unknown or declined to state	unknown	0	1
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	3	7	1
Placerville Area	13	9	6
North County	4	5	0
Mid County	1	5	0
South County	1	1	0
Tahoe Basin	0	2	0
Unknown or declined to state	0	0	0
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	1	1
Very low income	unknown	3	1
Low income	unknown	9	3
Moderate income	unknown	16	2
High income	unknown	0	0
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	8	2
Medi-Cal	unknown	15	5
Medicare	unknown	0	0
Uninsured	unknown	3	0
	unknown	3	0

Annual Report FY 2019-20

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Parenting Skills project progressed (e.g., whether implementation activities proceeded on target as described in the County's MHSA Plan), and any major accomplishments and challenges.**

   NMYFS provided parenting classes to all areas of El Dorado County at various times of the day and evening to accommodate family schedules. Free child care was provided at each class as needed. The facilitators would be available for thirty minutes before and after class to assist parents or offer suggestions or referrals as needed.

A challenge, most notably, was the mandatory stay-in-place order due to COVID-19. We had to cancel three (3) parenting classes scheduled from March 19th to May 27th. Consequently, we only had three (3) classes available. Our class in South Lake Tahoe was not attended by any parents.

2) **Briefly report on how the Parenting Skills project has improved the overall mental health of the participants, their families, and their communities by addressing the primary negative outcomes that are the focus of parenting classes (school failure or by PEI activities: (1) suicide; (2) incarceration; (3) unemployment; (4) prolonged suffering; and (5) homelessness.**

   The parents are provided new positive parenting skills to address negative behaviors in the home or school. Equally, discussion touches upon life stressors and how it affects the children. Parents are given information about indicators or behaviors of depression/suicide in children.

3) **Provide a brief narrative description of progress in providing the Parenting Skills project services to unserved and underserved populations.**

   We provide Spanish interpretation to our Latino population who wish to attend the parenting classes. In addition, most of the participants fall into the low income levels. New Morning provides lunch or dinner to the families when they attend the classes.

   Our administrative assistants contact the parents numerous times before the classes to ascertain any accessibility issues, special child care needs, and referral source for class. The Parenting Skills classes have disability accessibility and assist parents with transportation needs.

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

   The class facilitators are licensed Marriage Family Therapists who take great care to provide culturally and linguistically competent information and examples to participants. Furthermore, many of the classes include our *Promotoras* for the Latino participants. We make every effort to notify community partners of our parent classes (Community Hubs, EDCOE, county departments, and non-profit organizations).

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.**

   NMYFS collaborates with county departments, non-profit organizations, and private businesses to increase: Mental health awareness, stigma reductions, and cultural competency. We promote and participate in most of the outreach events throughout the year. In turn, we give this information to the parents at our classes. At the first session, we make an effort to have a community representative make a 5-minute presentation on their services (Community Hubs, First 5, The Center for Violence Free Relationships, and Victim Witness).

6) **Identify whether the Parenting Skills project participants were provided with further referrals for services at the conclusion of classes, and if so, what type of referrals were made (e.g., mentoring programs, recreation programs, individual counseling, group counseling, other classes).**

Our facilitators referred some parents to domestic violence centers, individual and family counseling, adult AOD service providers, community Hubs, and El Dorado County Behavioral Health. In addition, they would provide parents with extra information about the issues they were dealing with. They would encourage parents to contact our counseling center, child's school or various youth programs.

7) **Provide the outcomes of the assessment and customer satisfaction surveys, including pre- and post-class surveys. Outcome measures for the Parenting Skills project are:**

- **Measurement 1: Customer satisfaction surveys**
  Parents/guardians were pleased with the classes and learned extensive information. Many parents expressed interest in a parenting class regarding pre-teen/teen years.
- **Measurement 2: Client outcome improvement measurements**
  Improvements are most noticeable in our longer 10 week courses, where the parents work with their children to practice the skills that they are learning. Parents noted noticeable improvements after implementing different communication strategies with their children. Some parents observed positive emotional responses from their children when they praised their child's positive actions.
- **Measurement 3: Increased engagement in traditional mental health services**
  Not able to measure.
- **Measurement 4: Number of clients referred to County Behavioral Health and the type of treatment to which clients were referred, if known.**
  None
- **Measurement 5: Client self-report on the duration of untreated mental illness**
  Not known.
- **Measurement 6: If known, average interval between referral and participation in treatment.**
  If facilitator referred client to NMYFS counseling center, then interval would be based upon level of care. An average would be 30 to 45 days before client intake.
- **Measurement 7: A description of the methods Contractor used to encourage client access to services and follow-through on referrals**
  The facilitator would spend 1-to-1 time with parents before and after class. If the facilitator (therapist) believed that a referral to services would be beneficial, they would encourage the parent/guardian to seek services and provide follow-up if possible.

8) **Provide total expenditures for the Parenting Skills project and the type and dollar amount of leveraged resources and/or in-kind contributions.**
NMYFS has volunteers that provide additional support: preparation, copying materials, and preparing that week's curriculum.

9) **Provide any additional relevant information.**
None provided.

MHSA Year-End Progress Report

Community Education and Parenting Classes Project

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

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$19,500	$19,500	$19,500
Total Expenditures	$17,302	$17,856	$15,725
Unduplicated Individuals Served	120	150	105
Cost per Participant	$144	$119	$149
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	unknown	0	6
16-25 (transitional age youth)	unknown	7	8
26-59 (adult)	unknown	98	66
Ages 60+ (older adults)	unknown	16	12
Unknown or declined to state	unknown	29	13
Race	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	6.5%	5	3
Asian	3.3%	1	3
Black or African American	1.6%	5	1
Native Hawaiian or Other Pacific Islander	3.3%	1	2
White	76%	102	79
Other	3.3%	0	0
Multiracial	0	3	4
Unknown or declined to state	0	33	13
Ethnicity by Category	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**

Hispanic or Latino	6.7%	0	3
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	0	10	1
Puerto Rican	0	0	1
South American	0	0	0
Other	0	0	0
Unknown or declined to state	0	0	0
Non-Hispanic or Non-Latino			
African	0	5	1
Asian Indian/South Asian	0	1	1
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	1	0
Filipino	0	1	1
Japanese	0	1	0
Korean	0	0	1
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	0	0	5
Multi-ethnic	0	0	4
Unknown or declined to state	0	131	87
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Arabic	unknown	0	0
Armenian	unknown	0	0
Cambodian	unknown	0	0
Cantonese	unknown	0	0
English	unknown	122	92
Farsi	unknown	0	0
Hmong	unknown	0	0
Korean	unknown	0	0
Mandarin	unknown	0	0
Other Chinese	unknown	0	0
Russian	unknown	0	0
Spanish	unknown	0	0
Tagalog	unknown	0	0
Vietnamese	unknown	0	0
Unknown or declined to state	unknown	28	13

Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	unknown	10	0
Heterosexual or Straight	unknown	120	86
Bisexual	unknown	0	3
Questioning or unsure of sexual orientation	unknown	0	0
Queer	unknown	0	2
Another sexual orientation	unknown	0	0
Declined to State	unknown	20	14
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	unknown	unknown	29
Female	unknown	unknown	61
Declined to answer	unknown	unknown	15
Current gender identity:			
Male	unknown	unknown	28
Female	unknown	unknown	61
Transgender	unknown	unknown	2
Genderqueer	unknown	unknown	0
Questioning / unsure of gender identity	unknown	unknown	1
Another gender identity	unknown	unknown	0
Declined to answer	unknown	unknown	13
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	unknown	unknown	0
Difficulty hearing or having speech understood	unknown	unknown	2
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	unknown	5
Physical/mobility	unknown	unknown	0
Chronic health condition/chronic pain	unknown	unknown	2
Other (specify)	unknown	unknown	1

Declined to state	unknown	unknown	95
Veteran Status ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Yes	unknown	5	11
No	unknown	unknown	unknown
Unknown or declined to state	unknown	145	94
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	unknown	35	28
Placerville Area	unknown	36	41
North County	unknown	6	3
Mid County	unknown	7	6
South County	unknown	0	0
Tahoe Basin	unknown	0	1
Unknown or declined to state	unknown	66	26
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	2	4
Very low income	unknown	4	4
Low income	unknown	25	11
Moderate income	unknown	73	61
High income	unknown	13	12
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	92	78
Medi-Cal	unknown	19	15
Medicare	unknown	11	5
Uninsured	unknown	3	1

Annual Report FY 2019/20

Please provide the following information for this reporting period:

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 other major accomplishments and challenges.**

   Nurtured Heart Approach (NHA) day-long trainings were provided in 2019 in September and in December and in 2020 in February. All trainings took place in Placerville. An additional training had been planned for early in May of 2020 but the COVID-19 pandemic and the public health ban on gatherings prevented that training from taking place.

There were 105 total attendees at the Nurtured Heart Approach (NHA) trainings.

All those who attend the one-day training are offered six (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 small percentage who follow through with the calls. Those who do respond to emails offering to set up phone coaching commonly participate in one (1) to two (2) coaching sessions while a small minority use four (4) to six (6) sessions.

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.**

The Nurtured Heart Approach is likely to impact school success significantly since it helps children and teens feel far less discouraged and fosters greater persistence in their endeavors. The approach helps them feel more competent and more interested in getting attention for positive choices and behaviors thus they are more likely to make an effort to succeed at school.

The Nurtured Heart Approach is promising also in terms of reducing the likelihood of a child or teen needing to be removed from their home. The approach gives parents and caregivers clear guidance regarding how to help children and adolescents become calmer and less destructive and oppositional. The approach is also helpful in reducing self-destructive behavior, depression, and anxiety as it helps young people see themselves more positively in addition to helping them learn to calm and reset themselves. The approach thus tends to reduce both internal suffering and violence toward others. These changes are likely to lead to more positive outcomes in terms of avoiding incarceration and succeeding in school and in the workplace.

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. Twenty 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 some people who are economically disadvantaged; 17% of respondents indicated that they have Medi-Cal or or no health insurance.

Of participants who provided demographic information, 11% reported disabilities. Seven percent (7%) reported identifying as being part of the LGBTQ+ community.

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 over 30 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 and 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 private practice therapists, mental health agencies, the head of Foster and Kinship Education, Community Hub leaders, and educators (teachers, counselors, and school administrators) who can share the information with students' parents.

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

The training is publicized to a variety of individuals and organizations that provide parent support and education including Choices for Children and First 5.

Flyers regarding upcoming trainings were posted at the Placerville post office, at cafes in the county, and at other locations which have bulletin boards for publicizing community events.

Data provided by participants in terms of how they heard about the Nurtured Heart Approach training during the 2019-20 Fiscal Year broke down as follows:

Therapist or mental health agency	33%
Agencies providing parent help or education	9%
School personnel or school district	7%
Flyer	9%
Juvenile judicial system and/or Child Protective Services	3%
Substance abuse treatment agency	2%
Email	4%
Friend or relative	20%
Work	9%
Other	4%

Linkage with other services

Parents and caregivers who attend trainings are provided with information about services available in the county which provide support and/or parent education and/or counseling. Those parents who participate in follow-up phone coaching receive additional personalized help identifying resources as needed.

Stigma Reduction

Regarding stigma reduction, the Nurtured Heart Approach effectively re-frames the qualities that often get children and teens diagnosed with mental illness as potentially effective, adaptive qualities when successfully channeled. For example, the stubbornness and resistance that gets diagnosed as Oppositional Defiant Disorder can be reframed and developed as determination and persistence. The Nurtured Heart Approach helps bring out the positive aspects of young people and helps their parents see them as less mentally ill. In turn, young people see themselves as less disordered and feel less stigmatized and their behavior improves.

6) **Provide outcome 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**

Parents and caregivers are given Conners Scales to fill out at the beginning of the Nurtured Heart Approach trainings. Their responses reveal that there are certain common characteristics demonstrated by their children that motivate parents to attend the training (even though they have often previously attended a variety of parent trainings and had their child in assorted therapies). These characteristics include high reactivity, impulsivity, stubbornness, opposition, and anxiety.

The Conners' Scales have proven useful in identifying the characteristics which tend to lead to children not responding as hoped to "parenting as usual" and to most therapeutic interventions. It was hoped that the scales would also be useful in measuring with numerical data the outcome of using the Nurtured Heart Approach. Unfortunately it has been difficult to motivate parents to complete the Conners Scales after a couple of months of using the approach to measure changes.

- **Measurement 2: Participant Surveys**

Participant Surveys:

- Participants rated the presentation materials on a scale of 1 to 10. The average score was 9.2.
- Participants rated the presenter's delivery on a scale of 1 to 10. The average score was 9.
- Participants were asked to circle "Yes" or "No" regarding whether the presentation met or exceeded their expectations and 99% 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 88% circled "Yes".

MHSA Year-End Progress Report

Peer Partner Project

Provider: Stanford Sierra Youth & Families

Project Goals

- Engage youth and parents more fully in the child welfare case planning and services process.
- Provide informal supports to families by providing linkage to community resources that will support the efficacy of the family system.
- Empower families to make changes to address trauma and hardship, to keep families healthy, safe, and together.

Numbers Served and Cost

**The contract was executed February 26, 2019, therefore, there are no outcomes to report for FY 18/19.*

Expenditures	FY 2018-19	FY 2019-20	FY 2020-21
MHSA Budget	$95,000	$95,000	
Total Expenditures	$	$88,708	
Unduplicated Individuals Served		34	
Cost per Participant	$	$2,609	
Age Group	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
0-15 (children/youth)	N/A	4	
16-25 (transitional age youth)	N/A	8	
26-59 (adult)	N/A	22	
Ages 60+ (older adults)	N/A	0	
Unknown or declined to state	N/A	0	
Race	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
American Indian or Alaska Native	N/A	1	
Asian	N/A	0	
Black or African American	N/A	0	
Native Hawaiian or Other Pacific Islander	N/A	0	
White	N/A	30	
Other	N/A	2	
Multiracial	N/A	1	
Unknown or declined to state	N/A	0	
Ethnicity by Category	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**

Hispanic or Latino	N/A	0	
Caribbean	N/A	0	
Central American	N/A	0	
Mexican/Mexican-American/Chicano	N/A	2	
Puerto Rican	N/A	0	
South American	N/A	0	
Other	N/A	3	
Unknown or declined to state	N/A	0	
Non-Hispanic or Non-Latino			
African	N/A	0	
Asian Indian/South Asian	N/A	0	
Cambodian	N/A	0	
Chinese	N/A	0	
European	N/A	3	
Filipino	N/A	0	
Japanese	N/A	0	
Korean	N/A	0	
Middle Eastern	N/A	0	
Vietnamese	N/A	0	
Other	N/A	26	
Multi-ethnic	N/A	0	
Unknown or declined to state	N/A	0	
Primary Language	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Arabic	N/A	0	
Armenian	N/A	0	
Cambodian	N/A	0	
Cantonese	N/A	0	
English	N/A	34	
Farsi	N/A	0	
Hmong	N/A	0	
Korean	N/A	0	
Mandarin	N/A	0	
Other Chinese	N/A	0	
Russian	N/A	0	
Spanish	N/A	0	
Tagalog	N/A	0	
Vietnamese	N/A	0	
Unknown or declined to state	N/A	0	

Sexual Orientation ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Gay or Lesbian	N/A	0	
Heterosexual or Straight	N/A	30	
Bisexual	N/A	3	
Questioning or unsure of sexual orientation	N/A	0	
Queer	N/A	0	
Another sexual orientation	N/A	0	
Unknown or declined to state	N/A	1	
Gender ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Assigned sex at birth:			
Male	N/A	5	
Female	N/A	29	
Unknown or declined to answer	N/A	0	
Current gender identity:			
Male	N/A	5	
Female	N/A	28	
Transgender	N/A	0	
Genderqueer	N/A	1	
Questioning / unsure of gender identity	N/A	0	
Another gender identity	N/A	0	
Unknown or declined to answer	N/A	0	
Disability	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Difficulty seeing	N/A	7	
Difficulty hearing or having speech understood	N/A	0	
Mental disability including but not limited to learning disability, developmental disability, dementia	N/A	5	
Physical/mobility	N/A	1	
Chronic health condition/chronic pain	N/A	6	
Other (specify)	N/A	0	
Declined to state	N/A	0	
Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**

Yes	N/A	1	
No	N/A	33	
Unknown or declined to state	N/A	0	
Region of Residence	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
West County	N/A	5	
Placerville Area	N/A	12	
North County	N/A	2	
Mid County	N/A	3	
South County	N/A	0	
Tahoe Basin	N/A	2	
Unknown or declined to state	N/A	8	
Economic Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Extremely low income	N/A	12	
Very low income	N/A	12	
Low income	N/A	3	
Moderate income	N/A	7	
High income	N/A	0	
Health Insurance Status	**FY 2018-19**	**FY 2019-20**	**FY 2020-21**
Private	N/A	1	
Medi-Cal	N/A	31	
Medicare	N/A	0	
Uninsured	N/A	2	

Annual Report FY 2019-20

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Peer Partner 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.**

   Stanford Sierra Youth and Families team consists of two (2) Parent Partners and one Youth Advocate. Services implemented by the Parent Partners and Youth Advocate focus on support to clients to achieve wellness, recovery and resilience by building protective factors and networks of natural supports. This is being achieved through a number of approaches and modalities such as Seeking Safety (evidenced-based practice) being utilized through the Youth Advocate. The CANS is the tool being utilized to identify and reduce negative outcomes that result from untreated mental illness as well as identify areas of need to build protective factors for the parent whose child(ren) have been removed. The Transitional Readiness Scales helps the

youth and parent identify the seven (7) key factors necessary for resilience and efficacy and supports the family in building a plan to address low scoring areas.

The Parent Partners and Youth advocate attended (CMHACY) California Mental Health Advocates for Children and Youth conference virtually. Due to COVID-19 pandemic and the State's mandated shelter in place order. Engagement with youth and families has shifted to virtual platforms due to COVID-19 pandemic, except in extreme cases or crisis where in-person has been deemed more effective or necessary. Team members follow and utilize State and local recommended social distancing and wear recommended personal protective equipment (PPE). With COVID-19 and State and County's shelter-in-place, Parent Partners and the Youth Advocate have continued to hold weekly support groups via TeleHealth method to support the youth and families of the community. Topics such as, the power of human connection, effects of childhood trauma, overcoming addiction, building healthy lifestyles and reaching set goals, were covered. In order to continue to support our Youth and Families through these challenging times, the warm-line has remained available for parents/caregivers that would like to check in with someone to receive additional support. We received our first referral from the Tahoe office and our Parent Partner was extremely successful with engaging with father and was recognized by the worker. The worker explained how father's attitude has greatly improved and father is appreciative of the support and is no longer resistant to agency's assistance.

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

The Peer Partner project was able to support a youth that was on the verge of failing school, to graduate from high school! The project then supported youth with applying to college. Multiple parents were supported with finding and maintaining housing. Additionally, a youth who was in out-of-state placement was returned to her mom.

3) **Provide a brief narrative description of progress in providing services through the Peer Partner project to unserved and underserved populations. Underserved is defined in California Code of Regulations 3200.300 as "clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided with the necessary opportunities to support their recovery, wellness, and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement, or other serious consequences."**

The Peer Partner program is progressing in services to underserved and unserved populations by bridging communication with social workers, treatment staff and other community supports that can offer more resources and services. The Peer Partner program has also offered support groups, facilitated meetings with community partners and engaged with clients in treatment facilities and out of home placements.

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

   Peer Partners receive training in cultural responsiveness and address individual cultural needs with each youth and family. Peer Partners are also trained in recognizing implicit bias, community trauma, and encourage families to openly communicate their needs with other community providers and workers. Peer Partners have access to interpreter services as needed.

5) **Provide the number of potential responders engaged. "Potential responders" include, but are not limited to, families, employers, primary health care providers, visiting nurses, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel, community service providers, people wo provide services to individuals who are homeless, family law practitioners such as mediators, child protective services, and disabling mental illness, provide support, and /or refer individuals who need treatment or other mental health services.**

   The Peer Partner program engaged a diverse range of over 200 potential responders.

6) **The setting(s) in which the potential responders were engaged. Setting providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.**

   We engaged with potential responders in community settings, treatment facilities, child welfare office, Child and family team meetings, support groups, doctors' offices, Veterans Administration, telehealth, and in family homes.

7) **The types of responders engaged in each setting (e.g., nurses, principles, parents).**

   The types of responders are listed, but not limited to, youth and families, natural supports, treatment staff, community service providers, social workers.

8) **If known, provide the number of Clients referred to County Behavioral Health and the type of treatment to which Clients were referred.**

   Unknown

9) **If known and if applicable, provide information on Client self-report on the duration of untreated mental illness.**

   Unknown

10) **If known, provide the average interval between mental health referral and participation in treatment.**

Unknown

11) If known, the number of individuals who followed through on the referral and engaged in treatment.

Unknown

12) Provide the outcome measures of the services provided and of customer satisfaction surveys.

Parent Partner Outcomes: There were 11 clients who discharged from the Parent Partner program in 19-20 FY. Of those 11 discharges, 4 of those clients never engaged, and thus their outcomes will not be reported below in the measurements. Of the 7 parents who discharged and completed the program:

Measurement 1 **Report on the family reunification rates:** 3 clients were on the family reunification track, and 3/3 (100%) reunified with their youth.

Measurement 2 **Report on the family maintenance and stability rates:** 4 clients were on the family maintenance track, and 4/4 (100%) maintained their family unit.

Measurement 3 **Report on child safety as it relates to addressing child abuse and maltreatment risk factors:** 7/7 clients reduced child abuse and maltreatment risk factors.

Youth Advocate Outcomes:

N/A: There were 0 youth who discharged from Youth Advocacy in 19-20 FY and thus, no data is available to report.

Measurement 1 **Report on the reduction in seven-day notices:** N/A

Measurement 2 **Report on the improvement in foster care placement stability:** N/A

Measurement 3 **Report on behavior as it relates to a decrease in maladaptive behavior:** N/A

Measurement 4 **Report on behavior as it relates to an increase in strengths:** N/A

Measurement 5 **Report on the number of discharges to permanency:** N/A

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

No additional information was provided.

14) Provide any additional relevant information.

No additional information was provided.

Mentoring for Youth Project

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.

Numbers Served and Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$75,000	$75,000	$75,000
Total Expenditures	$75,000	$75,000	$75,000
Unduplicated Individuals Served	18	42	52
Cost per Participant	$4,167	$1,786	$1,442
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	17	42	52
16-25 (transitional age youth)	1	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 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	0	0	3
Asian	0	0	0
Black or African American	1	3	5
Native Hawaiian or Other Pacific Islander	0	0	0
White	10	30	37
Other	0	0	0
Multiracial	1	0	0
Unknown or declined to state	0	0	0

Ethnicity by Category	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	unknown	9	7
Caribbean	unknown	0	0
Central American	unknown	0	0
Mexican/Mexican-American/Chicano	unknown	0	0
Puerto Rican	unknown	0	0
South American	unknown	0	0
Other	unknown	0	0
Unknown or declined to state	6	0	0
Non-Hispanic or Non-Latino			
African	unknown	0	0
Asian Indian/South Asian	unknown	0	0
Cambodian	unknown	0	0
Chinese	unknown	0	0
Eastern European	unknown	0	0
Filipino	unknown	0	0
Japanese	unknown	0	0
Korean	unknown	0	0
Middle Eastern	unknown	0	0
Vietnamese	unknown	0	0
Other	unknown	0	0
Multi-ethnic	unknown	0	0
Unknown or declined to state	unknown	0	0
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	17	42	52
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	1	0	0
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	0	0	0

Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	NA	NA	NA
Heterosexual or Straight	NA	NA	NA
Bisexual	NA	NA	NA
Questioning or unsure of sexual orientation	NA	NA	NA
Queer	NA	NA	NA
Another sexual orientation	NA	NA	NA
Declined to State	NA	NA	NA
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	4	22	25
Female	14	20	27
Declined to answer	0	0	0
Current gender identity:			
Male	unknown	22	25
Female	unknown	20	27
Transgender	unknown	0	0
Genderqueer	unknown	0	0
Questioning / unsure of gender identity	unknown	0	0
Another gender identity	unknown	0	0
Declined to answer	unknown	0	0
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	unknown	0	0
Difficulty hearing or having speech understood	unknown	0	0
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	0	0
Physical/mobility	unknown	0	0
Chronic health condition/chronic pain	unknown	0	0
Other (specify)	unknown	0	0
Unknown or declined to state	18	42	52

Veteran Status *Collection of this information from a minor younger than 12 years of age is not required.*	FY 2017-18	FY 2018-19	FY 2019-20
Yes	0	0	0
No	18	42	52
Unknown or declined to state	0	0	0
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	13	24	28
Placerville Area	1	13	20
North County	0	1	0
Mid County	1	2	2
South County	0	0	0
Tahoe Basin	2	2	2
Unknown or declined to state	0	0	0
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	unknown	13
Very low income	unknown	unknown	20
Low income	unknown	unknown	10
Moderate income	unknown	unknown	7
High income	unknown	unknown	2
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	unknown	15
Medi-Cal	unknown	unknown	37
Medicare	unknown	unknown	0
Uninsured	unknown	unknown	0

Annual Report FY 2019/2020

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Mentoring for Youth 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 Mentoring for Youth fiscal year 2019/2020 concluded June 30, 2020. The numbers of children BBBS has served in this fiscal year continues to rise from 2018/2019 - now serving a total of 52 children, which was an increase of 10 youth. Of those 52 being served, 25 were new matches. The other 27 are matches that were made in other funding cycles, but continue to remain matched with the same adult mentor. When new matches are made, the goal is for the match length to reach at least one (1) year, as the positive outcomes for the child increase significantly the longer the match is together. Of the matches Big Brothers Big Sisters (BBBS) has made in the 2019/2020 only one (1) has closed premature to 1-year because the child moved out of state. BBBS's longest running

Big/Little match, funded by PEI funding, has been together for four and a half (4 ½) years. The most recent Big/Little match funded by PEI funding has been together for seven (7) months. During this unprecedented time of COVID-19, BBBS matches were unable to meet like they once regularly did. BBBS Program Mangers worked directly with parent/guardians and Bigs to meet "untraditionally". Many matches began Zoom meetings, or drive-by visits, spoke on the phone or reintroduced the pen pal.

2) **Briefly report on how the Mentoring for Youth 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 Youth project (suicide, prolonged suffering, school failure or dropout, and removal of children from their homes). Please include other impacts, if any, resulting from the Mentoring for Youth project on the other four negative outcomes addressed by PEI activities: (1) incarceration; (2) unemployment; and (3) homelessness.**

Every child benefits tremendously from at least one caring adult in their life, this can affect mental health, educational outcomes and parental support. All children, regardless of their family history face adversity and could benefit from a caring adult. Children being served by the BBBS program experience single parent homes, parental or childhood mental health issues, physical issues, low economic status, homelessness, unemployment, parental/caregiver incarceration and sometimes children experience multiple risk factors. All of the children served by BBBS gain consistency and stability from their Big. They know they can rely on them for their regular visits and can be a normal kid while they are with them. Overall, the mental health has improved with improved educational outcomes, peer relationships and adult relationships stronger. Bigs become partners for the parents and assist in helping the child thrive and the parent be successful.

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

BBBS predominately serves children and families that are either underserved or unserved. BBBS is able to serve these families and their children by being the "middle man", our volunteers [mentors] can see the needs not being met adequately and the agency can get the families connected with the service providers they need. Our mentors and the BBBS agency helps close the gap of lack of services for our families by providing stable, positive role models and creates partners between the parent/ guardians and the volunteer mentors.

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

The goal in every match is to make meaningful long-term matches for the children to receive the best positive impact. Ideally children would be matched with volunteers of the same racial/ethnic background. However, this is not always available. All of the volunteers are trained prior to their match with a cultural competency component. Throughout the match length, all BBBS volunteers are offered trainings to support their relationship. These trainings vary from ACE's, drug and alcohol and more. Additionally, each match is individually case managed so the specific needs of the child and volunteer are being met, referrals are made and coaching and support are given to assure volunteers are culturally and linguistically competent.

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 collaborates with several community and government agencies to adequately serve the children enrolled in programing. We continue to outreach and collaborate as much as we can. For the majority of BBBS referrals, BBBS is connected with the El Dorado County Office of Education and the local school districts. Our close relationship with local school districts allows BBBS to have ongoing access to the children in our program while they are at school, to monitor outcomes, match relationship building, collaboration for additional referrals and child safety. BBBS is involved in countywide resource meetings and collaboratives; Georgetown Ready by 5, Western Slope Community Strengthening Coalition funded by Ready by 5, DA Systems for Change, ACE's collaborative, SARB, and the Early Education Planning Council. Additionally, BBBS is involved in: Kiwanis, Rotary, Tahoe Young Professionals and all local chambers

6) **Provide the outcomes measures of the services provided and of customer satisfaction surveys. Outcome measures for the Mentoring for Youth project are:**

   - **Child Intake: Contractor will assess child and family whenever possible, for program effectiveness.**

     Every child referral for BBBS services is assessed and placed in a program if the needs are adequate with BBBS services. Rarely, are children turned away, but at times given the circumstances, they are unable to be served by BBBS. In these instances the BBBS Enrollment Manager and/or Associate Director work at proving referrals for other services in county.

   - **Volunteer Enrollment: Contractor will assess potential volunteers for acceptance into program.**

     Every volunteer is screened and trained prior to any involvement with a child. Child safety is our number one concern and the volunteer in-person interview asks several questions to gauge child safety.

   - **Child Assessment: Contractor will use completed pre-match and annual behavior evaluations and monthly volunteer match support of all enrolled children.**

     100 % of children matched with PEI funding have a pre-match and annual behavior evaluations completed. The initial evaluation is done during intake and written into the child's assessment. Annually, at the anniversary of the match, new behavior evaluations are completed. After the annual evaluations are done the child's case plan is updated with new goals individual for each child matched. Match support is done monthly for the first year of the match. This is done to make sure the match relationship is developing successfully, there are no child safety concerns and the child is progressing well towards their goals.

   - **Contractor will administer Big Brothers Big Sisters pre-match and end-of-school-year surveys, such as the "Start Early" interactive survey to enrolled children.**

The Youth Outcome Survey is given to children pre-match and annually. This survey measures outcomes from seven (7) categories [social acceptance, scholastic competency, educational expectations, grades, risky behavior attitudes, parental trust and truancy]. 100% of youth completed a baseline Youth Outcome Survey pre-match.

Highlights from this funding period: a significant number of youth increased their educational expectations - 100%, grades- 86% and social acceptance - 91%.

- **Contractor will administer Big Brothers Big Sisters "Strength of Relationship" survey to volunteer mentors.**

  Strength of Relationship Survey monitors the relationship between the Big and the Little. The highest score for a match relationship is five (5) - this meaning the relationship is strong, positive and worth while. Of the three-month post match surveys, the average score was four (4), of the annual surveys the average score was 4.4. This shows that, in the Big's perspective, the relationship between the Big and the Little grows stronger and they feel more connected. The higher the score, the stronger the relationship is and lasts longer.

- **Contractor shall provide testimonials, as appropriate, from parents, mentors and children.**

  "I do so much with my Big Brother. I go over to his house to swim, walk the dog, or just hang out and play catch or watch movies. I feel like I am part of his family."
  -Little Brother

  "We have a very special bond, she is such a happy and curious, intelligent child. There seems to be nothing she won't try. I love teaching her and helping her explore her talents & interests. In our time together, we've gardened, made greeting cards with pressed flowers, write poetry, sing and play on the piano, hike, picnic, visit museums & plays, baked, just to name a few. [redacted] asked me several times "How old must I be to be a Big Sister? When I grow up I'm going to be a Big Sister".
  -Big Sister

  "According to my Little's mother and principal, the highlight of the boy's week is having lunch with his "Big". We have made a game of reviewing his schoolwork and test grades and I have seen increased growth in him academically. My "Little" has showed an increased level of self confidence, maturity, better decision making and communication skills."
  -Big Brother

  "My little brother has provided me with greater perspective regarding my life. I am blessed by the program and my Little because it increases my drive to do more for (and with) my family, my community, and strengthens my commitment to the program."
  -Big Brother

  "I love my time with my Big Sister. She picks me up and we do things together. I look forward to seeing her every week."
  -Little Sister

7) Unduplicated numbers of individuals served, including demographic data.

25 new matches were made - which equates to 25 youth and 25 volunteers, total people: 50

8) **The number of potential responders reached by this program.**

There are a total of 52 total matches supported though PEI, which equates to 52 youth and 52 volunteers, total people: 104

9) **The setting(s) in which the potential responders were engaged. (Settings providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.)**

The large majority of the youth funded by PEI were engaged through school partnerships, however some were engaged through Child Protective Services, other youth agencies in county and families. Each individual match meeting places are different; throughout the length of the match these locations can change. Some matches meet at the child's school, out in the community, at libraries, public parks, restaurants, etc. To conduct case management, BBBS staff meets the child at their school, meets in the community with the volunteer, conducts phone calls, or at agency events. The majority of the case management is done either on the phone or in person.

10) **The types of potential responders engaged in each setting (e.g., nurses, principles, parents).**

The types of responders vary widely as we engage mentors across a very diverse platform. We serve the children of BBBS with volunteers in the medical field, first responders, law enforcement, business, school personnel and more.

11) **If known, the number of individuals with serious mental illness referred to treatment and the kind of treatment the individual was referred to.**

It is not always known what parents or guardians suffer from prior to a match taking place or even after, as the relationship is between the child and the volunteer. Of the children served with PEI, there have been no known serious mental illnesses.

12) **If known, the number of individuals who followed through on a referral and engaged in treatment.**

N/A

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

The total project expense of 2019/2020 was $102,800 which exceed the $75,000 funding provided by PEI by $27,800. The additional expenses were covered by BBBS agency fundraising events. The total expenses include staff salaries, mileage, and advertising for volunteer recruitment.

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

No additional information was provided.

MHSA Year-End Progress Report

Psychiatric Emergency Response Team (PERT) Project

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.
- Improved community health and wellness through local services.
- Improve access to medically necessary care and treatment.

Numbers Served and Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$300,000	$300,000	$375,000
Total Expenditures	$323,416	$379,135	
Unduplicated Individuals Served (may be duplicated)	161	677	
Cost per Participant	$2,009	$560	
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	18	54	36
16-25 (transitional age youth)	20	89	53
26-59 (adult)	73	394	169
Ages 60+ (older adults)	36	110	58
Unknown or declined to state	14	30	5
Race	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	5	18	2
Asian	1	5	11
Black or African American	0	19	27
Native Hawaiian or Other Pacific Islander	0	1	2
White	130	530	697
Other	12	0	15
Multiracial	5	12	0
Unknown or declined to state	8	37	29

Ethnicity by Category	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	0	0	50
Caribbean	unknown	0	0
Central American	unknown	0	2
Mexican/Mexican-American/Chicano	unknown	6	7
Puerto Rican	unknown	0	0
South American	unknown	0	0
Other	unknown	15	44
Unknown or declined to state	unknown	0	6
Non-Hispanic or Non-Latino			
African	unknown	unknown	4
Asian Indian/South Asian	unknown	unknown	1
Cambodian	unknown	unknown	0
Chinese	unknown	unknown	1
Eastern European	unknown	unknown	0
Filipino	unknown	unknown	1
Japanese	unknown	unknown	0
Korean	unknown	unknown	0
Middle Eastern	unknown	unknown	4
Vietnamese	unknown	unknown	3
Other	unknown	unknown	8
Multi-ethnic	5	8	1
Unknown or declined to state	156	31	72
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Arabic	0	0	0
Armenian	0	0	1
Cambodian	0	0	0
Cantonese	0	0	0
English	unknown	647	313
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	unknown	3	1
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	unknown	0	10

Sexual Orientation ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	unknown	2	2
Heterosexual or Straight	unknown	580	234
Bisexual	unknown	6	2
Questioning or unsure of sexual orientation	unknown	0	0
Queer	unknown	0	1
Another sexual orientation	unknown	0	0
Declined to State	unknown	89	83
Gender ***Collection of this information from a minor younger than 12 years of age is not required.**	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	unknown	369	177
Female	unknown	316	148
Declined to answer	unknown	7	1
Current gender identity:			
Male	unknown	369	480
Female	unknown	318	457
Transgender	unknown	3	3
Genderqueer	unknown	6	0
Questioning / unsure of gender identity	unknown	0	0
Another gender identity	unknown	0	0
Declined to answer	unknown	96	3
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	unknown	1	1
Difficulty hearing or having speech understood	unknown	4	2
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	27	24
Physical/mobility	unknown	16	8
Chronic health condition/chronic pain	unknown	38	7
Other (specify)	unknown	0	1
Unknown or declined to state	unknown	0	216

Veteran Status **Collection of this information from a minor younger than 12 years of age is not required.*	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Yes	unknown	28	25
No	unknown	649	764
Unknown or declined to state	unknown	0	62
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	48	202	See question #6 below
Placerville Area	50	237	See question #6 below
North County	11	79	See question #6 below
Mid County	14	67	See question #6 below
South County	8	32	See question #6 below
Tahoe Basin	0	0	See question #6 below
Unknown or declined to state	30	0	30
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	61	12
Very low income	unknown	73	17
Low income	unknown	118	92
Moderate income	unknown	357	68
High income	unknown	68	16
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	215	64
Medi-Cal	unknown	201	60
Medicare	unknown	149	3
Uninsured	unknown	112	3

Note: For individuals in crisis, it may not be feasible to collect all data.

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Please provide the following information for this reporting period:

1) **If known, the number of referrals to treatment, including the kind of treatment to which the person was referred.**

Referral	Number
Adult Protective Services	31
National Alliance on Mental Illness (NAMI)	3

Veterans Administration Services	17
Emergency Crisis Resources	511
Behavioral Health (Tracked July 1 – Dec. 31, 2019)	320
Child Protective Services	11
Advocacy	9
Medical	93
Food/Clothing/Shelter	11
Family and Natural Supports	46
Public Guardian	4
Transportation	3
Financial Aid	7
Substance Use Disorder Services	62
Other	15

2) If known, the number of persons who followed through on the referral and engagement in treatment, defined as the number of individuals who participated at least once in the program to which the person was referred.

61

3) **The number of Welfare and Institutions Code 5150 holds written at the time of contact by PERT members.**

27

4) If known, the average duration of untreated mental illness for individuals who have not previously received treatment.

Unknown.

5) If known, the average interval between the referral and engagement in treatment, as defined as participating in at least once in treatment to which referred.

Immediately – 35
On-going – 5
1 Day – 2
1 week – 1
Varies – 1
3 days – 1

6) Report on implementation challenges, successes, lessons learned, and relevant examples.

PERT went to on-call from working all day, due to the decreased amount of calls.

We are currently looking at changing the way we collect data to increase the ease of interpreting and having the data easily accessible.

PERT has partnered with the Placerville Police Department is in the city of Placerville to respond to the calls within their jurisdiction.

Follow-up calls are not always completed due to the difficulty in reaching the clients.

<u>For Region of Residence we have a total of various cities and towns around El Dorado County:</u>

Cameron Park – 56
Placerville – 55
El Dorado Hills – 36
Pollock Pines – 23
Somerset – 6
Georgetown – 8
Mt. Aukum – 5
Rescue – 9
El Dorado – 15
Diamond Springs – 18
Cool – 7
Shingle Springs – 17
Garden Valley – 4
Grizzly Flats – 5
Camino – 5
SLT – 1
Kelsey – 5
Lotus – 1
Greenwood – 1
Pleasant Valley - 1
Other – 16
Unknown - 30

Veterans Outreach Project

Provider: Only Kindness

Project Goals

- Provide outreach and linkage to services for approximately 100 Veterans and their immediate family members annually.
- Provide a single point of entry for homeless Veterans to connect to and receive services.
- Assist Veterans with housing and reduce the number of homeless Veterans in El Dorado County.

Numbers Served and Cost

Expenditures	FY 2017-18*	FY 2018-19	FY 2019-20
MHSA Budget	$150,000	$261,601	$150,000
Total Expenditures	$51,839	$261,601	$150,000
Unduplicated Individuals Served	38	126	157
Cost per Participant	$1,364	$2,076	$955

*FY 2017-18 Expenditures and data are only reflective of the period March 2018 - June 2018 due to the fact that the contract was executed in March 2018. Unused funding from FY 2017-18 was rolled forward to FY 2018-19.

Age Group	FY 2017-18	FY 2018-19	FY 2019-20
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	3	2	2
26-59 (adult)	23	80	95
Ages 60+ (older adults)	12	44	60
Unknown or declined to state	0	0	0
Race	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	1	6	5
Asian	0	0	0
Black or African American	0	2	5
Native Hawaiian or Other Pacific Islander	0	0	0
White	35	107	137
Other	0	7	5
Multiracial	2	3	4
Unknown or declined to state	0	1	1
Ethnicity by Category	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**

Hispanic or Latino	2	17	18
Caribbean	0	0	0
Central American	0	0	0
Mexican/Mexican-American/Chicano	0	9	9
Puerto Rican	0	0	1
South American	0	0	0
Other	3	8	1
Unknown or declined to state	0	0	7
Non-Hispanic or Non-Latino			
African	0	1	2
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other (Caucasian)	36	108	137
Multi-ethnic	0	0	0
Unknown or declined to state	0	0	0
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2018-19**
Arabic	0	0	0
Armenian	0	0	0
Cambodian	0	0	0
Cantonese	0	0	0
English	39	117	154
Farsi	0	0	0
Hmong	0	0	0
Korean	0	0	0
Mandarin	0	0	0
Other Chinese	0	0	0
Russian	0	0	0
Spanish	0	0	0
Tagalog	0	0	0
Vietnamese	0	0	0
Unknown or declined to state	1	9	3

Sexual Orientation ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Gay or Lesbian	0	3	4
Heterosexual or Straight	37	110	137
Bisexual	0	0	0
Questioning or unsure of sexual orientation	0	1	1
Queer	0	0	0
Another sexual orientation	0	0	1
Declined to State	3	12	14
Gender ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	36	113	131
Female	4	13	26
Declined to answer	0	0	0
Current gender identity:			
Male	36	111	126
Female	4	13	23
Transgender	0	1	2
Genderqueer	0	0	1
Questioning / unsure of gender identity	0	0	0
Another gender identity	0	0	0
Declined to answer	0	1	0
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	6	12	26
Difficulty hearing or having speech understood	33	127	73
Mental disability including but not limited to learning disability, developmental disability, dementia	6	41	48
Physical/mobility	18	66	73
Chronic health condition/chronic pain	14	54	76
Other (specify)	3	5	13
Declined to state	0	0	0
Veteran Status ***Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**

Yes	39	124	155
No (Family Member)	1	2	2
Unknown or declined to state	0	0	0
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	4	12	13
Placerville Area	13	66	79
North County	0	3	16
Mid County	3	15	14
South County	0	2	5
Tahoe Basin	5	2	10
Unknown or declined to state	15	26	20
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	26	78	104
Very low income	12	33	33
Low income	1	9	13
Moderate income	1	5	5
High income	0	2	2
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private / Other	9	13	22
Medi-Cal	11	39	52
Medicare	4	14	18
Uninsured	6	16	19
VA	13	62	87

Annual Report FY 2019-20

Please provide the following information for this reporting period:

1) **Briefly report on how implementation of the Veterans 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.**

   Implementation activities as described in El Dorado County's MHSA 3-year plan are proceeding on target: Reducing the negative consequences of untreated mental illness is addressed not only through connection to mental health supports or verification of such connection but also providing supportive services through times of crisis so that a Veteran's mental health remains stable. Our major accomplishments are: 1) the number of homeless Veterans who have been housed through this project and other leveraged funding, 2) the number of Veterans in the Criminal Justice system who have received needed ancillary support and 3) the collaborative success of the El Dorado County Coordinated Entry System in engaging and including homeless Veterans and connecting all Veteran service providers through a bi-weekly case management and triage work group so that we are all better able to provide services.

The overwhelming challenge of 2020 has been the COVID-19 crisis and how it is affecting our ability to do outreach. We also continue to experience the challenge of engaging with Veterans whose mental health issues themselves inhibit the Veteran from linking to needed services, Veterans with discharges typically not supported by mainstream Veteran services, and Veterans whose circumstances are barriers to housing and/or support.

2) **Briefly report on how the Veteran Outreach project has improved the overall mental health of veterans and their families, and how the Veteran Outreach project has addressed the negative outcomes that result from untreated mental illness (suicide, incarceration, unemployment, homelessness, prolonged suffering, school failure or dropout, and removal of children from home).**

By working with the Veterans Treatment Court Team, we help ensure the success of Veterans in the Criminal Justice System. Successful completion of Veterans Treatment Court can reduce felonies to misdemeanors and minimize restitution requirements. This reduces the likelihood of further incarceration and positively influences a Veterans ability to acquire and sustain housing and employment. Supporting a Veteran in other legal struggles allows a Veteran to keep their children at home. By connecting a Veteran and/or their family member to needed mental health support, we minimize prolonged suffering and suicidal ideation. Through outreach, we can be the trained-layman who recognizes suicidal language, defies stigma and discrimination and connects with a hurting Veteran, maybe making a difference between life and death. By providing supportive services and assistance through a crisis, we can stabilize a Veteran with a mental health issue so that it is not exacerbated and we can prevent another Veteran from developing mental health issues.

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

Veterans were identified in the El Dorado County MHSA 3-Year Plan as an underserved group. The Veteran Outreach Project serves only Veterans and their family members with a focus on those who are homeless and/or in the criminal justice system.

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

Intake for homeless Veterans is two-pronged as data must be included in the El Dorado County Coordinated Entry System in order for the Veteran to be placed on the County "By Name List" and be eligible to receive support from other service providers including VASH. Another set of data must also be collected for the Veteran Outreach Project. Intake for non-homeless Veterans involves only the data collection for the Veteran Outreach Project. Both intake processes identify any language and/or cultural barriers and ensures removal of the barrier by providing interpreters or culturally competent assistance.

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 COVID-19 crisis has negatively impacted the "walk-in" options of several Veteran service providers. El Dorado Veteran Resource (EDVR) office has been closed for several months, and while they were beginning to reopen early July with Volunteer support, the surge in COVID-19 cases is delaying that opening. Inquires at the County VA office about their operations have been unanswered. Volunteers of American (VoA) opened briefly but had to shut its office doors again and is trying to do most of their work by internet or phone. Intake and assessment are ongoing through Only Kindness and can be accessed through our outreach phone line 530 344-1864 and/or via email at vets@onlykindness.net. A flyer with "Available Mental Health Resources" is provided to all Veterans encountered through outreach efforts and/or at intake. Other mental health information from resources such as Each Mind Matters and the Suicide Prevention Network (SPN) are handed out and made available. Through Veterans Treatment Court, Veteran participants are linked to all forms of physical and mental health as part of a mandated treatment program. We hold SPN trainings for our staff and volunteers when it is available to help reduce any stigma and discrimination that we may be unconsciously holding. As an active member of the El Dorado County Continuum of Care (EDOK), we remain informed and connected to all local homeless service providers and through the COVID-19 crisis, the EDOK has been very busy, holding many web-based meetings to keep members informed about COVID-19 funding, Project Room Key and other unique assistance opportunities and services.

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

- **Measurement 1: Unduplicated numbers of individuals served, including demographic data.**
  Please see pages 1 – 4 of this report for unduplicated numbers served and demographics. Note: the number served represents Veterans for whom we were able to complete full intakes and provide direct services to. Outreach is more difficult to quantify as it involves sometimes brief connection and relationship building. We have handed out 300 outreach cards and had 123 Veterans sign in at the 2018 County Fair and 120 Veterans sign in at the 2019 County Fair. This totals 543 Veterans connected with by outreach efforts and does not represent the full number which also would include Veterans at the "Stand Down" and on the streets to whom we might provide homeless supply bags and other resource information.

- **Measurement 2: If known, the number of referrals to County Behavioral Health and the type treatment of treatment to which person was referred**
  Please note our contract specifies that Measurement 2 is: the number of referrals to treatment and the kind of treatment (not limited to County Behavioral Health Referrals only)

Referral Type (Kind of Treatment)	Number Referrals Made to Treatment
4 Paws 2 Freedom	0
Behavior Modification Classes (i.e.: DUI Wet and Reckless)	1
Community Based Substance Use Disorder Services (Tahoe Turning Point, Progress House, New Beginnings, Treehouse)	2
Community Based Support Groups	4
Domestic Violence Services (The Center, LVF, Batterers programs, etc.)	1

EDC Mental Health	6
Hospital or Private Healthcare Providers	11
Mather Behavior Health/Mental Health/Alcohol Recovery	16
NAMI	0
Other	4
Private Counselor working with Veterans	19
Skilled Nursing Facilities	0
Soldiers Project	0
VA Based Residential Recovery Programs (Walters House, Martinez)	0
VA Medical Center	3
Veteran Centers (Citrus Heights, Reno, etc.)	0
Veteran Resource Centers (SVRC, etc.)	1
Windows to My Soul, Equine Therapy	1
Total	**69**

- **Measurement 3: If known, the number of persons who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which the person was referred.**

Referral Type (Kind of Treatment)	Number of Referrals that Clients Followed Through With
4 Paws 2 Freedom	0
Behavior Modification Classes (i.e.: DUI Wet and Reckless)	1
Community Based Substance Use Disorder Services (Tahoe Turning Point, Progress House, New Beginnings, Treehouse)	1
Community Based Support Groups	1
Domestic Violence Services (The Center, LVF, Batterers programs, etc.)	1
EDC Mental Health	0
Hospital or Private Healthcare Providers	6
Mather Behavior Health/Mental Health/Alcohol Recovery	2
NAMI	0
Other	1
Private Counselor working with Veterans	1
Skilled Nursing Facilities	0
Soldiers Project	0
VA Based Residential Recovery Programs (Walters House, Martinez)	0
VA Medical Center	1
Veteran Centers (Citrus Heights, Reno, etc.)	0
Veteran Resource Centers (SVRC, etc.)	0
Windows to My Soul, Equine Therapy	1

Total	**16**

- **Measurement 4: If known, the average duration of untreated mental illness for individuals who have not previously received treatment.**

Time between Start Date of Mental Illness and Date Entered into Project	
Less than One Year	11
One to Two Years	0
Three to Five Years	10
Six to Ten Years	14
More than Ten Years	49

- **Measurement 5: If known, the average interval between the referral and engagement in treatment, defined as participating at least once in the treatment to which referred.**

Average Time (Years) between Start Date of Mental Illness and Date Entered into Project	
Average Time (Years)	24.38

- **Measurement 6: Implementation challenges, successes, lessons learned, and relevant examples.**

  Implementation challenges during 2020 center on the COVID-19 crisis and the difficulty completing outreach as well as accessing other service providers. It also is always a challenge to recruit skilled volunteers and appropriately experienced professionals. It is also difficult getting some Veterans in need to acknowledge mental health needs.

  Lessons learned include how to leverage Veterans Outreach Project funding and our role in the wider county, how to assist the local VA as it becomes the point of entry for Veterans to access services, how El Dorado County's new Coordinated Entry System can best serve Veterans in need.

  Successes include housing previously homeless Veterans and the myriad of services we were able to provide to Veterans in need to help stabilize mental health issues and illness. See below:

Service Category – Case Management	FY 19-20	Contract Period
Benefit Assistance	24	30
Budgeting Assistance	31	35
Document Processing or ID Assistance	12	14
Housing Placement Assistance	40	50
Housing Searches	32	39

Rental Application Assistance	31	33
Service Related Disability Application	5	5
Social Security Disability Application	10	11
Transportation to Health Provider	4	6
Total Services – Case Management	189	223
Service Category - Communication		
Assurance Wireless Phones	1	1
Minutes on Existing Phone Plans	4	10
Pre-paid Cellular Phones	0	6
Total Services – Communication	5	17
Service Category – Emergency Needs Fulfillment		
Duffle bags or Sea Bags	1	2
Hygiene Supplies for Emergency Needs	2	3
Pre-Paid Food Cards	9	103
Tents/Sleeping bags/Tarps	2	2
Toiletries for Emergency Needs	1	2
Total Services – Emergency Needs Fulfillment	15	112
Service Category – Health Services		
Mental Health Assistance	22	30
Physical Health Assistance	2	2
Total Services – Health Services	24	32
Service Category – Household Needs Fulfillment		
Cleaning Supplies	1	1
Cooking Utensils	0	0
Hygiene Supplies	0	1
Pre-Paid Food Cards	3	41
Toiletries	0	0
Total Services – Household Needs fulfillment	4	43
Service Category – Housing		

Campground Fees	0	0
Emergency Lodging	146	368
Mortgage Assistance	2	2
Rents	13	34
Security Deposit	4	14
Utility Deposits	0	0
Utility Payments	18	29
Total Services – Housing	183	447
Service Category – Transportation		
Auto Payments	1	1
Fuel	10	13
Insurance and/or Registration	6	16
Pre-paid Fuel Cards	8	94
Public Transportation	8	10
Smog Certificates	0	1
Vehicle Repairs and Maintenance	7	16
Total Services – Transportation	40	151
Service Category – Other		
Other	16	57
Total Services Provided	452	1050

Suicide Prevention and Stigma Reduction

Provider: Suicide Prevention Network

Project Goals

- Increase awareness of mental illness, programs, resources, and strategies.
- Increased linkage to mental health resources.
- Implement activities that are designed to attempt to reduce the number of attempted and completed suicides in El Dorado County.
- Change negative attitudes and perceptions about seeking mental health services.
- Increase access to mental health resources to support individuals and families.

Numbers Served and Cost

Regarding demographic data collection: Per the amended PEI regulations, effective July 1, 2018, the Contractor is only required to report on the number of contacts.

Expenditures	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
MHSA Budget	$40,000	$40,000	$60,000
Total Expenditures	$25,224	$39,992	$49,672
Unduplicated Individuals Served	unknown	733	unknown
Cost per Participant	unknown	$55	unknown
Age Group	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
0-15 (children/youth)	unknown	342	N/A
16-25 (transitional age youth)	unknown	304	N/A
26-59 (adult)	unknown	54	N/A
Ages 60+ (older adults)	unknown	33	N/A
Unknown or declined to state	unknown	0	N/A
Race	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
American Indian or Alaska Native	unknown	unknown	N/A
Asian	unknown	8	N/A
Black or African American	unknown	3	N/A
Native Hawaiian or Other Pacific Islander	unknown	unknown	N/A
White	unknown	363	N/A
Other	unknown	18	N/A
Multiracial	unknown	341	N/A
Unknown or declined to state	unknown	unknown	N/A
Ethnicity by Category	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Hispanic or Latino	unknown	unknown	N/A
Caribbean	unknown	unknown	N/A
Central American	unknown	23	N/A

Mexican/Mexican-American/Chicano	unknown	299	N/A
Puerto Rican	unknown	unknown	N/A
South American	unknown	19	N/A
Other	unknown	unknown	N/A
Unknown or declined to state	unknown	unknown	N/A
Non-Hispanic or Non-Latino			
African	unknown	3	N/A
Asian Indian/South Asian	unknown	8	N/A
Cambodian	unknown	unknown	N/A
Chinese	unknown	unknown	N/A
Eastern European	unknown	unknown	N/A
Filipino	unknown	unknown	N/A.
Japanese	unknown	unknown	N/A
Korean	unknown	unknown	N/A
Middle Eastern	unknown	unknown	N/A
Vietnamese	unknown	unknown	N/A
Other	unknown	363	N/A
Multi-ethnic	unknown	18	N/A
Unknown or declined to state	unknown	unknown	N/A
Primary Language	**FY 2017-18**	**FY 2018-19**	**FY 2018-19**
Arabic	unknown	unknown	N/A
Armenian	unknown	unknown	N/A
Cambodian	unknown	unknown	N/A
Cantonese	unknown	unknown	N/A
English	unknown	384	N/A
Farsi	unknown	unknown	N/A
Hmong	unknown	unknown	N/A
Korean	unknown	unknown	N/A
Mandarin	unknown	unknown	N/A
Other Chinese	unknown	unknown	N/A
Russian	unknown	unknown	N/A
Spanish	unknown	341	N/A
Tagalog	unknown	unknown	N/A
Vietnamese	unknown	unknown	N/A
Unknown or declined to state	unknown	unknown	N/A
Sexual Orientation ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**

Gay or Lesbian	unknown	unknown	N/A
Heterosexual or Straight	unknown	unknown	N/A
Bisexual	unknown	unknown	N/A
Questioning or unsure of sexual orientation	unknown	unknown	N/A
Queer	unknown	unknown	N/A
Another sexual orientation	unknown	unknown	N/A
Declined to State	unknown	unknown	N/A
Gender ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Assigned sex at birth:			
Male	unknown	350	N/A
Female	unknown	383	N/A
Declined to answer	unknown	0	N/A
Current gender identity:			
Male	unknown	unknown	N/A
Female	unknown	unknown	N/A
Transgender	unknown	unknown	N/A
Genderqueer	unknown	unknown	N/A
Questioning / unsure of gender identity	unknown	unknown	N/A
Another gender identity	unknown	unknown	N/A
Declined to answer	unknown	unknown	N/A
Disability	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Difficulty seeing	unknown	unknown	N/A
Difficulty hearing or having speech understood	unknown	unknown	N/A
Mental disability including but not limited to learning disability, developmental disability, dementia	unknown	unknown	N/A
Physical/mobility	unknown	unknown	N/A
Chronic health condition/chronic pain	unknown	unknown	N/A
Other (specify)	unknown	unknown	N/A
Declined to state	unknown	unknown	N/A
Veteran Status ****Collection of this information from a minor younger than 12 years of age is not required.***	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Yes	unknown	11	N/A

No	unknown	unknown	N/A
Unknown or declined to state	unknown	unknown	N/A
Region of Residence	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
West County	unknown	0	unknown
Placerville Area	unknown	0	unknown
North County	unknown	0	unknown
Mid County	unknown	0	unknown
South County	unknown	0	unknown
Tahoe Basin	unknown	733	unknown
Unknown or declined to state	unknown	0	unknown
Economic Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Extremely low income	unknown	unknown	N/A
Very low income	unknown	unknown	N/A
Low income	unknown	unknown	N/A
Moderate income	unknown	unknown	N/A
High income	unknown	unknown	N/A
Health Insurance Status	**FY 2017-18**	**FY 2018-19**	**FY 2019-20**
Private	unknown	unknown	N/A
Medi-Cal	unknown	unknown	N/A
Medicare	unknown	unknown	N/A
Uninsured	unknown	unknown	N/A

Annual Report FY 2019/20

Please provide the following information for this reporting period:

1. **Briefly report on how implementation of the Suicide Prevention and Stigma Reduction 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.**

   During the 2019/20 school year, we were able to successfully expand our Suicide Prevention program into the West Slope beyond South Lake Tahoe. The 2019/20 contract required in-class outreach and education to four middle schools on the West Slope. Suicide Prevention Network (SPN) successfully conducted Signs of Suicide (SOS) to the South Tahoe Middle School 6th grade class, Pleasant Grove Middle School grades 6th grade, 7th grade, and 8th grade, and scheduled SOS presentation with Pollock Pines Middle and Rolling Hills. Part of this success was due to the fact that we were able to hire a second employee at 20 hours a week to reach the West Slope. Unfortunately, Rolling Hills and Pollock Pines were canceled due to school closures caused by the COVID-19 Pandemic. COVID-19, and the fall out of canceled classes and programs was the only barrier to fulfilling the objectives required for the 19/20 contract.

2. **Briefly report on how the Suicide Prevention and Stigma Reduction 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 Suicide Prevention and Stigma Reduction project (suicide and prolonged suffering).

SPN has expanded the knowledge of local and national resources and distribution of crisis line info to the general community. Community members reach out through the SPN phone line by calling/texting, message through social media, and email. Although SPN does not serve clients, staff often meet with community members who have concerns about those they love. The success of the SOS program that is implemented in the Middle (and High School in South Lake Tahoe) is one example. During the winter a South Tahoe High School (STHS) teacher reached out for help with her daughter. The mother found a note and pills hidden in her daughter's bedroom and knew that she could reach out to SPN due to the familiarity of the SOS program on campus. With each year, we have been able to expand the program in South Lake Tahoe and the Western Slope. South Lake Tahoe had ZERO teen suicides this 2019/20 school year.

3. Provide a brief narrative description of progress in providing services through the Suicide Prevention and Stigma Reduction project to unserved and underserved populations.

SPN works hard to provide trainings and education to the agencies that provide direct services or support to clients and community members. SPN connects regularly with local non-profits, schools, and faith communities.

Suicide prevention outreach to underserved populations included:

- 4000+ coloring sheets with crisis numbers to LTUSD students in grades K-12 receiving food assistance during school closures due to COVID-19
- LGBTQ outreach to the ALLY (LGBTQ Students and supporters) club at South Tahoe High
- Presentation to the Mt Tallac Continuation High School
- Presentations to the staff at Tahoe Homeless Coalition, Only Kindness, Live Violence Free, CASA, and LTUSD School Board
- Scheduled to present at The Drugstore Project, a locally run, day-long comprehensive drug prevention program for middle school students designed to educate youth about the dangers of substance use and abuse. Canceled due to COVID-19

4. Provide a brief narrative description of how the Suicide Prevention and Stigma Reduction services are provided in a culturally and linguistically competent manner, including activities to reduce racial/ethnic disparities.

SOS presentations and materials are offered with Spanish subtitles and questionnaires are available for Spanish speaking students. When available, general outreach materials are available in Spanish. SPN has an ongoing relationship with Family Resource Center (FRC). The FRC primary, but not solely, serves the Latino population.

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.

Over the course of the year, SPN has also been involved in or facilitated numerous events and presentations. From July 2018- June 2019 SPN has participated in:

- 8 Cooperative Mental Health Community meetings
- Signs of Suicide (SOS) sessions for the entire 6th grade class at South Tahoe Middle and 6th, 7th and 8th grade classes at Pleasant Grove Middle School
- Signs of Suicide (SOS) sessions for the 11th grade class at South Tahoe High (half completed; half canceled due to COVID-19)
- 5 Suicide loss support groups (3 canceled due to COVID-19)
- 1 Suicide Awareness Walk-Emily's Walk for Hope (100-150 attendees)
- 1 free benefit fundraiser concert
- Lake Tahoe Community College month-long sign installation for Suicide Prevention Month
- 12 community outreach presentations
- 4 "Facebook Live" community interview totaling 1,685 views. June Topics included: Trauma, gardening for your mental health, the importance or rituals/routines, and Art for Mental Wellness.
- 2 TV appearances-general suicide prevention info and crisis numbers
- 6 radio appearances on KRLT
    - Radio appearances coincide with Mental Health Awareness Month and Suicide Prevention Month. Topics are related to Mental health and planned outreach events.
- 3 Tahoe Daily Tribune/South Tahoe Now articles
    - Coping with loss, Art Journaling for Mental Health, Helping to end the Stigma
- 3 STHS clubs/workshops (4 canceled due to COVID-19)

6. **Provide the outcome measures of the services provided and of customer satisfaction surveys. Outcome measures for the Suicide Prevention and Stigma Reduction project are:**

    - **Measurement 1: Using validated method, measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness.**

    During and following outreach presentations, SOS presentations and other community outreach events participants commonly make comments such as "I have never thought of it that way", "I didn't realize this was an issue in my town", and "I have a better idea of what to say now". During our many radio appearances, listeners comment live on the Facebook page and personally text the DJ, Howie Nave, to let him know how much they appreciate the candid and open conversations about suicide and mental health and share that they feel less alone when this conversation happens live on air.

    - **Measurement 2: Using a validated method, measure changes in attitudes, knowledge, and/or behavior related to seeking mental health services.**

    Much of the educational outreach we do as an agency involves comparing taking care of your mental health to caring for your physical health and how those two are intertwined and work together to create a whole and healthy human. For example, Melinda Choy of Elevate Wellness has been our guest speaker numerous times to talk to students at South Tahoe High about how your gut health affects your mental health. Participants in these type of outreach events commonly express surprise and fascination in regards to how normal and easy it can be to address your mental wellness through taking care of your physical health though diet, exercise, and hobbies.

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

MHSA: $49,672

8. Provide any additional relevant information.

In September 2019 a teenage male who attended Whittle High School in Douglas County, Nevada died by suicide. Although Whittle is on the Nevada side, it is only a few miles from South Tahoe High School and the students have many connections. The girlfriend, and many of the friends of this student, attended South Tahoe High. The girls volleyball team decided to make Suicide Prevention Network the recipient of their annual silent auction. SPN held a table at the game and auction and presented to the Jr Varsity and Varsity Girls' Volleyball team at STHS.

In many ways, outreach and education came to a sudden halt in March 2020 with the introduction of COVID-19. Many of our scheduled presentations were canceled and we suddenly found ourselves, along with everyone else, struggling to create new ways to reach our community. While we were unable to meet one-on-one or with groups, we continued with outreach via media and we came up with creative ways to reach our youth and families. We collaborated with South Tahoe High School art teacher Matt Kauffmann and mailed 1200 packets to South Tahoe High School students. The packets included art journals, a pen and a card with info on how art journaling is good for mental health, along with crisis numbers and websites. We also created an original coloring page each week with crisis info that was deposited onto the 800+ lunches every Friday that LTUSD distributed to families receiving food assistance while schools were online only.

The MHSA Team will provide technical assistance to the Contractor to better quantify data related to Outcome Measurement 1 and 2.

Community Services and Supports (CSS) Projects

Introduction

Community Services and Supports (CSS) Projects provide direct services to adults and children who have a severe mental illness (adults) or serious emotional disturbance (children) who meet the criteria for receiving Specialty Mental Health Services as set forth in WIC Section 5600.3.

This Outcome Measures Report accompanying the Fiscal Year 2021/22 MHSA Annual Update and provides outcome information for the projects included in the Fiscal Year 2017-18 – 2019-20 MHSA Three-Year Program and Expenditure Plan.

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.

The State has not yet identified standardized outcomes and indicators for CSS programs, however MHSA programs use standard service level indicators and outcome tools utilized by the Behavioral Health Division and its contracted providers:

- Measurement 1: Levels of Care Utilization System (LOCUS) for adults; Child and Adolescent Levels of Care Utilization System (CALOCUS) for children and youth
- Measurement 2: Outcome measurement tools (e.g., Child and Adolescent Needs and Strengths (CANS); Adult Needs and Strengths Assessment (ANSA))

Full Service Partnership (FSP) Program

Children's Full Service Partnership

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

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$1,800,000	$2,000,000	$2,780,000
Total Expenditures	$801,631	$1,148,686	$2,476,393
Unduplicated Individuals Served	99	120	187
Cost per Participant	$8,097	$9,572	$13,243

Age Group	FY 2017-18	FY 2018-19	FY 2019-20
0-15 (children/youth)	71	82	116
16-25 (transitional age youth)	28	38	71
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0

Gender	FY 2017-18	FY 2018-19	FY 2019-20
Female	51	67	99
Male	48	53	88

Region of Residence	FY 2017-18	FY 2018-19	FY 2019-20
West County	14	25	42
Placerville Area	30	31	64
North County	10	10	17
Mid County	6	14	16
South County	2	3	3
Tahoe Basin	22	22	29
Unknown or declined to state	15	0	0
Out of County	0	15	16

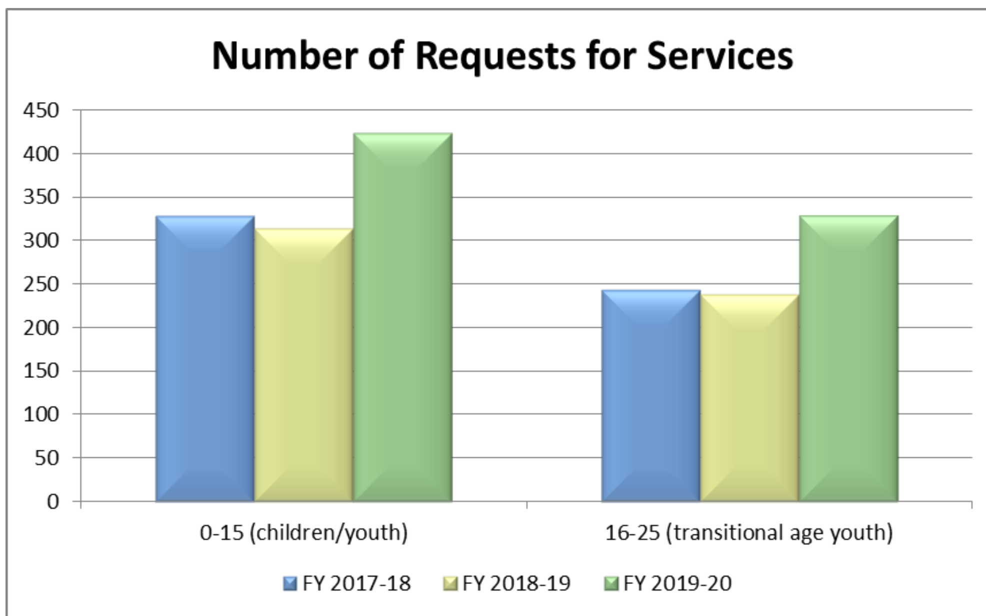
Race	FY 2017-18	FY 2018-19	FY 2019-20
American Indian or Alaska Native	2	2	5
Asian	0	0	1
Black or African American	2	4	8
Caucasian or White	67	74	99
Native Hawaiian or Other Pacific Islander	0	0	0
Other Race	12	8	15
Unknown or declined to state	16	31	59

Ethnicity	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	9	4	12
Other Hispanic / Latino	6	6	9
Not Hispanic	52	62	89
Unknown or declined to state	32	48	77

Primary Language	FY 2017-18	FY 2018-19	FY 2019-20
English	81	104	152
Spanish	2	1	2
Other Language	0	0	0
Unknown or declined to state	16	15	33

In July 2019, Mental Health performed a review of children receiving SMHS to ensure that the children were receiving services at the appropriate level based upon their CALOCUS and CANS scores. This resulted in some children being appropriately moved into the FSP program.

Additionally, in recent years there has been an increased awareness about mental health symptoms for youth on social media, and within the schools and primary care, which appears to have led to a greater number of referrals for SMHS for youth, with a 34% increase from FY 2018-19 for children age 0-15 and a 37% increase for youth age 16-25:



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

Measurement 1 (Days of psychiatric hospitalization)

Children's FSP and Enhanced Foster Care	FY 2017-18	FY 2018-19	FY 2019-20
Children Enrolled in this Program:			
Unduplicated Children Served	99	120	187
Unduplicated Children Hospitalized	6	13	9
Number of Hospitalizations	8	15	13
Average Length of Stay	6 days	9.8 days[1]	9.8 days[2]
All El Dorado County Children Medi-Cal Beneficiaries (under age 18): (whether receiving Specialty Mental Health Services or not)			
Unduplicated Children Hospitalized	47	51	48
Number of Hospitalizations	61	59	57
Average Length of Stay	7 days	8.5 days[3]	7.0 days

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

These outcomes come from reporting that is entered into the Data Collection Reporting (DCR) Systems, a database maintained by the State. Please see the Appendix for outcomes from the DCR.

[1] Two (2) children were hospitalized for three (3) or more weeks, accounting for the increase in average Length of Stay. Without those two (2) hospitalizations, the average Length of Stay is 6.2 days.
[2] One (1) child was hospitalized for three (3) or more weeks. Without that one (1) hospitalization, the average Length of Stay is 8.7 days.
[3] Five (5) children were hospitalized for three (3) or more weeks, accounting for the increase in average Length of Stay. Without those five (5) hospitalizations, the average Length of Stay is 6.7 days.

CASA

Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$20,000	$20,000	$20,000
Total Expenditures	$20,000	$20,000	$20,000
Unduplicated Individuals Served	288	308	268

CASA reported the following information in its FY 2019-20 Year-End Report:

1. **Briefly report on how implementation of the Foster Care Enhances Services – CASA 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.**

   We serve the abused, neglected, and at-risk children in the El Dorado County foster care system by recruiting, training, and supervising volunteer Court Appointed Special Advocates who, as officers of the court, "act as the eyes and ears of the judge and voice of the child".

   Our agreement with El Dorado County stipulates that we provide outreach, training, and group supervision. These services were successfully delivered through the following:

   A number of structural changes in our operations were implemented during the reporting period that resulted in marked growth in our ability recruit and train volunteers to positively impact the mental health of the children we serve. These include:
   - Program staff implemented and began in earnest, an online recruitment and "Application to Advocate" policy.
   - We developed Zoom In-Person trainings that have been replicated across the State.
   - Enhanced marketing through use of videos produced in-house, coupled with our social media presence, has resulted in reaching more potential volunteers with a contemporary message.
   - We have shifted all of our continuing education and peer coordinating meetings to a virtual format. This began as a COVID-19 adjustment, but has proven to be better attended and appreciated by our busy advocates.

   Our ongoing management and supervisory duties include providing direction to our volunteers, holding monthly continuing education classes, and assuring that volunteers comply with record keeping and other duties.

2. **Briefly report on how the Foster Care Enhanced Services – CASA project has improved the overall mental health of the foster care population.**

   Nationwide, it is estimated that 80% of the children in foster care suffer from mental health issues. The abuse, abandonment, or neglect that lead to a child being removed from his or her parents has traumatic effect. These Adverse Childhood Experiences (ACEs) are understood to lead to long term learning disabilities and behavioral problems. A comprehensive study by Kaiser Permanente in 1997 found that as the number of ACEs increases, there is a

corresponding increase in risk of substance abuse, violent behavior, depression, and suicidal tendencies, among other mental health issues. It has been our experience that virtually all of the children that we serve are prescribed psychotropic medication to combat anxiety, dramatic mood swings, and depression.

Given the above, and through our long experience with working with children in foster care, we feel that it is clear that the overall mental health of the foster care population is poor and in need of our intervention. It has been shown, per a 2006 audit study by the Office of the Inspector General, that when a foster child has a CASA advocate he or she is:

- Half as likely to re-enter the foster care system and/or to end up in long-term foster care (3 years or more);
- Likely to have more services ordered for them by the court;
- More likely to be adopted;
- And, perhaps most significantly, 98% of the children we serve do not re-experience abuse and neglect.

3. Provide a brief narrative description of the progress in providing services through the Foster Care Enhanced Services – CASA project to unserved and underserved populations.

During the FY 2019-20 reporting period, compared to the previous 12 months, Child Advocates of El Dorado County:

- Served fewer children, largely due to the reduction of detentions by Child Protective Services during the COVID-19 pandemic.
- Reduced waitlisted children to under 50 and moving into 2020/21 we feel ready to have advocates ready to be assigned as a judge orders a CASA. We currently have 35 unassigned advocates and 18 children on your waiting list.
- Successfully reduced the number of advocates resigning by 67% (9 resigned in FY 2019 compared to 28 in FY 2018).

As such, the $20,000 MHSA funding has enabled us to make significant progress in offering enhanced services to the abused and neglected children in the El Dorado County foster care system.

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

Over the course of time, we have seen that our volunteers reflect the overall demographics of El Dorado County, and understanding cultural diversity is one of the cornerstones of CASA volunteer training. After training, cultural and linguistic compatibility are key determinants when assigning volunteers to new cases. Additionally, the program manager in our South Lake Tahoe office is bilingual in Spanish and English.

Over the past fiscal year, we increased the number of bilingual advocates by 9% and increased our advocates' diversity by increasing the number of advocates who identify as a race/ethnicity other than Caucasian (29% in FY 2019-20 vs 21% FY 2018-19). Because of our increased

diversity we were able to assign a Spanish-speaking advocate to a child whose mother was monolingual (Spanish).

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.**

   Organizations that we collaborate with in Placerville include:
   - Unity Care (an independent living service)
   - Environmental Alternatives (a group home)
   - 3 Strands (human trafficking counseling and education)
   - Marshall CARES
   - Center for Violence-Free Relationships

   Our South Lake Tahoe office works closely with:
   - Tahoe Turning Point (a group home with substance abuse services)
   - Live Violence Free (which addresses domestic violence)

   Mandatory continuing education classes provide instruction on mental health topics such as Adverse Childhood Experiences (ACEs), Trauma-Informed Care, and Substance Use Disorders. These classes are held at our office and typically presented by experts from the community. Volunteers are also notified of classes and workshops at other local agencies, including Summitview Child Treatment Center, New Morning Children's Shelter, and Folsom Lake College.

6. **Provide the outcome measures of the services provided. Outcome measures for the Foster Care Enhances Services – CASA project are:**

   - Measurement 1 – number of new CASA volunteers trained: 33
   - Measurement 2 – Number of Katie A eligible foster children matched with a CASA volunteer: 362 children were served
   - Measurement 3 – Number of cases closed and report on placement outcomes, such as reunification (with family), adoption, kinship care, guardianship, etc.
     - 131 cases were closed
     - 39 adoptions
     - 9 emancipations
     - 58 were reunification
     - 25 other

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

   No additional information was provided.

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

   No additional information was provided.

Transitional Age Youth (TAY) Full Service Partnership

Provider: El Dorado County Health and Human Services Agency, Behavioral Health Division, South Lake Tahoe;
Sierra Child and Family Services, West Slope

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

Numbers Served and Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget – Total	$375,000	$400,000	$500,000
Total Expenditures	$11,425	$5,454	$107,418
Unduplicated Individuals Served	5	16	35
Cost per Participant	$2,285	$341	$3,069

FY 2019-20 includes both the services provided directly through the County in its TAY FSP and Mental Health Block Grant First Episode of Psychosis program (22 clients), and also through its Mental Health Block Grant First Episode of Psychosis contracted provider, Sierra Child and Family Services (13 clients).

Age Group	FY 2017-18	FY 2018-19	FY 2019-20
0-15 (children/youth)	0	0	2
16-25 (transitional age youth)	21	16	33
26-59 (adult)	0	0	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0

Gender	FY 2017-18	FY 2018-19	FY 2019-20
Female	7	7	17
Male	14	9	18

Region of Residence	FY 2017-18	FY 2018-19	FY 2019-20
West County	3	0	14
Placerville Area	6	7	12
North County	0	0	0
Mid County	2	2	2
South County	1	0	1
Tahoe Basin	9	7	5
Unknown or declined to state / out of county	0	0	1

Race	FY 2017-18	FY 2018-19	FY 2019-20
American Indian or Alaska Native	2	1	1
Asian	1	1	2
Black or African American	0	0	2
Caucasian or White	14	10	23
Native Hawaiian or Other Pacific Islander	0	0	1
Other Race	3	3	3
Unknown or declined to state	1	1	1

Ethnicity	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	2	3	2
Other Hispanic / Latino	1	0	1
Not Hispanic	17	10	18
Unknown or declined to state	1	3	14

Primary Language	FY 2017-18	FY 2018-19	FY 2019-20
English	21	15	33
Spanish	0	1	1
Other Language	0	0	1
Unknown or declined to state	0	0	0

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/juvenile hall
- Measurement 2: Number of Clients Graduating from Specialty Mental Health Services
- Measurement 3: Education attendance and performance
- Measurement 4: Number of days of homelessness / housing stability
- Measurement 5: Education attendance and performance
- Measurement 6: Employment status
- Measurement 7: Continued engagement in mental health
- Measurement 8: Linkage with primary health

Measurement 1: Key Event Tracking (KET)
Measurement 3: Education attendance and performance
Measurement 4: Number of days of homelessness / housing stability
Measurement 5: Education attendance and performance
Measurement 6: Employment status

These outcomes come from reporting that is entered into the Data Collection Reporting (DCR) Systems, a database maintained by the State. Please see the Appendix for outcomes from the DCR.

Measurement 2 Number of Clients Graduating from Specialty Mental Health Services
Measurement 7 Continued engagement in mental health

The following data is only reflective of the clients served by Mental Health directly.

Nine (9) TAY clients who were enrolled as an FSP at any time in FY 2018-19 remained open to SMHS at the end of FY 2018-19.

Participants	FY 2017-18	FY 2018-19	FY 2019-20
Unique Clients	21	16	22
Total FSP Episodes	23	18	23
FSP Episodes Opened:			
Total FSP Episodes Opened	14	12	18
New/Returning Client	*13*	*9*	*13*
Changed Program (same level of service)	*0*	*2*	*3*
Dropped Down in Level of Services	*0*	*0*	*0*
Increased Level of Services	*1*	*1*	*2*
FSP Episodes Closed:			
Total FSP Episodes Closed	16	13	13
Graduated / Exited Services	*12*	*9*	*8*
Decreased Level of Services	*2*	*1*	*2*
Increased Level of Services	*0*	*1*	*2*
Changed Program (same level of service)	*2*	*2*	*1*

Individuals within the TAY age range continue to be challenging to engage in services. However, of all age groups served by Mental Health, the TAY population has been the one to most quickly adapt to the use of telephone and telehealth for the provision of services. This age group is familiar with, and very comfortable with, using technology to communicate with others. The need to use telephone and telehealth for services during the public health emergency has been beneficial to these clients.

Adult Full Service Partnership

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, and help clients continue living in the community rather than

being placed out of county. These FSP clients require a high level of staff support and the client to clinician ratio is low.

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$4,675,000	$5,500,000	$5,400,000
Total Expenditures	$4,229,842	$4,360,421	$4,359,998
Unduplicated Individuals Served	121	123	128
Cost per Participant	$34,957	$35,451	$34,062

Age Group	FY 2017-18	FY 2018-19	FY 2019-20
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	10	6	7
26-59 (adult)	95	102	107
Ages 60+ (older adults)	16	15	14
Unknown or declined to state	0	0	0

Gender	FY 2017-18	FY 2018-19	FY 2019-20
Female	52	50	52
Male	69	73	76

Region of Residence	FY 2017-18	FY 2018-19	FY 2019-20
West County	8	8	9
Placerville Area	66	73	64
North County	1	2	6
Mid County	6	8	7
South County	1	2	1
Tahoe Basin	35	28	38
Out of County	0	2	3
Unknown or declined to state	4	0	0

Race	FY 2017-18	FY 2018-19	FY 2019-20
American Indian or Alaska Native	1	1	3
Asian	4	2	4
Black or African American	4	2	3
Caucasian or White	100	104	112
Native Hawaiian or Other Pacific Islander	0	0	0
Other Race	10	7	4
Unknown or declined to state	2	7	2

Ethnicity	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	2	3	1
Other Hispanic / Latino	11	7	4
Not Hispanic	99	108	112
Unknown or declined to state	9	6	11

Primary Language	FY 2017-18	FY 2018-19	FY 2019-20
English	117	121	123
Spanish	0	1	2
Other Language	3	1	3
Unknown or declined to state	1	0	0

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: Number of Clients Graduating from Specialty Mental Health Services
- Measurement 3: Continued engagement in services

These outcomes will be adjusted in the FY 2021-22 MHSA Annual Update, if needed, to better align with available data.

Measurement 1 (Key Event Tracking)

These outcomes come from reporting that is entered into the Data Collection Reporting (DCR) Systems, a database maintained by the State. Please see the Appendix for outcomes from the DCR.

Measurement 2 (Number of Clients Graduating from Specialty Mental Health Services)
Measurement 3 (Continued engagement in services)

Eighty-seven (87) adult clients who were enrolled as an FSP at any time in FY 2019-20 remained open to SMHS at the end of FY 2019-20.

Participants	FY 2017-18	FY 2018-19	FY 2019-20
Unique Clients	121	123	128
Total Episodes	129	131	136
FSP Episodes Opened:			
Total FSP Episodes Opened	72	70	70
New/Returning Client	*37*	*30*	*48*
Changed Program (same level of service)	*9*	*1*	*4*
Dropped Down in Level of Services	*14*	*21*	*8*
Increased Level of Services	*12*	*17*	*10*
FSP Episodes Closed:			
Total FSP Episodes Closed	71	66	73
Graduated / Exited Services	*22*	*29*	*35*
Decreased Level of Services	*29*	*18*	*22*

Participants	FY 2017-18	FY 2018-19	FY 2019-20
Increased Level of Services	*11*	*18*	*10*
Changed Program (same level of service)	*9*	*1*	*6*

Older Adult Full Service Partnership

There are no FY 2019-20 outcomes to report for this program. Fourteen Older Adult FSP clients were provided the full range of FSP services through the Adult FSP program.

Numbers Served and Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$100,000	$200,000	$300,000
Total Expenditures	$0	$0	$0
Clients Served	Through Adult FSP	Through Adult FSP	Through Adult FSP
Cost per Participant	$0	$0	$0

Assisted Outpatient Treatment (AOT)

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

Numbers Served and Cost

For AOT, the number of clients served means the number of individuals who were referred to AOT an individuals referred in a previous year but whose AOT referral has not been discharged (for example, if the referral is still open because the individual could not be located).

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) initially.

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$200,000	$40,000	$34,862
Total Expenditures	$13,798	$47,611	$10,725
AOT Referrals Open at any time During the FY	8	18	3
Cost per Participant	$1,725	$2,645	$2,681

The AOT program was initially designed with the intent to provide direct services to clients engaged in Specialty Mental Health Services as a result of an AOT referral. However, this model did not allow for AOT clients to receive the benefits of a treatment team approach. Therefore, AOT referred clients are served by the ICM team, which maintains a low client to clinician ratio and takes a team approach to help clients in achieving their treatment goals.

In the FY 2020-21 MHSA Plan, the AOT Program will be aligned with the Outreach and Engagement Projects rather than the FSP programs.

Additionally, to address the low referral rates, Mental Health is developing a Training and Education Plan for stakeholders, including consumers and families, as well as for Mental Health service providers.

Outcome Measures

- Measurement 1: Number of referrals received and the sources of those referrals.
- Measurement 2: Number of referrals resulting in engagement in services.
- Measurement 3: Number of days between receipt of an AOT referral and clients' engagement in outpatient Specialty Mental Health Services, if individual becomes engaged in services.
- Measurement 4: Number of AOT petitions filed.
- Measurement 5: Number of AOT referrals who remained engaged in services for at least six months.

Measurement 1: Number of referrals received and the sources of those referrals.

Welfare and Institutions Code section 5346(b)(2) identifies who may make a referral for AOT. Referrals came from the following sources:

Referral Source	FY 2018-19 Referrals	FY 2019-20 Referrals
Adult Housemate/Roommate	0	0
Immediate Family Member	8	3
Treatment/Care Facility	0	0
Hospital	1	0
El Dorado County Psychiatric Health Facility (PHF)	6	0
Treatment Provider	2	0
Law Enforcement/Justice	1	0
Court (effective 2021)	N/A	N/A

Measurement 2: Number of referrals resulting in engagement in services.
Measurement 4: Number of AOT petitions filed.

Status	FY 2018-19	FY 2019-20
Voluntarily Engaged with SMHS	7	1
Voluntarily Engaged with Mild-to-Moderate or other Mental Health Services	3	0
Engaged via Petition / Petitions Filed	0	0
Engaged via Conservatorship	2	0
Not Eligible for AOT	2	2
Incarcerated Prior to Engagement	3	0
Engagement Attempts Continue	1	0

Measurement 3: Number of days between receipt of an AOT referral and clients' engagement in outpatient Specialty Mental Health Services, if individual becomes engaged in services.

For the one individual who voluntarily engaged with SMHS: 25 days.

Measurement 5: Number of AOT referrals who remained engaged in services for at least six months.

The one individual who voluntarily engaged in SMHS, the individual remained voluntarily engaged for at least 6 months.

Wellness and Recovery Services Program

Wellness Centers (which include Outpatient Specialty Mental Health Services)

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

Both the South Lake Tahoe and West Slope Wellness Centers closed in March 2020 as a result of the public health emergency. As such, the number of individuals who accessed the Wellness Center were lower than usual. The average cost per client increased significantly in FY 2019-20 due to lower number of clients attending Wellness, but the same number of staff employed by Mental Health through the public health

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$2,300,000	$2,700,000	$2,600,000
Total Expenditures	$2,181,145	$2,085,334	$2,404,852
Wellness Center (West Slope Only):			
Wellness Center Visits	6,400+	7,100+	Not available for FY 19/20[4]
Cost per Visit	$341	$293	
Unduplicated Clients	310	324	
Outpatient Wellness Program Clients Served	415	371	364
Cost per Client	$5,026	$5,621	$6,607

[4] Evaluation of the data reflected the data was not accurately collected and therefore it is not available for FY 19/20.

Age Group	FY 2017-18	FY 2018-19	FY 2019-20
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	38	21	18
26-59 (adult)	334	309	304
Ages 60+ (older adults)	43	41	42
Unknown or declined to state	0	0	0

Gender	FY 2017-18	FY 2018-19	FY 2019-20
Female	222	196	183
Male	193	175	181

Region of Residence	FY 2017-18	FY 2018-19	FY 2019-20
West County	63	46	46
Placerville Area	163	124	120
North County	17	10	16
Mid County	38	38	27
South County	9	12	12
Tahoe Basin	122	135	129
Unknown or declined to state	3	1	1
Out of County	0	5	13

Race	FY 2017-18	FY 2018-19	FY 2019-20
American Indian or Alaska Native	8	11	9
Asian	5	4	5
Black or African American	8	9	8
Caucasian or White	352	298	283
Native Hawaiian or Other Pacific Islander	0	1	2
Other Race	30	25	32
Unknown or declined to state	12	23	25

Ethnicity	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	14	12	10
Other Hispanic / Latino	26	25	21
Not Hispanic	337	297	278
Unknown or declined to state	38	37	55

Primary Language	FY 2017-18	FY 2018-19	FY 2019-20
English	403	359	356
Spanish	2	3	1
Other Language	4	3	4
Unknown or declined to state	6	6	3

Outcome Measures

- Measurement 1: Number of participants and frequency of attendance
- Measurement 2: Number of Clients Graduating from Specialty Mental Health Services

Measurement 1 (Number of participants and frequency of attendance)

Category	FY 2017-18	FY 2018-19	FY 2019-20
Wellness Center (West Slope Only):			
Wellness Center Visits	6,400+	7,100+	Not available for FY 19/20[5]
Cost per Visit	$341	$293	
Unduplicated Clients	310	324	
Frequency of Attendance	n/a	n/a	n/a
Outpatient Wellness Program Clients Served	415	371	364

The frequency of attendance has not been reportable and was removed from the outcomes in the FY 2020-21 MHSA Plan.

Measurement 2 (Number of Clients Graduating from Specialty Mental Health Services from the Wellness program)

215 adult clients who were enrolled in a Wellness program at any time in FY 2019-20 remained open to SMHS at the end of FY 2019-20.

Participants	FY 2017-18	FY 2018-19	FY 2019-20
Unique Clients	415	371	364
Total Episodes	434	387	382
Episodes Opened:			
Total Episodes Opened	264	182	245
New/Returning Client	*221*	*166*	*212*
Changed Program (same level of service)	*0*	*4*	*8*
Dropped Down in Level of Services	*20*	*4*	*19*
Increased Level of Services	*23*	*8*	*6*
Episodes Closed:			
Total Episodes Closed	249	249	180
Graduated / Exited Services	*181*	*210*	*148*
Decreased Level of Services	*35*	*26*	*2*

[5] Evaluation of the data reflected the data was not accurately collected and therefore it is not available for FY 19/20.

Participants	FY 2017-18	FY 2018-19	FY 2019-20
Increased Level of Services	*13*	*10*	*14*
Changed Program (same level of service)	*0*	*3*	*16*

TAY Engagement, Wellness and Recovery Services

Numbers Served and Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget – Total	$200,000[6]	$600,000	$415,000
Total Expenditures	$199,547	$381,515	$331,838
Unduplicated Individuals Served	43	42	43
Cost per Participant	$4,641	$9,084	$7,717

Age Group*	FY 2017-18	FY 2018-19	FY 2019-20
0-15 (children/youth)	1	0	0
16-25 (transitional age youth)	41	41	43
26-59 (adult)	1	1	0
Ages 60+ (older adults)	0	0	0
Unknown or declined to state	0	0	0

Gender	FY 2017-18	FY 2018-19	FY 2019-20
Female	22	27	28
Male	21	15	15

Region of Residence	FY 2017-18	FY 2018-19	FY 2019-20
West County	8	9	6
Placerville Area	17	15	14
North County	1	1	2
Mid County	7	4	3
South County	2	1	2
Tahoe Basin	8	11	14
Unknown or declined to state	0	1	2

[6] Refers to MHSA funding only.

Race	FY 2017-18	FY 2018-19	FY 2019-20
American Indian or Alaska Native	2	1	0
Asian	0	1	1
Black or African American	0	0	0
Caucasian or White	38	30	29
Native Hawaiian or Other Pacific Islander	1	1	0
Other Race	1	2	8
Unknown or declined to state	1	7	5

Ethnicity	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	3	3	5
Other Hispanic / Latino	1	4	5
Not Hispanic	36	28	24
Unknown or declined to state	3	7	9

Primary Language	FY 2017-18	FY 2018-19	FY 2019-20
English	43	42	42
Spanish	0	0	0
Other Language	0	0	0
Unknown or declined to state	0	0	1

Outcome Measures

- Measurement 1: Number of participants
- Measurement 2: Number of Clients Graduating from Specialty Mental Health Services

Measurement 1 (Number of participants); and

Measurement 2 (Number of Clients Graduating from Specialty Mental Health Services from the TAY Engagement and Wellness program)

Participants	FY 2017-18	FY 2018-19	FY 2019-20
Unique Clients	43	42	43
Total Episodes	43	44	45
Episodes Opened:			
Total Episodes Opened	22	24	20
New/Returning Client	*16*	*21*	*17*
Changed Program (same level of service)	*0*	*1*	*2*
Dropped Down in Level of Services	*3*	*2*	*0*
Increased Level of Services	*3*	*0*	*1*
Episodes Closed:			
Total Episodes Closed	24	22	23
Graduated / Exited Services	*21*	*21*	*19*
Decreased Level of Services	*1*	*0*	*1*
Increased Level of Services	*1*	*1*	*2*

Participants	FY 2017-18	FY 2018-19	FY 2019-20
Changed Program (same level of service)	*1*	*0*	*1*

Community Transition and Support Team

Due to staffing shortages, clients eligible for this project have been served through the Adult Wellness program and their demographics are included with that program.

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 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$800,000	$850,000	$1,000,000
Total Expenditures	$525,575	$446,978	$1,026,906[7]
Requests for Services	1,337	1,322	1,593
Cost per Request	$393	$338	$645
Call Intakes (inquiries other than a Request for Service)	881	956	777

Although costs significantly increased in FY 2019-20 for this project, those costs reflect the addition of the Student Outreach and Engagement Centers and Mental Health Supports project, and for the first time in many years, full staffing on the Access Team. Coupled with the increase in the number of request for service, the cost of this project is on target with the anticipated expenditures.

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

Request for Services Source	Total
General (self-refer, doctor, hospital)	1,365
Child Welfare Services Referrals	126
Telecare Corp. (PHF) Referrals	53
Foster Care Presumptive Transfer Referrals	49
Total	1,593

[7] Includes costs for the Student Outreach and Engagement Centers and Mental Health Supports, which is also reported separately below.

Age Group	FY 2017-18	FY 2018-19	FY 2019-20
0-15 (children/youth)	329	315	423
16-25 (transitional age youth)	244	240	329
26-59 (adult)	707	691	739
Ages 60+ (older adults)	57	72	100
Unknown or declined to state	-	-	2

Gender	FY 2017-18	FY 2018-19	FY 2019-20
Female	706	680	810
Male	631	635	783
Transgender	-	3	-

Region of Residence	FY 2017-18	FY 2018-19	FY 2019-20
West County	215	208	247
Placerville Area	450	413	447
North County	57	63	76
Mid County	134	122	130
South County	42	33	46
Tahoe Basin	332	378	554
Out of County	73	56	73
Unknown or declined to state	34	45	20

Race	FY 2017-18	FY 2018-19	FY 2019-20
American Indian or Alaska Native	25	29	25
Asian	9	26	25
Black or African American	32	20	24
Caucasian or White	888	837	930
Native Hawaiian or Other Pacific Islander	1	1	9
Other Race	99	112	121
Unknown or declined to state	283	293	459

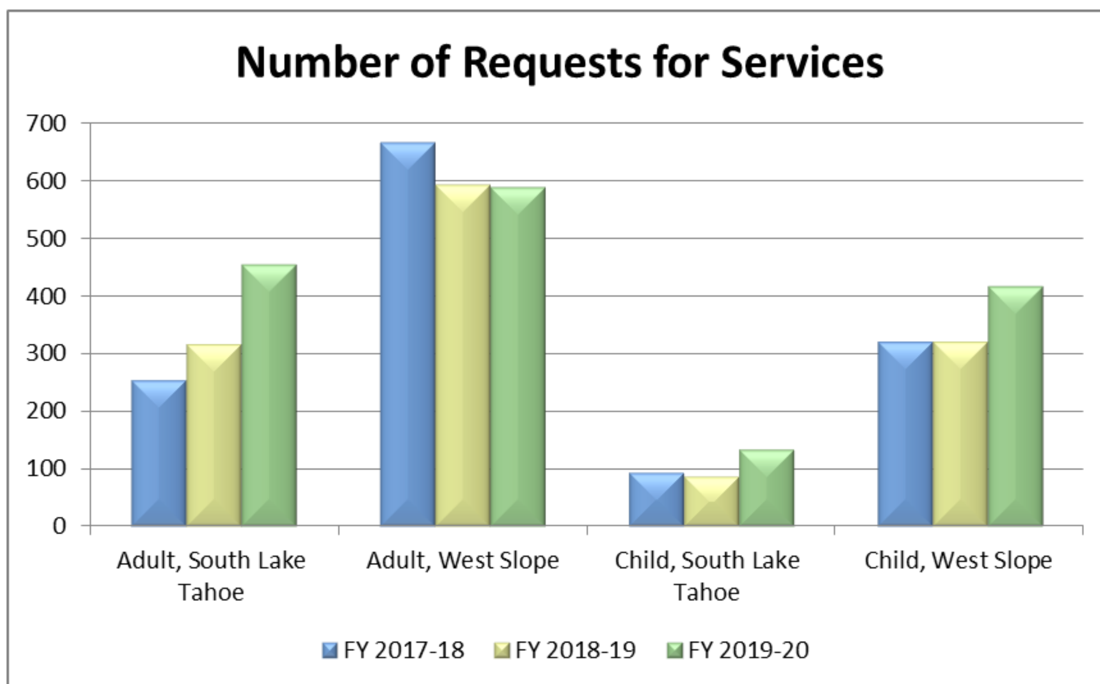
Ethnicity	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	67	68	87
Other Hispanic / Latino	62	82	80
Not Hispanic	805	742	816
Unknown or declined to state	403	426	610

Primary Language	FY 2017-18	FY 2018-19	FY 2019-20
English	1,184	1,211	1,438
Spanish	16	16	16
Other Language	12	3	14
Unknown or declined to state	125	88	125

Outcome Measures

- Measurement 1: Number of and resulting determination for requests for services
- Measurement 2: Length of time from request for service to determination of eligibility for Specialty Mental Health Services

Measurement 1 (Number of and resulting determination for requests for services)

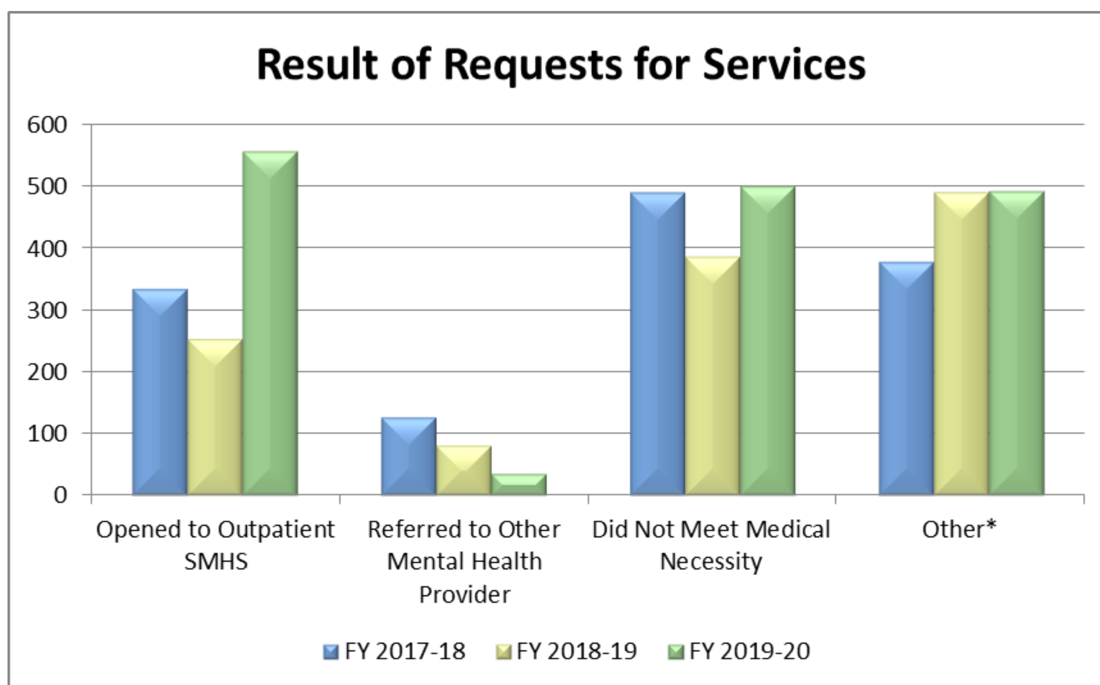


Reviewing the monthly data, there was an increase in the number of referrals for the first part of FY 2019-20, up to March 2020. In March 2020, safety precautions were implemented across the State that resulted in individuals staying home, not seeking elective medical services, and practicing social distancing. March 2020 also corresponds with a significant drop in requests for SMHS, continuing into April, and a slow increase starting in May and June.

Age Group and Location	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019
Adult, South Lake Tahoe	38	34	36	42	32	45
Adult, West Slope	59	55	45	51	49	50
Child, South Lake Tahoe	6	5	19	10	11	13
Child, West Slope	22	28	49	43	26	35
Overall	125	122	149	146	118	143

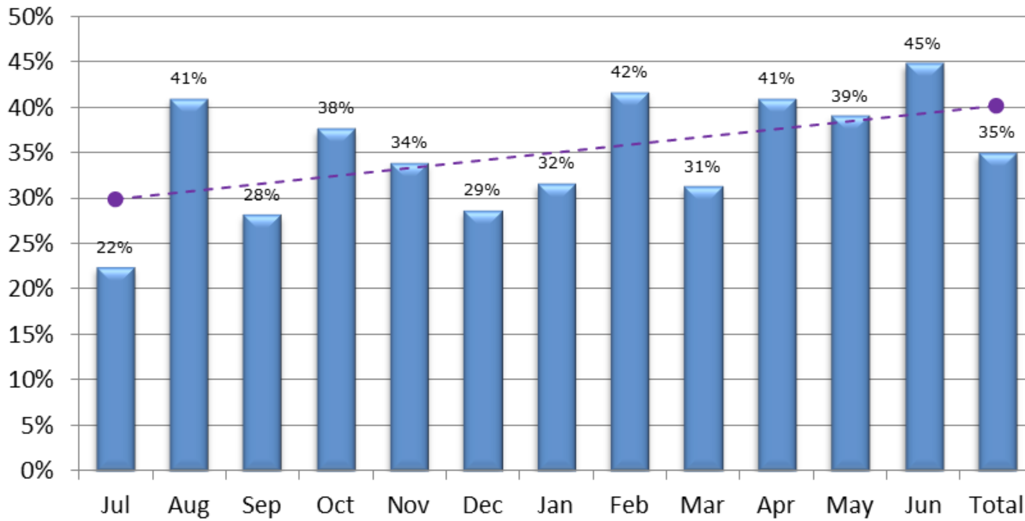
Age Group and Location	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	Total FY 2019-20
Adult, South Lake Tahoe	44	37	27	32	45	42	454
Adult, West Slope	45	55	44	42	44	50	589
Child, South Lake Tahoe	13	14	12	7	10	14	134
Child, West Slope	53	50	32	19	29	30	416
Overall	155	156	115	100	128	136	1,593

The outcomes of the requests for services are:



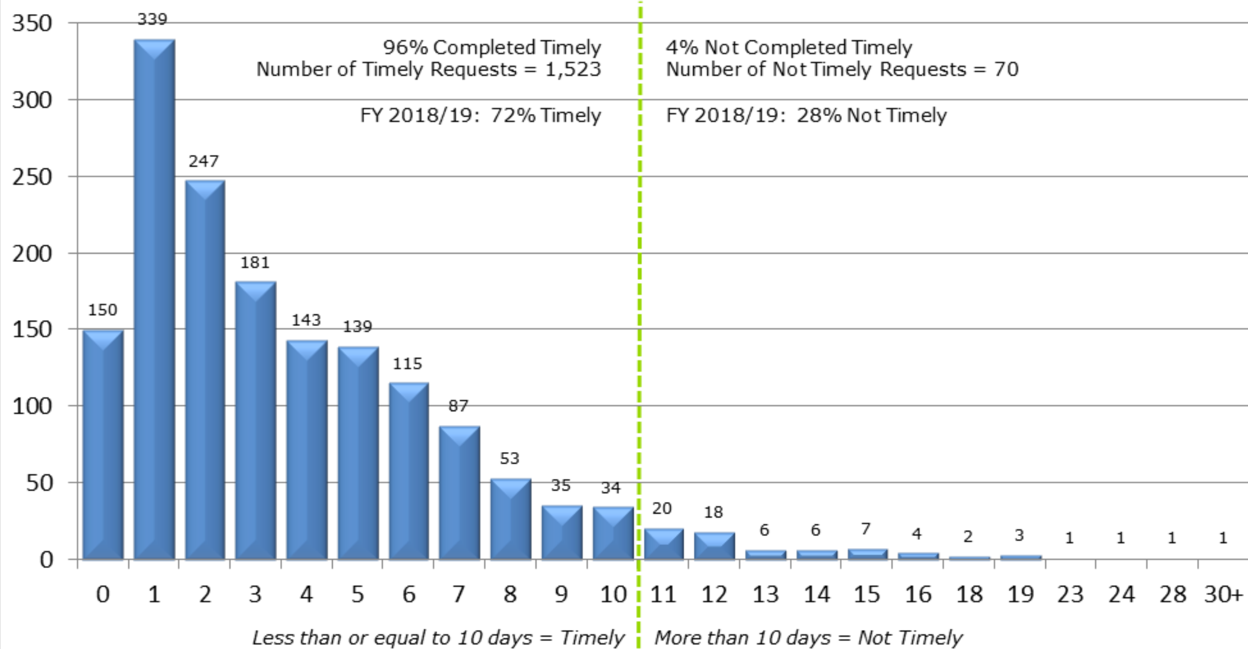
* "Other" includes the following: Referred back to court; mutual agreement to not proceed; request for service was cancelled; the beneficiary could not be contacted; referred directly to crisis services; and the beneficiary did not show up for the appointment.

The number of individuals who did not meet medical necessity for SMHS continues to be higher than Mental Health would like it to be, but for the first time in the period covered by the FY 2017-18-FY 2019-20 MHSA Three-Year Plan, the number of individuals opened to SMHS exceeds the number of individuals who did not meet medical necessity. This is positive sign and these numbers will continue to be monitored. It is believed that factors contributing to this increase include, but are not limited to, a change to the intake process in which appointments for the intake screening is made when the individual calls to request services; standardization of the intake screening process and ongoing training related to the process; higher acuity clients; and mental health impact to the public due to the ongoing public health emergency.



Measurement 2 (Length of time from request for service to determination of eligibility for Specialty Mental Health Services)

The timeliness to assessment identifies how quickly individuals requesting services are assessed for eligibility for Specialty Mental Health Services. State standard is for timeliness is that Medi-Cal beneficiaries must be offered an appointment within 10 business days of their request for service. In FY 2019-20, Mental Health was not able to track the time between the initial request for an appointment and the date an appointment was offered, so instead the number of days between the initial request for service and the date a determination of eligibility for SMHS was used to establish timeliness.



The significant increase in timeliness in FY 2019-20, as compared to FY 2018-19, is primarily due to a change in process. During FY 2016-17, FY 2017-18 and FY 2018-19, Mental Health experienced a low level of staffing on the Outreach and Engagement (Access Team) despite several recruitments for qualified Mental Health Clinicians. This resulted in higher than anticipated wait times when requesting services, along with a high number of individuals who could not be contacted.

Therefore, a change in process for responding to requests for services was implemented in mid-April 2019, resulting in significantly higher timeliness rates. Under the new process, when a beneficiary requests services, they are scheduled with a specific Clinician at a date and time agreed upon by the beneficiary. This new process has continued to be highly successful and will be continued.

Request Type and Location	FY 2017-18		FY 2018-19	
	10 Business Days or Less	11+ Business Days	10 Business Days or Less	11+ Business Days
Adult, South Lake Tahoe	50%	50%	73%	27%
Adult, West Slope	57%	43%	69%	31%
Child, South Lake Tahoe	36%	64%	68%	32%
Child, West Slope	52%	48%	77%	23%
Overall	**52%**	**48%**	**72%**	**28%**

Request Type and Location	FY 2019-20 10 Business Days or Less	FY 2019-20 11+ Business Days
Adult, South Lake Tahoe	95%	5%
Adult, West Slope	98%	2%
Child, South Lake Tahoe	90%	10%
Child, West Slope	94%	6%
Overall	**96%**	**4%**

Requests for Services for children in South Lake Tahoe have historically been lower than other request types/locations and Mental Health will continue to monitor the effectiveness of the Access program for that group, and adjust procedures as may be indicated.

Student Outreach and Engagement Centers and Mental Health Supports (Student Wellness Centers)

Provider: Sierra Child and Family Services

Project Goals

- Provide a dedicated Student Outreach and Engagement Center at each high school. The Center shall be accessible, inviting, and supportive to students seeking mental health education, mental health services, and linkage to community services and outreach.
- Provide individual assessments and counseling services.
- Provide outreach and linkage to community resources.
- Provide customized trainings with input from high school staff, faculty, students, and parents.

Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	Not Applicable	Not Applicable	$218,000
Total Expenditures	Not Applicable	Not Applicable	$176,302
Unduplicated Individuals Served	Not Applicable	Not Applicable	523
Cost per Participant	Not Applicable		$337

Sierra Child and Family Services reported the following information in its FY 2019-20 Year-End Report:

1. **The number of duplicated and unduplicated student contacts.**

   The Student Wellness Centers provided services for 523 unduplicated students. There were a total of 1,398 total contacts relating to these 523 students, 457 of which were collateral contacts with parents or other individuals pertinent to the students' needs.

2. **The number of student mental health assessments performed.**

   Every student entering the Wellness Center program receives a brief assessment of mental health needs, so 523 students received an assessment. Of those, 236 successfully navigated to services or formally closed. Navigations were to community providers, school-based providers, or parent-lead initiation of services in the community.

3. **The number of training/education opportunities provided in person, writing or other means; along with the target population, number of attendees, and training/education topic.**

   Total number of groups: 20
   Total number of attendees for outreach/training: 241
   Total number of website hits: 900*

   *Out of 900 hits, 555 were unique hits. Unique hits are defined as new visitors that are seeing the website for the first time.

   In addition the district published numerous updates regarding the Wellness Center programs, topics, and brief informational materials. The district social media platforms have an audience of approximately 12,000 people. We do not have an accurate count of how many people/opportunities were provided through this medium, but this is an area of development for next year.

   Training opportunities were provided in person, in writing, and by Zoom/Telehealth. Target populations were students, parents, faculty, and other support staff.

Training/Group Topics	
Introduction to the Wellness Center	Making assumptions about people
Coping with the CBT triangle	Coping with finals
Making positive social connections at school	Grief support due to a recent tragedy
Stress relief	Lettuce talk
Reducing stress	Enhancing friendships
Importance of routine	Reducing anxiety
Positive social connections and relaxation strategies	Social connection during pandemic/decreasing feelings of isolation
Setting a routine	Battling boredom
Anxiety	Positive communication
Healthy relationships	Summer fun/safety
Screen time	Remaining social during a pandemic
Staying healthy overall	

4. **The number of students linked to community services; the names of the community organizations to which students were referred; and the general reason for referral.**

   There were 121 students linked to services. 71 students were linked to an outside provider, while 43 students were linked to a school-based provider. There were 7 parent-led linkages following contact with Wellness Center staff*. A total of 115 students received brief services from Wellness Center staff, enabling them to emotionally stabilize and those cases were resolved/closed.

   *Parent-led Navigation: When this is noted on an assessment, it indicates the family was notified by the Wellness Center of a student mental health concern. After hearing the concern, the family followed up and scheduled an appointment with an already established or known provider. The name of the provider was not always disclosed to the Wellness Center.

Community Provides Utilized by the Wellness Center	
New Morning Youth and Family Services	James Larson, LMFT
El Dorado County Behavioral Health	El Dorado County Community Health Centers
El Dorado County Child Protective Services	Summitview Child and Family Services
Kaiser	Lori Larson, MFT
Patty Billingham, LMFT	Teri Gelgood, LMFT
Terry Weyl, PhD	Shingle Springs Health and Wellness
Arturo Rangle, LMFT	Jayann Askin, LMFT
Jennifer Alexander, LMFT, PhD	Anxiety Treatment Center
Noelani Rodrigues, PhD	Sarah Schumacher, LMFT
Marshall Emergency Room	Debbie Walsh, LMFT
Toby Landis, PsyD	It Takes the Village
El Dorado Community Hub/Public Health Nurse	Nora Mays, Substance Use Disorder Services Counselor/El Dorado County
Building Foundations Counseling Center	Various Primary Care providers

The Wellness Center software captures the reason for referral for each student.

Reasons for Referrals	
Depression	Anxiety
Panic attacks	Sleep problems
Social skills development	School attendance
School behavior	School achievement
Eating disorder	Family dynamic
Living situation	Trauma
Suicidal ideation	Self-harm
Runaway	Aggression
Emotional regulation	Mood tolerance
Mood management	Grief
Bullying	Sexual health
Substance abuse	Lack of motivation
Frustration tolerance	Family health struggles
Personal health struggles/traumatic injury	Living necessities
Housing	Stealing
Negative self-talk	ADHD management
Life transitions	Gender identity
Cultural issues	Concerns for peer

5. **Implementation challenges, successes, lessons learned, and relevant examples.**

There were two (2) large obstacles to overcome in year one of the Wellness Center project, and those obstacles contributed to many of the specific challenges listed below.

The first obstacle was the late start of services. Due to contract delays, the Wellness Centers were unable to formally open until October 2019. This late start prevented Wellness staff from

beginning any formal implementation of processes during the down time in July and August, as well as developing systems and relationships with staff.

The second obstacle was the school closures in response to the statewide guidelines for mitigation of COVID-19 in March 2020. While referrals and services continued in the Wellness Centers, this created a barrier for many students that we may never be able to quantify.

In short, during year one of implementation, the Wellness Centers were only able to fully operate on campus for five (5) months, and during that time, there were four (4) weeks of school vacations for the Thanksgiving and Christmas holidays.

Implementation Challenges:

- Establishing effective communication procedures between school personnel and Wellness Center staff.
- Wellness Center staff do not have access to Aeries. This makes obtaining demographic information and class schedules challenging. This became more challenging during school closures and breaks.
- Established scheduled Wellness Center Team meetings.
- Introducing Wellness role and protocol to school personnel.
- Developing procedures/steps for student drop-in times.
- Creating a system to document all types of services provided by Wellness Centers.
- Developing an appropriate space/environment to provide confidential support to students.
- Staffing Wellness Center to meet needs of new referrals.
- Balancing the time demands between individual referrals, groups, and training with only having one day a week at each site.
- The amount of support needed until navigation per student varies.
- Developing electronic record keeping system.
- Establishing guidelines to minimize user error on spreadsheets and documentation.
- Connecting with students without interfering with classroom demands.
- Possible need for defining level of need consistently between Wellness Center staff and school personnel, i.e., Level 1, 2, or 3.
- Developing a list of resources.
- Streamlining navigation procedure amongst Wellness Center Staff.
- School utilizing Wellness Center space for other school purposes, i.e., IEPs, meetings, classes.
- Dispersing communication to parents and students quickly during the school closure period.
- Establishing rapport remotely via phone or Zoom during school closures with new referrals.
- Supporting students with academic-related stressors during school closures.
- Developing brand-new Wellness Center website.
- Immersing Wellness Center into school culture.
- Developing protocols for student crisis intervention.
- Developing protocols for response to tragedy (i.e., student death, suicides, staff death, pandemic, school closures due to fire risk/power outages, community tragedies).
- Training support staff of Wellness Center protocols.

- Affordability of mental health care is a barrier that is difficult and unavoidable.

Successes:

- Developed 5 working/running Wellness Centers on each school campus.
- 1,398 duplicated/unduplicated services provided.
- 71 students navigated/linked to community providers.
- 43 students navigated/linked to school resources.
- Defined role of Wellness Center on campus to school personnel and students.
- Established positive communication between Wellness Center staff and school personnel.
- Identified point of contact/support person at each school (not including liaison).
- Developed an electronic record keeping system and established guidelines/expectations for the system. Developed system to capture support offered by Wellness Center.
- Developed procedure for new referrals, navigation, and follow-up.
- Identified appropriate response times for new referrals (up to 2-3 weeks, unless identified as a crisis/high risk).
- Developed positive rapport with referral/community partners.
- Established crisis response protocol for safety concerns of student.
- Established response protocol to tragedies (on campus and during school closure) with support from school personnel.
- Developed resources and training to send out via email during school closure.
- Continued to offer group and social connection via Zoom during school closures.
- During school closures, set up weekly Wellness Center staff meetings.
- Created Wellness Center website with continuous updates and addition of new resources/content. This allowed the Wellness Center staff to easily add education al content, send out Wellness updates and offer resource to parents/students.
- Utilized website to easily add educational content, send out Wellness Center updates/newsletter and offer resources to parents/students.
- Crisis resources are on website for easy access to information.
- Continued support during school breaks (spring, winter, and summer).
- Utilized 8th grade orientation event to introduce Wellness Center to incoming students.
- Developed and offered parent and student surveys during school closure to assess need of support.
- Utilized school run social media pages to send out information from Wellness Center.
- Increased number of students linked to community providers during second semester.
- Continued to navigate families during pandemic.
- Adjusted protocols/systems in order to fun efficiently during school closures.
- Started to involve Wellness Centers into school culture.
- Overcame multiple barriers to establish successful navigation linkage.
- Accurately and effectively kept documentation of all Wellness Center services.
- Identified limits of staffing and established system to maximize efficiency of Wellness Center.
- Develop positive rapport with students and families in the district.

Lessons learned:

- Regular (at least 1x) month meetings with the school administration and counselors and Wellness Center team is ideal.
- Too many people accessing the spreadsheet is contributing to user error.
- Developing at least two private meeting spaces for students within the Wellness Center is required to provide confidential support to students.
- Students were not very responsive to Wellness Center groups offered during the closure period over Zoom; individual support was preferred.
- Updating and maintaining the Wellness Center website by one team member is essential to keeping information and resources accessible and relevant to parents and students.
- The Wellness Center team will request more information on distance learning classroom procedures for the upcoming school year.
- A "Wellness Center Handbook" is being written to ensure consistency across the team members while working at various schools on any given day. This will also help in training new team members.
- An electronic record keeping system training tool has been developed to teach new staff how to properly document for the Wellness Center.
- Having more time at each school site would be helpful to address student needs in a timely/efficient/helpful manner.
- The Wellness Center is widely used by students, families, and school staff if rapport is built and the environment is comfortable.
- There is a limited amount of available resources in the community to meet the variety of student/family needs.
- Affordability of mental health care is a barrier that is difficult and unavoidable for some families.
- Accessibility (transportation) is a barrier to long-term mental health care that is difficult and unavoidable for some students and families.
- Students respond positively to mental support on campus. Consistent mental health access on campus for all school populations is needed and will be used if available.

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.

The demographic details below reflect only those individuals who are entered into Mental Health's Electronic Health Record (EHR) (Avatar) on the Mental Health side of the software. The medical record for many of the individuals served through this program is stored in the Substance Use Disorder Services side of the EHR, which cannot be accessed by the MHSA Project Team.

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$260,000	$325,000	$325,000
Total Expenditures	$173,683	$178,370	$175,652
Unduplicated Individuals Served	42	21	9
Cost per Participant	$4,135	$8,494	Not Calculated

Because the unduplicated Individuals Served do not reflect all clients served by the project, the cost per client is not calculated. The data issue has been resolved in FY 2020-21 and will be accurately reported with next year's outcomes.

Age Group	FY 2017-18	FY 2018-19	FY 2019-20
0-15 (children/youth)	0	0	0
16-25 (transitional age youth)	10	2	0
26-59 (adult)	31	18	8
Ages 60+ (older adults)	1	1	1
Unknown or declined to state	0	0	0

Gender	FY 2017-18	FY 2018-19	FY 2019-20
Female	14	4	2
Male	28	17	7

Region of Residence	FY 2017-18	FY 2018-19	FY 2019-20
West County	6	3	1
Placerville Area	22	12	4
North County	7	5	1
Mid County	4	0	1
South County	0	0	0
Tahoe Basin	0	0	0
Unknown or declined to state / Out of County	3	0	2

Race	FY 2017-18	FY 2018-19	FY 2019-20
American Indian or Alaska Native	2	0	1
Asian	39	1	0
Black or African American	0	0	0
Caucasian or White	0	19	6
Native Hawaiian or Other Pacific Islander	0	0	0
Other Race	1	1	1
Unknown or declined to state	0	0	1

Ethnicity	FY 2017-18	FY 2018-19	FY 2019-20
Hispanic or Latino	3	2	1
Other Hispanic / Latino	1	0	0
Not Hispanic	34	18	8
Unknown or declined to state	4	1	0

Primary Language	FY 2017-18	FY 2018-19	FY 2019-20
English	40	21	9
Spanish	0	0	0
Other Language	1	0	0
Unknown or declined to state	1	0	0

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.

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)

The majority of the data for clients participating in this project was being tracked through the Substance Use Disorder Services (SUDS) program and the data is therefore not available to the MHSA Project Team. This issue has been resolved in FY 20/21 and the data will be available to be reported next year.

Genetic Testing

Provider: Assurex Health

Project Goals

- To assist with the determination of appropriate medication(s) for clients.

Numbers Served and Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	Not Applicable	Not Applicable	$100,000
Total Expenditures	Not Applicable	Not Applicable	$0
Requests for Services	Not Applicable	Not Applicable	0

Outcome Measures

- Measurement 1: The number of clients who receive genetic testing.

Potential vendors were researched in late FY 2018-19 in anticipation of the approval of the FY 2019-20 Annual Update. The contract request for genetic testing using Assurex Health's "GeneSight®" product was submitted in June 2019, and the contract became effective on August 25, 2020. Therefore, there were no genetic tests ordered through the County in FY 2019-20 because the contract was not yet in place.

Numbers Served and Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	--	--	$100,000
Total Expenditures	--	--	$0
Number of Clients Tested	--	--	0

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 property manager maintains any wait 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. The funds were depleted in FY 2017-18. Housing supports for clients in the FSP and GSD programs is included in the costs for those programs.

Numbers Served and Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$183	$0	$0
Total Expenditures	$183	$0	$0
Number of Clients Served	1	$0	$0
Average Cost per Participant	$183	$0	$0

Innovation Projects

Introduction

Innovation Projects are defined as projects that contribute to learning, rather than a primary focus on providing a service. By providing the opportunity to "try out" new approaches that can inform current and future practices/approaches in communities, an Innovation project contributes to learning. Innovation plans must be approved ty the Mental Health Services Oversight and Accountability Commission (MHSOAC) prior to the expenditure of funds in this component.

This Outcome Measures Report accompanying the Fiscal Year 2021/22 MHSA Annual Update provides outcome information for the Innovation projects in the Fiscal Year 2019/20 MHSA Annual Update.

Pursuant to Title 9 California Code of Regulations Section 3580.010, the Annual Innovation Report shall include: The name of the Innovative Project; whether and what changes were made to the Innovative Project during the reporting period and the reasons for the changes; available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to the outcomes; program information collected during the reporting period, including applicable Innovation Projects that serve individuals, number of participants served by age categories, race, ethnicity, primary language, sexual orientation, disability, veteran status, gender, and any other data the County considers relevant. For Innovation Projects that serve children or youth younger than 18 years of age, the demographic information shall be collected only to the extent permissible by Article 5 of Chapter 6.5 of Part 27 of Portability and Accountability Act of 1996 (HIPPA), California Information Practices Act, and other applicable state and federal privacy laws. Further, sexual orientation, current gender identity, and veteran status is not required to be collected for a minor younger than 12 years of age.

During this reporting period, the County had one (2) active Innovation Projects: Community-based Engagement and Support Services Project and Restoration of Competency in an Outpatient Setting Project. The Restoration of Competency in an Outpatient Setting ended on April 3, 2019 and a copy of the final Innovation Report is included in this Outcome Report.

MHSA Year-End Progress Report

Community-based Engagement and Support Services Project (aka "Community Hubs")

Please report on the following Outcome Measures/Learning Objectives:

1) Does providing services at the library reduce stigma?

Promotion of health services, health education on resilience and mental health awareness by health staff within the library setting during programming is a primary prevention strategy to reduce stigma regarding mental health. Each participating library within the Hub program has had capacity to offer private meeting space for clients and health staff which can be used as an alternative to a visit to the client's home. However, some library locations are more frequently used than others. Anecdotal reports from public health staff imply that clients are amenable to setting meetings to access health team services in the Library setting. Early on in the implementation of the Community Hubs program there were incidences where clients did not engage with staff when other patrons that they know were present. As the Community Hub program developed access points such as schools and Boys and Girls Club, these locations have become additional options beyond the home and library settings.

Libraries are also incorporating mental health topics into their routine programming in partnership with the Hub Health team. This increases awareness within the community, as well as introduces prevention strategies and resources for mental health treatment. The community has been receptive and engagement is building. Clients have connected with health staff at the library for assistance connecting to mental health providers as a result of the reduced stigma.

Community Hub services are offered in access points beyond the library. Home visiting allows health staff to connect with clients in the comfort of their own home. Partnerships throughout the community have expanded access points to include schools, Boys and Girls Club, churches, transitional housing, and apartments. With the expanded access points, awareness throughout the community is increased and, ultimately, stigma is reduced.

2) Does increasing access to prevention and early intervention reduce long-term mental health costs?

In theory, increasing access to prevention and early intervention reduces long-term mental health costs. "Studies around the country prove over and over again that we are able to prevent or mitigate the effects of mental illness and allow individuals to live fulfilling, productive lives in the community. From the influence of genetics and prenatal health all the way into early adulthood, we are learning more about the critical points in brain development and life experiences that increase the risk for or provide protection against the development of mental health disorders." https://www.mhanational.org/issues/prevention-and-early-intervention-mental-health

3) **Does improving coordination and integration of physical and behavioral health services increase the number of clients accessing mental health services?**

   Coordination and integration of physical and behavioral health services has increased access to mental health services as well as individualized education during the course of Public Health Nurse (PHN) case management. 267 referrals for behavioral health services were initiated by public health staff during FY 19/20, with the most common resource connection being early intervention focused counseling services for clients.

4) **Does case management by a Public Health Nurse increase client screening and treatment for mental health services?**

   Hub Public Health Nurses (PHN) screen adults for behavioral health concerns, including postpartum depression, ACEs, and child development during the course of case management with postpartum women and families with children 0-18 as applicable. Additionally, clients and families are assisted with connection to providers of behavioral health treatment by the PHNs. Clients may not be comfortable addressing their mental health concerns with their Primary Care Providers. PHNs can reduce this barrier by educating clients to help reduce the stigma and by advocating on the patient's behalf. PHNs are also skilled in coordinating care between providers, which may include a Primary Care Provider, Mental Health provider and the client.

5) **Does a trauma-informed approach assist in reaching the hardest to serve mental health clients?**

   Using a trauma-informed approach, Public Health Nurses (PHNs) develop trusting relationships with clients through the course of case management. Clients are often open to sharing their risk-factors, signs and symptoms, stressors and other concerns with PHNs as a result. More importantly, clients allow PHNs into their personal space - their home, and PHNs are able to truly assess all factors (environment, relationships, resources, etc.) to get a complete picture of what the client may need. PHNs are then able to connect clients with prevention and early intervention measures such as the Mothers and Babies program, mom groups, counseling, self-care and healthy coping skills or a treatment plan that meets the clients needs. Other prevention strategies utilized include reducing stressors through connections to community resources, education and role modeling behaviors to build protective factors and skills, and increase support.

6) **Can Community Hubs be sustained thorugh local planning and leveraging of resources?**

   Community Hub partners began seeking opportunities and community support for fiscal sustainability of the Community Hubs program as a model for service delivery during the 2019-20 fiscal year. The Community Hubs are currently funded with a blend of sources through June 2021.

Please report on the following Learning Plan/Evaluation Objectives:

1) **Indicate the target participants and the name and brief description of any specific measures/performance indicators/or interview tools.**

   The target populations for this project is isolated pregnant women and families, including children birth through 18 years of age, within each supervisorial district who will be identified using data collected and

reported by El Dorado County Health and Human Services Agency's Maternal, Child and Adolescent Health Program. Consistent with the Maternal, Child and Adolescent Health Plan, the following indicators will be measured:

- Increased rate of early prenatal care entry in females by June 30, 2021, as measured by Vital Statistics data.
- Decreased rate of domestic violence calls by June 30, 2021, as measured by domestic violence-related calls for assistance data.
- Decreased rate of substance abuse hospitalizations in pregnant women by June 30, 2021, as measured by hospital discharge data.
- Decreased rate of mood disorder hospitalizations in pregnant women by June 30, 2021, as measured by hospital discharge data.
- Increased mental health and alcohol and drug screening and referrals for direct service.

2) Indicate the client level data measures (number of clients served, type and amount of screenings performed, specialty health referrals made and to whom, as well as number of clients who accessed these services).

Client level data is collected by Community Health Advocates (CHA) and Public Health Nurses (PHN). The number of clients served, type and amount of screenings performed, specialty health referrals made and to whom as well as the number of clients who accessed these services are listed in Tables 1-3 below.

CLIENT LEVEL DATA MEASURES (JULY 1, 2019 – JUNE 30, 2020)

Table 1. Referrals Received and Client Contacts

(Note: PHN is Public Health Nurse and CHA is Community Health Advocate)

Data Measure	Hub 1	Hub 2	Hub 3	Hub 4	Hub 5	Overall
Hub PHN Referrals received and assigned	N/A	N/A	N/A	N/A	N/A	**243*1**
CHA Linkage requests	**35**	**43**	**45**	**153**	**178**	**454*2**
Home Visits or Significant Contact with PHN or CHA	**147**	**211**	**487**	**673**	**493**	**2,011*2**

Table 2. Community Health Advocate Linkage requests by type and source

CHA Linkage request by type:	
Dental	**129**
Medical	**115**
Insurance	**156**
Community Resources	**330**

Table 3. Referrals Made by Health Staff per Hub and Total

Referrals from PHN staff to:	Hub 1*2	Hub 2*2	Hub 3*2	Hub 4*2	Hub 5*2	Overall*2
Mental Health Services	**29**	**19**	**89**	**89**	**41**	**267**

Services Received[*3,4]	12	8	47	46	8	121
Primary Care Physician	**23**	**16**	**90**	**80**	**55**	**264**
Services Received[*3,4]	13	11	37	60	17	138
Dental Provider	**19**	**19**	**115**	**102**	**106**	**361**
Services Received[*3,4]	3	9	86	72	13	183
Insurance Coverage	**26**	**42**	**134**	**207**	**134**	**543**
Services Received[*3,4]	11	16	80	157	51	315
Developmental Services	**6**	**12**	**37**	**4**	**11**	**70**
Services Received[*3,4]	2	5	21	1	2	31
Other PHN programs	**2**	**3**	**9**	**4**	**15**	**33**
Services Received[*3,4]	0	1	3	4	4	12
Other Community-Based Resources	**75**	**154**	**381**	**280**	**478**	**1368**
Services Received[*3,4]	39	81	230	256	297	903

Explanation of Data Limitations:

1. FY 19-20 data on PHN referrals is not Hub specific due to Hub PHNs covering multiple Hub areas.
2. Data measures may be underrepresented due to non-Hub PHNs providing coverage to the Hub program due to vacancies and using different data tracking logs without detailed referral information. Human error is a factor in capturing data through current methods available. Ongoing staff training, resolution of IT concerns and quality assurance continue to refine data capture.
3. Results of some referrals not captured in FY 19-20 data due to case status beginning late in fiscal year (i.e. during 4th quarter) or lost to follow-up.
4. "Services Received" means that client completed an appointment with a provider or had an appointment scheduled at the time of discontinued follow-up. There has been an underreporting of results in the current data collection methods.

3) **Indicate the program level data measures (e.g., assessing an adult's resilience by measuring isolation, education, developmental understanding, and support; process meausres reporting on the impact of services on wellness for children and their parents/guardians, family resilience, and access and barriers to service).**

First 5 family surveys are used to assess the impact of strategies in program implementation. The survey includes the Family Strengthening Protective Factors Parent Survey which assesses an adult's resilience by measuring isolation, education, developmental understanding, and support. Process measures report the impact of services on wellness for children birth through five and their parents/guardians, including family resilience, access and barriers to services.

Methodology and Changes from 2018-19:

Prior to the 2019/2020 programmatic year, First 5 El Dorado utilized version 1 of the Protective Factors Survey (PSF); beginning in 2019-2020, the second iteration of the survey (PFS-2) was utilized instead. Data around four protective factors was collected via the 2019-20 PFS-2 survey. These factors are comprised of Family Functioning/Resilience, Nurturing and Attachment, Social Supports, and Concrete Supports. Note that change over time (i.e. "growth") results are available only for the first three protective factors due to changes made in the PFS-2 survey tool.

FY 19/20 data: Many participants in Community Hub services that completed the survey experienced growth in each of the protective factors. Specifically:

- 39% (98/252) of Hub Program participants experienced gains relative to Family Functioning/Resilience.
- 36% (93/258) of Hub Program participants experienced gains relative to Nurturing and Attachment.
- 39% (101/258) of Hub Program participants experienced gains relative to Social Supports.

Among families surveyed, those who participated in the Children's Health program experienced growth in each of the protective factors:

- 63% (52/82) of Children's Health participants experienced gains relative to Family Functioning/Resilience.
- 43% (36/83) of Children's Health participants experienced gains relative to Nurturing and Attachment.
- 61% (51/83) of Children's Health participants experienced gains relative to Social Supports.

4) **Indicate the community-level measures (e.g., service impact, access, and barriers to services).**

Community level reporting was planned to be in partnership with El Dorado Community Foundation to better understand local needs and inform strategy implementation. Community level measures include members from each of the collaborating agencies meeting on a monthly basis to strategize quality improvement changes if necessary, based on successes and challenges identified at the team meetings. During fiscal year 17/18, El Dorado County Health and Human Services-Public Health Nursing team members finalized Community Needs Assessments (CNAs) and Health Outreach Plans for each Community Hub, identifying barriers and opportunities in reaching underserved families, and providing health education and outreach to geographical or socially-isolated populations. The CNA was conducted county-wide but focused on discovering or validating the individualized strengths and challenges in each Hub district with a preventive health lens through completion of windshield surveys, key informant interviews, community level surveying and data analysis. The CNA work was incorporated in the 2018 Community Hub Profile Report, expanding the outreach plan to include health, family engagement and early literacy strategies. This data was the basis for creation of a Collaborative Scope of Work (SOW) for FY 18/19 among all Hub partners for First 5 El Dorado Commission Contracts. The health focus for the Collaborative SOW aimed to address the health needs and

challenges within each Hub district. First 5 El Dorado, in partnership with the MCAH Program, also convened Hub communities to better understand service impact, access and barriers to services from 0-5 participant perspectives in Fall 18/19 and again in January 2020.

Hub team meetings continue on a monthly basis to better coordinate care and services by the health team and partners. Additionally, Hub Leadership meets on a monthly basis to strategize quality improvement changes based on successes and challenges identified at team meetings and to coordinate efforts among multi-disciplinary Hub partners. The qualitative data combined with county quantitative data provides a better understanding of community need and a continuous quality improvement process as well as guiding program implementation.

Please report on the operations timeline, successes, and challenges of the project.

CSAC award video filmed with team at Placerville Library. Collaborative promotion of "Brush, Book, Bed" and healthy routines for Oral Health Month. Community Hub leadership presented update on program to MHSOAC including service-level data and anecdotal stories related to behavioral health services in El Dorado.

PHN Program Operations Timeline during FY 19/20:

- July 2019 – Bilingual CHA starts for Hub 1/west slope; PHN covering Hub referrals left HHSA employment. All Health staff training on Neurodevelopmental Trauma by Teri Gelgood, LMFT. Collaborative Hub team event at Georgetown Library. Planning Health Education sessions for residents at Progress House.
- August 2019 – Collaborative planning meetings with Family Engagement Specialists (FES) partners related to parenting education and Hub Health team building. PHNs attended training on suicide postvention. All Hub staff received training on Parent Cafe model.
- October 2019 – Public Safety Power Shutoffs increase CHA linkages for families to basic needs support. Hub PHN involvement with ACEs-focused parent support groups. Collaborative Hub team event at Placerville Library. Ongoing Health Education session at Georgetown Boys and Girls Club began.
- November 2019 – Health Education sessions provided to residents at Progress House. Collaborative Hub team event at El Dorado Hills Library.
- December 2019 – Collaborative Hub team event at South Lake Tahoe Library. Collaborative Hub team event at Cameron Park Library.
- January 2020 – ACEs Education to Primary Care staff at EDCHC. Parent focus groups completed at libraries in all Hub areas. January and February FES and CHA collaborate for parent workshop fathers and children with CPS involvement. Weekly classroom sessions to build healthy decision-making skills with 3rd and 4th grade students begin at Pioneer Elementary. MHSA grant extension challenges and meetings with NAMI and Behavioral Health Commission by leadership.
- February 2020 – ACEs Education to medical support staff at EDCHC. County for MHSA grant extension process. Collaborative Hub team event at Cameron Park Library. Collaborative Hub team event at Georgetown Library. PHNs attend training on Understanding Mental Health Disorders: Anxiety, Depression and Personality Disorders.
- March 2020 – COVID-19 social distancing requirements cancelled in-person groups and outreach. Bilingual Hub 1 CHA left HHSA employment related to family needs.
- April 2020 – Increased linkage requests for support for basic needs increases. Hub team innovation to offer virtual outreach and individual client assistance and support by phone, Zoom and virtual methods. Teen Mental Health group via Zoom in collaboration with the Placerville library with focus on mental health impact of social distancing on the teen population and providing education and resources. SOW development with First 5 contractors and partners.

- May 2020 – Promoted May is Mental Health month through social media. Continued Teen Mental Health group in collaboration with the Placerville library. COVID-19 prevention education sessions by Public Health for local service providers. Outreach to childcare provider sites and EDCOE families to support with basic needs. Supervising PHN left HHSA employment. Promoted Hub services during COVID-19 outreach with HOT team in Placerville, Cameron Park and Pioneer.
- June 2020 – Continued Teen Mental Health group in collaboration with the Placerville library. Outreach to families with school-aged children during food distribution through EDCOE continued. Hub 3 CHA left health team for promotional opportunity. Outreach to medical providers over the phone to promote Hub services, collect immunization information, and provide information on local COVID testing sites. Door-to-door Hub promotion to families with children 0-18. Diaper distributions, in each Hub, as well as other locations, provided basic needs and resulted in new Hub connections.

Operational Highlights/Successes:

- Continued increase in PHN referrals and CHA linkages despite vacancies and staffing changes. The program received a total of 243 PHN referrals and 454 CHA linkage requests for pregnant women or families with children 0-18. This is up from 232 and 433 respectively during the previous fiscal year. This goal was addressed through presentations promoting the updated PHN Referral Criteria and knowledge of Community Hubs to local health care providers and community service providers as well as continued community outreach at local events targeting families with children. Most PHN referrals still originate from local health care providers. The most common linkage requests to the CHAs were self-referrals for connection to community resources or basic needs. Hubs health team also had an increase in referrals and coordination of service between Hub PHNs and CHAs to increase comprehensive health assessment.

- Parent Workshops were co-facilitated by CHAs and FES with PHN and Library support in Hubs 3 and 4 during winter 2019. The Hub 3 team completed a five (5) session series at the Placerville Library empowering fathers to engage with their children through play and learn groups. Hub 4 offered a four (4) session workshop at the library called "Eat, Grow and Learn". Hub 5 and Hub 2 planned collaborative parent support workshops with Child Welfare Services families that were postponed due to restrictions on group gatherings related to COVID-19. Hub 1 planned to engage new moms for parent support with prevention and early intervention strategies. All Hub teams offered an opportunity for families with young children to learn about the protective factors and space to connect with other families with children of similar ages and stages.

- The CHA from Hub 2 provided health education on Mindfulness activities for children and families at Super Hub events at the library as well as at Trailside Apartments in Cameron Park. Weekly sessions on making healthy choices for coping skills and decision-making (Botvin Life Skills Training) were also completed at Pioneer Elementary school for 8 weeks with two classrooms of 3rd and 4th grade students.

- Health staff conducted outreach to health care providers to promote referrals to PHN for care coordination and increase collaboration in serving families in El Dorado County. PHN leadership had ongoing meetings between Director of Barton Pediatrics and Maternal, Child, and Adolescent Health (MCAH) Program Director to increase behavioral health and developmental screenings among the pediatric patient population and coordination of referrals to both MCAH-High Risk Infant and Community Hub Programs. ACE Study awareness presentations and promotion of referrals to Community Hubs program to primary care providers and medical assistant staff at El Dorado Community Health Center were provided.

- Primary prevention health education was provided to residents at Progress House in Camino in November and February. PHN services and support were also promoted at Progress House. The presentation content on the importance of well child visits and navigating preventive health care was prepared by nursing staff and delivered by the Hub 3 CHA. Both staff and participants at Progress House had positive feedback and requested additional health education sessions in the future.

- Health staff continued outreach inside library settings, at community events that are family friendly and maintained office hours to be available for families at the library for connection to resources and assistance with access to health care needs. This shifted to virtual outreach and limited in-person opportunities due to COVID-19 prevention measures in place.

- Continued professional development of new and existing health staff including training on Maternal Mental Health 101 through Postpartum Support International webinars and at 2020MOM Mothers and Babies Course training, Suicide Post-Vention training, Understanding Mental health Disorders, and ongoing participation in the El Dorado ACEs Collaborative to reinforce understanding of trauma-informed approach and resiliency. PHN staff also gained access to the Brookes database to promote universal developmental screening for children in El Dorado County and to streamline getting results to parents and caregivers, which can allow for prevention and early intervention for developmental and social-emotional concerns. Received commitment from Barton to use Brookes Database to record their ASQs and respond to parental concerns in a more comprehensive way.

Challenges during this FY:

- The impact of the COVID 19 pandemic and associated preventive measures interrupted Community Hub objectives and planned activities. The teams were faced with new challenges and barriers by not being able to meet face-to-face, and with business closures and interruptions to preventive health care. Connection to dental providers was directly impacted due to school closures, cancellation of the dental van, and temporary closures of dental offices.

- Community Hubs Health team objectives continued to be impacted by staffing changes. PHN openings are difficult to fill in general, similar to other positions requiring professional licensure within El Dorado County. PHN positions experienced turnover in other Public Health programs besides the Community Hubs Program. The challenge of turnover paired with the nature of the Community Hubs as an innovative project designed to develop over a 5-year time frame, breaks continuity within the program and overall team because staff members are at varying levels of development and require additional training. Some of the current health staff does not have the benefit of first-hand knowledge and experience of completing the Community Needs Assessments which inform health team goals, especially outreach to the community and health education. The Community Needs Assessment process also aided in developing professional relationships that would be necessary to serve clients and families. PHN vacancies and cross-coverage impacts capacity to meet objectives within each of the Hub districts due to their role as a health lead providing direction and guidance to CHAs as well as consultation to partners.

- Data collection and evaluation of the health team services at client level as well as overall project level has been an ongoing challenge. Manual entry and collection of data is time consuming, labor intensive and increases potential for human error. The Community Hubs program has continued to utilize pre-existing tools because staff specialized in data collection and analysis are not available to develop replacement mechanisms within an electronic health record system (Patagonia). A transition to the electronic health

record system was anticipated for Public Health-MCAH by the end of FY 18/19; however, development takes considerable time and takes away from existing public health staff responsibilities. Support from a department analyst position was requested and is anticipated to begin next fiscal year to provide the infrastructure, implement new systems and expand evaluation measures for 6-18 populations, improving staff efficiency in data capture as well as reporting capabilities.

FY 20/21 Additional Program goals:

- Further expand preventive health education by Hubs health team in socially or geographically isolated populations with topics such as: Life skills, access to health care, substance use prevention, pre-conception health, stress reduction, healthy relationships, and/or ACEs and resiliency for families with children 12 through 18 years of age.
- Maintain and reinforce relationships with local health care providers through promotion of Hubs program as well as promoting routine developmental and behavioral health screening and assessments in primary care practice settings.
- With analyst support, develop and implement new Electronic Health Record which will increase consistency of screenings and assessments and improve metric tracking capabilities, as well as expand evaluation of the Hubs to include a resiliency measurement for families with children 6-18 years of age.
- Create a sustainability plan for Community Hubs beyond FY 20/21.

Community-based Engagement and Support Services Project (aka "Community Hubs")

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$672,375	$950,000	$1,250,000
Total Expenditures	$428,353	$536,847	$550,609
Unduplicated Individuals Served[1][2]	646	1,318	1,592
MHSA Cost per Participant	$663	$407	$346
Referrals to Mental Health[3]	48	122	267
MHSA Cost per Referral	$8,924	$4,400	$2,062

(A) Age Groups	**1592**
1. 0-15 (children/youth)	743
2. 16-25 (transition age youth)	130
3. 26-59 (adult)	353
4. Ages 60+ (older adults)	77
5. Declined to answer the question	289

(B) Race	
1. American Indian or Alaska Native	3
2. Asian	15
3. Black or African American	24
4. Native Hawaiian or other Pacific Islander	2
5. White	1140
6. Other	21
7. More than one race	15
8. Declined to answer the question	372

[1] Data measures may be underrepresented due to non-Hub PHNs providing coverage to Hub program using different data tracking logs without detailed referral information.

[2] Data measures may be underrepresented due to non-Hub PHNs providing coverage to the Hub program due to vacancies and using different data tracking logs without detailed referral information. Human error is a factor in capturing data through current methods available. Ongoing staff training, resolution of IT concerns and quality assurance continue to refine data capture.

[3] Data measures may be underrepresented due to non-Hub PHNs providing coverage to the Hub program due to vacancies and using different data tracking logs without detailed referral information. Human error is a factor in capturing data through current methods available. Ongoing staff training, resolution of IT concerns and quality assurance continue to refine data capture.

(C) Ethnicity	
1. Hispanic or Latino as follows	471
a. Caribbean	N/A
b. Central American	N/A
c. Mexican/Mexican-American/Chicano	N/A
d. Puerto Rican	N/A
e. South American	N/A
f. Other	N/A
g. Declined to answer the question	N/A
2. Non-Hispanic or Non-Latino as follows	
a. African	N/A
b. Asian Indian/South Asian	N/A
c. Cambodian	N/A
d. Chinese	N/A
e. Eastern European	N/A
f. European	N/A
g. Filipino	11
h. Japanese	N/A
i. Korean	N/A
j. Middle Eastern	N/A
k. Vietnamese	N/A
l. Other	N/A
m. Declined to answer the question	N/A
3. More than one ethnicity	N/A
4. Declined to answer the question	1110

(D) Primary Language	
1. English	1123
2. Spanish	432
3. Other Non-Threshold Language	37

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

(F) Disability	
1. Yes, report the number that apply in each domain of disability(ies)	
a. Communication domain separately by each of the following	
(i) Difficulty seeing,	N/A
(ii) Difficulty hearing, or having speech understood	N/A
(iii) Other (specify)	N/A
b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	8
c. Physical/mobility domain	N/A
d. Chronic health condition (including, but not limited to, chronic pain)	47
e. Other (specify)	N/A
2. No	
3. Declined to answer the question	

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

(H) Gender	
1. Assigned sex at birth:	
a. Male	666
b. Female	926
c. Declined to answer the question	0
2. Current gender identity:	N/A
a. Male	N/A
b. Female	N/A
c. Transgender	N/A
d. Genderqueer	N/A
e. Questioning or unsure of gender identity	N/A
f. Another gender identity	N/A
g. Declined to answer the question	N/A

El Dorado County: Final Innovation Report - Restoration of Competency in an Outpatient Setting

Background: On August 25, 2016, El Dorado County presented its two-year "Restoration of Competency in an Outpatient Setting" Innovation project to the Mental Health Services Oversight and Accountability Commission (MHSOAC). El Dorado County, Health and Human Services/Behavioral Health Division officially began implementation of the project on April 4, 2017. The project ended on April 3, 2019.

Pursuant to Title 9, California Code of Regulations, Section 3580(a)(2)(A), this is the final Innovation Report

Project Objective: At the time of implementation, most Restoration of Competency programs took place in the jail setting. There were some private agencies that provided Restoration of Competency services in a community setting, but those agencies used a case management and referral to a behavioral health model. El Dorado County's innovative model focused on Restoration of Competency in within the County's Behavioral Health building, in an outpatient setting, which included access to the Behavioral Health Wellness Center. It was anticipated that this approach would provide quality care for clients, keep clients out of jail, keep clients connected to family and friends in the community, and reduce the County's cost for State beds.

The Need: In 2016, Behavioral Health recognized that El Dorado County was experiencing an increase in individuals found incompetent to stand trial. Behavioral Health also recognized that like many counties, there was a lack of inpatient beds for competency restoration. In fact, on average, individuals in El Dorado County spent 23 hours per day in jail isolation, for two to eight months until an inpatient bed became available. It was determined that there would be a quicker rate of restoration from an inpatient setting than what was anticipated in an outpatient setting, but the data did not take into account the wait time in jails prior to the admission to an inpatient restoration of competency program.

This proposed project aimed to learn if restoration of competency in an outpatient setting would help misdemeanants maintain their connection to the community and strengthen their ties to the mental health system, while reducing the overall cost of restoration of competency services. Mental health services for participating misdemeanants could include a full mental

health assessment to determine mental health and substance use disorder services; family and community supports; medication compliance; supportive housing; psychiatric services; and Wellness Center activities (including managing emotions, exercise groups, conversation skills, sober living, smoking cessation, self-care, life skills, and mindfulness skills).

It was anticipated that restoration of competency services in an outpatient setting would serve eight to ten individuals annually.

Learning Objective: The primary learning goal was to determine if program participants experienced a reduction in recidivism and continued with mental health services after restoration of competency.

Proposed Budget: The proposed budget for this two-year project included:

County Staffing Costs	Operating Costs	Admin Costs	Evaluation Costs	Total Costs
$204,693	$7,000	$501,479	$13,838	$727,010

Actual Budget: Health and Human Services Agency is working on the FY 2018/19 year-end expenditures and this report will be amended once those values are available.

Outcomes: The Outcomes and Learning Objectives measured for this project included:
1. Length of stay in jail
2. Days to restoration
3. Maintenance of Behavioral Health services during and after restoration
4. Missed appointments
5. Return to jail or inpatient unit

Data: Pursuant to Title 9, California Code of Regulations, Section 3580.010, data collected on this project includes:

1. Age by category: 0-15 (children/youth) 0	0
16-25 (transition age youth)	1
26-59 (adult)	2
Ages 60+ (older adults)	0
Number of respondents who declined to answer the question	0
2. Race by the following categories: American Indian or Alaska Native	0
Asian	0
Black of African American	0
Native Hawaiian or other Pacific Islander	0
White	2
Other	0
More than one race	1
Declined to answer the question	0

3. Ethnicity by the following categories: Hispanic or Latino as follows: • Caribbean • Central American • Mexican/Mexican-American/Chicano • Puerto Rican • South American • Other • Number of respondents who declined to answer the question	 0 0 0 0 0 0 0
Non-Hispanic or Non-Latino as follows: • African • Asian Indian/South Asian • Cambodian • Chinese • Eastern European • European • Filipino • Japanese • Korean • Middle Eastern • Vietnamese • Other	 0 0 0 0 0 0 0 0 0 0 0 0 3
Number of Respondents who declined to answer the question	0
4. Primary language used by threshold languages for the individual county	English
5. Sexual orientation (not required for minors under 12 years of age) Gay or Lesbian	0
Heterosexual or Straight	1
Bisexual	0
Questioning or unsure of sexual orientation	0
Queer	0
Another sexual orientation	0
Number of respondents who declined to answer the question	2

6. A disability, defined as physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.
 	
Yes, report the number that applies in each domain of the disability(ies)
 	
• Communication domain separately by each of the following
  o Difficulty seeing
  o Difficulty hearing, or having speech understood
  o Other (Specify)
	0

• Mental domain no including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	3

• Physical/mobility domain o Chronic health condition (including but not limited to chronic pain)	0
• No	0
• Number of respondents who declined to answer the question	0
7. Veteran status (not required for minors under 12 years of age) Yes	0
No	1
Number of respondents who declined to answer the question	2
8. Gender Assigned at birth • Male • Female • Number of respondents who declined to answer the question	 2 1 0
Current Gender Identity (not required for minors under 12 years of age) • Male • Female • Transgender • Genderqueer • Questioning or unsure of gender identity • Another gender identity • Number of respondents who declined to answer the question	 2 1 0 0 0 0 0
9. Any other data that the County considers relevant.	

Changes made to the Innovative Project during the reporting period: None

Recommendation: The demand for this program was lower than anticipated. Only three participants were identified by the justice system (Court, Public Defender, District Attorney). One participant was not in jail at the time participation in the Restoration of Competency Innovation program was ordered. Mental Health could not independently identify other appropriate participants.

During the period of time covered by this Innovation program, there were seven in-jail participants ordered to be restored to competency while remaining incarcerated.

Outcomes Results:

1. Length of stay in jail - No participants returned to jail during their involvement in the Restoration of Competency program.
2. Days to restoration - Average of 28 days for two participants. A third participant was not restored to competency on an outpatient basis.
3. Maintenance of Behavioral Health services during and after restoration - Two participants engaged in Specialty Mental Health Services and one focused solely on

Restoration of Competency. After restoration, one participant remained engaged with Behavioral Health.

4. Missed appointments - 10% of the appointments were missed. 14% of the appointments were cancelled by the participant. 76% of the appointments were attended.
5. Return to jail or inpatient unit - One individual was placed in an inpatient unit for completion of restoration of competency. Post restoration, one participation was placed in an inpatient unit as a result of mental illness.

El Dorado County MHSA learned after the program ended that many of the justice system partners who worked day-to-day with the legal proceedings were not aware of the program. Therefore an important lesson learned from this program is that direct communication with all levels of an organization (not just with specific individuals and/or leaders) is of utmost importance to ensure that staff performing the duties are made aware of the options available.

Based on the low referrals, El Dorado County MHSA terminated this project at its original termination date, and no new outpatient restoration of competency program was established under a different component of MHSA. In the event that individuals are deemed by the Court to be appropriate for outpatient restoration of competency, those clients will be served through an outpatient Community Services and Supports (CSS) Program at a level that meets the clinical needs of the clients.

Workforce Education and Training (WET) Projects

Introduction

The Workforce Education and Training (WET) component includes education and training projects and activities for prospective and current public mental health system employees, contractors, and volunteers.

WET Coordinator Project

Project 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.

Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$30,000	$30,000	$30,000
Total Expenditures	$14,360	$11,272	$15,699

Outcome Measures

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

  Information about upcoming trainings applicable to Behavioral Health is distributed to the Behavioral Health Division managers and supervisors, and to community-based organizations or the public depending upon the topic of the training. Additional, contracts with training vendors continue to be established to ensure training can be scheduled when needed.

Workforce Development Project

Project Goals

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

Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$77,392	$20,000	$85,000
Total Expenditures	$43,872	$34,894	$32,638
Total Number of Trainings	23	12	115

Outcome Measures

- Measurement 1: The number of training opportunities for the public mental health system workforce, including staff, contractors, volunteers, and consumers.

Number of Staff Receiving Training: 59
Number of Training Topics: 115
Number of Hours of Training: 927.42

Title of Training	Number of Attendees	Duration of Training
Addictions: • Addiction and the Elderly • Addictions Series B Diagnosis And Treatment Part B • Addictions: Drug Seeking Behaviors and Pain Management • Addictions: Medically Assisted Recovery • Addictions: Module 1 Unit 1 - Intro to Addiction • Addictions: Module 1 Unit 2 - Twelve Step Groups and Steps - What Are They? • Addictions: Module 1 Unit 3 - Relapse Prevention • Addictions: Motivational Interviewing - An Introduction • Addictions: Suicide and Substance Use Disorders	Varied by Topic - 2 Total	1.0 - 1.5 hours
Aggression/Violence: • Violence & Mental Illness: Challenges in Risk Assessment	17	2 hours
Adult Needs and Strengths Assessment (ANSA)	20	6.25 hours
Assessment/Treatment Planning: • Clinical Assessments: Mental Status Examination • Virtual Assessment & Client Plan Development	2 per training	1.0 - 1.5 hours
Boundaries / Ethics: • Boundaries in Clinical Practice • Confidentiality: Back to the Basics • Ethics - Confidentiality and Legal Issues • Ethics I Part A: Decisions Involving Therapist and Patient • Ethics I Part B: Decisions Involving Therapist and	Varied by Topic - 6 Total	1.0 - 2.0 hours

Title of Training	Number of Attendees	Duration of Training
Patient • Ethics II - Confidentiality Part A • Ethics II - Confidentiality Part B • Ethics V Part A Spiritual Issues in Clinical Practice • Ethics XI Part A The Challenge and Dilemma of Technology • Ethics XI Part B Ethics and Countertransference • Ethics XI Part C Self-Disclosure and Human Relating • Human Rights Rules and Regulations to Assure Individual Rights v.2		
Cognitive Behavioral Therapy (CBT) for Personality Disorders	1	2.5 hours
Children/Adolescents: • Abuse and Neglect of Children	2	1 hour
Communication: • Empathetic Communication & Engagement in BH Webinar #2	1	1.5 hours
COVID-19 Related: • Intermediate Zoom Training • Staying Calm in the Midst of the COVID-19 Storm	1 per training	0.67 - 1.0 hours
Crisis Intervention: • Families of Seriously Mentally Ill The Forgotten Group • Crisis De-escalation Strategies • Crisis Intervention and Risk Assessment v.2 • Crisis Intervention Teams • Crisis Intervention Teams: Working Effectively with Law Enforcement v.2	Varied by Topic - 4 Total	1.0 - 2.0 hours
Cultural Competence: • An Introduction to Cultural & Linguistic Competency • Ask the Expert with Rachel Ray: Immigration 101 • Black Minds Matter • Bullying Prevention: Building a Culture of Respect • Client & Family Perspective • Cultivating a Culture of Inclusion • Culturally & Linguistically Appropriate Interventions and Services • Culturally and Linguistically Appropriate Interventions and Services • Family Resource Center - Latino Outreach • Hey White Therapist Here's Where We Start	Varied by Topic - 45 Total	1.0 - 2.0 hours

Title of Training	Number of Attendees	Duration of Training
• How to Fight Racial Bias • Know Thyself - Increasing Self-Awareness • Knowing Others - Increasing Awareness of your Client's Cultural Identity • Lifting Black Voices: Therapy Trust and Racial Trauma • Lifting LGBTQ Voices of Color: Racism Among Gender & Sexual Minorities • National CLAS Standards		
DBT: Intensive Training on Dialectic Behavioral Therapy	8	18 hours
DBT: Dialectical Behavior Therapy: An Introduction	5	1.0 hour
Disorders: • Schizophrenia: The Revolution in Treatment Part 1 • Schizophrenia: The Revolution in Treatment Part 2 • Schizophrenia: The Revolution in Treatment Part 3	1	1.0 - 1.5 hours
Diversity: • Counseling Lesbian Gay Bisexual and Transgender (LGBT) Clients v.2 • Cultural Competence: The Immigrant Experience Ethnicity and Families • Cultural Competence: The Immigrant Experience The Impact of Migration on Families • Cultural Competence: The Immigrant Experience The Legal Hoops of Immigration • Culture Counts: Mental Health Care for African Americans • Culture Counts: Mental Health Care for Asian Americans and Pacific Islanders • Culture Counts: Mental Health Care for Hispanic Americans • Culture Counts: The Influence of Culture and Society on Mental Health • Diversity in the Workplace • Diversity: Embracing Diversity in the Workplace v.2 • Exploring Cultural Awareness Sensitivity and Competence v.2 • Gender Competency: An Introduction What Does It Mean? • Women and Addiction: Consumption Patterns • Women and Addiction: Physiological Consequences • Women and Addiction: Treatment Considerations	Varied by Topic - 17 Total	1.0 - 3.0 hours

Title of Training	Number of Attendees	Duration of Training
Documentation: • El Dorado County Documentation Training • Clinical Documentation: Improving Your Clinical Documentation • Evidence Based Progress Notes and Record Keeping v.2	Varied by Topic - 28 Total	1.0 - 4.0 hours
Domestic Violence and Its Effect on Children	1	1 hour
LGBTQ Clients: Clinical Issues & Treatment Strategies	9	6.25 hours
General Practice Issues: • Assertive Community Treatment: An Introduction • Case Management 02 Models and Functions of Case Management: What Case Managers Do • Case Management 05 - The Recovery Perspective • Clinical Supervision 101: Advanced Concepts • Clinical Supervision 101: The Basics • Clinical Supervision Part D • Communication for the Behavioral Professional • Customer Service in Behavioral Healthcare: Part 1 – Introduction to Customer Service • Customer Service in Behavioral Healthcare: Part 2 – Advanced Concepts in Customer Service • Homelessness: Behavioral Health Services for People Who Are Homeless • Logisticare	Varied by Topic - 13 Total	1.0 - 2.0 hours
HIV/AIDS: A Comprehensive Review	1	7.0 hours
Law and Ethics: • CA Local Agency Ethics (AB 1234) • Law & Ethics: Day 1 of 2 • Law and Ethics: Day 2 of 2	Varied by Topic - 2 Total	1.0 - 6.0 hours
Management Supervision Workplace Skills: • Creative Problem Solving v.2 • Promoting Customer Service for Internal and External Customers v.3 • Wellness and You v.4	Varied by Topic - 2 Total	0.5 - 1.0 hours
Older Adults: • Abuse and Neglect of Elders • Demographics Issues and Challenges in Older Adult Behavioral Health • Working with the Elderly Part A	Varied by Topic - 4 total	1.0 - 2.0 hours

Title of Training	Number of Attendees	Duration of Training
Privacy and Security: • Confidentiality of Substance Use Disorder Patient Information • HIPAA: An Introduction v.4 • HIPAA: for Behavioral Health Professionals v.4 • HIPAA: For Behavioral Health Providers v.3 • HIPAA: for Substance Use Disorder Providers v.4	Varied by Topic - 11 Total	1.0 hours
Telehealth: • Empathetic Communication and Engagement in Behavioral Telehealth • Ensuring Success in Telehealth: What Staff Need to Know	Varied by Topic - 2 Total	1.25 - 1.5 hours
Trauma: Evidence-Based Trauma Treatments & Interventions	1	6.25 hours
Suicide Awareness and Prevention: • Adolescent Depression and Suicide • Suicide Part B - Elderly Suicide • Suicide Part C - Manipulative Suicide Threats • Suicide Assessment and Intervention • Suicide Prevention - Assess Environment and Culture for Risk • Suicide: The Tipping Point Part A • Virtual Crisis and Suicide Interventions - Webinar 7	Varied by Topic - 5 Total	1.0 - 1.5 hours

Capital Facilities and Technology (CFTN) Projects

Introduction

The Capital Facilities and Technology (CFTN) Projects are items necessary to support the development of an integrated infrastructure and to improve the quality and coordination of care.

Electronic Health Record System

Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$248,407	$252,617	$225,000
Total Expenditures	$106,898	$104,414	$189,521

Full implementation of software to increase communication with community-based partners has not yet been completely implemented. In FY 2019-20, many needed updates to the Electronic Health Record system were identified and in FY 2020-21, a staff member was assigned this project. Therefore, the costs for FY 2020-21 are anticipated to increase, however the improvements to the Electronic Health Record assist staff with appropriately capturing information in client medical records and reporting data.

Telehealth

Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$50,000	$100,000	$110,000
Total Expenditures	$0	$1,856	$21 ,853

With the continuing public health emergency, Mental Health continues to explore methods to maximize the use of telehealth (phone and video) to continue to serve its clients.

Community Wellness Center

Cost

Expenditures	FY 2017-18	FY 2018-19	FY 2019-20
MHSA Budget	$500,000	$500,000	$1,000,000
Total Expenditures	$0	$0	$0

Behavioral Health has not been able to locate a viable location for an integrated Community Wellness Center but continues to explore options in the community.

FY 2019-20
Revenue and Expenditure Report (RER)

State of California
Health and Human Services Agency

Department of Health Care Services

ANNUAL MHSA REVENUE AND EXPENDITURE REPORT and ADJUSTMENT WORKSHEET COUNTY CERTIFICATION

County/City: El Dorado County

Local Mental Health Director

Name: Nicole Ebrahimi-Nuyken

Telephone: (530) 621-6545

Email: nicole.ebranhimi-nuyken@edcgov.us

Document for Certification:

DHCS 1822 A MHSA RER Annual Report FY: 2019-2020

I hereby certify[1] under penalty of perjury under the laws of the State of California that the attached Annual MHSA Revenue and Expenditure Report or Adjustments to Revenue or Expenditure Summary Worksheet is complete and accurate to the best of my knowledge.

Nicole Ebrahimi-Nuynen, Director
Local Mental Health Director (PRINT)

Signature

1/28/21
Date

[1] Welfare and Institutions Code section 5899(a)

DHCS 1820 (02/19)

DHCS 1822 A (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Information Worksheet

1	Date:	1/28/2021
2	ARER Fiscal Year *(20YY-YY):*	2019-20
3	County:	El Dorado
4	County Code:	09
5	Address:	3057 Briw Road, Ste B
6	City:	Placerville
7	Zip:	95667
8	County Population: Over 200,000? (Yes or No)	No
9	Name of Preparer:	Michele McAfee
10	Title of Preparer:	Accountant II
11	Preparer Contact Email:	michele.mcafee@edcgov.us
12	Preparer Contact Telephone:	(530) 295-6910

DHCS 1822 B (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Component Summary Worksheet

County:	El Dorado	Date:	1/28/2021

		A	B	C	D	E	F
SECTION 1: Interest		**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**TOTAL**
1	Component Interest Earned	$110,402.00	$72,925.00	$41,402.00	$2,685.00	$21,818.00	$249,232.00
2	Joint Powers Authority Interest Earned	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

		A	B	C
SECTION 2: Prudent Reserve		**CSS**	**PEI**	**TOTAL**
3	Local Prudent Reserve Beginning Balance			$2,098,284.00
4	Transfer from Local Prudent Reserve	$442,882.00	$0.00	-$442,882.00
5	CSS Funds Transferred to Local Prudent Reserve	$0.00		$0.00
6	Local Prudent Reserve Adjustments			$0.00
7	Local Prudent Reserve Ending Balance			$1,655,402.00

		A	B	C	D	E	F
SECTION 3: CSS Transfers to PEI, WET, CFTN, or Prudent Reserve		**CSS**	**PEI**	**WET**	**CFTN**	**PR**	**TOTAL**
8	Transfers	-$700,000.00	$0.00	$200,000.00	$500,000.00	$0.00	$0.00

		A	B	C	D	E	F
SECTION 4: Program Expenditures and Sources of Funding		**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**TOTAL**
9	MHSA Funds	$7,072,888.00	$1,850,459.00	$550,609.00	$57,912.00	$211,623.00	$9,743,491.00
10	Medi-Cal FFP	$3,200,166.00	$0.00	$0.00	$0.00	$0.00	$3,200,166.00
11	1991 Realignment	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
12	Behavioral Health Subaccount	$157,055.00	$0.00	$0.00	$0.00	$0.00	$157,055.00
13	Other	$638,027.00	$0.00	$0.00	$0.00	$0.00	$638,027.00
14	**TOTAL**	**$11,068,136.00**	**$1,850,459.00**	**$550,609.00**	**$57,912.00**	**$211,623.00**	**$13,738,739.00**

DHCS 1822 B (02/19)
Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Component Summary Worksheet

County:	El Dorado

Date:	1/28/2021

		A
SECTION 5: Miscellaneous MHSA Costs and Expenditures		**TOTAL**
15	**Total Annual Planning Costs**	$15,711.00
16	**Total Evaluation Costs**	$0.00
17	**Total Administration**	$263,727.00
18	**Total WET RP**	$0.00
19	**Total PEI SW**	$81,234.00
20	**Total MHSA HP**	$0.00
21	**Total Mental Health Services For Veterans**	$166,572.00

DHCS 1822 C (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Community Services and Supports (CSS) Summary Worksheet

County:	El Dorado	Date:	1/28/2021

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	CSS Annual Planning Costs	$15,711.00	$0.00	$0.00	$0.00	$0.00	$15,711.00
2	CSS Evaluation Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	CSS Administration Costs	$156,776.00	$0.00	$0.00	$0.00	$1,867.00	$158,643.00
4	CSS Funds Transferred to JPA	$0.00					$0.00
5	CSS Expenditures Incurred by JPA	$0.00					$0.00
6	CSS Funds Transferred to CalHFA	$0.00					$0.00
7	CSS Funds Transferred to PEI	$0.00					$0.00
8	CSS Funds Transferred to WET	$200,000.00					$200,000.00
9	CSS Funds Transferred to CFTN	$500,000.00					$500,000.00
10	CSS Funds Transferred to PR	$0.00					$0.00
11	CSS Program Expenditures	$6,900,401.00	$3,200,166.00	$0.00	$157,055.00	$636,160.00	$10,893,782.00
12	Total CSS Expenditures (Excluding Funds Transferred to JPA)	$7,772,888.00	$3,200,166.00	$0.00	$157,055.00	$638,027.00	$11,768,136.00
13	Total CSS Expenditures (Excluding Funds Transferred to JPA, PEI, WET, CFTN and PR)	$7,072,888.00	$3,200,166.00	$0.00	$157,055.00	$638,027.00	$11,068,136.00

DHCS 1822 C (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Community Services and Supports (CSS) Summary Worksheet

County:	El Dorado	Date:	1/28/2021

SECTION TWO

	A	B	C	D	E	F	G	H	I	J
#	County Code	Program Name	Prior Program Name	Program Type	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
14	09	Children's Full Service Partnership		FSP	$1,673,748.00	$580,611.00	$0.00	$157,055.00	$64,979.00	$2,476,393.00
15	09	Transitional Age Youth (TAY) Full Service Partnership		FSP	$0.00	$99,030.00	$0.00	$0.00	$8,388.00	$107,418.00
16	09	Adult Full Service Partnership		FSP	$2,510,981.00	$1,672,212.00	$0.00	$0.00	$176,805.00	$4,359,998.00
17	09	Assisted Outpatient Treatment (AOT)		FSP	$1,001.00	$9,038.00	$0.00	$0.00	$686.00	$10,725.00
18		Older Adult Full Service Partnership		FSP	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
19	09	Adult Wellness Centers		Non-FSP	$1,570,892.00	$780,099.00	$0.00	$0.00	$53,861.00	$2,404,852.00
20	09	TAY Engagement, Wellnes & Recovery Services		Non-FSP	$116,862.00	$54,219.00	$0.00	$0.00	$160,757.00	$331,838.00
21	09	Outreach and Engagement Services		Non-FSP	$979,412.00	$0.00	$0.00	$0.00	$47,494.00	$1,026,906.00
22		Resource Management Services		Non-FSP	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
23	09	Community-Based Mental Health Services		Non-FSP	$47,505.00	$4,957.00	$0.00	$0.00	$123,190.00	$175,652.00
24		Genetic Testing		Non-FSP	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
25		Housing		Non-FSP	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
26										$0.00
27										$0.00
28										$0.00
29										$0.00
30										$0.00

DHCS 1822 D (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Prevention and Early Intervention (PEI) Summary Worksheet

County:	El Dorado	El Dorado	Date:	1/28/2021

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	PEI Annual Planning Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2	PEI Evaluation Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	PEI Administration Costs	$55,192.00	$0.00	$0.00	$0.00	$0.00	$55,192.00
4	PEI Funds Expended by CalMHSA for PEI Statewide	$81,234.00					$81,234.00
5	PEI Funds Transferred to JPA	$0.00					$0.00
6	PEI Expenditures Incurred by JPA	$0.00					$0.00
7	PEI Program Expenditures	$1,795,267.00	$0.00	$0.00	$0.00	$0.00	$1,795,267.00
8	Total PEI Expenditures (Excluding Transfers and PEI Statewide)	$1,850,459.00	$0.00	$0.00	$0.00	$0.00	$1,850,459.00

SECTION TWO

		A	B
		Percent Expended for Clients Age 25 and Under, All PEI	Percent Expended for Clients Age 25 and Under, JPA
9	MHSA PEI Fund Expenditures in Program to Clients Age 25 and Under (calculated from weighted program values) divided by Total MHSA PEI Expenditures	54.79%	

SECTION THREE

#	A County Code	B Program Name	C Prior Program Name	D Combined/Standalone Program	E Program Type	F Program Activity Name (in Combined Program)	G Subtotal Percentage for Combined Program	H Percent of PEI Expended on Clients Age 25 & Under (Standalone and Program Activities in Combined Program)	I Percent of PEI Expended on Clients Age 25 & Under (Combined Summary and Standalone)	J Total MHSA Funds (Including Interest)	K Medi-Cal FFP	L 1991 Realignment	M Behavioral Health Subaccount	N Other	O Grand Total
10	9	Latino Outreach		Standalone	Prevention		100%	30%	30.0%	$228,595.00	$0.00	$0.00	$0.00	$0.00	$228,595.00
11	9	Older Adult Enrichment Project		Standalone	Prevention		100%	0%	0.0%	$107,517.00	$0.00	$0.00	$0.00	$0.00	$107,517.00
12	9	Primary Intervention Project (PIP)		Standalone	Prevention		100%	100%	100.0%	$81,917.00	$0.00	$0.00	$0.00	$0.00	$81,917.00
13	9	Wennem Wadati: A Native Path to Healing		Standalone	Prevention		100%	100%	100.0%	$89,776.00	$0.00	$0.00	$0.00	$0.00	$89,776.00
14	9	Child 0-5 and Their Families		Standalone	Early Intervention		100%	100%	100.0%	$300,000.00	$0.00	$0.00	$0.00	$0.00	$300,000.00
15	9	Prevention Wraparound Services: Juvenile		Standalone	Early Intervention		100%	100%	100.0%	$103,918.00	$0.00	$0.00	$0.00	$0.00	$103,918.00
16	9	Expressive Therapy		Standalone	Early Intervention		100%	0%	0.0%	$10,650.00	$0.00	$0.00	$0.00	$0.00	$10,650.00
17	9	National Suicide Prevention Lifeline		Standalone	Early Intervention		100%	31%	31.0%	$8,175.00	$0.00	$0.00	$0.00	$0.00	$8,175.00
18	9	Mental Health First Aid		Standalone	Stigma & Discrimination Reduction		100%	25%	25.0%	$29,907.00	$0.00	$0.00	$0.00	$0.00	$29,907.00
19	9	LGBTQ Community Education		Standalone	Stigma & Discrimination Reduction		100%	25%	25.0%	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
20	9	Media Stigma Campain		Standalone	Stigma & Discrimination Reduction		100%	0%	0.0%	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
21	9	Statewide PEI Projects		Standalone	Stigma & Discrimination Reduction		100%	50%	50.0%	$60,000.00	$0.00	$0.00	$0.00	$0.00	$60,000.00
22	9	Community Education & Parenting Classes		Standalone	Outreach		100%	100%	100.0%	$138,525.00	$0.00	$0.00	$0.00	$0.00	$138,525.00
23	9	Mentoring for Youth		Standalone	Outreach		100%	100%	100.0%	$75,000.00	$0.00	$0.00	$0.00	$0.00	$75,000.00
24	9	Community -Based Outreach and Linkage		Standalone	Access and Linkage		100%	28%	28.0%	$361,615.00	$0.00	$0.00	$0.00	$0.00	$361,615.00
25	9	Veterans Outreach		Standalone	Access and Linkage		100%	0%	0.0%	$150,000.00	$0.00	$0.00	$0.00	$0.00	$150,000.00
26	9	Suicide Prevention Program		Standalone	Suicide Prevention		100%	30%	30.0%	$49,672.00	$0.00	$0.00	$0.00	$0.00	$49,672.00
27															$0.00

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 E (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Innovation (INN) Summary Worksheet

County:	El Dorado	Date:	1/28/2021

SECTION ONE

#		A Total MHSA Fund (Including Interest)	B Medi-Cal FFP	C 1991 Realignment	D Behavioral Health Subaccount	E Other	F Grand Total
1	INN Annual Planning Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2	INN Indirect Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	INN Funds Transferred to JPA	$0.00					$0.00
4	INN Expenditures Incurred by JPA	$0.00					$0.00
5	INN Project Administration	$41,935.00	$0.00	$0.00	$0.00	$0.00	$41,935.00
6	INN Project Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
7	INN Project Direct	$508,674.00	$0.00	$0.00	$0.00	$0.00	$508,674.00
8	INN Project Subtotal	$550,609.00	$0.00	$0.00	$0.00	$0.00	$550,609.00
9	Total Innovation Expenditures (Excluding Transfers to JPA)	$550,609.00	$0.00	$0.00	$0.00	$0.00	$550,609.00

SECTION TWO

#		A County Code	B Project Name	C Prior Project Name	D Project MHSOAC Approval Date	E Project Start Date	F MHSOAC-Authorized MHSA INN Project Budget	G Amended MHSOAC-Authorized MHSA INN Project Budget	H Project Expenditure Type	I Total MHSA Funds (Including Interest)	J Medi-Cal FFP	K 1991 Realignment	L Behavioral Health Subaccount	M Other	N Grand Total
10	A	9	Community-Based Engagement & Support Services		8/15/2016	9/19/2016	$705,992.00	$0.00	Project Administration	$41,935.00	$0.00	$0.00	$0.00	$0.00	$41,935.00
10	B	9	Community-Based Engagement & Support Services		8/15/2016	9/19/2016	$705,992.00	$0.00	Project Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
10	C	9	Community-Based Engagement & Support Services		8/15/2016	9/19/2016	$705,992.00	$0.00	Project Direct	$508,674.00	$0.00	$0.00	$0.00	$0.00	$508,674.00
10	**D**	**9**	**Community-Based Engagement & Support Services**		**8/15/2016**	**9/19/2016**	**$705,992.00**	**$0.00**	**Project Subtotal**	**$550,609.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$550,609.00**
11	A		Senior Nutrition Partnership		1/23/2020	Not Started	$900,000.00	$0.00	Project Administration	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11	B		Senior Nutrition Partnership		1/23/2020	Not Started	$900,000.00	$0.00	Project Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11	C		Senior Nutrition Partnership		1/23/2020	Not Started	$900,000.00	$0.00	Project Direct	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11	**D**		**Senior Nutrition Partnership**		**1/23/2020**	**Not Started**	**$900,000.00**	**$0.00**	**Project Subtotal**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
12	A							$0.00							$0.00
12	B							$0.00							$0.00
12	C							$0.00							$0.00
12	**D**							**$0.00**		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
13	A							$0.00							$0.00
13	B							$0.00							$0.00
13	C							$0.00							$0.00
13	**D**							**$0.00**		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
14	A														$0.00
14	B														$0.00
14	C														$0.00
14	**D**									**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
15	A														$0.00
15	B														$0.00
15	C														$0.00
15	**D**									**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

DHCS 1822 F (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Workforce Education and Training (WET) Summary Worksheet

County:	El Dorado	Date:	1/28/2021

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	WET Annual Planning Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2	WET Evaluation Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	WET Administration Costs	$9,575.00	$0.00	$0.00	$0.00	$0.00	$9,575.00
4	WET Funds Transferred to JPA	$0.00					$0.00
5	WET Expenditures Incurred by JPA	$0.00					$0.00
6	WET Program Expenditures	$48,337.00	$0.00	$0.00	$0.00	$0.00	$48,337.00
7	Total WET Expenditures (Excluding Transfers to JPA)	$57,912.00	$0.00	$0.00	$0.00	$0.00	$57,912.00

SECTION TWO

	A	B	C	D	E	F	G	H
#	County Code	Funding Category	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
8	9	Workforce Staffing	$15,699.00	$0.00	$0.00	$0.00	$0.00	$15,699.00
9	9	Training/Technical Assistance	$32,638.00	$0.00	$0.00	$0.00	$0.00	$32,638.00
10		Mental Health Career Pathways	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11		Residency/Internship	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
12		Financial Incentive	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

DHCS 1822 G (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Capital Facility Technological Needs (CFTN) Summary Worksheet

County:	El Dorado	Date:	1/28/2021

SECTION ONE

		A	B	C	D	E	F
		Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
1	CFTN Annual Planning Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2	CFTN Evaluation Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
3	CFTN Administration Costs	$249.00	$0.00	$0.00	$0.00	$0.00	$249.00
4	CFTN Funds Transferred to JPA	$0.00					$0.00
5	CFTN Expenditures Incurred by JPA	$0.00					$0.00
6	CFTN Project Expenditures	$211,374.00	$0.00	$0.00	$0.00	$0.00	$211,374.00
7	**Total CFTN Expenditures (Excluding Transfers to JPA)**	**$211,623.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$211,623.00**

SECTION TWO

	A	B	C	D	E	F	G	H	I	J
#	County Code	Project Name	Prior Project Name	Project Type	Total MHSA Funds (Including Interest)	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other	Grand Total
8	9	Eletronic Health Record System Implementation		Technological Need	$189,521.00	$0.00	$0.00	$0.00	$0.00	$189,521.00
9	9	Telehealth		Technological Need	$21,853.00	$0.00	$0.00	$0.00	$0.00	$21,853.00
10		Integrated Care Facility	Community Wellness Center	Capital Facility	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
11										$0.00
12										$0.00

DHCS 1822 H (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
MHSA Adjustments Worksheet

County:	El Dorado		Date	1/28/2021

SECTION ONE

	A	B	C	D	E	F
#	County Code	Account	Adjustment Type	Adjustment to Fiscal Year	Amount	Reason
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						

DHCS 1822 I (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
FFP Revenue Adjustment Worksheet

County:	El Dorado	Date:	1/28/2021

SECTION ONE

	A	B	C	D	E	F	G
#	County Code	Adjustment to FY	Cost Report Stage	Account	Beginning Balance	Adjustment Amount	Ending Balance
1							$0.00
2							$0.00
3							$0.00
4							$0.00
5							$0.00
6							$0.00
7							$0.00
8							$0.00
9							$0.00
10							$0.00
11							$0.00
12							$0.00
13							$0.00
14							$0.00
15							$0.00

STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY

Department of Health Care Services

DHCS 1822 J (02/19)

Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report
Fiscal Year: 2019-20
Comments Worksheet

County:	El Dorado

Date:	1/28/2021

	A	B	C
#	**Account**	**Fiscal Year**	**Comments**
1	Prudent Reserve	2019-2020	The transfer from PR to CSS is intended to decrease the PR funding level to the maximum allowed percentatage.
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

FY 2019-20
Data Collection Reporting (DCR) Report

El Dorado

DCR Data Outcomes Report

Fiscal Year 2019/2020

REPORT OF COUNTY'S FULL SERVICE PARTNERSHIP OUTCOMES IN THE DATA COLLECTION AND REPORTING (DCR) SYSTEM

CONTENTS

1.0 Introduction

2.1 Enrolled Partners – Adult Indicators
2.2 Enrolled Partners – Child Indicators

3.1 Partners Served

4.1 Assessment Data Quality Metrics

5.1 Residential Report

6.1 Mental Health and Substance Abuse Emergencies
6.2 Psychiatric Hospitalizations

7.1 Arrests
7.2 Incarcerations

8.1 Children's Education

Contents and 1.0 Introduction

1.0 Introduction

The Annual Reports template provides a simple means of producing County Full Service Partnership (FSP) Data Quality and Outcomes Reports for a specified fiscal year. Each report includes the following sections.

2.1 Enrolled Partners – Adult Indicators

The “Enrolled Partners - Adult Indicators” section of the Annual Reports template provides a summary of service need indicators present at the time of admission and the year prior for TAY, Adult and Older Adult partners, aggregated by their age group.

2.2 Enrolled Partners – Child Indicators

The “Enrolled Partners - Child Indicators” section of the Annual Reports template provides a summary of service need indicators present at the time of admission and the year prior for Child and TAY partners, aggregated by their age group.

3.1 Active Partners Served

The “Active Partners Served” section of the Annual Reports template yields snapshots of the population of partners served on the first and last day of the fiscal year, as well as the number of partners admitted and discharged in the fiscal year, and the total partners served at any point within the fiscal year.

4.1 Assessment Data Quality Metrics

The “Assessment Data Quality Metrics” section of the Annual Reports template was designed to assist in data quality monitoring, providing information regarding the timeliness and completeness of 3Ms and KETs for active partners within a given fiscal year.

5.1 Residential Report: Comparison of Most Recent Year in Partnership to Year before Partnership

The “Residential Report: Comparison of Most Recent Year in Partnership to Year before Partnership” section of the Annual Reports template is useful for analyzing the percent of partners and percent of days in various residential settings for the one year prior to participation in the FSP as compared to the most recent year in partnership for partners served up to four years in a partnership.

6.1 Mental Health and Substance Abuse Emergencies: Comparison of Most Recent Year in Partnership to Year before Partnership

The “Mental Health and Substance Abuse Emergencies: Comparison of Most Recent Year in Partnership to Year before Partnership” section of the Annual Reports template provides a summary of partners’ mental health and substance abuse emergency events and is useful for comparing the percent of partners who experienced mental health and substance abuse emergency events in the year before and the most recent year in partnership for partners served up to five years in a partnership.

6.2 Psychiatric Hospitalization Days: Comparison of Most Recent Year in Partnership to Year before Partnership

The “Psychiatric Hospitalization Days: Comparison of Most Recent Year in Partnership to Year before Partnership” section of the Annual Reports template provides a summary of partners’ psychiatric hospitalization days and is useful for comparing the percent of partners who experienced psychiatric hospitalization in the year before and the most recent year in partnership for partners served up to five years in a partnership.

Contents and 1.0 Introduction

7.1 Arrests: Comparison of Most Recent Year in Partnership to Year before Partnership
The "Arrests: Comparison of Most Recent Year in Partnership to Year before Partnership" section of the Annual Reports template provides a summary of partner arrests and is useful for comparing the percent of partners who experienced one or more arrests in the year before as compared to the most recent year in partnership for partners served up to five years in a partnership.

7.2 Incarceration Days: Comparison of Most Recent Year in Partnership to Year before Partnership.
The "Incarceration Days: Comparison of Most Recent Year in Partnership to Year before Partnership" section of the Annual Reports template provides a summary of partner incarcerations and is useful for comparing the percent of partners who experienced incarceration in the year before as compared to the most recent year in partnership for partners served up to five years in a partnership.

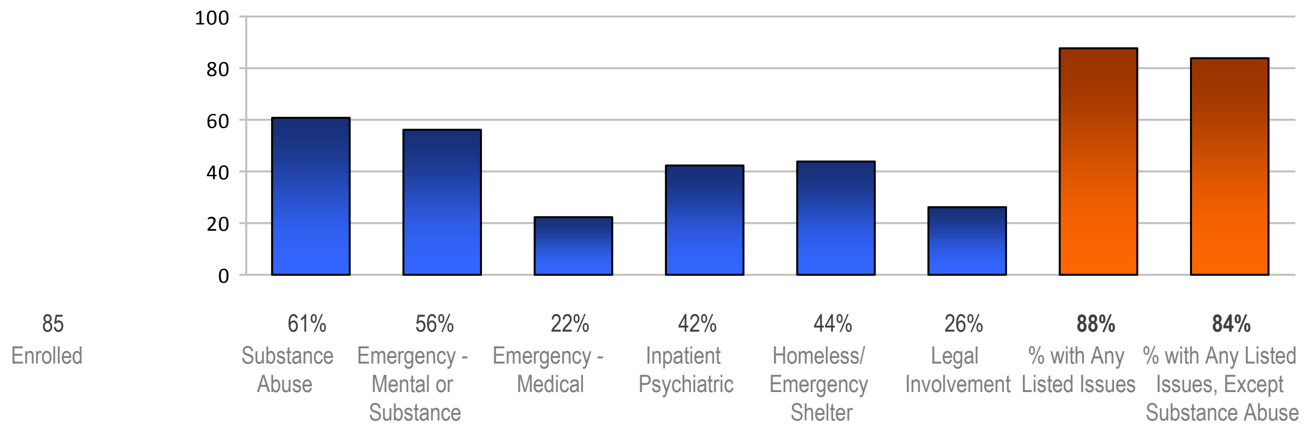
8.1 Children's Education: Comparison of Select Quarterly Assessments to PAF
The "Children's Education: Comparison of Select Quarterly Assessments to PAF" section of the Annual Reports template provides a summary of child partner school attendance and is useful for comparing the percent of partners with good or improved school attendance over time; specifically looking at attendance at 6 months, 1 year, and 2 years.

2.1 Enrolled Partners - Adult Indicators

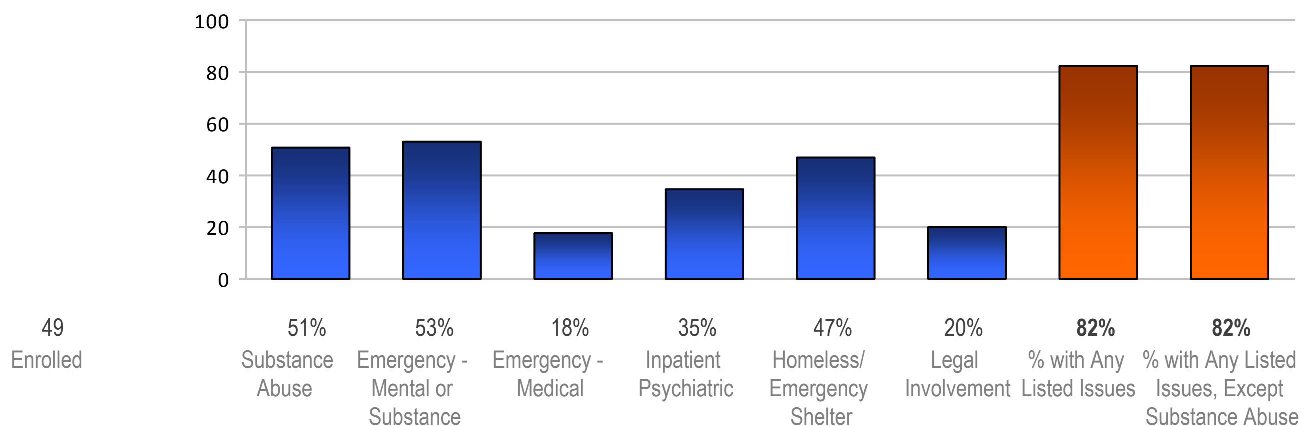
El Dorado

7/1/2019 to 6/30/2020

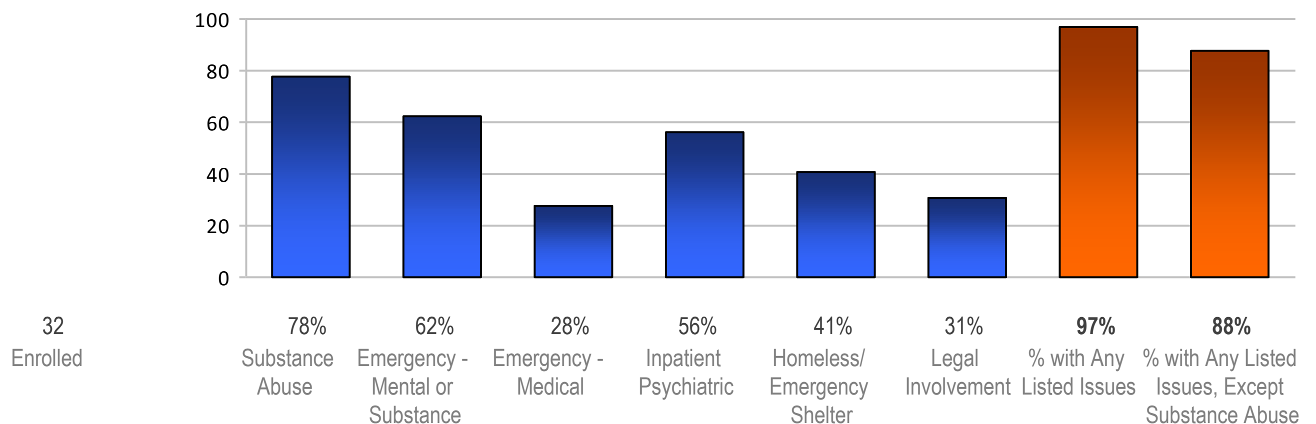
All TAY, Adult and Older Adult



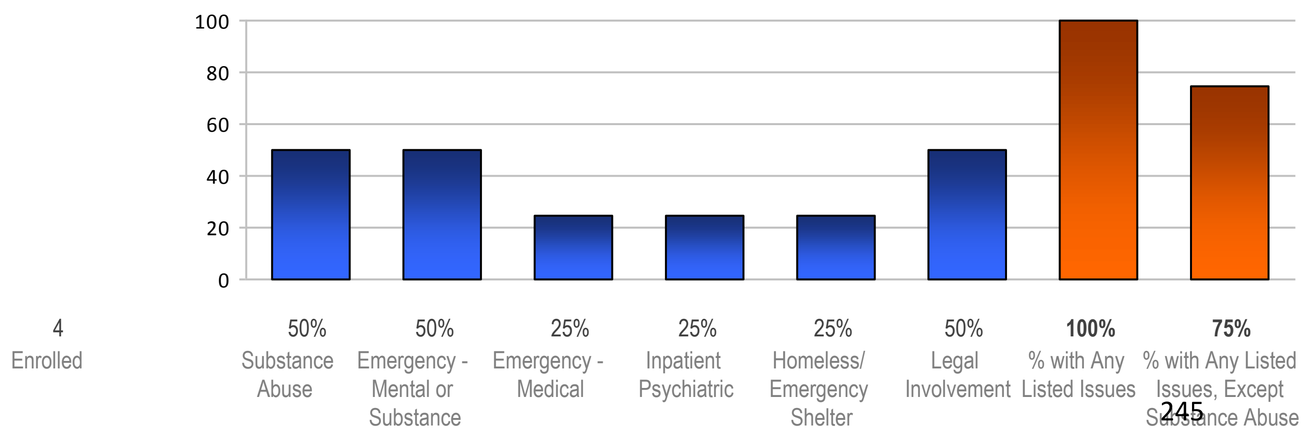
TAY



Adult



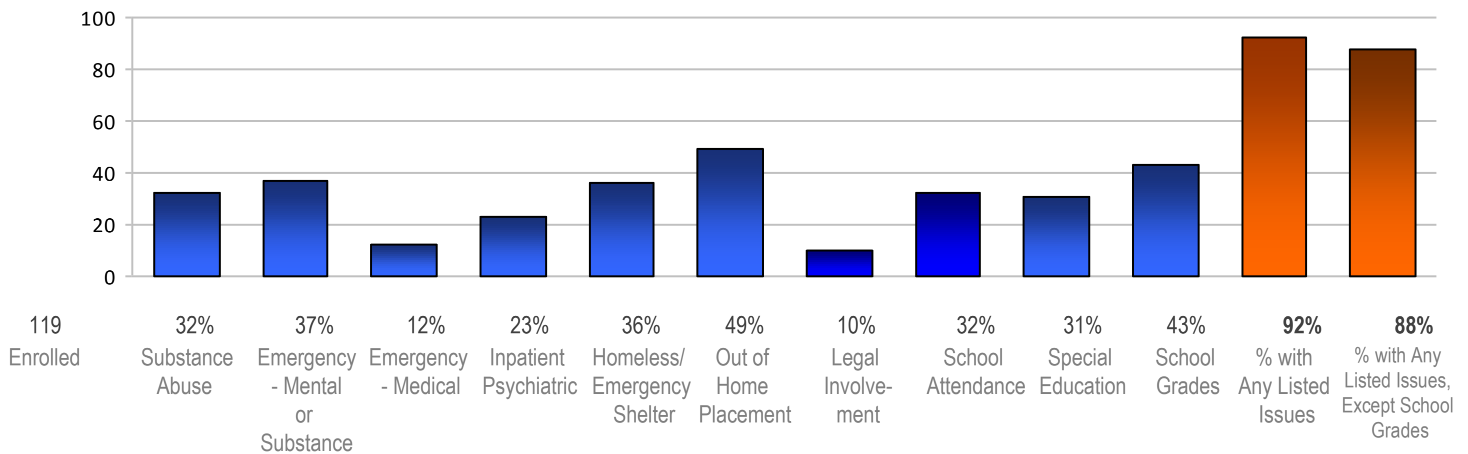
Older Adult



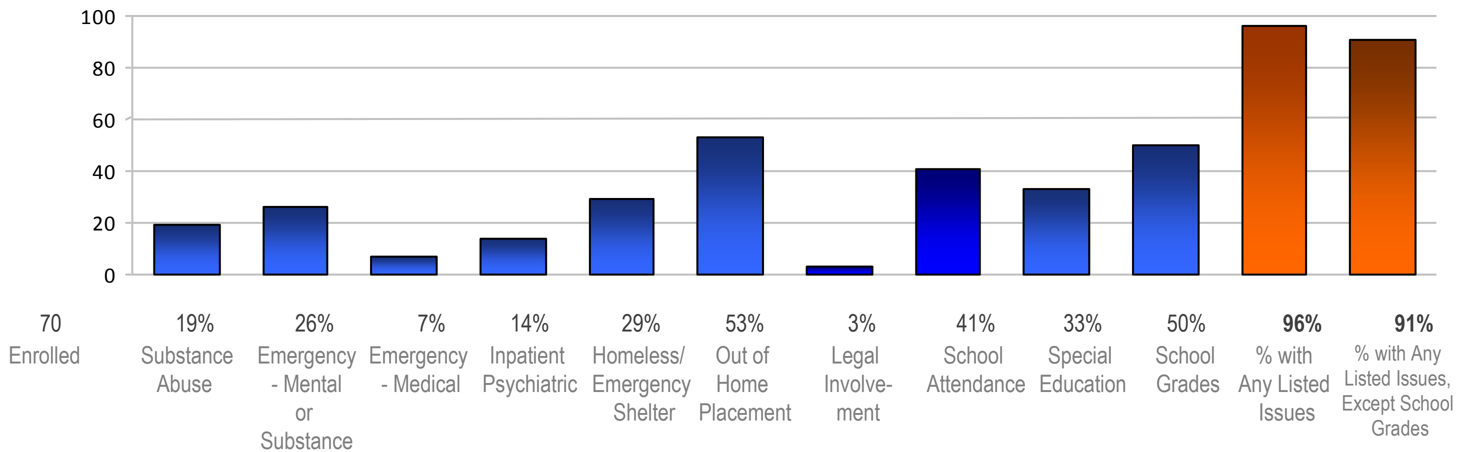
2.2 Enrolled Partners - Child Indicators

El Dorado 7/1/2019 to 6/30/2020

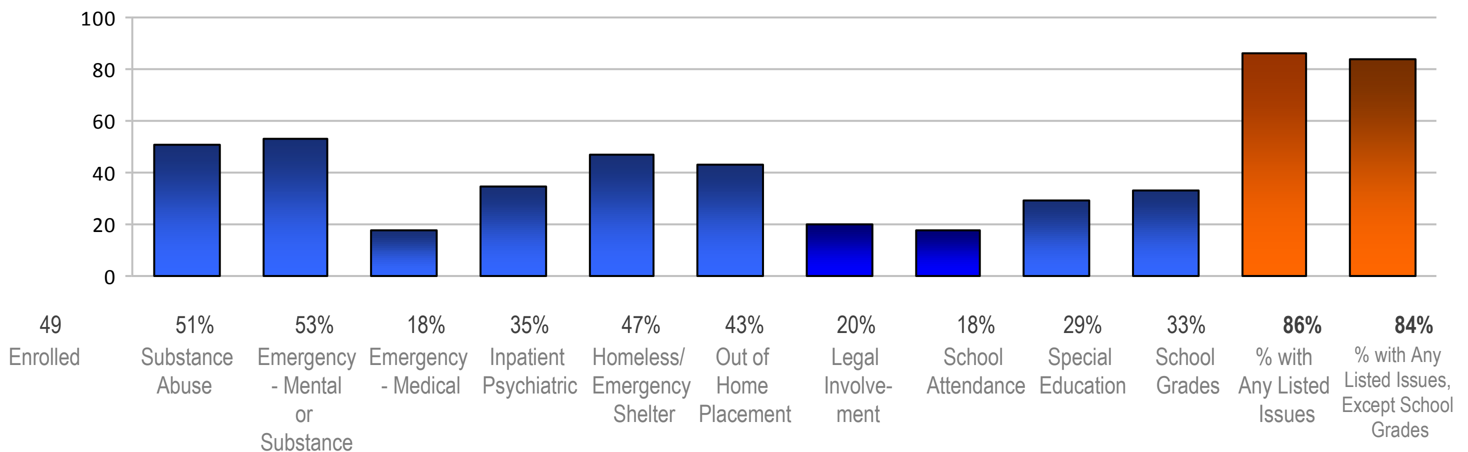
All Child and TAY



Child



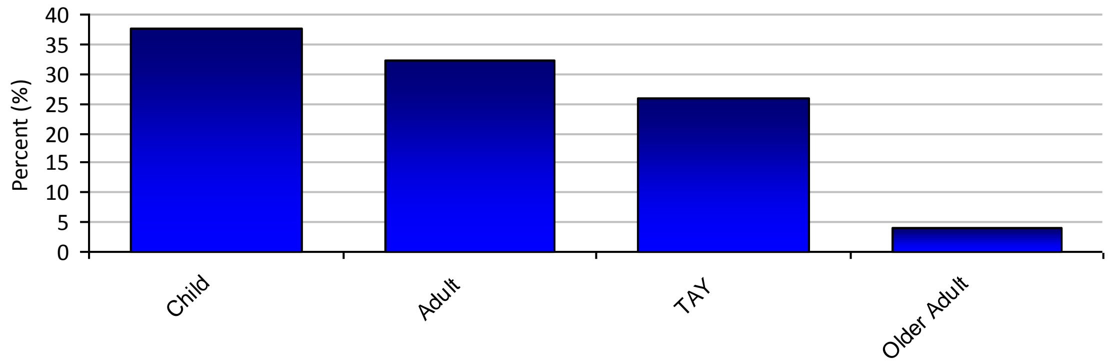
TAY



3.1 Active Partners Served

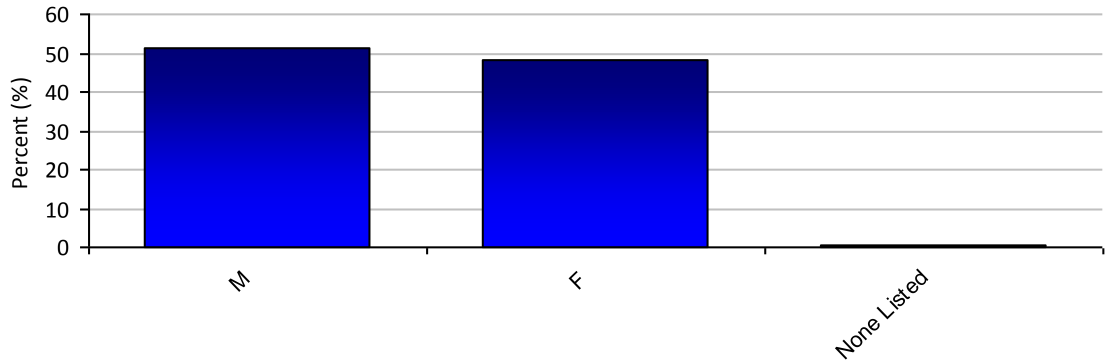
El Dorado 7/1/2019 to 6/30/2020

1. Age Group



	Serving on First Day		Admitted		Discharged		Serving on Last Day		Total Served	
Child	48	33.1 %	65	41.9 %	56	37.1 %	57	38.3 %	113	37.7 %
TAY	26	17.9 %	52	33.5 %	40	26.5 %	38	25.5 %	78	26.0 %
Adult	63	43.4 %	34	21.9 %	49	32.5 %	48	32.2 %	97	32.3 %
Older Adult	8	5.5 %	4	2.6 %	6	4.0 %	6	4.0 %	12	4.0 %

2. Gender



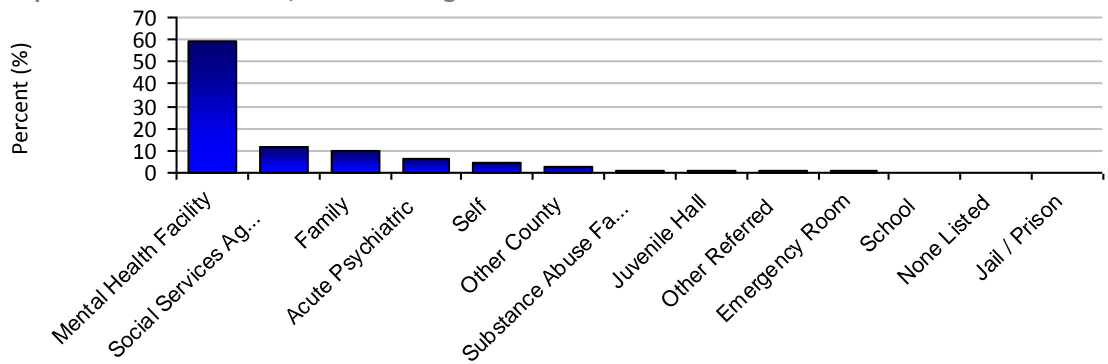
	Serving on First Day		Admitted		Discharged		Serving on Last Day		Total Served	
F	67	46.2 %	77	49.7 %	67	44.4 %	77	51.7 %	144	48.0 %
M	78	53.8 %	76	49.0 %	83	55.0 %	71	47.7 %	154	51.3 %
None Listed	0	0.0 %	2	1.3 %	1	0.7 %	1	0.7 %	2	0.7 %

3.1 Active Partners Served

El Dorado

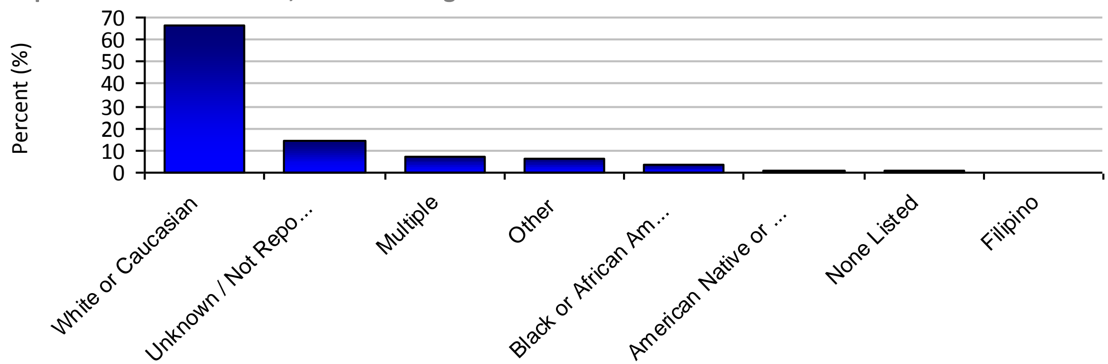
7/1/2019 to 6/30/2020

3. Referred By



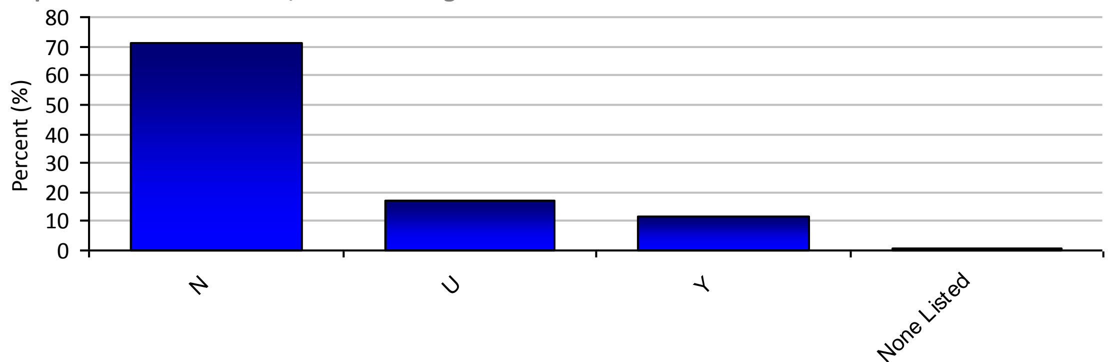
	Serving on First Day		Admitted		Discharged		Serving on Last Day		Total Served	
Acute Psychiatric	12	8.3 %	8	5.2 %	15	9.9 %	5	3.4 %	20	6.7 %
Emergency Room	2	1.4 %	0	0.0 %	2	1.3 %	0	0.0 %	2	0.7 %
Family	19	13.1 %	11	7.1 %	15	9.9 %	15	10.1 %	30	10.0 %
Jail / Prison	1	0.7 %	0	0.0 %	1	0.7 %	0	0.0 %	1	0.3 %
Juvenile Hall	0	0.0 %	4	2.6 %	3	2.0 %	1	0.7 %	4	1.3 %
Mental Health Facility	95	65.5 %	82	52.9 %	91	60.3 %	86	57.7 %	177	59.0 %
None Listed	1	0.7 %	0	0.0 %	0	0.0 %	1	0.7 %	1	0.3 %
Other County	3	2.1 %	5	3.2 %	1	0.7 %	7	4.7 %	8	2.7 %
Other Referred	2	1.4 %	1	0.6 %	2	1.3 %	1	0.7 %	3	1.0 %
School	0	0.0 %	1	0.6 %	0	0.0 %	1	0.7 %	1	0.3 %
Self	2	1.4 %	12	7.7 %	3	2.0 %	11	7.4 %	14	4.7 %
Social Services Agency	5	3.4 %	30	19.4 %	16	10.6 %	19	12.8 %	35	11.7 %
Substance Abuse Facility	3	2.1 %	1	0.6 %	2	1.3 %	2	1.3 %	4	1.3 %

4. Race/Ethnicity



	Serving on First Day		Admitted		Discharged		Serving on Last Day		Total Served	
American Native or Alaska Native	4	2.8 %	0	0.0 %	2	1.3 %	2	1.3 %	4	1.3 %
Black or African American	8	5.5 %	3	1.9 %	4	2.6 %	7	4.7 %	11	3.7 %
Filipino	0	0.0 %	1	0.6 %	1	0.7 %	0	0.0 %	1	0.3 %
Multiple	4	2.8 %	17	11.0 %	13	8.6 %	8	5.4 %	21	7.0 %
None Listed	0	0.0 %	2	1.3 %	1	0.7 %	1	0.7 %	2	0.7 %
Other	5	3.4 %	13	8.4 %	7	4.6 %	11	7.4 %	18	6.0 %
Unknown / Not Reported	17	11.7 %	27	17.4 %	25	16.6 %	19	12.8 %	44	14.7 %
White or Caucasian	107	73.8 %	92	59.4 %	98	64.9 %	101	67.8 %	199	66.3 %

5. Latino

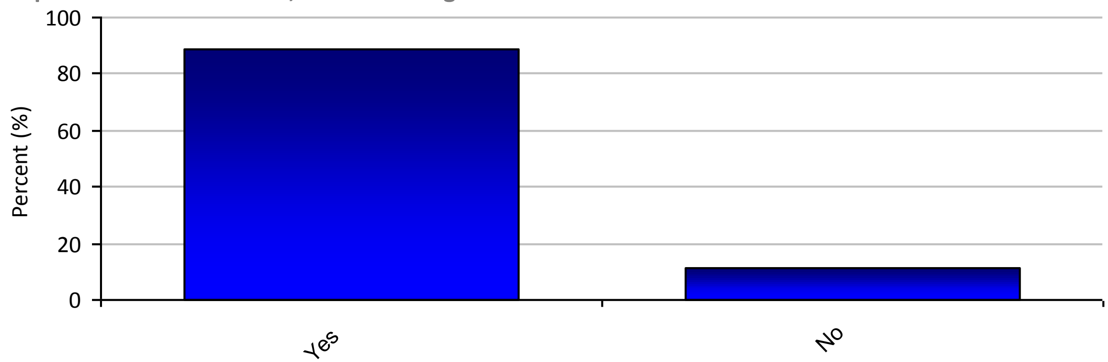


	Serving on First Day		Admitted		Discharged		Serving on Last Day		Total Served	
N	120	82.8 %	93	60.0 %	109	72.2 %	104	69.8 %	213	71.0 %
None Listed	0	0.0 %	2	1.3 %	1	0.7 %	1	0.7 %	2	0.7 %
U	14	9.7 %	37	23.9 %	26	17.2 %	25	16.8 %	51	17.0 %
Y	11	7.6 %	23	14.8 %	15	9.9 %	19	12.8 %	34	11.3 %

3.1 Active Partners Served

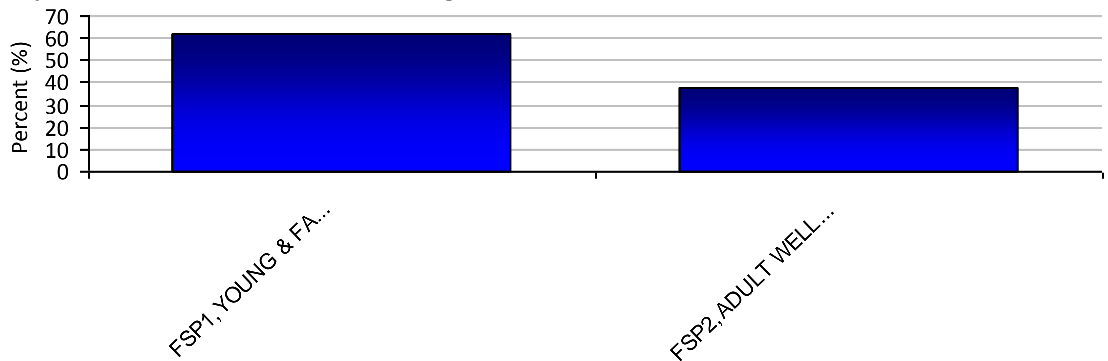
El Dorado 7/1/2019 to 6/30/2020

6. Continuous Partnerships



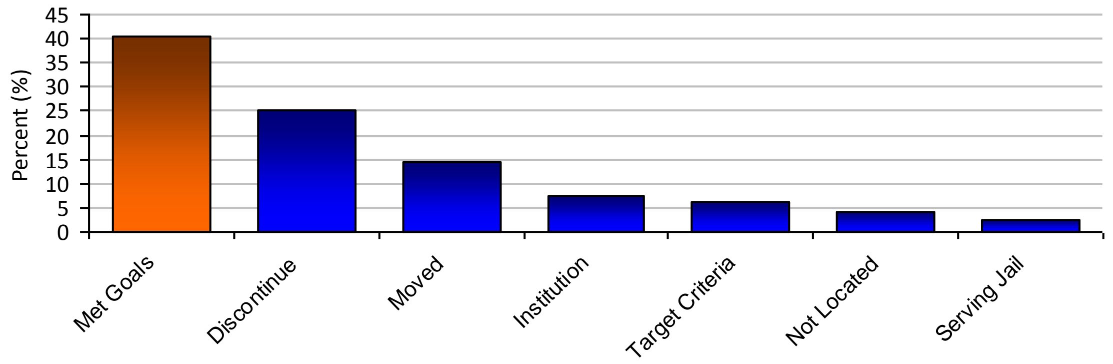
	Serving on First Day		Admitted		Discharged		Serving on Last Day		Total Served	
No	32	22.1 %	2	1.3 %	15	9.9 %	19	12.8 %	34	11.3 %
Yes	113	77.9 %	153	98.7 %	136	90.1 %	130	87.2 %	266	88.7 %

7. Current Program



	Serving on First Day		Admitted		Discharged		Serving on Last Day		Total Served	
FSP1,YOUNG & FAMILY STRENGHTHENING PROGRAM (FSP1)	72	49.7 %	115	74.2 %	93	61.6 %	94	63.1 %	187	62.3 %
FSP2,ADULT WELLNESS & RECOVERY SERVICES (FSP2)	73	50.3 %	40	25.8 %	58	38.4 %	55	36.9 %	113	37.7 %

8. Discharge Reason



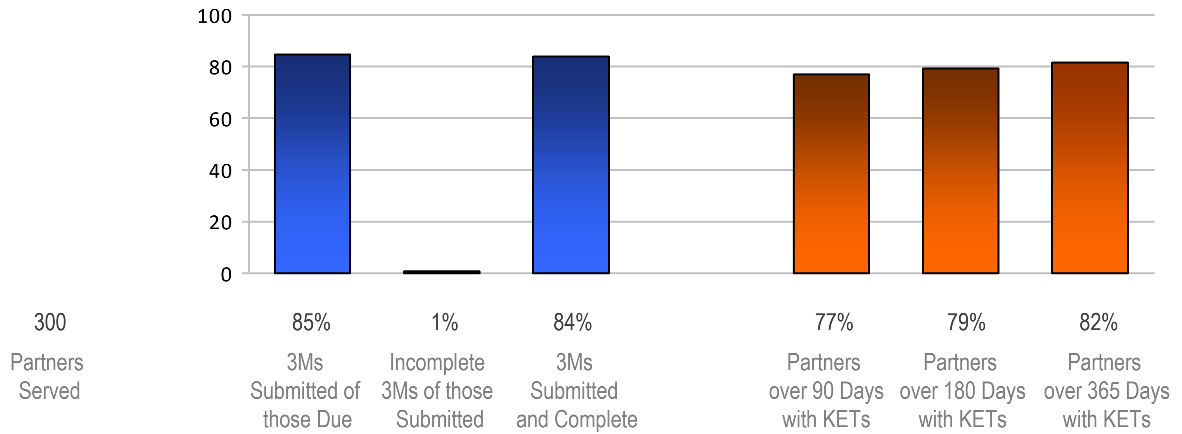
	Discharged	
Met Goals	61	40.4 %
Discontinue	38	25.2 %
Moved	22	14.6 %
Institution	11	7.3 %
Target Criteria	9	6.0 %
Not Located	6	4.0 %
Serving Jail	4	2.6 %

4.1 Assessment Data Quality Metrics

El Dorado

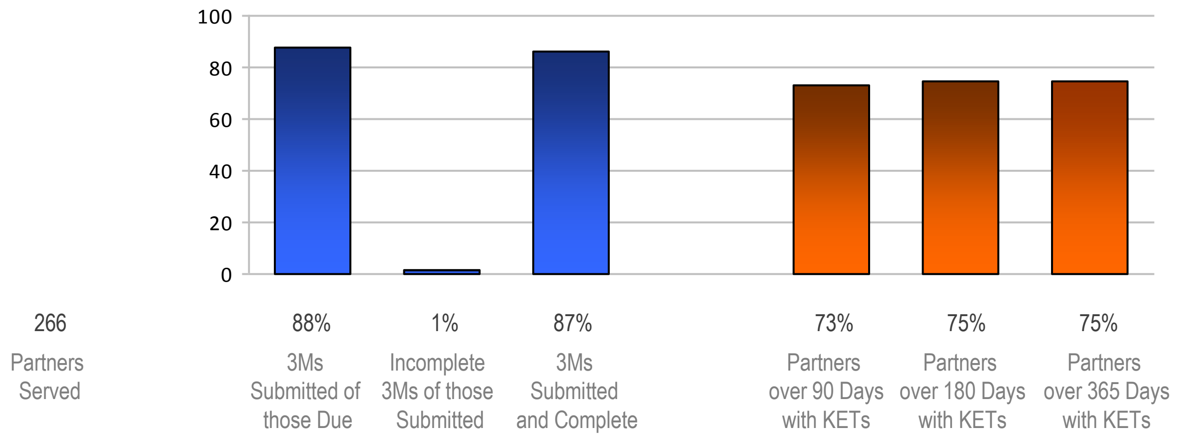
7/1/2019 to 6/30/2020

All



300	85%	1%	84%	77%	79%	82%
Partners Served	3Ms Submitted of those Due	Incomplete 3Ms of those Submitted	3Ms Submitted and Complete	Partners over 90 Days with KETs	Partners over 180 Days with KETs	Partners over 365 Days with KETs

Continuous Partners Only



266	88%	1%	87%	73%	75%	75%
Partners Served	3Ms Submitted of those Due	Incomplete 3Ms of those Submitted	3Ms Submitted and Complete	Partners over 90 Days with KETs	Partners over 180 Days with KETs	Partners over 365 Days with KETs

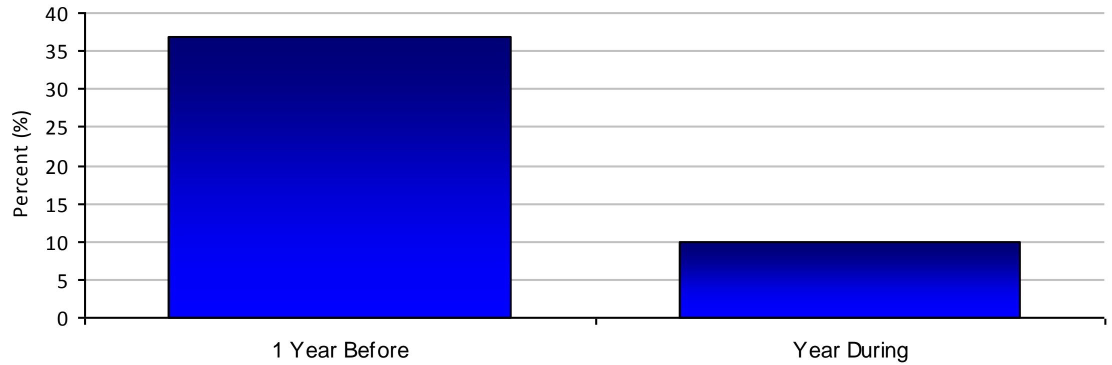
5.1 Residential Report: Comparison of Most Recent Year in Partnership to Year before Partnership*

Residential Setting	1 Year Before Partnership				Most Recent Year in Partnership				Change Since Before Partnership				
	Partners	Days	%Partners	%Days	Partners	Days	%Partners	%Days	Partners	Days	%Partners	%Days	Chart of %Days
Total	107	39,055	100.0 %	100.0 %	107	39,055	100.0 %	100.0 %	0	0	0.0 %	0.0 %	
With Parents	51	15,050	47.7 %	38.5 %	35	11,367	32.7 %	29.1 %	-16	-3,683	-15.0 %	-9.4 %	
Foster Home Non-relative	26	4,932	24.3 %	12.6 %	24	8,606	22.4 %	22.0 %	-2	3,674	-1.9 %	9.4 %	
Psychiatric Hospital	21	668	19.6 %	1.7 %	12	871	11.2 %	2.2 %	-9	203	-8.4 %	0.5 %	
Long-Term Care	15	3,697	14.0 %	9.5 %	3	744	2.8 %	1.9 %	-12	-2,953	-11.2 %	-7.6 %	
Apartment Alone	14	3,656	13.1 %	9.4 %	13	3,698	12.1 %	9.5 %	-1	42	-1.0 %	0.1 %	
Community Care	13	1,458	12.1 %	3.7 %	8	1,821	7.5 %	4.7 %	-5	363	-4.6 %	1.0 %	
Jail	11	1,074	10.3 %	2.7 %	3	344	2.8 %	0.9 %	-8	-730	-7.5 %	-1.8 %	
Residential Treatment	10	1,141	9.3 %	2.9 %	7	1,110	6.5 %	2.8 %	-3	-31	-2.8 %	-0.1 %	
Foster Home Relative	9	2,232	8.4 %	5.7 %	6	1,690	5.6 %	4.3 %	-3	-542	-2.8 %	-1.4 %	
Homeless	8	1,166	7.5 %	3.0 %	4	672	3.7 %	1.7 %	-4	-494	-3.8 %	-1.3 %	
Congregate Placement	8	911	7.5 %	2.3 %	19	4,265	17.8 %	10.9 %	11	3,354	10.3 %	8.6 %	
Emergency Shelter	7	783	6.5 %	2.0 %	4	747	3.7 %	1.9 %	-3	-36	-2.8 %	-0.1 %	
With Other Family	6	1,382	5.6 %	3.5 %	5	1,679	4.7 %	4.3 %	-1	297	-0.9 %	0.8 %	
Medical Hospital	6	104	5.6 %	0.3 %	2	18	1.9 %	0.0 %	-4	-86	-3.7 %	-0.3 %	
Group Home 12-14	3	273	2.8 %	0.7 %	0	0	0.0 %	0.0 %	-3	-273	-2.8 %	-0.7 %	
Group Home 0-11	3	150	2.8 %	0.4 %	1	154	0.9 %	0.4 %	-2	4	-1.9 %	0.0 %	
Other Setting	2	10	1.9 %	0.0 %	1	1	0.9 %	0.0 %	-1	-9	-1.0 %	0.0 %	
Individual Placement	2	6	1.9 %	0.0 %	1	98	0.9 %	0.3 %	-1	92	-1.0 %	0.3 %	
Unknown Setting	1	30	0.9 %	0.1 %	1	72	0.9 %	0.2 %	0	42	0.0 %	0.1 %	
Single Room Occupancy	1	332	0.9 %	0.9 %	5	1,020	4.7 %	2.6 %	4	688	3.8 %	1.7 %	
STRTP	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	
State Psychiatric	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	
Prison	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	
Nursing Psychiatric	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	
Nursing Physical	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	
None Listed	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	
Juvenile Hall / Camp	0	0	0.0 %	0.0 %	1	78	0.9 %	0.2 %	1	78	0.9 %	0.2 %	
DJJ	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	
Community Treatment	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	
Assisted Living	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	0	0	0.0 %	0.0 %	

**for partners served at least one year and up to four years in program*

6.1 Mental Health and Substance Abuse Emergencies: Comparison of Most Recent Year in Partnership to Year before Partnership*

7/1/2019 to 6/30/2020

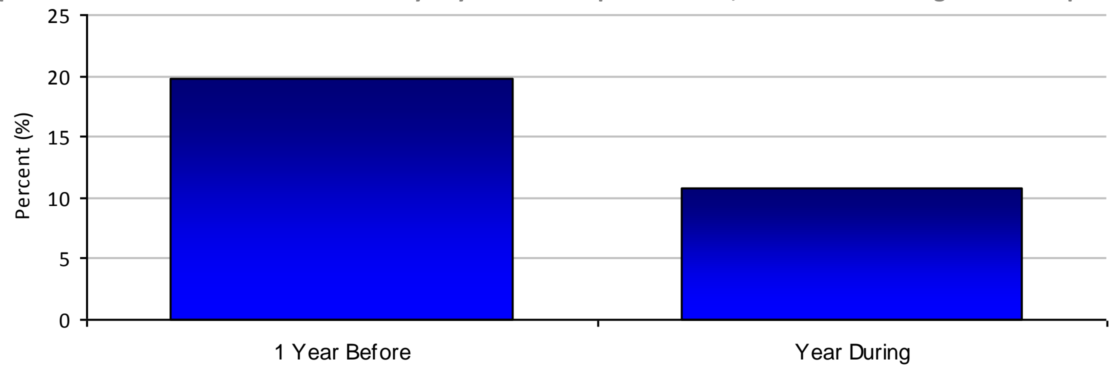


Partners	Timeframe	Partners with Events		Number of Events	Change in Events
111	1 Year Before	41	36.9 %	82	
	Year During	11	9.9 %	19	-63

**for partners served at least one year and up to five years in program*

6.2 Psychiatric Hospitalization Days: Comparison of Most Recent Year in Partnership to Year before Partnership*

7/1/2019 to 6/30/2020

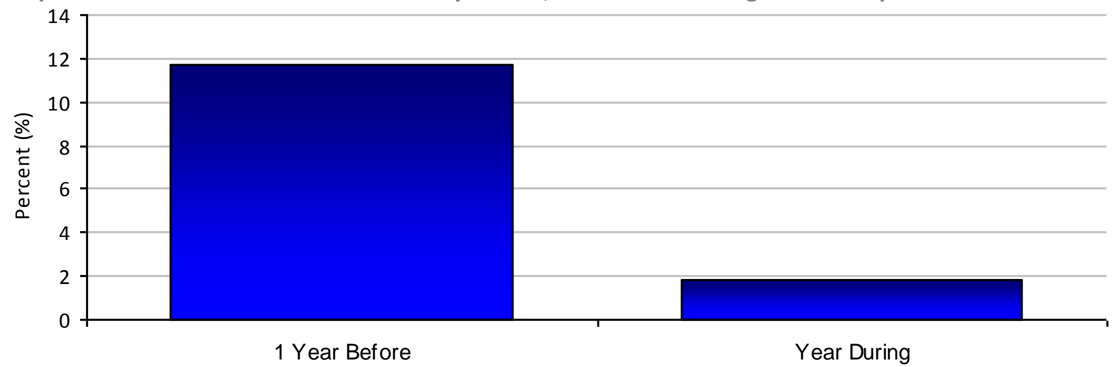


Partners	Timeframe	Partners with Events		Number of Days	Change in Days
111	1 Year Before	22	19.8 %	675	
	Year During	12	10.8 %	871	196

**for partners served at least one year and up to five years in program*

7.1 Arrests: Comparison of Most Recent Year in Partnership to Year before Partnership*

7/1/2019 to 6/30/2020

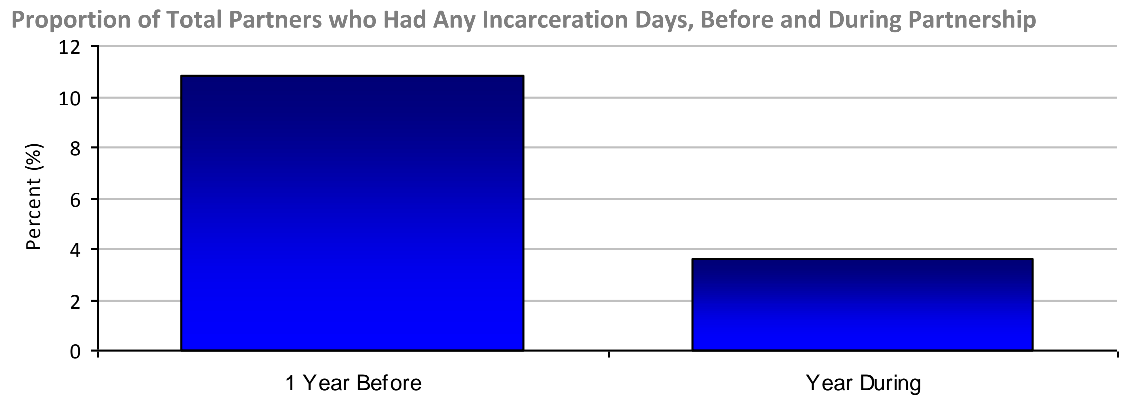


Partners	Timeframe	Partners with Events		Number of Events	Change in Events
111	1 Year Before	13	11.7 %	29	
	Year During	2	1.8 %	2	-27

for partners served at least one year and up to five years in program

7.2 Incarceration Days: Comparison of Most Recent Year in Partnership to Year before Partnership*

7/1/2019 to 6/30/2020

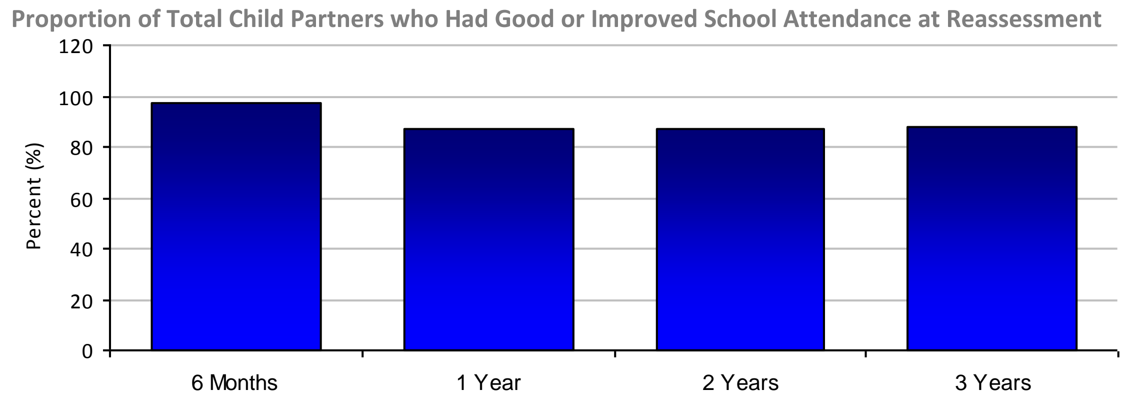


Partners	Timeframe	Partners with Events		Number of Days	Change in Days
111	1 Year Before	12	10.8 %	1252	**cannot be determined*
	Year During	4	3.6 %		**cannot be determined*

**for partners served at least one year and up to five years in program*

8.1 Children's Education: Comparison of Select Quarterly Assessments to PAF*

7/1/2019 to 6/30/2020



Total Partners			Partners Assessed	Had Good or Improved Attendance
102	served @	6 Months	67	97 %
83	served @	1 Year	45	87 %
33	served @	2 Years	15	87 %
12	served @	3 Years	8	88 %

**for partners served up to three years in program*